

APPLICATION OF THE
PRIMARY HEALTH CARE CONCEPT
TO TONGA

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BY

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FEBRUARY 1985.

TO MY FATHER, THE LATE
MR. SALES KAUTOKE

THIS THESIS CONTAINS NO MATERIAL WHICH
HAS BEEN ACCEPTED FOR THE AWARD OF ANY
OTHER HIGHER DEGREE OR GRADUATE DIPLOMA
IN ANY UNIVERSITY AND THAT, TO THE
BEST OF MY KNOWLEDGE AND BELIEF, THIS
THESIS CONTAINS NO MATERIAL PREVIOUSLY
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EXCEPT WHEN DUE REFERENCE IS MADE IN
THE TEXT OF THIS THESIS.

MR. B.S. KAUTOKE

FEBRUARY 1985.

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ABSTRACT

This thesis examines the primary health care concept, experiences gained in its development and argues that it can be applied to Tonga in a manner congruent to the local setting.

"Primary health care is a practical approach to making essential health care universally accessible to individuals and families in the community in an acceptable and affordable way with their full participation".¹ It also has social and sectoral dimensions requiring sectoral integration.

It will be shown that conventional health care based in hospitals and professionals, i.e. the secondary and upper levels of health care, are expensive and cannot expand in themselves alone to provide accessible essential health care to everyone in Tonga. The poor island agricultural economy of Tonga cannot support further expansion of this expensive and often unresponsive model, to make it accessible to the 76% of the population living in villages and scattered islands.

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1. WHO/UNICEF, "Primary Health Care. International Conference on Primary Health Care. Alma Ata, U.S.S.R., 6-12 September 1978," Geneva-New York (1978) pp. 4.

Primary health care is beneficial to Tonga in two major ways. Firstly it can make essential health care accessible to the 76% of the population living in villages and scattered islands. Secondly the major diseases which, if not treated, especially in children, result in death or debilitation, do not require sophisticated medicine and primary health care would reshape priorities to this end.

The use of paraprofessionals (village health workers, traditional birth attendants, sanitation workers) would be a major resource in applying primary health care to Tonga, acting as front line workers. It has been found that they could take care of about 90% of conditions requiring medical treatment in peripheral areas. It will be explained that the biggest cause of morbidity and mortality in Tonga are the respiratory and diarrhoeal diseases. With more attention to early treatment and health education carried out by paraprofessionals, most would be considerably less harmful than at present.

Women make ideal volunteer paraprofessionals in Tonga and their "kautaha" or village women committees, could organise campaigns for immunisation, village sanitation and family planning, effectively. They

are very influential in the Tonga society especially in the extended family system, "kainga". Failures have occurred to health programmes that do not include women.

Traditional healing practices in Tonga are a significant aspect of health care and will be shown that proved useful elements such as birth attendants can be incorporated into the health care system at the primary level.

The effective application of the primary health care concept to Tonga requires significant re-structure of the Ministry of Health. Hospitals and all the services at the secondary and upper levels of health care are essential but should not be permitted to expand so as to provide the only source of essential health care to everyone in Tonga. The peripheral health care services using the primary health care approach is to be expanded. The whole health care system would be oriented mainly to providing support to the peripheral health services and complementing their action by means of easy and timely referral of cases and problems beyond their competence. This support includes technical supervision, training and provision of supplies.

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To maintain the clinical effectiveness of the present 33 number of doctors and allow primary health care to develop, doctors and other professionals should remain in the four hospitals and reduce their hold of the overall health care system. Subprofessionals (Health Officers or medical assistants) should be increased in order to have one for every 2000 population. Sub-professional is at the lowest echelon of the bureaucracy of the Ministry of Health and they provide the linkage to the paraprofessionals and the rest of the community. At the same time the community should be involved through those of paraprofessionals and "kautaha", for training and educating themselves about their own health.

The application of primary health care to Tonga will have far reaching consequences, not only within the health sector but also other sectors at the community level. Advance planning is important to overcome obstacles in order to allow its smooth application. Doctors and nurses who are the traditional providers of health care can be successfully influenced by involving them and be persuaded that they are not relinquishing medical functions but gaining health responsibilities. Resistance from

the public can be defused by discussions in communities and in the mass media along with practical examples of primary health care.

Considering the local setting of Tonga, it is more appropriate to retain the bureaucracy of the Ministry of Health but needs to be made more responsive to the people and prevent it from overcentralisation. This may be brought about by community development and politicisation, i.e. more involvement in decision making and sharing of resources for the effective application of primary health care to Tonga.

INTRODUCTION

Despite great efforts made by governments and other organisations in health development using the conventional systems, the gap between the "have" and "have not" of adequate health care is so wide both within a country and between developed and developing countries. The conventional health care has become intolerably expensive. The emphasis is upon medical therapeutic services and has led to huge hospitalisation costs and preoccupation with technological intervention in disease processes.

Imitating their Western colleagues using the conventional model, developing countries have built their health infrastructure around hospitals and medical professions. Their limited resources have been hopelessly inadequate to the task. " More seriously, this model has led to a marked mal-distribution of limited effort, and in countries where population are located predominantly in rural areas (in contradiction to the urbanised West) expenditures in health have gone almost exclusively to support the bottomless pits which urban hospitals have become with resulting fatal neglect of huge rural population who have been deprived of even the basic sanitary and nutritional reforms which are now believed to have been crucial to success in

the highly developed countries".^{1.}

The great concern for adequate health coverage and accessibility to everyone, culminated in the emergence of the Primary Health Care Concept, which is a "practical approach to making essential health care universally accessible to individuals and families in the community in an acceptable and affordable way with their full participation".^{2.}

Primary health care also has social and sectoral dimensions requiring sectoral integration.^{3.}

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1. Douglas, R.M., "Primary Health Care and the declaration of Alma Ata", in "Primary Health Care. Report of a Workshop, 17th June, 1980". Australian Development Assistance Bureau, Canberra (1980), pp.6.
 2. WHO/UNICEF, "Primary Health Care, International Conference on Primary Health Care, Alma Ata, USSR, 6-12 September, 1978", Geneva, New York, (1978) pp.8
WHO.
 3. Elaboration of this definition and explanation of the primary health care concept are contained in chapter 3.

In April, 1979, the Tonga Government adopted for implementation the report of the International Conference on Primary Health Care held in Alma Ata, U.S.S.R., in September, 1978. That report states: "Governments have a responsibility for the health of their people which can be filled only by the provision of adequate health and social measures. A main social target of governments, international organisations and the whole World community in the coming decades should be the attainment by all people of the World by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice".

Tonga has been quite active in preaching the good news of primary health care at the international scene as shown from the following extract from the address to the Thirtieth World Health Assembly, May 1977, Geneva, made by Hon. Dr. S. Tapa, Minister of Health, Tonga, then President of the World Health Assembly:

"Our Organisation has already, and not without courage, shown the way to new concepts in health development. This presupposes a complete reappraisal and bold redistribution of health resources,

not only across the World but within each of the countries represented here to-day. Each country, according to its real needs, according to its possibilities and not by conservation, blind adoption or vain prestige, must plan and restructure its health system over a solid base of primary health care for all its citizens.

This means that in the region where I come from, indeed on the larger surface of this globe, we must, to begin with, develop our social and rural health services".^{4.}

Primary health care can be successfully implemented in Tonga but unfortunately it still remains inside partially implemented national development planning documents and has not left the conference room of the Tonga Ministry of Health. The main problem is that appropriate application of the concept in Tonga has not been devised, even though there are many existing potential factors in the Tongan society that could be mobilised and interwoven to form the network of primary health care for Tonga.

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4. World Health Organisation, "Thirtieth World Health Assembly", WHO Chronicle, Vol.31, (1977) p. 257.

Resources of the Tonga Ministry of Health are still heavily concentrated in Nuku'alofa. About 75% of the health budget is consumed by Vaiola Hospital, Nuku'alofa. Out of the 33 doctors, 20 are stationed at Nuku'alofa, 7 at outer stations and 6 on overseas training. People may be required to contribute labour and material to health projects but are not permitted to participate in health policy and planning decisions. The total operation of the health care system is totally left to the professions who are not oriented to work at the community level. 5.

There is a piece-meal approach to health need of the community level with emphasis on basic health care rather than primary health care. The health care system still heavily emphasises the conventional method as pointed out by Professor Davidson after a visit they made to Pacific island countries in 1980:

"The point I am making here is that the scarce resources available were being used in many traditional ways and in none of the countries that we visited

5. A good example of this problem using the case of nurses, can be found in Fillmore, H.E., and Leavy, M., "Assignment Report - 12 - 31 January, 1982, Tonga". WHO Regional office for the Western Pacific, Manila, (1982).

was there any evidence of attempt
to break away from the inherited
system other than in Papua New Guinea".⁶

This thesis, therefore, examines the primary health care concept, experiences gained in its development and argues that this concept can be applied to Tonga.

This is dealt with by first (Chapter 2) examining the major factors in the Tongan setting that are part and parcel of the health care system in Tonga. These are the physical, demographic, economic, social-cultural and political-administrative factors. The interaction of these factors set the standard of health care network in Tonga.

The next part (Chapter 3) examines the emergence of the primary health care concept and gives a definition of the concept as found in the literature. Based on this definition, the concept is then discussed in detail under four headings, namely, (i) resources for primary health care; (ii) community participation in primary health care; (iii) integrated development in primary

6. Davidson, L., "Report on a visit to study health care delivery in a number of Western Pacific islands", in Report of an expert group, "Special health problems of island developing and other specially disadvantaged countries", Commonwealth Secretariat, London, 1980, pp.83.

health care and (iv) organisation of the health care system for primary health care.

Chapter 4 discusses the application of the primary health care concept to Tonga. Health care in Tonga is explained first and followed by an examination of the (i) local resources for health care and their distribution. Emphasis is on underutilised resources, e.g. paraprofessionals, village women organisations and traditional medical practices; (ii) community participation in health care especially the development of a sense of community responsibility for their own health; (iii) the integrated approach in primary health care especially the integration of various sectors operating at the community level; and (iv) organisation of the system for primary health care.

Chapter 5 covers the consequences of the application of the primary health care concept and ways of overcoming the major obstacles. Chapter 6 concludes by summarising the arguments for applying primary health care to Tonga.

THE TONGAN SETTING

This chapter discusses the major factors in the Tongan setting that are part and parcel of the environment in which the health care system in Tonga operates. These are the physical, demographic, economic, social-cultural and political-administrative factors. The interaction of these factors set the standard of health care network in Tonga.

It is vital for health policy makers to be fully acquainted with these factors in order to be able to formulate health policies that are appropriate and specific to the Tongan setting.

Physical Factors

The Kingdom of Tonga is made up of 171 small islands, scattered over a sea area of some 360,000 square kilometers, from Teleki Tonga in the south to Niuafuou in the north, extending over a length of over 9,500 kilometers. Only thirty-six islands are inhabited. The rest of the islands are too small or too rough thus making them uninhabitable. The main island centres of population are Tongatapu island, Eua island, Lifuka island, Haapai, Vavau island and Niuafoou islands. The map of Tonga in Figure I gives a good picture of

the scattered nature of these islands. Table 1, page 9 shows the total land area and population of the five political districts of Tonga.

TABLE 1

Population Distribution and land area of the five political districts

Political District	Population	Per Cent Pop.	Area (km)
Tongatapu	57,411	63.3%	262
Vavau	15,068	16.7%	143
Haapai	10,792	12%	119
Eua	4,486	5%	87
Niuas	2,328	3%	38
Rest of Tonga (uninhab.)	-	-	31

Source: 1976 Population Census.

The scattered dispersal of the population over a wide array of numerous islands gives special difficulties for the health administration. The pockets of population in isolated islands are rather too small and is costly to provide adequate conventional health care to each one. National socio-economic developments have also been suffering the same dilemma and developments have, therefore,

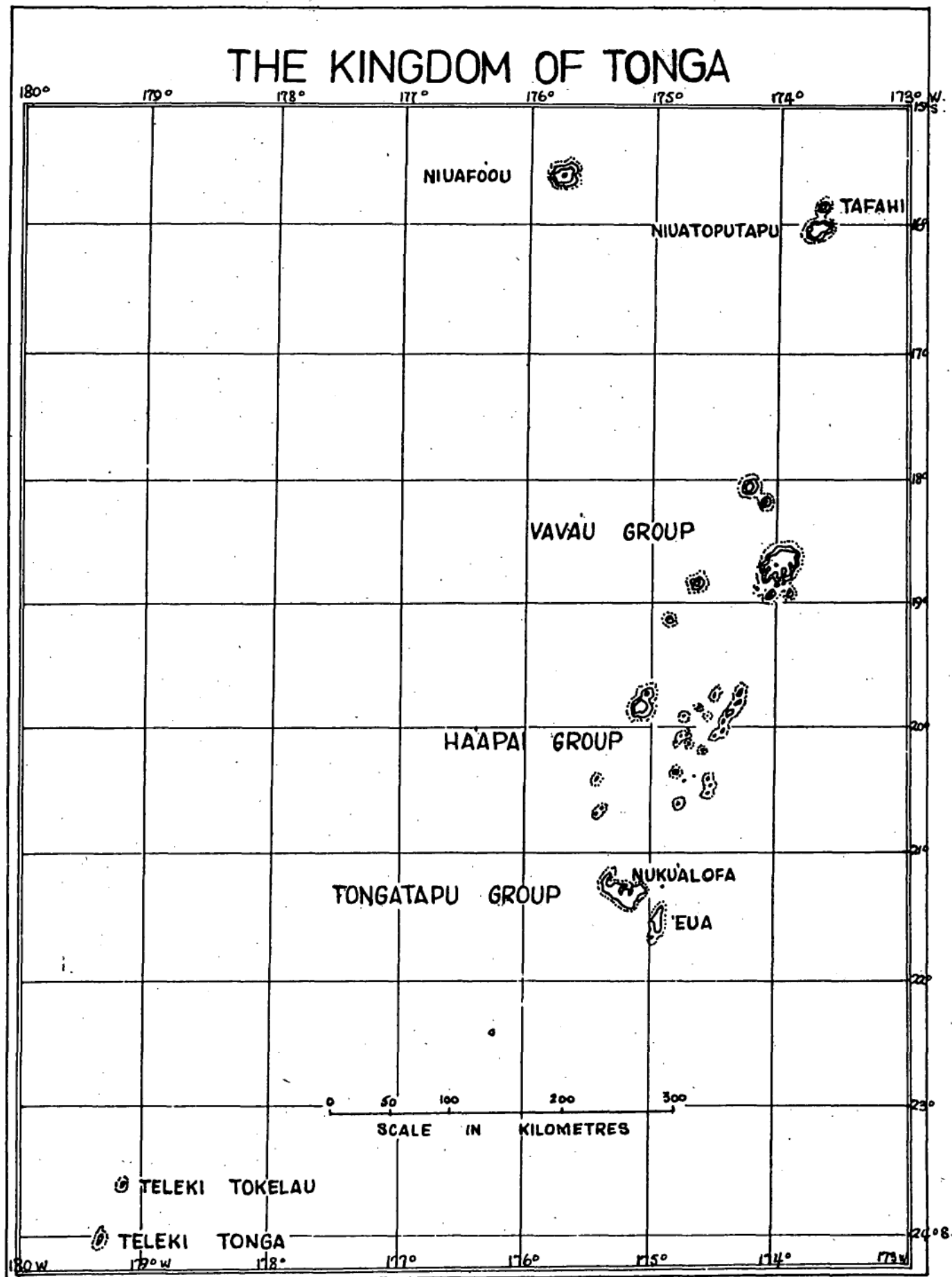


FIGURE 1

MAP OF THE KINGDOM OF TONGA

been restricted to Nukualofa,⁷ leaving the other islands in various levels of backwardness.

The task of the administration is not made easier by the reluctance of overseas trained health staff to be posted to isolated islands. These staff because they left Tonga straight after high school, came of age while overseas. Apart from their western training, they also acquire exotic tastes and values. The preference of these professional staff is to work in Nukualofa, the capital. When they are transferred by force to outer islands, they often behave as if alienated from the majority of the rural people. They are ill-equipped to work in a resource poor situation that they are unable to provide effective or responsive health care service.

The scattered nature of these communities also creates special problems with staff and programme supervision; staff consultation and communication; and referral of patients to more specialised medical institutions. Existing transportation and communication between islands are poor, expensive and time consuming.

7. A good account of these inequalities can be found in Sevele, F.V. "Regional inequalities in socio-economic development in Tonga: A preliminary study", unpublished Ph.D. Thesis, University of Canterbury, May 1973

Demographic factors

The most recent population census, which was conducted in November 1976, reported a total population of 90,085. The mid 1983 population was estimated at 111,869. Table 2, shows the growth and sex structure of the population.

After rising at an annual average rate in excess of 3% between the 1956 and 1966 census, there was a marked decline in the growth of population in the ten-year period between 1966 and 1976. It is believed that this was due to the continuation of a fall in the rate of natural increase and substantial outward migration. However it is not possible to quantify accurately the effect of these factors due to the unreliability of vital statistics and incomplete data on migration.

TABLE 2

Growth and Structure of the Population

	Population at Census Date		
	1956	1966	1976
Males	28,938	39,837	46,036
Females	27,900	37,592	44,049
Total	56,838	77,429	90,085
Av. Ann.			
Rate of increase	3.05%	3.14%	1.52%

Source: Tonga Government, "Kingdom of Tonga, Statistical Abstract 1983" Statistics Dept., Nukualofa, (1983)-(b), pp.7

The Ministry of Health reported the birth rate for 1982 to be 26.3 per 1000 while infant mortality rate to be 22.4. Infant mortality in Tonga is in a much better standard than its neighbouring countries such as Fiji (35), Samoa (35), Papua New Guinea (73) and the Solomon Islands (46 per 1,000), but inadequate when compared with developed countries.

The population of Tonga is of a young age structure, with just over 44% under 15 years of age at the time of the 1976 census. At the other end of the age scale, only 3.3% were over 65. The health care of a young population is easier and less expensive, for its health care pattern is more preventive services and early treatment. The health care of an old age population is more like expensive maintenance of old deteriorating vehicles, without spare parts.

A significant factor has been the steady internal migration to Tongatapu island and particularly to the capital, Nukualofa. By 1976, 64% of the population lived in Tongatapu, with 16% in the Nukualofa area and predominantly young people.

This movement appears to be "motivated by a search for wage labour, by the pull of the social and educational facilities of Nukualofa, by land pressures in areas like the Haapai group and by a desire on the part of younger

people to be free of the constraints of traditional village life".⁸ The concentration of better health services in Nukualofa cannot be discarded as one of the attracting factors.

Despite the migration to Nukualofa, the population of villages is still very high. Seventy-six per cent of the population live in villages of which 57 are located in Tongatapu, 14 in Eua, 27 in Haapai, 37 in Vavau and 12 in the Niuas. In terms of access to basic goods and services, villages located in Tongatapu are better provided for, than villages in the rest of the Kingdom.

The number of Tongans who have migrated to overseas countries is significant and has been estimated by some to be over 40,000.⁹ This figure is doubtful for it can be very much higher than this. The major movements are to New Zealand, U.S.A. and Australia.

8. Baker, J.R. "Contemporary Tonga - An Economic Survey" in "Friendly Islands. A History of Tonga, (ed.)

Rutherford, N., Melbourne (1977, pp.231.

9. Marcus, G. in 1981 estimated that 30,000 Tongans residing in various overseas locales and Kumar, V., in 1984 came up with a new figure of 40,000.

These migrants enter the host countries through various doors both legal and illegal. The Central Planning Department¹⁰ estimated that the annual legal net out-migrants per year in the interval 1976-79 was approximately 600 permanent migrants, which includes returning people at a rate of 30%, and 500 short term migrants. Of these persons:-

- about 40% are female
- the age group 20-49 year represents the majority totalling about 70% of all migrants.

The effect of this pattern of migration will affect fertility and the manpower structure of the country. This trend is likely to continue with the greater exposure to westernisation and expectations surpassing the confines of an island agricultural economy.

Manpower comprises that part of the population which is between the ages 15 through 65 years. It is divided into the labour force (i.e. those employed and those actively looking for employment) and that portion which is outside the labour force.

10. Tonga Government, "Kingdom of Tonga. Fourth Five Year Development Plan 1980-1985," Central Planning Department, Nukualofa, (1980) pp.117.

In 1976,¹¹ 23.8% of the population, totalling 21,400 were in the labour force. The population of working-age outside the labour force included 19,300 females (19.3%) mainly housewives, and 5,000 males (5%), mainly students. This big number of unemployed women is a greater potential that could be successfully tapped for health care services, e.g. health campaigns and health paraprofessionals.

The adult literacy rate has reached 78% and is due to great advances in education at the primary and secondary levels of general education. Primary education has been compulsory since 1876. The 1974 Education Act requires that every child between the ages of 6 and 14 living within reach of a government primary school shall attend that school or a similar school unless the child has completed six years of primary education. With respect to women alone, Faletau reported in a recent survey she made, that 95% of the women surveyed had attended primary education or higher.¹²

11. Tonga Government (1980) op.cit., pp.109.

12. Faletau, M., "Changing roles for Tonga's women", in Pacific Perspectives, Vol.11, No. 2, pp.52.

Economic Factors

Other than land, Tonga has very limited resources. After oil seepages were first discovered in 1968 on the islands of Eua and Tongatapu, oil exploration has been carried out few times but no positive signs of marketable oil resources were found. Attention had later been directed to underseas mineral wealth in the seas around Tonga and exploration is still going on.

Until any mineral finding of marketable value is made, agriculture still remains as the mainstay of the economy. It is estimated that 70% of the population depend primarily upon agriculture for their livelihood. Agricultural production is the predominant activity in the economy, consisting principally of the growing of crops for local consumption. Coconut-based products, bananas, vanilla, root crops and other fruits and vegetables make up most of the country's exports. The dominance of agriculture in the economy is likely to continue as there is significant potential for expansion of production of agro-based industries.

Parental poverty affects health in several ways. Many parents are so poor that they cannot afford to provide adequate housing, food, clothes and proper sanitary facilities for their family. The ability to meet this commitment is lessened by the claims of other institutions like the churches, village community, extended family and

government. It is clear that any hope of further health development will mean a great deal of sacrifice on every Tongan's part. Parental poverty also affects the taxation level, the returns from taxation limiting the available government expenditure, including health expenditure. Not much can be expected from an island agricultural economy with a per capita GNP of only US\$499 and still in transition from subsistence to market economy.

Social-cultural factors

Social stratification is very marked in Tongan society. The head of the Tongan society is the Royal Family. They are accorded the highest form of respect and honour. In many ways the wishes of members of the Royal Family are far more binding on Tongans than the law of the land. The Ministry of Health had often used this influence of members of the Royal Family to mobilise various health programmes but it is still on a minimum basis. Members of the Royal Family dearly feel this is a responsibility and they would put in more time and effort if requested by the Ministry of Health.

Next to the Royal Family in the social order are the nobles (nopele). There are 33 noble titles. They own hereditary estates, and villages within their estates belong to them in the Tongan custom although not legally.

The villagers are their people. The relationship between a noble and his villagers is one of reciprocity. The villagers contribute material, finance and labour. The noble helps the villagers with land allocation, mobilisation of community works and advice. Under the nobles are the "matapule", representatives of the nobles. The "matapule" represent the villagers when approaching the noble. He is, in many ways, treated as a minor chief, especially if he is of aristocratic blood.

The influence of the noble is fast eroding away due to increasing individualistic ownership of land. When one registers his piece of land, he loses touch with the noble. Villagers also claim unfair treatment by the noble and one-way flow of their reciprocity relationship in favour of the noble alone. Nobles are also rather unapproachable.

The role of the "matapule" as representative and speaker is still very influential because of their mastery of the etiquette of communication in the Tongan culture. The "matapule" has been frequently used to play the role of a reconciliator in village conflicts and speaker in public gatherings. This influence of the "matapule" could be exploited for purposes of health programmes in villages.

At the bottom of the social ladder are the commoners, roughly more than 90% of the population. The society of modern Tonga allows upward mobility for the commoners

through education, government bureaucracy, church hierarchy and accumulation of wealth.

Social stratification makes the Tongan population very status conscious with complexities in communication. A Tongan who is not sensitive to the etiquette of communication in Tonga frequently offends the listener especially in public places. This is often the case with new graduates working with the Ministry of Health.

Another significant aspect of the Tongan society is the extended family system of "kainga". The smallest unit in a Tongan community is the household, which consists of the nuclear family members, one or two grandparents and one or two single adult relatives. Combining the various households is the network of "kainga". Included in this network of extended family system are descendants of same ancestor, a cognate kin group. The "kainga" is a rather loose and amorphous group. Each Tongan has his own "kainga" for it is a group which has meaning only to a particular individual.

13

The "Kainga" is the same as what Maude refers to as the "kinsfolk", which now includes anyone with whom he can trace cognatic kinship but in practice the group which

13. Maude, A. "Population, Land and Livelihood in Tonga",
Ph.D. Thesis, Australian National University,
Canberra, 1965, p.53.

depends on such considerations as the closeness of relationship, residence, economic interest and rank.

Co-operation within the "kainga" is pretty strong for the sense of trust is high. Each member has his rights and duties to each and every other member of his "kainga". When help is needed by a member of the "kainga" the "kainga" members who live close by come to help without being asked. In many ways, the "kainga" serves as a social security system within Tongan society. As long as a Tongan has a "kainga" he is sure to be able to get food, clothing and a place to sleep no matter how poor he may be. When a patient is admitted to hospital, the several attendants who accompany him, usually have no problem in finding a "kainga's" home close to hospital where they can stay. When a patient is referred for further medical management overseas, the "kainga" is usually responsible for raising the financial cost required.

Christianity has a profound influence in the Tongan society. All Tongans are members of some church, attend church regularly and are loyal to all church activities, especially the annual church fund raising.

The church buildings and halls are one of the outstanding features of a village. A village of about 200 people may have four church buildings belonging to the four major churches found in Tonga. About 90% of the secondary

schools are run by the churches as are several dispensaries, pharmacies and health education programmes.

The "faifekau", or priest, play very important roles in village life, being much respected and honoured, often at the level of a "matapule" or noble. The "faifekau" influences people through sermons from the pulpit and also individual advice on various aspects of life ranging from economic to social. They understand life and forces that control and mobilise activities in villages under their care. The "faifekau" is therefore one of the most influential leaders in the village.

The rivalry between groups in villages and the religious fervour of the Tongans make them good donors to the "misinale", the annual church fund-raising. This, however, is not the case when it comes to paying taxes to government, although taxes are usually far less than the amount the average Tongan gives to his church annually. There is no real prestige attached to paying taxes and no stigma to not paying them. People often sell many of their badly needed goods so they can put more money into the "misinale", a co-operative spirit lacking with regard to government programmes and taxation.

It is important to discuss here the concept of health in the Tongan society. The Tongan people have the same term for "health" as for "life", that is, "Moui".

Tongans therefore visualise "health" as in complete "social and physical" well being as in the total and integrated elements of "life".

The Catholic church in Tonga preaches the development of the "total man" and argues that human life has five facets; they are, physical, intellectual, emotional, spiritual and community.¹⁴ Dr. S.T. Puloka, Head of the Public Health Division, Ministry of Health,¹⁵ informed the writer that the Catholic church's interpretation of "life" is the same as the Tongan society's concept of "health".

The Ministry of Health translates the word "health" as "moui lelei", i.e. "good health or good life". Dr. Puloka said that this is an old translation derived from the Tongan welcome greetings of "malo-e moui" and "malo-e lelei", which literally means "I am glad that you are full of life" and "I am glad that you are well", respectively .

14. Culling, B.F., "Education in Christian Living for Adults. A Catholic Church Programme in Tonga", paper presented at the South Pacific Commission's Regional meeting to discuss a Pacific approach to rural development, Noumea 1979, p.2.

15. Puloka, S.T., Head of Public Health Division, Tonga - a conversation with him in July, 1982.

The Tongan society's interpretation of "health" as "life" or the "total well beings of human being", very much help the development of the Tongan attitude toward "primary health care", where health is visualised not in the narrow clinical sense but integrated with all the factors that affect or promote health.

Administrative and Political factors

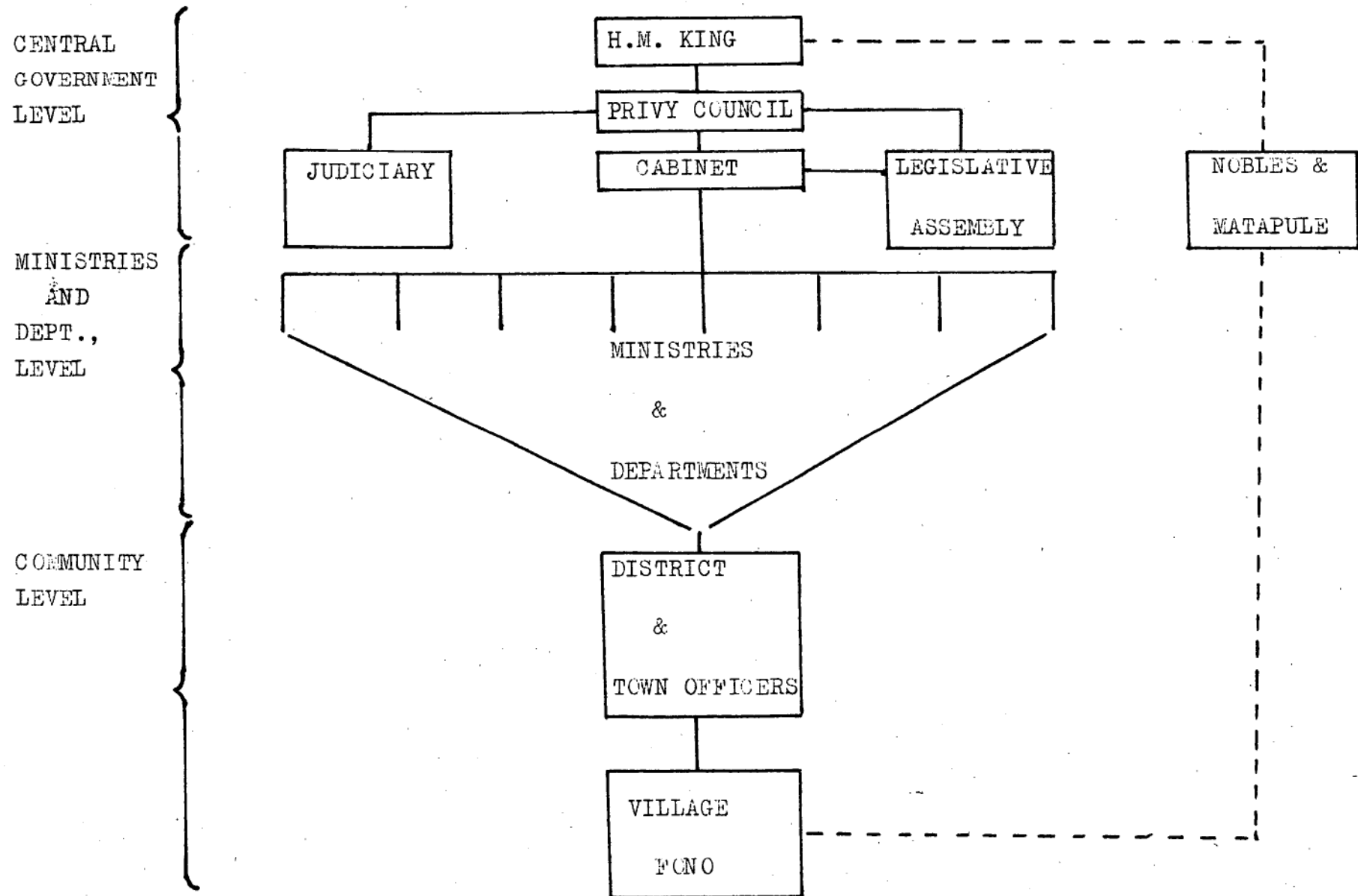
Tonga is a kingdom constituted under a Monarch whose heirs are entitled under the laws to perpetual succession to the throne. The constitution was adopted in 1875 and the country is known for its political stability. For seventy years to 1970 the kingdom was protected by the Government of the United Kingdom.

The government is divided into three bodies, the Privy Council and Cabinet, Legislative Assembly and Judiciary (refer to Fig. II). The Privy Council is composed of the members of Cabinet and others whom the King shall see fit to call to his council. The Privy Councillors assist the King in the discharge of his functions and is the highest executive authority in the kingdom.

Cabinet consists of the Prime Minister, as chairman, Ministers of the Crown and the two Governors of Vavau and Haapai. They are all appointed by the King and usually hold their respective offices until they retire from the civil service. Cabinet meets whenever it is

FIGURE II

ORGANISATION OF THE TONGA GOVERNMENT



considered necessary, and now it is every week. The Cabinet is to all intents and purposes the Government of Tonga. It appoints and disciplines members of the civil service, control all government properties and considers questions of land leases among others. The motions passed by the Legislative Assembly are considered by Cabinet before they become active and Cabinet has the right to refuse to act on any motions passed by the Legislative Assembly. It also considers requests and petitions from various ministries and its decision is final in such cases.

The Legislative Assembly meets once a year for a period of about four months. Its members are the Speaker, who is appointed by the King from the nine representatives of the nobles, all members of Cabinet and nine representatives of the people. The nine representatives of the nobles are selected by their peers, of which there are 33 noble titles in Tonga. The nine representatives of the people are elected by the people.

Party politic does not exist in Tonga. The top three in Tongatapu, top two in each of Haapai and Vavau groups and the topmost one in each of Eua and Niua, become elected representatives of the people and all enter as individual representatives. Elections of the nobles' and people's representatives are held once in every three years.

The administration of government is divided amongst eight Ministers of the Crown whose functions are divided into (i) Prime Minister and Minister of Agriculture, Forestry and Fisheries and Minister of Marine; (ii) Deputy Prime Minister and Minister of Lands, Survey and Natural resources; (iii) Minister of Education, Works and Civil Aviation; (iv) Minister of Police and Prisons; (v) Minister of Labour, Commerce and Industries; (vi) Minister of Health; (vii) Minister of Foreign Affairs and Defence; and (viii) Minister of Finance.

As pointed out earlier, Ministers are appointed by the King and they are, therefore, accountable to the King first and secondly to Cabinet and the Legislative Assembly. Ministers may propose amendments to existing regulations and new acts if they wish, for approval by the Legislative Assembly.

Within a Ministry, the Minister is both the topmost politician and topmost administrator. Below him is a head of department to whom the Minister may delegate some of his authorities. Both the Minister and the Head of Department are permanent staff members. Ministers are given the same respect as nobles and their influence both inside and outside government is one of the strongest in Tonga.

At the community level, Ministries depend to quite an extent on District and Town officers to explain government policies, plans and regulations to the people. These officers are also instrumental in getting people's support for government programmes. These programmes may be the erection of a health centre, digging wells or building a school. The people's assistance may be through labour, material contribution or finance. They are the only political leaders in the community, though there are many other kinds of social and ceremonial leaders. District and Town officers with initiative and skills in organisation are more effective in co-ordinating implementation of programmes in their area and are able to tap available resources both locally and from government. Health Officials can assist District and Town officers in this way.

District and Town officers were formerly appointed by the Prime Minister. Recently a deliberate official move had been made to encourage and develop local participation by making these offices elective.

A significant traditional institution at the community level is the "Fono". This is a gathering of all adults in the village called by a noble of a village, Town officer or District officer. These gatherings are used as means of informing the villages of government policies and

programmes or matters of local interest. Though discussions do take place in "Fono", most meetings of this sort are usually for dissemination of government orders and policies. The "fono" is an excellent medium of communication at the village level which should be used more fully than at present.

National pride in Tonga is strong and so too is pride in local or village achievements. This can be seen in the villagers' "aahi" (presentation for inspection of goods prepared during the year) and exchange of goods between women village committees. Each village always wants to outdo the other, if not on this year's "aahi", the one next year. Health officials could make use of this pride in village activities to implement health campaigns in villages.

CHAPTER 3

THE PRIMARY HEALTH CARE CONCEPT

This chapter examines why and how the primary health care concept emerged. A definition of the concept is then given along with the major components of the principle of primary health care, which takes into account the experiences gained since it was first formulated. Using this definition and explanation this chapter will then continue by examining the concept under four headings, namely, (i) resources for primary health care; (ii) community participation in primary health care; (iii) integrated development in primary health care; and (iv) organisation of the health care system for primary health care.

Emergence of the primary health care concept.

The primary health care approach arose in response to a mismatching of the allocation of resources for health improvement and health needs. The disadvantaged sections of the population, which make up the majority and usually reside in rural areas suffer poor health. However, they receive little health care service or the benefits of the health promoting measures, whilst more prosperous sections of the population, which make up the elite minority have at their disposal a relatively

developed health care service, including expensive hospitals that consume most of the health budget.

This disparity is most pressing in developing countries where the population is predominantly rural. The United Nation's figures for 1975 ¹⁶ show that in the developed countries, the rural population comprises about 30% on average of the total, whereas it exceeds 70% in the developing countries. At the same time people in many rural districts are isolated and dispersed so that public services of the conventional type, including health services, are difficult and expensive to provide. Isolation of a community from the outside world is bound to hamper communication and put a brake on the improvement of living standards. What is more, dispersal and isolation add to the difficulties of educating, training and employing expensive qualified manpower.

The health services in developing countries have been very much clinically oriented, based in hospitals of urban areas and staffed by professional people with western education and are organised under a big bureaucracy.

16. United Nations, "Trends and Prospects in Urban and Rural Populations: 1950 - 2,000", April(1975), ESR/P/W, New York.

The rural areas where the majority of the developing countries' population reside, are left mostly inaccessible to any appropriate health care.

This problem is not unique to Tonga for it also affects other developing countries. Djukanovic and (17) Mach reported in 1981 that in Burma, modern health care is readily available to not more than a third of the population and less than 10% of the villages have direct access to such care; some 70% of the health ministry's current expenditure goes to hospitals, while about 23% is allocated to health care at the peripheral area. In Democratic Yemen about 16% of the rural population has reasonable access to health units; nearly a half of the qualified doctors and nurses and hospital beds are located in Aden, the capital city containing some 15% of the population.

Analysis made on levels and trends in infant and general mortality shows that despite the fall registered in many developing countries over the last two or three decades, the pace and extent of progress achieved seem particularly inadequate. The rate of infant and

17. Djukanovic, V. and Mach, E.P., "Alternative approaches to meeting basic health needs in developing countries", UNICEF/WHO, Geneva, (1975) pp. 14.

general mortality for developing countries is still far behind developed countries and predominantly due to communicable diseases.¹⁸ As it will be explained further in chapter 4, Tonga suffers the same burden. Infant mortality rate for Tonga in 1982 is 22.4 per 1000 live births while Australia has gone down to 10.6 and New Zealand to 16. The general cause of mortality in Tonga is mostly due to respiratory and diarrhoeal diseases.

The disparity in health care between developed and developing countries can also be shown in the level of life expectancy at birth, which ranges from 25 years in Gabon to 72 years in Sweden. (Refer to Table 3). Tonga suffers the same fate with a life expectancy as low as 58 years only.

18. See Djukanovic and Mach (1975) op.cit, pp.13-14.

TABLE 3

Comparison of life expectancy at birth between
developed and developing countries.

LIFE EXPECTANCY AT BIRTH	
Country	Leb-Life Expectancy at Birth
Gabon	25 years
Nigeria	37 "
India	42 "
Mexico	58 "
Japan	68 "
U.S.A.	67 "
Sweden	72 "

Source: Conde, J. et al, "Integrated approach to
rural development, health and population",
Development Centre of the Organisation
for Economic Co-operation and Development,
(1979) p. 48.

One of the legacies left by various colonial powers is a system of health services and training curricula which are largely carbon copies of those of the metropolitan countries without consideration of the differences of the situations. Britain's independence gift to Uganda was a \$6 million, 1,000 bed hospital in the capital, Kampala. The daily cost per patient is the same as a bed in the most expensive hotel in the city. More importantly, the hospital consumes an incredible 19 30 to 60% of the total health allocation for the country. Lome hospital in West Africa has such luxury in contrast to general African buildings that future graduates are not likely to work in anything less luxurious.²⁰ To graduates trained only in such places, the "best" health care is that provided by the teaching of clinical specialities, and if they cannot practise this type of medicine at home they emigrate and practice it abroad. The health services in many Third World countries show signs of repeating the same trend.

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19. King, M., "Zambia in a doctor dilemma: can the cost of Lusaka's grandiose new teaching hospital be justified?". Economy, April (1968).
20. Dumont, R., "False start in Africa", Sphere Book Ltd., in association with Andre Deutsch Ltd., London, (1968).

History and experience show that conventional health services organised along "western" or developed countries' model based on centralised institutional lines, are unlikely to expand to meet the basic health needs of all people. The human, physical and financial resources required would be too excessive and the necessary sensitivity to the special problems of under-privileged and neglected communities would rarely be attained.

These dissatisfactions with accomplishments made using the conventional health care model surfaced the new model of primary health care. It has not been "invented" "but of the blue" but emerged from a long line of ideas developed gradually with reevaluation of existing approaches and assimilation of innovative experiences. The active exchanges of information among countries and interest shown by WHO and UNICEF heralded the need for an international meeting on primary health care.

In September 1978, an international conference on primary health care which was jointly convened by the World Health Organisation and the United Nations Children's Fund, was held in Alma Ata, in the U.S.S.R. There were delegations from one hundred and thirty four governments (including Tonga) and representatives from sixty seven United Nations Organisations, specialised agencies and non-governmental organisations. This conference adopted

the "Primary Health Care Approach" as a health care strategy to be developed through collaboration with governments. The conference promoted its acceptance and implementation so that all the people of this earth could achieve an acceptable level of health care.

Definition of Primary Health Care

²¹
Ross-Smith indicated that one of the particular problems involved in the provision of primary health care in island states of the South Pacific relates to widespread misunderstanding or lack of full understanding of the primary health care concept. I would therefore like to give here a definition of primary health care as found in the literature.

Before defining primary health care; what is "health?". It is rare to find a satisfactory and operational definition of health. The reason is that it is difficult to measure health; the lack of health or the state of well-being cannot be defined and measured directly or in absolute way. We know that bad health implies excessive mortality

21. Ross-Smith, C., "Primary Health Care in Island States", in "Primary Health Care, Report of a Workshop, 14th June 1980", Australian Development Assistance Bureau, Canberra (1980) pp. 35.

and morbidity in population or sub-population, e.g. children from 0-5 years old. The WHO has proposed a wide definition capable of justifying a consistent socio-economic policy:

"Health is a complete state of physical, mental and sociological well-being".

This definition does not raise any difficulty when it comes to understanding the integrated approach to health and socio-economic development. The economic, social and medical implications of well-being are all embodied in that content. The Tongan concept of "Moui" (health), is in line with this definition.

The best accepted definition of primary health care in the literature is that of the Alma Ata conference. It defines primary health care as "... essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford. It forms an integral part both of the country's health system of which it is the nucleus and

of the overall social and economic development of
the community".²²

Primary health care in essence "addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services accordingly. Since these services reflect and evolve from the economic conditions and social values of the country and its communities, they will vary by country and community, but will include at least: promotion of proper nutrition and an adequate supply of safe water; basic sanitation, maternal and child care, including family planning; immunisation against the major infectious diseases; prevention and control of locally endemic diseases; education concerning prevailing health problems and the method of preventing and controlling them; and appropriate treatment for common diseases and injuries".²³

22. WHO/UNICEF (1978) op.cit. pp.2

23. Ibid pp.2

The following are components of the principles of primary health care, which take into account the experiences gained since the principles were first formulated:-

- "- Health has multiple relationship with other aspects of development, and therefore, the activities of all sectors involved in the development need to be fully integrated.
- To ensure that adequate resources are available to communities when needed, firm national will and policies in support of primary health care approach are required along with resource allocation mechanisms that complement community efforts at the appropriate time.
- Communities need to be involved from the beginning in the planning and implementation of the national primary health care programme as well as of local primary health activities, so as to ensure that the programme and its activities meet the local needs and priorities, become shaped around the people's life styles and patterns, and promote community self reliance with respect to meaningful development.

- Primary health care activities require full utilisation of available community resources, especially those which have hitherto remained untapped and unrecognised.
- The health care component of the primary health care programme lays stress on:
 - (i) preventive measures; (ii) meeting health care needs of high-risk groups, such as mothers and children; (iii) health and nutrition education; and
 - (iv) utilisation of allopathic and traditional medical and health technology appropriate at community level.
- Health interventions are undertaken at community level by appropriately trained workers who, when possible, should be selected by the community.

- To ensure that the operational needs of community health care are met, other echelons of the health system are required to provide technical, logistic, and referral support.²⁴

Based on the above definition and explanation, this chapter continues by examining the following major elements of the primary health care concept:-

- Resources for primary health care;
- Community participation in primary health care.
- Integrated development in primary health care; and
- Organisation of the health care system for primary health care.

24. UNICEF/WHO., Joint Committee on health policy,

"Community involvement in primary health care:

A study of the process of community activation and continued participation", WHO, Geneva, (1977) pp.8

Resources for primary health care

The issues here are adequacy and equitable distribution of resources for health services; non-utilisation of potential community resources and search for and perfection of appropriate technology.

The scarcity of resources affects all parts of the health delivery system. It first shows itself at the national level, both in the routine allocation of yearly budgets to the various sectors of the economy and in the distribution of funds to authorities responsible for national development plan.

Though felt throughout the health system, the shortage of financial resources affects the larger, needier rural population more than the city dwellers. The shortage and maldistribution of human resources are just as striking. The distribution of professional personnel within developing countries is always almost inversely proportional to the distribution of the people.

R.A. Smith pointed out that "national commitment is absolutely essential for the development of support for a primary health care action strategy, for the mobilisation of resources, and co-ordination within and between the various sectors concerned".²⁵

25. Smith, R.A., "Primary Health Care - rhetoric or reality", World Health Forum, Vol.3, No.1, (1982), p.33.

Primary Health Care programme components brought together through a political mandate will increase the potential for permanent institutions, through adequate and equitable allocation of resources.

Shortage of resources is often coupled with ignorance of untapped resources within the community.

"The reasons for this differ from culture to culture and from situation to situation. In many cases it reflects such factors as the attitudes of health personnel, disregard of traditional systems and personnel, insufficient awareness of the need for community knowledge and involvement...".²⁶

With better community participation developed on the sense of responsibility for their own health, the people of the community could be easily generated to contribute their service, time, materials and supplies for the health programmes. A lot of indigenous systems providing health care could be tapped and they include - traditional birth attendants, midwives, bone-setters, traditional healers, etc.,

26. Djukanovic and Mach (1975), op.cit. pp.11

Some of them could be further developed with some education and be reclassified as primary health workers (paraprofessionals).

The term paraprofessional was coined by the Cornell Rural Development Committee²⁷, for academic purposes. This committee defined paraprofessionals generally as "workers with (i) no more than 12 months of pre-service or technical school training; (ii) who have direct service contact with rural dwellers; (iii) who play a semi-autonomous role in making day-to-day judgments and decisions; (iv) while operating as part of an organised private or public sector agency; (v) the typical paraprofessional is likely to be indigenous to the service area and to have no more than primary school education".²⁸

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27. Esman, M.J., et al, "Paraprofessionals in rural development". Centre for International studies, Cornell University, New York (1980) p.6.
28. Colle R., et al, "Concept Paper: Paraprofessionals in rural development," Centre for International Studies, Cornell University, New York, (1979), p.9.

A paraprofessional is different from a subprofessional. A subprofessional has about two years training; usually runs a health centre for a group of villages and usually supervises paraprofessionals. Subprofessionals are usually responsible to a qualified doctor. Barefoot doctors, medical assistants, health officers and health technicians working in the community level belong to the category of subprofessional. The paraprofessionals (village health workers, health aids, health -post worker, birth attendants) are the front line of the health care system and they make the first contact with individuals and families.

Paraprofessionals are usually recruited by the community and are given a few months basic training in preventive measures, health and nutrition education; meeting health care needs of high risk groups such as mothers and children and utilisation of minor medicine.

It has been found that paraprofessionals with limited training can provide many needed services to low income publics at a price which government and local public can afford. Properly trained and supervised paraprofessionals (primary health workers) can handle 90 to 95 per cent of the health problems in rural areas at a fraction of the cost of providing them by conventional

methods and organisations - even if the latter were available .²⁹ Therefore, with the availability of primary health care workers, probably only 5 per cent of the health cases need referral to professional doctors.

Primary health workers can claim a cultural affinity with their community, more appropriate to their needs than conventional services, and can promote the organisation and activation of local people to help provide their own service. Professionally qualified people, even when available, resist placement in rural areas; and when they are forced, they often behave alienated from the majority of the rural people and so ill-equipped to work in a resource-poor situation that they are unable to provide effective or responsive health care service.

Another significant potential resource in the community is traditional medicine. It is increasingly appearing and accepted in modern health care practice. The ayurvedic and Chinese medicine are the best known in the literature and have, in many aspects, been proved scientifically acceptable.

29. Esman, M.J., et al., (1980), op.cit. p. 4.

The following quotations from Bannerman are quite an eye-opener for the uninitiated in traditional medicine:

- " - A typical example is yoga, the practice of which is said to be helpful in counteracting the tension and stresses of modern life and treating mental disorders and neurosis....
- Since 1958, acupuncture has been used successfully to provide analgesia for both major and minor surgery. The fascinating discovery during the last decade of endogenous opioids (endorphins) in the mammalian brain coincided with a spate of eye-witness and anecdotal reports about the incredible feats of Chinese anaesthetics who, by the use of one single acupuncture needle, carried patients through ordeal of open-chest and brain surgery".

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30. Bannerman, R.H., "Traditional medicine in modern health care", World Health Forum, Vol.3, No.1, (1982) p.9-10.

International experts who studied primary health care experiences of China were quite impressed by the Chinese appropriate technology development and they reported:

"Every step in the development of the Chinese health care system in the past starting with mass mobilisation of prevention, followed by the development of co-operative health centres, the emergence of the 'barefoot doctors', the combination of traditional medicine and western medicine, the development of the commune and brigade network with its co-operative medical insurance schemes and of the whole supportive health care network at high levels, etc., - is a concrete and living expression of what constitutes appropriate technology". ³¹

There is no doubt that a lot of the traditional medicine used in Third World countries needs scientific validation through careful studies and evaluation, however.

31. WHO. "Primary health care - The Chinese experience Report of an interregional seminar", Geneva, (1983), pp. 74.

Community participation

Community participation in deciding policies, planning, implementation and controlling development programmes, is now widely accepted practice.

However, it is understood and interpreted in different ways in different countries, being greatly influenced by the overall political structure and the social and economic situation. For our purpose, the WHO/UNICEF definition of community participation is adequate:

"Community participation is the process by which individuals and families assume responsibility for their own health and welfare and for those of the community, and develop the capacity to contribute to their and the community's development".³²

This definition emphasises the sense of responsibility of members of the community and development of the capacity to contribute. Furthermore, people not only responsible for their own health but also the health

32. WHO/UNICEF (1978) op.cit. pp.20

of the community as a whole and share community burden equally. Earlier on people took it for granted that they have a right to good health but now it is both a right and a responsibility. It is this sense of responsibility that should be developed in the community's participation in health development.

The demands thrust upon the health care system are concerns both of the community member (consumer) and the health worker (supplier). Their viewpoints are not always identical and are sometimes in conflict. To a person from an island, for example, access to health care services may mean post a health staff to each island; to a health worker from the Ministry, it may mean a mobile clinic on a boat or a flying doctor moving around the island on scheduled time or on call.

To harmonise such conflicting viewpoints, it is important that the professional should have a continuing dialogue with the community. In this participatory approach, the community members will learn to identify their real health needs, to understand the national strategy for primary health care and to become involved and promote community action for health. The health worker at the same time acquires a better understanding of the community's feelings, the reasons for its views, the level of its aspirations and the pattern of its organisation.

This collaboration to identify the real health needs, requires deliberate organisation. "In India, the direct participation of basic communities in laying down the guidelines of their Second Plan was a failure... The main reasons were due to organisational problems. The community was not prepared for such collaboration, and certainly not in the form of direct democracy. When a peasant, who has hitherto been excluded from the information system and deprived of the benefit of basic education is asked what his choices are, in the field of health, he will probably answer: 'a hospital'. The hospital is then conceived of as representing a network of basic health services that are within the peasants' reach".³³

The contribution of individuals to the community may be in the form of ideas or initiatives; manpower such as digging of community wells; in monetary terms such as collections to build a health centre; or contributions in kind. "It follows that there must be a clearly defined relationship between the activities carried out by the government and those carried out by the people themselves. The relative contribution of each of the

33. Conde J. et al., "The Integrated approach to rural development, health and population", Development Centre of OECD, Paris (1979) p. 43.

two partners to health care activity as a whole should be determined by the political and socio-economic situation in each country".³⁴

Integrated development in primary health care

The artificial dichotomy between economic and social development has been discarded in favour of the view that the two are interdependent.

Therefore a combined attack on the economic and social roots of poverty was imperative. Recognition of the severe shortcomings of the conventional delivery systems led to the demand for a more "integrated" approach to development. These changes characterised the advent of the "Second Development Decade".

"Economic development means socio-economic development and health cannot be dissociated from socio-economic problems".³⁵

34. Djukanovic and Mach (1975), op.cit., pp. 16.

35. WHO (1977) op.cit., pp. 257.

Since primary health care is the key to attaining an acceptable level of health by all, it will help people to contribute to their own social and economic development. It follows that primary health care should be an integral part of the overall development of society. "Development here implies progressive improvements in the living conditions and quality of life enjoyed by society and shared by its members. It is a continuing process that takes place in all societies; few would claim that their development is complete".³⁶

Taylor and Hall showed "that using the general objective of improvement in the quality of life, optimum progress occurs when the major components of health, population and economic developments move forward together".³⁷

Among the major activities essential to socio-economic development, the large-scale, effective and relatively cheap primary health care programmes, have contributed and can continue to contribute substantially to human resources. Dramatic thrusts of economic development

36. WHO/UNICEF, (1978), op.cit. pp. 14.

37. Taylor, C.E. and Hall, M.F., "Health Population, and Economic Development", Science (1967), Vol. 157, p. 651.

have occurred when the amount of land available for cultivation or the size of the labour force has been sharply increased by removal of a health bottleneck through a programme such as malaria eradication.

Successful health programmes tend to produce qualitative improvements in general attitudes, such as recognition that change is possible, and the innovative thinking and action that cannot be expected of the sick and debilitated. Such attitudes tend to generate the conditions necessary for economic growth. A minimum level of health seems to be necessary for acceptance of the idea and practice of limiting or spacing births. Parents need assurance that children already born will have a reasonable chance for survival.

Primary health care requires the support of other sectors; these sectors can also serve as entry points for the development and implementation of primary health care. Malnutrition is at the heart of many diseases common in developing countries, and solving this problem requires investment in agriculture among other things. In many countries, the key may lie in adequate and safe water for drinking and irrigation, which may be the responsibility of the Ministry of Public Works. Education also makes considerable contribution to health. Studies in 29 developing countries have shown that infant and child

mortality were consistently lower with better educated mothers; each extra year of schooling on average meant 9 per thousand fewer infant and child deaths.³⁸

The basic idea underlying the integrated approach is that all sectors involved in the development process can and must contribute effectively to the struggle toward progress. In other words, according to Coombs, "integrated approach is the combination of naturally related parts into a more cohesive cost-effectiveness.... Any such system is intended to accomplish certain specified objectives in particular settings; but to do so it must have an appropriate process made up of a suitable combination of inter-acting, mutually supporting components; and to fuel this process, the system requires sufficient resource inputs on the right kind and combination".³⁹

38. World Bank Report, "Health and human development; issues and policies", in World Health Forum, Vol.3, No. 1., (1982) p. 109.

39. Coombs, P.H., "Meeting the Basic Needs of the Rural Poor", Essex, Connecticut, (1980) p. 15.

Organisation for primary health care

The system of health care structure is made up of various units and subdivided into various levels. The first level is the point of contact between the health system and individuals and this is the level where primary health care is delivered. The other levels of the health care system provide more specialised services which become more complex as they become more central. The primary health care level cannot function effectively without sufficient support from the higher levels of the health service. The latter must provide adequate technical information and supervision, material supplies, administrative support and training facilities. There must be hospitals to which patients may be referred when necessary; indeed the efficient use of these expensive institutions demand effective screening of patients at the primary level.

The WHO/UNICEF joint study on National decision-making for primary health care⁴⁰ concluded that in developing countries the primary health care approach involves a complex of health and development activities which interrelate with each other at various points and levels. At the primary level itself, this complex can be thought of as having three components:

40. UNICEF/WHO. (1981) op.cit., p. 51.

→ community-organised activities of a health and health-related character, enjoying intersectoral support;

- basic health services available within a reasonable distance of communities to provide health care, support and referral services;

- community health workers who, as members of the community, serve as a link with the basic health services.

Within this definition, basic health services constitute an integral component of primary health care. These basic health services can often consist adequately of quite small health units with some two or three trained workers (subprofessionals), provided they are well integrated with the community and enjoy good support from the secondary and higher levels of health care.

The health centre providing basic health care is a unit within the health services system but the relationship with the community health worker (paraprofessional) varies from country to country. In China the community-based health worker is clearly a member of the community.⁴¹

41. WHO (1983) op.cit., pp. 53

In other countries, such as in Iran, he/she is the peripheral arm of the health service structure.⁴²

In many of the others he or she has a dual role-community based and community-controlled but also a health service member.

The health and health related activities at the community level should be organised by a committee with representatives from the health services, the community and other relevant sectors. The UNICEF/WHO joint study of National decision-making for primary health care concluded that special health committees, linked exclusively to the health service and approaching health problems in an isolated manner, may not be the most appropriate mechanism for involving communities in decision-making about the wide range of activities necessary to bring about improvement in health.⁴³

Oforu-Amaah argues that in countries where village health committees have been set up, these should be either converted into village development committees and their scope of activities broadened to include other

42. Ronaghy, H., "Kavar Village Health Worker Project", Monograph No.2, Tropical Pediatrics and Environmental Child Health, Vol. 24 February 1978, p. 44.

43. UNICEF/WHO. (1981) op.cit.pp. 41.

developmental activities or they should be linked to such village development committees".⁴⁴

At the central level of the health care system, where health policies are decided, the input from other sectors and the people is very important, otherwise, decisions will be biased to views of health professions alone. Health is too important to be handled by the health professionals alone. Investments in other sectors also make useful contribution to the health standard. To co-ordinate all these efforts contributing to the health of the country, Davidson⁴⁵ suggests the formation of a national health advisory council with representatives from health, education, agriculture, finance and the community. The overall

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44. Ofosu-Amaah, V., "National experiences in the use of community health workers: a review of current issues and problems", WHO., Geneva, 1983, pp.36
45. Davidson, L., "Report on a visit to study health care in a number of western Pacific islands", in Report of an expert group, "Special health problems of island developing and other specially disadvantaged countries", Commonwealth Secretariat, London (1980) pp. 88.

use of national resources needs to be examined for its effect on health; the impact on health of the plans and projects of different sectors needs to be considered; the coherence of other policies with the redistributive objectives of the primary health care, will all be discussed at this council. Costa Rica and Democratic Yemen⁴⁶ are examples of countries which have instituted similar form of national health council.

46. UNICEF/WHO., Geneva (1981), op. cit. pp. 14 & 15.

CHAPTER 4

APPLICATION OF THE PRIMARY HEALTH CARE CONCEPT
TO TONGA

This chapter explores ways of applying the primary health care concept to Tonga. It argues that primary health care can be effectively applied to Tonga in a way that is congruent to the local cultural, political and economic situation of Tonga.

Health care in Tonga is explained first in order to set the picture of the health standard and health care system in Tonga. Issues concerning local resources, community participation and organisation of the health care system are then discussed as to how they can be generated and pieced together towards appropriate application of the primary health care concept to Tonga.

Health care in Tonga

Health care services in Tonga are provided almost entirely by Government through the Ministry of Health, with the exception of two private clinics run by retired medical officers and four dispensaries run by church organisations. The scope for a private sector in health services delivery in Tonga

will be limited because of the small island economy and a significant middle class has not developed.

The government health services are administered by the Ministry of Health from Nukualofa.

District health services are based at the four hospitals of Ngu at Vavau, Niuui at Haapai, Niueiki at Eua and Vaiola at Tongatapu. Vaiola hospital is also the training and central referral hospital. The administration's headquarter is housed under the same roof as Vaiola hospital.

Attached to the hospitals are fourteen health centres and eleven nursing stations. Some previous nursing stations have been incorporated into health centres and work is still being done on proper integration of the two.

The health centres and nursing stations are at the level of community health care and they provide basic health care. Each health centre is staffed by one health officer (medical assistant) and one public health nurse. The nursing station is run by one public health nurse. Tonga is still "muddling through" at this level of health care and proper direction is not clear. Earlier on the only form of health service at the community

level were dispensaries manned by dispensary assistants. Nursing stations were introduced after 1969 and staffed by public health nurses providing health care to mothers and children. In 1981 health centres were introduced to replace dispensaries and be integrated with nursing stations. Most nursing station buildings were upgraded to health centre buildings. The new staff category of health officers was introduced. Health centres and nursing stations provide basic health care at the district level.

The construction of hospitals, health centres, nursing stations and the provision of equipment was mostly financed under foreign aid. Some of these expensive hospital investments may have been more cost effective if invested in health centres and primary health care. Health planning has not been effectively run and information collection is still premature.

Because of its expensive hospitals, the Ministry of Health consumes 13% of the total government budget and is the highest in the Pacific. Table 3 shows the fast increase of government budget going into running of health services.

TABLE 3

TOTAL RECURRENT EXPENDITURE OF HEALTH SERVICES:KINGDOM OF TONGA FINANCIAL YEARS 1978/79 TO 1982/83

Financial Year	Total recurrent expenditure (in T\$)
1982/83	16,004,299
1981/82	14,735,833
1980/81	11,899,211
1979/80	9,850,081
1978/79	8,601,988

Source:

"Report of the Ministry of Health for
the year 1982", pp. 43

(Exchange rate: T\$1.00 = US \$.894)

The sudden increase since 1980/81 financial year is due to the opening of the new Niueiki Hospital and new Niuui Hospital in 1979, and the upgrading to an almost completely new hospital of Ngu Hospital, opened in 1981. A new central public health laboratory, which is part of a 3 million dollar laboratory project, financed under Japanese aid was opened at the beginning of 1984 and it will also be very expensive to run.

By law all Tongans can receive free medical treatment from the government. The revenue collected is only for such things as hospital accommodation, dentures,

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embalming and medical examination of travellers.

These revenues sometimes do not even cover the cost of collection.

Morbidity and mortality data are still insufficient and of poor quality. The only data source available generally on this area is the annual report of the Ministry of Health. This report consists of information that is hospital based rather than that of the wider national scene. Therefore the morbidity and mortality trends can only be discussed in a general and loose term.

The biggest cause of morbidity and mortality in Tonga, as in most developing countries, are the respiratory and diarrhoeal diseases. These are the two main killers, particularly in childhood. Other communicable diseases follow in importance.

Pneumonias and broncho-pneumonias are included under respiratory diseases, and usually the leading causes of mortality and morbidity. Gastroenteritis, typhoid and the diarrhoeal diseases as a whole are the second largest cause of mortality and morbidity.

Of the viral diseases, influenza, dengue, hepatitis and the viral components of diarrhoeal and respiratory infections are the most important. Poliomyelitis is no longer common and rabies is not endemic in Tonga.

Parasitic diseases are still very important, especially filariasis and intestinal parasitic infections (ascariasis, hookworms). Fungal infections are frequent and in the main affect only the skin.

The chronic diseases are rising markedly in importance as communicable diseases slowly come under control. Thus heart disease, hypertension, cancer and diabetes need attention. Obesity is common.

Mental illnesses and stress syndromes are not infrequent. The image of the carefree islander is a myth. Alcoholism is increasing but drug abuse is still comparatively rare.

Infant mortality is 21.7 per 1000 which is quite low compared with other South Pacific islands, but life expectancy at birth is rather unfavourable at only 58 years, compared with Fiji at 72 years, Western Samoa at 62 years and Australia at 74 years. Crude birth rate is at 26.3 per 1000 population and crude death rate is 5.9 per 1000 population.

Environmental sanitation is generally poor. Adequate sanitary facilities in the home or immediate vicinity is available to only 36.3% of the population. The Ministry of Health reported that in 1983 91.3% of the population have ready access to safe drinking. Water for cleaning, bathroom etc., is very scarce.

The trained professional health manpower in Tonga has always been and will remain in short supply. This is due to constraints outside Tonga's ability especially the cost of sending nationals for training overseas. Tonga now has 33 medical officers and according to the Ministry of Health's Planning Officer,⁴⁷ by the year 1991, the gain from new graduating medical officers sent by the Tonga Government for overseas training, will be balanced by the loss of existing medical officers due to retirement, migration, etc., Tonga therefore has to seriously look at other categories of health workers and alternative strategies to meeting its health needs.

The most important decision for the Tonga Ministry of Health is the way in which most benefit can be obtained for health money expended. A conscious investment in the community level of health care delivery using the primary health care strategy is the only alternative.

47. Wolfgramm, S.T., "Manpower Planning and Projection for the Medical Workforce - Ministry of Health", unpublished paper, Nukualofa (1983)

Resources in Tonga for primary health care

As explained, the poor agricultural economy of Tonga cannot support the continuing expansion of institutional clinical services of the conventional sense. Generous foreign aid has been supplied for the capital cost of existing big buildings and sophisticated equipment but Tonga cannot continue to meet the recurrent cost of further expansion of these conventional services. The national health budget cannot continue to rise at the present rate (see Table 3) and may even fall back.

In order to make essential health care accessible to every individual and families in Tonga, at a cost Tongans can afford, the primary level of health care should be developed and expanded using local resources and technology especially those that are underutilised. We need the present hospitals and all the services therein, and the only way to make them accessible to everyone is for the whole health care system to be oriented mainly to providing support to the peripheral health services and to complement their action by means of easy and timely referral of cases and problems beyond their competence. This support also includes technical supervision and provision of supplies.

The efficiency of the present minimum number of doctors of 33 could be maintained and even further developed if they are all retained in the four hospitals where their services are required, especially Vaiola Hospital, the central and main referral hospital. The old practice of posting some doctors to isolated communities is too expensive and a waste of resources. Much of the work in the local units do not require the services of a fully trained doctor. When new levels of health care workers are available to perform most of the health care services in local communities, along with improved communication and transport, "it should be less and less necessary to employ doctors in isolation from their professional colleagues under conditions in which their professional skills are wasted and being lost through lack of use".⁴⁸

A significant community resource the Tonga Ministry of Health can develop to a wide extent at the primary level of health care is paraprofessional. There would be few difficulties in Tonga setting up health paraprofessionals in every village especially those outside of urban areas. In 1982 the Ministry of

48. Irvine, R.O.H. et al, "Medical education in the South Pacific," Suva (1971), pp. 23.

Health carried out a pilot project on training and establishing paraprofessionals and five health workers were successfully established in some island communities.⁴⁹ They were selected by members of the island communities and are working as volunteers. Supplies and supervision are provided by the Ministry of Health. In 1983, Dr. B. Taumoepeau of the Tonga Health Training Centre visited these village health workers and reported her satisfaction with their work.⁵⁰

Another example of the potential of health paraprofessionals, are the distributors of rehydration powder for diarrhoea. Diarrhoea is one of the common ailments in Tonga especially among children. The Tonga Health Training Centre in 1982, worked with communities at the western side of Tongatapu.

49. Moa, P., "Ministry of Health Primary Health Care Project. Report 20th September to 5th October, 1982", unpublished, Nukualofa (1982)p.3.,
50. Tonga Health Training Centre Office records, Ministry of Health, Tonga (1983).

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Distributors were selected by the community and were trained by the Tonga Health Training Centre staff and students for a few months. At the completion of the training they were supplied with rehydration powder. Their function is to distribute rehydration powder to those in need and to give health education.

Some non-government organisations also have para-professionals under their umbrella. The Catholic Churches' family life programme have several para-professionals of their own who act as teachers of the ovulation method of family planning. They work as volunteers. The church provides training, supervision and supplies. Some of them are provided with bicycles.⁵¹ The Tonga Family Planning Association⁵² in their 1983 annual report, informs that they make use of 40 traditional birth attendants as family planning promoters. These traditional birth attendants were trained to be family planning promoters by the Tonga Family Planning Association. They are provided with a minimum allowance.

51. Catholic Diocese of Tonga, "Annual Report of the Family Life Programme 1983", unpublished, Nukualofa 1983.

52. Tonga Family Planning Association, "Tonga Family Planning Association Annual Report 1983", Nukualofa 1983.

There is a big potential in paraprofessionals to be used by the Ministry of Health in areas such as education concerning prevailing health problems and methods of preventing and controlling them; appropriate treatment for common diseases and injuries; maternal and child care including family planning promotion; organisation of the community for immunisation; basic sanitation and promotion of proper nutrition and safe water supply.

It is not necessary for one type of paraprofessional to perform all functions. There can be various types of paraprofessionals such as village health workers, sanitation workers, family planning promoters etc. The Ministry of Health has to provide training, technical supervision and supply.

From local experiences with paraprofessionals, there is no rush to work out remuneration now. They are still happily working as volunteers. Probably in the future when the spirit of volunteerism is lost together with the subsistence economy and market economy completely takes over, then serious consideration be given to appropriate remuneration for paraprofessionals. Their selection would still be better left to the community. The Ministry of Health carries out the training, and provides technical supervision and free supplies.

The role of women is another significant factor for the development of primary health care in Tonga and still very highly underutilised. About 50% of the population are women and yet only 7.7% participate in active labour force. The rest are mostly housewives.⁵³ Communal efforts and the extended family system are still very strong in Tonga and women play a very important and influential role. A review of the findings of a social study made by a World Health Organisation anthropologist confirmed that:

- " - a girl in the Tongan society is accorded a higher rank than all her brothers;
- all ceremonial affairs of a family are under the direction and supervision of the husband's sister, who is considered a superior being to whom all must listen;
- a brother and his children are considered as the servants of his sister and her children;

53. Tonga Government (1980) op.cit. pp.109-110.

- a brother must provide food and if necessary money and shelter for his sister, irrespective of whether she is single or married, with children or a widow;
- if a mother-to-be has difficulty in giving birth, the husband must inform his sister and ask her forgiveness so that the baby can be delivered easily:
It is usually considered that difficulty in delivery arises when the husband's only sister or the eldest sister is angry with either her brother or her brother's wife;
- a sister can choose the wives or husbands for her brothers' children and all concerned on both sides will be satisfied;
- a very high chief is considered a commoner in the presence of his sister or her children".⁵⁴

54. Fanamanu J., and Vaipulu, T., "Working through the community leaders. An experience in Tonga", International Journal of Health Education, Vol.IX, (1966), pp. 132.

To exclude women from participation in development would be a very big mistake and has often been experienced by the Ministry of Health. Fanamanu and Vaipulu reported in 1966 of the failures of the Ministry of Health's sanitation project in the two villages of Houma and Vaotuu where it was first introduced. An analysis was therefore made of the efforts and failures at these two villages and led to the conclusion that both men and women leadership should have been considered from the beginning. The village women committee was then revived and this new method of approach was then used in the next village of Masilamea and was a success.⁵⁵

There are two ways whereby women can contribute to the development of primary health care in Tonga. The first one is in the role of paraprofessional. It would not be difficult to recruit women paraprofessionals in Tonga. When the Ministry of Health implemented its village health workers pilot project in 1982, all the candidates were women,⁵⁶ and there were no difficulties in recruiting them.

55. Fanamanu J. and Vaipulu, T. (1966) op.cit.pp.131.

56. Moa, P., (1982)op.cit.pp. 3 & 4.

There are many traditional midwives or traditional birth attendants in Tonga and they could be successfully trained within a short time to become health paraprofessionals. The 40 traditional birth attendants now used by the Tonga Family Planning Association as family planning promoters are all women .⁵⁷

Banu recommends that traditional midwives and young women with a minimal educational background should form the core of primary health care workers (paraprofessionals). They are a real part of the village scene and have not been removed by years of western style education and urban living, being daily immersed in the life and problems of the village, and are therefore much better able to communicate than the professional outsider.⁵⁸ There will be no difficulty in finding such women in Tonga, and furthermore women in Tonga would be highly effective as paraprofessionals because of their influential role in the Tongan culture.

57. Tonga Family Planning Association (1983), op.cit.

58. Banu, L.P., "Rural women and health experience from Gonoshasthaya Kendra", IDS Journal, Vol.10 No.3(1979) pp.38.

The second contribution women can make towards primary health care in Tonga is through the "Kautaha", the village women committee. With 43.9% of adult women outside the active labour force,⁵⁹ it does not mean that Tongan women are lazy and remain idle. Women use their potential in other useful activities and the activities of the "kautaha" are some of them. The "kautaha" is an important component of village life in Tonga.⁶⁰ Faletau, in a recent survey she did in Tonga, found that about 90% of women 18 years and older belong to a "kautaha".⁶¹ Halatuituia et al. concluded in a survey report in 1979 that "kautaha" has enabled women to meet the demands or needs of the family and community and provide women with the feeling that they are building good homes; a good home being perceived as the basis of a good community and consequently a good country.

59. Tonga Government (1980) op.cit. pp.109.

60. Faletau, M., "Changing roles for Tonga's women", in Pacific Perspectives, Vol. 11, No. 2., pp. 45-55.

61. Halatuituia, L. et al., "Women co-operatives in Tonga", in Pacific Perspectives, Vol. 11, No. 2 pp.13-17.

The activities of the "kautaha" are quite diverse ranging from income generating activities such as handicraft making; to nutrition activities such as vegetable gardens and home economics; to health activities such as organising the village for immunisation campaigns and village sanitary inspections. The Ministry of Health workers who make use of "kautaha" have reaped invaluable successes. The mass treatment of Tonga against filariasis was carried out by the women "kautaha" all over Tonga.⁶²

This programme consisted of periodic distribution of anti-filarial tablets to every Tongan over an 18 months period in 1977 and 1978. Filariasis was a major health problem with an estimated 25% of the population infected with filarial worm before the mass treatment. Surveys carried out after the mass treatment showed that filarial infection had decreased to .08%.⁶³

With the coming of new young professionals without community orientation, the Ministry of Health in many places has lost touch with women "kautaha". The "kautaha" in Tonga play the same function as the women "Komiti" in Western Samoa and Schoeffel reports

62. Tonga Government, "Report of the Ministry of Health for the year 1977", Ministry of Health, Nukualofa (1978), pp.10".

63. Tonga Government, "Report of the Ministry of Health for the year 1980", Ministry of Health, Nukualofa (1981) pp.9

they are suffering the same problems. Para-professionals and subprofessionals would be in a better position to institute the link with the Ministry of Health. They live in the village with the "kautaha", being daily immersed in the life and problems of the "kautaha", and could form an integral part of the "kautaha" in a total approach rather than the partial vertical approach of professional outsiders. The paraprofessional and subprofessional approach seeks to reach effectively the villagers, promote organisation and activation of local public to help provide their own services, develop greater capacity to satisfy their needs by their collective efforts and still link productively to the bureaucratic servicing networks of government .

A significant local technology on health care in Tonga is traditional medicine. Tongan traditional medical practices are important and active components of the health care delivery. In 1982 32.1% of deliveries were carried out by traditional birth attendants. ⁶⁵ Moa reported on a survey in some of the islands in Tonga, that the Ministry of Health

65. Tonga Government, "Report of the Ministry of

staff visit these islands only once in three months and in between, the people resort to traditional medicine and whatever western medicine that can be found.⁶⁶ Parsons in a study she did in Tonga in 1981 concluded that "traditional healing practices in Tonga have not shown a decline since the days of European contact. Rather, they have developed alongside, and in spite of, western medical practices".⁶⁷ The importance of traditional medical practices is very well put by Moa:-

"Traditional healers and traditional birth attendants still play a major role in the provision of health care practice. Their ability to stand in time of needs coupled with the belief that they possess special powers to cure illness handed down to them by their ancestors acts as powerful instruments in maintaining the trust, respect and faith given to them by the people of these islands".⁶⁸

66. Moa, P. (1982) op.cit. pp.3.

67. Parsons, C.B.F., "Developments in the role of the Tongan healer", (1983), Journal of the Polynesian Society, Vol.92-1, March (1983) pp.31

68. Moa, P., (1982) op.cit. pp.3

The encouragement given to traditional birth attendants by retraining them and integrating them into the community health care system has brought astounding success as measured by the number of successful deliveries they attend and improvement in the maternal and infant morbidity and mortality indices.

Since traditional medicine is still widely practised to good effect, should it not be officially recognised, encouraged, improved upon, and integrated into the contemporary national health care system? Since it is widely accepted by the community, the Ministry of Health should work out ways of incorporating it into its primary health care services. Bannerman suggested that "whenever applicable, health professionals should be given orientation in the traditional practices of the areas in which they function, since without such knowledge they remain ignorant of what self-care the community generally undertakes and thus have no true appreciation of the community's own interventions to combat illness".⁶⁹

69. Bannerman, R.H., (1982), op.cit., pp.13.

- Another invaluable community resource that needs to be exploited to create community awareness of primary health care activities is school children. Tonga has a predominantly young population and school has achieved a good coverage of Tonga. This method is being used in other countries and could be applied in Tonga. The school health programme in Malvani, a poor district of Bombay, has clearly demonstrated that "there is no better medium for the dissemination of health education in a community than the community's children".⁷⁰ By using school children as health leaders in the immunisation programme, for example, a 90% success rate was achieved in the Malvani district, where it was previously 20%. Similar successful experiences are reported from Indonesia.⁷¹

70. Bhalera, V.R., "School children as health leaders in the family", World Health Forum, Vol. 2 No.3, pp.~209-210.

71. See Rohde, J.E. and Sadjimin, T., "Elementary school pupils as health educators; role of school health programmes in primary health care", Lancet, Vol.1 (1980) pp.1350-1352.

Primary Health care community participation
in Tonga.

As pointed out earlier, community participation in this thesis is taken as the process by which individuals and families assume responsibility for their own health and welfare as for those of the community, and develop the capacity to contribute to their and the community's development. This definition emphasises that community members should assume responsibility for their health but not to leave it all to government.

The law granting free medical treatment to all Tongans created some later difficulties to the Ministry of Health. People took it for granted that it is their right that government should give them "health care", free and of the best type. When the Ministry of Health started in 1970 making minimal charges for some of its services not directly included in medical treatment, it was a difficult task collecting these fees and huge outstanding accounts piled up which forced the Ministry of Health to try collecting some of them through the law court.⁷² This legal right for

72. Tonga Government, "Report of the Ministry of Health for the year 1978," Ministry of Health, Nukualofa (1979) pp.7.

free medical treatment has often got to the stage where patients demand that they have a right for overseas medical referral at the cost of government.

True participation in health development demands a mutual and reciprocal relationship between the Ministry of Health and the community. It seeks to build on the resources and strength of both the local community and higher levels of the Ministry of Health. This relationship can be instituted in Tonga mainly through three things: (i) a degree of decentralisation of the bureaucracy; (ii) local organisations; and (iii) catalyst with clear linkages established.

Because local government has not been developed in Tonga, the administrative decentralisation of the bureaucracy is from the central headquarters of the Ministry of Health down to district hospital level and then down to health centre level, particularly the latter.

The local organisation means the various organisations at the Tongan community level that have activities related to health care. As mentioned above, the "kautaha" or women village health committees are the most significant type at the community level followed by the village assembly. Village health

committees are active in some villages but not in others. The importance of forming Village Development Committees will be discussed later.

The churches' community development approach has been tactful and useful in this respect. Father Culling of the Catholic Diocese of Tonga wrote that "the aim of the Catholic adult education programme is to build up and deepen the sense of community and through community to proceed to community development...(It) is no good to talk about community but it is necessary to create an experience of community.....(They) found that traditionally there is a large measure of trust at the family and extended family level, but that at the inter-family level there is often suspicion and mistrust. By bringing people together in an environment where they have to relate to people outside their family group, (they) found that trust begins to be created, and this trust is the foundation for any successful community work".⁷³

73. Culling, S.F. (1979) op.cit. pp.2-3

It has been stated that many of these types of organisations at the community level are not democratic in the conventional western sense for they lack provisions for majority rule, competition for leadership and holding leaders accountable to members. "Nevertheless, where members are of relatively equal status, where norms retain the arbitrary exercise of leadership authority or where decisions are based on group consensus, such organisations may provide a relatively accurate expression of popular will, despite the absence of conventionally democratic procedures".⁷⁴

When properly mobilised, community organisations in Tonga are able to organise their own local resources, e.g. voluntary paraprofessionals to handle minor essential health care and health campaigns; sizeable amount of capital for community projects; labour and material for building of clinics and water supply, etc.

74. Uphoff, N.T. et al., "Feasibility and application of rural development participation: A State-of-the-art paper", Cornell University, Rural Development Monograph No.3 (1979) pp.40

The outside catalyst for primary health care in Tonga should be the subprofessional (Health Officer) at the level of health centres. His main role with respect to community participation is to facilitate the people in the community to articulate their own needs, organise development strategies and participate in their implementation. He is a vital point in the flow of communication from the community to the centre and vice versa, and within the community itself.

Organisation of the health care system for primary health care

As argued earlier, the only way to render all levels of health care in Tonga accessible to everyone is for the whole Ministry of Health to be oriented mainly to providing support to the peripheral services, where primary health care operates and to complement their action by means of easy and timely referral of cases or problems beyond their competence. This support also includes technical supervision and provision of supplies.

This orientation requires a significant restructure of the Ministry of Health; redesign of job descriptions and retraining of certain staff. This

reorganisation includes delegation of authorities on control of resources to district hospitals and health centres. Special programmes such as control of communicable diseases and family planning should be integrated into primary health care and relax the central control but strengthen the control at the health centre level. It is important for all the staff of the Ministry of Health to be given functions in administration and management, staff training and also health education of the community.

As argued earlier, health is too important, complex and interrelated for the health professionals alone to handle. Health is not only the narrow clinical aspect but all those aspects contained in the "moui" concept of the Tongan society, as explained earlier. Some structure is therefore necessary to be instituted in order to allow participation from other sectors and the community in health care and to control the overemphasis and the extravagant expenses by the professionals in hospitals and the clinical field.

Dr. Hutchinson in 1975 recommended the formation of a National Health Advisory Council. This council will be to perform this function to quite an extent. Professor Lindsay Davidson, after a visit to study the health care delivery in a number of Pacific islands, including Tonga, supported the same idea by stating that:

"....the provision of a national health advisory council with representation from health, education, agriculture, finance and the community could be useful in guiding the health administrations out of their present conceptual ruts". 76

The National Health Advisory Council operates at the national level but for primary health care to be effectively applied, channels of community participation have to be instituted at the community level to allow dialogue between community members and officials from the Ministry of Health and other sectors.

75. Hutchinson, A., "Draft health legislation for Tonga", typed copy with the Ministry of Health, Tonga (1975).

76. Davidson, L. (1980) op.cit., pp.88.

Communication at the community level can be better effected because "the formality of inter-ministerial institutions is avoided; the scale is smaller and the people involved usually know each other better. Local health personnel interacting with officials from other agencies (agriculture, education, public works, for example), and with representatives of the people, are often better placed to find workable responses to local problems than higher-placed officials in the national capital".⁷⁷

These people at the community level should not be professionals themselves but at the level of sub-professionals.

This communication at the community level can be instituted through the formation of a Village Development Committee with representatives from the community and the various sectors mentioned above. The old practice of forming separate village health committees to handle health care at the community level is not appropriate.⁷⁸ It will perpetuate

77. UNICEF/WHO., "National Decision-making for primary health care", Geneva, WHO. (1981), pp.31

78. Ofosu-Amaah V. (1983), op.cit., pp.36

the narrow minded view of health and will "result - from the vantage point of the rural families on the receiving end - in a bewildering fragmentation of disconnected, ill-fitting and often contradictory "messages" and advice on how to run their lives".⁷⁹

The usefulness and applicability of paraprofessionals to Tonga have been argued above but it is important, furthermore, that institutional mechanism be established in the Ministry of Health to give direct support, training, supervision and to be the contact point between the Ministry of Health's bureaucracy and paraprofessionals.

The ideal level of the Ministry of Health to perform this function are the subprofessionals (Health Officers and Public Health Nurses) staffing health centres. They are not professionals themselves and have better affinity with the community for they work at the same community setting. Professionals and those high up at the echelon of the Ministry of Health's bureaucracy would be unfamiliar with local conditions and would give

79. Coombs, P.H., (1980) op.cit., pp.10.

inappropriate ideas and methods. Experiences⁸⁰
in other countries support this argument.

Adequate health coverage of the whole of Tonga would depend very much, therefore on subprofessionals and paraprofessionals providing health care to every one and supported from above by professionals. Subprofessionals are required to run health centres for a group of villages with a total population of about 2000 per health centre. Health centres provide basic health care. In order to be consistent and avoid duplication and conflicts between health officers and public health nurses, they should work together as a team from the health centre only and do away with the existing nursing stations.

Paraprofessionals provide simple essential health care for every village and assist the subprofessionals in health care organisation and health campaigns in each village and island. It is therefore essential to have one or more paraprofessionals for every village or small island in Tonga.

80. For example, see Colburn, F.D., "Guatemala's rural health paraprofessionals", Centre for International Studies, Cornell University, New York (1980), pp. 25.

CHAPTER 5

CONSEQUENCES OF THE APPLICATION OF PRIMARY
HEALTH CARE

The proper application of primary health care to Tonga will have far reaching consequences, not only within the health sector but also other sectors of the community. The Tonga Ministry of Health should be aware of these consequences and make appropriate plans to overcome all major obstacles. Some of these consequences and ways of overcoming obstacles are listed as follows:-

(i) Opposition from Health professions.

Doctors and nurses are the traditional providers of health care and any changes that may threaten their traditional territory would face strong opposition. The WHO Director-General explained that "health services have evolved historically as the responsibility of one or a limited number of professions. These often have gradually become isolated from their community base and hence are increasingly divorced from the needs of the majority of the people. These professions and their programmes have acquired such an autonomy of their own that any change which threatens their influence, status and

involvement is fiercely resisted".⁸¹ Kasonde and

⁸²
Martin reported that one of the problems in the application of primary health care to Zambia is the very limited support from doctors reflecting their conventional training and aspirations for clinical careers and preference for urban life style.

The support of health professionals is highly essential to the proper application of primary health care. The orientation of professions to support and strengthen primary health care increases their responsibility. Their technical skills to solve health problems is applied in the light of social needs, to guide, teach and supervise health workers below them and to educate communities on all matters pertaining to their health. They are therefore given social and educational functions in addition to their technical functions.

81. WHO. "An integrated approach to health services and manpower development", WHO/EMRO Technical Publication No. 1, (1978), pp. 23.

82. Kasonde, J.M. and Martin, J.D., "Moving towards Primary Health Care: The Zambian experience", World Health Forum, Vol. 4, (1983), pp.25-30.

Moulding of attitudes towards orientation to the new function of professions has to start from the institutions where they are trained. This task may be possible with professions trained locally, e.g. nurses, but pretty difficult with those trained overseas. Because Tonga does not have a medical school, she has to continue sending medical students to universities in overseas developed countries, where the medical curricula are designed for the health care needs of developed countries.

These medical students would need to be oriented by the Ministry of Health to local conditions in the light of primary health care, at the initial stage of their employment. Health professions could also be successfully influenced by involving them in the development of primary health care. They would need to be persuaded that they are not relinquishing medical functions but gaining health responsibility.

(ii) Heavy administrative demand.

The effective application of primary health care makes fairly heavy administrative demands. An effective co-ordinated approach is needed, involving appropriate managerial process, supervision of

paraprofessionals, referral of serious cases, logistic support etc., Without this, primary health care workers are likely to become demoralised discredited and inefficient, and their recommendations for curative and preventive care to be disregarded.

To make sure that the principles of primary health care are translated into practice, a national managerial process is required. This includes planning, programming, budgeting, financing, control of implementation, evaluation, research, replanning if necessary and information support for all these activities. ⁸³ Decisions on broad planning is made at the central level fostering the development of primary health care, and responsibility is delegated down to various levels of the health care system for planning and operation. An essential decision that has to be taken at an early stage at the central level is to give priority to primary health care both at the community level and at the supporting levels. This fundamental decision then has to be translated into budgetary terms to make it possible to implement it.

83. WHO. "Managerial process for national health development. Guiding principles", WHO. Geneva, (1981) pp. 5-8.

Good supervision, continuing education and technical support of paraprofessionals have proved to be essential. Mechanisms for these must be established. As mentioned earlier, the Health Officer and the Public Health nurse would be the best officers of the Tonga Ministry of Health to provide supervision, support and continuing education to paraprofessionals for they work and live at the same district and are familiar with the local conditions.

Good logistical support is critically important, especially at village level. Better planning of delivery schedules, improved control and maintenance of vehicles, rigorous management of inventories and adequate financing would rectify a lot of the present problems.

In orienting the whole health care system to support primary health care, easy and timely channels should be instituted for referral of cases or problems beyond the competence of health workers at the community level up to upper more specialised levels of health care. Proper procedures have to be organised to ensure that each part of the referral chain performs first and foremost the function for which it is intended.

The transportation of patients to and from referral services has to be properly organised, making the most of available facilities. Sometime, unnecessary transportation of patients can be avoided if advice can be given over a communication link by whatever means exists or can be provided at low cost. Because of the scattered dispersal of population over small islands, referral of patients poses a big challenge to the health administration in Tonga. Foremost in solving and decreasing this obstacle is to provide an efficient radio communication system between isolated islands. The effectiveness of this system has been well proved in Nigeria.⁸⁴

Evacuation of patients may be better performed with the assistance of the Police and the Military for they have appropriate equipment and personnel for emergency services.

The heavy administrative demands in the primary health care require for all key personnel in the various levels of the health care system to be skilful in management. It is therefore necessary to train all health staff in management

84. A case study - "Nigeria; use of two-way radio in the delivery of health services" - in Djukanovic & Mach op.cit. (1975) pp. 92-94.

skills through the institutions where they have their initial training and inservice training sessions.

(iii) "Cheap health" argument from the public.

Resistance may arise from certain sectors of the public arguing that "secondary" and "tertiary" health care only are more important, for primary health care is just "cheap health care" masking the inferior quality and quantity of health care.

This resistance from the public can be "defused by discussions in communities and in the mass media. These discussions should aim at making the people appreciate that primary health care is realistic since it provides at a cost that can be afforded, essential health care for all in a spirit of social justice rather than sophisticated medical care for the few in a counter spirit of social justice".⁸⁵

Journalists and other professionals of the mass media can indeed play a major role in promoting primary health care using their recognised influence in shaping public opinion and raising consciousness of the people. This is supported by

Standard and Kaplun who argue that health providers should establish a permanent dialogue with media professionals.⁸⁶

The role of health educators is crucial in this respect. Emphasis on health education has been on a handful of overworked health education specialists to carry out the function of health education and ignoring the hosts of potential human resources in the Tongan society - the teachers, agricultural workers, community development agents, royalties, nobles, matapule (talking chiefs), faifekau (religious leaders) and traditional birth attendants. Paying attention to what people feel they want is not enough; it is necessary to go one step further and promote the active contribution that the lay public can make towards changing and improving their health care.

Practical demonstration of the application of primary health care would prove more effective than having professions from the Ministry to explain them to the public. This point had been clearly stated by the late Dr. Fanamama, former

86. Standard, K. and Kaplun, A., "Health education; new tasks, new approaches", WHO Chronicle, Vol. 37, No. 2 (1983) pp. 63.

health education officer, Tonga Ministry of Health:

"....in Tonga one cannot remove ignorance simply by having an expert explain the facts to the people. Unless the expert can give an absolutely convincing practical demonstration of the truth of what he says, people will be polite but sceptical. There is no particular respect in Tonga generally for expert opinion as such...." ⁸⁷

(iv) Politics of health care

The health care service of the Ministry of Health has evolved as a responsibility of professionals and bureaucrats (who are also themselves professionals). They are isolated from the community base and increasingly divorced from the needs of the majority of the people. The question raised now is how to keep the bureaucracy but make it responsible to the people and prevent it from overcentralisation.

87. in Fox, M.G., "Social Welfare services and development planning in the Pacific Islands", South Pacific Commission, Noumea, April (1976) pp.127.

As explained earlier, the Minister of Health, like other ministers in the Tonga Government, is appointed by the King and a civil servant, but not elected by the people. True accountability to the people, therefore, does not exist. The bureaucracy of the Ministry of Health in several respects tries to follow the Westminster model of government but in the vital areas, they are far from it. In the Westminster model, the bureaucracy is headed by a politician elected by and responsible to the people, and below him are the career bureaucrats.

The overcentralisation of the Ministry of Health could have been overcome by the system of local government, but unfortunately local government is not developed in Tonga. The Ministry of Health, like other government ministries in Tonga, run its services for the whole kingdom from the headquarters at Nukualofa, the capital.

Considering the present conditions of Tonga, the answer to the above question is community development and participation, which are vital elements of primary health care. The community level in Tonga already has various forms of community organisations but they need recognition by Government.

The Ministry of Health will benefit a lot from these organisations such as women village committees as explained earlier.

One may argue that organising the community for development is activation of the community level for political mass action and subversion against the authority. This is not the case here. Mass action only occurs when interaction and communication between the community members and those in authority is very much restricted and not openly encouraged.

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The UNICEF/WHO Joint Committee on health policy concluded that involvement could be conceptualised in terms of a broad spectrum with passive recipient of benefits (the dependent and non-responsible groups) to active involvement and voluntary contributions, at the other end (the self-reliant groups responsible for their development). Between these two extremes of involvement is the situation where members of communities share to a limited degree in decision-making and have marginal physical interaction with decision-makers and their opinions to "authorities" may be reduced to the use of mass action.

The effective application of primary health care to Tonga in a way where the bureaucracy is responsible to the people but prevent overcentralisation demands community development where purpose and content of development originate with the people and where voluntary contributions to programmes take place, thus contributing to a collective sense of belonging and dignity.

The village development committee and the National Health Advisory Committee, explained earlier, play important roles here in allowing a dialogue between the community members and the Ministry of Health, both at the community level and at the national level.

The role of the subprofessionals and paraprofessionals, as explained earlier, are important in linking the bureaucracy to the community. The subprofessionals and the paraprofessionals are the key health workers in the attempt to strike a balance in the responsiveness of the bureaucracy to the community and be catalysts in community development.

CONCLUSION

The Primary Health Care Concept can be effectively applied to Tonga. Essential health care can be made accessible to the 76% of the population living in villages and scattered islands at a cost Tonga can afford.

Hospitals and all the health services at the secondary and upper level of health care are essential but they should not be permitted to expand so as to provide the only source of essential health care to every individual and family in Tonga. The poor island agricultural economy of Tonga cannot support further expansion of this expensive and often unresponsive conventional health care model.

The only way to make essential health care accessible to every individual and family in Tonga is to develop and expand the peripheral health care services using the primary health care approach. The whole health care system would be oriented mainly to providing support to the peripheral health services and complementing their action by means of easy and timely referral of cases and problems beyond their competence. This support also includes technical supervision and provision of supplies.

The efficiency of the present small number of 33 doctors could be maintained if they all remain in the four hospitals where their services are required especially Viola Hospital, the central and main referral hospital. With new improved arrangement of communication and transportation it should be less and less necessary to employ doctors in isolation from their professional colleagues under conditions in which their professional skills are wasted and being lost through lack of use.

Fully trained doctors and other professionals as part of their orientation toward primary health care, are to provide supervision and on-going training to health personnel below them, i.e. subprofessionals (health officers or medical assistants and public health nurses), who staff health centres in districts or groups of villages each covering an area with about 2,000 population. Health centres are at the peripheral level and are an integral part of primary health care.

Subprofessionals supervise and provide on-going training to paraprofessionals (village health workers, birth attendants, sanitary workers, traditional healers, etc.). Paraprofessionals are the front line health workers, performing essential health care at the primary level.

It has been found that paraprofessionals could take care of about 90% of conditions requiring medical treatment in peripheral areas. It has been explained earlier that the biggest cause of morbidity and mortality in Tonga are the respiratory and diarrhoeal diseases. With more attention to simple early treatment and health education, carried out by paraprofessionals, most would be considerably less harmful than at present.

Community participation is an essential element of primary health care. True participation on this in Tonga demands a mutual and reciprocal relationship between the Ministry of Health and the community. It seeks to build on the resources and strength of both the local community and higher levels of the Ministry of Health. This relationship can be instituted in Tonga mainly through the degree of decentralisation of the bureaucracy; the local organisations; and the use of the sub-professionals as catalysts with clear linkages established.

Women make ideal volunteer paraprofessionals for Tonga and their "kautaha", village women committees, could organise campaigns for immunisation, village sanitation and family planning, effectively.

Over 90% of the women in Tonga are outside the active labour force, but they are very influential in the Tongan society especially in the extended family system, "Kainga". Examples have been shown of failures in health programmes due to the mistake of excluding women from participation in health development.

Another significant aspect of health care in Tonga that could be organised is traditional medicine. As Parson concluded in the study she did in Tonga - "traditional healing practices in Tonga have not shown a decline since the days of European contact. Rather, they have developed alongside, and in spite of, western medical practices". It is no doubt that some parts of the traditional medical practices are unsafe and should be discarded but wherever applicable, health professions should be given orientation in the traditional practices in order to remove their ignorance and appreciate the tradition of self-care within the community.

The effective application of primary health care to Tonga requires a significant restructure of the Ministry of Health; redesign of job descriptions and retraining of certain staff.

This reorganisation includes delegation of authorities on control of resources to district hospitals and health centres, especially the latter. Special programmes such as control of communicable diseases and family planning should be integrated into primary health care and relax the central control but strengthen the control at the health centre level. It is important to be given functions in administration and management, staff training and health education of the community.

Formation of village development committee generates not only community participation but also intersectoral co-operation with various sectors operating at the community level, especially agriculture, education and public works. The community should be represented. True dialogue among the Ministry of Health, the community with their felt needs and other sectors can be achieved here. In order to avoid conflicts of power and interest among the various sector staff, it is important to have the town or district officer as the chairman.

At the national central level, health is too important, complex and inter-related for the health profession alone to decide health policy matters.

A National Health Advisory Council is recommended here with representatives from health, education, agriculture, finance and the community. The Minister of Health can act as the chairman.

The proper application of primary health care to Tonga will have far reaching consequences, not only within the health sector but also other sectors at the community level. Advance planning is important to overcome obstacles in order to allow its smooth application. Doctors and nurses, who are the traditional providers of health care, can be successfully influenced by involving them and be persuaded that they are not relinquishing medical functions but gaining health responsibilities. Resistance from the public can be defused by discussions in communities and in the mass media along with practical examples of primary health care.

Considering the local conditions in Tonga it is more appropriate to retain the bureaucracy of the Ministry of Health but activate community development so as to make this bureaucracy responsible to the people and prevent it from overcentralisation. Local government is not developed in Tonga and the political head of the health bureaucracy is not

elected by the people but appointed by the King.

With community development primary health care
can be effectively applied in Tonga.

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