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On Programs, Processes, Approaches and Movements:
A Critical Analysis of Primary Health Care
Supported by a Case Study in Fiji

By

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A.B. (University of California) 1977

THESIS

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Chairman Date

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.....*Justice*.....*18 September 1987*

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ABSTRACT

The determinants of health in any society, industrialized or underdeveloped, are complex and very difficult to elucidate. Primary health care (PHC) has been enthusiastically embraced by most member states of the World Health Organization as the latest, best solution to the overwhelming health and social problems keeping millions of people from enjoying a full, healthy life. The principles of PHC rhetorically realize that true improvement of individual, community and national health status requires not only bio-medical advances but -- more importantly -- social, economic, institutional, and health care reforms. This descriptive study has two parts: Part One examines (from a global perspective) the historical, political, institutional and philosophical foundations of PHC and in Part Two, the researcher analyzes data collected from Fiji with the purpose of further clarifying factors that have affected the implementation of PHC there. The study combines a review of the international literature, an examination of documentary records from Fiji and findings from structured, open-ended interviews (designed and conducted by the researcher) with 67 respondents -- including community members, medical department staff, government planners and international agency workers. Results show that Fiji's PHC program has been affected by 1) its colonial style health care system; 2) the program and funding policies of the international agencies; 3) local politics, professional politics and public demand; and 4) the traditional structure of leadership and community participation. This study outlines the impacts of local realities on an international health model but obviates the need for further social science research to help Fiji make clear health care policy decisions.

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PART ONE

I. INTRODUCTION

a. Purpose of Study.

The World Health Organization has declared "Health for All by the Year 2000" as their global, organizational goal for the remainder of this century. Primary health care (PHC) has been the major approach of international efforts to accomplish this lofty goal. This study represents a critical analysis of primary health care, examining its development and implementation from a historical, institutional, philosophical and political-economic perspective. The two-part analysis rests upon a field study of the development and implementation of primary health care in the Fiji Islands of the South Pacific supported by an initial, background review and discussion of the international literature concerning primary health care.

Part One considers the form and purported objectives of primary health care, the role of international aid in the underdevelopment of countries, the institutional aspects of agencies involved in promoting and implementing primary health care, the impact of professional dominance in health care systems and, finally, the basic flaws of the primary health care model developed by the World Health Organization. The introduction includes some brief comments on the nature of health and on remnants of colonial relationships in the present world order.

Part Two examines the findings from the field study conducted in Fiji. After discussing the rationale and methodology of the field work Fiji's history, geography and climate is described. The discussion of

the historical past and present structure of health care describes how primary health care fits into its niche in the health care system of Fiji. Also discussed are the impacts on primary health care of international health agencies, the nature of leadership in Fiji, and public demand and professional politics.

b. Health and the World Order.

The determinants of health in any society are complex and very difficult to elucidate. Each society has ways of understanding and explaining its existence and the elements of culture that include birth, illness, death, wellness and methods of healing. Each society has developed ways of understanding what causes the loss of health and what restores it. Of course, individual societies have, on occasion, come upon other societies with different explanatory models for these elements. The societies involved in this cultural contact then undergo a metamorphosis of their explanatory models through either gradual acceptance of apparently better methods or explanations, complete loss of previous explanatory models due to cultural domination and enslavement or cultural experimentation followed by adoption of a new, amalgamated form of cultural model.

In this world there has been frequent inter-mixing of societies, now incorporated into larger organizations called countries. The countries have been placed into stratified classifications called the developed or industrialized world and the underdeveloped or Third World. Those in the first classification are mostly those countries of the Northern Hemisphere, the Westernized countries, countries that went through social/industrial revolution and scientification in the 18th and 19th

centuries. Part of the evolution of these countries included the Age of Exploration when daring persons sailed in small ships to "discover" vast areas of the world with amazing sights, incredible material wealth and many more people with very different appearances and cultures. These discoveries, generally south of the Equator, would eventually become the countries and regions of the underdeveloped world.

Over the following four centuries the process of contact and conflict ensued between these two worlds. The exploring nations found various ways -- considered to be processes of civilizing, developing and improving -- to occupy positions of great importance in these resource-rich areas populated with "primitive" peoples. Colonial frameworks were developed that simultaneously exploited the wealth of this world, governed the dominated, indigenous people and laid the groundwork for restructuring, using their own models, social and cultural values such as education, work ethic, systems of governance, morals, systems of law and improvement of self, family and environment.

In time, these areas -- ruled by various colonial powers -- became independent countries either because the indigenous people finally rebelled successfully against their exploitative overseers or because the material benefits were no longer sufficient for the colonialist to warrant their governing efforts. The separation, however, was not very complete and strong ties between the developed and the developing are maintained through corporate structures that withdraw raw materials for the former colonialists' material and martial societies. Another post-colonial relationship, multi-lateral and bi-lateral aid programs, have been developed to help the newly independent countries achieve a better quality of life for their citizens.

The foundation of this latter relationship has a broad and varied base. For some it is the remnant of the civilizing (also known as Christianizing) movement of the 1800's. For others perhaps it is the philanthropically expressed sense of guilt that the exploitation of these lands and peoples needs to be somehow rectified and subsequently glossed over by generous assistance. And lastly, for some there is still the motivation of the exploiter: to continue to benefit from these countries of great wealth they need to stabilize life there, keep people reasonably happy and healthy enough to participate in the stripping of the resources. This relationship, in its many forms with its many rationals, has generated the development of bi-lateral, multi-lateral, international, private and academic organizations. The main roles of these organizations are to clarify the problems in these countries and then objectify, plan, implement, and evaluate the programs and processes they develop to "solve" the problems. The overall, simplified goal of all these organizations is to "help" these less fortunate countries reach a state of relative (compared to the developed countries) well-being.

The primary health care movement is a classic example of a global effort -- containing all of the mixed motivations, justifications and historical precedents oversimplified in the preceding paragraphs -- attempting to assist millions of people to achieve a certain state of well-being, physically and mentally. A review of the literature pertaining to primary health care (PHC) leaves the reviewer with a strong sense of unsettledness. Hundreds of books, documents and academic discussions have been written about primary health care, its appropriateness, its successes, its failures, its political economy, its historical and philosophical foundations and its future. The very

complexity and importance of the issues associated with PHC has predetermined this enormous collection of academic-professional papers and tomes. The programmatic elements of PHC, as planned and implemented by countries and international bodies, continue to resist integration of the social and situational reality in which it operates.

II. JUSTIFICATION OF RESEARCH PERFORMED

a. Why this Study, Why Now?

This research would seem to be just another set of bound pages to pile on top of all the rest written about primary health care. It would be if it did not include the field study from Fiji. Despite all the pages written there is still ample room for country-specific analyses of primary health care because of the simple fact that PHC evolved from a generalized model. Primary health care is presented as a flexible model for countries to follow in the development of health care systems and capabilities. Such models, constructed from dozens of experiences in many different countries, are based upon assumptions that don't operate in countries where the model is subsequently applied. It is very important to examine primary health care from the perspective of a single country that has participated in the process of applying primary health care concepts and principals to its national health problems. Each country has its own unique history, cultures, environment, resources, relationships to other countries and the international community, and interpretation of primary health care; it becomes, therefore, difficult and senseless to generalize from country to country. This case-study of the "fit" of PHC in Fiji's health, social, political and economic setting

is an appropriate means for helping decision makers to understand the socio-cultural context of the approach they have adopted. It should also add to the growing body of literature that "demonstrates that the context of PHC ... as well as the different strategies and processes involved in their adoption and implementation, exert important influences on program outcomes" [Bossert and Parker, 1984:693].

When looking at primary health care programs there have generally been two evaluative approaches used. One attempts to evaluate whether primary health care has improved standards of health care by examining classical medical statistics that include overall morbidity and mortality figures, maternal death rates, infant mortality rates (IMR), family planning acceptance rates and other sets of statistics. In one article regarding the empirical evaluation of planning of health services this was called the "dose-response relationship" [Habicht and Berman, 1980:129]. The other type of evaluation attempts to judge the effectiveness of the programming activities through examination of organizational changes, increases in specific manpower allocations, or the creation of new social entities to accomplish planned objectives. The main aspect of this study was descriptive but certain evaluations of the planning and implementation of PHC in Fiji were also relevant.

The goal of this research was not to decide whether PHC (and its attendant organizational and conceptual elements) is right or wrong for Fiji. Until quite recently [Ministry of Health (MOH), 1984] there has been very little social science research done on health in Fiji because, similar to most countries, most decision-making bodies are dominated by medical doctors with biomedical backgrounds [Foster, 1982:193]. The general difficulty in achieving accurate quantification is sometimes used

by opponents, or half-hearted supporters, of the PHC approach to devalue applied research of this kind [Segall, 1983:1954]. But participant observation and use of records and open-ended interviews can provide the type of data needed to better understand how PHC fits into a national health care system [Justice, 1986].

This type of descriptive research about the context of PHC is often called the political economy of health. Baer, a medical anthropologist, defines political economy as "a critical endeavor which attempts to understand health-related issues within the context of the class and imperialist relations inherent in the capitalist world-system [Baer, 1982:1]. In recent years medical anthropologists and other social scientists have been paying increasing attention to this focus, particularly in primary health care [New, 1986:95]. I will briefly discuss aspects of the political economy perspective -- also strongly adhered to by others (Elling, 1981; Navarro, 1984) -- but only as one issue in the larger, social, cultural and political environment that affects primary health care. Malcolm Segall, in his paper on planning and politics for resource, also suggests that examination of primary health care programs must focus on the broader contexts (of which the political economy is one element) in which health care is delivered. This would include the historical development of the ideologies and realities of health professionals [Segall, 1983:1947] which I will also discuss.

b. Personal Involvement.

I chose Fiji for a case study because of earlier professional contact with their health care system. I returned to Fiji after a hiatus

of almost six years; from 1979 to 1981 I had served there as a Peace Corps Volunteer in the Ministry of Health -- on the national, divisional, district and community level -- in the same sorts of activities I have now analyzed and described in this study. The return visit to conduct research in 1987 was, in many respects, similar to seeing a movie for the second time: one always sees things not seen before, catches nuances of sight, sound and texture not observed during the first viewing. My return presented a unique opportunity for both evaluating the impact of my earlier work, as an actor in the primary health care production, and applying new perspectives gained from the passage of time and other work experiences to research insights.

I was startled to discover how many aspects of culture and social reality that I had failed to discern during my previous three year sojourn in Fiji. I had missed so much of the world around me, I had plowed ahead in my work, encased in my own cultural biases and perceptions while failing to interpret how these biases overrode the more immediate cultural reality I was ostensibly helping. I now realize that I constructed a personal interpretation of primary health care (one mostly founded upon the theoretical constructs promoted by WHO) without considering that Fiji might require a different sort of approach. My own inability to integrate technical knowledge with new insights and understanding about the socio-cultural reality in which I was operating often plagues many international development schemes, including PHC in Fiji. Many national and regional PHC efforts do not appear to have enough programmatic mechanisms for incorporating local elements of human and social reality, for consideration of newly realized political elements that run contrary to the planned expectations and objectives, or

for rejecting false assumptions on which entire portions of the program are based.

III. WHAT IS PRIMARY HEALTH CARE (PHC)?

a. Development of the Primary Health Care Approach.

The discussion about what PHC is begins with two formal definitions, as decided upon at the Alma Ata Conference in 1978:

PHC is essential health care based on practical, scientifically sound and socially acceptable methods and technology, made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination [WHO/UNICEF,1978].

And,

A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples 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 [WHO/UNICEF,1978].

The simple, direct nature of these two statements obscures the inherent complexity of the issues being addressed and the origins of the

concepts upon which PHC is based. Using these statements -- arising from the conference that involved health/medical/political leaders from 135 countries -- as guideposts gives the appearance that PHC began de novo in the year 1978. In reality, primary health care is not a new concept; it, in fact, incorporates concepts distilled from four decades of successes and failures that occurred in international health and development projects. Specifically, PHC is the offspring of two major development issues, rural health care and community development.

Since the 1940's, it has been recognized by some that traditional bio-medical approaches (utilizing a structured hierarchy of medical professionals, allopathic medicine, modern hospitals and dependent on the most recent medical technology) to achieving and maintaining a high standard of health for an entire, national population were often unsuccessful and very expensive. While one cannot minimize the successes of modern vaccines, the miracles of modern pharmacology or amazing achievements in diagnostic medicine, it was painfully obvious that not all people enjoyed these advantages in equal doses. This was very evident in developing countries which lacked both the financial and manpower resources to copy those bio-medical systems developed in Europe and the United States. Those industrialized regions had the necessary capital, existing training and development infrastructures and a high standard of socio-economic achievements incorporated into a socio-cultural foundation upon which the system was constructed. In the majority of developing countries, even where there was a reasonable facsimile of the hospital models, for example within a major city, many of the citizens of that locale did not enjoy standards of health comparable to those in the industrialized nations. The expectations of medical professionals for

bio-medical success seem unreasonable considering that health conditions were comparable in Europe and North America only 100 years ago. Most analysts clearly state that the general improvement in health standards and quality of life occurred only after a rapid amelioration of social and environmental conditions, not from medical care which until the 1930's could do very little for sick people [Stewart:7909,1975].

Some early attempts to improve the health of people in a rural area outside of the urban setting occurred with the establishment of health centers in Kenya, India and South Africa [Fendal and Tiwari,1980:78]. This was a first step in changing the focus of medical care and the term primary medical care came into vogue. Primary medical care is, in the narrowest sense, first contact care where patients could see a health worker; depending where one lived, a patient would see a physician (Europe) or a nurse/health worker/medical assistant (Africa, Asia, etc.) [Walt and Vaughn, 1982b:99]. Patients seen at this level, as opposed to secondary or tertiary levels with access to advanced technological medical services, had common complaints treated at low cost or were referred to a higher level of care in the case of more serious problems. Many health professionals, mostly physicians, continue to believe that primary health care can be best represented by expanding primary care services that offer basic medical care to all people.

The scope of health care offered in this model was outlined in the Bhore Committee Report (1946), which provided the basic framework for Primary Health Centres in India recommending the integration of curative and preventive services at various levels (centre, provinces and districts), the establishment of primary and secondary health centers for the delivery of comprehensive health care in rural areas and the training

of medical undergraduates in preventive and social medicine [ibid]. (The emphasis has been added to the recommendations of this report to illustrate the old adage, "Nothing new under the sun," also applies to PHC. The same terms are still operant today when discussing the objectives of primary health care). The focus of this approach still emphasized health/medical services delivered from a facility, although one more appropriate to the location and needs of people.

At approximately the same time, other rural-based programs were attempting to improve the socio-economic standing of people in rural areas of underdeveloped countries. Theories about national development were examined and some development experts questioned the benefit of strategies that improved only the physical elements of national growth such as industry, dams, roads and buildings [Walt and Vaughn,1982b:143]. Community Development, "a rural, across-the-board developmental approach stressing agriculture, health, education and communication" was built on decades of small-scale pilot projects [Foster,1982:183]. Like the later movement of PHC, this descriptive name caught the fancy of practitioners and became the acceptable way for referring to attempts to achieve better quality of life for the rural poor of the world. In 1956, the United Nations defined community development as "the processes by which the efforts of the people themselves are united with those of government authorities to improve the economic, social and cultural conditions of communities, to integrate these communities into the life of the nation, and to enable them to contribute fully to national progress" [ibid:184].

The common point for both of these programs in the 50's was the focus on rural populations. In most countries of the world, the inhabitants of rural areas had (and have) far less access to government

services or to the fruits of the classic economic developments such as industries, buildings and roads. By the 1960's people had become frustrated with the "trickle-down" approach to health and rural development that had left many millions of people virtually untouched [Muhondwa, 1986:1247]. Both these programs were attempts to bridge that gap, to concentrate on social services and community level programs, with varying degrees of success around the world. This focus on rural populations has been carried through in the PHC programs developed in the 70's and 80's. It may be that PHC has many potential applications in urban areas [Kingma, 1977] these areas have been generally ignored or considered to fall within the sphere of the urban hospital. This has promoted a sort of "reverse discrimination" against the vast urban communities in developing countries who could also benefit from a less technologically-dependent, community-based approach to their social and health problems.

In the early 1970's, twenty years after these conceptual changes, however, the basic deficiencies of health and quality of life for millions of rural poor persisted. Operating in their separate spheres, the two rural-based programs seemed not to have made a dent in the problems they were designed to attack. Within the international health/medical sphere there were stirrings of discontent, evident in academic presentations but also publically tabled in meetings and conferences of the World Health Organization. During the 51st Session of the WHO Executive Board, members discussed the "widespread dissatisfaction of populations about their health services..." [WHO, 1978a:3]. In the World Health Assembly held the same year, 1973, a resolution was adopted stating a need for "special emphasis being placed

on meeting the needs of those populations which have clearly insufficient health services..." [ibid]. The WHO Annual Report from that year introduces the achievements of the organization with the following statement:

The most signal failure of the World Health Organization as well as of Member States, has undoubtedly been their inability to promote the development of basic health services, and to improve their coverage and utilization [ibid].

Other international organizations, in addition to WHO and UNICEF were also recognizing the previous error of their developmental ways. The International Labor Organization (ILO) elaborated the concept of "basic human needs" in a 1976 landmark report that recognized that "people, not countries, are central to the development process..." [Knowles, 1980:67]. Positive steps were being taken towards a human-centered, not an institution-focused approach to development in the underdeveloped world.

Later pronouncements from WHO in 1975 included recognition of the insufficient access to health services of rural people, the potential for other than purely medical solutions to health problems through community participation, the principle of community self-reliance as a foundation for programs, and the need to "hold as soon as possible an international meeting or conference under WHO auspices to exchange experience on the development of primary health care as part of national health services" [ibid:2-3]. This call for an international conference was later realized at Alma Ata in 1978, from which came those two statements included at the beginning of this section. The second major slogan relating to the

immense, global health problems -- which was presented to the 30th World Health Assembly in 1977 by the Director-General -- proclaimed that the main target for WHO in the coming decades "should be the enjoyment of a level of health by all citizens of the world by the year 2000 that will be conducive to a high social and economic productivity" [ibid:4]. A strategy developed to achieve this goal includes 12 indicators through which WHO-supported programs can be monitored and around which the programs are built [WHO, 1981].

The latter part of the 70's and the early 80's saw the merging of the two ideals of the rural outreach programs formulated during the 40's, 50's and 60's: the ideal of easily accessible, non-hospital centered, appropriate health services for rural populations that concentrates on community participation in a developmental process that includes improvement of social and economic elements of rural life. The principle features of PHC resulting from this merger are:

PHC includes promotive, preventive, curative and rehabilitative services, to focus on the main health problems in the community;

PHC has at least eight minimum components - health, education, nutrition services, water supply and sanitation, maternal and child health care (including family planning), immunization, prevention and control endemic diseases, treatment of common diseases and injuries and provision of essential drugs;

PHC is intersectoral in orientation, involving coordination with activities in related sectors such as nutrition and public works;

PHC is based upon local self-reliance and community participation;
and

PHC makes use of all levels of health workers, including para-professionals, and is part of a larger system for referral for specialized care [paraphrased from WHO by Bossert and Parker, 1984:693].

The principles of PHC are so logical and comprehensive that one could assume that the many programs based upon this model would proceed with only minor hitches. The problems of implementing these far-reaching, and potentially radical, recommendations, however, became apparent almost immediately during the late 70's as will be discussed later. The fundamental benefits of this PHC "movement," however, must not be diminished or go unrecognized. For the first time a large body of health and development experts agree that the quality of life and health of millions (perhaps billions) of the world's people is, 1) totally unacceptable to the world community; 2) dependent not only on high-quality, professionally dominated medical care but on a broad range of determinants including social, economic and environmental factors; and 3) requires real, active commitment from international agencies and every governmental and social organization in a country to achieve even minimal success.

b. Two Basic Forms of Primary Health Care.

The prototype for comparing all primary health care effort is the PHC model, first given full expression at the Alma Ata Conference and refined over the past decade. The implementation of this prototype has been the cause of much international debate. This debate is often less than crystal clear, despite the declaration's apparent clarity. For example, one group found that they needed 92 definitions when they tried to assess how different groups understood primary health care in an

American community [Parker in Rifkin/Walt, 1986:561]. Two major schools of thought that do dominate the debate, those supporting "selective" primary health care (SPHC) and those advocating "comprehensive" Primary Health Care (PHC). The debate between these two began soon after the 1979 publication, in the New England Journal of Medicine, of an article describing a pared-down, epidemiologically-based and less ambitious version than the all-encompassing PHC model advocated by WHO [Walsh and Warren, 1979:145]. The authors stated that the large and laudable scope of the Alma Ata declaration was unattainable due to its prohibitive cost and the numbers of trained personnel required to implement the approach. [ibid:145] A more selective approach (and, therefore, presumably more likely to achieve some success) would attack:

the most severe public health problems facing a locality ... in order to have the greatest chance to improve health and medical care in less developed countries...we have tried to show the rationale and need for instituting selective primary health care directed at preventing or treating those few diseases responsible for the greatest mortality in less developed areas and for which interventions of proven high efficacy exist. [ibid:145]

The other school of thought, essentially adopting the original scope and intentions of Alma Ata, is alternatively called "comprehensive" or just PHC. The theory of this approach -- distilled from decades of program experiences (as more fully discussed above) -- is that improvement of health care delivery systems is only one of the needed reforms. It incorporates a philosophy of health and health care as basic

human rights that, if necessary, also require the reshaping of global developmental designs to include community participation in the decision-making and implementation of PHC activities. While improvements in the health sector are very important, "most improvements in health have been due to changes in economic, social and political structures rather than changes in the health sector" [Navarro, 1984:169]. Another author [Somarriba, 1980:51] noted that "effectiveness of most medical interventions will be heavily dependent on factors which lie in fields beyond medical control."

There are deep rooted philosophical differences between the two positions. As outlined by Rifkin and Walt, one difference relates to the role of medical intervention -- the major aspect of the "selective" approach but only one of a number of important elements in PHC. Secondly, the "comprehensive" proponents accept the need for potentially radical changes on "both the level of social, economic and political structures and on the level of individual and community perceptions" [Rifkin and Walt, 1986:565]. The "selective" interventionists base their expectations, similar to medical professionals, on fairly rapid, visible and quantifiable results. In a semantic sense, Rifkin and Walt state that the "selective" method is based upon short-term programs, while PHC is carried out through a comprehensive, long-term process [ibid].

This debate extends earlier arguments about whether the best method of health care delivery was "vertical" or "horizontal." These terms can be defined as:

the "horizontal approach" seeks to tackle the over -all health problems on a wide front and on a long-term basis

through the creation of a system of permanent institutions commonly known as 'general health services.'

The "vertical approach" calls for the solution of a given health problem through the application of specific measures through a single-purpose machinery [Gonzalez in Mills, 1983:1972].

The notion of "vertical" is related to "selective" in the sense that both are directed at specific illnesses or diseases. Many of the early health and medical interventions, in the modern bio-medical era, were mass campaigns, both curative and public health, designed to eradicate a single disease or illness. Many medical departments in the pre-independent developing countries set up sections for attacking malaria, leprosy, tuberculosis, and intestinal parasites. Some vertical programs also include, however, strategies that attack several diseases, such as immunization, or that provide a particular service such as maternal and child health services (MCH) or family planning [Mills:1972]. This method of health care delivery, although recognized by many observers to be insufficient for permanent, long-term improvement of health conditions in developing countries still has strong proponents in the world of international health.

A review of the programs presented by Walsh and Warren was performed by Banerji in 1984. His conclusions about the promotion of selective primary health care (SPHC) for developing countries were that it:

- 1) negated the concept of community participation with programs planned from the "bottom up";
- 2) gave allocations only to people with priority diseases leaving the rest to suffer;

3) reinforced authoritarian attitudes; 4) had a fragile scientific basis; and 5) had a questionable moral and ethical value in which foreign and elite interests overruled those of the majority of the people [Banerji in Rifkin/Walt, 1986:560].

Several other authors have also strongly criticized and fundamentally rejected the formulations of SPHC as elitist, regressive and unsound [Gish, 1982; Berman, 1982]. There are, however, many apologists for retaining the option of an applied SPHC approach, arguing that in this time of scarce resources low-cost, proven vertical programs must be considered paramount. Lipkin, in a commentary on the Gish and Berman articles in Social Science and Medicine, downplays the essential differences in the two schools of thought and defends the potential correctness of the "selective" approach while semantically defending the intentions of Warren and Walsh [Lipkin, 1982]. The selective strategy has also been favorably received by international agencies such as World Bank and UNICEF, academic institutions and research centers (Harvard University and Centers for Disease Control), bilateral aid agencies like USAID and powerful private institutions (Ford and Rockefeller Foundations) [Unger and Killingsworth, 1986:1010]. The struggle for theoretical primacy among these schools of thought, however, is not the only problem that the primary health care approach faces.

c. Flaws: Flies in the PHC Ointment.

Why there has been difficulty in moving from these upper-level achievements to lower-level national, regional and local accomplishments is the subject of this section. Research of this type must sift through

the shifting rhetorical sands of literature pertaining to PHC -- written by its proponents and by its critics -- to understand the weaknesses of the approach. As one critic noted, "the rhetoric associated with an effective rural (or PHC) health system in developing countries is quite frequently incompatible with the reality of the health care system" [Carlson in Mburu, 1979:577]. Several aspects of this reality continually threaten the successful utilization of the important theoretical advances of the primary health care approach.

First, the enormity of the world-wide problems that the PHC approach is attempting to tackle are mind-boggling. There can be no panacea that will quickly turn wide-spread, global socio-economic inequalities into a "brave new world". As seen in an earlier section, narrower, more rigid approaches (based on capital works projects and programs to increase the national GNP that only enriched a relatively small, elite sector of the population) have gradually changed into broader programs that attempt to reach previously ignored communities. These programs are laudable because they do incorporate the deeper awareness that health, or the economy, is inter-dependent on many more factors than considered in a bio-medical, or economist's, model. Problems have arisen because the lofty, idealistic, rational principles of the initial concepts are difficult to translate into practical action. In re-defining and re-orientating human efforts to achieve some measurable improvement in global health status the proponents of PHC must face up to a process, not a program, that will take many years to accomplish. The process will be completely dependent on inter-digitating aspects of health, society, equality, politics and world order.

Secondly, the principles of Alma Ata told people what to do but not how to go about it. Too many professional and lay people believe that the PHC principles are more than rhetorical policy, that these idealistic principles alone will suffice as programming elements that can be directly transferred to the field. Even WHO states that "in their post-Alma Ata enthusiasm many decision-makers assumed that, since primary health care was supposed to use simple methods, it would be simple to implement" [WHO, 1986:2]. The staff at WHO has lately realized that they naively thought that "once we had enunciated the principles of integration the actual practice would simply follow" [WHO, 1987:59].

Third, the PHC approach was expected to act as a flexible model that, in principle, allows for re-adaptation to local needs and situations. In reality, partly because of its conceptual appeal, partly because of its heavy international promotion by WHO and other international bodies, and partly because of many countries' desperate health situations demanding immediate action, it is often adopted without first exploring and defining the socio-cultural environment onto which it will be grafted in each country. Health planners in WHO and national governments have failed to grasp the complexity of social organization within rural settings and have failed to "construct a research foundation adequate for describing health and illness as ... processes constituted as much by forces of language, socio-cultural structure, political and economic organization as by biological and psychophysical events" [Connor and Higgenbotham, 1983:2]. For example, the sociopolitical structure in which the Chinese "barefoot doctors" worked was ignored by other countries trying to replicate this approach as probably the major reason for China's success. [ibid:8]

Lastly, despite PHC's universal, humanistic characteristics -- seemingly appropriate for all people in all lands -- PHC comes packaged with certain social, political and professional biases; it contains conceptual thorns that continually prick all those who have attempted to adopt the concept, whether "those" are a village, a rural local authority, a ministry of health, a national government or an international agency whose central objectives are now defined by the theoretical framework of PHC. For example, as many researchers have noted, rural inhabitants generally want curative care as much as their urban counterparts. But advocates of PHC often ignore this socio-cultural reality, instead labelling the villagers stubborn and ignorant for not quickly perceiving the true advantages of preventive health care -- something that took international health care professionals decades to grasp. Here, perspective narrowed by cultural bias perpetuates "the illusion that PHC is delivering new, valuable messages into a social vacuum" [Stone, 1986:296].

There are two other bothersome issues, to be discussed in the next two sections, influencing the planning and implementation of primary health care. One, PHC is still deeply embedded within the general framework of developmental assistance transferred from the industrialized nations to the underdeveloped countries. Two, health and medical professionals (with emphasis on the medical variety) still exert a powerful force on the shape and direction of any program attempting to improve the health standards of a given population, whether on an international, national or regional level. The impact of these issues is not insignificant.

IV. THE IMPACT OF AID AND PROFESSIONAL DOMINANCE

a. PHC in the Framework of International Assistance.

Most people probably feel that international assistance to the "disadvantaged" countries of the world is a fine and noble thing. The positive notion of giving to those less fortunate than oneself is deeply embedded in the Judeo-Christian cultures of the world. Many churchgoers in the Western world put money in the Sunday collection plate after a ministerial appeal to help the "poor, starving masses" -- in a country whose name they can't pronounce and couldn't locate on a world map -- because those unfortunate souls are not blessed with the modern advantages they enjoy. The impetus for this act of giving is partly guilt, partly true human empathy and partly based on the belief that it is the moral thing to do. Many international bodies operate on these three basic motivations with three others as well: cognition of geopolitical realities and international power struggles; preservation of the organization; and economic self-interest.

Some of the earliest international aid was given under the Marshall Plan in the post-World War II era, primarily to war-torn European countries. It has been said that one of the primary motivations of this enormous largess (two-thirds of it was given in outright grants) was to promote anti-communist governments in Europe [Myrdal, 1970:338]. In the 1950's, anti-communism also became a major motivation -- not the desire to meet their development needs -- for providing aid to the underdeveloped countries. [ibid:343]. This was obvious when one examined the principle recipients of U.S. assistance: Pakistan, South Korea, Laos

and South Vietnam. This geo-political self-interest in aid giving is still a basic element in American and other bilateral aid programs.

There have also been obvious elements of economic self-interest in most bilateral aid programs. One person stated that "it is in the basic interest of the United States to give aid" [ibid:354]. There is a general perception that aid is good for business. The Administrator for the United States Agency for International Development (USAID) under President Johnson, William S. Gaud, put it most succinctly when he stated:

The biggest single misconception about the foreign program is that we send money abroad. We don't. Foreign aid consists of American equipment, raw materials, expert services, and food -- all provided for specific development projects, which we ourselves review and approve...Ninety-three percent of AID funds are spent directly in the United States to pay for these things. Just last year some 4,000 American firms in 50 states received \$1.3 billion in AID funds for products supplied as part of the foreign aid program [ibid:355].

The United States is not the only country guilty of this cynical approach to helping the underdeveloped; other countries, like Britain and France, have tried to maintain close ties (and influence trade advantages) with their former colonies [ibid:357]. A Parliamentary Committee studying Britain's foreign aid programs did not mince words when it reported that "aid plays an important part in stimulating trade. Subject to the basic moral purpose of the aid programme, aid should be increasingly concentrated in those countries which offer the greatest

potential markets for goods originating from Britain" [ibid:358]. From my own personal experience working on a multi-million dollar bilateral family planning program in East Africa, I can estimate 60 per cent of the "assistance" was allocated for salaries and support of experts from the United States.

What has been the impact of this policy, motivated by the donor's self-interest, on the underdeveloped recipients? Because of the potential investment return for private businesses, the size of the programs have been very large, in millions of dollars. The projects "bought" very visible and impressive examples of development: hydro-electric dams, huge agricultural schemes, modern hospitals, wide roads to accomodate fleets of Mercedes and Cheverolet vehicles. Because of the monetary scale and presumed geo-political importance of these programs, only upper level officials of the donor countries and the recipient underdeveloped country have been allowed to participate in the decision-making process about what was appropriate and necessary for that country's development. In real terms, as was discussed above, development that purports to improve health and social status has created a host of expensive, difficult to maintain projects that has had only minimal impact on the most needy in underdeveloped countries.

The situation has improved somewhat due to alterations in development theory formulated in the 70's and 80's but there is still a tendency of many donor/development agencies to think big. After all, it is easily observable that there are thousands of bureaucratic employees whose livelihood depends on the poorest of the poor in this world. Small, appropriate development programs don't support many bureaucrats.

The concept of development and foreign assistance has now been institutionalized. This means that,

Today, it is the institution of development with its vast and powerful network of professionally trained 'developers'...that defines the problems, recognizes the needs, elaborates the strategies, designs the blueprints for action, prepares, proposes, finances, implements and evaluates the projects. It is the institution that decides on the best or most 'appropriate' technologies and equipment that should be needed for meeting countries' and people's developmental needs. It is also the institution that finally serves as a broker in 'assisting' governments and international or bilateral cooperation agencies both for identifying and acquiring the 'best' products on the market and for hiring the most 'qualified' experts and consultants needed for the purpose [Rahnema:31].

This analysis of the development establishment includes the multi-lateral agencies. Although multi-lateral agencies receive monies from many nations their programs share certain similarities with the bilateral agencies. In community participation programs promoted by health ministries in Latin America, the similarities were "surprising until one realizes that nearly all of them are aided and monitored by the same small complex of foreign and international agencies: WHO/PAHO, USAID, IDRC, IBD, UNICEF, FAO, Milbank Foundation, Rockefeller Foundation, Kellogg Foundation, etc;" [Werner, 1980:93]. The multi-lateral agencies (WHO, FAO, UNDP, UNFPA, ILO, and others) do receive a

majority of their funding from the largest, most industrialized nations; the United States generally contributes a significant proportion of the total budget for the United Nation's family of organizations. These contributions certainly carry some degree of programmatic control; one only needs to look back a few years to remember that the U.S. removed its support from UNESCO when it felt that that agency's policies and program directions were contrary to U.S. interests. The programs and projects of these agencies, similar to the bilateral assistance offices, also support large, politically powerful bureaucracies in New York, Rome, Nairobi, and Geneva which can continue to exist only with the maintenance, at similar or expanded levels, of program funding for developmental efforts.

The above, self-serving characteristics of the development agencies are not, however, the only reason that projects and programs in underdeveloped countries are often inappropriate and unsuccessful in solving health and social problems. In the case of SPHC -- previously noted to be popularly received by many international organizations, bilateral agencies and other influential institutions involved in international health care policy making and programming -- there appears to be several inherent constraints and forces leading these agencies to endorse this particular strategy. These include:

- 1) Donor agency funding requires results within the period of the funding cycle or the agency's mandate. This encourages short-term planning and readily measured program objectives; this rules out the measurement of factors such as the avoidance of suffering and the import of participatory structures; it also slows the creation of health infrastructure.

2) The cooperative activities of funding agencies frequently aim at the promotion of significant financial and research outlets for corporations and leading academic institutions of donor nations. (Consider the very lucrative production of oral rehydration salt (ORS) sachets for UNICEF's program against dehydration caused by diarrhea).

3) Institutionally, international cooperation agencies and research institutions seek to respect the financial and institutional status quo of recipient nations; this favors the adoption of health program strategies placing little constraint upon national health budgets and making only minimal demands upon the existing institutions of the recipient nations [adapted from Unger and Killingsworth, 1986:1010].

Given this organizational pressure to adopt certain development approaches, in this case selective primary health care, the discussion turns to an examination of the World Health Organization (WHO) and where it fits into this pattern of institutional impact on international health care policies and programs. As the leading advocate of Primary Health Care (PHC), its organizational characteristics play a large role in how WHO goes about achieving its institutional goals. WHO is certainly not a static entity; its approach to health care issues has appeared to change over time. In earlier times, before the formal advent of PHC, many of the positions of the development establishment were mirrored by the programs of WHO. In sequential order, "population control" programs, "technological transfer," "self-care and self-reliance," and "cooperative and mutually beneficial new economic order" have been presented by WHO as integral aspects of their programs [Navarro, 1984:165]. This sequence of programmatic shifts perhaps reflects a positive, organizational growth in

WHO's approach to health and health care. But the reality, according to Navarro, is that WHO is a,

political agency which reproduces and distributes political positions through its technological discourse and practices ... Like any other international apparatus, WHO is the synthesis of power relations (each with its own ideology, discourse, and practice) in which one set of relations is dominant [ibid].

b. Issues of Medical Imperialism.

The medical profession, one of the dominant powers in the international sphere described by Navarro, directs the programmatic directions of not only WHO but almost all health and medical systems. The medical profession tends to promote a "professional imperialism" (imperialism being a policy of extending an empire and influence over another group in this case) that colors many health care approaches. Selective primary health care, with its vertical, medically-orientated approach, is one example of the professional outlook of physicians.

Both WHO and UNICEF are heavily staffed by physicians, even at the highest levels of decision-making and policy setting. The prevailing attitude in WHO is that "physicians, by virtue of experience and training, have generalized competence in fields that transcend the narrow boundaries of their professional preparation and practice" [Foster, 1987:711]. It is not, therefore, surprising that the framers of PHC noted that "physicians and other professionals will need to be persuaded that they are not relinquishing health functions but gaining health responsibilities" [WHO, 1978]. This represents a practical recognition

of the power that physicians hold in determining what type of health care is delivered. But it circumvents the major institutional issues of professional control and program management.

The creation of a power elite in health care begins during the physicians training period. The training that most physicians receive, whether in developed or developing countries, is a socializing process that creates a class of professionals who are accustomed to leadership roles (head of the medical team), to making decisions involving life and death (possibly the ultimate power role), to looking at problems with short term solutions decided upon after consultation with other professionals (with similar training, outlook and power status) and to looking at situations curatively, not preventively.

The medical profession's powerful influence on health care policy is aided by the fact that health is equated with medicine in the minds of many politicians and of the population at large [Ulgalde, 1979:112]. In the public health (now the primary health care) sector this confusing of medicine with health is combined with an "esprit de corps" physicians have developed within the bureaucracy and which facilitates access to positions of power..." [ibid:112]. As with any group exercising its power, the medical profession is reluctant to share with others presuming to plan and implement health care policies. Medical professionals in underdeveloped countries, trained much like those in the industrialized countries, often "obstruct progressive reforms in health care as they try to protect their control over medical education, their monopoly of medical practice, and thus their status and incomes" [Brown, 1979:586]. This is less evident in countries colonized by England, where the medical professions have less autonomy and are more directly controlled by the

government such as when they served the colonial administration [ibid]. (This latter point was found to be true in Fiji, which was an English colony until 1970).

Medicine and the medical profession, in this environment of power over the direction of health care systems, has created a situation of "colossal pre-emption of funds and personnel ... (and) has become ... irresponsible and counterproductive" [Stewart, 1975:7909]. This insight -- similar in scope to the understanding that selective primary health care is not adequate for permanently improved standards of health and socio-economic position -- hasn't prevented the medical profession from advocating an expanded role in international health care. One American physician, Lipkin (the same person who downplayed the deficiencies of SPHC), states that "with hundreds of millions of people all over the world in dire need of medical care, perhaps we should be exporting doctors, as we do food" [Lipkin, 1985:960]. Another physician advocates the formation of a "physician peace corps" to correct the imbalance of physicians [Lundberg, 1984:511] in the spirit of humanity and internationalism.

All of these proposals, whether based on altruism or desire to extend the professional monopoly, ignore the reality of how doctors usually are distributed in any location:

(a) About 75 percent of doctors will engage in private practice in the major urban areas.

(b) 20-40 percent will probably specialize in hospital or academic medicine.

(c) The additional doctors will monopolize additional non-medical staff and facilities.

(d) A proportion will emigrate, mainly to the insatiate suction pump of medical vacancies in North America, U.K., and other developed countries [Stewart, 1975:707].

Considering this information, and what is generally observed in the field, the medical profession needs to share its decision-making powers with other health care -- nurses, medical assistants, health inspectors, health planners, health educators and community health workers -- to enable an approach which does not incorporate an often inappropriate bias towards the health care needs of the general population. Countries must resist relying so heavily on traditional medical training, one that propagates the situation above, and train more for their needs, as outlined through research for the primary health care approach. The move to broaden the approach to improving health standards beyond the realm of bio-medicine demands a change in the physician centered and dominated planning and implementation process. Combating deeply entrenched professional attitudes requires a true willingness on the part of international and national health bodies to implement changes in their bureaucratic structures that mirror changes in the approach to health care in the field.

V. CONCLUSIONS FROM PART ONE

Primary health care is a major advance in the understanding of and approach to critical problems in health and social conditions throughout the world. Proponents of PHC rightly point out that, after many decades of field experience, the earlier development approaches reinforced power

structures and didn't reach the truly needy of underdeveloped countries. But PHC appears deceptively simple, and rests upon assumptions -- the major weakness of any ambitious model -- that ignore the reality of international, national and local political, cultural, historical and economic situations. Because PHC often operates in the realm of generalizations -- on country and societal levels -- its data base is often not very appropriate when applied in one particular country, region or village. Part Two will re-examine the issues discussed in Part One with reference to Fiji.

PART TWO

1. DESCRIPTION OF FIELD WORK

a. Research Rationale and Situation Description.

The researcher conducted field research for the case study in Fiji from May to August, 1987. A literature review turned up few papers, generally located in Fiji or the East-West Center in Honolulu, concerning primary health care in the Fiji or the South Pacific. There are several likely reasons for the paucity of academic literature, not including official agency and government documents specific to programs in Fiji. Firstly, similar to other island nations of the Pacific, Fiji has a small population and a small land area in comparison to the large developing countries of Africa, Asia and the Americas. Secondly, there seems to be an impression that these islands of coconut palms, gentle breezes and sandy beaches are mostly free of the health and socio-economic crises more highly publicized and evident in the other, larger nations and, therefore, do not warrant the attention from PHC experts and researchers. While it is true that Fiji -- using standard socio-economic variables -- is in the more developed category of developing countries, its situation regarding long-term improvements in social and health conditions is fragile. These issues include independence, land distribution, nuclear power and natural disasters but are rarely accepted by the world community as health issues [Finau, 1987:2].

The island nations of the Pacific present situations both unique and highly amenable to careful research about the social and health conditions there. It is an enormous region, approximately equal in size

to Africa but the land area only comprises 2 percent of the total [Newell, 1983:1441]. There are 20 island nations -- including Papua New Guinea (PNG) with its 3 million inhabitants and 98 percent of the total South Pacific land area -- with a combined population of 4.8 million in 1979 [ibid]. Many of these nations have their populations scattered on dozens or even hundreds of small islands. Except for Tonga, all of them were colonized, with economies linked to various larger nations, many of them in the Pacific "rim" area [ibid]. Only in the last twenty years, and in many cases the last decade, have there been significant moves towards independence and the expression of national identity [ibid]. Despite the comparison with Africa's size, the Pacific must be considered separately from the developing countries in Africa and Asia; the Pacific worldview has been described by one author in the following manner:

The aspirations for material goods and for services of the Pacific peoples are already so high, and rising, that rural development, as presently conceived and executed, is not for a rise from poverty, which in general they do not have, but a shift from one form of relative affluence to another ... the indigenous peoples of the Pacific have never been peasants and do not have the attitudes to labour and life born of centuries of struggle for survival [Hau'ofa in Finau, 1987a:3-4].

Fiji's post-independence process of searching for a national identity was still evident during the time I was conducting research for the case study. On May 15, 1987, there was a military coup with the ouster of the democratically elected government which had only served one month in office. Experienced political analysts would not be hard

pressed to find that the recent instability is deeply rooted in the soil of historical, colonial policies, ideological clashes between traditional and modern, Western-style cultural systems, inter-ethnic, tensions and international geo-politics. But I will not attempt to analyze the complicated social and political issues surrounding the takeover in this paper, confining my comments to how the current political situation highlights elements that impact on primary health care in Fiji. The two, underlying premises of this thesis -- 1) that primary health care is a process of policy-setting, planning and implementation, and (2) cannot be separated from the larger social, political or cultural milieu in which it sits -- was indeed born out by the events occurring in Fiji during my three-month stay.

I arrived in Fiji in late May, one week after the coup. Uncertain about its effect on my proposed research objectives, I moved cautiously while renewing old contacts and beginning the early phases of my data collection. There was never any risk to my safety; this was probably the mildest coup in history, with not one life lost during its occurrence. Nevertheless, life in Fiji was definitely altered; there was much uncertainty about the future and obvious racial tension between the two main ethnic groups, the indigenous Fijians and the Indian citizens of Fiji. A large number of people, mostly Fiji Indians, had emigrated in the months immediately after the coup and many more were contemplating such a move if the political situation did not stabilize. I was allowed, however, to conduct my interviews and study official documents, not only without interference but with the usual graciousness and helpfulness that the world has come to associate with the people of Fiji. It generally seemed that people, when interviewed, gave me their full attention but

there were certainly times when people did not appear to be concentrating on the issues I was examining. The impact of the coup on people's lives was much more important to them than my research, but I am unable to state specifically how this affected my interview results. An interesting effect on health in Fiji was the immediate decrease in outpatient numbers in almost all hospitals and health centers in the first month after the coup; people obviously had more on their minds than the alleviation of minor health complaints.

b. Research Methods and Categories of Data.

The field work in Fiji was based upon two research questions:

- 1) What form has primary health care taken in Fiji?
- 2) What factors influenced the direction primary health care has taken?

To illustrate issues affecting primary health care, I conducted two main modes of information gathering, combining documentary evidence with in-depth interview findings. There were four implicit types of analysis that could be derived from this field approach: 1) Analysis of the factors that affected the local perception of primary health care, the policy decisions and the style of bureaucratic implementation at the central level of government; 2) Analysis of factors that affected the interpretation and implementation of primary health care activities as interpreted by government staff in rural areas; 3) Comparisons between central policy directives and the reality in the field as described in interviews with field staff and community members; and 4) Comparison of

interpretations by government personnel and international agency workers of the role and form of primary health care in Fiji.

The initial five weeks of field work were spent in the capital of Fiji reviewing the general health and primary health care documents from the Ministry of Health files, office shelves and library while simultaneously conducting open-ended interviews with government civil servants and international agency staff.

The two primary forms of data collected were:

- 1) Documentary evidence included official ministerial files, published government policy papers, academic position papers, local professional journals, national newspapers, and activities reports/budgets from the international agencies. The material was reviewed for information regarding the history of health care and primary health care in Fiji, the political decisions regarding policy, resource distribution and budget allocations for primary health care activities, and personal opinions (kept in the official files) of workers directly involved with primary health care activities in the office and in the field.

- 2) Structured interviews with respondents from the three main groups augmented the documentary data. A total of 67 interviews were conducted over a three month period with comparable data collected from the respondents using three standardized questionnaire formats with open-ended questions (in Appendices I to III). Respondants in Group One were the administrative and field staff of the Ministries of Health, Rural Development, Finance and the Central Planning Office (see Appendix I). Respondants in Group Two were professionals from various international agencies playing a direct role in primary health care activities. The

questions for this group were somewhat different than those for Group One (see Appendix II). Respondants in Group Three were members of several rural communities. A separate questionnaire was administered to this group, conducted in Fijian by the researcher, seeking to solicit ideas and opinions about primary health care from the consumer level (see Appendix III).

Interviews lasted from approximately one-half hour to almost two hours. The interview settings included ministerial offices in the capital city of Suva, large secondary level hospitals, smaller rural hospitals, rural health centers and community homes in villages and settlements. A statistical breakdown of the interviews shows:

Professional interviews:

- government health care personnel	28
- government health care personnel (foreign)	5
- international health workers	11
- international agency personnel (non-health)	3
- other government personnel in related programs	8
- local non-government organization personnel	<u>2</u>
	T = 57

Community interviews

- community health workers	3
- community health leader	1
- general community members	<u>6</u>
	T = 10

The ethnic breakdown for the citizens of Fiji in the professional category was indigenous Fijians, 21; Fiji Indians, 13; and other groups, 4, for a total of 38. The community respondents were all indigenous Fijians. There were a total of 19 respondents from other nations working either in the government, for an international agency or non-government agency. Respondants were not randomly selected for this research. The selection of respondents was based on my perception of their professional role relative to primary health care or on personal work contacts developed during my earlier Peace Corps tenure. Some of the field sites visited included areas where I had previously worked with both government and community people. In approximately 40 percent of the interviews with government contacts, the people had actually worked before with me and another 20 percent were aware of my Peace Corps activities. Sixty percent of the community respondents knew me personally from my earlier community level work in the Fiji primary health care program of 1979-81.

To what degree this familiarity between researcher and respondents biased the data collected is impossible to determine. In many instances, however, my previous experiences and personal relationships seemed to encourage trust and allow for a greater degree of openness between myself and the people I interviewed. Certainly, due to the current political climate, I would never have been allowed the freedom to do my field work if there was any question about the actual intent of my research. In any case, it was important for me to interpret the impressions conveyed by myself and my subjects, to substantiate my present research role as distinct from my earlier activities. Such impression management -- defined as "attempts to convey a desired impression of one's self and to interpret accurately the behaviour and attitudes of others ... (and) an

inherent part of any social interaction" [Berreman, 1962:4] -- was critical in my work, as it is in any field research of this type.

II. FIJI PROFILE

a. History.

Fiji was "discovered" by Europeans during the 17th and 18th centuries while traversing the Pacific, looking for new lands. Various different captains of sailing vessels -- Tasman (1643), Cook (1774), and Bligh (1789) -- reported the existence of Fiji but systematic exploration and charting was not completed until the end of the 19th century [Bavadra and Kierski, 1978:1]. As is the case with many former colonies, the wealth of Fiji -- in the form of sandalwood and beche-de-mer -- was the primary cause for the establishment of settlements by the whites. In 1874, the High Chiefs of Fiji, led by Ratu Cakobau, signed the Deed of Cession to Britain and Fiji became a colony [ibid]. A colonial administration was established to oversee the economic interests based on the burgeoning coconut product and sugar industries and to govern the native Fijians. The colonial administrators followed the principle of Indirect Rule, permitting the traditional chiefly system to control the traditional aspects of Fijian customs and regulations [Nayacakalou, 1975:3]. The colonialists extended this protection of the "Fijian way of Life" into the economic sphere, resisting the employment of Fijians on copra (coconut) and sugar plantations by importing indentured laborers from India and other Pacific Islands [ibid]. This in-migration of workers contributed to Fiji's present multi-ethnic character, which is also one of the major issues -- the political rights of native Fijians

versus those of "immigrant" Fiji Indians. Fiji gained independence in 1970.

b. Geography.

Fiji consists of over 300 small islands, of which 100 are inhabited [Bavadra and Kierski, 1978:2]. About 90 percent of the 700,000 plus people of Fiji live on the two largest, volcanic islands of Viti Levu and Vanua Levu [South Pacific Commission, 1985:1]. There are two main ethnic groups, the indigenous Fijians of Melanesian descent and the Fiji Indians, mainly descended from indentured workers brought to Fiji from 1879 to 1916. After the five-year period of service most Indians chose to stay in Fiji and formed the foundation of the present Indian population. Latest census figures (1986) show that Indians (49 percent) slightly outnumber Fijians (46 percent). The remainder of the population consists of Chinese, other Pacific Islanders, Europeans and mixed racial groups. The official language is English, although most ethnic groups tend to use their native tongue in day-to-day activities with people of their own culture [ibid].

The climate in Fiji is generally pleasant, temperatures ranging from 15 to 35 degrees C. The larger islands have distinctive windward/wet and leeward/dry sides that affect the pattern of rainfall and have affected the pattern of agricultural development; most of the sugar cane plantations are on the leeward sides of the two largest islands [ibid]. Despite this relatively mild picture, however, Fiji is subject to both hurricanes and droughts that have a significant impact on the life, economy and health of the people. One relief official has observed that:

these disasters may in global terms be negligible, but in the context of the small Pacific island states, they represent a substantial impact on the national resources, capacity for recovery, and potential for future development and self-reliance [Carter, in Finau, 1987b:961-62].

Major hurricanes in the 80's seriously disrupted economic development and acted as a large drain on the governments resources. Droughts are common on the smaller coral islands in the eastern part of the group, and this year's drought has significantly decreased the value of the sugar crop. These incidences point to the fact that "few bases of economic development (including tourism, agriculture and fisheries) are not at risk from severe hazards..." [South Pacific Commission, 1985:2].

c. Economy.

The economy of Fiji is primarily agrarian and sugar is its backbone, being 68 percent of all exports in 1981 [ibid:4]. Other important export dollar earners are tourism, timber, fish, copra and coconut, cocoa and some manufactured goods [Central Planning Office, 1985]. It is a very fragile economy (evident after hurricanes, the fluctuations in world sugar and copra prices, tourist influx and the current post-coup situation) that contributes to Fiji's dependence on outside assistance in order to achieve national development objectives. A widening gap in the balance of trade during the 1980's and a steadily growing national debt - \$500 million in 1984 - continue to threaten the country's relative economic well-being [ibid]. A World Bank study reported that Fiji is one of the most import dependent countries in the world [World Bank in South Pacific Commission, 1985:3] but its economy is actually one of the most

self-reliant in the South Pacific region [ibid:3]. Fiji's dependence on foreign investment threatens its goals of self reliance and economic diversification but is unlikely to change in the future [ibid:4]. Foreign aid remains a significant factor in Fiji's economy; it received \$31.2 million in 1983 for various sectors [ibid:5].

Despite these shortcomings, Fiji has the most vigorous economy and the brightest prospects of any nation in the South Pacific region. The per capita Gross Domestic Product was \$1777 in 1985 [Central Planning Office, 1985:13] and -- to the limited extent it indicates standard of living -- can be very favorably compared to underdeveloped countries of Africa and Asia, very few of which have per capita GDP's over \$1000. Although there is some indication that there are significant inequalities of land ownership in parts of the country [Brookfield in South Pacific Commission, 1985:6], it has been noted that:

the structural organization of the sugar industry is such that it induces an unusually wide diffusion of the income generated from external sugar sales, thus permitting a very large proportion of the population to participate either directly or indirectly in sugar-related economic activities, to the extent that the Fijian sugar industry differs greatly from the typical picture of export crop production in the Third World where the absence of secondary effects is regarded as a major disadvantage of export crops [Ellis in ibid:7].

d. Health.

Health indicators also place Fiji in upper levels of the underdeveloped world. Life expectancy at birth is about 70 years and the

infant mortality rate (IMR) was 22 per 1000 in 1983 [WHO/WPRO, 1986:63]. It has escaped the heavy financial and human drain of malarial diseases and most other "tropical" diseases -- yaws, leprosy, and tuberculosis -- have been successfully brought under control during the last 3 decades.

With these relative advantages, it might be asked why primary health care, and the study of it, are even necessary in Fiji? I must admit, that when I went into Fiji I had an unspoken thesis in mind: if Fiji, with far fewer problems than the "average" African nation, cannot successfully implement primary health care (or PHC) then it would seem that this concept is beyond the reach of many of the very least developed countries. But, as I subsequently found during my field work in Fiji, (and as a minor socio-economic variation to comments made by Heggenhougen in reference to Tanzania), the integration of PHC often faces a difficult road when "the equitable distribution of health services was a major concern and health was seen, already then, as an integral part of an overall social and economic development process. It is quite a different matter to develop a PHC approach within such an atmosphere. Here the main problems are lack of drugs and transportation -- of limited resources -- and problems in management and organization" [various citations in Heggenhougen, 1984:221]. The following discussion will illustrate the underlying factors that impact on the challenge of, and justify the need for, planning and implementing primary health care in Fiji.

III. HISTORY AND PRESENT STRUCTURE OF HEALTH CARE IN FIJI

a. History.

Gish clearly states that, "in all probability, there has never been a society without its own ways of contending with illness [Gish, 1979:204]. It is also probably true that no colonial power has ever "intervened decisively to destroy popular traditional healing" [Feierman, 1985:74]. Long before the arrival of the Europeans there were traditional practitioners in Fiji who used massage techniques and herbal remedies that are still widely used today. Before the emergence of the bio-medical system after the Cession of Fiji in 1874, traditional healing provided a full range of curative medical service which included bone-setting, midwifery and psychoanalysis [Mataitonga, 1984:39]. Although plant medicines were illegal, and considered to be witch doctoring [Weiner, 197?:7], during colonial times they are still widely used. (I observed one episode in a government health office where the nurses were enthusiastically ordering large quantities of a mixture prepared by a traditional practitioner who was told where to collect the plants in a dream).

Feierman states, in his paper discussing the struggle for the control of healing in African nations, that "the political and economic forces which shaped...history also established the framework within which patterns of diagnosis and treatment, health and disease, emerged" [Feierman, 1985:73]. This fits the health history of Fiji perfectly. In Fiji's medical department history, starting in 1875, the first recorded major health problem was a measles epidemic which claimed many lives. This disease was introduced into Fiji by Ratu Cakobau following a visit

to Sydney, Australia and killed approximately 40,000 Fijians, one third the estimated population of the island group. It was followed closely by epidemics of influenza and dysentery [Fiji School of Medicine, 1987:89]. The epidemic resulted in the appointment in the first colonial medical officer who, in 1879, set up a program to train native Fijian vaccinators to protect the indigenous population from small pox "which initiated the long history of Medical Training in Fiji" [Ministry of Health: Departmental History]. Small pox and cholera arrived in Fiji with the first group of indentured Indians coming to work in the sugar cane fields [Fiji School of Medicine, 1987:89].

The future path of health care in Fiji was determined by these early health incidences and, later, by the changing socio-economic situation in Fiji. An introduced disease, small pox, came with indentured laborers brought to harvest sugar cane by the British colonialists. The first medical response by the colonial medical officer was to train local health workers. Traditional practices could not deal with this outside invader and the foreign medical model gained official ascendancy. Although it is not clear from the historical records what happened in Fiji, in many other colonized parts of the world, the health of the natives for their own sake was only the third reason for the subsequent set-up of the classic colonial medical department. The most immediate concern was to protect the health of the colonialists by preventing the spread of disease to them from the native populations [Gish, 1979:205]. Secondly, there was the need to ensure the smooth flow of products such as tea, coffee, rubber, sisal, cocoa and sugar to the home countries [ibid]. It might be presumed that this was also true in Fiji under the British.

The conquest of colonial areas led to an early domination of European forms of organization and scientific systems including a medical care system that had three major components -- the urban hospital, the rural dispensary and the hygiene or public health element [ibid]. This pattern was closely followed in Fiji with the additional program of training indigenous persons to operate in the colonial medical service. In 1888 the first three Fijian men, logical successors to the native vaccinators, graduated from a three-year course at what later became known as Suva Medical School. They were licensed as Native Practitioners (NP) [Fiji School of Medicine, 1987:89]. Nurse training commenced, also in Suva, in 1893, taught by a Miss Francis Webberburn, a personal friend of Florence Nightingale [MOH, undated:1]. Thus, all of the transposed elements of a foreign culture of medicine and health care were in place in Fiji by the turn of the century. The imprint of the colonial system has persisted up to this day in Fiji. Health professionals, either Fijian or foreign, seem to have always assumed that there was never any other acceptable system to ensure the health of the people of Fiji. In an introduction to a book about the first principal of the formal medical school in Fiji, it was stated:

Last century, the health of Pacific people was at its lowest ebb. New diseases were introduced to which they had no immunity. Conditions on plantations and ships, in mines and the new urban settlements where islanders worked, led to their death in disturbing numbers. By the turn of this century some of the worst excesses were overcome and island populations were stabilizing. In the last generation or two the health of Pacific people has been the best ever... [Guthrie, 1979:i].

There was never any question that there was another way or other reasons for improved health standards, other than the development of the European model of health care service delivery. It has only been in the last 25 years or so that people have questioned this narrow mindset. But the ideals of this system persist in Fiji through its training institutions and the structure of its health care bureaucracy and delivery system.

b. Imported Models -- Fiji's Medical Training.

Medical technology and professionalization exported from the industrialized countries to underdeveloped countries have also brought with them the prevailing standards of bio-medical education. The support of curative mechanisms, advanced technology and in-hospital care has been transferred to medical and nursing students in these nations, to the detriment of large sections of the population (as discussed previously). A major actor in this exportation has been the Rockefeller Foundation, which first assisted China with its medical education program in 1914 [Brown, 1979:585]. The Rockefeller Foundation, encouraged by an expatriate doctor working in Fiji, also contributed funds to the expansion of the medical school in Fiji in 1929 [Fiji School of Medicine, 1987: 90]. In the years that followed the school was continually upgraded in order to better prepare its graduates to practice curative medicine. The course of study was lengthened over the years from the original three to five years, the graduates from the longer course were then called Assistant Medical Officers in the late 50's [ibid]. Fendall and Tiwari noted that this development was a positive part of the

realization of the importance of medical officers that could work in rural areas [op cit:78] but this was not the final stop for Fiji's training program. The latest, major curricular change was made in 1982. The first group of students to be awarded a full MBBS (similar to medical degrees offered by the U.K., New Zealand, and Australia) was enrolled after nearly a decade of debate over the impact of this change. Both WHO consultants and the Fiji Medical Association supported the new curriculum. Others, who felt that it was more important to train professionals to local needs, to place more emphasis on appropriate primary health care and that there was a risk that this internationally recognized degree would enable more doctors to emigrate out of Fiji, were ignored in the end.

The outcome of this curricular transition offers a good example of how the emphasis on traditional bio-medical practice has been promoted through external assistance, encouraged by local medical professionals (with the same socialized, professional outlook as those in more industrialized nations) and finally helped into place by the very organization, WHO, which is alternatively pushing appropriate medicine and primary health care. One of the major starting places for instituting changes in health care priorities towards the implementation of PHC would necessarily be in the training institutions. This has occurred in the Fiji School of Nursing by implementing recommendations made by WHO in 1983 after the ministry realized that the basic training of nurses did not prepare them to carry out the specific activities required under the PHC approach. But the professional hierarchy that exists in Fiji, like most countries, still seems to resist alterations in the training program for physicians. There is a "Community Medicine"

course included in the school's curriculum but it is sketchy and, according to one member of the faculty, not considered to be a very important part of the training process by either the students or the more influential clinical specialty faculty. An influential medical educator has noted that:

the actual time devoted to specific curriculum components, e.g. social medicine, behavioural sciences, maternal and child health is less important to eventual outcome than the style of teaching and emphasis of the teacher, though it is the former that is usually stressed when trying to train doctors who will show more concern for the community [Waterson, 1982:102].

The impact of the socialization process occurring in professional training has not been measured quantitatively but it is possible to observe that when a cadre of professionals is trained in a certain way, requiring certain environments and tools to utilize their learned skills, there will be an impact on the health care delivery system. Traditionally trained doctors and nurses need hospitals and health centers to work in. When the emphasis of their training is curative and bio-medically based, they will need to be provided with technological tools and pharmacies to carry out their tasks. The form of the medical care system in Fiji reflects this logical path of reasoning.

c. The Bureaucracy -- The Ministry of Health (MOH).

The health care delivery system in Fiji has a well-developed infrastructure, designed during the colonial era. On the political side, the Minister for Health is responsible for the health care portfolio in

Parliament. Under the Minister is the Permanent Secretary for Health (PSH) who is responsible for the implementation of health policies [MOH, 1984:6]. The Ministry is centralized and there are two major sections, headed by directors, under the PSH: Hospital and Support Services (HSS) and Primary and Preventive Health Services (PPHS) [ibid]. Generally, HSS is responsible for all curative services, pharmaceuticals, dental care and nursing service matters while PPHS covers public health inspection, family planning, primary health care and health education. The PSH, the directors and assistant directors of the two major sections and the head of family planning are all physicians.

Overall, the system is divided into three divisions, broken down further into 19 sub-divisions with 64 medical areas containing 94 nursing districts [MOH, 1986:6]. In theory, curative, preventive, promotive and rehabilitative functions are well integrated in all health programs and activities [WHO/WPRO, 1986:61]. Each division has a major hospital and each sub-division has a rural-type hospital with approximately 25 to 50 beds. The divisional hospitals are headed by medical superintendents; the rural, public health responsibilities are overseen by the divisional medical officer who supervises all the activities in the sub-divisions, including the hospitals. In essence then, the major hospitals operate much like major hospitals anywhere but the rest of the system, including the essential medical personnel, has a curative and preventive role. One high-ranking medical officer stated that, because of this dual role, these lower level facilities were not really hospitals; they could not provide the secondary care expected of a true hospital.

Primary health care is mainly implemented at the sub-divisional, medical area and nursing district levels. The medical staff -- doctors,

medical assistants and nurses -- carry out responsibilities that include general diagnosis, minor surgery, dispensing of medications, giving health education talks, conducting MCH clinics and holding family planning sessions. Much of this work has not changed over the last three decades. Fiji's medical system, despite its bio-medical tendencies since colonial days, has always given much emphasis to rural health care delivered from health centers and nursing stations located in even the most remote interiors and distant islands. An extension of the town sanitary inspector of Europe, the health inspector, looks after environmental hygiene in cities, towns and rural areas. One might conclude, therefore, that Fiji has always practiced a form of primary health care because of the willingness of the government, and its professional staff, to go to remote rural areas to provide basic curative care and various forms of preventive and promotive activities.

Up until the formal advent of primary health care, however, the leaders of Fiji (much like those of other newly independent countries) did not question the essential character of the health services they adopted. Fiji was similar to other new nations which ambitiously "embarked on the preparation of medium and long-term health development plans...usually proposed the rapid expansion of virtually all aspects of the health services ... aspired to spread these services to the whole of the population ... the new services to be of a 'high standard'..." [Gish, 1979:206]. Fiji's annual reports from the mid-60's indicates that this is exactly the path they followed, limited only by the budgetary allocations. The expansion and improvement appear to have had some impact, judged by the successful decreases in infant mortality rates, maternal death rates and annual population growth, but how much of this

success is attributable to improvement in Fiji's socio-economic status is open to debate. And, despite the development of rural outposts, there still remains a nagging sense that "the rhetoric emphasized preventive and rural priorities at the same time that expenditures were overwhelmingly curative and urban" [ibid].

IV. PRIMARY HEALTH CARE COMES TO FIJI

a. Three Components of Acceptance.

As mentioned earlier, it is difficult to analyze the integration of PHC into the original medical systems in countries like Fiji because they had already adopted, in principle, policies of equal access to health care and the socio-economic development of rural areas. Aside from adopting the rhetoric developed by WHO and other international organizations Fiji's process of accepting PHC is most easily seen through three components: 1) the hundreds of seminars conducted for government personnel and community members to discuss the aspects and activities of PHC; 2) the formation, in many cases revival, of village or area health committees to consider the objectives of PHC, develop potential activities affecting health, and to cooperate with on-going government efforts in rural public health and development projects; and, 3) the training of community health workers (CHWs) by the Ministry of Health.

In Fiji, the advent of PHC (the WHO variety) first came about after direct contact with this approach through attendance by medical officials at early, WHO-sponsored PHC conferences in other countries and through encouragement by locally based WHO personnel. The first, national primary health care seminar was organized after an enquiry by WHO and a

visit by the Western Pacific Regional Director in 1977 [MOH, 1977:3]. The seminar was funded by UNICEF; the Western Pacific Regional Office (WPRO) acted as the executing agency and the seminar was jointly planned and organized by Ministry of Health personnel and Suva-based WHO office.

Subsequent PHC conferences and seminars, held overseas and in Fiji for staff from the Ministry of Health and other ministries involved with rural issues (Agriculture, Education, Rural Development, Fijian Affairs) were accompanied by frequent articles in the daily newspapers and reports on the radio describing the new approach. Fiji is both a very literate country and a very small one; the press (with presentations in English, Fijian and Fiji Hindi) has always made a significant effort to print items about health, health care and health care services in Fiji. When PHC was getting off the ground, its attractive rhetoric became good press and, today, almost everybody knows well the term primary health care.

The next phase of the introductory process of PHC was taking the approach directly to the people. Again with WHO backing, the ministry prepared and carried out hundreds of PHC seminars, initially for many villages on the area level and later for a few villages with each seminar. The ministry's primary health care file is literally packed with the program outlines and the seminar reports from 1979. Each division, and later sub-division and medical area, was directed the central ministry office to ensure that all the villages in their area held one of these seminars. Other government ministries also attended in order to explain how their projects -- including water supply, subsistence farming, cash cropping and school health education -- were also part of the comprehensive PHC approach. The organizers of each seminar were allowed to collect \$200 (later \$100) from the ministry's PHC

fund to reimburse the village participants for bus fare and catering the seminar. At certain times over the last several years, memorandums in the files indicate that there was an immediate drop off of these seminars when the money ran out. When the new allocation from WHO came, they started up again.

The main messages communicated to the people in these seminars were the principles of self-help, improvement of environmental sanitation, putting in safe, piped water supplies, cooperating with the ministry in public health activities such as immunization, MCH, and health education, and growing nutritious foods. During my Peace Corps work in Fiji I never found the village audience to be anything less than respectful and attentive in these seminars. They asked questions, made comments about their village problems and, at the conclusion, stated that they had learned a great deal and that the seminar was very helpful. For the Ministry of Health, merely holding a seminar meant that it was successful.

These seminars were often accompanied by, or followed soon after, the formation of village and area health committees to implement the advice and activities recommended at the seminar. These committees were not completely a novel idea since there had been women's associations (Ruve) during colonial times that participated in public health efforts [MOH, 1981:1]. The aim of these committees was to coordinate the community's developmental activities and to liaise with the government on issues of concern relating to health and standard of living. Most Ministry of Health personnel in rural areas were active advisors on these committees.

In 1980, early in this seminar process, the Permanent Secretary for Health issued a circular on primary health care to help guide the health

staff. It continued to stress community reliance and outlined 3 steps for implementation:

- (a) establishing contact with the people...
- (b) conducting seminars...
- (c) establishment of village health clinics [MOH, 1984:2].

The circular essentially underscores the ministry's basic approach to PHC in those days, to continually reiterate the basic WHO principles, hold seminars, encourage the staff to work with the people and help form committees. I am personally familiar with the indirectness of this approach; as the health education officer in one of the divisions I assisted in carrying out many of these early directives. I was concerned at that time, as I still am, that the translation from rhetoric to reality is not as easy as WHO seems to believe. I believe that practical, successful implementation of PHC demands more than just a reiteration of policy, no matter how sensible or logical the policy seems to be. A report from one of the seminars our divisional team conducted in 1980 recommended that:

A primary health programme demands a broader scope of actions beyond the simple maintenance of village sanitation and the installation of water-seal toilets...Some medical workers also feel that there is a lack of direction beyond the initial seminars. The short-range goals of improving village conditions and sanitation are clear but the long range advantages of educating the rural people about ... health basics remains obscure and unstated. Both long- and short-range plans, furthermore, are being hindered because of a lack

of real departmental commitment in staff or money, to follow-up the positive steps taken with the special WHO funds at these seminars...

The Permanent Secretary's reply gives a picture about the common assumptions and misunderstandings of PHC implementation in Fiji during the 1980's. His memorandum to the divisional medical officer included the following comments:

- dismay that "my informal discussion with the divisional staff...had not enabled them to understand what we are trying to do and what primary health care is all about,"
- "primary health care starts everywhere and ends nowhere,"
- "...the staff must find a focal point in the community in which to establish contact. Once this focal point is established and the people are receptive to the idea of improving their own standard of health by contributing manpower, material and financial resources, then seminars to get this idea across to as many people as possible should be undertaken," and
- "I have purposely avoided issuing circulars on the subject of primary health care because our approach to people must vary from area to area."

As I re-read these comments, after 7 years, I was struck again by what bothered me about the primary health care approach being advocated in Fiji. Focusing on the underlined sections it is still apparent that the integration of PHC into the normal operations of the ministry was attempted without any real direction. Under the guise of flexibility, although a necessary element of PHC, the ministry avoided clarifying exactly what were its overall objectives and, beyond this, how these could be achieved. The expectation that informal discussions or circulars could, by themselves, explain the very complex concepts of primary health care (which to this day are illusive to people who have studied the subject for years) was naive. Without really examining what sorts of factors -- bureaucratic, political, or cultural - existed in Fiji, the program was superficially grafted onto the relatively successful rural health care delivery system.

In this research many ministry repondants complained that their PHC efforts lacked direction due to a lack of a clear, operational policy. They were guided only by rhetorical signposts. Others complained that the money very often became more of an issue than the actual content of the seminars; several pointed out that the traditional Fijian culture, although easy to access, also dictated that at least half of a seminar (usually held over one or two days) was devoted to traditional ceremonies which demanded, and received, at least as much attention as the promotive objectives for primary health care.

The final major focus of primary health care in Fiji became the training of community health workers (CHWs). These workers, to be selected by the community themselves, are the backbone of many PHC programs around the world [Werner, 1977; Behrhorst, 1975; and others].

Their roles vary from place to place but in Fiji they are expected to be community advocates for healthy change, liaisons between the community and government medical staff, able to treat minor conditions and refer more serious illnesses to government facilities, and to conduct health education sessions for their community. From early attempts in two areas in 1981, the program has expanded tremendously throughout the islands. Although there is no accurate count of how many have been trained, and how many are still working, it is estimated that over 800 CHWs have been trained in Fiji. Like the seminars, they have become powerful symbols of the primary health care program in Fiji. But, like the seminars, a lack of operational policy has hurt their effectiveness.

A general outline for their training was only completed in 1985 but it has not been consistently used, possibly because some consider it far too advanced for the CHWs. As the primary health care evaluation, performed in 1984 by WHO and the Ministry of Health, noted: "it appears uncertain how consistently the workers will be involved, beyond simple curative duties, into preventive aspects and community leadership" [MOH, 1984:28]. Their main role is as extenders of health care, reducing the work load on rural health care staff and helping direct rural people to appropriate care. Again, as with the seminars, the point I am trying to make is not a criticism of the intent of the CHWs because they are a valuable asset to both the community and the government of Fiji. But their existence within the primary health care program has proceeded without sufficient evaluation of what they are expected to achieve, and how they truly fit into the cultural framework in which they sit.

b. Analyzing Aspects of the Adoption of PHC in Fiji.

Superficially, a strong government commitment to PHC appears to have developed over the last decade. While Fiji's Seventh Development Plan (1976-1980) makes no mention of primary health care, only describing the public health programs normally carried out by the Ministry of Health, the Health Sectoral Plan of the Eighth Development Plan (1981-1985) makes specific note of PHC and the Health-For-All strategies, and names the objectives, targets and activities of the eight primary health care components (Fiji usually describes nine because it separates drinking water and environmental sanitation) [MOH, 1980]. But depth of this commitment is deceptive because Fiji already had substantial activities addressing the nine components laid out by WHO; primary health care just became "Programme 1" (as outlined in Development Plan 8) that fit into the medical care system next to "Programme 2," hospital and rural medical services. This makes it very difficult to substantiate actual changes -- as opposed to rhetorical changes clearly evident in government policy papers, pronouncements in the local newspapers, and speeches made by officials of the Ministry of Health -- made to health care during the process of adoption of the PHC approach.

More substantially, there appears to have been no change in budget allocation for activities subsumed under the primary health care program. There has been a re-orientation of rural medical staff's job focus -- through ministerial directives, memorandums and seminars -- to emphasize primary health care objectives, and more funds were allocated for the construction of rural health centers and nursing stations but this does not represent a real shift in government budget priorities towards PHC. In most cases, as my respondents discussed, most of the extra funds

needed for increased rural outreach were derived by stretching the existing budgets for sub-divisions, health centers and nursing stations. As stated earlier, the rhetoric does not often match the reality; so it appears too, in Fiji on a budgetary level.

An examination of the budget for health care over the last 25 years gives some sense of the expansion and focus of the health care system in Fiji. In 1961 (still under colonial administration) the total medical department budget was approximately \$2 million dollars, 13 percent of the total colonial budget [MOH, 1970:77]. The per capita expenditure was about \$4.71. By 1970, the first year of independence, the medical department budget had increased to \$3.8 million (but only 9.5 percent of the total budget) and represented a per capita expenditure of \$6.50 [ibid]. After only another decade the budget had ballooned to \$19.4 million, only an 8.35 percent share of the national budget but a per capita expenditure of \$30 [MOH, 1980:31]. In 1984, the last year for which figures are available, the health budget was about \$36 million with the related per capita figure of \$52 [MOH, 1984:16].

This data does show that, despite an increasing population base, the government of Fiji was determined to provide a fairly high standard of health care services. The data, however, is not sufficient enough to break down the expenditures from the 1960's and 1970's budgets into categories according to curative care and preventive activities. The best indicator of the government's commitment, regarding services, is the per capita figure. Many other underdeveloped countries struggle to provide \$15 of health care per person. The period between 1970 and 1980 was a time when the Ministry of Health set and realized goals to build many more nursing stations in rural areas; there was a general expansion

of the system's ability to provide basic care to almost all the remote interior areas of the larger islands and the far flung islands.

The more detailed data available from Ministry of Health budgets of the 1980's permits a deeper analysis of how Fiji was spending its health care dollar. The most striking aspect of these budgets is the large percentage allocated for personnel, which in Fiji falls under the category of personal emoluments. In essence, all health care in Fiji (except for a small number of private practitioners and clinics) is provided by the Ministry of Health. This means that the staff are civil servants and their salary/support is part of the yearly budget. In 1980 personal emoluments equalled 86.5 percent of the total health budget. By 1984 this had dropped to 77.3 percent but was still the major expense of the health sector [MOH,1984:18]. This is at the high end of comparable figures for other developing countries, which usually spend 60 to 90 percent of their health budgets on personnel [Mullan and Bryant, 1984:3146].

What conclusions can be drawn from characteristics and trends of these budget numbers? Fiji's health care budget, despite its relatively high per capita figures, appears inadequate for the population of Fiji when considering that much of the money goes to support the staff. Fiji pays its civil servants relatively well -- depending on which other country is used as a comparison. If the comparison is New Zealand or Australia then the health staff can be considered underpaid. This appears to be the comparison used by the staff, particularly the physicians. On the other hand, in comparison to other developing countries where civil servants often need second or third jobs to support their families, the Government of Fiji pays its employees well; it is

quite possible for the Ministry of Health personnel to support their families comfortably. (See the quote from Hau'ofa about the affluent attitudes of people in the Pacific). The salary expectations of government health care staff have taken a big bite out of the health care budget. The perfectly understandable desire for a comfortable living and a comprehensive health care system, however, has contributed to unrealistic expectations of what the ministry can achieve with its limited health budget. Public and professional expectations have had a great impact on the form of health care in Fiji, as I will discuss later.

Additionally, under the medical service program budget of 1984 roughly 50 percent of the total allocation goes to urban hospitals and health centers, 13 percent to sub-divisional hospitals, 9 percent to rural medical and nursing stations, 3 percent to public health services and 6 percent to drugs and medical supplies [moh, 1986:17]. Three comments may be made from these statistics; first, as is usual with the bio-medical, post-colonial model, a greater percentage of the health budget is devoted to populations in urban areas. In Fiji, the rural population was estimated to be about 63 percent in 1984 [WHO/WPRO, 1986:62] but according to the 1984 MOH figures only 22 percent of the budget was given to sub-divisional hospitals and medical facilities providing basic services to rural people. Secondly, the budget still reflects the propensity in Fiji to emphasize health care delivered from traditional facilities which tends to re-enforce the public's view of a ministry whose main service is only curative. While it is true that most staff at and below the sub-divisional level are considered to have a dual role, curative and preventive, the facility-orientated infrastructure encourages the staff to concentrate on curative services within the

walls, to hold outpatient clinics and generally be besieged by people seeking general medical care, not primary health care definitions or preventive advice. Finally, there is no separate line item in the budget for primary health care. Officials in ministry headquarters usually explain this by describing the dual role of staff, the budget for primary health education materials produced by the central office, transport utilized in making field visits critical to primary health care outreach and the ministry's position that each staff member, on every level of care, conveys the primary health message to the public. Further investigation revealed that, in fact, the funding for activities labeled specifically as primary health care, including the seminars and some of the support for CHW training, (as opposed to those more traditional activities such as health inspection, immunization, family planning, nutrition, and maternal/ child health services that are now considered part of the total primary health care approach) actually comes almost exclusively from external sources. These have been principally WHO, often as the executing agency, and UNDP or UNICEF who provide the actual funds. This has influenced the character of PHC in Fiji, as will be discussed below.

When asked whether there should be budget changes to accommodate the basic goals of PHC a majority of government respondents replied strongly to the affirmative, although the physicians interviewed often believed to the contrary. One medical superintendent actually thought that too much emphasis had been placed on rural populations in the past 20 years and that future budgets should target improvements in hospital-based, curative care. Almost unanimously, however, the respondents said that there should not be a decrease in money for curative services, only an

absolute increase in PHC funding. Most believed that even curative services were under-funded and could not withstand a budget decrease without a significant drop in the quality of care.

V. HOW INTERNATIONAL AGENCIES HAVE INFLUENCED PHC IN FIJI

There are many international development agencies with offices in Suva, the capital of Fiji. Besides the bilateral agencies of Australia, New Zealand, Japan and the United States, there are approximately 30 of the United Nations "family" of agencies who cooperate on some basis with Fiji [United Nations, 1985:1]. The main organizations that are relevant to primary health care are United Nations Development Program (UNDP), United Nations Fund for Population Activities (UNFPA), World Health Organization (WHO), United Nations Children's Fund (UNICEF) and the United States Peace Corps Office. Despite the similarity they all share in expressing the desire to help Fiji plan and implement the primary health care approach, each has its own organizational objectives that are often contradictory and unhelpful in Fiji's development process. Countries like Fiji, with their dependence on foreign assistance, vary 1) in their ability to dictate to these agencies what sort of projects they wish to promote and, 2) in their ability to absorb efficiently the funds in a way that benefits and strengthens their own development objectives. Most of the government employees in the planning and health sector and the representatives of these funding agencies gave Fiji high marks in both these areas of aid utilization. Nevertheless, I found that the funding policies and the internal objectives of the external agencies

have a great potential to influence the directions of Fiji's primary health care program.

I have stressed the fact that the main impetus for primary health care in Fiji has come from international agencies, particularly WHO. WHO has had a sub-regional office in Fiji, covering much of the South Pacific, for many years. There has always been a close working relationship between Fiji and the WHO staff based there. Although WHO does not appear to give greater support to Fiji, which is more socio-economically developed than the other island nations within its area of responsibility, central office staff of the Ministry of Health and WHO workers in Suva stated that "when they can get on the phone to discuss programs or literally walk across the street for consultation it benefits Fiji." One U.N. official claimed that Fiji's requests for project funding is effective because "they have learned all the tricks from their WHO counterparts." The physical proximity of the ministry helps circumvent the usual formal routes towards programming funds and has created a situation where the Ministry of Health, with its PHC so identical to the WHO model, has been called a "slave of WHO." One consultant further commented that the basic reason for this "match" was that WHO constantly brings in consultants -- who all speak the same "lingo" and talk the "party line" -- which influences the few, centralized decision-makers in the Ministry of Health who are in frequent contact with WHO.

Other than the desire to "help Fiji follow the PHC approach," it doesn't appear that WHO in Fiji has any definitive or long-range goals. Over time the main emphasis of their assistance has shifted and, at times, been contradictory. This can be attributed, in part, to the fact

that WHO considers all elements of health care to be in its domain and in part to its funding by programs, not by country. While it is busy promoting the integrated, horizontal aspects of PHC, it is also stating that "health laboratory services will be strengthened to meet the diagnostic, case managing and monitoring needs of curative and preventive medicine ... Measures will be taken to promote and improve the use of ionizing radiation and other imaging techniques" [WHO/WPRO, 1984:xviii].

For many years WHO supported the traditional bio-medical and public health aspects, including sanitation and family planning, in Fiji. In the mid-70's the main program assisted by WHO was the Family Health Programme, funded by UNFPA. (Many of the programs in which WHO is involved, as the technical or executing agency, are actually funded by UNDP, UNFPA or UNICEF.) The focus of this program, as the name indicates, was to direct efforts towards the family instead of the individual. There was a WHO Advisor to the Programme whose term of reference stated that he was to concentrate on the fields of MCH, family planning and health education through assistance to the ministry in the planning, programming, implementation, management and evaluation of the programme [MOH, 1979:1]. Essentially, then, he was helping the ministry focus on traditional, vertical programs at the same time that WHO was pushing integrated primary health care. Efforts such as this that have continued to emphasize vertical programs even while publically rejecting that emphasis; countries like Fiji will follow this tortuous route to their detriment because of their need for technical assistance and monetary input to achieve certain objectives. But the price is a confusing shift of priorities over time that retards Fiji's ability to operate efficiently. WHO, on the other hand, can implement many of these

projects, each with separate funding and separate personnel, without ever suffering the consequences. The situation is, therefore, a vertically staffed and oriented agency that is purportedly promoting integrated primary health care.

The vertical interests of the other agencies have also hindered the formation of a coherent, long term policy within the Ministry of Health. UNICEF has long been an agency that operates primarily on a vertical basis. Although UNICEF was an integral part of the Alma Ata Conference planning and implementation, its programmatic focus on children has operated on its own set of objectives. Since the late 70's UNICEF has simultaneously promoted oral rehydration therapy (ORT) to prevent deaths from infantile diarrhea and the expanded program of immunization (EPI). These are very important efforts but the training and orientation for these programs often compete for the field staff's, primarily district nurses, time. Several respondents within the Ministry of Health noted that demands of the vertical programs, including MCH and family planning, were too much for a district nurse to handle well, given their level of training and support.

In Fiji, the major focus of UNICEF has been mother and child nutrition. It has worked closely with the Ministry of Health, the Ministry of Agriculture and the National Food and Nutrition Committee in programs designed to prevent malnutrition discovered in several nationwide surveys since 1980. Here again, the intentions and objectives of the program appear reasonable; it is only that these agency priorities encourage health staff in the field to look at only one health problem at a time. For example, when the UNICEF program emphasized weight for height surveys, new groups of CHWs, supported by UNICEF funding, are

trained specifically to assist in these surveys, and health education sessions are organized to train mothers. But what happens to the other aspects of primary health care in the mean time?

UNFPA also has been recently, unintentionally responsible for some fragmented program priorities within the ministry. It has been a major actor in an interesting story of how a global ideal is translated into policy and action at the country level, potentially pushing aside other, on-going programs.

In 1984, the Prime Minister for Fiji participated in the International Conference on Population held in Mexico City. Upon his return, discussions initiated in the Cabinet and the Central Planning Office led to family planning being given the "highest priority" during the Development Plan Nine period (1986-90) [MOH, 1986b:1]. The Ministry of Health was assigned the responsibility for bringing the birth rate down to 25/1000 live births (from 30/1000) and reducing the annual population growth rate to below 1.9 percent (from 2.1 percent) by the year 2000. A Ministerial Task Force was appointed after a meeting of a Family Planning Ad Hoc Committee. During a 1986 family planning workshop several reasons were considered important for explaining the decreased success of Fiji's family planning efforts, once considered by IPPF to be one of the best in the world [ibid]. These included:

(a) a change in the official emphasis on the Family Planning programme;

(b) a shift in priority from Family Planning to other Primary Health Care activities; (italics mine)

(c) a reduction in financial commitment to Family Planning in 1970's which continued during the DP7 and DP8 periods. [ibid:66]

These three rationales for program failure incorporate all the worst elements of conflict of interest between vertical programs and shifting priorities -- promulgated by international agencies -- and long-term, integrated processes of more benefit to Fiji. The family planning program should be an important, integral aspect of PHC, rather than blaming the recent re-orientation towards PHC for family planning's lack of success. The fact that the statistical goals of this re-energized program are no different than those stated during the last five year period, 1981-85, underscores the program-redirecting influence of verticalization. Later in the workshop report, the complaint is stated that because of integration with several other programs such as nutrition, hypertension, eye care, sanitation, and diabetic care, specialized nurse and medical personnel who spent a major part of their time on family planning can no longer adequately accomplish their family planning tasks in the field [ibid:68]. This comment supports the observations of senior nursing officials that the heavy demands of vertical programs, combined with the objectives of integrated PHC activities, are often too much for a nurse to competently achieve.

The outcome of this re-emphasis on family planning, although generally denied by my respondents in both the Ministry of Health and the international agencies, is a call to gather funding and determination to mount a proper campaign to attack the problem. A National Center for Family Planning and Population Activities will be established with a staff of six and a detailed workplan for the next five years. A budget of \$1.5 million for the five years of the program was proposed, with \$1.2 million of it earmarked for staffing [ibid:85]. Because UNFPA has spent

\$1.5 million on family planning activities over the last 10 years (this seems to belie the claims that primary health care got all the attention, since this is substantially more money than PHC activities have received) without clear results it wants to carefully track these funds. This desire for budgetary control has led to the specialized section being set up in the ministry and makes it far more likely that the program objectives will more closely match the wishes of WHO/UNFPA than of the government of Fiji. The saying: "He who pays the piper, calls the tune," is very evident here.

Another overseas agency I would like to discuss is the United States Peace Corps which is not involved in development financing but does provide technical assistance through manpower support. The Peace Corps has had volunteers in Fiji for over 20 years. It has always had a very high volunteer per capita ratio probably because the presence of the major U.S. bilateral funding agency, USAID, has a more limited presence in Fiji than in other developing countries, and Peace Corps represents a positive U.S. presence in Fiji. (One officer of USAID in Suva believed that this was because the American government did not consider Fiji of enough strategic importance to warrant more assistance.) Similar to other agencies, the Peace Corps' stated goal is to assist Fiji in its development process, by providing volunteers with varying degrees of training and experience. Volunteers have participated within the general primary health care program of the Ministry of Health since 1979, when I was first assigned there. At that time there were four health educators working in each of the then four divisions on programs of health education and primary health care development. Volunteers have had a significant, positive impact on the program, particularly in the area of

educational material production, where they have acted as artists and planners, and in the training of both ministry staff and CHWs in areas of primary health care.

The number of volunteers working in the ministry eventually expanded from the original four persons to approximately thirty at the beginning of 1987. This expansion has had several potentially negative impacts. First, the availability of volunteers has kept the ministry from establishing needed staff positions of health education and planning. The "cheap labor" provided by volunteers has helped the ministry solve its chronic staff shortages but the short, two-year terms of most volunteers has led to a damaging lack of continuity and permanence in vital primary health care programs. Secondly, the expansion of health volunteer programs occurred without clearly stated goals and plans for overall integration with Ministry of Health objectives. Many of the programming decisions were made on an informal basis between the Peace Corps Health Program Officer, a local nurse, and the ministry. These realities prevented a true evaluation of the impact of, and need for, volunteers in the ministry's PHC activities. Peace Corps is presently evaluating its program support of health care activities but it remains to be seen if they will take the step most donor agencies avoid: admit the possibility that they are doing more harm than good in Fiji while pursuing their own organizational policies. Although this situation is very dissimilar from the other donor agencies, it could be an element of primary health care not often considered in program evaluations.

VI. LEADERSHIP, TRADITIONAL CULTURE & PRIMARY HEALTH CARE

Many projects and programs -- whether in health or rural development, in a government bureaucracy or private business or in a large political organization or a small village community -- are dependent on strong, insightful leadership for their success. This can also be said of the primary health care approach; from the very top of WHO -- where the personnel commitment and vision of the Director-General, Dr. Halfdan Mahler, has fueled the primary health care movement for over 10 years -- to the local village health committee where a retired school teacher applied his single-minded dedication to the improvement of his community. While the essential qualities of leadership have been examined in many sociological studies, there seems to have been little or no examination of the role of leadership in primary health care.

After nearly ten years of experience and study in this field I was struck by a peculiar element common to many successful primary health care activities on a variety of levels. Each of these projects involved a single, charismatic, driving personality who put all of his or her considerable energy into the project. Consider, for example, Behrhorst in Chimaltenango, Guatemala; the Aroles (a husband and wife team) in Jamkhed, India; and Werner from Project Piaxtla in Mexico. Probably all of these people would deny that their role was so critical but I believe, that modesty notwithstanding, that without these individuals, and others like them, the successes would have been significantly less or failures. Of course, there is no adequate way to evaluate a leader's role in PHC, any more than of any other pivotal leader in history.

There are several major reasons for why this type of charismatic, unselfish leadership seems to be a critical element in the primary health care approach. First, the forces acting against the implementation of primary health care are considerable. In many places the medical professional, pharmaceutical and capitalist interests often fight against the implanting of primary health care principles of health care egalitarianism, standard drugs lists and appropriate technology. Any national or regional primary health care program must resist both the overt and subtle pressures applied by these extremely powerful and cohesive species. A committed leadership, with the committed co-workers, colleagues and participants, is an integral part of this resistance. Secondly, in some countries (although not Fiji) primary health care has integrated a process of awareness, concientisacion, and self-reliance that so threatens the ruling elites that they have resorted to murdering the CHWs as agents of change [Heggenhougen, 1984:219]. And thirdly, the concepts of the primary health care approach, although logically and apparently rational, are so subtly complex and programmatically vague that it often takes the committed vision of a leader or leaders to shepherd it through the intricate processes of policy setting, planning, pilot efforts and more permanent entrenchment. I believe that where this is lacking, on any social or bureaucratic level, the primary health care approach is non-viable.

The issues of leadership are equally important in Fiji. I have had the opportunity to observe this both during my professional and more recent research experiences there. As mentioned in the introductory section, my own programmatic tunnel-vision prevented me from truly understanding the vitalness of leadership during my Peace Corps years but

I still realized that some of my own work depended on a few key individuals. I will discuss that shortly.

The process of promoting and adopting the primary health care approach, on international and national levels, has included very little cultural, anthropological research. This is very unrealistic because PHC is not being implanted into a vacuum. This is also true in Fiji where the issues of leadership -- traditional, bureaucratic and democratic -- are important aspects of not only primary health care but all development efforts. These are also issues of national importance today as the people of Fiji struggle to define how democracy and traditional leadership should interact. It was to my advantage, although a difficult and tense period for the residents, to be in Fiji at a time when questions of leadership were asked daily in the press and in private conversations. To understand how these questions are pertinent to this study, it is important to understand the traditional form of leadership and the national form of government.

All indigenous Fijians are descendant from specific groups resident in villages, the basic living unit. Their blood relationships through this line of descent determine their traditional ownership of the land and their allegiances to the heads or chiefs of these units. The ancient patrilineal line of descent formed the yavusa; each of the sons of this head formed their own social units called mataqali and in a similar manner the first family of sons in each mataqali founded the various i tokatoka [Nayacakalou, 1975:11].

The village has an important bearing on the structure of Fijian descent groups and is also the primary unit of social organization in Fijian society [ibid:14]. In overall structure the village usually has

two orders of segmentation, the mataqali and the i tokatoka. At the head of the village, based on seniority of the above mentioned groupings, is a traditional chief, the turaqa-ni-vanua. Above that level is a further grouping, alternatively considered a collection of yavusa or an association of villages, the vanua [ibid:22]. There is also a traditional leader, or tui, of this unit also.

The importance of this structure comes when examining the community decision-making process, such as would be important in primary health care. In brief, from Nayacakalou, the chiefly office:

confers upon the incumbent a definite right, subject to conditions, to make decisions on all matters affecting the group as a group. Although an individual member of such a group has some freedom to deal with his own affairs as he likes, there are few contexts in which his group considers them to be entirely his own, because his actions are likely to have implications for his group, which therefore takes a keen interest in the welfare of its members. Thus 'private affairs' may be brought into the orbit of 'group affairs' In practice, most matters are group matters and are known as ka vakavanua (matters of the land), which involve the group in its relations with other groups in the village or outside it. The chief's jurisdiction covers all matters vakavanua, and he has a definite right to make decisions on behalf of the group. When decisions are reached otherwise, they are inconclusive because they may be repudiated by him until he stamps them, as it were, with the seal of his authority [ibid:31-2].

These issues are most relevant to the primary health care approach at the village level, where the principle of community participation has been a foundation of all activities. Fiji, taking the WHO methods to heart, has always been committed to incorporating the traditional village structure when introducing primary health care. The Working Group conducting a primary health care evaluation in 1984 noted:

The background to community participation in rural Fiji has not yet been analyzed from sociological and anthropological perspectives (but) ... It has been repeatedly affirmed that the traditional Fijian way of life was consistent with primary health care ... factors such as interest in communal welfare, self-help traditions and organized community action. It was commented that the chiefly structure still exists, that health workers need to make the right contacts at village level and that chiefs need to see their own role in health promotion...An occasional concern is the poor progress in leaderless villages. [moh/who:76]

The important sentence in the above paragraph is the last one. The traditional society appears to be run on the principle of a 'benevolent dictatorship.' As noted by Nayacakalou, the chief retains the final veto in all village matters, although in principle decisions are made by consensus. In Fiji, primary health care will not run without the "stamp of approval" from the traditional chiefs. The common people of the villages do participate in primary health care seminars and village/area health committee meetings; but they are often reluctant to speak their opinions if it seems to contradict the wishes of the chief, usually

present in person or by proxy during these sessions. As one public health nurse noted, "there is peer pressure against people who want to think as individuals." Due to the strong hierarchical authority, which operates in all village activities whether it is building a church or community hall, receiving an honored guest or holding a PHC seminar, the people are not well versed or accustomed to making individualistic decisions. As stated, this is most evident in leaderless villages where primary health care has been less than successful. For Fiji, then, the traditional system has been an effective companion to organizing and directing community participation. This is very different from countries such as Guatemala where the democratization process embodied in the acceptance of primary health care principles has included a restructuring of some village societies.

This culturally inherent means of gaining a whole communities cooperation in Fiji has had another impact on the primary health care program as a whole. From available records it appears that approximately 90 percent of the primary health care efforts -- represented by the major activities such as holding seminars, forming health committees and training CHWs -- have occurred in rural Fijian communities with far fewer activities occurring in Indian settlements. During my interviews I found that respondents (Indians and Fijians, government and international workers) had many explanations for this -- including the tendency of Indian physicians to prefer clinical work rather than public health postings, the assumption that rural Fijians are more needing of primary health care assistance than Indians, and the assumption that the Indian population is generally not interested in health care self-help projects, just better access to modern facilities. But the explanation that is

most pertinent to this discussion is that Fijian cultural characteristics produce a viable and cooperative community. The Fijians, with their unified village situations under recognized, respected leaders, are much easier to bring together than the more scattered Indian community, usually broken into family units only sometimes related to other families in the general vicinity. Each Indian family pursues its own source of income and expects to benefit from the fruits of labor as a family, not communal, unit. (In Fijian village the communal drain on people's time, energy, and finances was several times mentioned during interviews with primary health care staff in the field as a reason why, contrary to the organizing benefits of the structured Fijian community, people's attention to primary health care activities was not consistent.) Also, Indians in rural settlements can be prosecuted for non-compliance with public health standards while Fijians in villages are exempt. This fact alone has meant that Indians, in general, have a better standard of environmental sanitation -- a factor in the earlier stated assumption that they are less in need of grass-roots primary health care.

During the period I was in Fiji conducting my research this issue of voluntary, communal cooperation in health and development projects versus compulsory participation in environmental sanitation via legal statutes was of some importance. As stated in the Fiji Profile, there had been a Fijian Administration operating during the colonial period that governed the Fijians' traditional life and customs. After independence this entity became part of the Ministry of Fijian Affairs -- under which the Ministry of Rural Development also falls -- and continued to look after the indigenous people's land, customs and welfare. This system, up until 1967, included a government administrative structure that paralleled the

chiefly, ruling system in the villages, the districts or tikina and the provinces. The appointed native officials, under Indirect Rule, were called, respectively, the turaga ni koro, the Buli, and the Roko [Nayacakalou, 1975:83]. This administrative system was

empowered by law to organise some of the activities of the Fijian people for their own social, economic and political development ... concerned with Fijian welfare (that is with the promotion of higher standards of living through the building and upkeep of schools, better sanitation, better housing, water supply and even the planting of food) ... The system depended heavily on the traditional structure of leadership [ibid:85].

Similar to the traditional system of leadership, this administration had a very paternalistic style of authority. When coupled with the authority of the medical department, it meant that any person not complying with the regulations could be subjected to fines. If a family resisted orders to clean up their house or kitchen, it could be burned to the ground on the word of a medical officer. But, as mentioned above, this system with its regulations was abolished in 1967. The importance of this was that in March 1987, the system was re-started with its attendant Fijian by-laws, because the traditional and government leaders felt that the standard of living in villages had severely deteriorated without the legal, bureaucratic back-up to traditional chiefly control. The unspoken belief of some respondents, including some very senior officials in the Ministry of Fijian Affairs, appeared to be that rural Fijians could not be expected to push themselves without pressure from ruling officials and regulations.

Many local government respondents, both Indians and Fijians, were of two minds when questioned about the return of village by-laws, including public health standards, and their role in the PHC approach. Although most agreed that it was better to educate people and include their participation on a voluntary basis than to compel them to cooperate. But many, particularly the Fijian health workers, also appeared to have beliefs similar to the senior officials; if people don't cooperate in activities that are good for them then there should be some recourse for the government to gain that cooperation. This didn't appear to be a contradiction for some, despite being the antithesis of Freire's ideal of community conscientisacion as the most important element of community participation. I believe that it reflects the basic Fijian acceptance of paternalistic social structures. It also was very interesting that many of the villagers seemed to have the same feelings about the necessity for administrative and traditional pressure, although they were quick to point out, in private, chiefs and officials that acted against their interests. While the ideal of community participation is important, in Fiji it should be understood that true participation in the decisions about health care and development at the village level does not occur. The government has presented the rural people with a pre-packaged PHC plan which effectively needs only approval by the traditional leaders before the actual participation, following the prescribed prescription, begins.

These same issues of leadership, or the lack of, were evident in several of the places I visited during my research, some of them places where I worked before. Two villages, side by side, comprising members of the same mataqali, showed obvious differences related to the quality of

leadership. In one, with a strong and dedicated leader, the village looked prosperous, clean and even had a few homes with videos. The other was claimed to have had suffered from longstanding disputes between the two i tokatoka; the weak leadership of the members of one group was quite evident in the state of village health and life. The people of that village seemed to resignedly accept this state of affairs, despite the negative impact it had on the quality of their lives. As one community respondent said, "You can't overthrow the turaga (chief) in Fiji," meaning that one must accept the status quo whether it is good or bad.

One final note on the interaction between leadership and primary health care. It came to my attention during this field work that several of the early, committed medical staff who initiated some of the first primary health care efforts also were of chiefly status, obviously lending greater weight to their efforts in their own communities where they were stationed. In another case, a very influential, dedicated leader of a area health committee described how the traditional position of his matagali, that of critical advisor to the chiefs, allowed him to criticize conditions in his area without suffering the repercussions that the average villager would experience after making the same statements. It is difficult to evaluate which of the factors, government/traditional authority or personal attributes of dedication and creativity, played a greater role in the success of these area projects but this juxtaposition certainly represents a compelling mixture.

VII. PUBLIC DEMANDS, LOCAL POLITICS AND DOCTORS

a. What the People Want?

Public demand has been a major influence, interrelated with several factors, upon the way PHC has been perceived and implemented in Fiji. The government system, staffed by civil servants, provides most of the health care available to the people of Fiji; the private sector offers only limited services.

In Fiji's form of parliamentary government, public demand for services -- channeled through local politicians and professional interest groups -- can shape the decisions the government makes about how and where it spends its health dollars. Individuals or groups of individuals can relay these demands through a special interest group, an elected official or through the press.

Although it is not accurately known what people want from their health care system, since no one has ever conducted a Fiji-wide public opinion survey about health care, it is widely presumed that people want more hospitals, more health centers, more doctors and nurses. The most visible elements of the health care system are its hospitals and, as Ugalde has pointed out, in the minds of politicians and the public, health is equated to medicine [Ugalde, 1979:112]. When people think about health care, they consider what is available when they are sick and what type of care will cure their ills and make them feel better as the important issues. It is the curative side of health care that fulfills this demand.

It would be a mistake to consider, however, that all communities have the same demands of the health care system. Elliot has observed that:

the priority accorded to health care varies directly with the level of development of the community. The higher the general level of education; the higher the general level of income...; the greater the exposure to mass media; ... the higher priority is accorded to health care ...[Elliot, 1979:68].

As noted earlier, Fiji's people have achieved a standard of living that has shaped their outlook on development and what they want out of life. In looking at their health care system they compare what's locally available with Auckland, New Zealand, not with Addis Abbaba, Ethiopia. Although the rural population appears not to desire as much health care sophistication as urban dwellers do, rural respondents in my field work often stated a greater desire to have more district nurses and health centers not more community health workers.

There also appears to be some difference between the Indian community and the Fijian community in their expectations and utilization of the health care system. Many of the health care professionals interviewed noted that Indians were more likely to come into the outpatient department with minor complaints than Fijians, who often waited until very late to have serious illnesses seen in the clinic. One doctor said, "I spend most of my time telling Indian patients that their illness is not serious and telling Fijian patients that their illness is serious." Another public health worker mentioned that she believed that

the Indian community doesn't ask for primary health care like the Fijians do -- they just ask for more hospitals. The Indian community, with a greater urban population than Fijians, can therefore influence the public demand for more urban-centered, curative care offered from hospitals. As one member of the Fiji Medical Association stated, the Indians pay their taxes and expect a 100 percent return in the health care offered to them. One must assume he meant hospital services, not environmental sanitation programs.

b. How the Media Affects Government Health Care Decisions.

The press in Fiji reports on many health care issues. My review of the two daily newspapers from 1979 uncovered articles about bio-medical advances, international health news, medical economics, primary health care issues, local health statistics (number of hospital beds, nurses and doctors), and complaints about the Ministry of Health and the state of health care in Fiji. Because of this extensive press coverage the general public in Fiji seems very sophisticated about health care matters -- I was often asked during my Peace Corps work in the rural areas about heart transplants and kidney machines -- and are very aware of the disparities between the medical care available there and in the industrialized nations. This creates a demand for medical sophistication that is well beyond the capacity of Fiji's financial and manpower resources to satisfy. It creates pressure on the government to provide medical services instead of expanding their primary health care approach.

Negative press coverage appears to carry great weight in Fiji's Parliament and in the headquarters of Ministry of Health in Suva. In 1978 there were several well-publicized incidents involving some patients

in government hospitals. The government, pressured by the public outcry, formed a committee of inquiry to investigate the problems. The preamble from the resulting report lends great insight to the powerful force of public disclosure about health care service problems:

A series of incidents took place in mid-1978 involving patients of some hospitals as well as members of the public who had sought treatment in the outpatient departments of a few hospitals. There was some indication that the standard of health that general public was entitled to receive was not up to expectations. Some members of the public expressed concern over these incidents with the result that the Minister for Health, The Honourable E.J. Beddoes, following a debate in Parliament, appointed a Committee of Inquiry into the Health Services in Fiji [Parliament of Fiji, 1979:1]. (Emphasis added).

Readily apparent, from this short statement, is the path of public pressure, through press releases, on the elected government and then, on the government ministry responsible for planning and providing health care services to the population. In a positive sense, the parliamentary system in Fiji and the free press creates a government responsive to public opinion and public need. But, it can also force the government to alter its long-range plans because it is always responding to short-term crises. The headquarters staff of the Ministry of Health have adopted a crisis mentality because of pressure placed on them by bad press reports, special interest group pressure and elected and appointed officials. This problem wreaks havoc on the ministry's ability to follow planned

policy; for, example, they have been forced to continue building rural health care facilities -- demanded by the public through their government representatives -- despite the ministry's desire to rely more on PHC activities to improve rural health conditions.

The continual barrage of public demands on a health care system with limited resources obviously plays a significant role in how those resources are distributed. A country such as Fiji cannot afford to meet all the health demands of its citizens, who have come to rely on the heavily subsidized government services. There remains one additional, very powerful, element that affects Fiji's ability to carry out its primary health care policy: the medical profession, both private and government.

c. The Role of the Medical Profession.

Doctors often play a pivotal role on the impact of public demand on services. In the public mind they represent health care and this makes them the logical brokers for health care decisions. With their cohesive, powerful professional interest groups, such as the Fiji Medical Association, they can support the public's demand for more services and support their own professional need for modernization and specialization at the same time. The choices, about resource allocations in the health care system, that have been made usually "emerge from the aggregate response of doctors to the pressures placed upon them wherever they happen to be located and using such facilities as happen to be at hand" [Abel-Smith, 1972:7].

In the early 1980's there was a demand, supported by the medical association, that Fiji's Ministry of Health purchase an ultrasound unit

for use in the care of pregnant women. The ministry decided that there were insufficient resources to buy and maintain this medical technology. The response of the physician group was to take its appeal to the public, through the press; they started a fund-raising program that eventually collected enough money to purchase the machine. The issue here is not so much whether Fiji could make use of the equipment; the ultrasound technology is a very valuable tool in obstetrics. What is important is the role the physicians, and the press, played in creating a public demand for a service the government felt it could not afford. (Ironically, this ultrasound machine was not working during the time I conducted my research because of a lack of spare parts and proper maintenance.)

It is very wrong to portray all physicians as self-serving, power-hungry manipulators of public opinion. In Fiji, the doctors work long, difficult hours to provide care for the people of their nation. In rural areas, they have often taken a back seat to other health care professionals in the organization of PHC activities. Their dedication to health care in Fiji is beyond question. But their professional role, and their public status, gives them great power in defining the shape of the health care system in Fiji. How they use that power -- as much a part of their responsibility as the saving of lives and the relief of suffering -- greatly affects Fiji's ability to carry out its health care development objectives, including primary health care.

VIII. FINAL CONCLUSIONS

The complexity of the concepts inherent in primary health care and of the issues surrounding it demands that the PHC approach is carefully evaluated. PHC's improvement on earlier health and development approaches is very valuable but that very improvement can be threatened if the myriad factors affecting its planning and implementation are not well researched and considered by policy makers. The concepts of primary health care are inherently vulnerable [Hill and Henning, 1987:41] and must be closely monitored to see if they match the situation where those concepts are being applied.

The inherent assumptions of the primary health care approach must also be compared with the situational reality where the approach is being applied. These assumptions are:

- 1) that the needs of all developing countries are the same;
- 2) that a population's remoteness from urban centers automatically guarantees their acceptance of primary health care activities and health posts instead of medical care and hospitals [ibid:42];
- 3) that a country's socioeconomic status -- and trends of diseases and illnesses -- remain static and, therefore, amenable to the same approach as was required ten years ago, or even five years previously;
- 4) that similar rural populations, such as Fijians and Indians in Fiji, will have similar health care needs; and,
- 5) that primary health care is free of values carried by the medical/international establishment of which it remains an integral part.

Fiji offered an excellent opportunity to examine the institutional and cultural foundations onto which the PHC approach was placed.

Although Fiji's socio-economic status indicate a different, higher stage of development, Fiji was resolutely lumped together with other developing nations when WHO first introduced its PHC model to Fiji. Unfortunately, there was never any sociological or anthropological research done in the beginning to assist in the process of realistically adapting the PHC approach to the actual health and social needs of Fiji. While initial errors and false assumptions are to be expected in the early years of planning and implementing such a complex process, the current situation in Fiji indicates that there is still no agreement -- on a governmental or a professional level -- about how the PHC approach is best carried out. In this paper the forces acting upon the PHC approach in Fiji were described, including public demand, colonial history, traditional leadership and the policies and programs of the international agencies.

The coup in Fiji, and its attendant political issues, has become the most significant factor that will determine the future of the people of this island nation. The impact is already visible on the economic condition of Fiji; lost revenues from tourism and sugar has meant a lowering of expectations for development processes improving life in Fiji. The health sphere of Fiji will also be affected. Already 30 civil servant physicians have emigrated because of political situation. This loss of curative care potential will again focus attention on medical services, to the detriment of primary health care activities in both rural and urban areas. The future is uncertain in Fiji as it is for many countries around the world. Primary health care incorporates the concepts of social justice and co-operative human potential in defining the path towards health and social welfare. It is hoped that Fiji will

find some way to incorporate those concepts into its national development process, including providing health care, in the future.

APPENDIX I.

INTERVIEW QUESTIONS - GOVERNMENT PERSONNEL

1. Please describe your job and its responsibilities.
2. What is your academic background and other training experiences?
3. What have been your previous professional experiences before this post?
4. Are you aware of the primary health care program in Fiji? What do you understand its principles and objectives to be?
5. Do you feel that the PHC principles and guidelines are realistic or too ambitious for Fiji? Why?
6. Please discuss your role in planning and implementing health care activities in Fiji. Have you ever been involved in rural health care or rural development?
7. In your opinion, what do you see as the government's responsibilities towards maintaining the health of its people?
8. Is PHC solely the responsibility of the Ministry of Health?
9. In your opinion, what should be the Ministry of Health's priorities in its health care system? Please discuss the budget implications of your answer?
10. What has kept the government from better carrying out PHC in Fiji?
11. What are the major social and health problems facing the people of Fiji in the future?
12. Why has Fiji enjoyed a relatively good standard of living?

APPENDIX II.

INTERVIEW QUESTIONS - AGENCY PERSONNEL

1. Please describe your job and its responsibilities.
2. What is the history of your organization's presence in Fiji? Please describe past contributions to the people of Fiji -- either funding, technical assistance, equipment, etc. -- made by your organization.
3. What are the present projects or activities of your organization?
4. Are you familiar with the term primary health care? Please describe for me your understanding of this concept.
5. Do you feel that the assistance provided to Fiji through your organization fits in with the objectives of PHC? In what way?
6. What do you consider to be Fiji's priorities in order to fulfill the major goal of Health for All by the Year 2000?
7. What has prevented the government and/or other organizations from better planning and implementing PHC (and other types of health care) in Fiji?
8. Would you describe the main problems above as being based upon history, politics, economics, the bureaucracy or social problems?
9. Who are your primary contacts in the government? Is it the policy of your organization to suggest projects to the government or to wait for the government to approach you?
10. With what other organization, if any, do you interact or co-operate with here? Is this on an official or personal level?
11. What reasons would you give for the statement: Life in Fiji can be considered to be of good quality?

APPENDIX III.

INTERVIEW QUESTIONS FOR COMMUNITY MEMBERS

1. What things are important in keeping an individual healthy? A family? A community?
2. If you have an illness or disease where do you seek help? What other types of health care are also available to you? Under what situations would you go to those other sources of care?
3. What are the major problems facing the people in your family or community? Which of these problems can be solved by a family? By a community? Only with government assistance?
4. Have you heard about primary health care? Please describe in your own words the goals of this program.
5. Have you ever attended a community health committee meeting? What is the purpose of these meetings?
6. Of the health problems in your community which can be solved with PHC activities? Before the PHC program, were there other government services or projects that tried to solve these problems?
7. Which activities or programs of the government have been the most helpful?
8. Who has the ultimate responsibility to keep people healthy in your village? How important is community input in achieving better health?
9. What would help your family or community's health and welfare most?

REFERENCES

- Abel-Smith, B. "Health Priorities in Developing Countries: The Economist's Contribution" in *International Journal of Health Services*, vol 2, no. 1:5-12, 1972.
- Arole, Mabelle and Arole, Rajanikant. "A Comprehensive Rural Health Project in Jamkhed (India)" in *Health By The People*, WHO, pp. 79 - 91, 1975.
- Baer, Hans A. "On the Political Economy of Health," in *Medical Anthropology Newsletter*, vol. 14, no. 1:1-2, 13-17, 1982.
- Baker, Timothy D., et. al. "US Physicians in International Health" in *JAMA*, vol. 251, no. 4:502-4, 1984.
- Bavadra, T.U. and Kierski, J. "Fiji Profile" - Paper prepared for publication in Country Profile series of the Population Council, Suva, Fiji, 1978.
- Behrhorst, Carroll. "The Chimaltenango Development Project in Guatemala" in *Health By The People*, K. Newell, ed., WHO, pp. 30 - 53, 1975.
- Berman, Peter A. "Selective Primary Health Care: Is Efficient Sufficient?" in *Social Science and Medicine*, vol. 16:1054-59, 1982.
- Berreman, Gerald D. "Behind Many Masks: Ethnography and Impression Management in A Himalayan Village," in *The Society for Applied Anthropology*, Monograph No. 4, 1962.
- Bossert, Thomas J. and Parker, David A. "The Political and Administrative Context of Primary Health Care in The Third World" in *Social Science and Medicine*, vol. 18, no. 8:693-702, 1984.
- Brown, E. Richard. "Exporting Medical Education: Professionalism, Modernization and Imperialism" in *SS&M*, vol. 13A:585-95, 1979.
- Bryant, J.H. "WHO Program of Health For All by the Year 2000: A Macro-SYSTEM for Health Policy Making - A Challenge to Social Science," in *Social Science and Medicine*, vol. 14A:382, 1980.
- Central Planning Office. *Fiji's Seventh Development Plan, 1976 - 1980*. Suva, Fiji, 1975.
- Central Planning Office. *Fiji's Eighth Development Plan, 1981 - 1985*. Suva, Fiji, 1980.
- Central Planning Office. *Fiji's Ninth Development Plan, 1986 - 1990*. Suva, Fiji, 1985.

- Connor, Linda H. and Higgenbotham, Nick. A Sociocultural Perspective on Rural Health Development: A Proposal for Educating Health Professionals in Asia and the Pacific. East-West Center, Honolulu, 1983.
- Elling, Ray H. "The Capitalist World-System and International Health," in International Journal of Health Services, vol. 11, no. 1:21-51, 1981.
- Elliot, Charles. "Is Primary Health Care The New Priority? Yes, But..." in Contact, Special Series #1, 1979.
- Evans, John R., et. al. "Shattuck Lecture - Health Care in the Developing World: Problems of Scarcity and Choice" in The New England Journal of Medicine, vol. 305, no. 19:1117-27, 1981.
- Feierman, Steven. "Struggles for Control: The Social Roots of Health And Healing in Modern Africa" in African Studies Review, vol. 28, nos. 2/3: 73-147, June/Sept., 1985.
- Fendall, NRE and Tiwari, IC. "Trends in Primary Health Care" in Tropical Doctor, vol. 10: 78-85, 1980.
- Feuerstein, Marie-Therese. "Rural Health Problems in Developing Countries: The Need For A Comprehensive Community Approach" in Contact, Special Series #3, 1980.
- Ministry of Health and Social Welfare. Fiji School of Medicine Handbook. Suva, Fiji, 1987.
- Finau, Sitaleki A. Health Science of The South Pacific: The Challenge. Paper presented at the 56th Conference of The Australian and New Zealand Association for the Advancement of Science, New Zealand, January, 1987a.
- Finau, Sitaleki A. "Community Priorities Following Disaster: A Case Study from Tonga," in Social Science and Medicine, vol. 24, no. 11:961-66, 1987b.
- Foster, George. "Community Development and Primary Health Care: Their Conceptual Similarities" In Medical Anthropology, vol. 6:183-95, 1982.
- Gish, Oscar. "The Political Economy of Primary Care and 'Health by the People': An Historical Exploration" in Social Science and Medicine, vol. 13C:203-11, 1979.
- Gish, Oscar. "Selective Primary Health Care: Old Wine in New Bottles?" in Social Science and Medicine, vol. 16:1049-54, 1982.
- Grosse, Robert N. and Harkavy, Oscar. "The Role of Health in Development" in Social Science and Medicine, vol. 14C: 165-9, 1980.
- Guthrie, Margaret W. Misi Utu: Dr. D.W. Hoodless and the Development of Medical Education in the South Pacific. Institute of Pacific Studies, Suva, 1979.

Habicht, Jean-Pierre and Berman, Peter. "Planning Primary Health Services From A Body Count?" in *Social Science and Medicine*, vol. 14C:129-36, 1980.

Hartwig, Charles W. "Church-State Relations in Kenya: Health Issues" in *Social Science and Medicine*, vol. 13C:121-7, 1979.

Heggenhougen, H.K. "Will Primary Health Care Efforts Be Allowed to Succeed?" in *Social Science and Medicine*, vol. 19, no. 3:217-24, 1984.

Heller, Thomas. "The Patterns of Medical Practice in England and the Third World" in *Contact*, no. 33, 6/76: 1-7

Hill, Peter and Henning, Arthur. "Primary Health: Handle With Care," in *Tropical Doctor*, vol. 17:41-45, 1987.

Islam, Kamak and Bachman, Sally. "PHC in Bangladesh - Too Much to Ask?" in *Social Science and Medicine*, vol. 17, no. 19:1463-66, 1983.

Justice, Judithanne. "The Invisible Worker: The Role of the Peon in Nepal's Health Service" in *Social Science and Medicine*, vol. 17, no. 14: 967-70, 1983.

Justice, Judith. *Policies, Plans, and People: Culture and Health Development in Nepal*. U.C. Press, Berkeley, 1986.

Kingma, Stuart J. "Finding the Community in Our Crowded Cities," in *Contact*, no. 38, 1977.

Knowles, John H. "Health, Population and Development" in *Social Science and Medicine*, vol. 14C:67-70, 1980.

Lipken, Mack. "Who Needs More Doctors?" in the *New England Journal of Medicine*, vol. 313, no. 15:960-61, 1985.

Lundberg, George D. "Exporting Doctors to a World in Need" in *JAMA*, vol. 251, no. 4:511, 1984.

MacCormack, CP. "Community Participation in Primary Health Care" in *Tropical Doctor*, vol. 13:51-4, 1983.

Mahler, H. "Primary Health Care: Health for All and the Role of Doctors" in *Tropical Doctor*, vol. 13:146-8, 1983.

Mataitoga, Vuli. *Country Report on the Integration of Traditional Medicine in Primary Health Care in Fiji*. (for WHO), 1984.

Mburu, FM. "Rhetoric-Implementation Gap in Health Policy and Health Services Delivery For a Rural Population in A Developing Country" in *Social Science and Medicine*, vol. 13A:577-83, 1979.

Mills, Anne. "Vertical Vs Horizontal Health Programs in Africa: Idealism, Pragmatism, Resources and Efficiency" in *Social Science and Medicine*, vol. 17, no. 24:1971-81, 1983.

Ministry of Health. Medical Department History. (paper found in ministry files), no date.

Ministry of Health. Annual Report for the Year 1970. Suva, Fiji.

Ministry of Health. Report on the First National Primary Health Care Seminar, 26-29 July, Suva, Fiji, 1977.

Ministry of Health. Family Health Programme. (Progress report on WHO executed, UNFPA funded programme.) Suva, 1978.

Ministry of Health. Annual Report for the Year. Suva, Fiji, 1980a.

Ministry of Health. Sectoral Programme for Primary Health Care during Development Plan Eight (1981-1985). Suva, Fiji: 1980b.

Ministry of Health. Health System Support for Primary Health Care. (Paper prepared in response to WHO Director-General's request.) Suva, 1981.

Ministry of Health and Social Welfare. Evaluation of Primary Health Care in Fiji. From the Working Group of the Ministry of Health and the WHO Office in Fiji, November, 1984.

Ministry of Health and Social Welfare. Annual Report for the Year 1984. Parliamentary Paper No. 1, 1986a.

Ministry of Health. Report on National Workshop on Family Planning. Suva, Fiji, October, 1986b.

Morley, David (ed.) "Some Steps Through Which Hospitals May Become More Deeply Involved in Community Health Care" in *Contact*, no. 20, 1974.

Muhondwa, E.P.Y. "Rural Development and Primary Health Care in Less Developed Countries" in *Social Science and Medicine*, vol. 22, no. 11:1247-56, 1986.

Mullan, Fitzhugh and Bryant, John. "Doctors -- Barefoot and Otherwise," in *JAMA*, vol. 252, no. 22:3146-48, 1984.

Musgrove, Philip. "The Impact of the Economic Crisis on Health and Health Care in Latin America and the Caribbean," in *WHO Chronical*, vol. 40, no. 4:152-57, 1986.

Myrdal, Gunnar. "Aid" in *The Challenge of World Poverty; A World Anti-Poverty Program in Outline*. New York, Pantheon Books, pp. 336-85, 1970.

Navarro, Vicente. "A Critique of the Ideological and Political Position of the Brandt Report and the Alma Ata Declaration" in *International Journal of Health Services*, vol. 14, no. 2:159-72, 1984.

Nayacakalou, R.R. *Leadership in Fiji*. University of the South Pacific (with Oxford University Press), Melbourne, 1975.

- New, Peter Kong-Ming and Donahue, John M. "Strategies for Primary Health Care by the Year 2000: A political Economic Perspective," in *Human Organization*, vol. 45, no. 2:95-103, 1986.
- Newell, Kenneth W. (ed.) *Health By the People*. WHO, Geneva, 1975.
- Newell, Kenneth W. "Primary Health Care in the Pacific" in *Social Science and Medicine*, vol. 17, no. 19:1441-47, 1983.
- Parliament of Fiji. Report of the Select Committee of Inquiry into the Health Services in Fiji. Parliamentary Paper no. 28, 1979.
- Quinley, John C. and Baker, Timothy D. "Lobbying for International Health: The Link Between Good Ideas and Funded Programs: Bread for the World and the Agency for International Development," in *American Journal of Public Health*, vol. 76, no. 7: 793-6, 1986.
- Rahnema, Majid. Unpublished document concerning the global impact of international assistance. Undated.
- Ratcliffe, John. "Social Justice and the Demographic Transition: Lessons for India's Kerala State" in *Health for All*, D. Morley, ed., 1984.
- Rifkin, Susan B. "Community Participation in Health: A Planner's Approach" in *Contact*, Special Series #3:1-7, 1980.
- Rifkin, Susan B. and Walt, Gill. "Why Health Improves: Defining The Issues Concerning 'Comprehensive Primary Health Care' and 'Selective Primary Health Care'" in *Social Science and Medicine*, vol. 23, no. 6:559-66, 1986.
- Segall, Malcolm. "Planning and Politics of Resource Allocation for Primary Health Care: Promotion of Meaningful National Policy" in *Social Science and Medicine*, vol.. 17, no. 24: pp. 1947-60, 1983.
- Smith, Richard A. "Realistic Manpower Planning for Primary Health Care: Practical Considerations" in *Tropical Doctor*, October, pt. 1:148-54, 1984.
- Somarriba, Maria das Mercedes G. "On the Limitations of Community Health Programs" in *Contact*, Special Series #3:61-67, 1980.
- South Pacific Commission. *South Pacific Economies, 1981 Statistical Summary*. 1984.
- South Pacific Commission and International Labour Organisation. *Immigration, Employment and Development in the South Pacific (Country Report No. 4: Fiji)*, South Pacific Commission, Noumea, 1985.
- Stewart, Gordon T. "Medicine and Health: What Connection?" in *The Lancet*, March 29:705-08, 1975.

Stock, Robert. "'Disease and Development' or The Underdevelopment of Health": A Critical Review of Geographical Perspectives on African Health Problems" in *Social Science and Medicine*, vol. 23, no. 7:689-700, 1986.

Stone, Linda. "Primary Health Care for Whom? Village Perspectives From Nepal" in *Social Science and Medicine*, vol. 22, no. 3:293-302, 1986.

Ugalde, Antonio. "The Role of the Medical Profession in Public Health Policy Making: The Case of Colombia" in *Social Science and Medicine*, vol. 13C:109-19, 1979.

Ugalde, Antonio. "Ideological Dimensions of Community Participation in Latin American Health Programs" in *Social Science and Medicine*, vol. 21, no. 1:41-53, 1985.

Unger, Jean-Pierre and Killingsworth, James R. "Selective Primary Health Care: A Critical Review of Methods and Results" in *Social Science and Medicine*, vol. 22, no. 10: 1001-13, 1986.

United Nations. *Pacific Partners: A Guide to United Nations Agencies in the Pacific*. Sydney, 1985.

Walsh, Julia A. and Warren, Kenneth S. "Selective Primary Health Care: A Interim Strategy For Disease Control In Developing Countries" in *Social Science and Medicine*, vol. 14C:145-63, 1980.

Walt, Gill and Vaughn, Patrick. "Primary Health Care: What Does it Mean?" in *Tropical Doctor*, vol 12: 99-100, 1982a.

Walt, Gill and Vaughn, Patrick. "Primary Health Care: How Did It Evolve?" in *Tropical Doctor*, vol. 12:145-7, 1982b.

Waterson, Anthony. "The Doctor and the Primary Health Worker" in *Tropical Doctor*, vol. 12:101-3, 1982.

Weiner, M.A. *Secrets of Fijian Medicine*. University of California, Berkeley, 197?.

Werner, David. "The Village Health Worker -- Lackey or Liberator" paper presented at the International Hospital Federation Congress, May, 1977.

Werner, David. "Health Care and Human Dignity -- A Subjective Look at Community-Based Rural Health Programs in Latin America" in *Contact*, Special Series #3:91-107, 1980.

Werner, David. *Public Health, Poverty, and Empowerment -- A Challenge*. Convocation Address at John Hopkins School of Public Health, 1985.

WHO. *Global Strategy for Health For All by the Year 2000*. Geneva, 1981.

WHO. *National Health Development Networks in Support of Primary Health Care*. Geneva, 1986.

WHO. "Primary Health Care in Practice," in World Health Forum, vol. 8:56-66, 1987.

WHO/UNICEF. "Milestones to Primary Health Care," in Information for the International Conference on Primary Health Care. Divisions of Public Information, WHO:Geneva, UNICEF:New York, 1978a.

WHO/UNICEF. Final Report of International on Primary Health Care, Alma-Ata. 11 September, 1978b.

WHO/WPRO. Proposed Programme Budget Estimates for the Financial Period 1986-87. Manilla, 1984.

WHO/WPRO. Evaluation of the Strategy for Health For All by the Year 2000. (for the Western Pacific Region), vol. 7:61-64, 1986.