# The Institutionalization and "Medicalization" of Family Planning in Tonga

*Development of the clinical and medical infrastructure facilitated the increase in the proportion of family planning acceptors*

**By Henry Ivarature***

This article focuses on the introduction and establishment of family planning in Tonga and argues that family planning has been medicalized. In the process of institutionalizing family planning through the formal medical structure, what has occurred is that women — the focus of this national policy – have had their reproductive and sexual environments medicalized. Also, family planning at the macro level, aside from its clinical and medical objectives, has taken up a regulatory function for the socio-economic and developmental aspirations of the state.

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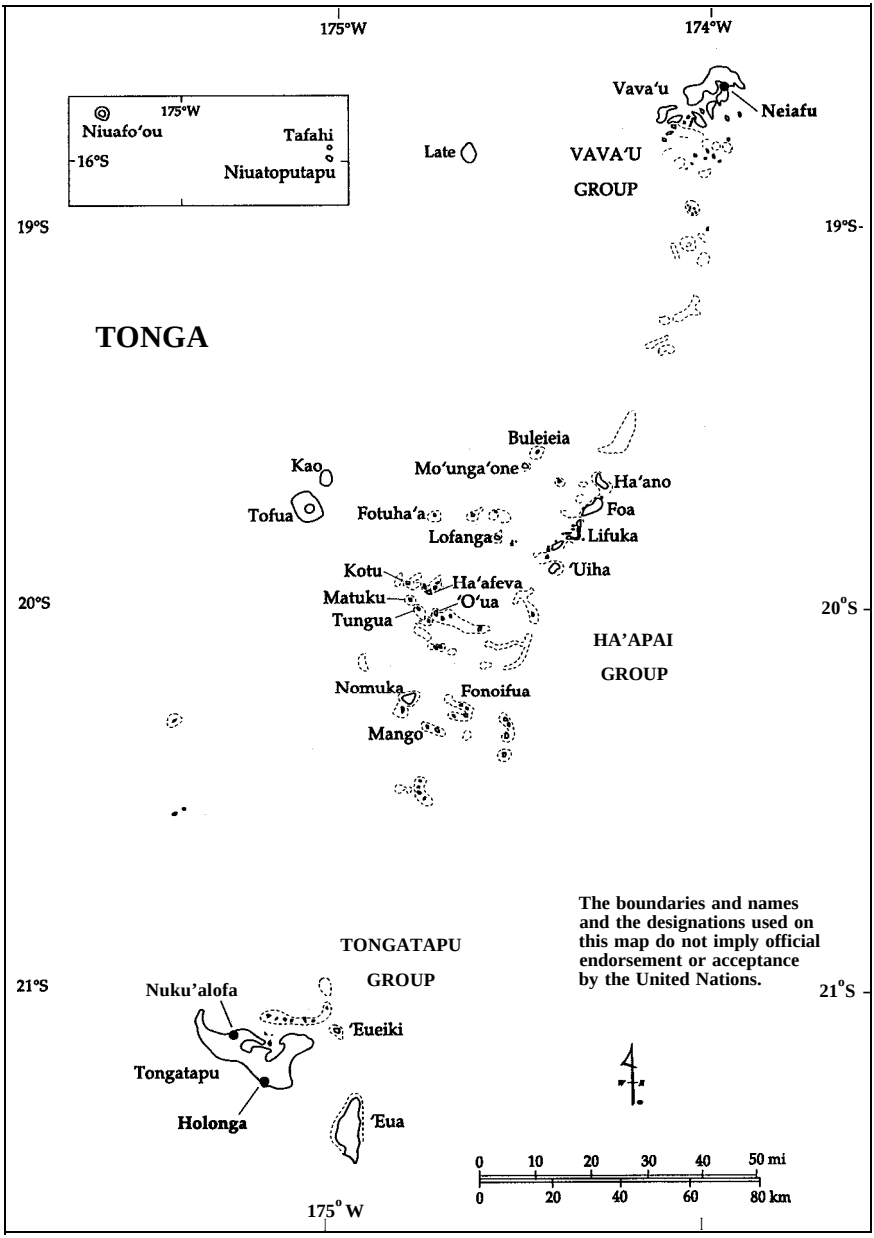


The boundaries and names and the designations used on this map do not imply official endorsement or acceptance by the United Nations.

**Table 1. Population size and annual rate of growth, Tonga, 1956-1986**

| Census year | Population | Period | Annual growth rate (%) |
|---|---|---|---|
| 1956 | 56,836 | | |
| 1966 | 77,429 | 1956-1966 | 3.09 |
| 1976 | 90,799 | 1966-1976 | 1.51 |
| 1986 | 94,649 | 1976-1986 | 0.49 |
| 1996 | 97,446 | 1986-1996 | 0.29 |

*Source:* Government of Tonga (1991). *Sixth Development Plan 1991-1995* (Nuku'alofa, Central Planning Department), p. 62, Table 4.1; Gerald Haberkorn and Christelle Lepers (1998). *Pacific Island Populations* revised edition (Noumea, South Pacific Commission), p. 66.

## Tonga

Tonga is a country of limited land area, i.e. 747 sq km. Its 150 islands (see map) comprise the Tonga archipelago, also known as the Friendly Islands. Rapid population growth until the early 1970s has resulted in a high population density of 120 persons per sq km and an acute land shortage, especially with regard to the number of Tongan males who are lawfully entitled to two plots of land for agriculture and residence. Fortunately, since around 1970, emigration has alleviated temporarily whatever social, economic and demographic pressure annual rates of natural increase may exert on the country. As shown in table 1, emigration has been largely responsible for reducing the annual growth rate from 3.09 per cent between 1956 and 1966, to 0.29 per cent between 1986 and 1996. This dramatic decline has reduced the degree of overcrowding throughout the archipelago.

The social structure of Tonga consists of the royal family at the apex of the society, with King Taufa'ahau Tupou IV currently head of government. The nobility rank beneath the royal family and their significance emanates from recognition as traditional leaders, with certain rights and privileges. Their societal authority and rank is especially evident during ceremonial, cultural and other daily events. Ranked below nobles are a class of lesser chiefs known as *matapule* who, like nobles, have certain rights and privileges, but these do not override those of nobles. At the base of the social hierarchy are commoners, the majority of Tonga's population. All Tongans display their relationship to others, whether of higher, lower, or equal rank or status, through such mediums as language, dress, participation in ceremonies, cultural obligations and collective and personal behaviour. Social relations between and among these classes of people are

demonstrated through societal norms that for generations have been woven into the country's cultural, social and political fabric. The form of government in Tonga is a Western constitutional system based on the British model, but incorporating Tongan forms of authority and rank in order to acknowledge the existence and significance of various social strata in its society.

The challenges of adequately maintaining or supporting a rapidly expanding population are well known. In addressing rapid natural growth, the policy focus appears to be directed at one group of people -women – and narrowly confined to family planning services. In Tonga, the national programme of population management is gender-specific and over-emphasizes the role and position of women in its implementation. Consequently, rhetoric on the social problems of rapid population growth and its perceived consequences is narrowly defined on a gender and institutional basis. The limited focus of family planning programmes on women and their implementation by the medical establishment leads to the danger of medicalizing a small aspect of population management, when what is involved is the wider aspect of human resource development. Locating family planning services or programmes alongside health services is seen as inevitable, but the very fact of attaching population management to the overall health objectives of a government also inevitably facilitates the process of medicalizing it. To illustrate this process as it is occurring in Tonga requires a historical approach to past experiences of family planning within the medical establishment and as a development instrument of public policy.

## Institutionalization of family planning

A limited family planning service was introduced in 1958 in the capital of Nuku'alofa (see map on page 36), through the activities of the International Planned Parenthood Federation (IPPF) rather than as an initiative of the Government of Tonga. The government, in particular the medical department of the Ministry of Health, was ill-prepared to introduce such a "health service". No one had been trained in family planning; further, the medical infrastructure essential for implementing such services nationwide was absent. The impetus for introducing family planning arose from demographic trends in Samoa and Tonga in the 1950s that signalled the need for measures of population regulation (Bakker, 1979), reinforced by the findings of a survey of five Pacific island countries sponsored by IPPF. Both countries had experienced high rates of population growth as a

result of better medical services and improved living standards, which had resulted in the reduction of mortality rates.

Family planning became "official government policy" in 1962, when funds were allocated in the recurrent estimates of the Ministry of Health for its implementation (Government of Tonga, 1976:276). In 1965, a programme on family planning was instituted when a Tongan medical officer with specialized training was appointed part-time medical officer in charge of the family planning clinic (Government of Tonga Annual Health Report, 1965:8; Government of Tonga, 1976:276). His appointment signalled the recognition of family planning, until then viewed by the govermnent as a means for improving the health of mothers and their offspring. Prior to this, services were provided by a senior staff nurse, occasionally assisted by a junior staff nurse.

The start of the family planning service was marred by many administrative problems, in particular, high rates of staff turnover, lack of properly trained staff and the absence of infrastructure and skilled personnel in the Ministry of Health. Moreover, the number of people who sought family planning services was disappointingly small. In 1958, a total of only 226 visitors were recorded (Government of Tonga Annual Health Report, 1958:13), most of whom were using contraceptive devices more or less regularly, followed by 218 acceptors in 1959, of whom 36 were new acceptors (Government of Tonga Annual Health Report, 1959:13). In 1960, only 25 women were reported to have visited the clinic; in that year the senior nurse with professional training and skills was transferred from Tongatapu to Vava'u.

As a result, family planning services were temporarily suspended in 1961 due to a lack of skilled medical staff, ironically at the same time that the annual health report commented on the rapid rise in population and the need to reduce fertility by both natural and artificial methods. When services resumed in 1962, a total of 93 women visited the clinic, but only three were new aside from the 16 who came regularly. Attendance in 1963 showed more promise, with 75 women out of 196 visiting regularly (Government of Tonga Annual Health Report, 1963:7). In 1964, when clinic days increased from twice weekly to become a daily service (except for weekends), the total number of new acceptors improved slightly. In 1965, family planning services in Nuku'alofa were incorporated into the maternal and child health clinic, where those nurses undertook family planning activities (Government of Tonga Annual Health Report, 1965:8).

In 1964, a second family planning clinic was opened on the northern island of Vava'u. In the first month, attendance was very high, but subsequently declined rapidly (Government of Tonga Annual Health Report, 1964:7). During its first year, 284 married women visited the clinic for consultations, although only 36 attended regularly. By 1965, just 12 married women were clinic visitors, four of whom were new. Such low attendance was attributed to a shortage of contraceptives (Government of Tonga Annual Health Report, 1965:8) even though demand for family planning services was seen officially to be gradually increasing. Despite the irregularity of clinic hours at Vava'u, 32 sterilizations were performed in 1966 (Government of Tonga Annual Health Report, 1966:7). In Tongatapu, labour shortages meant that the family planning clinic could open for only two days each week. Appeals for assistance to overseas organizations were successful, however, and the Population Council donated 2,000 intrauterine devices (IUDs) (Lippes Loop). With two medical officers instructed in fitting the IUDs, and with their involvement in conducting clinics at Vava'u and Ha'apai hospitals (see map on page 36) it was not surprising that this contraceptive method reported relatively high usage in 1966, when a total of 469 women were fitted with IUDs (Government of Tonga Annual Health Report, 1966:7).

## Family planning in formal development

Although family planning services continued to appear in recurrent budget estimates for the Ministry of Health, they received minimal reference in the country's first development plan, published on 1 July 1966. Beyond the establishment of a national programme the previous year, three somewhat coincidental events gave population issues greater visibility. The first was the publication of an article entitled "The population problem", featured in six issues of the weekly *Chronicle*, by John Rocke, a well-known gynaecologist from the United States, who was also Professor of Medicine at Harvard University *(Tonga Chronicle*, 30 April-3 June 1965). Consideration, among many themes, of the position of the Roman Catholic Church on population growth and of different religious attitudes towards biological reproduction and responsible parenthood elicited offers from heads of local churches to provide written statements of their views on family planning.

The second event, in July 1965, was the annual meeting in Nuku'alofa of the South Pacific Health Board, then executive arm of the South Pacific Health Service. The agenda item, family planning and population control, led the board to urge participating governments (Fiji, New Zealand, Samoa

and Tonga) as well as the Western Pacific High Commission to establish and develop family planning as an integral part of their public health plans *(Tonga Chronicle*, 13 August 1965). Similar advocacy was contained in the annual Ministry of Health report (Government of Tonga Annual Health Report, 1965:8); a subsequent request by the government for assistance from overseas organizations reflected the urgent need for trained medical staff and clinical supplies.

By far the most significant fact, however, was that the new King of Tonga, Tupou IV, had raised questions about population as early as 1950 at the first meeting of the South Pacific Conference. On 21 June 1966, at his first official speech to the Legislative Assembly, he called for the introduction of family planning and in doing so compared population densities in Tonga and India: "By planning their family, a husband and wife with four children would be able to ensure that they would be in a position financially to care for their children, clothe and educate them, and thus give them the opportunity of sharing in the future progress of the Kingdom" *(Tonga Chronicle*, 24 June 1966:4). He also noted the declining size of land allotments for subsistence gardens and the unavailability of land for commercial projects, the burden placed on the community by the high incidence of illegitimate children, and the decline in income from the Kingdom's major export (*copra*) just as population numbers continued to rise.

Despite fleeting mention of a family planning programme in Tonga's first development plan, proposals to expand maternal and child health services did serve as a further catalyst. The annual health report for 1966 called for the rapid establishment of family planning clinics - similar to the one in Tongatapu -in Ha'apai, 'Eua, Vava'u and the outer islands of Niuatoputapu and Niuafo'ou (see map). The sense of urgency to open clinics reflected the belief that 5,000 out of an estimated 20,000 women in the fecund age group (15-46 years) could be protected from undesired pregnancies (Government of Tonga Annual Health Report, 1966:7). An alarming increase in the number of induced abortions was further justification of the need for more clinics to prevent unwanted pregnancies.

Up to 1966, only one nurse had received brief practical training in family planning, aside from three medical officers who had had limited secondments. In an effort to increase the number of specialized personnel, in December 1967 the Kingdom and the South Pacific Commission jointly sponsored a regional seminar on maternal and child health (MCH)

including family planning, that was held in Nuku'alofa (Fanamanu, 1969:18; Simmons and Yee, 1976:3). The seminar called for the establishment of a population planning board and argued that the concept of family planning needed to be communicated far more to the adult population, through two primary approaches. The first consisted of approaching the mother and the second sought the support of women leaders of formal and informal groups. In the former, casual discussion with mothers attending MCH clinics was advocated to overcome problems of shyness and as a way of having indirect contact with husbands, while professional visits to local pastors and priests was a way to help women whose religious beliefs outweighed their willingness to use contraceptives. The latter approach, to persuade mothers to accept family planning, required the assistance of influential women, such as the wives of hereditary title-holders and church leaders, and of women leaders of *tapa*- and mat-making groups, health committees and local midwifery.

In 1968, family planning was integrated with the MCH project and a medical officer appointed to oversee its implementation (Government of Tonga Annual Health Report, 1968:10). Following submissions in 1967 for international assistance, more help arrived from IPPF and the United States Peace Corps, in the form of contraceptive supplies, skilled personnel and overseas training for Tongan medical personnel. IPPF fellowships in 1968 enabled three health workers to undertake family planning courses in Singapore (Government of Tonga Annual Health Report, 1968:3, 11). Indeed, progress throughout that year was spectacular, with staff of the Public Health Section presenting a weekly radio programme on family health and also sponsoring film shows, complemented by individual counselling and home visits by MCH nurses. The integration of family planning with MCH was a key factor in attaining the highest reported use of contraceptives since 1958 - a total of 787 acceptors, of whom around 600 were new (Government of Tonga Annual Health Report, 1968:24-25). Nevertheless, the annual health report insisted that further programmes in educational awareness were essential.

In December 1969, the establishment of the Tonga Family Planning Association further strengthened official advocacy of family planning services (Government of Tonga Annual Health Report, 1969:8). More international assistance came through a fellowship from the East-West Center, in Hawaii, for a medical officer to study family planning programmes in Hawaii, Republic of Korea and Taiwan Province of China. A tremendous increase in family planning acceptance was reported by the

Ministry of Health in 1969, largely as a result of an extensive public awareness campaign conducted in 45 villages on four of the main islands. This programme also involved several government and non-government institutions and, for that year, 846 people were said to have begun using contraceptives. Of those, only 216 discontinued, while overall 1,011 acceptors were reported to have practised contraception (Government of Tonga Annual Health Report, 1969:23). For the first time, remote islands such as 'Eua, Niuatoputapu and Niuafo'ou provided clinic reports, in turn reflecting the functional integration of family planning with maternal and child health services. Some questioned this approach to complex issues of "overpopulation", however, and one prominent educationalist considered it "a makeshift solution". In a long article in the *Tonga Chronicle* (22 August 1969), a more even distribution of wealth was one of several alternatives identified to address issues of population, food and living space.

Another family planning clinic, the Roman Catholic Mission Voluntary Family Planning Service, was opened in 1970 in Nuku'alofa by the Catholic Church to teach and assist women in using the rhythm and ovulation methods (Government of Tonga Annual Health Report, 1970:10). Early the same year, at government request, a 'knowledge, attitude and practice" survey was carried out by two consultants from the School of Public Health, University of Hawaii (Wolff and De Sanna, 1970). Since the work of the Tonga Family Planning Association and the Catholic Mission Voluntary Family Planning Service was confined to Nuku'alofa, very few women on other islands used the pill or the IUD which, with condoms, were the most widely used contraceptives in Tonga (Government of Tonga Annual Health Report, 1970:29). On Tongatapu, in 1970, there were 400 acceptors of IUDs, largely owing to the provision of five new clinics with personnel trained to fit them.

With a foundation for family planning established firmly in Tongatapu, what remained was to expand and consolidate services in the rest of the Kingdom. Identified as a national objective in the second and third development plans, the Ministry of Health undertook the task of ensuring the integration of family planning into the prevailing system of public health care (Government of Tonga, 1970; 1976). Although this integration was said officially to be "recognized" from 1968 (Government of Tonga Annual Health Report, l968:10), in fact the process was probably incomplete until around 1975. Thus, family planning, which began between 1958 and 1970 as an activity with little social and health significance, was to become between 1971 and 1980 a social and health policy of immense national importance

**Table 2. Family planning acceptors in Tonga, 1958 to 1990**

| Years | Number of acceptors |
|---|---|
| 1958-1970 | 7,797 |
| 1971-1980 | 16,477 |
| 1981-1990 | 14,547 |

*Source:* **Compiled from Government of Tonga (1958-1990).** ***Annual Reports of the Ministty of Health*** **(Nuku'alofa, Ministry of Health).**

(see table 2). The second development plan sowed the seeds for this transition, although, given highly ambitious targets, the allocated funds were a negligible 1.22 per cent of the proposed total expenditure of T$4,778,220, or only T$58,460 (US$l = T$1.70). This budget was expected to be able to provide contraceptive protection to no less than half the married female population, as well as to achieve, by 1975, a birth rate of 20 per thousand (Government of Tonga Annual Health Report, 1978:2; Government of Tonga Annual Health Report, 1970:35). Even more ambitious was the third development plan, which proposed to increase by 75 per cent the proportion of married females protected through family planning by 1980 (Government of Tonga Annual Health Report, 1976:280).

More realistic was the implementation in 1971 of the maternal and child health/family planning project, financed primarily by the then United Nations Fund for Population Activities (UNFPA), now called the United Nations Population Fund. Post-partum family planning, which became part of the MCH framework throughout Tonga, was the most successtil outcome of this project and focused on women who delivered children at Vaiola Hospital in Nuku'alofa. In 1973, there were 239 such acceptors, 113 of whom were fitted with IUDs, 42 women had sterilization operations, 16 were introduced to the pill, and 35 and 33 respectively accepted the condom and ovulation methods (see table 3). The overall total expenditure of UNFPA to implement this project between 1971 and 1978 was T$390,111 (Government of Tonga Annual Health Report, 1977:13). Additional and complementary funds were provided by IPPF, the Peace Corps, the Pathfinder Fund, the governments of New Zealand and the United Kingdom, and through the Economic and Social Commission for Asia and the Pacific.

A preliminary review, as part of the third development plan for the period 1975-1980, found that the MCH/FP project had achieved some

**Table 3. Trend of contraceptive use in Tonga, 1971 to 1990**

| Methods of contraception | Years | | Totals |
|---|---|---|---|
| | 1971-1980 | 1981-1990 | |
| IUD | 3,141 | 1,529 | 4,670 |
| Pill | 1,771 | 2,256 | 4,027 |
| Tubal ligation | 686 | 551 | 1,237 |
| Vasectomy | 11 | - | 11 |
| Condom | 3,601 | 2,678 | 6,279 |
| Rhythm method | 741 | 493 | 1,234 |
| Depo-Provera | 4,520 | 5,941 | 10,461 |
| Others | 2,006 | 1,100 | 3,106 |
| Total | 16,477 | 14,548 | 31,025 |

*Source:* **Compiled from Government of Tonga (1971-1990).** ***Annual Reports of the Ministry of Health*** **(Nuku'alofa, Ministry of Health).**

success. Half the population of married women in the Kingdom were receiving family planning services and there had been a decline in the birth rate (Government of Tonga, 1976:277). However, the "too ambitious" goal of achieving a birth rate of 20 per thousand by 1975 had been constrained by the increasingly rapid entry of young people into the reproductive age group and marriage. To target these fecund groups, numerous awareness activities were undertaken from 1975 to 1977 and a weekly article on family planning was published in the local newspaper. In the intermediate term, planners did not anticipate a decline in rates of population growth, but rather assumed that natural increase would remain constant at the 1972 rate of 2.4 per cent per annum (Government of Tonga, 1976:80). In fact, a mid-term review did report the birth rate as falling from 29 to 26 per thousand during the period 1975-1977, the first two years of the third development plan (Government of Tonga, 1978:4, 16). According to the then government census officer, family planning and emigration were the two factors most likely to have been responsible for this situation (*Tonga Chronicle,* 10 February 1977; Moengangongo, 1988:59), while Bakker (1979:22) attributed fertility decline from 1971 to the activities of the Tonga Family Planning Association and the Ministry of Health.

Assessments of these demographic rates received support from a survey of acceptors taken in August 1976, which showed 45.7 per cent of all married women of reproductive age to be using contraception (Government of Tonga Annual Health Report, 1976:8). The lowest reported number of such acceptors was in the district of Ha'afeva, Ha'apai with 4.8 per cent,

while the highest level of 63.3 per cent was recorded in Kolonga, Tongatapu. Overall, the island of Tongatapu reported 53 per cent of married women of reproductive age to be acceptors, followed by Vava'u with 37 per cent, 'Eua with 32 per cent, and Ha'apai with a low of 25 per cent (Government of Tonga Annual Health Report, 1976:8; Tatola, 1976b). More than half of them were younger than 30 years of age (Tatola, 1976a). Whereas the 1970 knowledge attitude and practice survey revealed that only 39 per cent of acceptors had three or fewer children (Wolff and De Sanna, 1970) by 1976, 57 per cent of acceptors belonged to the low parity group. More than half of these more recent acceptors used contraceptive methods that were highly effective (IUD, Depo-Provera, sterilization); about one third relied on somewhat unsatisfactory ones (condom); and only about one fifth practised less reliable methods (rhythm or other: see table 3; Government of Tonga Annual Health Report, 1976:8). The most significant findings of this survey were that acceptors were young, had fewer children once they adopted family planning, and that most were using highly effective methods of contraception.

## Application of medicalization concept to family planning in Tonga

The concept of medicalization has to be understood as a process of social control (Bilton and others, 1996:424), which occurs in three forms. The first is the incorporation and redefinition of lay approaches in dealing with illness and other natural bodily processes, such as fertility management, pregnancy, giving birth and ageing that once were handled within the confines of the community, but have since been assumed by organized medicine (Bilton and others, 1996:430). For example, unusual mental conditions traditionally interpreted as demonic possession or related to witchcraft have become redefined as psychiatric conditions. Pregnant women who present themselves at formal medical settings often undergo a variety of procedures such as regular antenatal checkups, vaginal examination before and during labour, ultrasound monitoring and hospital delivery. Seen in this context, decisions regarding family size have become a matter of public policy, now largely the responsibility of medical experts and health programmes.

The second form in which medicalization takes place is the efficacy of scientific medicine (Bilton and others, 1996:431). Better drugs, advanced surgical techniques and procedures, and antibiotic medication reflect the scientific progress of medical research and clinical practice. Should women

desire to regulate their fertility and family size, modern and effective methods of contraception can be obtained from clinics and hospitals, instead of using traditional practices such as periods of prolonged abstinence. In Tonga, confirmation of this point is seen in the dramatic rise in the number of family planning acceptors who use Depo-Provera (see table 3). The effectiveness of scientific medicine, nevertheless, has been challenged by the incidence of iatrogenic illnesses — that is, illness that develops as a result of medical intervention (Illich, 1975). Among these are the side effects of chemical and mechanically based contraceptives, of which Depo-Provera has been one of the most controversial — even in the South Pacific. Other factors that encourage the development of medicalization include self-interest and the socially engendered belief in a population of the utility of medical knowledge, technology and practice. The danger with over-emphasizing the role of the medical establishment in providing family planning services is that governments may become increasingly dependent on medical professionals, medical programmes and pharmaceuticals to manage rates of population growth and to consider far less other policy options such as formal education, waged employment and professional opportunities for women.

The third form of medicalization is the marginalization of alternative medical therapies (Bilton and others, 1996:432), including treatments such as acupuncture, homeopathy, herbalism and chiropractic that are often excluded from orthodox medical practices. These and similar treatments often exist outside the formal health care sector and are considered lay rather than expert, natural as opposed to synthetic, organic rather than chemical, and holistic as opposed to mechanistic (Bilton and others, 1996:433). The strength of orthodox medicine in Tonga has often marginalized the role of traditional healers, so that the skills of such practitioners go unrecognized, even while they continue to offer alternative services within the informal sector.

In the third world, the medicalization of public policy objectives — such as the regulation of population growth through family planning programmes — represents a rationalization and a bureaucratization of what is perceived as a "health problem". Central to this objective is the application of the label "healthy" or "healthful" to certain valued forms of behaviour and of "sickness" or "disease" to other, devalued forms of behaviour. From a sociological perspective, these labels are used independently of whether or not there is a biological basis to that which, objectively, has given rise to a designated "sickness" or "disease". The process of "medicalizing" or "sanitizing" reproductive behaviour, such as

having too many children without adequate spacing, becomes relevant to the state and to its broader policy objectives. Hence, people or individuals are socialized to alter their way of viewing family size, the desirability of children and biological reproduction. In this sociological perspective, medicine, medical services and medical technology hold enormous powers of socialization to serve as a form of social control, which in turn means that medical professionals, programmes and structures are undertaking an "extra-medico" function on behalf of the state. In the process, their role, expertise and functions also acquire a political function, a principal factor of which is the state's acknowledgement of the medical profession in order to serve its goal of public policy.

Four features of medicalization can be seen in the history of family planning programmes and services in Tonga. First, at the macro level, the control over reproduction is carried out through the introduction and implementation of family planning. An increasing population, with concomitant land shortages, overcrowding, unemployment and environmental degradation, necessitates the application at the national level of measures of population regulation. In other words, the unregulated biological reproduction of the population has dire economic, social, environmental and political consequences for the whole Kingdom. Hence, the implementation of family planning programmes throughout Tonga and later their integration within the MCH framework widens the scope of government regulatory policies to cover a broader mass of people, in particular women and their reproductive decisions. In assuming responsibilities for family planning and in providing clinical services, the role of the medical establishment similarly widens to include that of social control over the population at large. Consequently, the medicalization of family planning throughout the Kingdom of Tonga may be viewed as part of this regulatory process.

Second, at the micro level, the regulation by the medical establishment of the bodily functions of married women was inevitable through the implementation of family planning. Programmes such as post-partum counselling, discussions with mothers at MCH/FP clinics, women's leaders and acceptors as advocates, and traditional birth attendants all were mechanisms to target individuals to regulate their fertility. In informal settings, such as in villages, the programme had traditional birth attendants, women's groups, religious groups and traditional healers play this regulatory role. Even the use of gossip, rumour and hearsay, whether or not informative and accurate, was employed (Fanamanu, 1969:52). A policy defined by gender inevitably allowed medical professionals access to the

personal and social environments of women. Pregnancy and birthing, traditionally the domain of the female, have for health reasons become a medical process whereby pregnant women undergo prenatal, post-natal and paediatric consultations. This process has been consolidated and reinforced by the construction of medical facilities and by a physical infrastructure that caters specifically to the female population, thereby excluding the participation of males in the reproductive process. Consequently, the institutionalization of family planning in Tonga has served to medicalize women's sexual, menstrual, pregnancy and birthing functions.

Third, family planning information, education and communication campaigns in the 1970s demonstrated how the government used the media to restructure reproductive behaviour and perceptions of family size. Indirectly, such campaigns promoted the restraint of desire, such as the need to discipline and channel sexual energies. Although the programme targeted both husbands and wives, the latter became the primary focus and all members of the adult population were exposed to these awareness programmes. Furthermore, family planning was advocated to alter and influence people's lifestyles in order to prevent illness and misery, as evident in public awareness campaigns undertaken by the Ministry of Health. Essentially, and at the macro level, national "propaganda" on family planning served to regulate the bodily functions of people (notably women) for the broader socioeconomic and developmental objectives of the state.

Fourth, a redefinition of traditional views and presentations of family and sexuality has occurred, since awareness campaigns more or less served to alter the individual's conception of family, children and reproduction. The successful presentation of the self to the larger society is in having a model small family, with planned and well spaced pregnancies. The role of government in the provision of health services and in influencing health is powerful and pervasive. By providing health services such as family planning and articulating what constitutes an ideal family size, the government assumes responsibility for the control of bodily behaviour (Mathews, 1992:103). Since the control of the body is central to the control of sexuality, the goal of regulating the social order is in practice the regulation of gender sexuality and reproduction (Turner, 1984:91).

The concept of medicalization is part and parcel of this regulatory process. First, it involves the development of boundaries, in which medicine marks the social limits of gender behaviour and specifies what is considered normal and what is deviant. Second, it provides a situation of domination and negotiation, in which one gender group becomes the focus of public

policy. Third, it is an arena for the maintenance or change of personal consciousness. The implementation of family planning as population policy socially reconstructs and defines gender, in which process public health programmes — including the regulation of fertility -play a central role.

## Conclusion

This article has outlined, at the institutional level, the process of medicalization for family planning. This process began in Tonga when family planning services became part of the Ministry of Health, supported through budgetary allocations and as part of the country's development agenda. In the end, the medicalization process merely consolidated itself, the statistical manifestation of which is seen in the annual increase of women who accepted various contraceptive methods at MCH/FP clinics. Family planning targets for two successive development plan periods, during the decade from 1970 to 1980, were highly unrealistic, but nevertheless provided the medical establishment with the ability to utilize highly effective (and sometimes controversial) contraceptives such as Depo-Provera to attain the projected and ideal rates of population growth. Development of the clinical and medical infrastructure also facilitated the increase in the proportion of family planning acceptors. Nevertheless, the recognition and introduction of family planning services at an early stage of the demographic transition, along with its consequent medicalization, is testimony to govermnent attempts - however limited - to move towards a sustainable future.

Since the responsibility for family planning throughout Tonga rested with the medical establishment, medical professionals because responsible for achieving family planning targets and specified rates of population growth. Aside from the overt medical benefits of family planning itself, institutionalizing these national programmes within the medical establishment empowered its professionals to prevent the negative consequences of biological reproduction. Family planning also assumed an economic role, a developmental purpose and a demographic rationale, as opposed to the narrowly clinical objectives — all roles well fitted to the functions of the medical establishment – that is, to assist families in spacing pregnancies and to cater to women's reproductive and general health. In terms of broad national policy options, these measures are narrow, limited and overly dependent on one, admittedly important, government body. The failure to achieve programme objectives and family planning targets generally reflects the limited scope of such a policy for the wider purpose of population management.

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