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‘Traditional’ Healers, Speaking and Motivation in Vava’u, Tonga: Explaining Syncretism and Addressing Health Policy

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ABSTRACT

Bilateral health system development in Tonga is implicated in a misrepresentation of ‘traditional’ healing that has serious implications for the provision of health care. It has strengthened the tendency to homogenise and stereotype a diverse body of healers in counter distinction with biomedicine. The diversity of and syncretism in non-biomedical local healing practice is little appreciated in policy debates. Addressing the epistemological, social and linguistic context of syncretism in terms sensitive to healers’ concerns and conceptualisations is vital to build on the pre-existing collaborations between health professionals and a diverse body of healers in a country that has experienced a marked shift from communicable to non-communicable disorders. This paper examines the diversity and syncretism of five of the most popular ‘spirit’ healers in Vava’u, Tonga in terms suggested by healers themselves using the Tongan concept and value of *tauhi vaha’a* (to evoke and intensify relatedness) as an analytic tool. The creativity implied in healers’ socially constitutive use of language with ancestors, relatives, patients, churches and the hospital questions the value of any notion of traditionality and suggests considerable grounds for collaboration.

Key words: Tonga, syncretism, traditional healers, WHO, health services development

INTRODUCTION

AUSAID-run health sector reforms since 1999, supported by the World Bank, WHO and NZAID, have put Tonga’s ‘traditional’ healers under unprecedented economically oriented scrutiny, with wide implications on the success of bilateral health services development (AUSAID 2004, 2006). Despite WHO (World Health Organisation) policies on encouraging involvement of healers in public health and the formulation of a national policy on traditional medicine, Tonga’s health services have engaged little nor had much official impact on healers (WHO 2002). They are neither professionalized nor officially valued by the Ministry of Health despite their widespread popularity. Families and some hospital workers who support their

treatments within hospital perimeters often contravene a poorly enforced ban from hospital facilities.

A recent National Health Accounts report details resource flows in the health care system and aims to direct health financing reform. It serves well to illustrate a new development encouraged nexus of relationships that draw medical anthropological concerns with syncretism into a much wider engagement with health services development. The report estimated an annual household expenditure on traditional healers of 74.9% of people's out of pocket health expenditures (Ministry of Health 2004, ii). This economically framed recognition of the value of healers' role in primary health care superficially supported those who had argued that in some areas, such as mental health, mainstream medical services do not have, without the help of healers, the capacity to treat all that passes for sickness in Tonga (Puloka 2004, pers. com.). However, the institutionally backed implication that healers do it for the money, is an attack that goes straight to the heart of what is supposed to be the ethic of 'traditional' healing. This contradicts both previous anthropological research and WHO policies that argue that non-biomedical healers in Tonga merit the adjective, 'traditional'.

The estimated figure of TOP 37.09 (approximately AUS\$ 25 or US\$18 at 2004 exchange rates) per visit to a healer was certainly not representative of any of the popular healers I had worked with in Vava'u, none of whom was making any significant material or financial benefit from their practice (Ministry of Health 2004: 41; Poltorak 2002). As Bloomfield argued in 1984, not asking for rewards for their services was a defining feature of traditional healing. She detailed the case of one 'paediatrics traditional healer' whose hands were crippled with arthritis that was blamed on her putting out her hands for rewards (Bloomfield 1984: 8). This is explained in terms of abuse of powers that are God given that inevitably leads to losing the ability to cure (McGrath 1993). The sensitivity of healers to such slander has meant that in Vava'u the *tukuto'o*, the traditional parting gift from the family of the patient to healer in the case of successful treatment, is often refused or is much smaller in value than was given in the past.

The economic evaluation also fed into the dominant and unqualified doctor led criticism that healers often delay treatment to the hospital that leads in some dramatic cases to amputation or occasionally death (Poltorak 2002). McGrath (1993: 112) recounts the often repeated case of a young baby that died as a result of overconfidence in the use of Tongan remedies. The evaluation thus affirmed financial reward as one key rationale for delay without recognition that in many cases patients are brought to the hospital first but are left unconvinced that hospital medicine is appropriate or can be useful. A lack of understanding of health seeking behaviour among many doctors coupled with an education that devalues social factors in sickness causality means that in general doctors look down (*sio lalo*) on healers. In Tonga their education and ability to speak English marks them as high status in relation to much less educated healers, further limiting interaction. Picking up on New Zealand and Australian English, doctors may even inappropriately label them 'witch doctors'. This misrepresentation is similar to the increasingly popular and derogatory use of the word 'poofa' to refer to transgendered males (*fakaleitisi*) (see Besnier 2002). Poor doctor-patient communication is linked to an instructional bias in the way high status people relate to lower status relatives or employees. In the absence of a relative in the hospital from whom one might be able to demand better treatment by virtue of extended family links, many people, if they have the money, go to private practitioners or travel overseas.

As one observer to policy discussions admitted, the economic evaluation of healers also supported the decision in the Strategic Development Plan 8 to review the possible introduction of user fees for health services currently provided free to all Tongan citizens and the introduction of voluntary health insurance schemes (Central Planning Department, 2006: 45). After all, the argument went, if people are paying healers so much money for dangerous treatment, they should at the very least pay for appropriate medical treatment.

The survey could be criticised for its methodological failure to specify the criteria for the

selection of healers, to survey healers on other islands or to qualify the contrasting benefits of going to see a healer or doctor. However, the most serious criticism is its simplification of a complex situation, and homogenisation of a diversity of healers, some very supportive and unofficially supported by health professionals. Here was a return to a more polarising, and homogenising pre WHO (2002) discourse, as much a misrepresentation of healers as its polar opposite, a homogenising romantic rhetoric conflating ‘traditionality’ and ‘authenticity’.¹

HEALERS AND SYNCRETISM

Tongan policy representations of healers have been largely informed by dichotomies sharply distinguishing TM (traditional medicine) from WSM (western scientific medicine) in ‘the perception of disease causation’ (Finau 1994: 53). These ironically may have been influenced by a pre-Christian Tongan split of spirit and non-spirit caused illness which endures in a present day popular distinction between Tongan and non-Tongan illnesses (Jilek 1988). These, nevertheless, contradict most health professional’s familial and pluralistic experience of Tongan medicine from an early age. Few children would have escaped being given various tonics (*vai*) by local healers or family members at the same time as biomedical remedies. They also ignore the degree to which biomedicine in Tonga can be regarded as an indigenous modernity with an enduring commitment to ‘cultural forms of time and personhood that are described as “traditional”’ (Young Leslie 2005:280). This is evident, for example, in funerary kinship obligations being an acceptable reason for being absent from work and the brother-sister taboo informing the choice of staff to work in surgeries where genitalia may be exposed (Ibid. 2005).

Ignoring this Tonganisation and echoing Foster’s (1976) personalistic/naturalistic distinction, Finau argued that TM’s model of causation, which lies in ‘the disturbance of relationships with gods or supernaturals, society, or the land’ contrasts with WSM’s model in which causation of disease ‘is an abnormality of organ function, which is a biostatistically defined variation from a standard, an ideal value of a species design’ (Finau 1994:53). In these terms, Finau argues, TM treats illness and WSM, disease. Such a model was implicitly supported by early anthropological research that typically generalised healer’s explanations to give a seeming representative picture of Tongan medicine (see Cowling 1990; Parsons 1984, 1985). Whether preferring to characterise Tongan healing practice on the basis of conditions (Parsons 1985) or homogenised categories of a Tongan concept of disease (Singh et al. 1984), they nevertheless neglected the multiple uses, understandings and on occasion lack of knowledge of the same terms. Last (1981) had already established the unsystemised nature of much ‘traditional’ healing, criticising the then current anthropological notions of traditional medicine as a classifiable system, with coherent principles that could be counterpoised with biomedical understandings.

PSYCHIATRIC COLLABORATION WITH HEALERS

From 1996 to 1998 the only Tongan psychiatrist, Dr Mapa Puloka, organised three WHO supported workshops with traditional healers who treat unusual behaviour. The resulting revelation of healers’ lack of systematisation, their fluid use of terms and the benefits of collaborating with them to identify early onset of conditions, which warrant immediate medical treatment, have been restricted to mental health services. Dr Puloka found healers treating behavioural disturbances had little in common except the use of the term ‘*avanga* (sickness caused by spirit), which he then used as a basis of hybrid Tongan terms to communicate psychiatric concepts to the wider public (Puloka 1998, 1999; Poltorak 2007). The workshops led to informal interaction between some mental health workers and healers in the villages where patients were living. During the workshops healers were invited to write about their practice. This was then compiled with a list of their remedies and the conditions they claimed

to treat. This enabled better communication with patients and their families as they were able to get a more accurate medical history that included treatment by healers, information that formerly would have been hidden from psychiatric services. Resisting a blanket stereotyping, Dr Puloka's collaboration demonstrated the wide spectrum of healers was associated with a wide spectrum of treatment from beneficial to outright dangerous. One healer in his seminar who mixed panadol, leaves and 7up as a remedy, was clear evidence of the degree of syncretism in healing on the main island of Tongatapu. Information from the workshops coupled with case histories of patients in their care enabled greater appreciation of the relationship between attributions of efficacy and stigmatisation. This is illustrated by the following case study of a prominent patient (P).

In New Zealand P received 'traditional' healing for unusual violent behaviour. This didn't work so the family sent him to Tonga. Dr Puloka was invited to treat him in the family home to avoid wider awareness of his condition. The negative reactions of the family were confirmed in the way they looked at him. On taking a history he realised it was a clear case of bipolar disorder, despite no family history of the condition. The family had gone from healer to healer and yet the patient became more dangerous, often smashing things. Dr Puloka treated him under section 9 of the mental health act. He responded well to treatment and the episodes stopped, allowing him to enrol in a tertiary institution. During one of the first workshops a particularly famous healer claimed that the family had acknowledged his remedies as having cured the patient. Dr Puloka said nothing, recognising this as both a strategy of the healer to bolster his reputation and the family to avoid the stigmatisation that would result from wider recognition that the patient had a psychiatric disorder. This same healer was many years later discovered to have started adding small amounts of an anti psychotic medication into his remedies in the year after the workshops.

Dr Puloka also based his communication of psychiatric concepts on knowledge of indigenous terms gained from these workshops (Poltorak 2007). He acknowledged healers' efficacy for some short term conditions but encouraged admission for longer and more enduring conditions such as schizophrenia ('*avanga motu'a*'). During this period a greater number of patients was admitted on the recommendation of healers, most in the months after each workshop, with the effect lasting about a year. However, the low value accorded to mental health services in the Ministry of Health means that this initiative has not been upscaled nor its benefits widely shared.

Since 2000, funding of transport for visits of psychiatric nurses to the community has been severely limited by wider budget cuts, limiting interaction between healers and psychiatric nurses and social workers. Funding for Psychiatric Services is currently only 1% of total ministry of health spending, some 10% of recommended WHO guidelines of 10% of total health spending (Puloka 2009, pers. com). Since 2008, only defaulters of modicate medications have been visited in the community. The psychiatric unit now largely relies on patients being brought to the hospital under a section order, by the police or by concerned relatives. Dr Puloka has relied on low cost interventions such as building greater community awareness through radio and TV broadcasts. This he balances with an individual grassroots involvement in a central Kava club called 'Ulutea where he encourages the discussion with a mix of people and patients on the historical origin of particular psychiatric type concepts and the history of mental illness in Tonga. Further collaboration with healers is limited by the changing priorities of the WHO as well as little funding for such programmes by the Ministry of Health.

HOMOGENISATION AND DIVERSITY IN THE ANTHROPOLOGICAL LITERATURE

Despite Howard and Borofsky's (1989) claim in 'Developments in Polynesian Ethnology' contemporary ethnographic interest in intracultural variability and diversity took a decade to appear in Tonga. A diversity of healing practice was implicit in research revealing the

instrumentality present in mothers' health decisions for their children (Young Leslie 1999) and the regional diversity often denied in previously more rigid and homogenising descriptions of Tongan sociality (Evans 2001; Francis 2003). Given Marcus' (1980) somewhat agency denying definition of Tonga as a 'compromise culture' it is surprising that healers' religious synthesis and engagement with medical terms, treatments and procedures (originating in early missionary hospitals) had not been recognised earlier. As MacPherson and MacPherson (1990) have argued for Samoa, 'much of what is supposed to be traditional and indigenous is probably of relatively recent origin and part of a growing, rather than declining, body of knowledge' (1990: 13). Traditional healing, in these terms, has always been syncretic, evolving in relation to hospital medicine. The claim for traditionality must be seen in light of its political and social function to claim authenticity and value ancestral links.

Langford (1999) identifies one key failing in the notion of syncretism, that it implies the existence of 'two or more distinct and internally consistent traditions *that* meet and intermingle in a largely mechanistic process' (Langford 1999: 33). Given Taussig's (1980) critique of the ideological implications of the reification of the patient and the drawing from diverse cultural practices of medicine, it follows that a model applied to healing syncretism would suggest 'that what seems like syncretism is actually a particular moment in an ongoing intercultural mimetic and counter-mimetic reverberation' (Taussig 1987, In Langford 1999: 33).

In examining this intercultural reverberation in local terms my approach develops the most exemplary examination of healers in the South Pacific, MacPherson and MacPherson's (1990) 'Samoan Medical Belief and Practice'. Samoan and Tongan traditional medicine share many features and mutual historical influences that continue to the present time. The MacPhersons acknowledged the great diversity in Samoan healing practice but 'opted to focus on the cores of belief and practice' in a 'compromise which has been shaped to some extent by our intended audience'; health professionals, Samoans, people connected to Samoa and anthropologists (MacPherson & MacPherson 1990: 13). Here I choose to write for a very similar audience, albeit Tongan rather than Samoan with the addition of health policy makers, but with a different aim appropriate to current circumstances. By examining the origins of diversity and syncretism in mimesis, in terms suggested by healers' themselves, I am better able to satisfy the need for epistemological dialogue (Gegeo and Watson-Gegeo 2001), accessibility for Pacific islanders (Hereniko 2000), and reciprocity and utility (Smith 1999) that is now much more justifiably salient in the anthropology of the Pacific than it was in 1989.

POLICY AND THE IMPLICATIONS OF SYNCRETISM

The question of syncretism takes on policy implications in contexts of increased rationalisation of health service delivery and research strategies that seek to define healers in terms not of their choosing (Dole 2004, Pinto 2004). Failure to recognise syncretism is at once political, linguistic, social, institutional, developmental, economic, historical and epistemological. The developmental fetishisation of the 'traditional' and its contrast with modernity has considerable potential negative impacts on development outcomes. Pigg (1995, 1997) details how in Nepal, the actual effect of bracketing out the 'traditional' is to make them irrelevant to health service development. Lamphere (2004) argues for a convergence of applied, practising and public anthropology to ensure greater collaboration with studied communities, wider communication to publics and greater influence on public policy.

My research was born out of collaboration with Dr Mapa Puloka who requested that my research address a Tongan model of mental illness in the island group of Vava'u, where no mental health services existed and where he had not carried out any workshop with healers. His recognition of syncretism was one of the starting points of the research. His desire for a Tongan model of mental illness is manifest in this paper's focus on the social, linguistic and epistemological. I use the dichotomy that typically divides health professionals and healers to draw out the degree to which the diversity and syncretism of healers' explanations and actions

can be attributed to their linguistic strategies constituting intersubjective relations with biomedicine. The TM/WSM and naturalistic/personalistic dichotomy thus becomes a heuristic to support Dr Mapa Puloka and to suggest further reasons and the basis for wider collaboration between healers and the hospital. This gains added epistemological weight through the use of a Tongan concept, often celebrated by healers in their practice, as an analytic tool.

The MacPhersons' claim that environmental, structural and personal factors strongly influenced variability in healer's beliefs and practices understated the degree of creativity in healing (MacPherson & MacPherson 1990: 11). A phenomenologically inspired approach using the Tongan concept of *tauhi vaha'a* (the evocation and intensification of relatedness), reveals how intersubjective relations feature more strongly as explanations of the diversity and syncretism of healing practice than structural factors such as 'gender, age, educational background, social status and religious affiliation' (Jackson 1989, 1996, 1998; MacPherson & Macpherson 1990:11). Following Taussig, healers' agentive acts both mimic the TM/WSM and naturalistic/personalistic distinction in their own understandings and presentation of the distinction between spirit caused and non-spirit caused conditions (*mahaki/fakamahaki*). They also assert the essential unity underlying that distinction. Healers have always unintentionally protected doctors from litigation by diagnosing poorly treated conditions in the hospital in terms of spirit engagement that does not imply blame of the hospital (Poltorak 2002).

A critique of the misrepresentation of healers also becomes an opportunity to engage with the Tongan ministry of health and WHO on the feasibility, or possibility, of a national policy on traditional medicine and thus bring medical ethnography 'into the domain of policies, programs and practices' (Kleinman 1995:256). To do so with a rigorous attention to particular healers and case studies of their treatments is both in tune with the way people in Vava'u relate to knowledge and also satisfies a deficit in the accessible medical anthropological work on Tonga. I start by introducing one healer in terms of the most valued aspect of her practice.

THE DIVERSITY AND CELEBRATED IDIOSYNCRACY OF HEALERS

The most important thing about Tongan healing is one's faith in it. The power of that treatment comes from God. The most important thing about the healing I do is that the power of my treatment does not come from expertise like doctors who go and study and get a degree. The healing I do, I close my eyes, I pray, and God gives me the power and the knowledge to carry out the healing. The most important thing about Tongan healing is that it is divine. That is something Tongan people still have faith in. I am merely the instrument. God gives me the power to do his work.

Akosita was a well-known *fefine faito'o* (woman healer) in Vava'u, Tonga. Her statement, in response to a question about the most important aspect of her practice, mirrors the heartfelt ethic of many healers that emphasises the importance of *tui* (belief, faith) and of being a vehicle for the power of God. For Akosita the power and efficacy of *faito'o fakatonga* (Tongan medicine) lay not in expertise but was divinely inspired. Akosita's constant willingness to treat, despite the inconvenience, was affirmed by her profound trust in and reliance on God and of her wish to do his will. It was in variations of this Christian ethic that most 'traditional' healers introduced their practice to me during fieldwork in Vava'u between 1998 and 2000. They spoke of the great inspiration they take from the bible and ministers' sermons and quoted frequently from the bible to explain their practice. Their pure motivations, some explained, were a reflection of their personal qualities of *loto fietokoni* (of a helpful disposition) and *loto 'ofa* (kind hearted, of a kind or loving disposition) and manifest in their claims that no matter how difficult and tiring the treatment was, they would not refuse treatment nor charge a fee.

This was despite the fact that often they were so busy they had no time to attend to other economic or family activities. Even the most popular healers, though they may on occasion be given *me'a 'ofa* (gifts) in gratitude for their treatments, cannot make a living out of their

healing. While their involvement was quite out of step with the relaxed nonchalance of most work activity in Vava'u, it was in tune with the way in everyday banter and conversation Vava'uans distinguish themselves from the main island Tongatapu in terms of a greater emotionality and investment in family life. This is captured in the nickname of Vava'u, *Fatafatamafana*, which roughly translated means warmhearted. Healers narrated dramatic events of illness that the one main hospital in Neiafu, serving a population of approximately sixteen thousand people, could not treat and how they had stepped in and saved patients when they were *tali mate* (waiting or expecting death). Similar stories were told by people of their experiences of Tongan medicine, of healing confounding doctors and hospital. In their explanations, some healers also betrayed a pleasure in the *fatongia* (duty) that initially they had resisted, but then carried out in response to people's *faka'ofa* (moving to sympathy or pity) and their requests for help. In the company of friends and other familiars they enjoyed the praise, the attribution of *ivi* ('power'), and the social kudos and influence they had in questions of illness. They, no doubt, enjoy the social confidence and involvement in other people's lives that their generosity and helping engenders. Their verbalised ethic evokes membership of their respective churches and is a profound celebration of the Tongan value of *fetokoni'aki* (mutual help and assistance). Both inspire a confidence that requests for treatment will be met. The seeming commonality in purpose reflected in healers' explanations of their motivation contrasts with the great diversity in the practice, conceptualisations, personality and personal histories of particular healers.

DIVERSITY IN TERMS OF REMEDY AND EXPLANATION

The most analytically significant comment about other healers' practice was made to me by Loloa, a well-known retired healer in Neiafu. She explained that every healer has their own *faito'o* (remedy, treatment) and *fakamatala* (explanation). The many possible context dependent meanings of words, and a noun/verb mutability in the Tongan language mean that neither remedy nor explanation are entirely adequate glosses, but they will serve for the sake of ease of reading. In one of the only analytic comments from a healer made about healers as a generalisable category was also a suggestion how to analyse and present that diversity in an epistemologically sensitive way.

Loloa's comments contrasted dramatically with the confident explanations of other practising healers on their practice but who betrayed little interest in the practice of other healers. Perhaps the fact of her retirement and the fact that she now recommends people to go to a nearby healer, whose treatment she has seen once, allows her to be less partisan. The few comments I heard were invariably humorously disparaging of the techniques, reputation or remedies of other healers. That her comment was atypical and made after retirement is profoundly suggestive of both her current sense of responsibility to other healers and to a lack of involvement among practising healers themselves. The individuality of healers' ways of treating and explaining their treatments suggests that they seek to distinguish themselves from each other. Their actions are directed, in contrast to those paid professionals such as ministers, teachers and doctors, not in relation to a profession shared by others and in a common training but in their own specific ancestral, religious and experiential trajectories. Their healing knowledges are rarely shared and are specific to their families. That is not to say that there are no similarities in the practice and conceptualisations of some healers, shared by many other people in Vava'u, but that in general such similarities are regarded locally inconsequential to their practice. It is in part their local idiosyncrasy that makes them notable and worth consulting.

The only times they are generalised as a group is when their practice is compared either positively, as Akosita does, or derogatorily, by many health professionals, to hospital medicine. In the pragmatics of seeking healing, healers are known primarily by their particular names and secondarily as being a *fefine* or *tangata faito'o*. A definitive translation of *fefine* or *tangata*

faito'o, is neither 'female (or male) healer' nor 'a woman (or man) who heals'. In use it is less a solid marker of a profession than for example a teacher, rather more a description of what they do and the ethic they hold. Because so many people have their own healing remedies in Tonga the professional distinction is not one Tongans are apt to make.

PLANT USE

The diversity of healing practice and the degree to which healers use biomedical terms is also absent in much of the ethnobotanical research on Tonga. Whistler (1991, 1992), while exemplary in coverage of the uses and identification of the Tongan flora, has affirmed the idea of use of plants for specific conditions, the need to categorise healers despite the lack of any local category (a point that Whistler concedes) and a problematic detaching of the plant remedy from the healer or individual who uses it. The possible and potential pharmaceutical properties of plants are overplayed (eg Ostraff et al. 2000). To varying degrees, plant use may be led by religious reasons or popularity rather than actual or attributed pharmacological properties. One explanation for why so many plants are useful in Tongan medicine is that God *fakaivi'i* (to give power or ability to, to enable) them. This allows some healers I worked with to pick any plant and use it in place of the more appropriate plants, if they are particularly busy or unable to gather the ideal plant, with seemingly no diminution in efficacy.

The symbolic power of plants in the context of new recognised remedies with heightened meaning will arguably have a more powerful 'placebo' or meaning effect (Moerman 2002). A focus on the traditional also detracts from the continuing creativity involved in choice of botanicals and the indigenisation of pharmaceuticals (see Etkin et al. 1990). At any one time in Tonga, people are creatively combining plants and remedies in new ways as a result of dreams or recommendations. Plants are constantly being reinvented for new and novel uses as the many remedies for diabetes and heart disease attest.

Collocott rather disparagingly and despairingly described the search for healing at the beginning of the century: 'The trouble with the Tongan practitioners is that they have little or no idea of diagnosing a complaint. They just try one thing after another, and the massage, excellent as it is, is frequently employed where it is not only useless, but even dangerous. Diagnosis is replaced by a series of trials and failures; as the Tongans say, "We'll have a try." If one thing does not show quick results, try another. A man went to the missionary and asked for medicine for a little girl. "She is very ill indeed", he said, "yesterday we gave her seventeen sorts of medicine and she is not better yet". One medicine man, or woman, after another, tries his cure, till one is found which gives promise of success, which shows a "sign", or until death cuts short the experiment, and gives a verdict which is accepted with pious resignation as the will of the Lord' (Collocott 1923: 137). As McGrath (1999) affirms, using the metaphor of healers as islands and people travelling from island to island in search of healing, that process has changed little in form since the beginning of the century. Diagnostic concerns have always been secondary to the central ability to be able to *kole tokoni* (ask for help) from someone who can help. This is an act that usually follows the revelation of relatedness to the person and leads to its intensification through the process of healing. People in general have more faith in people's response to requests for help than in the diagnostic categories used to define sickness. Thus in Tongan experience, healers are all different because one comes to request help from them or learn of them through a multitude of different social links. Tongans are not surprised by the diversity of different potential remedies.

PERSONALISTIC & NATURALISTIC CAUSALITY

In applying Foster's (1976) notions of personalistic and naturalistic causality of illness to bush medicine in Trinidad, Littlewood (1988) argued that 'the two types of knowledge are not incompatible, nor mutually exclusive, nor distinct' (Littlewood 1988: 129). Personalistic

causality involves an intervening agent such as a spirit, deity or sorcerer. Naturalistic causality refers to sickness theorised in impersonal systemic terms. Littlewood (1988) emphasised Foster's notion as a heuristic model to uncover the general schema of illness in Trinidad and argued that in many instances bush medicine could be seen as naturalistic in aetiology.

Loloa characterised the diversity of healers in terms of their remedies and explanations. This diversity has a quality closer to Littlewood's distinction than that of Finau's TM/WSM dichotomy. Even those healers, whose interpretations might be characterised as the most personalistic of all healers, used naturalistic explanations to explain susceptibility or how healing works. Within Foster's schema, the explanations of healers capable of treating *tēvolo* (spirit, ghost) caused conditions varies to the degree to which they emphasised personalistic explanation (those that involved spirits only) and explanations in which there were naturalistic features (typically some capacity of the body that made it more likely for the spirits to affect the person). In recognising the diversity and syncretism of healer's practice it is also important to preserve the terms they use to describe the situations and conditions they treat. These may be understood in different ways by different healers. Translation may reify a concept or condition that might be very fluid or have the quality of both a noun and verb in use in Tongan. The term *tēvolo* itself is a good example, given that its adverbial meaning (devilish) can be used to demonise immoral practices. As a noun, however, it describes a spirit closely resembling a human being or in biblical contexts, a devil. The context influences whether or not the spirit is regarded as immoral. For the benefit of Tongan readers and those who will use this research to initiate dialogue between the ministry of health and healers, I preserve some terms in the original Tongan, glossing in brackets. I give brief intermediary translations based on Churchward (1959) of some of the terms that appear most frequently.

SPEAKING AND *TAUHI VAHA'A*

The fundamental factor in understanding the diversity of remedies and explanations follows from a commonly attributed characteristic of the more popular healers. Of all the healers, the most widely known were those who were described in complimentary terms as *poto he lea* (skilful at speaking/speeches), *poto he fakamatala* (skilful at explanation) or pejoratively as *ngutu lahi* (big mouth).³ This was largely born out in the explanations I received in the extensive interviews I carried out with healers. By and large they were erudite, eloquent and powerfully convincing about their practice. To speak—as Malinowski (1935) and Firth (1975) established for Pacific Island cultures—is a socially constitutive act. Healers differ fundamentally from most doctors in that they have to speak with, and in terms understandable and evocative to, their patients. In doing so, they do not fail, as positivist medical and social science does, 'to conceptualise social life, its object, as a practical achievement' (Robillard 1992: 11).

While occasionally contentious, healers' use of *tēvolo* (spirit, ghost) to explain sickness follows logically from the ability of deceased relatives to cause sickness in living relatives. This is exemplified in the act of *ta'aki akafia*, where intruding roots are removed from the skeleton of a dead relative, in order to treat pain in the corresponding body part of a living relative. People are aware that *tēvolo* may be invoked to explain particularly embarrassing events within families. In most cases, though, *tēvolo* as cause of sickness is accepted partly because it is a more socially acceptable and less stigmatising explanation than sickness as divine punishment for past wrongdoing (Poltorak 2007). The association of sickness and potential stigma is linked to the potential of people to *luma* (to ridicule) the original cause of sickness as the result of a shameful or embarrassing act. As healers frame their explanations in religious and local terms, the implications of their diagnosis must also be judged in those terms. As institutionally free agents, their conceptualisations cannot help but constitute their religious, local and familial experiential and political trajectories. In doing so healers exemplify the value and concept of *tauhi vaha'a* to patients and institutions in their practice.

Herein lies some of their *mana* or efficacy of their personhood which is best understood in terms of relation, not a substantive spiritual substance (Keesing 1984, MacClancey 1986)

Thaman (1988) translates *tauhi vaha'a* as 'maintaining harmony of the "space" between oneself and others' which she argues is derived from *tauhi* (nurturing), *vā* (space between), and *ha'a* (lineage) (Thaman 1988, 120). Ka'ili affirms that *tauhi vaha'a* is manifest in acts that 'sustain social relations with kin and kin-like members' (2005, 92). As individuals attributed with power (*ivi*) my translation for *tauhi vaha'a* (to evoke and intensify relatedness) communicates a greater degree of creativity in healers' acts of speaking (Poltorak 2007). As will become clearer in the case studies that follow a definition of sickness must not only be regarded as a description or diagnosis, but as a word that has effects. The power of healers, resides in part in the degree to which they evoke and intensify relatedness for healing purposes, which along with its accompanying three other values- *Faka'apa'apa* (to show deference or respect or courtesy), *Toka'i* (to consider the feelings or judgement of) and *fetokoni'aki* (to help one another) (Churchward 1959)- are often used to assert an authentic and traditional Tonganess.

DISTINGUISHING HEALERS

What distinguishes the categories of *fefine faito'o* (female healer) and *tangata faito'o* (male healer) who treat people affected by *tēvolo* from the many people who possess herbal remedies or particular healing techniques? Within Tonga as a whole I take it to mean that they have a reputation and are resorted to for treatment by people beyond their extended family. I distinguish them from other healers who are more specialised, and who typically treat conditions that are more exclusively naturalistic in origin.⁴ Bloomfield splits practitioners in Tonga into *kau faito'o faipele* (card playing curers), *kau faito'o fakalotu* (religious curers), *kau faito'o fakatonga* (Tongan traditional curers), *kau faito'o fanau iiki* (Paediatricians), *kau faito'o fasi* (bone setters), *kau fotofota* (masseurs) (Bloomfield 1986:219). I prefer to call them *fefine faito'o* or *tangata faito'o* who can treat *tēvolo* caused illness rather than assign them to a category of healer such as *kau faito'o fakatēvolo*, because rarely are *tēvolo* caused conditions their exclusive concern. Also, as I will go on to discuss, some healers find the label *fakatēvolo* inappropriate. *Tēvolo* may be the cause of any longstanding and difficult to cure sickness as well as the more dramatic display of unusual and prototypical behaviour associated with *tēvolo* caused sicknesses. This is because *tēvolo* can explain potentially any condition that has an effect on a person's ability to relate as expected.

Jilek (1988) interviewed five male healers and two female healers. He suggested that since five of the seven healers were assisted by daughters and none by sons, in future Tongan healing would become a predominately female vocation. That certainly seems to be the case for Vava'u. Of the eighteen healers I interviewed only one was male.⁵ In answer to why, the only male healer on Vava'u that I interviewed argued that men were unmotivated and couldn't be bothered to heal, they leave it to the women. The most important aspect of his practice was 'To desire and consent to heal and to be motivated'.

Since in his terms men were unmotivated to heal suggests that there are other vocations open to them. There is increasing pressure for men to provide money as well as food for their families and church. This means either wage labour or long periods of time in the bush, which makes them relatively inaccessible for healing. Also, qualifying the idea of healing as only vocational, there is the possibility that men are simply not being asked to heal. Many healers talk about initially not wanting to heal but then doing so because people pleaded with them to help.

Women in this sense are typically easier to ask. They are popularly regarded as being more *talangofua* (easy to ask, obedient) and more likely to be at home than men. Also, it is women who are usually in charge of the health of young children. Most women healers, who treat *tēvolo* caused conditions, first mention the fact of treating women's and children's

sicknesses, which may on occasion be *tēvolo* caused. Such cases form a larger part of their practice. The most popular healers can heal because of personal circumstances, which means that they are usually not the main wage earner.

HEALERS' REKNOWN

The first aspect of the diversity of healers who can treat *tēvolo* caused conditions one faces as a researcher is how 'well known' they are within Vava'u.⁶ Some are known by their first names across most of the island group and on occasion in Tongatapu, others only within their extended family and their nearby villages. Their reknown is a reflection both of their supposed characteristics, capabilities and acts but also of the modes of communication (along extended family, village, church lines) and social events that allow people to hear about some individuals more than others. A healer may be well known to many but not necessarily popular, nor the first resort in cases of illness. Church, village and household preferences and gossip often guide their popularity. It is difficult to describe a generalised public perception of healers because of their diversity and because people typically do not experience themselves as part of a generalised public. WHO recommendations of promoting public awareness are largely redundant in a Tongan context (WHO 2002:42).

In Vava'u, introductions are largely superfluous. People know each other by virtue of extended family relationships, or their mutual involvement in church, village or school events. My collaboration with different healers was established on the basis of mutual interest and how busy they were after an initial introduction by the public health nurses. I spent the most time with Lilopau and Akosita, and their families. I use pseudonyms throughout.⁷ With Lilopau I served a quasi apprenticeship, attending and helping her with many of her treatments over a period of a year. Both spoke of me as an adopted son and on occasions I was jokingly castigated for not visiting more often. The mutual help and support from these two families continues to the present day.

Lealiki, Pisila and Siosiofanga I interviewed on at least four occasions each, though I witnessed relatively few of their treatments. My choice to focus on healers who could treat *tēvolo* caused conditions, the result of my interest in local emblematic 'mental disorders' and collaboration with the psychiatrist, Dr Mapa Puloka, was not as exclusive as it might seem to be. The process of seeking healing goes against any strict categorisation of healers in exclusive terms; *tēvolo* can potentially cause any difficult to treat condition and people seek help from whoever might be able to help for vague conditions that are difficult to define. *Tēvolo* caused conditions were not the exclusive concern of any of the five healers. One of the most popular healers, Akosita, had chosen not to treat in terms of *tēvolo* as a following case study demonstrates, preferring to conceptualise in terms of 'nerves' but would nevertheless treat people who others regarded as being influenced by *tēvolo*. As her son eloquently put it, implicitly distinguishing his mother from other healers, his mother now treated the body.

All healers were middle aged and shared a confidence in their positions born of involvement in the Wesleyan Church or Church of Tonga, connections born of marriage and having grown up children. Lilopau's and Pisila's positions in the natal villages where they lived were strengthened by being related to a talking chief and having married a prominent Church of Tonga minister respectively. Pisila had only recently returned to Vava'u after thirteen years in Samoa. By contrast, Lealiki, Siosiofanga, and Akosita had grown up in Nuku'alofa. Akosita, had been in Vava'u for forty years, her marriage to an important talking chief ensured considerable influence. Lealiki had married an influential teacher at the Wesleyan high school posted to Vava'u only ten years before. Siosiofanga had benefitted least from her marriage and residence in an out of the way village in Vava'u. She gained a reputation because of her elaborate healing washes over plastic sheeting, that some people compared to a swimming pool.

Any personal introduction is an inevitably idiosyncratic reflection of a person's

relatedness to that person and others. My comparison of the healers is grounded in how people described them, my experience of them, their most obvious local connections and, following Loloa's suggestion, the most salient aspects of their treatment strategies and explanations of their practice.

DIVERSITY AND RELATEDNESS

I now turn to the diversity of the remedies and explanations of the five healers and examine the degree to which they are tied to their acts of evoking and intensifying relatedness. I take *faito'o* to signify both the verb (to treat, cure or try to cure by medical means) and the noun (medicine or medical treatment of any kind). The *faito'o* of a healer encompasses the techniques of healing and the plants used. The techniques are visible to all. The plants, however, are usually treated as ancestral secrets and are not spoken about in front of non-household members. Many healers can trace an ancestral healing lineage going back four generations and claim that their treatment is identical to their ancestors. This is supported in some cases by *pepa faito'o*, books of remedies that are passed on and occasionally re-transcribed from generation to generation. Not all healers, however, write down remedies, and on occasion it is only when a healer dies that the realisation dawns that a particular remedy has not been recorded. The transmission of knowledge is most commonly through involvement and aptitude. Children of healers from an early age are sent to collect remedies from the bush by their parents and witness many treatments. Few start to heal seriously until their mother, father or other relative, from whom they learnt, can no longer treat or passes away. The procedure of *fanofano*, in which the healer holds the hands of his/her acolyte, and says a few words, confirms the transmission of healing power. Its shortness suggests that the essential transmission of ability has already taken place. Most people say that the ability to heal is *tuku fakaholo* (handed down from generation to generation/or from predecessor to successor).⁸ Many also claim that without the process of *fanofano* treatments would not work and that the healer has some kind of *ivi* ('power'), which is necessary for successful resolution. But there are many healers who continue to heal, seemingly successfully, who did not receive a transmission of healing, and there are some who are popular but acknowledge quietly no healing pedigree whatsoever.

Of all the various techniques of treatment used by healers, the technique of *tulu'i* (to administer medicine by squeezing the medicine and dripping the resulting liquid) is the most explicitly directed at breaking the sensual engagement of a person with the *tēvolo*. I take the diversity of this technique and its importance with respect to other treatments, to be emblematic of the variability of other aspects of the treatment of healers, which I have not been able to examine in depth here.⁹ Preparation involves either *tuki* (crushing between two stones or other hard objects) or *mama* (chewing) before putting the resulting mush into a piece of fabric which may or may not be dipped in water before use. *Tulu'i*, with plants that are repugnant to *tēvolo*, is the procedure that elicits the most dramatic evidence of the power of *tēvolo*. Affected people are able to anticipate the arrival of the healer, because of the *tēvolo* sensing the smell of the plants that the healer is bringing. It is, thus, the threat of *tulu'i* that often leads to the dramatic behaviour of the affected person who will often try to escape by running to the bush. Lealiki mentioned that occasionally dogs are required to find the person.

From the five healers there is a variety of different ways to *tulu'i* and its degree of importance with respect to associated treatments. For Lilopau, it is the treatment *par excellence*, used for almost all conditions. For Akosita *tulu'i* is an accompaniment to liquid treatments given internally. All of the five healers *tulu'i* the eyes, though two other healers I interviewed do not, for fear of causing blindness. Some *tulu'i* the nose, most the mouth, but only Lealiki and Pisila *tulu'i* the ears. The accompanying pressing (*lomi'i*) on the eyeballs, is extremely painful in Lilopau's treatment and explains in part why her practice is notable in her terms for eliciting the *ngala* (to cry noisily or loudly) of many patients, absent in some others

and resembles more of a light massage in others. Most of the plants used have been referred to in the literature though they are regarded as family secrets.¹⁰ For example Jilek lists (*lautolu 'uta* (*Vigna adenantha*), *lautolu tahi* (*Vigna marina*), *nonu* (*Morinda citrifolia*), *uhi* (*Euodia hortensis*), *ngatae* (*Erythrina variegata*), *sipi* (stem) (*Entada phaseoloides*), *tetefa* (*Badusa corymbifera*) (Jilek 1988:168) and Bloomfield (*Lautolu (tahi and 'uta)* leaves, *uhi* leaves, *nonu* (*Morinda citrifolia*) leaves, *mo'ota* (*Dysoxylum forsteri*) leaves, *Siale Tonga* (*Gardenia taitensis*) bark and *Heilala* (*Garcinia sessilis*) leaves (Bloomfield 1986:124).

Some healers conceptualise varying strengths of plants. Akosita and Lealiki, both originally from Tongatapu, used the same two plants for both *tulu'i* and the liquid internal remedies (*vai*); one for more serious conditions the other for less serious conditions. Interestingly, *siale Tonga* (*Gardenia taitensis*), widely used by many healers, was regarded as too strong and dangerous for use by Lilopau who preferred several more obscure plants that no-one else mentioned. Siosiofanga, however, used the same *tulu'i*, but different liquid internal remedies (*vai*) for different conditions.

HEALERS' CATEGORIES OF ILLNESS

The diversity of different treatments and remedies used by healers is evidence of their healing ancestry. Their explanations and the action of explaining, which includes their use of terms, reflects the degree to which they are creatively evoking and intensifying relatedness to effect a cure. In contrast to their remedies, explanations are spoken and are therefore more likely to change from generation to generation in response to a host of social circumstances and healers' wish to evoke and intensify relatedness to different people and institutions. Healers claim to be able to treat both *mahaki* and *fakamahaki*. Of the two terms, the translation of *mahaki* in relation to health is less problematic but not entirely unambiguous. The translations of Churchward (sickness, disease, ailment, sick person, patient), Bloomfield (disease, patient), Mariner (*mahagi*- sickness, disease) broadly concur with Jilek's translation of 'illness in general, of natural causation.' (Jilek 1988:167). However *mahaki* can also mean: temperamental or characteristic fondness or liking, 'weakness', craze, addiction and also used to refer to the patient suggests that in use out of the hospital it is less disease in a biomedical sense than a description of a state in which the sufferer is implicated to varying degrees. What healers claim to be *mahaki* seem more descriptions of symptoms in biomedical terms.

Nor does the term *puke* unambiguously or exclusively refer to 'disease'. *Puke* can mean (to take hold of, to seize, to hold, to arrest) and also (to be sick, ill, unwell, ailing). Thus *puke fakatēvolo* is both a description of a situation (being seized by a *tēvolo*) and also an assertion of sickness. The above healers are not oriented towards a positivistic notion of 'disease'. There seems little confidence in the essential ontology of all illnesses as exclusively naturalistic; people and *tēvolo* are always implicated in holistic states of sickness. The current dichotomous models comparing TM and WSM do a disservice to healers positing naturalistic influences on sickness and doctors, such as Dr Mapa Puloka, who recognise the importance of the social and spiritual in influencing disease states.

FAKAMAHAKI

For Churchward *fakamahaki* is synonymous with '*āvanga* (*tēvolo* caused sickness) or nearly synonymous with *fakatumamahaki* (causing or producing sickness or disease, injurious to health).¹¹ Bloomfield's translation of *fakamamahaki* as any illness which is slow to heal and assumed to be caused by evil spirits (her translation for *tēvolo*) (Bloomfield 1986:186), is contradicted by several healers' assertions that *fakamahaki* was characterised by the fact that it was quick to heal. There are many ways that the term *fakamahaki* is used. Jilek, for example, defines it as a general term for illness caused by super-natural agents (Jilek 1988:167). He also refers to Helu's assertion that 'the dichotomy of all illnesses into *mahaki* and *fakamahaki*

conditions goes back to pre-Christian times' (Ibid :167) perhaps reflecting a naturalistic (*mahaki*) / personalistic (*fakamahaki*) distinction?

Mariner's translation in 1827 of Fuccamahagi (*fakamahagi*) as to sicken, to disorder (Martin 1979), Churchward's previously mentioned translation and the use of the prefix '*faka*', which indicates likeness or causation (Churchward 1985:253), suggests the intention of agents. Mariner's translation of 'to sicken' best captures the way *fakamahaki* is used, it is less condition than the spiritual provenance of condition. A working translation for *fakamahaki* is thus the agency of sickness with the agent typically a *tēvolo*. A comparison with Bloomfield's and Jilek's translation suggests a dilemma best summed up in the question, can *fakamahaki* be regarded as a *mahaki* or in other terms can the agency of sickness be considered as a condition itself? Pisila's assertion that the cancer, evidently a *mahaki*, of the man she claimed to have cured in Samoa was in fact *fakamahaki*, suggests that the heuristic distinction of *mahaki* as naturalistic, and *fakamahaki* as broadly personalistic, is a useful one.

SAME 'STATE', DIFFERENT NAMES

Lilopau, Lealiki, Pisila and Siosiofanga used different terms and distinguished between the different terms in terms of seriousness, symptoms and degree of relationship with *tēvolo*. Lilopau makes a strong distinction between *te'ia* (to be stricken by a supernatural being) and '*āvanga* but rarely uses *fakamahaki*; she prefers the term *fakatēvolo* as a general term to describe most of what she treats. Lealiki, by contrast, used the term *fakamahaki* almost exclusively. Of the patients I asked her to record in a notebook, almost all were *fakamahaki*. Pisila suggests two types of '*āvanga* of different seriousness, whereas Siosiofanga has a host of '*āvanga*, each with a designated behavioural symptom. I cannot examine here the degree to which they used the terms in practice. Lilopau, Pisila and Siosiofanga's use of terms contrasted with Lealiki and several older healers I interviewed, who argued that all conditions were essentially *fakamahaki*. When I expressed my confusion at the number of different terms one healer explained:

(H) There is only *fakamahaki*, what is different are the names, *te'ia*, *fakamahaki*, '*āvanga*, that's all, overall that is all. They are all the same. What is different are the names.

(MP) I don't understand, why are there many names?

(H) I don't especially know why, they were named that way. People in the past, our ancestors called them different names. They are the same but they have different names.

(MP) Is it better to say *fakatēvolo* or *fakamahaki*?

(H) *Fakamahaki*.

If *fakatēvolo* and *fakamahaki* can be synonymous why do some of the healers prefer the term *fakamahaki*? One healer, Fangupu, was extremely explicit in explaining her preference for a variant of the term *fakamahaki* over *fakatēvolo*. I had come to visit her in the company of a nurse from the hospital. Fangupu is one of the older healers, originally from Ha'apai, but is now living as part of her daughter's household in a strongly Mormon village in Vava'u.

(H) It is better to say *faito'o fakamahaki*. Don't say *fakatēvolo*.

(MP) Is it more suitable to say *faito'o fakamahaki* or *fakatoto kovi*? Is it the same thing?

(H) Same thing, the same, *fakamahaki*, *fakatēvolo*, *fakatotokovi* but it is better to say *fakamahaki fakatotokovi*. To say *fakatēvolo* is to suggest that we don't pray, that we believe/have faith in *tēvolo*. There is only one kind of illness and that is *fakamahaki fakatotokovi*.

Fangupu claimed that *fakamahaki fakatotokovi* is the most suitable term. She later went on to explain how people are affected by *tēvolo*, so evidently she is not questioning the

essential cause. The term's appropriateness seems more important than a strict definition. *Fakatotokovi*, according to a nurse, is the Tongan translation of low haemoglobin. But in 1967, at least one healer in Lapaha, Tongatapu understood *fakatoto kovi* as a 'kind of spirit sickness' and treated it with *fakainu* and *tulu'i* with a mixture of the plants *lautolu 'uta*, *lautolu tahi* and *nonu* (Parsons 1981: Appendix C 35).¹² Lealiki and Akosita both argued that *fakamahaki* was in part due to *totosi'isi'i* (lit. little blood), introducing a naturalistic explanation to explain increased susceptibility, but still seemingly preserving the *tēvolo* as the agent. What are healers then doing in social terms when using terms such as *fakamahaki* or *fakamahaki fakatotokovi*, or introducing naturalistic explanations that are understood differently by doctors and nurses in the hospital?

In positing a naturalistic susceptibility or a composite naturalistic term, healers evoke and intensify relatedness to the nurses and doctors of the hospital and draw on terms that have higher appropriateness and status by virtue of being associated with the expertise of the hospital. This is a solid social and epistemological basis for collaboration between healers and health professionals. *Fakamahaki* is more suitable because it is a composite of the term *mahaki* which is the hospital's most widely used term for disease. Fangupu's case is particularly illustrative. She joined the Mormon church because of living with her daughter who had converted because of marriage. She is also receiving hospital treatment for diabetes. Mormon teachings do not encourage an active interest in *tēvolo*, though they acknowledge their existence. By using the term *fakatotokovi* she evokes and intensifies relatedness to her new Church, her current household and the hospital from where she is receiving treatment. The term is naturalistic as understood by them, but personalistic in her terms. Fangupu does not know what the term really means in terms of haemoglobin, nor does she care to, but she appreciates the ramifications of using it to evoke and intensify valued relationships. The spoken ethic of healers evokes and intensifies their membership to their respective churches. Their insistence that the constituents of their remedies have remained unchanged in the transmission from generation to generation reflects their engagement with the rhetoric and conflation of traditionality and authenticity.

However, it is in their particular explanations for events of sickness that healers most demonstrate their ability to evoke and intensify relatedness within the particular social contexts of the sick individuals they are requested to treat. The following case study examines this in relation to the distinctive explanations of two well known Wesleyan healers Lilopau and Akosita for one patient Lupe, who was treated by both. The case study is also illustrative of the increasing resort to healers that has accompanied the rise in often symptomatologically vague conditions such as diabetes and cardiovascular conditions (see WHO 2003). This is the result of wholesale changes in diet and lifestyle in Tonga and most other islands in the Pacific region that has marked the shift from communicable to non-communicable disorders (Evans et al. 2001, 2002; Gani 2009). Non-communicable disorders now make up 75% of the causes of death in Tonga, with injuries (11%) and communicable diseases (11%), followed by HIV, TB and malaria combined at 4% (WHO 2004). A recent MOH report reveals the five leading causes of death (number of cases in brackets) as: (1) diseases of the circulatory system (196), (2) neoplasms (62), (3) symptoms, signs and abnormal clinical and laboratory findings (58) (4) Disease of the respiratory system (54) (5) Certain infections and parasitic diseases (35) (GOT 2007). Complications from diabetes or poor dietary restriction adherence which may fall into category (3) above are increasingly causing death. Some 80% of the prevalence of type 2 diabetes (15.1%) was undiagnosed in 2002. The prevalence has more than doubled since 1973, with 57.7% of male patients and 66.7% female patients consulting traditional healers (Colagiuri et al, 2002). The benefits of workshop based knowledge exchange and/or collaboration with healers to understand their treatment of people with diabetes would be useful to address poor resort to treatment for cuts, enforce regular attendance at clinics, encourage better dietary practices and earlier diagnosis of diabetes.

CASE STUDY: HIGH BLOOD PRESSURE, NERVES OR AMOROUS TEVOLO

In November 1998, Lilopau was called to treat a large lady in her early fifties named Lupe in a nearby village. Lupe's daughters were very concerned because on visiting some relatives in another village she did not eat, just drank water, sat and slept. She had almost died, they explained, using the term *mate*, which can mean both to die but also to lose consciousness. Though she had been like this for a year it had never been this serious. They knew Lilopau's dismissive opinion of hospital medicine. Their false insistence that they had not taken her to the hospital served to garner increased support. Lupe had actually been diagnosed with hypertension as an outpatient at the hospital three months before and returned to the hospital the day after Lilopau's final treatment. They claimed that it was only when Lilopau came, that they realised it was *puke fakamahaki*. Lilopau diagnosed *te'ia*, the most serious of conditions she had previously defined as the result of the slap of a *tēvolo*. She explained that Lupe had been seeing male *tēvolo* who wanted to sleep with her. Another sign was her resistance to being treated. I joined Lilopau on the third day of treatment. Several members of the household followed the protocol to always attribute improvement to the present healer and explained that she had become considerably better. The most interesting dialogue followed the initial dripping of remedy into Lupe's eyes, nostrils and mouth. I describe the healing encounter in the present tense.

After a short rest Lupe sits up and drains all the liquid and mucus from her nose, mouth and eyes. The amount of green coloured mucus that comes out from her nose is phenomenal. This is the test of *te'ia* and the proof of my treatment, says Lilopau, explaining that the green liquid is not *ihu pe'e* (mucus in the nose) but *vai kafo* (a kind of pus). 'The *tulu'i* goes into the head and travels around the head and comes out as *vai kafo*. Do you 'believe' it now?' she asks. Even during the accompanying ten-minute vigorous massage of her face and neck, she remains impassive throughout. The women support Lilopau's comment on Lupe's improved awareness. They also confirm that before she was finding it very difficult to breathe, her throat was blocked and she felt *mākona* (satiated) all the time. Lupe does not participate in the conversation, though she does smile a lot more after the session while a grandchild climbs all over her. Lilopau suggests bringing some ice cream, which is easier to eat. One of the women's comments that she has high blood pressure, implying she has been taken to the hospital, gets no response from Lilopau. Lupe then moves from the house to the garden where the leaves have already been boiled for the healing wash. The mixture is tipped into a baby bath from which Lilopau scoops up some of the mixture with a small bowl and propels it at Lupe's face. Then, while I take over this procedure, Lilopau vigorously massages Lupe from the top of her head to the bottom of her back. When almost all the mixture has gone Lupe picks up the baby bath and tips the remainder over her head. She then picks off all the leaves that have stuck to her body and goes off for a shower, returning back to the room looking somewhat more invigorated. Everyone remarks on the fact of her eyes being wide open. Lilopau arranges to return the following day and takes the opportunity to visit some friends in the village. When asked she confirms the seriousness of Lupe's condition in terms of *tēvolo*.

Lupe continued to return to the hospital to be checked and prescribed the Nifedipine for high blood pressure even after she was taken, several weeks after Lilopau's final treatment, to Akosita. By coincidence, Akosita recounted the story of her treatment on our first meeting in May 1999. Her translated and abridged account detailed the extent of their help and preserved something of her style of narration and emphasis:

This year they brought a lady, who was completely incapable of doing anything. She just slept. Her family was fed up with trying to get her to do something. She just slept. It was frightening. She slept face up, snored and was hardly conscious. Mucus and saliva dripped off her face. They had already taken her all over the place, thinking it was *fakatēvolo*. But when they brought her to me, I told them straight away, no. She

had already been sent home from the hospital, the hospital didn't know what she had. So I told them, no, this lady, there's a nerve in her head and that is the cause of her sleeping. So I treated her that afternoon. They left her with us. I brought the medicine and treated her at six. She slept till eleven and then went to bed at half past twelve. When she woke up the next day we treated her again and gave her some food to eat. I told her to walk outside and sit down. I watched her and noticed that she got up and walked around and exercised. Her sleeping was because of the nerve. We treated her on Thursday, Friday, Saturday, and Sunday, by which time she was really well. On Sunday, we went to church with her, to our church, both the service in the morning and the afternoon. We prayed together with her. On Monday we took her back home. When people are brought here, I try to understand completely what the illness is. They had already taken her all over the place for treatment. But their trying was futile and without result. They thought I wouldn't be able to treat her, she had already been sent home from the hospital, they thought she was going to die. But they brought her to me and I told them. 'It's my belief that it's a nerve'. And that's the way it was. You can see. Now she is completely better. I treated her leg only, it was a nerve. The treatment was massage with leaves. The water had already been heated, boiled, brought it straight over and put her leg and toes in. There was no *tulu'i*, she didn't drink any remedy and I did not touch her head.

Akosita's diagnosis focused on her understanding of nerves in the body and argued that the treatment of the leg as well as exercise and going to church healed the damaged nerves in her head. She made it clear, however, that she did not touch the head when treating, implying a knowledge of being able to treat nerves from other locations in the body. She was critical of other people's perception that it was *tēvolo* caused.

Lilopau described her condition as *te'ia*, in her terms the result of the slap of the *tēvolo* and the most serious of the conditions she can treat. Lilopau's tendency to contradict her own definitions or criticise the need for clearly defined conditions, was demonstrated in her insistence that in this case several male *tēvolo* had wanted to sleep with her. The implication was sexual. While on other occasions she explained how the *tulu'i* to the eyes simply breaks the person's experience of the *tēvolo*, on this occasion she formulated a quasi-naturalistic mechanism for the functioning of the *tulu'i*. It travelled around the inside of the head and emerged later as a particular kind of *vai kafo* (pus). For her, the *vai kafo* was the proof of her treatment as well as confirmation of Lupe's *te'ia*.

DISCUSSION: THE VERBAL BASIS OF SYNCRETISM

The MacPhersons' (1990) focus on structural features explaining diversity and the WHO's emphasis on generalising traditional healers both understate healers' capacity for creativity and interest in biomedicine, and thus the possibility and different degrees of collaboration. Of all the healers, I had most contact with Lilopau and Akosita and, therefore, by implication know the extent of their creativity and possibility of collaboration. Of the five healers, Lilopau was most personalistic in her explanation, Akosita most naturalistic. Lilopau had the least confidence in biomedical concepts. She often questioned the use of terms such as *pakalava* (stroke) and *toto mā'olunga* (high blood pressure). What the hospital regarded as *mahaki* (disease, illness) are potentially *fakamahaki* (*tēvolo* caused) in her terms, hence her great confidence in treating all kinds of sicknesses. Though she went to the hospital for treatment of arthritis on her knee, she gained greater relief from re-arranging the bones of a relative. She was the only healer who publicly categorised her area of expertise as *fakatēvolo*.

By contrast, though Akosita had the greatest confidence in biomedical concepts she still questioned the hospital's diagnosis for Lupe. As our relationship developed, she spoke more of how she preferred to define conditions in terms of the '*sino*' (body) and not *tēvolo*. Her

focus on liquid internal remedies (*vai*) most resembled in form some of the treatments, which the hospital gives to patients. She emphasised the importance of nerves in understanding *fakamahaki* cases based on a solid understanding of nerves being like '*uo'ua* (muscles) and capable of breaking. She seemed the most popular with the public health nurses I knew, who respected her remedies for childhood conditions. She had also been treated in the hospital for a serious illness.

Akosita's and Lilopau's position of confidence within the community was affirmed by their attainment of the role of lay preacher (*kau malanga*) in the Wesleyan church. Their actions, in response to a history of peoples' requests of help, have led to them becoming prominent interpreters of illness, evoking and intensifying their relatedness to many actors on that journey. Such influence underlies a strong potential brokerage role between biomedical and non-biomedical healing.

Akosita had more contact with people who are familiar with more biomedical and scientific notions of illness and the body. She had more contact with relatives overseas, her son is a trained electrician, a daughter studies overseas. She moved from Nuku'alofa, where people are, no doubt, more biomedically aware, to Vava'u. Lilopau has spent most of her life in her village, she has great influence in her household and within the village and her perspective is rarely challenged. Many people identified her practice as the most traditional as it was least accommodating of biomedical concepts. The strength of her influence, her *ivi* ('power') in local terms, is manifest in taking the ideas she was exposed to, and applying them to a much greater degree than other healers. She countered the intrusion of biomedical ideas by putting her perspective even more forcefully. Ironically, while most critical of a biomedical epistemology by diagnosing almost exclusively in terms of *tēvolo*, she is probably least likely to encourage critique of the hospital in biomedical terms.

The other healers, as social members of Vava'u life, are also intensifying relatedness in a similar process, though falling between the two extremes, which Akosita and Lilopau seem to represent. For example, Lealiki's marriage to a schoolteacher and a dramatic experience of *tēvolo* in the hospital goes some way to explain her conciliatory explanation which stresses ascertaining the personalistic involvement of an agent and naturalistic measures to conceptualise susceptibility. She saw a *tēvolo* dressed up as a doctor in the hospital after the birth of her third child when diagnosed with *toto'si'is'i* (low blood count). The *tēvolo* did not return after they gave her blood, and her husband brought her some Tongan remedy to drink. A lack of blood, she argued, makes it easier to see the face of the *tēvolo* and easier for the *tēvolo* to *fili* (choose) the person.

The case of Lupe's treatment illustrates the extent to which, though different in content, both Akosita's and Lilopau's explanations evoke and intensify their relatedness to Lupe's household in their interpretations. In neither explanation was there any sense of blame on the household. Explaining the sickness in terms of a broken nerve or a *tēvolo* locates the cause of sickness outside the control of the household and Lupe and reduces any implied stigma.

CONCLUSION: IMPLICATIONS ON POLICY

The particular diversity and syncretism of 'traditional' healing in Tonga suggests little benefit from following the regionalised strategies of the WHO. The fact that healing is woven into the social and religious fabric of a Christian constituted Tongan society, suggests the redundancy of promoting 'public awareness of and access to traditional medicine' or fostering 'respect for the cultural integrity of traditional medicine' (WHO 2002:42). No more respect needs to be fostered with a generalised public. Doctors and policy makers need to better appreciate the way that most people navigate pathways through the choices of treatment. Greater knowledge of the particular practices and understanding of key syncretic healers in relation to key symptoms of concern would enable more efficient and timely treatment. Neither evaluating 'the economic potential of traditional medicine' nor

establishing ‘appropriate standards for traditional medicine’ suggest the likelihood of building a more profound appreciation of healer’s position in policy circles in terms they would recognise (WHO 2002: 42). Lilopau’s syncretically framed concern to show me the proof of her treatment would suggest that the evidence-based practice emphasis of the WHO would have some purchase. However, neither Lilopau’s nor Akosita’s focus on nerves or ‘brain pus’ would seem to biomedically strengthen their claim for the efficacy of their healing. If anything, by revealing these terms they seem to detract from the most significant phenomenological component of their healing, the considerable, physical, psychological and transformative support they provide that follows from their concern, faith and love. The alleviation of stigma and galvanising family in support around a patient are key in the absence of significant treatment at the hospital. Any analysis of the efficacy of traditional healing within an evidence-based model would have to take this into consideration. One aspect of the efficacy of healers’ practice follows from their arguing in religious and accessible terms. One would not want to devalue the ability of people in Tonga to bear sicknesses and have faith in future resolution that healers foster.

All the five healers welcomed greater collaboration and recognition of their practice by the hospital. Health professionals would certainly benefit from the knowledge of public resort to treatment and patients’ perceptions of illness that healers provide. Their creativity, interest and critical experience of biomedical practice suggest the potential for fruitful collaboration. However, the syncretic terms in which healers are constrained to represent their practice do not enable them to do justice to their healing. The contribution of anthropology in this context is to reveal the wider social dynamics of healing, that enables policy makers to question and retheorise on the basis of what is actually taking place, rather than the locally insensitive strategies encouraged through bilateral development. The Tonga national health account survey is a poor start, its epistemic bias contributes little to better understanding.

Epistemological dialogue, accessibility, reciprocity and utility in relation to policy and programming would best be served by an increased focus on different notions of efficacy in the Tongan context. This would most beneficially build on the workshop led example set by Dr Mapa Puloka and the psychiatric unit and extend its relevance to other departments in the Ministry of Health.

Csordas and Kleinman’s (1996) categorisations of the different theoretical approaches to healing (persuasive, structural, clinical and social support) would serve as a useful initial catalyst to frame the Tongan locus of efficacy to a wider policy audience. Both healers and doctors treat the mistakes of each other, and both on occasion cause greater suffering because of their treatment. And yet because of the importance of maintaining social relationships both healers and doctors will typically be attributed some degree of efficacy, and not be informed of the fact that traditional and biomedical treatment is being carried out at the same time. Greater collaboration and better mutual knowledge has to follow the appreciation of why there is so much public support for healers and such poor communication in the hospital context.

Understanding the current social, economic and religious influences informing attribution of efficacy to doctor’s and healers practice is a necessary balance to claims of traditionality or scientific objectivity, particularly if notions of efficacy are everywhere ‘guided by cultural, political and moral values’ (Desjarlais 1992: 224). The rigorously empirical, through focus on particular cases, is the most Tonga sensitive way to reframe the debate on efficacy and resort to treatment. Particular nurses and healers are already loosely supporting each other in Vava’u. It would be better to build on the many links and history of healers’ engagement with biomedicine already established. If a national policy is necessary it should be formulated on the basis of the mutual recognition of currently unrecognised influence and support to engage healers, health professionals, health policy makers, the public and the church on the issue of sickness and stigma, and better ways of communicating to patients.

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This paper is dedicated to Akosita, a healer, mother, friend and person of exceptional courage, dedication and *'ofa* (love). Her death from breast cancer several years after apparently recovering from a previous episode treated at the hospital and the self-medication of one of her most powerful remedies reveals the complexities of improving health in Tonga. The inadequacies of hospital facilities in Vava'u, and the faith in her remedies that gave her hope and great ability to deal with her suffering are implicated to degrees difficult to ascertain. It is tragic that the very system of healing she had started to more openly embrace failed her in the final instance. I hope that her creativity and steadfastness to the ethics that guided her practice, without apportioning blame, might serve as an inspiration to future attempts to build more substantial bridges between healers and public health services. I thank the many healers in Tongatapu and Vava'u who gave their time to explain their practice and share stories of healing. For much help and support I thank Dr Mapa Puloka and the staff of the Psychiatric Unit in the Vaiola Hospital, Tongatapu. The Public Nurses at the Prince Wellington Ngu Hospital in Neiafu helped me without fail and facilitated many of the initial meetings with healers. Please see Poltorak (2002) for a more detailed list of the large number of people who helped and facilitate the research in Tongatapu and Vava'u. The main part of the research for this paper was carried out between 1998 and 2000. Visits in 2005, 2007 and 2009 enabled further research and qualifications to be made to earlier data. I gratefully acknowledge the support of the ESRC (Economic and Social Research Council) for doctoral and post-doctoral funding.

NOTES

1. See Young Leslie (2004) for a review of a film 'Kau Faito'o: Traditional Healers of Tonga' that conflates traditionality with authenticity.
2. '*Avanga*: sickness caused by *tēvolo*; *Te'ia*: to be stricken by a supernatural being or power, popularly regarded as very serious; *Fakamahaki*: synonymous with '*avanga* or *fakatapumahaki*-causing or producing sickness or disease. *Tēvolo* caused condition; *Fakatēvolo*: As or like pertaining to *tēvolo*; *Mahaki*: sickness, disease or ailment; *Kahi*: name applied to various diseased swellings, such as goitre, scrofulous swelling and piles or hemorrhoids; *Hangatamaki*: boil, abscess, carbuncle or other such swelling; *Vai*: liquid, water, liquid medicine (short for *vai faito'o*); *Tulu'i*: to drip medicine; *Kaukau*: healing bath or wash.
3. The pejorative comment was made of a famous healer/midwife who had died some years back and whom I had been recommended to see before arriving in Vava'u. The speaker was a nurse with personal experience of her unsanitary deliveries. Many of the women had to be treated in the hospital afterwards for infection. The healer, she said, had a big mouth and was able to persuade the people that her treatment and explanation were correct.
4. Broken bones and muscular problems may be treated by mostly male *kau faito'o fasi*. Some people specialise in one or several kinds of *kahi*, sometimes translated as hemorrhoids but often encompasses conditions relating to blockage or stiffness (Bloomfield 1986:115). Many people have remedies and techniques for treating *hangatamaki* (general category for swellings, boils and abscesses), with particular techniques and plants. Even more people are very enthusiastic about a particular remedy that may have been given to them by a relative or in a dream. Some women and men are well known for a particular *vai* (liquid medicine usually prepared by boiling leaves, bark and fruit of tree, shrubs and plants with water) which may or may not be regarded as a panacea. *Kau ma'uli* (traditional birth attendants), though very popular in the past and still consulted now, play a much lesser role in the delivery of babies. Most babies are delivered in the hospital.
5. In Tongatapu, the situation is very different. In 1998 the then mental health worker compiled a list of 23 healers with whom she was familiar and who could treat conditions potentially diagnosable in psychiatric terms. Ten were male. Of the nine she categorised as exclusively *fakatēvolo* healers, four were male.
6. 'Well known' is my working translation for the local term '*ilonga* that Churchward (1959) translates as: to show, show up, be seen, be recognizable; distinguished by a special mark or characteristic; conspicuous, outstanding, notable, memorable.
7. Analysis of the characteristics of healers that are influenced by the politics and degree of social cohesion in their villages is hindered by the required ethical practice of not naming the healer and their villages. Some healers had no objection to being named and would have welcomed more attention and recognition of the work they do. Several, however, were intimidated or worried about possible negative response from the hospital. In this research, standard ethical requirements of the protection of research participant identity served to enable discussion of case studies in which there are contestations of accountability and diagnosis. Other research has typically not described such case studies or dealt with accountability. Jilek (1988) named one healer and the village he was from (he is now living in the US) and Weiner (1971) named all the healers he worked with. Katz

- (1993) in Fiji did not name healers 'out of respect and in accordance with people's wishes', I suspect in part because of new evangelical groups and their derogatory stereotyping of healers' work as that of the *tevoro*, a term he translates problematically as devil.
8. The way people talk about *tukufakaholo* in instances of sickness, suggests that the mode of transmission for many is either through the blood or some kind of intrinsic link between relatives.
 9. For example: (1) the degree to which *vali* (poultice) is important, which plants are used, (2) The degree to which healers use tests such as *tulu'i 'a'ahi* (testing *tulu'i*). For *fesi'ia* (body pain attributed to the touch of a *tēvolo* (See Whistler 1992 : 40)) some healers maintain that if the leaves stick to the skin this confirms the diagnosis, (3) Their reference and adherence to the *lao faito'o fakatonga* (law of Tongan medicine) that states that results should be evident within two or three days. This was only explicitly referred to by Lealiki, (4) The degree to which they adhere to a morning/afternoon twice daily schedule of treatments, (5) the degree of importance of the *kaukau* (healing wash) which seems to be the key treatment in Vika's treatment, (6) The degree of difference in the components of the different *vai* that they use, and (7) The importance of patients living with the healer.
 10. In respect to those healers who regard their remedies as family secrets, I do not detail the plants used by particular healers unless they were common knowledge. Some plants are popularly known to be effective against *tēvolo*. Most ethnobotanical knowledge is not regarded as secret knowledge, partly because of a religious ethic that explains that God *faka'ivi'ivi* (puts power) into plants, a great enthusiasm for a new remedies and a sense that the healer's 'power' is instrumental to successful healing (Bloomfield 1986). There are also some countervailing tendencies. Knowledge of some traditional medicine which used to be held as family secrets, as noted above, is now more widespread as a result of healers asking people to provide the ingredients of a particular medicine themselves.
 11. Tregear suggests the idea of cajolery in defining *avaga* as 'to be in love with; to bewitch; to be possessed by an evil spirit'. He also cites a French missionary dictionary that defined *avaga* as 'caresses used to obtain something; a marriage between a person and the devil' (Tregear, 1904: 113).
 12. Healer of Lapaha aged 43 13th March 1967 Cream for *fakatoto kovi* (kind of spirit sickness): 8 leaves of *lautolu 'uta*, 8 leaves of *lautolu tahi*, 6 small fruits of *nonu*. Pound these leaves and fruits together, then wrap them up with *kaka* (fibrous integument at the top of coconut palms [Churchward 1959] and tie. Prepare this medicine as usual and then give to the person to take 2 or 3 sips. After that apply the remaining medicine (as a *tulu'i*) on his body and put a few drops in his eyes, nose and ears. If it is effective, the person will not be frightened and will not talk to himself any more, instead he comes to his senses. He feels comfortable and wants to go to sleep. *Tapu*: He is not allowed to stay home by himself at any time until he is fully recovered. (This remedy is one of many recorded in Parsons [1981] that were gleaned from accounts recorded under the direction of Tupou Posesi Fanaua and held in the Palace Records Office).

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