Abstract

The Kwaio people of central Malaita, Solomon Islands who retain the culture and religion of their ancestors, face a stark choice when seeking treatment at Atoifi Adventist Hospital—relinquish fundamental precepts of Kwaio culture and religion by entering the hospital, or remain true to Kwaio beliefs and stay away. Many choose the latter. The result is considerable untreated acute and chronic illness and preventable death. For people who have converted to Christianity Atoifi Adventist Hospital poses fewer cultural barriers and is one of the most respected and best equipped hospitals in Solomon Islands. However, for those who have chosen not to become Christian, the ongoing exclusion they face has resulted in antagonism and mistrust between their community and Atoifi. This thesis describes and analyses the colonial-Christian discourse in which the hospital was established and action taken to achieve a long held desire of many Kwaio people—a facility at Atoifi where health services are attainable without the rejection and desecration of Kwaio culture and religion. Using a Participatory Action Research methodology that challenges the dominant colonial-Christian paradigm, this study seeks to understand the nature of Participatory Action Research through its pursuit of culturally appropriate health services at Atoifi.

This thesis outlines how the research process brought together a disparate collection of groups and individuals to analyse the oppressive situation at Atoifi and propose action to establish a culturally appropriate health facility there. It describes how, in the final stages of the participatory planning process for the facility, Atoifi was thrown into crisis when its Australian business manager was murdered on campus. The resultant near collapse of hospital services and the tenuous relationship between the hospital and the local community required the facility be re-conceptualised. A local village health worker, a key collaborator in the research process, who had established a culturally appropriate health post in the mountains fifteen years previously was central to this re-conceptualisation. He coordinated local community action which eventually led to the community funding and constructing the facility at Atoifi. This facility does not require the rejection or desecration of Kwaio culture to access health services at Atoifi.
The implications of using Participatory Action Research as an anti-colonial methodology and its utility in addressing oppressive situations such as that at Atoifi are discussed in the final section of the thesis. The methodology’s application and ability to facilitate significant personal and social change are embedded in the emancipatory theory established by Paulo Freire. The importance of participative processes which work with people not on or to people is discussed as well as the importance of embracing flexibility and complexity, rather than attempting to control. Reflecting on Freire’s work, the thesis finally analyses how love of people can act as a foundation for commitment to others through dialogue and participation and how, based on this, praxis has the ability to liberate oppressive situations such as those faced by the Kwaio at Atoifi.
Statement

This work has not previously been submitted for a degree or diploma in any university. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made in the thesis itself.

Signed: ___________________________ Date: ______________________
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I am indebted to a considerable number of people for their assistance with this research. The people of East Kwaio must initially be acknowledged for their enthusiasm and persistence in seeing this project through. Their generosity, patience and willingness to host and share knowledge with an inquisitive visitor since 1992 has resulted in numerous enduring friendships. So too relationships with numerous staff at Atoifi Adventist Hospital have grown and strengthened. Friendships established when I was a fresh graduate and they students in Atoifi’s School of Nursing have grown and matured to where now I am producing a doctoral thesis and a number of them hold senior management positions. There are too many people in both the Kwaio community and Atoifi to list individually, however I would like to highlight a number who have made significant contributions. Those in the Kwaio community, firstly to Esau Fo’ofafimae Kekeubata, whose story and involvement is so important it is included in the text of this thesis. Others who have made significant contributions include John Aniwa’i Late’esafi, Jackson Waneagea, Wilson ʻElota, Batamani Maenaa’adi, the late Kasaa Riʻimana, Bebea, Fa‘amolaa, Jimmy Riʻifana, Soʻofiʻia and Meafeʻua. At Atoifi, Lester and Hettie Asugeni, Humphress and Relmah Harrington, Kelvin and Julie Aengari, James and Rowena Asugeni, Hillary Toloka, Nashley and Heulyn Vozoto, Benjamin Polosovai, Judith Egwalamo, Rod and Cheryl Cooke, Lem and Lani Lecciones, Brenton and Ruth Baillie and Ray Hobbs. There have also been numerous Seventh Day Adventist Church employees who have assisted, including Dr Percy Harold, Jonathan Duffy, Pr Bruce Roberts, Pr Ray
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# List of Acronyms and Abbreviations

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<thead>
<tr>
<th>Acronym</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>AAH</td>
<td>Atoifi Adventist Hospital</td>
</tr>
<tr>
<td>ADRA</td>
<td>Adventist Development and Relief Agency</td>
</tr>
<tr>
<td>AHA</td>
<td>Adventist Health Association</td>
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<tr>
<td>ASC</td>
<td>Atoifi Support Committee</td>
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<tr>
<td>ASPI</td>
<td>Australian Strategic Policy Institute</td>
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<tr>
<td>AusAID</td>
<td>Australian Agency for International Development</td>
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<tr>
<td>BM</td>
<td>Business Manager</td>
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<tr>
<td>BSIP</td>
<td>British Solomon Islands Protectorate</td>
</tr>
<tr>
<td>BSUM</td>
<td>Bismarck Solomon Union Mission of the Seventh Day Adventist Church</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>CLGF</td>
<td>Commonwealth Local Government Forum</td>
</tr>
<tr>
<td>CPRF</td>
<td>Community Peace and Restoration Fund</td>
</tr>
<tr>
<td>DON</td>
<td>Director of Nursing</td>
</tr>
<tr>
<td>ESIM</td>
<td>Eastern Solomon Islands Mission of the Seventh Day Adventist Church</td>
</tr>
<tr>
<td>EU</td>
<td>European Union</td>
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<tr>
<td>GNI</td>
<td>Gross National Income</td>
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<tr>
<td>GRA</td>
<td>Guadalcanal Revolutionary Army</td>
</tr>
<tr>
<td>HF</td>
<td>High Frequency</td>
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<tr>
<td>HMAS</td>
<td>Her Majesty’s Australian Ship</td>
</tr>
<tr>
<td>IFM</td>
<td>Isatambu Freedom Movement</td>
</tr>
<tr>
<td>IUHPE</td>
<td>International Union for Health Promotion and Education</td>
</tr>
<tr>
<td>KDA</td>
<td>Kwaio Development Association</td>
</tr>
<tr>
<td>MEF</td>
<td>Malaita Eagle Force</td>
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<tr>
<td>MP</td>
<td>Member of Parliament</td>
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<tr>
<td>MS</td>
<td>Manuscript</td>
</tr>
<tr>
<td>NGO</td>
<td>Non Government Organisation</td>
</tr>
<tr>
<td>OPD</td>
<td>Outpatient Department</td>
</tr>
<tr>
<td>PAR</td>
<td>Participatory Action Research</td>
</tr>
<tr>
<td>PHC</td>
<td>Primary Health Care</td>
</tr>
<tr>
<td>PNG</td>
<td>Papua New Guinea</td>
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Prologue. A Journey through Time, Place and Space

It is hazardous to repress knowledge of non-empirical realities which most of the world still ‘touch’, but which a small minority called intellectuals refuse to believe exist (Trompf 1991:91).

This study is possible only because of an enduring friendship with the people of East Kwaio, Malaita, Solomon Islands. My first contact with the people of East Kwaio was in 1992 when I arrived at Atoifi Adventist Hospital as a volunteer medical laboratory scientist. I was unaware the decision to volunteer at Atoifi would fundamentally change the way I understood the world and dramatically change my professional interests to the extent that a decade later I would produce a PhD thesis on the interactions between the hospital, its services and the Kwaio community. I had recently graduated from Queensland University of Technology, Brisbane, Australia, where I had learned the scientific principles of biomedicine. I was keen to utilise these for the betterment of humanity. However during my work at Atoifi I saw that services based on Western theories of biomedicine and delivered by an overtly proselytising Christian organisation did not meet the needs of the community. I soon became aware members of a particular sector of Kwaio society were excluded from health services at Atoifi because of the cultural and religious offence caused by the delivery of health services. These were the ‘bush people’, several thousand people who lived in the mountains behind Atoifi and who upheld the culture and religion of their ancestors. Unlike most of their fellow Solomon Islanders, this group had made a deliberate decision to maintain ancestral religion. This decision made them a cultural, religious and political minority in their own land which resulted in their exclusion from hospital services.

The medical laboratory I managed was fronted by a large verandah where I would often see groups of people sitting. Having learned neither Pijin nor Kwaio language prior to my arrival meant I was unable to speak with them directly in the first months of my stay. Hospital staff told me these were ‘heathen’ people from the ‘primitive’ Kwaio bush. I was told they were ‘devil worshipers’, who were ignorant of or who had rejected Christianity. Although Atoifi was celebrated as ‘a light on the hill’ to
proclaim the Christian message it was having little effect on these people. It was explained because of ‘the heathen’ being ‘undeveloped’, ‘backward’ and ‘holding onto the devil’ they were not able to go into the hospital building which resulted in many of them dying of preventable conditions. The benefits of the hospital were clearly being delivered to the coastal Christians but not people from the mountains who follow ancestral culture and religion. Hospital staff described the bush people as living in ‘dirty’ villages with their pigs who only came to the hospital as a last resort. This was often too late for medical interventions to be effective. Atoifi was built in the 1960’s as a self-sufficient campus in a time of European superiority when European culture, religion and lifestyles were perceived (by those in power, that is European Missionaries and their native converts) as superior to those of Malaitans. Although the Solomon Islands received independence from Britain in 1978, colonial attitudes were entrenched in policy, practice and attitude at Atoifi. Operated by a proselytising Christian organisation meant any change to systems established by European missionaries were perceived by some as going against the ‘will of God’.

When I arrived in 1992 the perpetuation of these attitudes was ongoing and unchallenged by the majority of local and international staff. Being a young energetic person in this environment was a recipe for adventure. Fanon could have been describing me when he wrote “in the heart of every European in the colonies there slumbers a man of energy, a pioneer, an adventurer…there is something of a cowboy and the pioneer even in the intellectual” (1965:133). The adventure that I embarked upon led me to an enduring and deep friendship with Esau Kekeubata, a village health worker who lives and works with his kin a days walk into the mountains. What I experienced challenged the colonial attitude and Christian paradigm that dominated at Atoifi and that I had quickly become apart of. Early in my time at Atoifi I would scold the groups of people who sat on the verandah outside the laboratory as their tobacco smoke would waft through the windows. I would abruptly tell them to go to the kitchen about 40 metres away if they wanted to smoke. I had not been told (either by them or staff) that this was an impossibility because the kitchen was adjacent to the maternity ward, a place men, and many women, from the Kwaio bush are unable to go because of ancestral rules that restricted people from areas close to women delivering babies. My attitude was not only authoritarian but my actions dehumanising for those
people who were publicly humiliated and told to enter a taboo area. Although I cringe now at the thought of being involved in such actions and treating people as if they had no dignity, this was the norm and reflected the organisational and religious culture of superiority when interacting with the ‘heathen, devil worshipping and underdeveloped’ bush people.

Despite this Esau invited me to visit his mountain home and stay with his kin. I became fluent in Pijin and with a basic understanding of Kwaio language was able to interact with people who had been labelled ‘heathen’, ‘devil worshipers’ and ‘primitive’. I learned their names and they mine. We conversed about life, family and health. The labels and attitudes I had so quickly learned at Atoifi did not reflect the joy I experienced when engaging with my new friends on a truly human level. I observed Esau’s approach to health services for his people. He was respectful of culture and religion and worked in a participative manner with the community. The community participated by giving direction, advice and logistical support to Esau in his health programs at the clinic and community. Although Esau worked for Atoifi in a satellite aid post, he operated in a manner which was fundamentally different from what I observed at Atoifi—one that engaged the community and had its support. This sparked the initiation of a reflective process that continues to this day. Having a science degree and working within a scientific paradigm for the advancement of health of the community gave me few frameworks or theories with which to make sense of what I was experiencing. I had little structure in which to place the tensions I experienced and the theoretical and practical progression that I needed. It was clear there were two groups of people in Kwaio, the ‘backward heathen’ living in the mountains and the ‘enlightened Christian’ living on the coast. The Christians would talk at the heathen but not with them. It was exceedingly clear the situation was oppressive for the bush people who had become my friends and there was no end in sight to the colonial attitudes and dominant Christian paradigm driving practice at Atoifi. I knew medical science was not providing the benefits it had promised but I was unable to articulate any alternative.

Although I initially agreed to work at Atoifi for one year (1992), I stayed for almost two and a half. This further strengthened my friendships and gave me time to reflect
on the oppressive situation for the bush people, particularly in the provision of health services. I visited Atoifi briefly again in 1995 and 1997 before my journey led me to return to university and study a Master of Public Health. This enabled me to discover frameworks, theories and approaches in which to place my questions and reflections which continued regarding the oppressive situation faced by the bush people. During my course of study I became close friends with the late Dr Eberhard Wenzel. Eberhard was known for his provocative and innovative thinking and action. As well as being a renowned academic he created and maintained the World Wide Web Virtual Library Public Health and the International Public Health Watch, a web based service covering international and national organisations regarding their public health action. (His website including his published and unpublished papers have been preserved as they were on 17 September 2001, just prior to his death. They can be accessed at www.ldb.org.) I thrived under his tuition and mentorship and became aware of public health frameworks and theories that enabled me to make sense of the questions that lingered since first arriving at Atoifi. Reading the works of Paulo Freire (1970, 1972, 1978, 1994, 1998a, 1998b), Franz Fanon (1965, 1967a, 1967b), Ivan Illich (1976) and Collins Airhihenbuwa (1995) among others gave me the frameworks and paradigms, not only to understand the historical and colonial situation of exclusion and oppression at Atoifi, but also a potential way forward on both a theoretical and practical front for the betterment of health in Kwaio.

In 2000 I undertook my first formal research at Atoifi and with the Kwaio community. This documented the barriers faced by Kwaio who followed ancestral culture and religion in accessing services at Atoifi (MacLaren 2000). Recommendations from the community urged the establishment of culturally appropriate health services at Atoifi to provide health outcomes for all Kwaio that did not discriminate because of religious beliefs or social, cultural or political standing. A long standing wish of the bush people was to access health services which did not cause cultural or religious offence. A specific recommendation from the community was to engage them in planning, managing and reviewing health services at Atoifi. A formal document outlining the barriers to accessing services faced by the bush people was presented to the hospital administration. They agreed to investigate how culturally appropriate services could be achieved at Atoifi. This included the possibility of a culturally
appropriate facility specifically for the bush people dubbed the ‘bush ward’. This opened the way for me to collaborate with hospital staff and community members to challenge the dominant colonial attitude and Christian paradigm and be involved with a new approach to health care at Atoifi.
Introduction

I walked to the board room at Atoifi Adventist Hospital on Wednesday, 10 July 2002 full of anticipation. I was to join the Atoifi Support Committee, a group of Kwaio community and Atoifi Hospital leaders, to formally discuss the ‘bush ward’ for the first time. The ‘bush ward’ was envisaged to be a culturally appropriate facility at Atoifi to address the needs of several thousand Kwaio people who do not access services there. Two years earlier, after investigations into why people stay away from Atoifi, the long held community desire for a culturally appropriate facility had been formally presented to hospital administrators (MacLaren 2000). A decision was then made to progress with planning the facility. This was the first time in the hospital’s 37 year history such planning was to take place.

Though Atoifi Adventist Hospital is one of the most respected and sought after health care institutions in Solomon Islands, and people from across the country travel there for treatment, many people in the immediate community do not receive the full benefits of the hospital established on their ancestral land. Core cultural practices and fundamental beliefs of Kwaio religion were violated by the very system through which health services were delivered. Those who follow such Kwaio cultural practices have little choice but to stay away from the only hospital in their region. This meeting, however, pointed to a potential new future, in which Kwaio culture was central to the planning, development and ongoing management of health services. If that potential was realised, Atoifi would for the first time begin to benefit all Kwaio people.

For the past 135 years the Kwaio people of Malaita, Solomon Islands have been involved in ongoing conflict and confrontation with outsiders who have attempted to impose their foreign ways. They are a proud indigenous people unwilling to accept the blatant dismissal of their traditional ways. Indigenous groups across Malaita, the Solomon Islands, and the Pacific, as elsewhere, have all been engulfed in a history of domination and subjugation caused by colonisation and Christianisation (Young 1926; Cormack 1944; Tippett 1967; Hilliard 1969, 1974, 1978; Laracy 1976; Boutilier, Hughes and Tiffany 1978; Steley 1983, 1989; Whiteman 1983; Keesing
1989a; Garret 1992; Burt 1994; Johnston 2003). For many, this has meant engagement with the process of colonisation and Christianisation to pursue modern lifestyles, foreign goods and new opportunities. Within the Solomon Islands, the Kwaio are unique in their resolve to maintain their own ways and pursue ‘development’ on their own terms. This does not mean that Kwaio do not desire development—for over a century Kwaio have wanted and asked for health, education and economic development (Akin 1993; Keesing 1992). When such development projects have prioritised Kwaio culture and recognized religious beliefs, then significant community support has followed—when foreign cultural and religious beliefs have been prioritised they have been resisted. This balancing act causes ongoing tension between the, at times, contradictory goals of desiring change and cultural autonomy. This tension however is not unique to Kwaio and continues in numerous communities where people selectively seek medical knowledge or treatments and reject others where these are “perceived as promulgating ideologies that threaten the moral order” (Lock and Nichter 2002:8).

The history of colonisation, regardless of the coloniser, has been one of domination and subjugation of one people over another (Ife and Teroriero 2006:199). Across the Pacific Christianisation has been inextricably linked with colonisation, with similar effect. As Johnston (2003:13) states “Christian missionary activity was central to the work of European colonialism, providing missionaries and their supporters with a sense of justice and moral authority.” The ideology of colonialism, strengthened with the evangelical zeal of the missionaries, maintained that the process of colonisation was in the best interest of ‘the natives’ and they were indeed doing them a favour by introducing not only a superior form of civilisation, but the accompanying superior spiritual tradition (Said 1993; 1995; Fanon 1994; Johnston 2003). Although many groups across the Solomon Islands came to believe in the superiority of the colonising power and Christian religion (although this is by no means complete, nor are the two necessarily concomitant in people’s minds), the Kwaio stand out as one group who have resisted them as an anti-colonial statement.

Health services have often accompanied the colonial and Christian expansion in the Pacific and elsewhere. They have provided much needed medical treatments and
public health initiatives, but have also proved problematic to their recipients. Franz Fanon (1965:121-145) analysed how the colonised in Algeria rejected the medical care provided by the colonisers, not because of fear of the technological or a reliance on traditional medicine, but because it was provided by “the conqueror”. In an anti-colonial stance that defined the health system as a part of the colonial apparatus the Algerians perceived the health system as ‘politically polluted’ and stayed away. Direct parallels can be made with the Kwaio in their anti-colonial stance and rejection of health services as they were being provided. Given that Atoifi Adventist Hospital is operated by a mission organisation, the thesis will describe how it has been key in the Christian apparatus on Malaita. The anti-Christian stance of many Kwaio only amplifies their resistance to health services.

Although most former colonies are now in a post-colonial era, the effects of the colonising society continue to dominate. As Smith (1999:7) argues, the colonising society continues to “determine and shape the quality of people’s lives” in post-colonial situations. From this perspective Atoifi is not an isolated case. Stephens et al. (2006: 2024) state, “European colonialism is at the heart of the creation of current reality for Indigenous peoples in many regions”. This is not perpetrated by European descendants alone but also by dominant groups in the countries. The Christian dominance (perpetuated by local, national and international power structures) which is documented throughout this thesis serves as an example of this. Anderson et al. (2006:1775) argue, “For Indigenous societies in the Pacific, colonisation has been a multilayered process with Indigenous lives entangled in the shifting fortunes of [colonial] powers.” This underpins how health services have been established and operate and the basis of local populations’ reactions to them. The colonial legacy has left many Indigenous peoples across the world without easy access to basic health services because of financial or geographical factors. Where they are available people are often reluctant to use them because of insensitive or discriminatory practices, or because they are culturally inappropriate (Dutta-Bergman 2004; Stephens at al. 2006; Montenegro and Stephens 2006). This is occurring from Africa to Asia, and across the Pacific and the Americas (Bird 2002; Stephens at al. 2005; Anderson et al. 2006; Ohenjo et al. 2006; Subramanian, Smith and Sabramanyan 2006). This has sparked a move towards the establishment of culturally appropriate health services to address
the health needs of these communities. In recent years there has been significant discussion of culturally sensitivity, cultural awareness, cultural safety and cultural competency in health services. This has generated everything from simple education and awareness programs to fully integrating local Indigenous knowledge and expertise into health planning and delivery through community controlled health services (Watson et al. 2001; McLennan and Khavarpour 2004; Anderson et al. 2006; Ellison-Loschmann and Pearce 2006; Parker et al. 2006). It has also lead to an increase in community-based participatory research that not only involves but centralises local knowledge and practice (Palafox, Buenconsejo-Lum, Riklon and Waitzfelder 2002; Stringer and Genat 2004; Bailey, Veitch, Crossland and Preston 2006; Hurst and Nader 2006; Koch and Kralik 2006; Reason and Bradbury 2006).

I have used the concept of ‘culturally appropriate’ health care throughout this thesis and in its title. This concept goes far beyond basic cultural awareness and cultural sensitivity to incorporate health care services that are compatible with the norms, values, beliefs and expectation of the population the health service is there to serve. Culturally appropriate health care strives to cover all aspects of health planning, health development and service delivery, including diagnosis and treatment, prevention and promotion, research and policy development (Yeboah 2001:252). The concept of culturally appropriate health care as I use it here incorporates, but goes beyond, the concepts of (a) cultural competence – the capacity of the health system (individuals and organisations) to have a set of behaviours, attitudes and policies that enable the system to work effectively with people with diverse values, beliefs and behaviours; and (b) cultural safety – based on the experience of the recipient of care and whether they engage with a health care system that recognises difference and diversity in human behaviour and social structure (Williams 1999; Betancourt, Green and Carrillo 2002; Anderson et al. 2003; Betancourt et al. 2003; AIDA and RACP 2004; NHMRC 2006). Culturally appropriate health programs are embedded in culturally appropriate paradigms which enhance and magnify the production of meaning, value, pleasure and knowledge. Culturally appropriate health programs are those where “varied cultural expressions and meanings are affirmed and centralised, and the production of cultural identity can be legitimating and empowering relative to
promoting individual, family, community and societal health” (Airhihenbuwa 1995: xiv).

A number of theoretical approaches used in medical anthropology are evident throughout this thesis. Firstly, I explore Kwaio socio-cultural adaptations since the introduction of western medicine, which has many characteristics of medical anthropology’s ecological/evolutionary model (Joraleman 1999; McElroy and Townsend 2004). My analysis of the structural barriers to health care at Atoifi shares characteristics with critical medical anthropology. That is, to understand how medical/healing practices are regulated and to evaluate how health services are provided, with an eye to improving availability and effectiveness of health care. Critical medical anthropology developed, as did the research question investigated in this thesis, from concerns with external impacts on local communities, the inequalities in the availability of medical resources, and the influence of Western biomedical practice over local practice (Singer and Baer 1995; Strathern and Stewart 1999:185).

That said, this study also addresses a shortcoming of critical medical anthropology: Whereas it tends to downplay the agency of local people and their ability to create their own meanings from, and solutions to, ill-health, I place these at the centre of my study, and work towards practical solutions to the problems at stake. This resonates with the Applied Medical Anthropology approach, which engages the researcher in a more active role which can lead to social change (Joraleman 1999). Singer (1995:80-196) argues that a “critically applied medical anthropology” is possible through a “system changing praxis”. This confronts systemic health problems and actively engages with communities to better their health conditions and outcomes. This approach is inherent in the Participatory Action Research (PAR) method used in this study, and in the detailed descriptions of local leadership and community action found throughout the thesis.

The works of Paulo Freire have heavily influenced this study and its challenge of the colonial past by working with people and not on or to people. Freire’s participatory approaches are key to consciousness-raising and becoming critically conscious of the socio-cultural reality in which one lives. His concept of conscientisation asserts that it
is not as recipients, but as active, knowing subjects, that people are able to achieve a
deepening awareness of how their lives are shaped through a recognition of their
socio-cultural reality and their capacity to transform that reality (1972:51).
Conscientisation joins people in action and reflection to transform their world through
praxis (1972:75). Freire (1996:26) states, “An unjust order is the permanent fount of
‘generosity’, which is nourished by death, despair and poverty”. Central to the
methodology and outcomes of this research was engagement with local agents of
change to challenge the unjust order at Atoifi which results in unnecessary deaths in
the Kwaio community because of the culturally inappropriate way health services are
delivered.

With recognition of the colonial-Christian discourse and its legacy of establishing
health and education systems across the so called ‘developing’ world, interest is
growing in the role of faith-based organisations in ‘development’ practice across the
world (Luker 2003; Southern et al. 2003; UNFPA 2004; Bakewell, Warren and
Winterbottom 2005; Hauck, Mandie-Filer and Bolger 2005, Alkire 2006). This
colonial-Christian discourse which informed practice across the Pacific and elsewhere
has been central to health care policy and delivery at Atoifi Adventist Hospital. This
had served Christian converts and their families well, but at the same time it had led to
an oppressive situation for Kwaio who follow their ancestral religion. This research
spans these fields with its aim to investigate the impact of both past and present
policies and practices at Atoifi, and to facilitate a process to address a long-held wish
of the Kwaio people: to receive the benefits of a modern hospital on their land without
repudiating their core cultural and religious beliefs. The colonial system had failed the
Kwaio people, as it has numerous other Indigenous groups across the globe, and this
was an opportunity to use an anti-colonial methodology, in the form of Participatory
Action Research, to investigate culturally appropriate health services at Atoifi and be
a catalyst for them to materialise. Out of this context emerged the research question
addressed in this thesis: Can the Participatory Action Research process result in
culturally appropriate health services for Kwaio bush people at Atoifi?

This thesis brings together a wide range of ideas and topics in the study of culturally
appropriate health care. The broad field of public health brings together anthropology,
Introduction

history, research methodology and health services research. This thesis draws on published and narrative accounts of events to facilitate a better understanding of the cultural, historical and political context and how contemporary events affected the research process and its outcomes.

The first chapter gives a broad overview of the Solomon Islands from its early colonial history, through independence and the recent ‘ethnic tension’ of 1998–2003. This is followed by a detailed ethnographic description of the immediate research context of Kwaio and an explanation of the barriers faced by Kwaio people who follow ancestral religion and culture in accessing services at Atoifi.

Chapters 2 and 3 specifically place Atoifi within a broader historical context. I begin with the labour trade and describe events until 2000. How the Kwaio dealt with the colonial government, and the establishment and growth of the Christian missions is outlined throughout chapter 2. How health services played a key role in the expansion of the missions, particularly the Seventh Day Adventists (SDA) in Kwaio is also described. Chapter 3 details the establishment of Atoifi, and significant events in the planning, building and operating of the hospital from the 1950’s through to 2000. From this detailed history of how health services are embedded in the colonial-Christian paradigm, chapter 3 goes on to describe an apparent paradox in health services supported by the SDA church – a remote clinic established by a village health worker that centralises indigenous Kwaio culture and religion. The detailed history in these chapters provides a rich context in which to interpret the contemporary events detailed in chapters 5–8. To interpret contemporary events without knowledge of Kwaio’s social, cultural, religious, political and economic history assures misinterpretation.

Methodology is discussed in Chapter 4, including the anti-colonial nature of Participatory Action Research as I use it. PAR’s theoretical and philosophical foundations are detailed and its application to investigate culturally appropriate health care at Atoifi are then established. The research process is explained and an Action Research Model presented to graphically represent the research approach and methods.
of data analysis. The methodology demonstrates my responsiveness to the Kwaio context and how the research question emerged from this context.

The next three chapters (5–7) present a detailed description of the turbulent but rewarding processes undertaken between 2002 and 2005 with community and hospital leaders to investigate culturally appropriate health care at Atoifi. These chapters include case studies to demonstrate not only current exclusion at Atoifi, but the social, cultural, political, economic, religious and methodological issues faced throughout the research. Chapter 5 begins with an overview of the rapid change that took place at in the Solomon Islands and at Atoifi between 2000 and 2002. The narrative continues to describe how the research was undertaken, events which fundamentally changed the research environment, and how the research process had to change and adapt to the new situation. The structure of the process remains true to the PAR process of constantly collecting, presenting and reflecting on data in order to be responsive to the realities of the research process and unexpected complexities prior to progressing to action. This does not follow a conventional academic form, but this is not expected when undertaking or writing PAR (Winter 1996; Dick 1992; 1993; 2002).

Atoifi Adventist Hospital was thrown into tumult in May 2003 when the hospital’s accountant was murdered. Chapter 6 explores these events and how the institution, community and research project negotiated the aftermath. Chapter 7 details the resumption of services at Atoifi, analyses events which caused the bush ward to be re-envisioned, and describes actions that led to its establishment and its eventual opening in June 2006.

The final chapter reflects on the colonial-Christian order perpetuated at Atoifi and the methodological imperative of using PAR in the anti-colonial struggle. It discusses PAR, its utility in addressing oppressive situations such as that at Atoifi, and its ability to facilitate significant personal and social change. I then reflect on a number of key lessons learned while undertaking the research, including the importance of participation, flexibility and local leadership when embracing the complexities of study in such situations. This is all embedded within the emancipatory tradition established by Paulo Friere and draws heavily from his work to reinforce the
foundations of this research. Despite the colonial-Christian discourse, people who follow Kwaio ancestral religion and culture are not ‘marginals’ that need to be integrated into the structures of oppression; rather, they are fully human with an ability to knowingly act on the world to change it for the better. This thesis serves as an example of how change is possible and how it occurred at Atoifi Adventist Hospital through the establishment of a culturally appropriate health facility for the Kwaio people.
1. Health Services within the Solomon Islands Setting and Kwaio Cultural Context

1.1 Solomon Islands

Geography and Population

The Solomon Islands is a South Pacific archipelago stretching between Papua New Guinea to the northwest and Vanuatu in the southeast. The 1.35 million km² of ocean contains 992 islands and atolls that range from rugged rainforest-covered landmasses to tiny coral atolls. Of these, 347 are inhabited and the majority of people live on the six main landmasses of Makira, Guadalcanal, Malaita, Isabel, New Georgia and Choiseul.

The Solomon Islands national census in November 1999 stated a national population of 408,000 with an annual growth rate of 2.8% percent (Solomon Islands Census Office 2000). This grew to an estimated population of 470,000 in 2004 with a growth rate of 3.1 percent (World Bank 2005a). The Solomon Islands has a young population with 40 percent under 15 years old. The population is 93 percent Melanesian and 4 percent Polynesian, with the remaining Micronesian, Asian and European (WHO 2005). The Island group is extremely diverse linguistically with 74 indigenous languages and 64 dialects (Tryon and Hackman 1983). The population is predominantly village based. 84 percent of the population live in rural villages (UNDP 2002). Most villages have less than one hundred people (World Bank 1999). A predominantly subsistence lifestyle is practised in villages with gardening and building sago palm leaf houses consuming much time. In terms of religion, 95 percent of the population self-identify as Christian, the remainder uphold traditional religious beliefs. The country had a GNI per capita of US$560 in 2004, down from US$750 in 1998 (World Bank 1999; 2005b) Life expectancy is 61.9 years for males and 63.1 for females (WHO 2005).

Historical Overview

Historians believe some of the Solomon Islands may have been settled as early as 20,000 – 30,000 B.C. (Taika 1989). There is significant archaeological evidence from
across the Solomons of permanent settlement from 1000 B.C. (Rukia 1989). Until the mid-sixteenth century no visitors had come to the archipelago other than neighbouring Pacific Islanders. In 1568 the Spanish explorer Mendaña sailed through the Islands giving them names, many of which survive to this day. Mendaña returned in 1595 to attempt colonisation but he died of malaria and his crew returned in defeat. Not until the late eighteenth century did outsiders again travel to the Solomon Islands, first British, French and Spanish explorers and then Sandalwood traders. Although there were some conflicts, life for most Islanders remained essentially unchanged (Corris 1973).

Figure 1.1: Map of Solomon Islands

Between 1871 and 1904 European ‘blackbirders’ collected labourers for colonial sugar plantations: up to 19 000 went to Queensland and 10 000 to Fiji (Corris 1973; Moore 1985; Akin 1993). During the first years of the labour trade Islanders were kidnapped, although from the mid-1880s onward most were ‘recruited’ to the plantations. The initial kidnapping helped motivate attacks against recruiters and
several ships were destroyed and their European crews killed. Many labourers from Queensland and Fiji returned with a new religion, Christianity, which steadily spread across the islands. Chapter 2 will detail the events and impacts of the labour trade in East Kwaio.

World War II engulfed the Solomon Islands in 1942 when the Japanese invaded the Central and Western Solomon Islands, including the colonial capital of Tulagi (White et al 1988). The Japanese built an airfield on Guadalcanal near the current capital of Honiara. The United States forces fought the Japanese during the second half of 1942 in the ‘Battle of Guadalcanal’, one of most famous campaigns of World War II. The United States forces prevailed and claimed the rights to name the airfield: Henderson Airfield, after U.S. Major Lofton Henderson. The name remains.

**Government**

In 1893 the British Government declared the Solomon Islands a Protectorate, bringing foreign law and a government structure, although this had little direct impact in the early years, particularly on Malaita. The government increasingly asserted control over Solomon Islanders, and subjugated Malaitan warriors and bounty hunters (*lama*). The Kwaio resisted this imposition of foreign assertion on their sovereign rights to traditional land and customs, and this culminated in the killing of District Officer W. R. Bell in October 1927 (Keesing and Corris 1980). Chapter 2 will detail the events prior to and subsequent to the killing of Bell. Later years saw other anti-colonial movements including the Fallows ‘Chair and Rule’ movement in Ngela and Isabel in the late 1930s, and a movement towards a proactive self-determination initiated by Aliki Nono’ohimae, Nori, and others from ’Are’are in southern Malaita. This movement, Maasina Rule—‘the rule of brotherhood’—spread across Malaita, Ngella, Makira and other parts of southeastern Solomons. Maasina Rule was unique in that it united both Christian and those upholding ancestral religion in an anti-colonial political force. Chiefs were appointed to confront government and demand justice in matters of *kastom* (custom) and to end racism and exploitation (Akin n.d.; Keesing 1978b). The government, although initially sympathetic, eventually opposed Maasina Rule and arrested its leaders (Worsley 1968; Laracy 1983; Keesing 1992). Its
influence waned, leading to its demise as an organised movement in the early 1950s. Maasina Rule paved the way for greater political involvement for Solomon Islanders and a government council was elected in 1970. On 7 July 1978 Solomon Islands gained independence from Great Britain, retaining the Queen as the Head of State. Since independence successive governments have been unable to significantly change the British political/bureaucratic system to reflect the complex social and cultural context of the Solomon Islands. There is little allegiance to political ideology and people often vote along family or religious lines (Fraenkel 2004:43; Moore 2004:33). There is significant corruption and mismanagement at both bureaucratic and political levels. Headlines such as “Poor Governance costs Solomon Islands a Billion dollars” in the national newspaper, the Solomon Star, (4 Oct. 2005) and “Corruption is Alive and Well” (Roughan 2006) exemplify this. This, in part, led to a general lack of faith in government and almost complete breakdown of systems of government from 1998–2003. In 2003 Prime Minister Allan Kemakeza invited the Regional Assistance Mission to Solomon Islands (RAMSI) to re-establish law and order and governance systems. The naming of Snyder Rini as new Prime Minister after the April 2006 national elections sparked riots which destroyed most of Honiara’s Chinatown area. Solomon Islands political commentator Tarcisius Tara Kabutaulaka connected the riots and the failing system of government, stating the riots “question assumptions about the Westminster parliamentary system and its ability to create a representative government” (2006).

Religion

Today 95 percent of Solomon Islanders identify themselves as Christian. The past 160 years has seen the Solomons’ religious systems transformed from traditional ancestral ones upheld by each cultural group to most people belonging to one of several mainstream churches: Roman Catholic, Anglican, Methodist, South Sea Evangelical or Seventh Day Adventist. Christianity in the Solomons has a tumultuous history starting with the first missionary to the Solomons, Bishop Jean-Baptiste Epalle, a French Catholic Marist who landed at Makira Bay and then Isabel in December 1845. Epalle visited Pinhudi where he became involved in a skirmish in which he received five axe blows to the head. He died three days later. The Anglican mission started, not by sending missionaries, but by taking young men to their missionary school in
Auckland to train and return to convert their own peoples. The first Solomon Islander went to Auckland in 1850. In 1861 the missionary diocese of Melanesia (the Melanesian Mission) was formed with John Coleridge Patteson as Bishop. Patteson visited the Solomon Islands in 1871, and was killed with two of his companions at Nukapu in the Reef Islands in Temotu Province. The Methodist Church (now the United Church) was established in 1902 when John Francis Goldie led a group of settlers near Munda in Roviana Lagoon. The Methodists made an agreement with the Anglicans to work in the western part of the country and leave the east to the Anglicans. The Seventh Day Adventists were not bound by this agreement, however, and Captain G. F. Jones arrived in Viru harbour on New Georgia in 1914 on the invitation of trader Norman Wheatley who was in conflict with the Methodists in the area. The last major denomination to arrive, the South Sea Evangelical Mission (SSEM), has its roots in returning labourers from Queensland who were involved with the Queensland Kanaka Mission (QKM). Florence Young led the first QKM party to Malaita in 1904, though many QKM converts had already established Christian settlements. The QKM became the SSEM in 1907. There are numerous smaller denominations in the Solomons, including Jehovah’s Witnesses, Christian Fellowship Church, Assemblies of God and other evangelical groups (Laracy 1976; Hilliard 1978; Fugui 1989; Steley 1983; 1989; Garret 1992; O’Brien 1995).

Each of the denominations have, from their beginnings, taken differing stands on Indigenous culture and its role in the Christian church. Hilliard comments:

In their approach to Indigenous culture, the Anglicans were unique. The Marists showed pragmatic tolerance; the Solomon Islands Methodist mission under J. F. Goldie was preoccupied with Western-style material progress; the SSEM, the Presbyterians and the Seventh Day Adventists abhorred anything that savoured paganism. By contrast, the proud self-image of the Melanesian mission was that of a tolerant bearer of Christianity to the Melanesians, whose objective was to conserve as much as possible of the traditional social and cultural order as the basis of the Melanesian Christian church (Hilliard 1978:194).

An analysis of the Seventh Day Adventists, the denomination directly involved with this research, gives a mixed reaction:

Seventh Day Adventists have been the most insistent of all upon giving up Malaitan customs and transforming society along the lines of the Western Christian model... On the other hand, Seventh Day Adventist missionaries do more than anyone else for
material welfare. Their missions include schools, hospitals, workshops and commercial enterprises that are exemplars of progress. Their white missionaries exert more direct influence on converts than others do, but they train Melanesian teachers who serve in satellite mission schools and who will take over mission activities when they are technically, doctrinally, and spiritually qualified to do so (Ross 1978:177).

Ross continues:

Adventist groups win admiration for their devotion, energy, and self confidence. They get bad marks for being sanctimonious and pushy. Some respect their Puritanism, others do not. Their stringent taboos make sense to Malaitans, who are used to living with a taboo system—once, that is, one accepts the validity of their particular revelation (Ross 1978:179).

Chapters 2 and 3 will further outline the religious history and context on East Malaita, and their importance in understanding the research environment.

‘Ethnic Tension’ and International Intervention

It is not my intention to detail the recent political events in the Solomon Islands (1998–2005) since they have been documented and analysed by numerous authors, including Amnesty International (2000), Fugui (2001), Wainwright (2003 & 2005), Australian Department of Foreign Affairs and Trade (2004), Dusevic (2004), Fraenkel (2004), Kabutaulaka (1999; 2004a; 2004b; 2005), Moore (2004), Pacific Islands Forum Eminent Person’s Group (2005) and Fullilove (2006). Nonetheless, a broad overview will serve as a foundation for understanding the local effects of the ethnic tension described throughout Chapters 5, 6 and 7.

Since before, and subsequent to, independence in 1978 ongoing political volatility and antagonism has existed between the peoples of Guadalcanal and ethnic Malaitans who reside in and around Honiara and other parts of Guadalcanal (Kabutaulaka 1999). This ignited in 1998–1999 when militants clashed violently. This has been euphemistically called the ‘ethnic tension’.

“The events on Guadalcanal are often described as ‘ethnic tension’. They were always much more than this. They involve social, economic and political issues with origins in the colonial era and embedded deep within the social, cultural and demographic structures of the archipelago” (Moore 2004:93).

The conflict centred around ethnic Malaitan incursions on, and use of, Guadalcanal land and resources and their domination in business and government. Malaitans had
been used as a mobile workforce since the nineteenth-century labour trade began. Given the limited ‘development’ on Malaita, many Malaitans travelled abroad to find education, and to work in and around Honiara, leading to the situation were Malaitans dominate business and government. This exacerbated the alienation many traditional landowners of Guadalcanal felt over successive governments not recognising their traditional land tenure systems when purchasing large tracts of land for ‘development’. Although these purchases may have been ‘legal’ for the modern state they excluded many who saw the land as ‘theirs’ within the traditional land tenure system (Moore 2004:95). Some traditional landowners saw others profit from their land. Guadalcanal militants wreaked havoc through murders, kidnappings and property destruction. In June 1999 up to 20 000 ethnic Malaitans fled back to Malaita. Malaitan militants fought back and during the year a total of 35 000 people were displaced across the country (Fraenkel 2004:53–62; SPC 2005). Tensions escalated further early in 2000 when the Malaitan militants calling themselves the Malaita Eagle Force (MEF) claimed responsibility for several killings on Guadalcanal. Law and order had declined to such a degree that by April 2000 Prime Minister Bartholomew Ulufa’alu wrote to Australian Prime Minister John Howard requesting Australian police personnel be a part of a multinational group to work alongside Solomon Island police to maintain law and order (Moore 2004:4). There was ongoing fighting in and around Honiara between Malaitans and Guadalcanal militants who had become known as the Guadalcanal Revolutionary Army (GRA) or the Isatambu Freedom Movement (IFM). Howard told the Australian Parliament:

No country outside of the Solomons can control the situation. We can simply try to influence it. In the old days they could use gunboat diplomacy. That doesn’t apply today. If we were to send in troops, we may end up simply being the meat in the sandwich (Howard 2000).

On Monday, 5 June 2000 a coup d’etat dubbed by its instigators as a ‘civil takeover’ of the Solomon Islands government, was instigated by the Joint Military Operation, a group comprising the MEF and members of the Police Paramilitary Force. Prime Minister Bartholomew Ulufa’alu was placed under house arrest and forced to resign. The Governor-General, Father Sir John Ini Lapli, was placed under police guard. Andrew Nori, a former parliamentarian and now spokesman for the MEF, announced on Solomon Islands Broadcasting Corporation (SIBC) radio that MEF units had
seized the main police armoury in Rove, Honiara before capturing guns from the prison and other police stations across Honiara.\(^1\) Australian-funded patrol boats were captured and stripped of their weapons, and there was a mass release of prisoners. One of the patrol boats, the *Lata*, was used two days later (Wednesday 7 June 2000) to attack IMF militants near Henderson Airfield at Lunga. Many foreigners were evacuated by the Australian naval vessel HMAS *Tobruk* on 11 June and others the following week on a Royal New Zealand Air Force jet. Many Solomon Islanders were confused over their international friends leaving since, “It was clear from the start that the foreigners were not the target. It was a row between Solomon Islanders” (Fugui 2001:552). Over the following months law and order crumbled in the face of rampant criminal activity and increasing clashes between the MEF and IFM.\(^2\) The MEF even built a makeshift tank from a bulldozer and took control of rural areas immediately east of Honiara. The ongoing conflict closed down export industries such as fisheries, gold mining and palm oil with subsequent loss in foreign income. Parliament sat to elect a replacement prime minister on 28 June, with more than half the parliamentarians absent due to MEF intimidation. On 30 June Manassah Sogavare was elected the new Prime Minister. This meeting of parliament took place aboard the HMAS *Tobruk* which was anchored off the coast.

A peace agreement was signed by leaders from both Guadalcanal and Malaita in the Australian city of Townsville in October 2000 (http://www.commerce.gov.sb/Gov/Peace_Agreement.htm). This thirty-page agreement granted amnesty to militants for the surrender of arms stolen from the police armoury during the ‘civil takeover’. Large sections of the community celebrated the agreement with public handshaking and embracing in Honiara between the two ethnic groups (Fugui 2001). An International Peace Monitoring Team was set up to monitor compliance with the Townsville agreement (This was subsequently

\(^1\) Andrew Nori is a lawyer, the first Solomon Islander to establish a private law firm. His father, also named Nori, was a founder of the Maasina Rule movement in `Are`are in the mid-1940s. Andrew Nori was Minister for Home Affairs and Provincial Government from 1986–1989.

\(^2\) The conflict was not only on Guadalcanal. In June a sign was posted at Gizo, the capital of Western Province, that the two hundred Malaitans living there had 21 days to leave. On 12 June, 40 men from Bougainville (thought to be linked with the Bougainville Revolutionary Army) crossed the border, seized weapons from the Police armoury in Choiseul, and shot a Malaitan at Gizo (Moore 2004:14).

Despite the agreement, the monitors, and the return to normal of aspects of daily life, ex-militants retained many guns and law and order was almost nonexistent. The situation’s volatility was evident when ex-Police Commissioner and member of the Peace Monitoring Council Fred Soaki was shot and killed in the Malaitan provincial capital of Auki in February 2003 (ABC 2003; PeopleFirst Network 23 Aug. 2003; Fraenkel 2004:154, 155). A former policeman and MEF commander Edmond Sae was arrested for the murder, but escaped from Rove prison two weeks later, increasing suspicions about the links of high-ranking police officials to the MEF. Sae returned to Malaita and subsequently shot two men at the Auki police station. He is now being sought by RAMSI forces on Malaita.

Much of the violence turned from inter- to intra-ethnic, and violence was common between Malaitans and between Guadalcanalese. It was often difficult to differentiate between the MEF and police, as noted by Bishop Terry Brown of the Church of Melanesia Diocese of Malaita in a letter to Andrew Nori on 7 August 2000 (cited in Moore 2004:139):

> The Auki Police Commander (who is sympathetic to the MEF) claims that the Auki security situation is good but it simply is not the case. People are frightened. When you call the police and they send the eagles, you do not know if they are real or imitation eagles.

One Guadalcanal militant leader, Harold Keke, did not take part in the Townsville Peace negotiations nor was he covered under the amnesty offered by it. Although he had been involved with Guadalcanal militant activities since 1998, he had become an ‘independent warlord’ who, among other things, captured a Solomon Airlines plane and held the pilot to ransom in 2000. In 2001 he was also involved with the attempted assassination of Guadalcanal Premier Ezekiel Alebua. Then, in August 2002 Keke claimed responsibility for assassinating politician and priest Father Augustine Geve (Moore 2004:191). In June of that year, just days before I arrived in the Solomon Islands to start my fieldwork, ten men from East Kwaio and one from Bougainville
launched a mercenary expedition led by convicted murderer Karistoo (Karistoo had made a daring escape from Rove prison in the 1990s), to the Weathercoast of Guadalcanal to capture Keke. The group travelled in a motorised canoe supplied by MEF commander Jimmy Rasta Lusibaea, but were gunned down and killed by Keke and his men. There was ongoing conflict on the Weathercoast with almost one thousand people fleeing to camps for displaced people outside Honiara. In April 2003, Keke and his group kidnapped and murdered six members of the Melanesian Brothers who had gone to negotiate peace in the region.3

The country was also suffering economically and assistance was sought from and granted by Taiwan. The Solomon Islands voted to admit Taiwan to the United Nations and briefly discussed importing toxic waste from there (Roughan 2002b; 2004). Debate continued within Australian political circles over Australia’s role in assisting the Solomon Islands (ABC 2002). Australia’s Foreign Minister Alexander Downer stated:

Sending in Australian troops to occupy Solomon Islands would be folly in the extreme. It would be widely resented in the Pacific region. It would be very difficult to justify to Australian taxpayers. And for how many years would such an occupation have to continue? And what would be the exit strategy? The real show-stopper, however, is that it would not work – no matter how it was dressed up, whether as an Australian or a Commonwealth or a Pacific Islands Forum initiative. The fundamental problem is that foreigners do not have answers for the deep-seated problems afflicting Solomon Islands (2003a).

Despite Minister Downer’s impassioned defence of not intervening, by July 2003 the Australian government had done an about face. Prime Minister Sir Alan Kemekeza wrote to Prime Minister John Howard in April requesting Australian intervention. This was not the first time Canberra had received such a request. The previous two Prime Ministers, Ulufa’alu in 1999–2000 and Sogavare in 2000–2001, both sent similar pleas (Moore 2004:201). Australia sent an Air Force jet to Honiara in June 2003 to collect Kemakeza and inform him of their intention to intervene. Moore (2004:205-206) asserts Kemekeza also sent a letter to Indonesia at the same time as Australia to request assistance. Australia’s knowledge of this request was posed as another reason for Australia to act when it did. That month the Australian Strategic

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3 The Melanesian Brothers are an order of the Anglican Church of Melanesia who fearlessly entered conflict zones to talk with militants on both sides, and urge peaceful resolutions to the conflict. They
Policy Institute (ASPI) published a document titled ‘Our Failing Neighbour: Australia and the Future of the Solomon Islands. An ASPI Policy Report’ (Wainwright 2003). It urged a multinational agency be established to take control of the Solomon Islands. The first phase would include the deployment of international police to restore law and order and the second the rebuilding of Solomon Island’s capacity for effective government. It was estimated this would take up to ten years (Wainwright 2003:4). On returning to Honiara, Kemekeza gained bipartisan parliamentary support, a prerequisite for the intervention. On 24 July 2003 troops from the Australian Defence Force led the Regional Assistance Mission to Solomon Islands (RAMSI), landing at Red Beach near Henderson Airfield as logistical and military muscle for the police force to follow. Over the next few weeks 2 225 military and police from Australia, Fiji, Samoa, Tonga, New Zealand, and Papua New Guinea were deployed to the Solomon Islands (Fraenkel 2004:159).

RAMSI ‘Operation Helpem Fren’ (To Help a Friend) was headed by an Australian civilian administrator, Nick Warner, who had been High Commissioner to PNG (1999–2003) and who had held senior diplomatic positions in Africa and Asia (www.dfat.gov.au/dept/exec/warnernick_bio.html). He oversaw a remarkable period of Solomon Islands history. Instead of resistance, the RAMSI military forces were welcomed by throngs of people who had massed at the airport to watch the spectacle. In the following few weeks, 2 500 weapons and 30 000 rounds of ammunition were surrendered including from high profile politicians (Moore 2004:212). Military units were based at Henderson Airfield, away from Honiara, with the police being the most visible elements. By December 2003 more than half of the military forces were withdrawn, with most others leaving in 2004. RAMSI was then primarily a policing and governance organisation working with Royal Solomon Islands Police and government departments. By April 2005 more than 3 700 weapons had been recovered and 400 arrests made, including Harold Keke in August 2003 and MEF Commander Jimmy Rasta Lusibaea in October 2003 (Downer 2003b; Kabutaulaka 2004b; Wainwright 2005). Institutional reform included the removal of 25 percent of the Royal Solomon Islands Police Force and the disbanding of the paramilitary division. Arrests included 88 officers and two deputy commissioners, for charges are locally known as tasiu, and many have a reputation of holding supernatural powers.
ranging from murder and corruption to other serious offences. New recruits were trained and international police were stationed at a network of new and existing police stations across the country. Legal experts and government advisors were commissioned to improve accountability and transparency in government. Not everyone in Solomon Islands welcomed RAMSI. On 22 December 2004, Australian Protective Services officer Adam Dunning was fatally shot by a sniper while patrolling the outskirts of Honiara. This followed a non-fatal sniper attack several months earlier (Skehan and Contractor 2004; Wainwright 2005:3). Although a number of politicians and business leaders have been charged, convicted and sentenced, one of the challenges faced by RAMSI is going after the ‘big fish’ involved in corrupt activity (Wainwright 2005:5). Many of these are the very leaders who invited RAMSI into the country. Other challenges include how to sustain ongoing assistance without breeding dependency in the face of lingering security concerns (Wainwright 2005:5).

Security was a concern during and after the April 2006 national election. Despite the peaceful April 5 national election, the announcement of Snyder Rini as Prime Minister a week later sparked riots in Honiara. There was a widespread public perception that Rini was corrupt and had been bribed by Asian businesspeople (Kabutaulaka 2006). Two days of riots concentrated on Asian businesses which resulted in the majority of Honiara’s Chinatown being looted and burned to the ground.

These national events of course influenced my research overall, but the most direct impacts on it came from events in Kwaio itself, to which I now turn.

1.2 Kwaio

Kwaio is one of the twelve language groups on Malaita traversing the midpoint of the island of Malaita. Of the nine provinces of the Solomon Islands, Malaita is by far the most heavily populated with 157,000 people (CLGF 2005). The island is 160 km long, 35 km wide at its widest point in Kwaio, and has some 10 languages. Like the
rest of the Solomon Islands its people rely on a subsistence economy of gardening, fishing or gathering seafood, and raising pigs or chickens. With oral tradition being the dominant form of communication, most traditional knowledge is handed down orally from generation to generation. The research was undertaken in East Kwaio, with a land area of approximately 390 km². For simplicity I use “Kwaio” throughout this thesis to indicate East Kwaio, unless specified otherwise. The area is administratively and geographically designated according to its three natural harbours (or passages) of Uru, Sinalagu and ‘Oloburi. East Kwaio is home to approximately ten thousand people. All three harbours have people living on the coastal fringe and mountainous interior although until the twentieth century few people lived on the coast, and none at all at Sinalagu. Coastal people today are almost exclusively Christian and most mountain people uphold the religion of their ancestors.

My overview of the features of Kwaio life here is not intended to be exhaustive. There has been extensive high-quality ethnographic study undertaken in Kwaio by Roger Keesing from 1962 until his death in 1993 and by David Akin from 1979 until the present. I will refer to their work throughout this thesis, supplemented by research findings of my own. While my research overlaps with theirs in some areas, particularly by highlighting Kwaio cultural practice in content and approach, mine is above all a study in public health. My goal is to explore the complex and multi-variant relationship between the Kwaio people and health services. While Keesing and Akin were both based in the mountains behind Sinalagu Harbour, and I have also studied in that area, Uru Harbour has been a core study area for my project. Thus I have included a detailed history of the Uru region in Chapter 2 to provide insights into the cultural context and history of the immediate research environment. Here, however, I will describe Kwaio life more generally, first for the Kwaio living in the mountains, and then those who live on the coast.

A Brief Cultural Sketch

Living in the mountains of their ancestors, the Kwaio people hold to many traditional practices, and at times fiercely resist the ‘development’ the outside world offers them. Life could be seen as continuing as it has through the ages, as young men carry bows, arrows and traditional clubs; girls and women naked but for traditional ornaments dig
gardens of taro, sweet potato and yam in rainforest clearings; shell valuables are exchanged for compensation, marriage ceremonies and mortuary feasts; and priests sacrifice pigs to the ancestral spirits on whom prosperity and everyday life depends (Keesing 1982a).

Figure 1.2: Map of Malaita

Food crops including taro, sweet potato, yams, various green leafy vegetables, sugar cane, banana, coconuts and paw paw are grown and cyathaea tree ferns and canarium almonds (known throughout the Solomon Islands as ngali nuts) are gathered from the forest. Betel nut and tobacco are also grown and consumed widely. Although Malaita is heavily forested, almost all forest, except for shrines, is secondary growth, with garden land left fallow for a decade or more before being used again for gardens. Food is also hunted: birds, possums and insects from the forest and fish, shellfish and
eels from the rivers. Pigs are raised in each hamlet although these are not eaten routinely as most are *fo`ota*—consecrated to particular ancestors and eaten by ritually mature men. There are some pigs that are not consecrated and are able to be eaten by both men and women. Presenting a picture of a people holding tightly to traditional practices, would be an oversimplification of the dynamic processes that make up Kwaio life, and ignores the desires many have for change, including ‘development,’ particularly education and medical services in the mountains (Akin 1993). While Keesing concentrated on, and structured his writing around, the struggle for cultural autonomy and the deliberate resistance to the development of the outside world, Akin focuses on the processes of change in Kwaio society and the tensions between, on one hand, the devotion to ancestral ways, cultural autonomy and self reliance and, on the other their engagement with foreign goods, institutions and structures; between old and the new. (Examples see Akin 1999a, 2003, and 2004 and Keesing 1992).

Kwaio live in dense rainforest on steep slopes rising to 1300 metres. Gardens are cultivated in rainforest clearings, with clumps of trees left untouched signifying shrines where Kwaio priests sacrifice pigs to and converse with the spirits of ancestors and ancestresses—*adalo*. *Adalo* are integral to everyday life in a system which in many ways makes little differentiation between the living and the dead. *Adalo* watch their descendants who zealously keep to a complex set of rules. Violation of these rules brings punishment in sickness, death, social or economic failure or other misfortune. Confession with sacrificing pigs is the only way to cleanse the violation and restore good living, *to`oru le`anga* (MacLaren 2000). 4 *Adalo* are also protectors from malevolent and wild spirits and other dangers and without them descendants would be in mortal danger. *Adalo* are beings that both help and punish, the source of success, gratification and security, the cause of illness, death and misfortune, and the makers and enforcers of rules. Sacredness and strict rules not only apply at sacrificial shrines, but also to the layout of Kwaio settlements. Bodily functions of women, particularly during menstruation and childbirth, are strictly kept to appropriate areas

4 “Some ancestral powers are secured not merely through sacrifice and obedience to rules, but also by performing magics. Some magics are performed as part of sacrificial and other rituals, while others can be performed in any context. They often work mechanically, and may be performed even by non-descendants” Akin (1993:27).
and must be separate from domestic areas. Likewise, the sacrificial practices of priests are sacred and must be separate from the Kwaio settlement.

**Spiritual Realms**

Children grow up aware of their relationships with the spirits and their links to land. One of the most common phrases a Kwaio child will hear is *e abu*, ‘its taboo’. This ‘forbiddeness’ of acts, places and things is a contextual and relational boundary of ancestral power and prescription (Keesing 1982a). The ancestral spirits have an intimacy and immediacy as members of a family group and community, and are involved in everyday life. Akin states:

> Ancestral spirits are best understood as members of the social groups of those descendants who propitiate them. When alive, they gardened the same land (sometimes as the original cultivators), lived in the same places, followed the same religious rules and, in the case of more recent spirits, even sacrificed pigs to the same older ancestors. Like living people, ancestors have personalities, moods, egos and jealousies... Spirits are emotionally attached to their descendants, as are their descendants to them (1993:25–26).

Children grow up observing their parents and relatives daily talking with these unseen family members and start to encounter ancestors within their own dreams. Ancestors can tell descendants how they want their rules to be followed in new situations. Akin (1993:704–5) likens this to having access to the founders and writers of the constitution, being able to modify and make relevant ancestral rules for new contexts. When illness or misfortune occurs the causes are investigated through divination, asking which ancestor is unhappy, which ancestral rule has been violated, and who has caused the trouble. Divination is undertaken by many men and a very few women and involves breaking knotted strips of cordyline leaf when asking specific questions of ancestors, and observing how the leaves break.

Spiritual realms influence every event including rituals at the harvest of gardens. Before taro or yams are eaten by the community, the ‘first fruits’ are presented to ancestors, calling out their names in order from the founder through all succeeding priests to the most recent *adalo*. The priest presents the produce to *adalo* through the smoke of the burnt ‘offering’. Only after this can the men of the community eat the taro or yams subsequently harvested. A similar procedure is performed by the priest
on behalf of the women to desacralise the produce for them to eat (Keesing 1982a:119–121).

Spiritual realms and the application of ancestral rules can both be seen in the typical Kwaio hamlet layout. A hamlet is situated on land that is handed down through a patrilineal system. The Kwaio kinship system is cognatic, but there is a ‘patrilineal bias’, particularly regarding land rights. This means people connected to the land through matrilineal links have secondary land rights—they may live or garden on the land, but only with permission from patrilineal descendants with primary land rights which, ideally, is never refused (For details readers are directed to Keesing’s numerous papers of the 1960s and 1970s on Kwaio kinship). Hamlets are typically occupied by members of one extended family, and average about ten people in size. The hamlet layout is far from random, and reveals much about ancestral religion and practice. The first distinction Kwaio make is between the hamlet and the forest surrounding it. The clearing in which the hamlet is located (lalabata) is domesticated space and the realm of adalo proper, the spirits of ancestors. The surrounding forest, the darkness of night and marginal places are the abode of adalo kwasi, ‘wild spirits’, which are malevolent and dangerous (Keesing 1982a; Akin 1996).

Hamlets are internally divided into spatial areas along an axis that runs up and down the slope, where certain actions and behaviours are prohibited, required or confined. They give an insight into Kwaio cosmology, as Keesing explains:

> Although Kwaio seldom dwell upon ultimate questions of origins and meanings and explanations, they live in a world ordered by invisible lines, a world divided sharply by boundaries and categories that have a deep symbolic and pragmatic force. Preserving these boundaries, and following the rules for crossing them, is an imperative of everyday living, a matter of life and death (1982a:58).

In the middle of the clearing are one or more domestic dwellings, the `ifi. This one-room building is the centre of everyday life where both men and women can eat, sleep and socialise. The `ifi is internally divided along an invisible line on the hard packed

5 Throughout this thesis I use the term ‘hamlet’ to describe the small family settlements built by people who follow ancestral religion in which ancestral rules are maintained and determine physical layout and human behaviour. I use ‘village’ to describe larger coastal Christian settlements of up to several
mud floor, transecting fire hearths over which food is cooked. This line divides the men’s upper side and the women’s lower side. Men can go to the women’s side, but usually do not, and their sitting and sleeping mats, water bamboo and other possessions are on their side. Women go to the men’s side only to clean. Pig pens, tofi, are built under the eaves in the lowest part of the house. These pens are accessible by the pigs from the outside, and food can be thrown into the pens from inside the ‘ifi.

The high side of the clearing, above the ‘ifi, is the men’s area, the gula i langi, where a men’s house (ta’u) is built, a garden of sacred plants (cordylines and gingers among others) is planted, and a small shrine is located where sacred objects and sometimes ancestral skulls are kept. Women cannot enter this men’s area and numerous rules govern men’s behaviour while there. There are many general rules, however exact behavioural rules vary from hamlet to hamlet depending on which ancestors residents’ sacrifice to. There is a men’s toilet (sake’a) in the forest to the side. Men who are sacred because they have performed sacrifice or eaten sacrificial pork are restricted to the men’s area of their hamlets, usually for one day. If a priest performs particular types of sacrifice, especially suunga high sacrifice, or, in the past, rituals connected to warfare, he may remain in his ta’u for several weeks, gradually becoming desacralised through a series of rituals. He cannot be touched during this time, his name may not be spoken (he is called suru’ai), and he must eat from a special garden. During this time he may have an assistant to help him.

On the lower side of the clearing, below the ‘ifi, is the women’s area, the kaakaba. This includes the menstrual area and menstrual huts—the bisi or tobi. Women and girls stay in this area during their menstrual period (though other, non-sacred women can enter the area and huts to socialise whether menstruating or not). They must harvest food from special gardens while in the bisi. Below the bisi is the women’s toilet area sake’a ni geni, and still further below, in the forest, is a childbirth area that contains a rough shelter, a fale ni lafinga, where the new mother will remain for between ten and twenty days before gradually being cleansed in a sequence of rites.
The new mother cannot be touched while in the *fale ni lafinga*, and in some places her name cannot be used and, like the taboo priest, she is called *suru’ai*. Men cannot go to the *kaakaba* for any reason.

As Keesing (1982a:60–74) and Akin (1993:34–36) outline, men’s and women’s areas symbolically mirror one another. There are many similar rules that govern who can and cannot go into the areas and what can and cannot be brought into and out of them. Nothing from the menstrual area can go to the childbirth area or *vice versa*. After an extended number of days in the childbirth area the mother and child go first to the menstrual area and then to the *’ifi*, and gradually become desacralised through a series of rituals.

As long as practices are contained within appropriate areas there is no danger to anyone in the hamlet of ancestral wrath. However, if boundaries are crossed such violations will usually mean ancestral punishment will follow. For example if a women’s faeces, urine or menstrual blood enter the hamlet clearing rather than the women’s area, or worse still, if childbirth blood or afterbirth enter the clearing (or even the menstrual area), this must be reported to ancestors and pigs must be sacrificed. If they enter a house or a garden, it must be abandoned, and a defiled house’s roof must be removed. As Akin states:

> These rules are not simply a matter of female substances being dangerous to men; ancestors might punish a woman if another urinates or menstruates in her family area. These substances are thought dangerous to men and women alike when allowed to enter the wrong place (1993:35).

The principle of men and ‘male things’ being physically above women is not only symbolic in the hamlet layout. Women and their things cannot be physically above men or their possessions. This means a woman cannot step over or be higher than a man or his possessions in any way. As Akin (1993:36) points out, this principle is broader than merely a gendered one, and extends to more sacred things being properly above less sacred things. For example man’s shrines must be above the men’s house, and less sacred men cannot step over more sacred men nor less sacred women over more sacred women. This extends to some sacred women having their own toilet areas and separate menstrual huts, which other menstruating women may not enter. The variations in how this and other basic principles are applied to specific situations
by particular spirits, (and sometimes by one spirit’s different descendants) can be extremely complex. A brief explanation of the Kwaio concepts of abu and mola are required to explain this further.

Abu versus Mola

I will summarise Keesing’s (1982a:64–74) explanation of abu (taboo) and mola (not taboo) in the following description. It is too simplistic to merely say that in the Kwaio symbolic system women represent ‘down’ (menstrual hut, realm of reproductive powers and childbirth) and are polluting and thus abu to men who represent ‘up’ (men’s house, realm of ancestral powers, communicating with ancestors and death). It would also be overly simplistic to gloss over abu as simply ‘sacred’ or ‘forbidden’ and the alternate state, mola, as ‘ordinary’ or ‘permissible’. The distinction between abu, and mola being ‘non-abu’ is explained by Keesing:

Abu is not an absolute state: a person is not abu in and of himself or herself, but only in relation to other people who stand contextually in a different position. A place is not abu in and of itself, but only from the perspective of someone who is in a contrasting, mola position (1982a:65).

Thus a woman giving birth, the childbirth hut, the menstrual hut and women’s toilet are abu, but only from the perspective of those who cannot enter there. A men’s house or shrine is abu from the perspective of those who cannot enter, not in and of themselves. What is abu for one person is mola for another. For example it is abu for a priest to be in the ‘ifi after a sacrifice but mola for him to be in the men’s house. Keesing gives another example:

It is abu for anyone other than the mother in childbirth and her attendant to sleep in the childbirth hut; it is abu for them to sleep anywhere else. The menstrual area is abu for them (because they would ‘defile’ it); the menstrual area is abu for men because it would ‘defile’ them (1982a:65).

Keesing goes on to expand, using the example of a woman in the menstrual area:

From the standpoint of the community, she is abu, in the sense of being ritually isolated. But while she is in the menstrual area she is exactly where she is supposed to be: it is mola for her to be there, it would be abu for her to be in the clearing. Women’s bodies are not spoken of, or rather thought of, apparently, as inherently unclean. Rather, the dangerous substances that emanate from women’s bodies must
be kept within their proper bounds. When they go outside these bounds, they transgress ancestral rules” (1982:69).

Burt explains the concepts in the neighbouring language group of Kwara’ae (For a detailed analysis of abu and mola in Kwara’ae see Burt 1994:32–37).

In Kwara’ae something is tabu in a context where it has to be protected from specific prohibited acts which might fa’alia or ‘spoil it’ (to use the Kwara’ae translation). Things may be ‘spoiled’ by real or symbolic acts, by word as well as by deed. Where there is no question of one thing ‘spoiling’ another, the relationship between them is mola, meaning free of restrictions, neutral or, as Kwara’ae variously translate it, ‘clear’, ‘open’ or ‘allowed’, in that the actions concerned are permitted. Mola is the opposite or absence of tabu and hence is relative or contextual in exactly the same way. (1994:34)

I will discuss the implications of abu and mola later in the chapter.

Finance and Economy

Traditional shell money, bata, serves as the general medium of exchange throughout the Kwaio mountains. This indigenous money, manufactured in Kwaio, consists of white to grey shell discs, kofu, approximately 3mm in diameter and 2mm in thickness. Kofu are threaded on to varying lengths of fibre string to make the many different denominations of shell money ranging from a few disks to multi-stringed valuables of over 6 metres (For a partial list of Kwaio shell money denominations refer to Keesing 1978a:196). Large shell money denominations are often exchanged in public presentations, while smaller denominations are used for general buying and selling of commodities such as betel nut, taro or lime. Foreign things such as rice, pipes or tin fish can also be bought with bata. Shell valuables have social worth as well as financial worth and when used in social contexts it brings renown to the giver and their kin group.

There are three main contexts for the public social exchange of bata: mortuary feasts, brideprice payments and compensation payments (Akin 1993:47–62). Although the Kwaio have participated in the cash economy for more than one hundred and thirty years, ‘government’ currency, seleni (from shilling) has no social standing and is barred from social exchanges such as mortuary or brideprice payments, and to a lesser
extent compensation payments (Akin 1999b; Akin and Robbins 1999). This reflects the fundamental way Kwaio perceive themselves as members within society. Individuals have standing primarily through their kin group and their ability to function within it. The individual acquisition of seleni through the cash economy apart from one’s kin group, in itself, gives no ability to gain prestige or renown as it is only through the social interactions of bata exchange that such renown and prestige come. Kwaio who accumulate seleni when working in Honiara or plantations across the Solomons purchase goods such as knives, rice or tinned fish which they exchange for bata on their return to Kwaio. It is only when seleni has been changed into bata that the potential for social renown exists through compensation, mortuary or brideprice payments (Akin 1999a). Although bata has the qualities of cash in small denominations, when strung together into large valuables they take on an additional social meaning. These valuables then pass on qualities of Kwaio society that Kwaio see to be lacking in foreign ways, as they are used to create, strengthen or repair enduring social relationships. An impressive feast, large brideprice or adequate compensation is impossible to finance alone, and requires support from many others. Such support will only be forthcoming if one has supported others in the past (Keesing 1978a; Akin 1999a). Compensation is of central importance in Kwaio dispute resolution, and a history of reciprocal giving is essential to receiving the support even from one’s own kin (Akin 1999b). Although seleni is primarily used by coastal Christians, they are still involved in the traditional shell money economy, particularly in bride price and compensation. Although many of the churches disapprove of their parishioners involving themselves in such activities the practice is widespread.

Feuding and the Lamo

One way in which the Kwaio world was quite different in the past was that, until the British forced ‘pacification,’ men known as lamo—warriors, bounty hunters and executioners—enforced social laws and carried out executions for honour or sometimes for money. These men were part of a system where pride and honour were paramount, murder was relatively common, and violence was sometimes glorified. Killings occurred in retribution for sexual violations, curses, insults and thefts, and confrontations often sparked long-term blood feuding. A bounty of pigs and shell
valuables called a *sikwa* would be put up for any *lamo* to claim on the killing of a prescribed victim or member of a prescribed kin group. There were constant and ongoing feuds as strings of bounties and revenge killings occurred between and within kin groups. Lamo used the power of their ancestors when killing for a *sikwa*. Some fighting ancestors, *adalonimae*, not only gave their descendants power for warfare, but expected them to use it. A man might be pushed by an ancestor to commit violent acts. Success would please ancestors, which benefited everyone in the group, much as a successful feast would. Thus what appeared anti-social from the perspective of victim’s group could be highly social from the perspective of the killer’s group. Not all groups had strength in warriors, but rather their ancestors gave them power in gardening, particularly for taro for feastgiving, and pig raising. These groups were not defenceless, however, since they could use their wealth to sponsor large bounties to avenge wrongs against them (Akin 1993:63). The role in feuding taken by warriors, priests and ‘important men’ from across other language groups of Malaita have been recorded by anthropologists for three-quarters of a century (Ivens 1927; 1930; Hogbin 1939; Russell 1950; Cooper 1972; Ross 1973; 1978; Coppet 1981; Keesing 1985a; Burt 1994).

The labour trade first came to Kwaio in 1869 when two young men were taken from near ‘Oloburi Harbour (Keesing 1992:33). They became a part of the human cargo that, for more than three decades would provide a workforce for the sugarcane plantations of Queensland and Fiji. As the labour trade became more established many men returned with cloth, pipes and twist tobacco, although most prized were, first, steel knives, axes, plane blades, and before long, firearms. As more guns entered Kwaio through the last decades of the nineteenth century there is speculation that the power of the *lamo* became even more prominent, turning bounty hunting into a profit seeking venture (Keesing 1992). Although the British Solomon Islands Protectorate was established in 1893 it was not until 1909 that any administrative presence was established on any part of Malaita, and even then it remained tenuous for years. Not until the 1920s did a district officer, William R. Bell, begin to extend control over the ‘wild’ east coast of Malaita, disarm the powerful *lamo*, and stop their bounty hunting (Keesing and Corris 1980).
Kwaio Today

Kwaio today is an area of great diversity and contrast. Akin’s 1993 thesis “Negotiating Culture in East Kwaio, Malaita, Solomon Islands” examines processes of change and the often conflicting processes of local and foreign ways that are experienced by the Kwaio. Over two-thirds of Kwaio are now Christians. In almost all cases the Christianisation process has involved Kwaio leaving their ancestral land in the mountains to live in large Christian villages on the coastal fringe to be ‘separate’ from their ‘heathen’ kin. These converts have tenuous rights to land, at best, in their new homes. The South Sea Evangelical Church (SSEC) and Seventh Day Adventist Church (SDA) are the largest and longest serving denominations in Kwaio. The Roman Catholic Church has significant and growing numbers, and a small group of Jehovah’s Witnesses are also present. There are a few Anglicans. Most Christian villages are large settlements, and many have several hundred people. Christians are required to discard most ancestral rules, including in the physical layouts of their villages and the separation of women during menstruation and childbirth. These have been replaced by rules introduced by missionaries, though some people retain some of them, at times against church wishes. Houses are built raised off the ground, often two stories high. Christian churches across Malaita are however far from identical with the introduced ‘European Christianity’. They are a blend of the new and the old, introduced theology mixed with traditional ways (Burt 1994). There is fierce and decades-old rivalry between each of the denominations over doctrines and practices. The Christianisation process has not only divided Malaitans along Christian sectarian lines; it has left a geographical boundary between those upholding the religion of their ancestors, the bush people, ta’a i fataia, and the Christian coastal, soloata, people, although this is no longer as distinct now as in previous decades. Throughout this thesis I will use the term ‘bush people’ for those people who follow ancestral religion and live in the mountains, and ‘Christian’ or ‘coastal’ to describe those who live in coastal Christian villages.  

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6 Although numerous descriptors and labels have been used for the different groups in Kwaio, I use ‘bush people’ and ‘coastal’ or ‘Christian’ throughout this thesis to describe the two groups. These descriptors are less than exact since some Christians live in the ‘bush’ and a few non-Christians live on the coast. However because these exceptions are small in number I use in a general sense ‘bush people’ to designate those who follow their ancestral religion and live in the mountains, and ‘coastal’ or ‘Christian’ to describe Christians living on the coastal fringe, unless otherwise specified. I have used terms such as ‘pagan’ and ‘traditionalist’ in the past (for example MacLaren 2000; 2001a; 2003a;
Although there has been a history of movement from the mountains to the coast, the movement has not all been one-way. Numerous people have left their mountain homes to become Christians, only to return to the religion and land of their ancestors. In recent years there has been a trend of small numbers of Kwaio Christians returning to their mountain homelands. This has been accelerated by population pressures and drastic soil degradation from over-gardening near the coast, a result of both natural population growth and Kwaio fleeing the ethnic tensions in Honiara. There are numerous ongoing land disputes in Christian villages, which often involve the second generation living on land they have no customary rights over, even though their parents may have been welcomed there decades ago. Families have been evicted from land on which they have grown up, and their houses abandoned.

The return of Christians to their ancestral lands in the mountains is occurring to the greatest degree in the Uru interior, particularly in the Lafea, which has had a relatively lower population density even in the pre-European past. In the Lafea there are three SSEC settlements with over one hundred residents, an SDA settlement with thirty six residents and a Roman Catholic settlement with forty. While small SDA and SSEC settlements were established there in the mid-1980s, and one Catholic settlement before that, new church settlements have been established in 2001, 2004 and 2005. The lack of transport, communication, health and education infrastructure in the mountains however inhibits many people from returning.

Despite the physical and philosophical divide between coastal and bush people there is significant traffic and contact between the two groups, and they retain strong

2004a; MacLaren and Kekeubata 2004a; 2004b), however I chose not to use these terms in this thesis since they carry negative connotations with some readers. Both imply people stuck in the past and inflexible toward change or innovation, traits that do not typify Kwaio bush people. Other terminology considered included ‘ancestrally governed’, which may, again, convey a sense of rigidity and resistance to change, and ‘custom people’, which may obscure the important roles custom plays in the lives of Christian people. Other descriptors used by coastal Christians for the bush people include itini (heathen) and wikiti (derived from the English ‘wicked’). These were considered inappropriate here. Alternatives to ‘coastal’ or ‘Christian’ were sukuru (derived from the English ‘school’ as a legacy of the early mission endeavours of running schools as evangelical tools), or misini (mission). Both terms are used in both coastal and bush communities, but were not considered for this dissertation. In the past there were no coastal populations at all in Sinalagu and ʻOloburi harbours, although “sea people” (ta’a i asi) lived on islands in Uru Harbour, and a few places along on the coast there. The same was true in
genealogical, political and economic links which makes up a loose ideological system that defines their interrelationships (Keesing 1989a). Keesing (1982a:234), Ross (1978:178) and Burt (1981:14) all point out that across Malaita both Christians and those upholding ancestral religion believe in each others theologies; the divinity of Jesus and the power of ancestral spirits. It is simply a matter of who they choose to follow—a matter of allegiance. This reality is something that many denominational leaders, particularly SDA leaders, have not come to terms with. Much evangelical effort is put into ‘preaching the word’ so the ‘ignorant’ may have doctrinal knowledge and change accordingly. Far more pragmatic issues are involved in people becoming Christians and choosing a denomination. For example, people may agree with the doctrines of the SDA church, but become or remain SSEC or Catholic because unlike Adventists, members of those churches can raise pigs, the most significant form of income and wealth for most people (For a detailed description of the dynamic relationship between Christians and non-Christians in Kwaio see Akin 1993:474–514). It is easier to discuss the philosophical underpinnings of either Christianity or ancestral religion with either group, than an outsider may initially expect. This has been the case since the labour trade in Kwaio. I have had senior leaders from the Kwaio bush quote Bible passages to me. Keesing (1967a:96) recalls similar situations and commented “some pagans show great sophistication in Christian custom and ideology”. It is my conclusion that this sophistication has only increased. For example, a past paramount chief of the Kwaio Fadanga attended the SDA primary school on the coast at Ibo as a young man. He returned to the mountains to take up a leadership role in the bush community. On one occasion he critiqued all the major denominations in Kwaio in relation to ancestral religion in an hour-long monologue during my visit to his hamlet in 2000. The acknowledgment of multiple spiritual entities is unproblematic for Kwaio since historically different kin groups have sacrificed and upheld the rules of different ancestors rather than a single spiritual being.

Government services are lacking across Kwaio, particularly in the mountains. The area’s first police post was not established at Atoifi until 2004. While theoretically in
control, the government has little direct influence in the mountainous interior. Although there are modest government services on parts of the coast they are virtually non-existent in the mountains—there are no government schools, medical services, roads or police presence. The government runs schools and medical clinics for coastal communities, but not in the mountains. Other government services are also lacking in the Kwaio mountains. The official population of East Kwaio of 11,217 (Solomon Islands Census Office 2000) is underestimated by approximately 1,000 because census officials did not visit all areas in the mountains. This has serious implications for policy and planning in Kwaio. A further example of this occurred in the lead up to the April 2006 national election when government officials were sent to rural areas to ensure voters were registered for the national election. Although this occurred on the Kwaio coast the officials did not visit the Kwaio mountains. Numerous bush people eligible to vote were unable to do so as they remained un-registered.

Much of the political ideology and struggle for autonomy continued in Kwaio after the demise of Maasina Rule and related movements in the early 1950s. Throughout the 1960s and 1970s there were overtones of Kwaio independence from the Solomon Islands. A group named the Kwaio Fadanga (‘meeting’) was formed (Keesing 1992:144–150). This was a Kwaio council in which Kwaio kastom and traditional law, and relations with the government were discussed; the Fadanga is still active. During May 2000 the Malaita Provincial Government officially recognised 60 traditional ‘chiefs’, both on the coast and in the mountains in Kwaio.

**Health and Health Services**

Health and curing, *gulanga*, are inextricably linked to spiritual paradigms throughout Kwaio. The *adalo* are the all-powerful sustainers of life and influence sickness, health and wellbeing. Kwaio curers combine physical procedures with ancestral powers to treat any ailment. Plants are used as poultices in conjunction with placing taboos on particular foods and activities. In some cures, these taboos are lifted when ancestors receive the first portion of food, through the medium of smoke, when the patient and curer eat together after the ailment is cured. Explaining why illness or accident occur is also important. If a person cuts themselves with a knife or axe ancestors will be asked why it happened. The answer is usually a social explanation. Thus spiritual,
social, and physical aspects are central to health. Although Western medicine is often sought, it is conceptualised through this spiritual paradigm; to treat foreign secular illnesses and the symptoms of ancestrally caused illness as “curing treats the symptoms of illness and injury; only sacrifice or other atonements can treat the causes” (Keesing 1982a:119, my emphases). Although many Christians formally deny the influence of adalo on their health, many informally engage with this system, on some occasions seeking curers from the mountains to treat their ailments. Examples of this are outlined in Chapter 5.

The government’s slowness in providing social services in Kwaio is nowhere more evident than in the provision of health services. The Kwaio are keen to engage with health services and take an active role in their planning, since they perceive many benefits. But they must be delivered in a way that is compatible with ancestors and their rules. Akin (1993:458–459) suggests the Kwaio appreciation of Western medicine dates to the labour trade, but especially to a Rockefeller-sponsored campaign against yaws and hookworm between 1928 and World War II. Over 2000 yaws treatments (novarsenobenzene) were given in the Kwaio bush in one fortnight in 1940 (Bengough 1940 cited in Akin 1993:570). While these treatments had a minimal impact on decreasing mortality, they did significantly decrease morbidity and chronic illness and increase quality of life (Akin 1993:459). While these campaigns were welcome, they did not establish an ongoing system to deliver health services to the population. Before World War II government health policy consisted primarily of penning pigs and suppression of cultural practices deemed unhealthy. Government officials and missionaries blamed health problems on elements of indigenous culture or inherent weakness of spirit more than introduced disease (Cormack 1944:68; Akin 1993:460). Despite this assessment, the cramped and unhealthy living conditions of large coastal Christian villages were also blamed for ill health and population decline. Missionaries themselves stated that “sickness is rife and disease is found on every hand” (Cormack 1944:243) and “the Tropical Islands of the South Seas are teeming with germ life” (Cormack 1944:246). There is evidence that the missionaries themselves were adding to that burden. In one survey over a two-year period (1920–1922) in three districts of North Malaita there were net declines in population in the Christian villages, while there was a net increase in bush hamlets (Hilliard 1978:268).
That Christian villages were larger than bush hamlets, and often sited on low lying coastal land close to swamps, meant that disease could spread more efficiently than in the smaller mountain settlements. Akin expands on this, stating that Kwaio hamlets:

Tend to be much cleaner than Kwaio Christian villages in terms of water supplies, toilet facilities, and culinary practices. This is due in no small part to sanitary behaviours dictated by religious rules that have been discarded by missions (1993:466).

Anthropologists and medical experts pointed to European dress as unhygienic. Hilliard (1978:268) records that by the 1920’s missionaries had universally condemned elaborate European clothing as a common cause of disease. The Maasina Rule movement in the 1940’s had hygiene policies which commentators of the time thought produced a healthier population (Forster 1948 in Akin 1993:460).

From the 1950s onward the Government attempted to provide health services initially with ‘dressers’ and then a clinic at coastal Sinalagu and ‘Oloburi, with limited success, particularly for people living in the mountains.

The [Malaita] council dressers are all situated on the coastal belt, they rarely tour, and the bush people are extremely unwilling to make the long journey to them (Jack-Hinton 1958 cited in Akin 1993:461)

An example of the nexus between ancestral rules and health services was evident when the government planned to build a rural health clinic on the coast at Sinalagu Harbour in 1963–1964. It was to be used for a dispensary and maternity clinic. The bush people were resigned to boycotting the entire clinic since it would violate strict menstrual and childbirth taboos (Keesing 1967a:95–96). Keesing advised the government to separate the two sections and build the dispensary away from the maternity clinic, advice which the government heeded.

There were a number of medical tours into the Kwaio mountains in the late 1970s and particularly early 1980s by doctors from the government’s Kilu’ufi hospital in Auki. These were not continued, in part because of meagre resources and staff changes. Drs Martin Baker, Mike Clark and David Marshall, an Australian eye surgical team, and a Peace Corps Volunteer trained as a paramedic all toured the Kwaio bush between 1980–1983, directed by David Akin who was living in Kwaio at the time. The 1983
departures of Akin and Baker (the island’s proactive Chief Medical Officer) were the main reason that the tours ceased. Subsequent requests by Akin in the 1980s and mid-1990s that a Kilu’ufi doctor tour the mountains received no response. Earlier, Kwaio had been included in the Harvard University-based biomedical expedition in the 1960s, with numerous expedition follow-up representatives visiting Ngarinaasuru, above Sinalagu Harbour, into the early 1980s. However, there were no ongoing health service initiatives beyond the immediate health care provided (Friedlaender 1987).

Although Kwaio people are enthusiastic to receive medical care, many religious rules have been problematic to its delivery. Misunderstandings by the government and missions, the other major provider of health care, in how to incorporate indigenous concepts into health care have failed to provide adequate services for Kwaio. There is a very basic government medical facility at Lagafasu on the coastal slopes above Uru. This aid post is staffed by a nurse aid who provides elementary medical treatments. It has not been set up to incorporate Kwaio culture or ancestral rules. Because it is near the Kwaio-Kwara’ae border it is remote from the greatest population centres in the mountains and relatively few bush people visit there. The most dramatic example of the failure to incorporate Kwaio concepts of health is found at Atoifi Adventist Hospital.

1.3 Atoifi Adventist Hospital

**Background**

Christian missions have for decades provided the Kwaio people with more social services, particularly health services, than the government. After long-standing plans to extend their health services, in 1966 the SDA Church opened Atoifi Adventist Hospital on a site in Uru Harbour. It has earned a solid reputation for high quality medical care and patients come from across the Solomon Islands to seek treatment there. However, from its very beginnings both government and Kwaio bush people have had issues with Atoifi. Government health officials have charged that the hospital concentrates on the evangelical goal of conversions to the church rather than better health for Malaitans, and pursues spectacular hospital based curative procedures to the detriment of community health programs (Baker 1987). Inextricably linked to
this is the fact that Kwaio bush people have never fully enjoyed the benefits of the hospital. Since it first opened its doors, Atoifi has presented the Kwaio who follow ancestral religion with a painful choice: if they wish to make full use of the hospital, they must, in doing so, repudiate precepts fundamental to their religion. Consequently, few have benefited as they should from having what is perhaps the country’s premier health care facility on their ancestral land. Their exclusion has resulted in preventable deaths and chronic disease in the community. It has also contributed significantly to a broad perception held by many Kwaio, both Christian and not, that after forty years Atoifi remains an alien and socially distant institution. This perception has undermined the hospital's ability to realise its full potential for the Kwaio people, or for the Solomon Islands as a whole.

Chapter 3 will provide a detailed history of Atoifi and Chapters 5–7 document recent events. However, it is important to first describe how health services have failed the Kwaio.

**Exclusion from Services—An Ongoing History**

Throughout the history of Atoifi curative models of health care have dominated. Improvements in community health have been perceived as natural outcomes of the provision of hospital services based on the treatment of disease. The numbers of patients treated, rather than an increase in life expectancy or decrease in infant or maternal death, have historically been used to justify the continued operation of the hospital. Addressing the problem that many in the mountains were not, and are still not, included in basic health programs has not been a priority for hospital administration. For example, Immunisation programs are conducted in coastal communities and a limited number of mountain communities. Large numbers of mountain communities remain un-immunised. Curative (clinical) procedures have dominated and in cases where preventative programs have been delivered they have taken the form of pre-scripted health education embedded in the medical and religious paradigms of hospital leaders. Atoifi’s School of Nursing has primarily taught clinical techniques and procedures. Although nursing students undertake a ‘rural clinic experience’ block within their training this has historically prepared them to follow clinical procedures in remote villages rather than to engage in community health
initiatives. In 2005 nursing students received, for the first time as a part of their formal program, cultural awareness training delivered by a community leader from the mountains. Hospital leaders have had either medical or business/accounting degrees and have demonstrated limited understandings of the social determinants of health. Staff with a community health focus have historically been in the minority. Kwaio culture has been seen as insignificant or as an obstacle for service delivery, and never incorporated into service provision. This philosophical approach to health services, overarched by the evangelical zeal with which the SDA church uses the hospital as a tool to evangelise ‘the heathen’, has exacerbated the exclusion faced by Kwaio who follow ancestral religion.

In early 2000 I investigated barriers faced by Kwaio who follow ancestral religion in accessing services at Atoifi (MacLaren 2000). The following section is based on these findings. Coastal Christians, although concerned by many of these issues, do not face the same level of exclusion to those who follow ancestral religion.

**Spatial Organisation:** The spatial organisation of the hospital is opposite to that of a Kwaio hamlet. The hospital is built on the gentle slope of a ridge with the maternity ward at the top of the slope, the female ward below and male ward further down. In a Kwaio hamlet the men’s sacred house, the tau, and sacrificial shrine must be on the upper end of the slope and the women’s menstrual house, the bisi, and delivery area—the fala ni lafinga—are on the lower end. The latter must be concealed from sight from the hamlet by thick rainforest. The hospital complex is joined by a single roof making it, in Kwaio conceptions, a single ‘house’. Going anywhere within this single ‘house’ is equivalent to going into the female menstrual house, bisi, and even more serious, the women’s delivery house. While Kwaio have determined that this is mola for most non-sacred women (again, varying according to their ancestors), it is abu for men. Ritually mature men are effectively barred from entering the hospital complex at all because it involves crossing cosmological boundaries which require a purificatory sacrifice to negate ancestral retribution that would result. A second story was built above the outpatients’ department in 1979/1980, which allows women to be physically above men. Again, this excludes men from the facility. Medical treatment cannot be given or received without massive pollution or relinquishment of core...
Kwaio beliefs. When built, a pharmacy for medicine was sited on the bottom floor, leading many in the bush to refuse any medicine originating from Atoifi.

**Toilets:** Toilets are located in each ward. Prior to 1984 these toilets were in a separate building adjacent to each ward. As I noted earlier, within Kwaio hamlets there are separate toilets for men and women, in men’s and women’s areas respectively. They are never in a ‘house’ or domestic dwelling. If a person, particularly a woman, urinates or defecates in a domestic dwelling, this is *abu* and causes massive pollution. The dwelling will become defiled and be abandoned. In the mountains, water is not used to ‘flush’ away excrement, which would ultimately flow into streams and rivers which the community rely on for drinking or bathing. It is also considered *abu* to have the ‘same’ water used to drink and flush away excrement. Atoifi uses flush toilets. The hospital complex with its single roof is defiled by the presence of even one toilet. There is a single toilet in the outpatient department for both men and women, breaking ancestral rules and creating an anathema for Kwaio. A toilet in the upper story directly above the pharmacy ritually and severely desecrates the medication under it and renders the pharmacy unusable to many. When the bathrooms were renovated and upgraded in 2001 there was no attempt made to provide sanitation outside the main hospital building, or any consideration of waterless systems. Bush people use the mangrove forest near the wharf as a toilet area. Male and female areas have been designated by the community itself.

**Water:** Water usage is tightly regulated by Kwaio ancestors, with water collected for men and women in separate, designated bamboo tubes. Bush people do not use piped water, but rather collect water from nearby, specified water sources. Water used by menstruating women or during childbirth never comes into the central domestic area of the hamlet, the *lalabata* (a rule facilitated by their being down-slope). Water is never used near or associated with the toilet or toilet area. Ditches are dug to divert runoff water from the men’s and domestic houses so it never runs into the toilet or women’s areas. At Atoifi, water is piped from the water source in the mountains into holding tanks on the ridge above the hospital and from there piped to the hospital and the staff houses through a gravity-fed system. The main pipe from the holding tank to the hospital flows directly under the maternity ward. Water from this main pipe then
enters a network of pipes to bathrooms to flush toilets, and to the laundry to wash, among other things, theatre equipment. Water from the same system is used for cooking and drinking for staff and patients. The hospital water is symbolically contaminated as it not only travels under the maternity ward but is used for toilets and to wash theatre equipment. Most bush people do not use piped water at Atoifi.

**Kitchen Facilities:** Atoifi does not provide food for patients. In 1984 a single kitchen (open brick building with open fireplaces) was built to provide a facility for patients’ guardians to cook for them. The kitchen was built directly adjacent to (approx 5 metres away from) and physically lower than the maternity ward. This made the facility unusable for bush people, particularly men, since it is in the *falenilafinga*, a place *abu* for men. Guardians from the Kwaio mountains often cook instead in the surrounding bush. One commented, “We are not animals, but we stay around in the bush like animals because we can’t use the kitchen”. Prior to 1984, each ward had an individual, detached kitchen adjacent to it to allow families to cook for their sick relatives. Some men would cook and sleep in the male ward kitchen. When these were replaced with a single kitchen constructed below the maternity ward the kitchen was rendered unusable.

**Operating Theatre and Laundry:** General surgery and obstetric procedures are conducted in the operating theatre at Atoifi. This violates the symbolic separation of women’s obstetric and general procedures. Men who enter the operating theatre are defiled because it is under the single roof and because obstetric procedures occur there. Linen from the general wards, operating theatre and maternity ward is washed in a single laundry. This renders all linen contaminated with the highly polluting blood of childbirth. The simple act of lying in bed on the linen provided is defiling and requires ancestral purification.

**Disposal:** Blood and other body fluids of hospitalised men and women are disposed of together using a common system of burial. Cosmological boundaries of men’s and women’s *abu*-ness are broken and defile ancestors. Vomit and sputum are disposed of by flushing down the toilet, mixing substance from the mouth and excrement causing massive defilement. In the early years at Atoifi, blood, placentas from childbirth and
body parts removed in surgery were incinerated. The smoke would rise above sacred shrines defiling them. This practice no longer occurs.

**Service Delivery:** The delivery of medical services by female staff continues during their menstruation period. It is *abu* for a man to be in the same location as a menstruating woman. Ancestral wrath can make the patient’s condition worse because of this crossing of cosmological boundaries. Many Kwaio, from both bush and coast often use natural remedies but are afraid to admit to using traditional medicines while at Atoifi. A Western medical paradigm that discredits ‘natural’ therapies dominates hospital policy. In an apparent paradox, many staff are knowledgeable in natural remedies and, if consulted after hours, suggest these be used instead of Western medications. They will not, however, prescribe these remedies in the hospital setting.

**Maternity Services:** Maternity services do not acknowledge the *abu*–ness of a woman delivering a baby in Kwaio society, or the purification rituals she will perform prior to returning to her hamlet. A new mother in the mountains must eat food from a garden specifically planted for this time when she is *abu*. She will stay in the *falenilafinga* for 10–12 days prior to transferring to the *bisi*, where she will stay for a set number of days, or longer until all post-partum bleeding ceases. Given that Atoifi is often many hours walk from a woman’s hamlet, it is impossible for many to uphold this requirement. Atoifi does not grow a garden specifically for women in the maternity ward, nor is there a *bisi* where women can stay after discharge from the maternity ward. The infant’s ‘child health book’ is given to the mother on discharge. She cannot take this back to the *lalabata*, the domestic area of the hamlet, since nothing can be taken from the *falenilafinga* which is *abu*, to the *lalabata* which is *mola*. Mothers instead give the books to Christian kin to store for them, and they are often lost. Very few women from the Kwaio bush deliver their babies at Atoifi.

**Antenatal Services:** Antenatal services are delivered in a room formerly used as a delivery room and directly adjacent to the current delivery suites. This is equivalent to

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7 This will vary from kin group to kin group, dependant on the system that has been put in place by the particular groups of *adalo* they sacrifice to. This length of time reflects a significant shortening of post-birth taboo periods in past decades through the use of imported magics referred to generically as *gwari* (see Akin 2003, 396–398).
the *falenilafinga*, the delivery hut within the delivery area in a hamlet. When women visit antenatal services at Atoifi they must go through the same purification ritual as if they had been to the *falenilafinga*, which may take several days. The ‘cost’ of the visit is thus seen as prohibitive relative to the benefits gained.

**Cost:** While the amount of money involved to access services at Atoifi may be relatively modest, 1 SBD for an outpatient visit and 5 SBD for admission, the real ‘economic cost’ for the bush people is massive. Entering the hospital complex requires a purificatory sacrifice to ancestors to atone for the breach of Kwaio cosmological boundaries. This may require up to 20 pigs be sacrificed (The exact number of pigs varies depending on the status of the person and the number of ancestors that a relationship is maintained with). If pigs are not sacrificed, further sickness, misfortune or death will occur within the kin group. Pigs may be specifically bred in preparation to visit the hospital, and this can take months or years. Alternatively, those with sufficient shell money may purchase the required number of pigs. These costs are often too high, however, and people are left unable to utilise services.

**Christianisation:** The alternative to sacrificing pigs for ancestors because of entering the hospital complex is to totally relinquish the Kwaio ancestral religion and become a Christian. This requires the abandonment of hamlets, community and ancestral land in the mountains and, when discharged from Atoifi, to live in a crowded coastal Christian village. The religious form and practice of that particular Christian village are adopted. The costs in this process are high and require an abandonment of traditional religion, traditional land and traditional social order to adopt foreign ones. There are currently multiple land disputes along the Kwaio coastal strip between those who hold traditional land rights and those who live there because of the process of Christianisation, some of which Atoifi has facilitated. There are other reasons Kwaio people become Christians (Akin 1993:502–514), however Atoifi has facilitated the Christianisation process throughout its history. This is a practical outcome of the relinquishment of Kwaio religion required to access services at Atoifi, more than a theological or doctrinal decision. The Christianisation process exacerbates the significant environmental pressure on the heavily populated coastal strip. The process
of Christianisation is celebrated at Atoi fi, as a statement from an Australian nurse exemplifies: “The most rewarding thing I have found out here is the experience of seeing heathen people give up their custom ways and come to Christ” (Banks 1978:2) (Keesing discusses the implication of Christianisation at length in his paper “Sins of a Mission: Christian Life as Kwaio Traditionalist Ideology” (1989a)).

Due to the above barriers, Kwaio bush people have little choice but to remain ill and miss out on benefits others enjoy at Atoifi.

Rhetoric and Contradictory Reality

The exclusion of bush people from services and resultant preventable morbidity and mortality persists despite basic principles held by both the SDA Church and the medical profession. The SDA church upholds as a foundation the principle of ‘religious liberty’, that is, the right of an individual to belong to any religious body and not be discriminated against due to membership with this group (Steley 1983; 1989; 1991). The church is a member of the International Religious Liberty Association and uses the Association’s “Guiding Principles for the Responsible Dissemination of Religion or Belief” as a code of conduct (Coombe personal communication 5 Aug. 2002; Coombe 2002:2; Record 6 July 2002:6–7). As a health care institution Atoifi has ‘health for all’ as a foundation principle. Nurses learn throughout their training that health is not the exclusive right of the rich, powerful, one ethnic or religious group, but a right for all people. At graduation nurses take an oath to treat all patients equally regardless of race, religion or gender. These core principles have historically not been reflected in policy or practice at Atoifi. The results are injustice, exclusion and inequalities.

8 The ‘Guiding Principles for the Responsible Dissemination of Religion or Belief’ can be accessed at http://www.irla.org/documents/reports/respdissemination.html. The SDA SPD (http://adventist.org.au/about_adventists/organisation) website puts religious liberty and human rights as their first priority stating: “Seventh-day Adventists in the South Pacific believe in communicating our faith through programs and events that meet spiritual, physical and social needs. We aim to serve you through our involvement in—

- Religious liberty and human rights issues
- Health and wholeness
- Education and personal growth
- Social and community issues
- Provision of humanitarian aid and development”
Because Atoifi is the only major ‘development’ in Kwaio, bush people cite it as an example of how ‘development’ necessitates repudiation of Kwaio culture. The result is wholesale rejection of ‘development’ and Atoifi is used to illustrate why any project should be accepted only on Kwaio terms and conditions (Akin 1993). In this way, Atoifi policies have had negative impacts far beyond the hospital itself, and have undermined all economic and social projects and opportunities in Kwaio. This is the exact opposite of the influence envisioned for the hospital when it was planned.

The response to Kwaio exclusion at Atoifi recorded through the 2000 research was a set of recommendations from the Kwaio community to establish culturally appropriate health services at Atoifi. One of these recommendations was an explicit and long-standing desire of the bush people to have a specific building on the Atoifi campus where health services could be accessed without repudiating their core cultural and religious beliefs. Atoifi administrators agreed for me to lead an investigation into how such a facility, later named the ‘bush ward’, could be established. This thesis is a record of my involvement in the process and how the Kwaio community and Atoifi staff worked toward this goal. It is important to first embed the response into the social, cultural, political and religious history of Kwaio. This history, outlined in the next two chapters, will allow an in-depth understanding of the complex nature of the research environment and the need for a responsive research approach.
2. Culture, Colonisation, Christianisation—the Experience of East Kwaio.

Atoifi Adventist Hospital has a reputation as a provider of high quality health care and patients travel from across the Solomon Islands to seek treatment there. However those who uphold the religion of their ancestors, whose forebears owned and cared for the land on which the hospital sits, must repudiate precepts fundamental to their religion to access Atoifi’s services. Consequently, the benefits of the hospital are not shared by all sections of the community. This chapter presents a historical context in which to place current events at Atoifi documented in this research. It outlines the complex relationship between Kwaio culture, the colonial and Christianisation processes and their impact on health and health services.

Much of what is documented in this chapter was learned through oral histories both through interview and unsolicited. This has been supplemented by observation of, and experience with Kwaio bush people, Kwaio coastal people, Atoifi people (current and past, both Solomon Island nationals and expatriates) and others with connections to Atoifi. Having lived at Atoifi and visited regularly since 1992 has allowed me many occasions to discuss the cultural, historical, political and religious context at Atoifi. What follows outlines the events that directly influence today’s experiences in Kwaio, drawing on what I have learned and expanded upon by available literature.

2.1 Atoifi Adventist Hospital in Historical Context

Atoifi Adventist Hospital is located at the southeastern end of Uru Harbour, the northern most of three harbours that make up East Kwaio. The SDA mission built the hospital in 1965 after an extensive search of Malaita to locate a site to expand their health services. The piece of land was locally known as `ato`ifi. Although Uru is in a

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9 One of the numerous meanings of the word `ato is a very steep rafter in the roof of a house, and `ifi meaning house. I have had it explained the ridge at Atoifi was so-named because the steep ridgeline had sides at a similar angle to the rafters of a typical house (if Atoifi was named as such the proper spelling/pronunciation would be `ato`ifi). I have also had the meaning explained to me as literally ‘difficult house’, as another meaning for `ato is ‘difficult’ or ‘hard’ and the word `ifi being house. This
deep harbour suitable for shipping, it was remote and had no existing infrastructure. Atoifi developed as a self-sufficient campus. It has provided and maintained its own water and electricity supplies, transport links (wharf and airstrip), internal road network and staff housing. All staff (most of whom are not from Kwaio) lived on campus, except those from surrounding villages. Atoifi provided its staff and the community with services including a post office, bank, a workshop with fuel available and a small retail store. The only Kwaio communication link with the outside world was Atoifi’s HF radio used to communicate with church and government agencies. A satellite telephone and email system was installed for hospital administration in 2000. This was a very expensive, technologically fickle system and not available for the public. This expanded in 2005 when a Solomon Telekom telephone and internet system was established for both hospital and public use. Thus Atoifi grew into a service hub for East Kwaio that enjoyed more resources and services than most government stations. Many people in the community still call the Atoifi campus ‘town’ since it resembles a town more than a hospital, and contrasts markedly with villages nearby. This gap between village life and campus life has increased in recent years with the influx of consumer goods such as televisions, videos and other electrical goods. Akin 1993:11—12 explains Kwaio perspectives of ‘town’: “Towns are portrayed as impersonal and alienating, profoundly lacking the deep sense of community found at home; town people live a transient and groundless existence. The cash economy is depicted as asocial or even antisocial, offering only fleeting rewards”.

The hospital, although one of the best equipped and respected health care institutions in the country, has been controversial from its very beginnings. To appreciate the social, political, cultural and religious issues present at Atoifi today, an understanding of the history of Kwaio interactions with Europeans, their God, government and health services is necessary. This chapter, and the one that follows, will outline how the Kwaio people have negotiated—in some cases embracing, in others struggling against—the introduction of new ways.

may be a modern explanation of the meaning of Atoifi reflecting more contemporary ideas (Akin personal communication 2003). The Atoifi area is also known as Taunau a - literally the ‘home of the crab’, a deserved descriptor as I have had crabs inside in my house at Atoifi.
2.2 Uru Harbour History

The Labour Trade

The first European ships to sail through the Solomon Islands in 1586 belonged to the Spanish expedition of Mendaña. Though they landed in southern Malaita, in `Are’are, they had no contact in Kwaio. There is no record of the trading and whaling ships that frequented Solomon Islands’ waters in the early nineteenth century venturing to the eastern coast of Malaita, though a few probably did. The Anglican Melanesian Mission ship *The Southern Cross* first contacted Malaitans at Sa’a in Southern Malaita in 1866, but did not visit the east coast (Burt 1994:86; Hilliard 1978:48). The first Kwaio contact with Europeans came with the onset of the labour trade. Labour ships plied the waters of the Western Pacific, first to kidnap and then to ‘recruit’ islanders for the plantations of British, German, and French colonies. By far the most Solomon Islanders went to the sugar plantations of Fiji and, especially, Queensland. Between 1863 and 1914 over 100,000 islanders served as a labour pool for European enterprise in the region (Corris 1973:1). Of the 62,000 Melanesians taken to Queensland, the largest number from a single island were from Malaita, approximately 9,000 from 1871–1904 (Price and Baker 1976:115; Moore 1985:xvii–xx). By percentage of population, East Kwaio was probably the most intensely recruited area of Malaita, particularly during the last half of the trade. Some 1250 recruits went to Queensland, and over 2000 Kwaio men may have laboured abroad overall (Akin 1993:83). The first ship documented to have taken Kwaio men was the *Nukulau* in 1871. The *Nukulau* captured 10 men from Sinalagu and sailed on to Leli Island. The violence of the first contact was dramatic, as Burt (1994:88) states:

> From Sinalagu it came on to Leli Island, where thirty men in three canoes approached the ship. Two canoes came close and the ship’s crew threw down pieces of iron, wrecking the canoes and killing one man. The rest swam to the third canoe but as it was taking them on to shore the ship’s crew shot and killed three of them, then the ship ran the canoe down and the crew pulled up twenty five of them out of the water into the ship’s boats and tied them up.

One of the twenty-five men captured was Lau’a from Uru. He took part in one of the most infamous events of the labour trade when, after being offloaded from the
Nukulau\(^\text{10}\) to the ship Peri in Fiji, the captives killed the crew and threw them overboard. The Peri drifted for five weeks until it was found off the North Queensland Coast. During this time captives from Kwai Island (just north of Uru) and Lau’a were starving and started to eat the other prisoners. When they were found, Lau’a was one of only 14 survivors.

The kidnappings were soon replaced by voluntary recruiting as regulations were put in place and the demand for European goods grew. Particularly coveted were Snider rifles that were used in feuding and to collect blood bounties put up for killings. In 1883, Anglican Bishop Selwyn claimed that every returnee carried one or more guns and three to four hundred rounds of ball cartridge (D’Arcy 1987:59 cited in Akin 1993:86). In 1902 Resident Commissioner Woodford estimated that there were 4000 to 5000 Winchester repeating rifles on Malaita (Moore 1985:79). Senior men sent younger men on the recruiting ships to collect an initial “beach payment” from recruiters for each man (early on paid in rifles) and the goods they would return with. On their return from the plantations, the goods were shared and redistributed. However, it is estimated that up to one-third of recruits to Queensland did not return as Scarr noted:

Debilitated as a result [of refusing terrible rations], and battened down in a confined, evil smelling hold, [the Islanders] fell prey to virulent epidemic dysentery from which, for instance, in 1879, 57 of 153 recruited by Fiji’s Stanley died. In 1877 Queensland’s Bobtail Nag lost 8 of 102 recruits from the disease (1970:230, quoted in Keesing 1992:33).

Mortality rates gradually declined as the trade progressed, probably due to growing resistance to European diseases (Shlomowitz 1989). When recruits did not return their deaths were mourned and revenge was sought. Blood bounties of pigs and shell money were put up for the killing of any European (Keesing 1992:34). This made recruiting a dangerous business, and during the first three decades Malaitans earned the most bloodthirsty reputation of all the Solomon Islanders (Akin 1993:89). Attacks

\(^\text{10}\) The voyage of the Nukulau has been confused by some authors (including Keesing) with the voyage of the Carl, another ship involved in barbaric events. The Carl was also in the Solomon Islands in 1871, but did not visit Malaita. However after the 80 men they had captured from across the Solomons rebelled, the crew shot them and threw 70 overboard. Thus, although Keesing (1986:270; 1992:33) names the boat that picked up the 10 Kwaio men from Sinalagu the Carl, it was actually the Nukulau. (Burt 2002:195-196).
on ships allowed lamo (warriors) to kill the crew and claim bounties, and brought loot in the trade goods carried for beach payments. The first attack on a recruiting ship in Uru was in 1880, when the Fijian recruiting schooner *Borealis* was attacked by men under the lamo Maesuuaa near Uruilangi Island at the entrance of the harbour. The men paddled to the *Borealis* ostensibly to offer themselves as recruits (Lounga cited in Keesing 1992:34; Corris 1973:33). Once aboard they killed five Europeans and one Fijian and looted the ship of its cargo. The ship’s captain, government agent and boat’s crew were ashore recruiting and escaped (Akin 1993:90). They rowed to north Malaita where they located three other recruiting ships; The *Flirt, Dauntless* and *Stanley*. The ships returned to Uru and retook the *Borealis*. The ships’ crews with men from Kwai harbour (just north of Uru) recovered the ship’s goods and wiped out Uruilangi Island and coastal villages (Akin 2000).

[They had] attacked the island, driven the natives off, and had burned the village, cut down all the coconut trees, and ruined it; that the natives of the island had been obliged to desert it, and were scattered about the mainland… Every habitation was destroyed … every single coconut tree had been cut down… and the whole place was a scene of utter desolation. One or two villages on the mainland had also been destroyed and the trees felled.


During this punitive strike 40 to 50 houses were burned and 100 coconut trees were cut down (Akin 1993:91). An unknown number of Kwaio were killed and four prisoners were taken and imprisoned in Fiji (Moore 1985:351–352).

In February 1882, less than a year and a half after the punitive attacks on Uruilangi Island, the Queensland recruiting ship *Janet Stewart* was attacked near Leli Island. Although Keesing and Corris (1980:11) claim that Maesuuaa was behind the attacks, Burt (1994:93-94) outlines accounts of the attack of the *Janet Stewart* attributed to Mae’ela from Ngongosila Island in nearby Kwai Harbour. Akin (1993:92) suggests that it is likely that Kwaio and Kwara’ae from Ngongosila conspired in the venture. The method of attacking the *Janet Stewart* was very similar to that of the *Borealis* with four crew and the government agent killed and possibly the 35 recruits from South Malaita (Corris 1973:33; Burt 1994:94). The cargo was looted and the vessel burned and sank. Although Maesuuaa was involved there is no evidence of a punitive
attack in Uru, though the following June a British warship attacked Ngongosila, burned its houses and felled its palms (Akin 1993:92; Burt 1994:94; 2002:200).

The next major ship attack was not in Uru but neighbouring Sinalagu Harbour. Spurred by the success of Maeasuuaa, the lamo `Arumae of Tetefou in the mountains behind Sinalagu initiated an attack on *The Young Dick* in 1886 (Keesing 1986). He was keen to collect a blood bounty put up for the death of a European to avenge Boosui, who had been kidnapped and taken to Queensland and falsely rumoured to have died there (Akin 1993:93). The attack was a disaster for the attackers, for although four Europeans and one recruit were killed, as many as 14 Sinalagu men died (Akin 1993:93; Keesing 1986; Lounga in Keesing 1992:38–42; Moore 1985:352). This was the final full-scale ship attack in Kwaio.

There were smaller-scale ship attacks in the following years. Recruiting boats of the *Sybil* were fired upon in 1891 up the Kwaiba`ita River (the border between Kwaio and Kwara`ae), and four crew wounded. Gala, a Kwaio man from the bush behind Uru Harbour was seeking to avenge the death of a relative in Queensland (Burt 1994:96). Two months later HMS *Royalist* shot at Gala’s village of Busu (Burt 1994:96, 115). Three years later, in 1894, the *Sybil II* was attacked between Uru and Kwai with one Malaitan and one European killed (Moore 1985:350), and in 1901 Roderick McCabe, a recruiter with the *Roderick Dhu* was shot while recruiting in the area, to collect a bounty offered in East Fataleka (Moore 1985:352; Burt 1994:115).

Recruiting slowed in 1901 when the Queensland government, pressured by white labourers, passed legislation to end the labour trade. This was the initiation of the White Australia Policy that was to guide Australian society for the next half-century. New arrivals were not allowed to enter Queensland after 1904, and Melanesians residing there were deported in 1904 and 1906. The return of so many men caused considerable disruption to life across Malaita and violent conflicts erupted in many areas, including Uru (Burt 1994:116). A number of Melanesians did remain in Queensland, many of them from Malaita (Moore and Mercer 1976, 1978a, 1978b; Moore 1978, 1982, 1985, 2001; N Fatnowna 1989; T Fatnowna 2002.). Recruiting for
Fiji ceased in 1911 after pressure from Resident Commissioner Woodford and plantation owners in the Solomons who required labour (Akin 1993:120).

The initial contacts between Kwaio in Uru Harbour and Europeans were similar to much of the rest of Malaita, with violence and brutality on both sides. The kidnapping of Malaitans precipitated retaliatory attacks on any European. Likewise European punitive expeditions were indiscriminate and deemed anyone living in the area responsible and in line for collective punishment. Although both sides responded by different means, indiscriminate retaliation followed remarkably similar patterns.

**God and Government come to Uru**

Those labourers who did return brought back two key imports that transformed Kwaio society. The first was steel tools, including guns. As these tools infiltrated the Kwaio mountains in the late nineteenth and early twentieth centuries there was probably an increase in the activity of the *lamo*, partly to collect blood bounties put up for relatives who had died in Queensland or Fiji and partly over internal feuding (Keesing 1992). The second import from Queensland was a new religious system—Christianity. This system was a direct challenge to Malaitan ancestor worship and replaced Malaitan symbols, rituals and practices with those learned from Europeans abroad, often modified through creative interpretation and Malaitan sensibilities. Although most returned to their ancestral worship, some returnees brought the Christian message with zeal to convert their Kwaio kin. Isaac Lau’a returned from Fiji in around 1901 and set up a small mission village at his home in Uru (Burt 1994:113). After a short time his wife, brother and sister-in-law were murdered and he fled to Ngorefou in the Lau Lagoon.11 Lau’a returned to Uru in 1905 and established a mission village with the support of Anglican missionaries. Despite gaining some converts the mission closed after Lau’a’s death three years later (Akin 1993:131-132; Burt 1994:113). In

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11 This was a similar pattern to that of Alfred Amasia from Ngongosila Island who had been captured by the *Nukulau*, survived the *Peri*, and returned to Ngongosila only to have his wife murdered, after which he also fled to Ngorefou. In 1902 Amasia was murdered near Ngorefou by two men from Uru in return for killing their ‘father’ at Kwai before he was captured and taken to Fiji thirty years previously (Burt 1994:113). For a full account see Burt 2002.
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1904 a Queensland returnee, Daniel Tala`ae, set up an Anglican school of 10 people in Uru, but this, too was short lived (Akin 1993:131; Gwa’italafa 1984:18).

The most dramatic changes occurred during the mass repatriations of 1904 to 1906 when Malaitans who had been living in Queensland for years and even decades returned and openly challenged the Kwaio spiritual order. Many had been associated with the Queensland Kanaka Mission (QKM) established in 1886 by Florence Young and her brothers at Bundaberg in southern Queensland. Florence Young first encountered ‘Kanakas’ on the family sugar plantation ‘Fairymead’ in 1882, and by the time the QKM was established four years later was running Bible classes with eighty Islanders every Sunday (Young 1926:42). Because the first missionaries taught Bible classes, Christianity and Christian villages came to be called *skul* (school; Kwaio *sukuru*). In 1904 Florence Young made her first trip to the Solomon Islands, and was called to visit Christian returnees who had set up a *skul* at Sinalagu. On her second trip to Kwaio in 1905 she was disappointed to find many of her flock had returned to their ‘heathen fashion’ after initially trying to convert their kin (Keesing 1992:49).

With the return of so many Melanesians to their home islands, QKM missionaries took the decision to relocate their operations to the Solomons. In 1906 the QKM headquarters and training school were opened at Onepusu on Malaita’s southwest coast. That same year another QKM station was built on Ngongosila Island to serve the eastern coast, including nearby Uru (Akin 1993:128). The first resident missionary was Mr J. Watkinson who travelled the coast encouraging the establishment of Christian settlements (Burt 1994:119). In 1907 the QKM closed in Queensland and started its Solomon Islands branch under the name of the South Sea Evangelical Mission (SSEM), which fifty-seven years later became the South Sea Evangelical Church (SSEC) (Burt 1994:206; Hilliard 1969:48).

The Christian returnees from Fiji and Queensland faced violent opposition to their new mission settlements. Large numbers returned to ancestral ways.

Typical of Kwaio was Afolosi, father of Larikeni of Fanuariri, who told his son that during 14 years living in Queensland ‘he had been a little bit Christian, but when he came back here he had let go of the mission at the seaside and climbed back up into the bush’ (Akin 1993:125, 126).

Hopkins, an Anglican missionary said of some returnees:
He landed yesterday in polished boots, starched shirt and collar, tie etc.; tomorrow he is running about naked, or very nearly so, shell in hair, gun in hand on some bush feud which his return has perhaps started (SCL 1908:242 cited in Burt 1994:116).

Consequently the mission removed men from their own communities to a training centre at Onepusu and, after training, returned them as ‘teachers’ (Akin 1993:129). By 1909 a number of Christians at Sinalagu included Queensland returnee Diakafu (Jacob), previously an ancestral priest, and his Makiran wife Topsy who ran a school in the bush at Buubuu. Up to 50 people attended their skul, and 14 were Christians (Young 1926:198). They were forced by people from the area to relocate to ‘Ailamalama on the crest of the ridge separating Uru Harbour from the sea. This was just across the water from Urulangi Island, the home of Maenasuaa, the ship hunter of 1880 and 1882. There they were joined by the first SSEM missionary to Uru, Frederick Daniels. Around this time (about 1910) a newly established skul at Busu near the Kwara`ae border in Uru closed after the Christian Jonathan Ngu fled with the daughter of warrior leader Gala to the SSEM station at Onepusu (Burt 1994:123). This was a particularly volatile and violent time in the Uru district and in mid-1911 Malaita’s first District Officer, T. W. Edge-Partington, reported that in the Uru-Kwai area “there have been about 12 school [Christian] murders in the last fortnight” (1911, cited in Akin 1993:126).

Violence against the mission advance continued and in June 1911, Frederick Daniels became the first European missionary killed at Uru. Daniels had been stationed at nearby Ngongosila for 18 months and worked intermittently at the new SSEM station at 'Ailamalama (Hilliard 1969:54). Daniels was shot after his dawn church service by 'Alakwale`a and his brother Kwa`iga from Farisi in the Uru mountains. An investigation by Anglican missionary Hopkins concluded that the “motive centred around the seduction of a Kwaio girl by a mission teacher, and Daniels intervention in getting the couple away to safety at Onepusu” (Keesing and Corris 1980:13). Florence Young asserted the murder was to claim blood money put up for a white man to revenge the killing of a labourer on a plantation (1926:214–216). Authorities were mislead when told that Maenasuaa was to blame (Akin 1993:138). In the 1960’s Kwaio leader and politician Jonathan Fifi`i asked one of the surviving perpetrators, 'Alakwale`a, what his motives had been (Fifi`i 1989:75–76). ‘Alakwale`a said they
could see Christianity invading their ways and that Diakafu, once an ancestral priest, a
sacred man, who had come across to `Ailamalama from Buubuu was flagrantly
violating the taboos and “just staying with menstruating women”. “It looked as
though our customs were going to die” (in Fifi’i 1989:75). The second reason was
their anger over a curse his mother had made after he and Kwa`iga ate a bamboo full
of her canarium almonds.

We talked about it. I said to Kwa`iga, ‘I want us to do something. Something that will
have to make her run away, something that will bring fear. What we should do is kill
that white man down there, Mr Daniels. So everyone will run away, and she’ll be
afraid (`Alakwale’a in Fifi`i 1989:76).12

By this time the British Solomon Islands Protectorate (BSIP) was well established,
although the government had little influence on Malaita outside a small area around
the government station at `Aoke on the west central coast. The BSIP had established
its capital in Tulagi in the Nggela group of islands in 1893. The first Resident
Commissioner C. M. Woodford was based there from 1897. This was the beginning
of what the Malaitans came to call gafamanu (government), a term that covers both
the institution and its officers (Burt 1994:114). The first permanent government
presence on Malaita was established at `Aoke in 1909 in the person of the resident
District Magistrate T. E. Edge-Partington (Akin 1993). Being an outpost of the British
Empire, the BSIP was ostensibly established to protect and ‘civilise’ the natives
(Keesing and Corris 1980:14). Missionaries demanded of the government in Tulagi
that Daniels’ murder be punished with a heavy hand, although Florence Young and
several other SSEM missionaries called for punishment to be directed only at the
murderers (Akin 1993:167). The killing of Europeans—unlike the killing of Solomon
Islanders, was deemed by the BSIP an outrage that called for stern retaliation
(Keesing and Corris 1980:14). Five months later Fiji based HMS Torch, executed a
punitive expedition on the area. Edge-Partington arrived first with Anglican
missionary Arthur Hopkins as guide and interpreter. He immediately went to
Uruilangi and destroyed canoes and arrested two men and forty women. One women

three years before this, the first effective punitive expedition into interior Malaita had occurred in west
Kwaio after an attack on a ship and the murder of a European on board. Kwa`iga and `Alakwale’a
therefore had good reason to imagine that Europeans would react to Daniels’ assassination by forcing
them to run away.
drowned as she attempted to escape. Two days later in an early morning raid Edge-Partington, the Torch’s captain, twenty two native police, twenty five seaman and marines and a surgeon attacked the people at Farisi. They killed five Kwaio (including a woman and child who were burned alive), desecrated shrines and burned houses (Akin 1993:139; Keesing and Corris 1980:14–15). The next morning Woodford and the High Commissioner Sir Francis Henry May from Fiji oversaw the total destruction of Uruilangi Island though its people had little involvement in the murder (Akin 1993:139; Keesing and Corris 1980:14). Hopkins had led the commissioner to believe that Maeasuaa was behind the murder, but the only involvement of the people of Uruilangi was that a young man from there had paddled K wa`iga and `Alakwale`a across the harbour. Lounga (in Keesing 1992:53) claims that four or five people were killed, women raped and shell valuables stolen, however Akin (1993:166–167) notes there were a number of versions of events, some of which do not mention the killings or rapes, and he doubts that rapes occurred. All accounts do describe the complete destruction of Uruilangi.

Despite government claims that the punitive expedition had intimidated the locals into submission, less than a week later the recruiting ship Ruby was attacked by men in the Kwaiba’ita valley, just across the Kwara`ae-Kwaio border (Burt 1994:126; Fifi`i 1989:111; Keesing 1992:50–55; Keesing and Corris 1980:14–15). The force and violence of the punitive expedition demonstrated to the Malaitans that the government would punish the death of a European Christian. This was not the case for local Christians, however, many of whom had been killed in the area in the preceding decade. The Daniels episode had major implications for the relationship between Kwaio and Europeans and the missions. The Anglican ‘Melanesian Mission’ withdrew its teachers from Uru after the attacks and lost influence in the area until the 1930s (Burt 1994:126). The SSEM also abandoned its Ngongosila base and did not station another missionary there until Northcote Deck arrived in 1923 (Burt 1994:126,127; Hilliard 1969:54). Kwaio resolve to resist the missions was greatly strengthened during this time (Akin 1993:141). No other European missionaries resided in Uru until 1924 when the SDA Mission was established.
In 1915 District Magistrate Edge-Partington resigned in frustration and was replaced by District Officer William Bell. Bell, a hard and violent Australian who had worked as a government labour agent was to change the history of Malaita, and in particular East Kwaio forever (Keesing and Corris 1980; Akin 1993:141). He “knew and cared more about Malaitans than any of his predecessors— or successors” (Keesing 1992:58). He replaced Edge-Partington’s ineffective police troops with disciplined soldiers made up mostly of North Malaitans. Akin (1993:141–142) states:

Though they were militarily well disciplined, thievery and gratuitous violence were their standard practice. Their propensity for shrine desecration and looting merely continued long-standing government punitive procedures.

Unlike Edge-Partington, Bell extended his operations and government control well beyond the coastal fringe and into the bush (Burt 1994:130). Bell was keen to pacify the island and saw the subjugation and intimidation of the lamo as central to this endeavour (Keesing and Corris 1980:66–80; Akin 1993:142). Bell’s tactic was to “confront individual lamo and their henchmen from a position of military advantage, forcing them one by one to capitulate” (Akin 1993:143). He took on men at the centre of power in Kwaio society, warriors who drew their power and wealth from feuding and the bounty system (Akin 1993: 1–62, 142; Keesing and Corris 1980). As Bell forced the lamo to surrender, he himself increasingly became a Malaitan-style strong man (Keesing and Corris 1980:68). He also had a policy to carefully confiscate the lamos’ guns and to co-opt them into positions as local government constables (Akin 1993:143). This made him very unpopular in some quarters. He mused to SDA missionary Anderson, “if I were to fall and break my neck going down the track, you’d have presents coming from all directions, so pleased would the people be to hear I’d been killed” (Anderson 1980h:6). With Bell’s administration exerting more control over Malaita and its lamo, small Christian villages became more secure and their numbers grew across the island (Burt 1994:131).

Bell oversaw the establishment of headmen and constables around Malaita as middlemen between himself and the local population. This strategy helped him organise local government operations and a system for collecting taxes across the island (Keesing and Corris 1980:78–79). Despite this, Bell had little effect on East Kwaio for several years. He patrolled in East Kwara’ae, just to the north of Uru, in
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1917 and several times in 1919 and reported optimistically that Kwara’ae was reasonably under control (Akin 1993:145; Burt 1994:141–144). During 1921, the year that the government instituted a ‘native head tax’ on males 16–40 years old he visited Uru, Sinalagu and ‘Oloburi to confiscate guns and make arrests (Bell 1921 in Akin 1993:145). He envisaged problems in Malaitans’ ability to pay and his own ability to collect the tax and postponed collection until 1923. Kwaio was the last major area on Malaita where Bell had little control and he wanted to use the tax to force the Kwaio lamo to publicly submit to his government (Akin 1993:148). Keesing and Corris explain that there were a numer of reasons behind the tax.

The reasons behind the introduction of the tax were mixed: some officials argued that tax payment was a ‘civilizing’ measure; the revenue to be raised was welcome to the administration; such taxes were in force in other parts of the Colonial Pacific, in African and other colonies, where they served to force natives into wage labour (1980:74).

It was not incidental that the emerging BSIP copra industry was facing a looming labour shortage.

**Establishment of the Seventh Day Adventist Mission in Uru**

With the benefit of government protection and the spread of the Christian message, missionary support again returned to the area. Norman Deck reopened the SSEM mission station at Ngongosila Island in 1923 (Burt 1994:147), and a year later on 22 Sept 1924, the Seventh Day Adventist Mission established a station near ‘Ailamalama, a kilometre from where Frederick Daniels had been murdered 13 years before (Anderson 1980e; 1980f). This was led by an Australian missionary Pastor John David Anderson and his wife Guinevere who had worked in the Western Solomon Islands since 1920 (Anderson 1980a:8–14). Anderson’s move to Uru was opposed by District Officer Bell, who felt it added to his work to have a European missionary there. Despite the progressive subjugation of the lamo across Malaita,

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13 The Andersons worked on Telina in Marovo Lagoon for 12 months from 1920 to 1921(Anderson 1980a). They then transferred to Viru (the location of the first SDA mission station in the Solomon Islands in 1914) for two years (1980d). While at home in Australia on furlough in 1923 they were asked to transfer from Viru to Malaita (1980d:11). They published an 18-part memoir in the SDA publication the *Australasian Record* in 1980/1981, and I have drawn extensively from this for much of the detail here.
establishing the SDA mission was seen as a dangerous enterprise by the missionaries. Cormack, an early SDA missionary noted:

Being more virile than the darker-hued natives of the Western Solomons, Malaita’s population of more than sixty thousand people is drawn on extensively for plantation and shipping labour. A cruel, hot-headed, and treacherous people, bound by an intricate system of superstitious and 
tambus, the Malaita man is very difficult to approach with Christian teachings. He resents any encroachment on his customary habits, whether they come from government officials, traders or missionaries. The history of Malaita since the advent of the white man has been written in blood. Even today the white man walks the bush roads at his peril and must guard meticulously against violation of the many mysterious tambus to be met on every hand (1944:199).

Anderson was alarmed when, within a few days of arriving, he discovered human bones including skulls in the area the mission had been given to establish. He was subsequently told the land was an old cemetery (Anderson 1980f:11). It is little wonder Anderson found few Kwaio willing to help him build his house:

It was soon evident that we had come to live among very different natives from those of the Western Solomons. Every respect was shown the missionary in the West; here it was not so. Nobody came to build or help in any way on this, the first day, and very little help came during the months which followed. Instead of our house being ready for occupation in six weeks, it took us six months (1980f:11).

When the SDA station, known as Lokai, became established the people of Uruilangi grew concerned that Anderson might face the same fate as Daniels and that this might again instigate the destruction of their island by the government. Anderson recalls:

One morning we awoke to find the people in great distress. They were frightened, and they all nervously talked at once and some cried, while others ran about as if trying to escape something. Our engine-boy felt that he had definitely pulled his canoe well up on the shore, and now it had gone. For sure, the “bushmen” had taken it, with plans to use it to row over at night and kill us as they had Mr Daniels of the South Sea Evangelical Mission a few years earlier. We tried to persuade them that the tide could come in very high and take it. But there was no hope of consoling them. They were terrified that we would be killed and the Government would send a big ship and, not knowing it was the bushmen, would blow their island up. They then would have to go to the mainland and be killed by the bushmen, their dreaded enemies. We sent the boat out to search the sea and in a few hours the canoe was sighted, drifting helplessly. Soon it was towed to the mission and the peace was restored (1980g:10).

As Anderson established the SDA mission in Uru there was little growth of the fledgling skul. There was, however, a constant link between health and the Christian enterprise. Additional to their theological training the Andersons had ongoing medical
training. “Furlough had been spent at the university, studying tropical diseases for six months; another was spent studying dentistry, and so on” (1981e:11). Medical work became a part of everyday life for the missionary.

“Appalled by the diseased condition of the people of the interior, Pastor Anderson with his medical kit cautiously penetrated deeper and deeper into the jungle. In their villages he gave simple treatments; then he unrolled a set of Bible pictures and gave simple talks” (Steed 1970:56).

Anderson stated, “the more we became acquainted with the language and customs, the wider the area we were able to cover, in our endeavour to bring physical and spiritual aid” (1980f: 11). The Andersons built a leaf veranda on the gable end of their home for “school, giving of medicine, and all native work” (1980g:11). “Early pioneer days saw some crude treatments and surgery, but the Lord used it all as a very powerful and efficient means of healing” (1980g:10). This was not only an efficient means of healing but also of increasing the numbers at the small mission station. Anderson outlined how a young man from the ‘inland’ came to Lokai to seek medical attention for an ulcer on his lower leg. They treated him by applying several doses of sugar directly onto the wound and then removing the ‘proud flesh’ with a strip of bamboo. “When he was almost cured, we invited him to be our cook-boy. He readily accepted, but had no ideas what this meant. We began schooling him” (1980g:11).

As exemplified above treating ailments was not only a means of bringing healing to the individual, but was also a spiritual battleground, as described by Cormack:

In pre-mission times the witch doctor, or medicine man, was frequently called in the case of sickness, and it’s known that he often traded on the credulity of his patients, and that he was himself was aware that many of his charms and incantations were mere trickery. The influence of superstition probably explains the indifference often displayed to the welfare of the sick and injured (1944:244).

It is ironic that three pages later Cormack writes:

The missionary must be prepared to turn his hand at many revolting tasks. He is often called upon to attend cases that are well outside his limited scope of medical knowledge, but in such cases he does his best, and where knowledge fails, the power of God is especially felt bringing about the desired result (1944:247).
Norman Deck and the SSEM missionaries at the nearby Ngongosila Island watched Anderson and the newly established SDA station at Lokai in Uru with suspicion and actively opposed their doctrine and methods (Burt 1994:157). (The SDA mission was not to establish itself in the nearby SSEM stronghold of East Kwara‘ae until the mid-1930s when an evangelist from Choiseul gained converts at the coastal village of Busu‘ai. (Burt 1994:157)). Deck claimed that SDA practice in Uru was to attract and obligate converts by offering presents and only later introduce tithes and arduous rules against eating pigs and other foods. Interestingly food taboos are a common occurrence in Kwaio practice, with ancestors placing restrictions on specific foods for particular descendants. Deck stated that the SSEM could not imitate the SDA by offering presents but felt they would need to be liberal with their medical attention to offset this (Deck 1927 Anderson outlined such a situation when a man arrived at their house:

He wanted a slash knife. She [Mrs Anderson] told him we were not traders, nor were we here to sell things. We were missionaries who taught school and taught about God... “You come to school here,” she told the man, “and you get mission knife to do work on the mission – but you can’t take it away. You must stop here, at school, read and write and work along mission. No more (1981d:11).

Despite this opposition from the competing mission and the failure of the Kwaio to convert in any significant numbers, the small mission station at Lokai persevered. Although the Andersons were able to administer their ‘crude treatments’ to local people, their ‘powerful and efficient means of healing’ seemed not to cover themselves and in the first year they both succumbed to sickness which required they return to Australia. This was not the first time serious illness had inflicted the Anderson family while in the Solomon Islands. In 1922, while living at Viru, New Georgia, Guinevere and their first born daughter Myrtle who was one year old, were admitted to the government hospital in Tulagi and returned to Australia for treatment of malaria. Guinevere returned after 4 and a half months and Myrtle spent 12 months with her maternal aunt in Australia. She was reunited with her parents during their furlough to Australia in 1923 and returned to Malaita with her parents (Anderson 1980d). Throughout Anderson’s memoirs sickness was a common theme within their family, particularly malaria. Steley (1983:209) states that of the 43 SDA European missionaries in the Solomon Islands from 1914 – 1942 nearly a third (at least 13) were
permanently repatriated to the ‘homeland’ because of health problems. This did not include those who returned temporarily to recover from health problems or those who died.

On his return to Uru, Anderson oversaw the SDA mission as it slowly grew. The first SDA baptism, of “Jackie and his wife” occurred at Lokai in 1926 (Steley 1983:63). They were not from Kwaio, but north Malaita and had accepted the SDA mission while working in the Western Solomons. They had returned with Anderson to establish the mission at Uru. By 1927 the SDA missionaries had established a mission “forty miles to the north” (Anderson 1980h:6). In that same year the mission had also “placed a teacher” in nearby Port Diamond (Sinalagu Harbour), and they were visiting there on the mission ship the *Advent* on 4 October 1927. This was the day that the Kwaio lamo Basiana stepped into the line to pay a tax to District Commissioner Bell at Gwee`abe, a small peninsula of land protruding into Sinalagu Harbour, and killed him with a single blow from an old rifle barrel.¹⁴ Within three or four minutes Bell’s cadet K. C. Lillies and thirteen Solomon Islanders were dead (Keesing and Corris 1980). This day has defined Kwaio history, becoming the reference point for most of the historical, political and religious undertakings in the almost 80 years since.

Today, the Bell killing and its aftermath remain a key touchstone in the Kwaio definition of themselves in relation to the outside world. When analysing subsequent Kwaio history or modern Kwaio politics, to forget about the events of 1927 virtually assurses misunderstanding (Akin 1993:154).

A day earlier, on 3 October, Anderson and the head of the SDA mission Pastor Peacock were returning to Uru after a visit to a new SDA village along the northeast coast, when they saw the government ship *Auki* leaving Uru *en route* to Sinalagu to collect taxes there. Bell and his crew had just taxed the people of Uru. Anderson and Peacock knew there were threats made against Bell and his party, and that pigs had been sacrificed to gain supernatural guidance and power for an attack (Anderson 1980h:6). Bell also knew the danger; he had been threatened on many occasions

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¹⁴ There had been an attempt on Bell’s life two years earlier (October 1925) in East Kwara`ae when the warrior Ngwaki from 'Ere`ere struck Bell in the face and broke his glasses. His attack was provoked by the imposition of the head tax, however it was ill-conceived and Ngwaki was arrested and jailed in Tulagi (Burt 1994:153).
(Keesing and Corris 1980). There was widespread anger and hostility over the newly imposed head tax, as Anderson recalls:

“Many of the old men, on finding out they could not buy anything with their [tax] receipt, were disgusted. “What name this government?” they muttered. “He steal im money belong we fella. We falla no give more money along im – nothing!” (1980h:6).

There had been a confrontation between Bell and Basiana during the 1926 tax collection. Basiana resisted paying and thereby refused to yield to government control. The tax was set at 5 shillings. Jonathan Fifi`i (1989:7) gave a widely recalled account of what happened:

When the tax was collected, Basiana had given four shillings to Mr Bell instead of five. Mr Bell had said, “No, you have to pay five shillings – that’s the law!” Basiana had said “Five shillings are impossible for me. I’m a man from the bush and I haven’t gone to the plantation – where could I earn a fifth shilling? I’ll give you an important valuable, instead of five shillings.” Mr Bell refused “No. You go back. You go back this afternoon and look around for a fifth shilling. Then you bring it back. You have to pay the tax tomorrow.” So Basiana climbed the hill, thinking to himself. He went all the way up to the bush, to his own place, high in the mountains at Gounaile.

When he got there, he went to his men’s house and got his crescent pearl shell: a sacred shell chest pendant inherited from his ancestors, and consecrated to them. At first he thought he might trade that dafi for someone’s shilling. But then his mind turned another way. He was really angry. He took his dafi, consecrated to his ancestors, and smashed it to pieces. He took one of the pieces from the smashed pearl shell and began to grind it down. All night long and into the next day he ground and ground and ground it down, until by dawn it was the same size and shape as a shilling piece. So he had those four shillings, four pieces of money, and his fifth was the piece of dafi. At dawn he went down to Gwee’abe, where Mr Bell had the tax house built. He went to Mr Bell and put the four shillings and the piece of shell down on the table in front of him. “Mr Bell, the one shilling was impossible for me. But this is my own shilling, one I ground down. You want money with the head of your king on it. But this shilling I ground for you is consecrated to my ancestors; your fifth shilling has been passed down from my ancient ancestor. You have to accept it! You can’t refuse to take it!”

Mr Bell could not believe it. “Oh you bastard. Don’t you do it again! I want five real shillings. Not a piece of seashell like this.” “This isn’t just an ordinary shell. It’s just the same size and shape as those shillings of yours. But yours have your king on them, and mine has my ancestors on it. This is my fifth shilling” “It’s all right for this time, but don’t you do that again. Next time I will put you in jail.” Basiana was very angry about that. “I’ve broken up that important dafi passed down by my ancestors, and Mr Bell doesn’t even think it’s worth anything”.

15 Although this is a common (and published) account of the events prior to Bell’s killing, a key informant of David Akin’s living in Basiana’s hamlet at the time of Bell’s killing dismissed this dafi story as apocryphal. It is nonetheless clear that Bell did call Basiana a bastard, which had a major impact on him and his subsequent actions (Akin personal communication Aug. 2005).
There were several bounties posted for the killing of a white man to avenge the deaths of Kwaio men in the recent past, and there was also widespread anger because “bush” people (Kwaio: *ta’a i busi*) had been jokingly disparaged as *ta’a i bisi* (menstrual hut people) by some coastal Christians. Stating men come from the *bisi* constituted a serious curse. This was all influencing Basiana.

Basiana brooded about the possibility that he could collect all three lots of blood money – shell money and pigs – if he killed Mr Bell. He also brooded about that *dafi*. And he brooded about that curse Mr Bell had made, calling him a “bastard”, and about the curse where people from the bush had been called the “Bisi” people. Basiana put all those things together in his mind, and he called the warrior leaders together...”Let’s kill him! Let’s kill him and collect those blood bounties!” So they began to plot to kill Mr Bell (Fifi’i 1989:8–9).

Anderson and Peacock wanted to meet Bell to discuss leasing land for the mission in Uru Harbour. After seeing the government schooner *Auki* heading for Sinalagu on 3 October, they sent the *Advent* to anchor in Sinalagu and walked overland across the isthmus that separates Uru and Sinalagu, visiting several villages along the way (Anderson 1980h:6–7). Anderson remembers:

We met a man at one village who had been to Mr Bell in Diamond Harbour to pay five shillings. When Mr Bell gave him his receipt, he told the man to get back to his village and make room for the men who were coming down to kill him! (1980h:6)

Anderson and Peacock arrived at Sinalagu and spent the night on the *Advent*. The morning of 4 October, they went across to Gwee’abe to meet with Bell and his party. The recruiting ship *Wheatsheaf* was there since its master Bonnard was trying to arrange a land lease with Bell (Keesing and Corris 1980: 131–132). Anderson and Peacock found Bell and his cadet Kenneth Lillies at the tax house with Bonnard and “about twenty-five native police” who were well armed with rifles and revolvers (Anderson 1980h:7). The missionaries were told by Bell that the application to lease land was only acceptable if prepared on recognised forms. Bonnard volunteered to accompany the two to his ship to get them.

About to leave, we looked up to the top of the mountain where we could see a long line of natives approaching. During the time we were with Mr Bell, a group of natives needing injections had assembled on the deck of our boat. We began preparing to attend to them. By the time we had everything in readiness, a long line of warriors passed along the beach track only a few yards from where we were anchored. They carried old rifles which they had been ordered to bring in, as well as their five
shillings tax. They also carried clubs, spears, bows and arrows, long slash knives – everything they could find to help them with their plan (Anderson 1980h:7).16

Bell then lined the group of men up and continued to collect taxes. To show he was not afraid, and on the urging of one of his Malaitan police officers, he sent all but five of his constables into the tax house behind him (Anderson 1980h:7; Keesing and Corris 1980:133–134). This was seen as unwise, as Anderson (1980h:7) recalls:

Our own headman from the district called out from where he was resting under a tree, just over from us: “Mr Bell – don’t you stop there! You go to your boat and have the men taken over to you, two by two, in your dingy!”

Bell refused the advice, thinking to do so would be a sign of weakness. Anderson treated patients on the *Advent* until his syringe broke, after which he handed out ointment. He then moved to Na`onaatala near the harbour entrance (Anderson 1980h:7; Keesing and Corris 1980:133). As Anderson was leaving Bell addressed the Kwaio warriors:

I’ve come to collect taxes today. My police say they can see you’ve come to fight with us today. But I don’t want to fight with you. I told them if you wanted to make trouble with us you’d have to start it yourselves. We’ve come in peace. (Bell in Keesing and Corris 1980:135–136)

Basiana told the warriors to put down their weapons and pay their tax. Basiana and his kin lined up and paid without incident, but unbeknownst to Bell the warriors were taking up attack positions. Basiana then rejoined the tax line, this time with the barrel of his rifle, which had been consecrated to his ancestors and wrapped in leaves. When Basiana arrived at the front of the line, he brought the rifle down on Bell’s head, killing him instantly. The ensuing mayhem lasted only a few minutes as about 30 Kwaio warriors attacked the party. Those involved were a minority of the more than 200 men present and not representative of the several thousand Kwaio people living in the mountains, most of whom had nothing to do with the attack. Lillies and 13 Solomon Islanders from the party were killed. Several escaped by swimming back to the *Auki* and the *Wheatsheaf*. One Kwaio warrior was killed and six seriously injured, one of whom later died (Keesing and Corris 1980:135–145).

16 Men always bore weapons wherever they went, whether or not they intended to fight. To this day men routinely carry weapons including clubs, bow and arrow or large knives, and indeed it is abnormal to see a weaponless man.
Anderson and Peacock were near Na’onaatala when they were told by two separate groups that Bell and his party had been killed. They dismissed this as rumour until “we were met by two of our own boat’s crew. They had come to tell us what happened, and to see us safely back to our boat” (Anderson 1980h:7). As they returned to the Advent, they saw Bonnard approaching on the Wheatsheaf and were soon joined by the Auki, which carried the bodies of Bell and Lillies wrapped in canvas from the Wheatsheaf (Keesing and Corris 1980:149).

As we talked, the government schooner in charge of the boatswain arrived. We looked into the cabin and there were the two men very carefully wrapped in canvas. After a quick conference, it was decided to take the two white victims to Ngongosila, an Island about forty miles to the north. The men would be buried alongside some of the Europeans who had suffered the same fate years before (Anderson 1980h:7).

The burial service for Bell, Lillies and one native constable who died between Sinalagu and Ngongosila was attended by the SDA missionaries as well as SSEM missionaries Norman Deck and his sister Joan (Anderson 1980h:7). Upon return of the Advent to Uru “the local natives were very restless and fearful. They fully expected reprisals and began calling upon the spirits of their ancestors. They also sought advice from us” (Anderson 1980h:7). A meeting was scheduled for the next day to discuss the situation with the residents of Uru. Several hundred people gathered, and Pastor Peacock gave the following address:

I have only one thing to say to tell you. Go back to your homes. Gather all your belongings and leaves to cover your new houses, and come back here quickly! Then build new houses near the water, so the soldiers who will come can easily meet with you. Of course, if you have been with those who did the killing, you must go to the Government and tell just why you were there. When everything is straight, you and your people will have nothing to fear (in Anderson 1980i:10).

Thus began a mass movement of people from the mountains to the coastal fringe and the beginning of a major Christianisation process in Uru and all of East Kwaio (However most people returned to their mountain homes and ancestral religion in subsequent years, leaving only small Christian settlements on the coast).

Scarcely had the words been spoken, before the bush tracks were full of nervous men, moving at full speed to their homes. Before the day was over, houses were rising in quick succession. Pigs were squealing, dogs barking, fowls cackling, cats meowing,
as their owners, with full-sized loads of vegetables, water pots and babies, trudged toward their new places of abode (Anderson 1980i:10).

When the news of the assassination at Gwee’abe reached Tulagi, Resident Commissioner Kane was on tour and Secretary to the Government Captain N.S.B. Kidson was in command – “A man whose ignorance of the realities of the Solomons was profound, and whose judgment proved less than sound” (Keesing and Corris 1980:150). The events were distorted by Kidson and rumours of the death of missionaries on Malaita were passed on as fact. Anderson (1980i:10) recalled a few days after the assassination a ship approached their mission station:

A dingy under gun cover, came to shore, bringing a leading Government officer from headquarters in Tulagi... As I moved toward him, he thrust out his hand and caught mine saying, “Allow me to shake hands with a dead man! To all at Tulagi, you and your wife and two children are dead. We have come to collect your belongings!”

The government officer urged the Andersons to leave Malaita and return to Australia. When they refused he made them promise to move onto their boat the Advent and not sleep at their station. Moving aboard the Advent was made easier by the warning received earlier that day from Norman Deck that their lives were in danger. They had been warned several days prior by local people that the murderers were going to come and destroy all the missionaries (Anderson 1980i:10). The Andersons took up an offer by Deck to assist them in preparing their boat, and so made their way to Ngongosila for a day and night. Wire netting was placed around the thirty-one-foot ship to keep the children from falling overboard (Anderson 1980i:10). When I interviewed Mrs Mertyl Hermann (nee Anderson) in November 2004, she recalled as a small girl being terrified of the events happening around her and spending several weeks with her family on a small cramped boat, only being able to go ashore periodically. Despite not utilising their land base and living on what became known as “the fowl house boat” they continued their missionary endeavours along the east coast of Malaita (Anderson 1980i:10).

Twelve days after the massacre, on Sunday, 16 October, the Andersons were at a newly established mission village inside Sinalagu Harbour when: “Hardly believing our eyesight, we saw the entrance blocked by the cruiser, HMAS Adelaide, as the vessel passed slowly through the narrow passage” (1980i:11). This was the beginning
of the infamous punitive expedition which has reverberated throughout Kwaio and Malaitan life ever since. The Australian warship was requested by the British Colonial Office to lead the retaliation, since many in the government, plantations and missions feared a general uprising (Keesing 1992:65). Many European planters, mainly Australians, volunteered for the punitive expedition. They quickly became known as the ‘Breathless Army’ or ‘Whisky Army’. Together with the marines they were ineffectual as they cursed and sweated their way up the steep mountain slopes, many collapsing before they reached the top of the first ridge (Keesing and Corris 1980:160). They burned and pillaged the settlements they found, but most were already deserted, their residents either having fled to Christian villages of coastal kin or into the mountainous interior (Keesing 1992:66). After a few weeks the European forces were debilitated by the conditions and weak with disease, but had not got near any of the fugitives, who knew the terrain and how to survive from food available in the bush. The real danger to the Kwaio fugitives lay with the North Malaitan police. More than 880 Malaitans, mainly from the north, had volunteered to help avenge Bell and their kin who had been killed with him (Keesing and Corris 1980:156). These men knew they now had an opportunity to gain vengeance against the Kwaio under the auspices of the colonial government. The Malaitan police patrols wrought havoc in the Kwaio mountains with full knowledge of the British officers. They had guides from the coastal Christian villages and with their knowledge of Kwaio customs, they were able to desecrate and destroy many Kwaio shrines and sacred objects, throwing ancestral sculls into women’s menstrual huts and women’s menstrual mats into shrines. Women were gang-raped, men, women and children were shot on sight and prisoners were arbitrarily executed. Gardens were poisoned with herbicide, pigs shot and shell valuables stolen. To put an end to the punitive raids most of the fugitives surrendered to the headmen and by the end of December all but one had surrendered (Keesing and Corris 1980:148–183). Fifi`i (1989:14) recalls:

Basiana saw all this happening. Nobody captured him, nobody bound him up. He came down of his own accord. He saw innocent old people and women and children being killed, shot down in cold blood. He saw his people dying of exposure from living in the bush and moving from place to place. So he just came down himself, and surrendered at Uru: “I’m Basiana, the man you want”. Other warriors being hunted by the police came down by themselves and just surrendered.
About 200 Kwaio men were imprisoned in Tulagi, where thirty-one, many of them innocent of any crime, died in a dysentery outbreak. Six warriors, including Basiana, were condemned and hanged. Fourteen were handed long prison sentences (Keesing 1992:71). Exactly how many Kwaio were killed directly in the punitive expedition is unknown, but Keesing and Corris (1980:178–180) put the number somewhere between sixty and sixty-five. This does not include some killings that occurred in the ‘Oloburi and Uru mountains or further afield. Kwaio accounts put the death toll from across Kwaio at over 2000. They include not only the people shot and killed, but also those who died in Tulagi, children who died of exposure and hunger hiding in the rainforest, and deaths as a result of accidents or illness from ancestral punishments for the desecrations of shrines and sacred objects. They also blame the punitive expedition for taro blights that wiped out the staple crop in the 1930s and 1950s (Keesing and Corris 1980:182; Akin 1993:230). Many people believe they are still suffering misfortune, and a general weakness of Kwaio society due to the ancestral wrath caused by the desecrations.

The government, embarrassed at the reports of the punitive expedition, dismissed Anderson’s reports of the atrocities as misleading. Stanley Masterman (later Malaita’s District Commissioner widely reviled by Malaitans for brutality), was temporarily assigned as the Gwee’abe Base Commander, and wrote in a report in late 1927:

I found it necessary to take steps to suppress Mr Anderson, the Seventh Day Adventist Missionary at Uru. He was making exceedingly wild statements regarding the number of casualties sustained during the expedition for arrest of the murderers. (in Keesing and Corris 1980:180).

Anderson (1980i:11) recalls:

As with war of any kind, the innocent suffered at times. Reports of bush happenings filtered through … Women and children, to avoid hunger, braved their way to their own gardens only to be shot dead. When this became known, a “hush, hush” was tried, but to no avail. The news reached the “heads” and an investigation was made. Certain reports were proved to be true.

By this time Anderson had returned to Lokai after eight weeks on their boat and as the punitive expedition continued, hundreds of people continued to present themselves to
Christian villages for protection. This increased the need to place ‘teachers’ in villages. Anderson went to the village of Gwagwa’ekwala and:

Pointed out clearly to all present that I would take down the names of all those present that I would take the names of all those who desired to live as mission people. But on no account must they give me their names if they had been in any way connected with the massacre (1980j:10).

Despite people coming to mission villages, ‘native soldiers’ came and arrested suspects. The SDA mission village of Gwagwa’ekwala was targeted—in the first raid forty arrests, the second twelve, and in the third four. Those left behind accused the mission of assisting the government in arresting the suspects. Anderson denied this and pointed to how he had only included those on his list who had not been involved in the assassination (Anderson 1980j:11).

Peacock wrote of Kwaio in early 1928:

Our work around that centre had developed in a wonderful way since the trouble started, and many definite calls for missionaries are now coming in from folk that we never heard of before. The prospects for Malaita look very bright and we think this is the beginning of a big work down there (1928:3).

Although most people living in the mission village attended “morning and evening worship,” and Gwagwa’ekwala was known “far and wide for its good houses, green lawns and maternity hospital” (Anderson 1980k:10), they still adhered to “solidly encased heathen customs which held the people” (1980j:11). This was the case in most coastal villages where bush people lived as nominal Christians for the years after the punitive expedition. “Doubts as to the power of the heathen spirits began to be seen more and more, as younger boys and girls in their teens came regularly to school” (1980k:10). As the situation settled, many returned to their mountain homes and their ancestral religion. Sacrifices were required of them to appease ancestors

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17 Although Anderson lists a ‘maternity hospital’ as part of the infrastructure located at Gwagwa’ekwala, this would most likely have merely been a location to give birth, rather than a ‘hospital’. There is no record of any trained medical personnel at the mission at the time. Steley (1983:47) notes, “When better trained islanders became missionaries they were given instruction so that they could provide a rudimentary medical service in the form of dressing of wounds and dispensing of simple treatments”. There are numerous examples of this throughout Anderson’s memoirs of the establishment of the SDA mission on Malaita. SDA mission stations in Melanesia provided transport, education, medical, employment, social and religious facilities for the surrounding population and often operated as a “mini states” (Steley1989:132).
angry at the soldiers’ desecrations of shrines and other taboo violations. The economic cost was great and decades later considerable resentment remained toward the groups involved in Bell’s assassination; some are still angry today.

The relationships and interactions between the bush people and coastal Christians remained volatile over the ensuing years. This exacerbated problems in the struggling SDA mission which, despite attempts to increase numbers, continued to lose converts. Anderson (1981b:11) remembered, “One day my wife said to me: ‘Death seems to follow us wherever we go – at Makwano, Uru or Sinarangu (sic) – mountain, river or coastline. What is it? We have an army of converts under the soil, but hardly one living!’” In hindsight this seems prophetic. On 15 May 1929, while the Andersons were attending committee meetings at the SDA mission headquarters at Batuna in the Marovo Lagoon, one of their teachers, Simi, from Ranoga in the Western Solomons, was attacked and his wife Meri (from Marovo) and a Kwaio convert were murdered. This occurred at Kwalakwala, the first satellite SDA mission station in Uru. The missionaries claimed the Kwaio convert, Akuasia [`Akwasia], had been instructed by her uncle to carry material for a pagan feast he was planning, but she refused stating she wanted to be a ‘mission girl’ and “No more return to the ways of the devil” (Anderson 1981c:10; Cormack 1944:204–209). Anderson continued, “If you do not obey, your brother says if he meets you on the road, he will murder you!” the old uncle told her” (1981c:10). Jonathan Fifi`i (1989:43–44), an SDA himself, gave a Kwaio perspective of the incident:

His [Simi’s] wife had been killed at Uru by a Kwaio man named Oongi, the brother of Headman `Adi [Maenaa`adi]. Oongi’s close female relative wanted to marry a young man from Marovo. Oongi tried to prevent this, but people there said this was now the way of the mission. Oongi tried to prevent it, but those two really wanted to get married. So Oongi got very angry and killed the girl who wanted to marry the Marovo man and killed Simi’s wife as well.

In another Kwaio account given to David Akin in 1996, Ma`aanamae, who was at the scene, explained that Oongi murdered `Akwasia due to a dispute over the correct amount of bride price paid by a young man, Waku, from Marovo. Oongi was unhappy with the outcome, particularly his share, and went down and murdered `Akwasia (Akin, personal communication, 4 Nov. 2004). Missionary accounts give other reasons: “Vakukana is the second boy. He was to have married `Akwasia. The
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murderer is now claiming that it was because of their engagement that he committed the awful deed, but we know that it was because the girl refused to return to heathenism” (Cormack 1944:208). What is clear is that Western Solomons teachers continued to seduce Kwaio women over the next decade, which resulted in damaging the mission’s reputation and eventual removal of all Western Solomons teachers from Sinalagu by 1940 (Sandars 1937:3; Akin 1993: 227, 279).

All accounts agree that ‘Akwasia was murdered in the mission house; Simi’s shoulder was injured by the barrel of Oongi’s rifle and he escaped; and Simi’s wife Meri had her skull crushed by Oongi’s rifle while trying to run away (Anderson 1981c:10; Cormack 1944:204–209; Ma’aanamae 1996). Headman Maena’adi brought his brother Oongi in and handed him over to the ‘soldiers’ (Ma’aanamae 1996). He was taken to ‘Aoke, then to Tulagi (Anderson 1981d:10; Cormack 1944:207–208), where he was hanged (Ma’aanamae 1996). After Simi recovered he worked at Uru for a short while, then was transferred to Funafou in Lau Lagoon (north Malaita) to start the SDA mission there (Anderson 1981d:10; Steley 1983:65–66; AR 22 July 1929:8). Despite marrying one of his converts from North Malaita he suffered considerable hardship there, including an attempt on his life soon after arriving (Anderson 1981d:10–11; Fifi’i 1989).

Anderson’s term on Malaita finished in 1930 and he was transferred to Ranoga in the Western Solomon Islands.18 There was no European SDA missionary on Malaita until late 1932 when A. F. Parker was posted to Kwalabesi on the coast of Lau Lagoon, close to where Simi was working, to take charge of the SDA mission on Malaita (Steley 1983:66-67, 152–153). The mission in Uru and other parts of Kwaio continued under the leadership of teachers from the Western Solomons. This proved problematic throughout the 1930s and despite intense opposition from both Uru and Sinalagu against Western teachers being posted there, the SDA mission continued.

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18 Anderson remained in the Western Solomons until 1938, when he was transferred to New Zealand and then to Australia. He returned to the Solomon Islands as Superintendent of the SDA mission in the Solomon Islands and Bouganville in 1949. In 1950 the mission organisation was split into Eastern and Western sections with Anderson leading the administration in the Western territory, where he returned to Batuna in Marovo. He returned home to Australia later that year (Anderson 1981e:10). He died in Brisbane in July 1967 (Parmenter 1967:14, Anderson 1996:23).
At Sinalagu, Alizama, a married man, seduced a girl at Sinalagu and ran off with her to Kwailabesi. He was dealt with by the court, and later, bush natives of Sinalagu to whom the girls was related asked me [District Officer] to request the mission to place no more Western natives at Sinalagu. I discussed the matter with Mr Pascoe….

Later this year proposals were made to marry the girl seduced by Alizama to Simi, a native of Ranonga, Gizo. Simi was involved some years ago in an affair which ended in the murder of an Uru girl and Simi's wife by an Uru bush man, and the conviction and hanging of the murderer. The pagan relatives of the girl he now wished to marry raised the strongest objections, and the matter has, as I believe, been dropped.

A few days ago I visited Sinalagu and yet another Seventh Day Adventist teacher, Lilopio of Kolobangara seduced another local girl at Uru. When I arrived at Sinalagu feeling against SDA western teachers was running very high indeed (Malaita District 1939).

Western teachers were removed from Kwaio in 1939, however in 1940 they were returned by Ferris and Pascoe. Steley (1983:218) states “The Solomon Islands Mission Committee minutes reveal a steady flow of actions throughout the 1930s dismissing teachers because of ‘misconduct’”. The district officer explained:

I was again approached by elders of Kwailalae, Wariu and Kwangafe [Kwangafi], from which lines unmarried girls in the SDA village come. They asked why Ililingora had returned, and that he should again be removed. I spend considerable time talking to them, and it was quite clear that there has been no relaxation in their feeling against all western teachers, of whom they want none to remain. I felt similar feeling at Uru (Bengough 1940a).

Such incidents were not uncommon and “resulted in a double murder, a hanging, and several other incidents after which Bengough [Malaita District Officer] removed all Western Solomons teachers from Sinalagu for their own safety” (Akin 1993:227).19

There had also been controversy two years earlier in 1937 when the SDA mission had attempted to impose a bride price limit of three shell valuables (Sandars 1937:3).20 When dissatisfied relatives challenged the imposition, one father, who had joined the SDA mission in 1927 after the Bell assassination, told his daughter to elope and run

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19 This was not the first time the SDA mission had to face issues of ‘moral lapse’. In 1922, Jack Radley, the European engineer on the mission ship the Melanesia based at Batuna was dismissed from mission service after being ‘involved with a Marovo girl’. He remained in the Solomon Islands for several years after this working for a trader (Steley 1983:213). Steley (1983:279) also lists Walter Broad the SDA mission superintendent 1934–1937 as departing the Solomon Islands after a ‘moral lapse’.

20 There remains controversy over bride price to this day. Although many of the Christian denominations place limits on the amount of bride price, and it is against ‘church policy’ to demand a particular amount of bride price, there seems to be no limit to the amount a family can give for bride
away. The District officer, G.E.D. Sandars, heard the case and judged in favour of the bush relatives, stating the marriage was not satisfactory until a bride price could be negotiated. Sandars then told the concerned men he would back the girl’s relatives to get a fair bride price and that they were responsible for negotiating the fair bride price, not the mission (Sandars 1937).

During this period the SDA mission faced opposition from not only those retaining ancestral religion but also the other proselytising Christians at the SSEM. Members of the two churches were recorded brawling “with rulers and fisticuffs” over theological matters (Sandars n.d:122 in Akin 1993:227). This was not new as there had been considerable tension between the SDA missionaries and the Methodists, led by Rev Goldie, in the Western Province in the previous decade (Steley 1983:222–262). In 1933 Malaita District Officer J. C. Barley reflected, “The bitter rivalry and competition between missions are the direct and indirect cause of at least fifty percent of the troubles and squabbles which the district officer is called upon to settle” (Barley 1933 cited in Akin 1993:227–228). SEM missionary Norman Deck wrote:

Adventists do not observe comity of missions. So it is common experience, alas, that they often try to reach converts already won for Christ, endeavouring to deflect them from the mission body which God used for their conversion to become Seventh Day Adventists, often using questionable means to this end, such as offering them higher remuneration than they will have received if they will come over (Deck n.d. cited in Steley 1983:240).

There was also concern that the SDA mission was losing converts. Missionary Norman Ferris (AR 7 July 1983:2) wrote in 1938 that young Malaitan SDA converts were signing onto recruiting boats as soon as they were old enough “and somehow we lose grip on them”.

price. Thus the asking of bride price (and in some cases accepting) is deemed to be wrong, but the giving is without problem.

Although I have never observed ‘rulers and fisticuffs’ between the SDAs and other denominations during my time in Kwaio, there is certainly a lingering bitter rivalry and competition for souls which continues to create animosity in the community. During the 1990s there were several instances where bitter theological battles raged after SDA staff at Atoifi presented divisive SDA doctrine prior to public health talks on the front lawn of Atoifi before outpatients being opened on market day (Wednesday mornings, when there are often several hundred people waiting for the various clinics offered at the outpatients department). See Record 30 Mar. 1991.
In 1934 Arthur Parker, SDA missionary based at Kwalabesi, returned to Australia and married Dr Dorothy Mills after his first wife had died in 1930 at Batuna from childbirth complications (Steley 1983:149). They returned to North Malaita and established Kwalabesi Adventist Hospital. Thus “began an energetic, medically oriented approach to mission work which began to break down barriers resulting in an acceleration of accessions to the mission” (Steley 1983:66). Though the base of the European SDA missionaries was no longer at Uru, they continued to be influential in the progression of the mission and health services there.

**Mission Medical Services**

Medical endeavours started as a part of the Protestant mission strategy in the 1840s with much of the initial impetus coming from the Edinburgh Medical Mission Society.

“...The combination of preaching with medicine was widely hailed as an ‘integral and essential’ part of the Christian missionary enterprise, a demonstration of the ‘gospel in action’ and – because cures often led to conversions – a proven agency of evangelism” (Hilliard 1978:267).

The first permanent hospital in the Solomons was started by the Melanesian Mission at Maravovo on Guadalcanal in 1913, but was closed three years later in 1916 when the doctor was recruited for war service (Hilliard 1978:267). In the 1920s the only colonial medical service was a two-doctor medical department of the BSIP. Missionaries from all missions were attracted to the idea of mission-run medical facilities.

The SDA church coming from the protestant tradition has, from its very beginnings had a strong health emphasis. The SDA founders, puritans of the mid-1800s in North America, differed from other religious groups established at the time in three ways. The first two were theological (the second coming of Christ and observance of the Seventh Day Sabbath), and the third was the principle of health reform. Health reforms became a part of a healthier lifestyle that included abstinence from alcohol,

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22 Early missionaries claimed that for uncivilised peoples who knew no better, there was no need for professional treatment. One of the founders of the Anglican Church in the Solomon Islands John Selwyn wrote: “There is great virtue in Epson Salts administered with no niggard hand; castor oil, poured out of the bottle into the mouth, can hurt no one; Cockle’s pills painkiller, are potent remedies. And, above all, nursing and hot water are unknown quantities in most wild lands” (Selwyn 1896 cited in Hilliard 1978:267).
tobacco and other drugs, moderation in eating, promotion of vegetarianism (although there was tolerance of ‘clean’ meats according to Old Testament rules), therapeutic reform and dress reform (Steley 1989:14). Initially the reforms were for the SDAs themselves, although they soon became used to convert people to the church. This was despite “The Adventist leadership in the 1850s [being] a sickness-prone clique of zealots whose grinding devotion to the task of spreading their Remnant message frequently left their membership depleted through ill health” (Steley 1983:9).

The first SDA health institution established in Michigan in 1866 was intended to allow those who frequented it to “become acquainted with the character and ways of our people, see a beauty in the religion of the Bible and be led into the Lord’s service” (Damsteegt 1977:238). The church expanded rapidly over the next half-century, and opened the College of Medical Evangelists in 1909 for “the sole purpose of evangelising the world more rapidly through the work of the physician and other health workers” (Neufeld 1976:1042–1043). The health reform message became central to SDA theology and an essential tool in proselytising throughout the world, including the Solomon Islands. As Steley (1983; 1989) explains this message was, in part, used by the fundamentalist organisation to reinforce the idea that their religion should be a whole-of-life experience, both physical and spiritual. The SDA lifestyle was a unique package, meaning they would be both physically and spiritually set apart from the community, and would see the community of believers as their family. This often meant alienating kin and other social ties, perceived by outsiders to be extreme asceticism and fanaticism cutting SDAs off from close association with those of other religious faiths and from general society (Steley 1983:15). “Seventh Day Adventists often refer to themselves as a ‘peculiar people’—in the sense of being separate from the world” (Steley 1989:29). This also included being separate from all other churches, Catholic and Protestant alike, who were seen as being ‘Satan-infiltrated’ and therefore ‘lost’, not like the SDAs who had the ‘truth’. “Adventists were self-condemned to social confinement” (Steley 1989:31). (Interestingly, when I made contact with people who had worked for the SDA mission in the Solomon Islands to discuss the history of Atoifi for this research, almost all would open with the question ‘Are you an SDA?’). By 1914, the year G. F. Jones introduced the SDA mission to the Solomon Islands, “the Seventh Day Adventist Church had developed its own ethos.
which was based on a distinct world view. They saw themselves as the Remnant church with a warning to present to the world. “Their task was to prepare as many as would accept for the imminent second coming of Christ” (Steley 1983:33). The health aspects of the mission became known as the ‘entering wedge’ for its ability to prepare people for evangelisation (Banks 1980:10; Steley 1989:15). Missionaries would also be health workers and the connection between health and salvation remained inextricably linked, remaining to the present day (Banks 1980a:10; Hope 1991:18–19; Kuma 1992:6; Stacey 1999:10–11; Nash 2005a:1,5).

In the Solomon Islands, the SDA mission was started in Viru Harbour, New Georgia by Welsh missionary G. F. Jones. The establishment of the mission was greatly helped by the English planter and trader Norman Wheatley, who was in dispute with the established Methodist mission and was keen for another mission to establish itself in the area. He prepared the way for the SDA mission by calling it the ‘clean’ mission due to the church’s reputation for being health conscious. New mission converts did not only go through a spiritual transformation, but also a physical one, as diet, housing, clothing and general living conditions were altered. Many of the European missionaries had health (often nursing) qualifications, while others were given basic training prior to being sent to the Solomon Islands. For example in 1924 Pastor and Mrs Wicks, Tutty and his wife, and J. S. Archer were all nurses. In 1926 eight European SDA missionaries to the Solomon Islands attended a short course in nursing and tropical diseases at the Sydney Sanitarium (Steley 1983:146). The first health institution was built as a part of the establishment of the new SDA mission headquarters at Batuna in Marovo in 1924 and was commissioned in 1926 when the Australian nurse Evelyn Totenhofer took charge. Batuna ‘hospital’ specialised in fomentation and sulphur baths for the fungal skin infection bakua (Steley 1983:71). She certainly saw the connection between health services and the progress of the mission: “Thank God for ‘the right arm of the message’ and that it can be used to the saving of souls” (Totenhofer 1927). Other missionaries emphasised similar sentiments such as, “Every worker who takes up the yoke with Christ will share the three-fold responsibility of preaching, teaching and healing. Experience in many lands has shown that medical work is a vital adjunct to the proclamation of the advent message.” He continued, “In the Pacific Islands medical work is inseparable from the
proclamation of the gospel” (Cormack 1944:243, 244). Though the SDA mission delivered a significant contribution to the people of the Solomon Islands through their medical work, Steley repeatedly makes the point that this did little to increase the number of converts. The growth of the SDA mission was roughly comparable to the other missions (Steley 1983:79, 133, 156–162).

Medical Services on Malaita

The SDA mission was not the first to establish a hospital on Malaita. This was done by the Anglican mission which established a hospital in 1928 at Fauabu in West Kwara’ae (Fox 1962:249). It took shape following the arrival of a young Cambridge medical graduate L. M. Maybury. The BSIP promised to supply certain drugs and £200 annually on the condition that patients be treated equally regardless of religious beliefs. Two thousand pounds had been given by an English lady benefactor for foundation expenses, but instead of being used for the hospital wards, elaborate houses for doctors and nurses were built leaving the hospital wards to be built from “unsubstantial and insanitary native construction” (Hilliard 1978:269). This was only corrected by the Finance Board when an angry doctor threatened legal action and to publicise the misapplication of funds (Hilliard 1978:269). Services expanded from this hospital throughout the region utilising temporary medical aid posts. The early years of Fauabu were characterised by instability: “Everything at Fauambu depended on the calibre of a single doctor, with three changes of direction within the first seven years, there was no continuation of policy” (Hilliard 1978:269). (Similar sentiment was held at Atoifi when in 2003 a senior nurse there expressed ‘we go back to zero every time an old administrator goes and a new one comes–there is no continuity’). Maybury established a leprosarium but it was closed in 1933 due to inadequate resources. It was re-established in 1938 on a smaller scale.

The SSEM did not operate any large-scale medical facilities or hospitals. The SSEM routinely provided medical treatments through their missionaries and teachers. SSEM missionary Northcote Deck, who joined in 1908 and was a doctor and as Burt (1994:134) describes “Traditionalists (or relapsed Christians) were taken to [SSEM] mission stations or ‘school’ for medical treatment and possible conversion”.

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In 1933, prior to SDA missionary Arthur Parker leaving his base at Kwailabesi for furlough in Australia, he notified the Australasian Union Conference (AUC) (The SDA headquarter in Australia, later to be named the Australasian Division and currently named the South Pacific Division) of a piece of land at Su’u Harbour on West Malaita which would be suitable for a shipping depot. The AUC knew of Parker’s intention to marry Dr Dorothy Mills during his furlough, and so immediately designated the site for a proposed hospital. When Parker returned to Malaita with Mills-Parker it was with the understanding they would soon have a hospital to operate since the Amyes family of Christchurch had made £1,200 available to construct a hospital in the Solomon Islands (Steley 1983:150). Because the majority of Malaita’s population upheld their ancestral religions, Parker saw this as an opportunity for medical evangelism to assist the expansion of the mission.23 On 3 July 1934, the AUC Executive Committee agreed on the site for the new hospital and secured the three available leases. Negotiations with the BSIP in Tulagi followed and in January 1935 the church membership in Australia and New Zealand were asked to raise £500 for the purchase of the land and extras for the new hospital (AR 21 January 1935:6).

The following May the Solomon Islands Mission Committee met and decided the proposed Su’u site was not the best location, and the hospital should instead be located at Ariel cove on Kolobaggara in the Western Solomons. Competition and rivalry between the two missions (SDA and Methodist) in the Western Solomons were evident on every front. This was particularly the case in the provision of health services after the Methodists opened a hospital at Roviana in 1927. Nurse Totenhofer (1929:3) reflected, “We feel sad to think our church people having to go to another denomination to get help that we could be giving them if we had a doctor here”. Likewise, Steley comments, “For some Methodists, it was as much an embarrassment to have to use the Adventist Hospital as it was irksome to have the Adventists use the Methodist Hospital” (1983:161). How much this mission rivalry was behind the decision not to base the hospital on Malaita, I cannot say, but it certainly influenced the decision. Anderson (1937:4) wrote: “We have every reason to believe that ere

23 There are several oral accounts of the Langalanga people, just south of ‘Aoke desiring a hospital in their lagoon. Steley recalls (personal communication 1 Apr. 2005) being told by Langalanga people in Honiara in the 1970s that their people had wanted the hospital built in their region. Langalanga people
long we shall have in the Solomon Islands a hospital that will be a credit to the denomination and a wonderful soul winning agency”.

By the time the Amyes Memorial Hospital was opened in 1937 there were few Western Solomon Islanders who had not become Christian and as such the only soul winning possible was by ‘sheep stealing’. Steley notes, “Reports of baptisms were conspicuous in their absence” (1989:137). The government was not happy with the SDA mission building the hospital at Kukudu, since the Malaita district officer, Sandars, wanted it on the east coast of Malaita, a place Parker had investigated as a possible site (Steley 1989:137; Malaita District 1936:29; Fifi`i 1989:111). Amyes Hospital was directed by a Canadian, Dr Edmond Finkle for two years, after which nurses took charge. It was closed in 1942 due to the Japanese invasion and reopened in 1947 with a doctor again in residence (Steley 1989:137). The hospital was downgraded to a clinic in 1951, and remains in operation today.

Parker was undeterred by the committee’s decision. With the money from the sale of the Su’u land, and some additional funds, he had established a hospital at Kwalabesi by mid-1936. It was dedicated in mid-1937 with Dr Finkle in attendance (AR 9 August 1937). Due to health problems, Arthur Parker and his wife returned to Australia in 1939, after which the hospital was left with no senior staff until expatriate nurses David Ferris and his wife arrived about a year later (Steley 1983:152). Kwalabesi ‘hospital’ continued to be staffed by European nurses until they were evacuated in 1942 prior to the Japanese invasion (Fifi`i 1989:43). After the war European nurses returned, and in 1953 a segregated forty-bed leprosarium was added.

Jonathan Fifi`i (1989:111) recalled how the origin of Atoifi Adventist Hospital was also linked to Parker in the 1930s. In 1935 Pr Parker visited with an SDA convert named Farage from Gwagwa`ekwala in Uru Harbour from his base at Kwalabesi. He have bemoaned the problems at Atoifi and, in pointed anti-Kwaio rhetoric, stated that similar problems would not have occurred had the hospital been built in their area.

24 On many occasions this hospital is referred to as a clinic or medical dressing station (Ross 1978:183). This is possibly because Kwalabesi for most of its existence was run by expatriate nurses and not doctors. After the departure of Dr Mills-Parker expatriate nurses managed the hospital and there was a good working relationship with the Anglican Fauabu Hospital, that did have a resident doctor. Serious cases were sent there. Ross (1978:183) claims Kwalabesi was built in 1948, and this could have marked an expansion of services following the return of the missionaries after the wartime evacuation.

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suggested a hospital be based in the area to serve the people of eastern Malaita. Farage suggested Atoifi as the best location and Parker was told of the different groups holding rights to the land. The plans for the hospital at Atoifi had not eventuated when Pr Parker and other European missionaries were evacuated on the SDA ship the Melanesia on 11 February 1942 prior to the war (Cormack 1944; Fifi’i 1989:43). Most government and mission officials (although not all) left Malaita during World War II from 1942–1945 (Laracy 1988).

The desire to establish a hospital in east Malaita was reignited after the war when European SDA missionaries returned to the Solomon Islands in 1946. The SDA mission requested that the Malaita District Commissioner G.E.D. Sandars obtain a piece of land for them on the Kwaio foreshore so they could build a hospital. This was obviously an ongoing issue as Sandars (n.d.:141) stated “I was all for this and had done my best in the past to obtain this land but had always been refused.” Sandars went so far as to involve the Maasina Rule25 leader Nori, from ’Are’are, to assist in negotiating for the land on behalf of the church when they toured east Malaita together in 1947:

I talked sometimes to Nori about this and pointed out to him that it would be of inestimable benefit to the Koio [sic] people if they had medical services at their disposal and he agreed with me. I told him that in the past I had tried on many occasions to buy a piece of land for the Seventh Day Adventist Mission but that the people owning the land which was suitable for this project had always refused, would he try his hand. He said yes, he would get it for me.

Anyway, we pulled into this anchorage and I left Nori to it to see what he could do. After two days of talking apparently he fared no better than I did and was quite unable to obtain a right to this land in order to build a hospital (Sandars n.d.:141).

Whether Nori was using the negotiation of this land to increase his political influence, and as leader of Maasina Rule (an anti-government movement) advising landowners to refuse to cooperate with Sandars is difficult to say. Though no agreement was reached the desire to establish the hospital continued, as did the search for land, and Malaita District Commissioner Colin Allan reported in 1951 that there was continued

25 Maasina Rule was an anti-colonial movement that united Malaitans of all Christian missions and those retaining ancestral religion against the Colonial Rule of the British. The movement started in 1945 and its leaders (chiefs) were arrested and jailed in 1947. Mass arrests continued for several years and the movement subsided slowly, eventually ending in a stalemate with the government in 1952, and the founding of the Malaita Council. For detailed accounts of Maasina Rule see Laracy 1983, and for the movement in Kwaio specifically see Fifi’i 1989, Akin 1993, and Keesing 1992.
interest and enthusiasm for gaining suitable ground, with Pastor Newman inspecting a potential site (Allen 1951). Newman continued to communicate with the colonial government on the issue throughout 1952 (Malaita District 1952; Newman to Anderson 25 Mar. 1952 and 12 Apr. 1952 cited in Steley 1989:138). Several years later negotiations leading to the eventual establishment of Atoifi Adventist Hospital took place. The next chapter outlines the establishment of the hospital and Kafurumu clinic in the Kwaio mountains as alternative responses to the health care needs of the Kwaio community.
3. Atoifi Adventist Hospital and Kafurumu Clinic—Alternative Responses in Historical Context

The cultural, colonial and Christian context prior to Atoifi Hospital being established was described in the previous chapter. The first section of this chapter outlines the continuation of the colonial/Christian enterprise and how church administration established and entrenched policies at Atoifi. The second section will outline an anti-colonial response to this enterprise to address the health care needs of the Kwaio people. It will summarise how Kafurumu clinic was established and how it acts as an alternative, anti-colonial model of health care in Kwaio. The events outlined in this chapter are based on published and unpublished documents and interviews with numerous current and past Atoifi staff (national and expatriate) and community members. This historical context provides a base from which to interpret the narrative of the research process outlined in Chapters 5, 6 and 7 and to place them along the continuum of the lived history of Kwaio.

3.1 Atoifi Hospital Establishes

In the mid 1950’s the newly created administrative unit of the SDA mission, the Bismarck Solomon Union Mission (BSUM) reignited the wish to build a medical facility on Malaita where neither government nor churches had established them. This was, in part to match its established counterpart, the Coral Sea Union Mission, which ran Sopas Adventist Hospital in Enga, in the PNG Highlands. BSUM was aware the facility at Kwalabesi was in need of repair and inaccessible to the large population of the east coast of Malaita, thus it targeted the east coast for a site (Piez n.d.). This renewed hospital plans postulated by both government and mission for some twenty years.

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26 The BSUM was created in 1952 as an administrative unit to manage the growing church membership in the region and covered the Admiralty Islands, St Matthais Group, New Ireland, New Britain, Bougainville and the Solomon Islands. Around the same time the SDA mission in Vanuatu (then the New Hebrides) was also planning a hospital to be based at Aore near Luganville. It was opened in 1961 with Dr Joeli Taoi, a Fijian, as medical director, with funds raised under the auspice that it would be ‘a major evangelising agency’ (AR 7 February 1955:11). The Aore hospital operated until 1978 and many baptisms were claimed because of the hospital’s presence, however numbers of baptisms were never published (Steley 1989:137).
In 1958, president of Eastern Solomon Islands Mission (ESIM) based in Honiara, Pr Roy Harrison, met with Lance Waddington, nurse at Kwalabesi. They travelled to Uru Harbour on the SDA ship the MV *Dani* to “answer a call from the Kwaio people for a clinic in their area” (Piez n.d.:1). They were met by a delegation who made an “official request that a permanent medical outpost be located in their midst” (Piez n.d.:2). The request was passed to the ESIM and on to the next layer of administration—the BSUM. Soon after, in 1959, Lance and Joan Waddington were transferred to PNG and replaced by Ellis and Patricia Gibbons.

Gibbons and Harrison took up the search for a suitable site along the coasts of East Kwara‘ae and East Kwaio. They looked seriously at sites at Nazareth and at the future Atoifi location. BSUM President Eric Boehm and Treasurer/Secretary Eddie Piez visited both sites in 1959. The treasurer of the Australasian Division (The Administrative level above the BSUM), Bill Zeunert, later visited the Atoifi site and toured the entire east coast to confirm the location’s suitability (Piez n.d.).

The decision was made to acquire the site at Atoifi because it was located in a sheltered, deep harbour suitable for building a wharf. It had fresh water and enough space to establish gardens and build the hospital complex including staff housing. When negotiations to acquire the land began, competing claims of ownership emerged. The mission could not purchase the land directly from the land-owners, instead were bound to lease it from the government who planned to purchase the land. The competing claims eventuated in a dispute which went to a native court to decide the rightful owner and arrange for acquisition. The court was held in a village across the harbour from the present site of Atoifi in 1962 (Malaita District 1965). The District Officer, Ellis Gibbons and a local man, Ma’unisafi, were present the day of the court hearing. When the contesting party had not arrived by 3:00 P.M. the District Officer declared Ma’unisafi the owner of the land and papers were signed (Piez n.d.). Those with customary rights over the land who were not recognised by the court were angry that they had missed out and would not be entitled to any proceeds from the sale of the land.
Jonathan Fifi’i (1989:111–112) recalled this period of Atoifi’s history. I will quote him at length:

In 1935, the SDA missionary Mr Parker was at Kwalabesi. He came to Uru and saw the land there. A Kwaio Seventh Day Adventist named Farage, from Gwagwa’ekwala, had asked for a mission station in our area. Mr Parker came and saw that lots of people were sick there. There were lots of infections, lots of illness, but there was no medical help for them. Mr Parker approached Farage: “We’d like to build a hospital, to help sick people here.” Farage said, “That’s good. The best place to put the hospital would be the land at Atoifi.” They looked around for a suitable piece of land. Mr Parker asked, “Who owns this land?” Farage said “The ‘Ugule’ekafu people and the people from Otelagwa own this land. To’ola owns one piece, and Ma’unisafi owns the other. They are the main owners.” So Mr Parker looked carefully at the land, and wrote down the descriptions of the boundaries.

He was very busy in his work at Kwalabesi, but he didn’t forget about that piece of land. His wife was a doctor too. They worked in Kwalabesi and then eventually went back to Australia. When they left, the plan he had drawn up in preliminary fashion just was left there.

Eventually in 1964, long after the war had interrupted their work, this idea was revived. “Let’s go and have another look at that piece of land at Atoifi.” The church officials went and looked around the land. “Oh, this is a good place.” They said to the local people, “You sort out who owns the land, so the mission can buy it. A hospital here will help all the people of East Malaita, all the way from Ata’a to Takataka. This hospital isn’t just for the SDA people. It’s for the heathen people, and for people in other missions, as well as Seventh Day Adventists. Curing the sick people isn’t a matter where you can leave anyone out because of their religion.*

They talked about it and put pressure on Ma’unisafi, who claimed to be the owner: “I’m the representative for this land,” said Ma’unisafi. They talked about it, but no agreement could be reached about the land. People said “No, it’s mine!” Lots of people pressed for claims to the land, and eventually it came to court. There was lots of discussion about who had rights according to custom. The traditional leaders explained that it wasn’t just Ma’unisafi who had rights over the land. The Otelagwa people, the Gule’i people, and even I—Jonathan Fifi’i—have rights over that land. I’m descended from a woman named Falaifu, who married from there to my place. But that was long ago. I didn’t say anything about that. We were descended from Falaifu, a woman from Dari’akwasia which was part of the land they were going to build the hospital on. But I didn’t press any claims to it. It wasn’t worth wearing out my voice joining in the dispute.

* Unfortunately, although Atoifi Hospital provides services to the pagans—people they call ‘Bushies’—in designing the hospital, the Adventists chose to join the childbirth ward to the rest of the wards by a continuous roof, despite warnings that this would ‘contaminate’ the whole hospital, in terms of Kwaio custom. Hence pagans, especially men, make relatively limited use of the hospital.

Fifi’i went on to explain the court’s decision.

The court didn’t consider the rights of all the others who were related to the land. Custom wasn’t taken into account. The land was awarded to Ma’unisafi, at the expense of Falaifu and all the people who had rights to it. The government had
promoted Ma’unisafi as if he were the only one who owned the land—so he was the only one who was going to get paid for the sale. But that went against custom. All the people related to it were to get nothing. That’s not the way our customs define rights to the land. Land isn’t something you grow yourself, like a plant. It’s not something you feed. Land is something an ancestor cleared, generations back. He married and had descendants generations later, the descendants of the man who cleared the land all own it. They live on it together, and they own it together. So it’s not something only one man owns. That decision went against our customs.

The transaction was sealed. Ma’unisafi got his money, so he was happy, but those who were left out were angry. People started working there, clearing the land. They built some houses. A white man who knew about carpentry came. He was in charge of all the carpenters who were working there, supervising the building projects. The buildings went up.

Once the District Officer had adjudicated on the ownership of the land, plans for the hospital proceeded. A special offering from the worldwide SDA church raised AUD104,096, half for the establishment of Atoifi Adventist Hospital and the other half for Betikama Adventist School in Honiara. This offering was not collected until December 1965, although knowledge that funds would be forthcoming allowed work to begin at Atoifi. The New Zealand Leper Trust, a previous donor at the SDA facility at Kwalabesi, donated funds for the construction of the children’s ward and infant welfare section (Piez n.d.). Ellis Gibbons was given responsibility to prepare the site. He organised construction of the wharf and road and clearing of the land by local SDA villagers. There were a number of concerns in the initial stages over the use of rocks for the wharf, but after they were addressed work progressed. Concrete blocks were made on site using local sand and gavel with labourers paid 3 pence per block (Piez n.d.). Missionaries recalled “murmuring about the court decision” when site preparations began, given those who had lost in the court hearing were dissatisfied, however there “wasn’t a lot of unhappiness about”. “Unfortunately, by January 1964, the settlement for the land had not been finalised by the government and the mission paid an amount of $100 to the owners to keep faith with them and allow the work to proceed” (Piez n.d.:3). This was noted at the time as the project being “held up for over a year while the land ownership problem was cleared up” (Piez 1965:4). When builder Lionel Smith arrived in 1964, (he had spent some time with Gibbons at Kwalabesi clinic fixing that facility prior to continuing on to the Atoifi site) the team had already made 4000 concrete blocks and had received a tractor. Until then all work had been done manually. During 1964 Gibbons was transferred from Kwalabesi to Batuna after which he had only peripheral involvement with Atoifi. He was to be
replaced at Kwalabesi by Brian Dunn, however on the establishment of Atoifi, Dunn was asked to set-up medical services there. Gibbons was replaced by Peter Cummings, a minister with no medical training who established an evangelical training centre there. Gibbons was the last European medical staff to be stationed at Kwalabesi. Since then the clinic has continued to be staffed by Solomons Islanders. The evangelical training centre was expanded in 1981 (Barritt 1981:9)

The responsibility to design the layout of the hospital was given to Lester Hawkes, Health Director for BSUM based in Rabaul. He had worked in PNG from 1946. He designed Atoifi hospital based on Sopas Adventist Hospital in Wabag, Enga Province in the PNG highlands. He and Brian Houliston, based at the SDA mission at Kambubu in New Britain, drew the basic plans for the hospital and staff houses from photographs of the site (Piez n.d.): “The plans were approved by the Union [BSUM] and sent to the Division for approval on 23.1.63. After final approval, Brian Houliston then provided the working drawings for the builders” (Piez n.d.:3).

Having worked in PNG for many years Hawkes was aware of many Melanesian cultural taboos. Because of this a decision was made not to build two-story buildings at Atoifi since it would contravene cultural rules. Specific reasons were not fully understood, as he had no detailed Malaitan or Kwaio cultural knowledge—just that the locals would be affected by “womens’ sickness”. Despite not completely understanding the cultural significance of two-story buildings it was deemed important enough to exclude any such buildings from the hospital design. No attempt was made to consult with local Kwaio people in the design or construction of the hospital. Malaitans, even those who worked for the BSUM played no part in advising on Kwaio culture as the Malaitan workers were described as “committed mission men”. Though Gibbons had served at Kwalabesi for several years where approximately 85 percent of the population followed ancestral religion, and had daily

27 Many of those involved in the hospital design were unaware of the desire by the SDA mission in the Solomon Islands to build a hospital at Atoifi prior to 1959. This serves as an example of what Steley described as a severe lack of continuity and lack of shared knowledge in the leadership of the SDA mission throughout its history (1983, 1989). Others have described the SDA missionaries as practical people, in contrast to the intellectuals who often headed other missions, particularly the Anglican Melanesian Mission (Hilliard 1978, 2005; Ross 1978). This allowed the SDA mission to establish well run and maintained mission stations compared to other missions, but analysis of their strategies often appeared to lack continuity and rigour.
faced the practicalities of providing health services for Malaitans, he was not consulted. Workers on the ground assumed the designers had the necessary knowledge and in addition, the planning took place at a higher level by church administration, hundreds of kilometres from Malaita. The design was thus completed and approved by European missionaries, some of whom had never visited Malaita and who had only a basic understanding of Malaitan culture. I have found no evidence of Malaitans being a part of the planning of the hospital other than the allocation of land at Uru. Although the people I interviewed thought the maternity ward was not deliberately connected to the rest of the hospital in order to violate Kwaio customs, they all agreed that the thinking of the time was that if people wanted or needed medical help they should conform to the way it was delivered, even if that required breaking cultural rules. The primary intention was to convert people to Christianity from heathenism, and to accommodate Kwaio customs in the hospital design was something contrary to the missionaries’ aims.28 A. Mitchell (1965:14), president of BSUM, wrote:

In a desperate effort to meet the challenge of heathenism’s last remaining stronghold in this union, and to provide succour for the thousands who stand in need of both physical and spiritual health, we are right now planning the establishment of a modern fifty-bed hospital at Atoifi on the island of Malaita.

Once the plans were approved and logistics of the ambitious building program in the remote location thought through, work commenced. Lionel Smith was joined by two other European builders, Mervyn Poly and Malcolm Long. A barge was built in Honiara to transport sand and gravel to the site. The Malaita Mission’s ship MV Dani was made available, while the hospital’s own ship MV Raratalau was built in Rabaul (Piez n.d.). Medical treatment for the surrounding villages was delivered throughout the building phase by Lionel Smith and his wife Gertrude. Medical Director of the Australasian Division located in Sydney, Dr Sigi Kotz, visited in 1964 identifying thirty-five different diseases in the area (Kotz 1965:15–16). Following Kotz’s visit he made suggestions for modifications, which the BSUM passed on 4 June 1964. No Malaitan input was sought on the modifications. On a visit in early 1965 mission officials reported progress and that they were confident “the people will be willing to

28 Some nurses did not see themselves as evangelists, but were often accompanied by Solomon Island pastors, preaching with a picture role. Were (1965) outlined this mix of medical treatment and evangelical outreach from Kwalabesi clinic in North Malaita.
come to the hospital for treatment, and will allow us to give them medicine for their souls” (Piez 1965:4).

Staff were sought prior to the hospital opening. Several Solomon Islanders were encouraged to train, including Haynes Posala, who was working at the SDA Bible Correspondence School in Rabaul. Posala started medical studies in Port Moresby in 1963 and became the second doctor at Atoifi. The first doctor was medical director Dr Lyn McMahon, appointed in December 1964 and who took up the post in 1966. Horton Sale, like Posala from the Western Solomons, also went to Port Moresby to train as a laboratory technician. The first nurses appointed to Atoifi were Brian and Valmae Dunn who arrived from Australia in December 1965.

Hostility simmered between those who had been paid by the mission for the land and those who claimed collective rights to it (Malaita District 1966a). Old grievances became entangled in new ones (Fifi’i 1989; Keesing 1992) and some militant Kwaio fearing further invasion plotted to kill the first white man to work at the new hospital (for a detailed account of this see Fifi’i 1989:111–114). Keesing (1992:139) explains how the old and new became entangled:

The land acquired for the hospital extended up the hill close to several shrines, some of which were still used by the pagans for sacrifice. Disputes raged, and hostilities simmered among the aggrieved landowners and militant pagans fearing the consequences of further invasion and desecration of sacred places. (The hospital was to be built just across the water from `Ailamalama, where Fred Daniels had been assassinated in 1911, and just down from Farsi, the settlement destroyed by the punitive expedition: the old grievances became entangled with the new ones).

Lester Hawkes, BSUM Health Director at the time gives his perspectives in his 2004 manuscript:

In the case of the Atoifi land the Government discovered the owners. They also discovered that a man named Peter Marena Saki (sic) was the principal owner. He would receive annually £154 which he was to divide among the lesser owners. In this particular instance the Government decided to make a slight shortcut in the matter of payment. Instead of the Mission paying to Crow*** (sic) who then paid Peter, it was simpler for the mission to pay Peter direct. All were agreed on this. Peter then divided the money to those who had an, interest in the land. Each received a proportion of the money according to the amount of interest he had in the land.

Among the minor owners was Enda’e, the local devil priest. Peter handed Enda’e £5, the amount the village people had decided was correct for him but Enda’e was angry. He believed that he should have received £20. His pride was hurt and, in his eyes, his standing in the village was belittled. In his thinking it was the hospital which had
belittled him. He would have to do something about this. Local custom to restore credibility and standing had always been to settle the matter with a spear. But spears don't kill buildings. He decided he would wait till the real "hospital" arrived in the form of medical workers.

Although there had been white men—Lionel Smith, Mervyn Polley and Malcolm Long—working in the construction of the new hospital they were not targeted. Toward the completion of the main hospital buildings Brian and Valmae Dunn, recent nursing graduates of Sydney Sanitarium and Hospital (now Sydney Adventist Hospital) arrived to establish medical services. On Thursday evening 16 December 1965, in their second week at Atoifi, Dunn responded to a knock on his door. A young man was requesting medical attention, so Dunn sent his assistant to collect some medication from the hospital. As Dunn turned to go into his house he was speared through the chest with a length of reinforcing rod. The rod entered through the back of his chest and protruded from the front. Workers at the hospital were unable to remove the spear and so cut each end off the rod. Dunn was transported by a small boat belonging to the nearby Catholic Mission at Kwalakwala to Kwalabesi in North Malaita, and transferred to the larger SDA mission ship MV Dani for the trip to the Anglican Fauabu Hospital in West Malaita. Dunn was transferred again onto the larger Anglican mission ship the MV Baddley at Fauabu to `Aoke. He was then flown to Honiara, arriving almost twenty-four hours after the attack. The rod was removed in Honiara at the central hospital. He survived the operation but died on Sunday 19 December because of the laceration of his heart muscle by the rod (Hawkes n.d.; BSIP 1965; Lindley 1965; Malaita District 1965; Frame 1966; Malaita District 1966b; Steed 1970).

Fifi`i (1989:113–114) explained what happened next:

The government accused two men of the murder. One was Susu Fa`ari. The other was `Ada`ii. They said it was Susu Fa`ari who had speared him at night, and that `Ada`ii had incited him to do it. They took `Ada`ii and Susu Fa`ari to court. I was assessor, advisor to the judge. I heard all the evidence, with Chief Justice, Mr Birdley.

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29 Steed’s 1970 book, Impaled: The Story of Brian Dunn, a Twentieth Century Missionary Martyr of the South Pacific follows the life of Brian Dunn. Although containing some historical inaccuracies, for example the location and details of the 1927 Bell Massacre, it does give an insight into many of the issues of the time. The chapter entitled “Battling Heathenism” outlines many Malaitan customs seen as problematic for the Christian conversion process. Customs specifically mentioned included those surrounding childbirth at Kwalabesi in North Malaita. The mission obviously knew of these customs and the implications for health care and yet made no attempt to incorporate these concerns into the design of Atoifi hospital.
On the basis of what I heard and what I already knew about the land involved in our customs, I decided that it wasn’t Susu Fa’ari who had done it. I saw ‘Ada’ii’s sorry state. I heard what Susu Fa’ari had to say for himself. I decided that they didn’t have grounds for convicting them. They had grounds for suspecting him, that was all. So they were acquitted. The Chief Justice said, “There is insufficient evidence to convict you.” I felt the same way. According to our standards of custom, it didn’t seem the right person. I think ‘Ada’ii was really aggrieved, and that he said someone should go down and kill Mr Dunn. But I think it was someone else who heard him do it. I’m sure it wasn’t Susu Fa’ari.

Keesing (1967a:89) asserts that the killing of Brian Dunn was an isolated act and was generally condemned by the bush people. Many Kwaio feared the murder would spark another punitive expedition by the government. Despite the acquittals in February 1966 and heightened fears at Atoifi, there were no further incidents and the building program continued (Malaita District 1966c; Pritchard 1966). Brian and Valmae Dunn were replaced by fellow Sydney Sanitarium and Hospital graduates, Len and Betty Larwood. Len Larwood was a determined and energetic man and led the expansion of Atoifi for thirteen years until 1979.

**Opening and Expansion of Atoifi Adventist Hospital**

After forty-two years of SDA mission evangelical and medical activity in Uru, the long awaited hospital opened. August 25 1966 saw missionaries, government officials and local people gather for the ceremonies (Mitchell 1967:1–2). Seven SDA mission ships and a number of others, including the government’s *MV Mary* carrying Dr James McGregor, the BSIP director of medical services, and the *MV Princess* carrying the Acting High Commissioner for the Western Pacific, conducted a sail past of the wharf during the opening festivities (McGregor 1966; Piez n.d.). At the time of the opening McGregor described Atoifi: “[the] hospital is well-designed, sturdily built and very adequate. When fully equipped in a few months time, it will be almost as good, in its way, as the Central Hospital.” He went on: “the medical officer in charge, Dr McMahon from Sydney, struck me as a remarkably good man, and a very competent medic” (1966:1). McMahon was the most qualified doctor in the Solomon Islands, a Fellow of the Royal College of Surgeons. On his arrival McMahon soon became aware the hospital’s design was an issue for many Kwaio people. He became

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30 MacGregor a Scottish doctor had worked for the British Colonial Medical Service since 1951, serving initially in Sierra Leone and then in the Solomon Islands from 1957. The High Commissioner for the Western Pacific, Sir Robert Foster, had visited the site prior to the official opening.
aware that because the maternity ward was connected to the main hospital buildings, Kwaio people perceived the entire hospital complex to be polluted by childbirth and many men would not enter any part of the hospital complex. McMahon had not been involved in the design of the hospital, but soon became aware the design team had no perception of local customs or approaches to health. He became uncomfortable at how white people took no notice of local customs of people they had come to serve. Despite this changing the layout of the hospital was not discussed given the perceived superiority of introduced Christianity and medical systems over local religious and cultural practices. Despite the administration’s knowledge of Kwaio customs surrounding menstruation and childbirth there were no plans for incorporating these into medical practice in the early years at Atoifi.

The conflict between Kwaio custom and medical services at Atoifi was not without precedence. As outlined in chapter 1, Keesing had advised the government in 1963/4 to change the design of a health clinic (dispensary and maternity clinic in a single building) to be built at Sinalagu (Keesing 1967a:95–96). This was at the very time of Atoifi’s design and site preparation, and there had been a leaders’ meeting of the newly formed administrative unit, the Malaita Mission, at the site in 1964 (Cummings 1965:4). Cummings (1965:4) reported, “When the Malaita Mission was organised about a year ago we had our meetings right on the hospital site, for the people to get an idea of the need, and inspiration of the venture”. There was also interaction with the community at the time “Other mission people and some of the heathen around about have worked together with us, and these three projects [clearing the land, clearing some mangroves and building the wharf] are now completed”. Bush people decided to boycott the Sinalagu clinic because of its flagrant violation of prohibition on contact with childbirth. The government heeded Keesing’s advice and the maternity section of the clinic was not built, only the dispensary. Keesing (1992:140) later described attitudes of the time: “The Adventists on Malaita have steadfastly refused to take religious beliefs of the pagans seriously enough to accommodate to them”.

As medical director McMahon was unusual in that he did not see Atoifi as primarily an evangelical tool of the church, however others did including Atoifi’s chaplain,
from the Western Solomons named Reuben. He was a strict adherent to the teachings of the SDA church and expressed an evangelical zeal learned from white pioneer missionaries. Steley (1989:504) states “The Adventist motivation for involvement in medical missions originally was primarily for evangelical purposes, and only secondarily as a means of assisting their fellow men”. Although Steley goes on to say that by the 1970s this had reversed for the church in general, this was not the case at Atoifi. The rhetoric and practice of Atoifi being primarily a soul-winning enterprise has continued throughout Atoifi’s existence to this day (Dawson 1986; Record 16 Mar., 30 Mar., 27 July 1991; Kuma 1992; Nash 2005a). This enterprise was clearly stated at the time by Rampton 1966:6.

The new Uru Hospital is expected to greatly enhance our work on this outpost of heathenism. Many villages, particularly in the mountain regions, remain shackled to devil worship, and we hope to see a break-through before long. Mitchell (1967:1) stated “To date, these [primitive heathen] have resisted every overture of the gospel ever made. Could it be that the ‘right arm of the message’ a new approach, should reach in from this strategic point?” (In Adventist tradition – medical work is/was often referred to as the ‘right arm of the message’ or ‘right arm of the gospel’, meaning that health services act as a vehicle for advancing the Christian message. Another common term used in Adventist expression is describing health services as the ‘entering wedge’ (Banks 1980a)). Despite many Kwaio being excluded because of the design of the hospital, and a cyclone destroying some buildings in November 1966, the complex expanded (Dever 1967). Cyclone Angela also almost totally destroyed the SDA mission station at Kwalabesi, including the leprosarium, which was relocated to Atoifi after this (Cummings 1967). The establishment of the initially well funded and equipped hospital at Atoifi “marked a major shift in the power relationships and regional political economy in Kwaio country” (Keesing 1992:140).

The next decade saw the steady expansion of services and development of Atoifi campus into a self-sufficient settlement.31 Len Larwood was the driving force for most
of the development and was known as ‘Mr Atoifi’ (Smith 1980). Larwood managed the construction of an airstrip which involved more than two years of draining swamps, clearing heavily forested land, and covering the surface with gravel. This was an incredible endeavour given the forest was initially cleared by hand and later with a small tractor. The first plane, a Piper Aztec named _J L Tucker_, landed on December 2 1975 (Larwood 1976a). The construction and operation of the airstrip were not without their problems. Initially the suitable land was not made available and “land negotiations were proving difficult” (Larwood 1976b:8), and in early 1974 the construction of the airstrip was halted due to lack of funds (Lee 1974). On completion there was community anger at the ability of women to be in the plane and thus above men and their shrines. A staff member on the first flight recalled having bush people demand $200 or the equivalent in pigs to perform a purificatory sacrifice to their ancestors for the violations caused by the plane. As flights became more regular, priests from ‘Ere’ere on the Kwaio-Kwara’ae border sought to end flights to and from Atoifi which flew directly over them and thereby violated their pollution rules. Keesing (1982: 236–237) published their 1977 letter to the SDA mission, scribed by their Christian relatives.

Dear Director of S.D.A and the pilot of S.Steck [Piper Aztec] Plain.

I just want to let you know that I don’t want your plain to fly over my village including Ere ere area from now on. I stop in for the following reasonable reasons:  
1. The plain carry women with bloody babies.  
2. He always fly over our most Holy Alters when we burnt offering to our devil.  
3. It always causes death to our people because the devil get angry and kill people.  
4. Many pigs are kill to mean the plains fly over our devil.  
On behalf of majority of headden [heathen] people who are living here if you are Christian please don’t set your flyth over our area for it causes us death.

Thank you  
Yours sincerely Ere ere Devil Priests  
1. Timikooliu  
2. Maerora  
3. Maealea

The aircraft continued to fly in and out of Atoifi.

assistance for its existence. This reliance on external financial support has been a constant problem for the hospital and has threatened the hospital with closure on a number of occasions throughout its history as funding sources ebbed and flowed. This situation continues today. (Lee 1974; Larwood 1978; Garne 1983; Record 14 Nov. 1992; Record 5 Oct., 5 Nov. 1996; Record 2000; Stacey 2001).
In 1973 a hydroelectric generator was constructed to supplement the petrol and diesel generators and provide more consistent electricity. The plant was the first hydroelectric scheme in the Solomon Islands and was officially opened on March 3 1974 by the High Commissioner for the Western Pacific Mr Donald Luddington (Hay 1974; 1975). Atoifi replaced the MV *Dani*, inherited from Kwalabesi in 1976, with the MV *Famouri*, a larger and more robust vessel (Larwood 1976c). Larwood (1976c:1) reported 10,660 patients were seen and treated at clinics based from the MV *Dani* in 1975. A school of nursing was started in 1973, training nurse aids under the tutelage of Australian nurse educator Ian Cameron (Cameron 1974). There was no culturally specific content taught at the school of nursing regarding the Kwaio people as graduates would work at hospitals and clinics throughout the country and thus ethnicity at that time was perceived as irrelevant. During this time of expansion funds were often limited and plans required modifying. In 1974, in addition to work on the airstrip grinding to a halt, improvements in the water supply were shelved, repair and widening the wharf postponed and funds for the tutorial block, library and administration offices diverted to cover the working capital deficit. Staff were stood down, including builders, and the hospital operated with three fewer trained nurses than the year before (Lee 1974). Despite the dedication and hard work of Larwood and his team to advance services at Atoifi, there was little improvement in services for the bush people. Church administrators described Larwood as a ‘hard nose type’ with a ‘colonial spirit,’ which allowed him to source funds to continue Atoifi while it was in financial trouble, but also meant that cultural issues were not seen as important. He was also described as authoritarian and an energetic and passionate man who was in a hurry to get things done, often too hurried to take time to think things through sufficiently. Despite these characteristics, his humanity was obvious and he was known to accept people as they were and was friends with coastal and bush people alike despite his distain for ancestral religion.

As Atoifi grew, it became known as a centre that focused on high-profile cures that would attract potential converts. Several surgical teams visited to treat patients. Large
amounts of specialised resources were deployed to treat a small number of patients.\(^{32}\) Not only did bush people not access services because the complex was ritually polluted and culturally unsafe, but there were no significant health outreach programs into their areas. David Akin (1993:471) explains:

[The] government had been hindered by the isolationist policies of the church and its general lack of enthusiasm for cooperative planning. While provincial doctors were shifting their efforts towards preventative medical policies in the 1970s and 1980s, Atoifi continued to devote its resources to more spectacular curative undertakings.

Martin Baker, government medical officer of the time also claimed the hospital concentrated on gaining converts to the church with impressive curative procedures rather than supporting preventative programs for community health (Baker 1987; Personal Communication 18 April 2005). Surgeries were not always a success as Akin (1993:574) described during his research in Kwaio.

At one point members of the Atoifi staff attempted sophisticated cataract surgery on several patients, imitating procedures they had seen performed by a visiting Australian Eye Surgical Team. The Adventist boat had picked up people who had been selected as patients for the team’s next visit but had taken them instead to Atoifi. The surgeries failed, leaving the patients with inoperable blindness in the eyes treated. The resulting peculiar condition of these patients was thereafter sardonically referred to by visiting eye surgeons as ‘Atoifi eye’.

The subsequent visiting eye surgeons refused to operate at Atoifi and wrote on these patients’ notes ‘Blinded at Atoifi.’ This further strained relations between the government and Atoifi.

Enmity between Atoifi and the government was described by one church official of the time as presenting a “huge barrier”. The government Ministry of Health did little to help Atoifi and the near absent communication between health authorities and Atoifi was worsened by the perceived intransigence of Larwood. The urgency of work

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\(^{32}\) This policy continued throughout the history of Atoifi. A report in March 1998 stated a ten-member team had travelled from Loma Linda University Medical Centre in California, USA and had sent teams for the previous three years. The team included a pastor (Record 1998). Also see Larwood 1976d; Totenhofer 1976. Some teams did attempt to engage with the community including a visiting Australian dental team in 1974, however there is no evidence of these being incorporated into broader, ongoing community or preventative health initiatives (Martin 1975). Atoifi staff have also been involved in other high profile and expensive medical and evangelical teams including a church owned sailing boat to evangelise and deliver medical services “to act as an entering wedge to offer life and hope in the islands” in 2005 (Nash 2005b). The commissioning of the SBD800 000 yacht gained national attention, as did the theft of two of its solar panels when anchored off Honiara a week after its arrival from Australia (Mamu 2005b).
at Atoifi took precedence over attempts to appreciate Kwaio cultural conceptions of health. Although Larwood was informed of cultural perspectives, he chose not to modify policy to reflect this. Workers of the time recalled that “we were too busy treating patients that came into the hospital to have much time to think about those that didn’t come in”. The hospital and its operations during this time were described as a “white Raj” by one church official. This influenced the thinking of expatriates in the Solomons who perceived the SDA mission as a “lunatic fringe” religion (Personal Communication, Baker 18 April 2005). Steley (1989:505) described the situation:

Atoifi’s role as an ‘acute care hospital’ has been questioned. Instead it is suggested, it should serve the community health needs, and might, thereby extend its influence. This was at the core of the disagreement between Len Larwood and Martin Baker, who thought that Larwood ‘was attempting to establish something akin to an independent state’ without regard to government requirements. The fact that it developed in the way it did could be said to reflect the failure of Adventists to adapt their operations to the needs of non-Western countries.

The evangelical zeal of the early missionaries continued with Atoifi staff seeing the hospital as primarily a way to increase the church role and only secondarily as a medical service for the community. Although ebbing and flowing with different leadership this has been the consistent pattern at Atoifi throughout its history. Akin (1993:471) states: “The senior doctor at Atoifi openly acknowledged to one government medical officer in 1981, the first mission of Atoifi was to attract converts to the church. Better health for Malaitans was an important but clearly secondary goal”. This continued through the 1990s, with converts reported ahead of health gains, for example “Over the years articles in the RECORD [sic] have documented the success they’ve [Church owned hospitals] had in both healing and spiritual ministries in their regions. For example, recently a man was converted after a second admission to Atoifi Hospital” (Manners 1994:6). A missionary to the Solomons in the late 1970’s reflected there was “very little consideration of culture” during the time at Atoifi. Larwood had an attitude that the Kwaio needed to be educated to overcome their taboos and to ‘progress’. Expatriate and Solomon Island staff throughout the seventies, eighties and nineties indicated the hospital was principally serving the needs of Christians and aimed to increase church numbers with little effort made to serve the bush people or attempt to understand how to serve their health needs.
In an article by Jeanette Timmins, an Australian laboratory technician working at Atoifi in 1978, she articulately outlined that many Kwaio perceived sickness as associated with ancestral powers, or the withdrawal thereof. She also explained the process of divination to ascertain which ancestor had caused the sickness and why. She correctly explained how medicine would only address the symptoms and the cause, the ancestral cause, would then have to be addressed. There was no evidence of this understanding incorporated into policy or health initiatives, rather that the only way to achieve health outcomes was that old ‘heathen’ ways be replaced by new Christian ways. On the death of an old woman from TB she wrote “Shock gave way to anger then – anger at the people who say missionaries are interfering ‘do-gooders’, and that primitive people are happier left alone to their old ways. Would these people think this, I wonder if they had known Larica? Would they think this if they had seen the difference between the lives of the Kwaio heathen and our Christian nurses?” (Timmins 1978:2)

The Administration Block and the Tuusitori

As services expanded at Atoifi, it became obvious there was a need to expand the administrative offices to accommodate senior staff, provide space for a bank branch, a radio communication room and commercial space. Larwood drew the plans, having designed churches and schools across Malaita. The planning and construction of the administration block was another slap in the face for the bush people and another blatant violation of Kwaio culture.

By the late 1970s Atoifi had placed repeated requests to the government to accredit the school of nursing, so graduates could become registered nurses. Nursing tutors had a problem with an “old style English nurse” who held the capacity to accredit the school, but who did not recognise the tuition at Atoifi. The government linked Atoifi’s request for accreditation with its own request that Atoifi expand its sub-standard outpatient department since it was “congested, overcrowded and inefficient” (Banks 1980b:8). Thus started the design to simultaneously expand the outpatient department and add administrative office space. $150 000 was sourced from the Australian
Government via the Solomon Islands government to fund the construction. Larwood was assisted by John Banks, WPUM Health Director, in designing the facility. Plans progressed for the administrative offices to be built on a second story, directly above the newly expanded outpatients department causing widespread concern as another blatant contravention of Kwaio cultural rules that had been purposefully avoided by designers of the hospital fifteen years earlier. Larwood and other Atoifi leaders were aware of the Kwaio cultural rules of men being unable to be physically below women. This was discussed in relation to the new facility. They were aware many Kwaio people would not enter two-story houses of staff at Atoifi, however there was no change to the design. A senior church official told me that during that time “there was no deliberate attempt to provide services for the bush people as they were heathen”; the hospital was there to provide services for the Christian people and those that wanted to submit to Christian practice. Australian staff commented a year earlier that “The staff are dedicated and enthusiastic about pushing the work ahead, and their kindness has an obvious influence on the patients and their relations. Seventh Day Adventists have reason to be proud of the work their church is doing to relieve suffering” (Timmins interviewed by Banks 1978:3) (This exact rhetoric was used at Atoifi when I worked there fifteen years later). There is little doubt this was the case for the Christians however for the bush people it was a different situation (Keesing 1989). If the bush people became Christian they could access services, if they chose to remain in their ancestral religion they could not.

Resistance from the community against the project proceeding continued throughout its planning. Expatriate staff of the time recall Larwood attended, what was described as a ‘hot’ meeting with local chiefs where he informed them the project would continue despite their objections. Larwood saw this as a part of the education process the Kwaio needed to go through to learn to discard their superstitious taboos:

When Atoifi Adventist Hospital was opened ten years ago the obstetric patients who came were few and far between. However, over the years this has changed. Women now see the real advantages in coming to hospital for delivery. The taboos and customs are not so binding; prejudices have been broken down, and as a result, in 1975 there were almost three times as many babies born at Atoifi as there had been in the first year (Larwood 1976e:13).

33 Tuusitori is the Kwaio word used for the two-story section of Atoifi hospital.
Considering this, it is not unreasonable for David Akin to comment: “An observer cannot avoid suspicions that the church has offended deliberately” (Akin 1993:471). Akin was present at numerous meetings in the Kwaio bush where the two-story extension was discussed. Delegations were sent to Atoifi to speak to administrators about offences it would cause. The project went ahead with the full knowledge that it would exclude some Kwaio from using Atoifi’s services (Personal Communication, Akin 10 March 2005). The design included a toilet on the second floor exacerbating cultural offence. The toilet was directly above the pharmacy and deemed all medications below it polluted and unsuitable for consumption. Not only were people unable to enter the building, they could not take medicine dispensed from the pharmacy. For the same reason, many avoided outreach clinics from Atoifi that visited the bush. “It was so morally irresponsible and absurdly mismanaged, I found it hard to believe at the time” (Personal Communication, Akin 10 March 2005). Akin (1993:473) explains further.

This [the two story] was understandably viewed as a blatant slap in the face of the non-Christian community and heightened their alienation from the hospital. Several bush areas barred Atoifi medical clinics, and many pagan men refused to take any medicine from Atoifi. Some ancestors decreed through divination that even younger men could no longer visit the hospital, especially not the new building. It is important to recognise that the Adventists have not made these construction or other policy decisions in ignorance; they have been well informed of the religious significance of their actions far in advance. The consequences of their insensitivity have been many unnecessary deaths and extensive suffering among bush people effectively excluded from benefits of a modern hospital on their own land.

The plans were approved by the Western Pacific Union Mission (WPUM) and drawn by draftsmen in Honiara. Despite everyone at Atoifi being fully informed of the community’s concerns when I interviewed senior church administration of the time (expatriates who were based at WPUM in Honiara) they could not recall any detail. The Chairman of the Hospital Board, (an Australian living in Honiara) could not recall any community discontent. The Health Director at the Australasian Division at the time stated the “two story office building was not seen as a problem - although it may have been”. He believed that community concerns were taken into consideration during the design and stated “I do not believe people were excluded by the overall design”. This exhibits either an absence of understanding and/or a lack of
communication to the chair of the body and his immediate superiors who were responsible for the strategic direction of the institution, or conveniently selective memory. Although Larwood was described as a “one man band” who ran an “independent state” there seemed to be little organisational learning from operating the hospital for the previous fifteen years or understanding of its implications for the community.

Larwood did not see the outpatients extended or the tuusitori constructed. He died on 15 August 1979 when the tractor he was driving rolled en route to repair the hydroelectric plant. Len Larwood was buried at Atoifi a few days later in a grave overlooking the wharf and Uru Harbour.34

The construction of the outpatients’ extensions and administration block were started in 1979. After Larwood’s death a volunteer builder, Ron Bailey, from Australia who was working at Batuna mission station, was requested to reorganise the building program at Atoifi, which also included an extension of the operating theatre. A team of builders from Newcastle (Australia) commenced work on the extensions in December (Smith 1980). The building was completed in the first half of 1980 and opened on August 5 1980 (Banks 1980b). Dexter Cobbin, a Sydney Adventist Hospital trained nurse with qualifications in hospital administration replaced Larwood. He was told on numerous occasions during construction that many people were unhappy with the building project. He had not been involved with the planning nor organising the building team and did not make any changes. Cobbin had little understanding of the cultural environs and although he responded to requests to treat bush people outside the hospital building on several occasions he did not include significant consideration of Kwaio culture during his time as hospital manager. Concerns of the bush people were dismissed as only coming from troublemakers in the community. Atoifi continued with leaders seemingly oblivious to particular needs of the community it was there to serve. The year after the tuusitori was opened the Atoifi School of Nursing was officially recognised by the Solomon Islands government and began its registered nursing program.
The 1980s—Consolidation and Confrontation

The campus at Atoifi continued to expand in the 1980s however projects were not of the magnitude of those in the 1970s. The cracked and decaying concrete hydro surge tank was replaced in 1980 with a 10 000 gallon fibreglass tank (Cobbin 1980). Financial pressure continued to affect the hospital’s operations, with conflict between the business manager Ira Dawson, who replaced Cobbin, and the higher church leadership over funding (Dawson 1983a; 1983b; Garne 1983). Smaller projects such as the building of a kitchen house were undertaken in 1984. This caused anger among bush people as the kitchen was built directly adjacent to, and below, the maternity ward, meaning they could not use the kitchen (MacLaren 2000:45). An earthquake measuring 7.6 on the Richter scale damaged numerous buildings at Atoifi on 8 February 1984. A number of houses were condemned and needed to be replaced, serious structural cracks appeared in the hospital wards and the wharf partially subsided (Moe 1984).

Later that year Atoifi became caught in internal Kwaio politics that threatened to become violent and caused the temporary closure of the hospital. Folofo’u of Kwailala’e had been paramount chief of Kwaio since the mid-1970s and had built his political influence around his resistance to government influence and reassertion of Kwaio autonomy (Akin 1993:438). Although not a feastgiver or important priest, he was a powerful diviner. He was known for his temper and use of ancestral curses, often inappropriately, to force things his way. “All he used to do was throw curses around: swearing by his head, swearing by his sister-in-law, cursing shrines and sacred stones. He’s an important man for divination but he was never the priest for his A’aisuala people” (Fifi’i 1989:155). “Whatever happens that runs against Folofo’u’s will, he makes some curse or another. He curses and curses and curses. Those are matters of life and death. Folofo’u has defiled us. That’s not the proper way of cursing” (Fifi’i 1989:165). He led a movement, based on Kwaio kastom law, to have Kwaio secede from the newly independent Solomon Islands. He was also at the forefront of a huge compensation claim for the murder and atrocities of the 1927

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34 In late 2003 Larwood’s grave was moved closer to the hospital, (to near the memorial to Mary Simi who had been murdered in 1929) due to land subsidence at the original site caused by road construction
punitive expedition. This was the centre of his political platform and he stated there could be no cooperation with the government until this was paid in cash (Akin 1993:444). Fifi`i (1989:163—164) recalls how Folofo`u rejected offers of ‘development’ from senior government ministers that included a medical clinic in the bush in place of cash compensation. Folofo`u realised his power and popularity lay almost exclusively in openly defying the government and as such would only stay in power as long as relations with the government remained confrontational (Akin 1993:444)(Also see Akin 1999 for other reasons why substitutes for compensation were not acceptable). When negotiations over the 1927 compensation claims broke down Folofo`u made a conditional ancestral curse against the national elections to be held in Kwaio on 14 November 1984. The ritual injunction would only take effect if people took part in the vote. A large number of people across Kwaio boycotted the election, some in support of the boycott itself, others in fear of the demand for compensation in violation of the curse. Atoifi was a polling station for Uru where Folofo`u’s influence, particularly in Christian villages was not as strong as at Sinalagu and `Oloburi (Keesing 1992:166). Most Atoifi staff and students cast votes. When Folofo`u discovered Christians at Uru and particularly at Atoifi had voted he sent word he was coming down to claim his purification compensation for ignoring his ritual injunction (Keesing 1992:166). Understanding the volatility of the situation the government sent police from the special Field Force Unit to Atoifi on the afternoon of the election and all expatriate staff were evacuated immediately. Folofo`u’s supporters in the Kwaio Fadanga had threatened violence and to dig up the Atoifi airstrip (Keesing 1992:166). Folofo`u and his sons Kwa’ilamo and `Ubuni, with 200 Kwaio Fadanga supporters went to Atoifi on Friday 16 November to collect the compensation. The medical director of Atoifi explained that staff had voted in the election as Solomon Islands citizens and that if they were unhappy with the election process to talk to the government about it, not Atoifi staff (Australian Record 12 Jan. 1985). Provincial government officials and police negotiated with Folofo`u and by 4 P.M. all threats were removed. Folofo`u claimed “We weren’t really going to dig up the airfield or destroy anything. We weren’t going to kill anyone. That was just a threat. But you, the government, the people who voted, have to give me money as purificatory compensation. You have to purify me, and I’ll be satisfied” (Busumae in the mid-1990s.)
interviewed in Keesing 1992:167). Folofo’u was later paid purificatory compensation of $1000 by the government officials at Gelebasi.

Assurances were given to Atoifi staff there would be no further interference following the agreement on Friday 16 November. However unrest broke out when two Kwaio Fadanga ‘police’ entered the Atoifi campus on Sunday, 18 November. A decision was made to temporarily withdraw all medical and other services and evacuate all national staff. On Monday 19 November this was actioned. Staff were given holidays and full-scale services did not recommence until they returned. In the interim a temporary ‘clinic’ was run (Australiasian Record 12 Jan. 1985).35

The next major event to impact Atoifi was the destruction wrought by cyclone Namu on 18 May 1986. The cyclone damaged many hospital buildings. Roofs were blown off the student nurses’ home and numerous other buildings and fallen trees caused extensive damage to buildings. Many buildings suffered extensive water damage as windows were blown in. Power poles were bent to the ground and flooding caused 10 centimetres of silt to cover the airstrip. The filter system of the hydro completely filled with gravel and the road was blocked with fallen trees (Dawson & Dawson 1986). Atoifi became a major distribution point for food, clothing and corrugated iron to rebuild villages in Kwaio (Wright 1986). One of the groups who came to Atoifi for assistance was from the Lafea, deep within the mountainous interior. People here, like those across Kwaio had their homes and garden’s destroyed and sought help from the distribution point at Atoifi. At least five people died in landslides in the Lafea (Dawson & Dawson 1986). Initially those distributing assistance disbelieved accounts of the numbers of people living in the Lafea, since people there had little contact with the government or other services. Government censuses had not covered this area and there was no record of the population. Contact with these people eventually led to the

35 This was not the last time Folofo’u used confrontation; a year later when a further round of voting occurred after the Electoral Commission overturned the November 1984 election results. Folofo’u again attempted to stop the voting process. He and around sixty of his supporters arrived at Nunubilau village on the shores of Sinalagu Harbour and sparked an incident with the Police Field Force Unit in which police shot above their heads and used tear gas to subdue those trying to disrupt the election (Busumae in Keesing 1992:169). The elections overall went ahead and the standing candidate Fa’asifoaba’e was returned. This was the last major confrontational stand of Folofo’u and after this incident much of his support crumbled (Akin 1993:446; Keesing 1992:172). Folofo’u died in 1991 and his son Kwa’ilamo was installed as the new paramount chief in a ceremony at Ngarinaasuru in 1992, which I attended.
establishment of a satellite aid post to deliver basic medical services (South Pacific Record 1987a; 1987b; Chee 1988). A detailed history of Kafurumu clinic and its establishment is described later in this chapter.

The 1990s—Evangelical Zeal and Lost Opportunities

The 1990s saw a further slowing of large infrastructure projects at Atoifi, with repair, maintenance and upgrading of existing facilities the priority. The evangelical zeal of staff, far from slowing, was a feature. In 1992 an article written by the CEO was headed “Atoifi Hospital at Work” the subtitle “The health work is vital to the growth of the church in the Western Pacific” (Kuma 1992:6). The article did not present statistics of health initiatives, rather statistics of evangelistic campaigns the hospital chaplain ran. The effectiveness of the hospital in improving health statistics was not mentioned; the number of conversions was. Around this time articles in church publications were written titled “Atoifi Commences Outpatient Outreach” (Record 30 Mar. 1991), “Gospel Penetrates in Solomon Islands” (Record 30 Mar. 1991), “Atoifi Hospital Seeing Results from Witnessing” (Record 16 Mar. 1991), and “Atoifi Contact Spurs More Baptisms” (Record 27 July 1991). The Australian business manager, repeatedly stated in public forums that Atoifi was primarily to win souls for the church and only secondarily to provide health services for the local population.

During 1992 a new X-ray machine was installed and a team comprised of Australian and New Zealand staff of Sanitarium Health Food Company were sponsored by the company to build a two-story extension to the school of nursing (Record 14 Nov. 1992). The maternity ward, like much of the hospital, had deteriorated and was in poor condition with the tropical environment accelerating decay. Termites had damaged timber structures and work was urgently needed to maintain a basic maternity service. This gave administrators an opportunity to rectify a situation that had been an issue from its beginnings—the linking of the maternity ward to the rest of

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36 There was community disquiet over practices that favoured the surrounding SDA villages. Allegations were made over favouritism for treatment, resources or employment. During 2001 a visiting Australian dentist voiced concern at the high proportion of SDA patients he saw in the mornings while he would see patients from other denominations in the afternoons. Despite this constant underlying tension ongoing support for the hospital was relatively high. This was demonstrated in 1998 when the community, including the bush people donated funds to keep the hospital operational during a time of dire financial hardship.
Chapter 3: Atoifi Hospital and Kafurumu Clinic—Alternative Responses in Historical Context

the hospital complex. This opportunity was not taken. The maternity ward was renovated and expanded in the same location. The work was led by a building team from an SDA church in Esperance, Western Australia who were at Atoifi for 2 weeks.

During the early 1990s Atoifi hosted an increasing number of refugees and rebel fighters from the neighbouring Bougainville civil war. In 1993 a high-ranking soldier of the Bougainville Revolutionary Army was treated at Atoifi after being shot in battle with the Papua New Guinea Defence Force. In 1995 Atoifi administration authorised the construction of a house on campus to accommodate Bouganvillian refugees at the Atoifi. Funds were sought and granted from Adventist Development and Relief Agency (Aitken 1995). This project was questioned by some in the community: A house was provided for people from another country, yet none provided for Kwaio people, some of who had to walk for two days to get to Atoifi. This was despite multiple requests to have simple houses built at Atoifi for people from the three regions of Kwaio (Uru, Sinalagu and ´Oloburi), particularly important for tuberculosis patients and their families, may of whom stayed on the hospital campus for up to three months.

In the second half of the decade the hospital continued to face financial pressures. Minor repairs on buildings proceeded with the assistance of volunteer teams from Australia (Record 5 Oct. 1996). During 1997 $150 000 was donated to upgrade the airstrip which had become unsafe (Record 1997). In 1999, the CEO and medical superintendent, a Solomon Islander, reiterated the goal at Atoifi: “Atoifi is committed to evangelism, that’s the reason for its existence” (Stacy 1999:10). In the final years of the decade, Guadalcanal and Malaitan militants fought a civil war known as the ‘ethnic tension’. In 1999 with an almost complete breakdown of government control and law and order 20 000 Malaitans fled Honiara and returned to Malaita. Because of the ongoing conflict government funding for the hospital was sporadic, and by 2000 Atoifi faced a “funding crisis” with income covering only 50% of operating costs

37 As the rebel fighters were unable to gain treatment from any Papua New Guinea medical facilities many escaped across the border to the Western Solomon Islands and on to Honiara. Some felt threatened by Papuan New Guinea-linked organisations in Honiara and sought treatment at Atoifi. Many people, both civilian and rebel fighters were shot and killed in their attempt to cross between PNG and Solomon Islands waters by the PNG Defence Force.
(Record 2000). New senior management were recruited that year from Solomon Islands and internationally. This signalled the beginning of a new phase in Atoifi’s history which is outlined in detail in Chapter 5.

3.2 Kafurumu Clinic—An Apparent Paradox

An example of the incorporation of Indigenous Kwaio concepts of health within health care systems is present at Kafurumu clinic, one of Atoifi’s satellite medical aid posts. The clinic has been conceptualised, established, operated and expanded to be in and of Kwaio. It has a unique history and has shown a distinctive ability to negotiate the cultural, colonial and religious context in Kwaio. It stands as an anti-colonial statement and proves that health services do not need to submit to the dominant colonial/Christian order. Kafurumu Clinic is situated deep within the Kwaio interior in the Lafea, 7 hours walk from the coast. Although people from the Lafea have been involved in events influencing Kwaio history for the past century the area has had minimal development and its people uphold beliefs and lifestyles that differ little from their forebears. The Lafea is in the centre of Malaita and covers the area west of the ridge where the Kwaio lamo Basiana lived and was dramatically affected by the 1927 punitive expedition. A road (wide walking trail) constructed during Maasina Rule in the late 1940’s is still evident in the area. Many men from the Lafea worked on plantations in Queensland during the labour trade and more recently in plantations across the Solomon Islands. There is considerable contact, including through marriage links, with the people of West Kwaio (on the western flanks of Malaita’s highest peak, Mt Tolobusu), the Kwaiba’ita valley (the Kwaio-Kwara’ae border) to the north and Sinalagu and ’Oloburi to the east and south.

The early history of Kafurumu clinic was much like other medical endeavours that were part of the Christianisation enterprise. The catalyst for the establishment of the clinic came in May 1986 when cyclone Namu destroyed significant sections of Malaita. The cyclone damaged buildings at Atoifi and destroyed houses and gardens across Kwaio (Dawson & Dawson 1986). Torrential rain caused widespread flooding

38 Although Kafurumu is known as a ‘clinic’ and will be named as such throughout this thesis, it is more accurately an ‘aid post’. It delivers basic medical procedures and is staffed by a village health worker.
and landslides destroyed houses and gardens and decreased the population of fish and birds available for food. Atoifi became a distribution point for aid after the cyclone (Wright 1986). Teams of people from Atoifi assessed the damage and recorded the number of people affected. Villages on the slopes immediately behind Atoifi were surveyed, however those deeper in the Kwaio mountains remained without help. Having become aware of the assistance available, people from the Lafea, led by their chief Silas Nika went to Atoifi. They told the authorities their area had been particularly hard hit by the cyclone and no longer had the ability to fully feed themselves. They were provided rice to supplement a meagre diet eked from the cyclone damaged bush.

Those distributing assistance at Atoifi disbelieved Silas Nika’s accounts of the number of people in the Lafea, as there were no official government statistics for the area and authorities were unaware of people living there. As people re-established gardens they continued to depend on food distributed from Atoifi. The situation was made more difficult when the flooding rain of the cyclone was followed by a drought where less than half the annual average rain fell. Crop disease also affected the recovery of gardens (South Pacific Record 21 Feb. 1987). In July 1986, the business manager from Atoifi, Ira Dawson, was led to the area to assess the situation first hand. He had been warned against travelling to this area by the coastal Christians, who said he would be killed, but Dawson was determined and went anyway. Silas Nika showed Dawson the destruction and the number of people affected. On his return Dawson informed the government who sent two officials to the area to perform a census. They discovered a population of approximately five hundred. According to local accounts this is the first time the government acknowledged the population of the area.

Dawson made another visit in November with officials from the Australian High Commission who provided the aid. They found the food situation was still critical (South Pacific Record 21 Feb., 28 Mar. 1987). Medical personnel from Atoifi in the

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39 Some people had radios and were able to listen to broadcasts after the cyclone, stating affected people could go to certain distribution points for food and other basics. The prime minister gave a speech addressing the people of the Solomon Islands, and explained the government was coordinating assistance measures.
team saw “most of the people were suffering malnutrition, and we made a commitment to continue sending supplies and try to get some tinned fish to supply protein” (South Pacific Record 28 Mar. 1987:12). The trip was not one of humanitarian endeavour alone. Members of the medical team led “Singing and taught [Christian] action songs to the children” (South Pacific Record 28 Mar. 1987:12). Dawson told Christian stories and hoped to utilise a well known tool to advance the Christian message, the picture role, on his subsequent visits (South Pacific Record 28 Mar. 1987). Assistance from Atoifi continued for some months until gardens were re-established. Subsequent visits were formalised into regular three monthly clinic trips. During 1987 a young man from the area was admitted suffering tuberculosis to Atoifi for two months. His father was treated by Atoifi staff during a visit to the Lafea. Atoifi staff claim this was the “turning point” which led to a request for a more permanent medical presence in the area (Chee 1988:11). Kwaio accounts recall the events differently however the ‘invitation’ was welcomed by Atoifi. The response included a medical presence with an evangelical edge. A male nurse visited the area for two weeks. The medical superintendent’s report did not record a single health intervention:

We sent a registered male nurse there for two weeks. He set up a school for the village children, using children’s Bible stories as textbooks. And on Sabbaths he held church services. He came back brimming with excitement. He said that all the children, suitably bathed and clothed, had attended school, while adults stood around listening to the story of redemption (Chee 1988:11).

In the same report Chee (1988:11) described the location Atoifi operates within: “Behind Atoifi are the ‘hills’. The people who live there have never mixed with the coastal residents. They are hostile, primitive and steeped in spiritualism. No groups – government or private – have dared to venture there”. Whether this was a deliberate misrepresentation, or a genuine ignorance of his own mission’s history in Kwaio back to 1924, when the first missionary regularly toured the Kwaio ‘hills’, I have not been able to establish. Much of this misinformed rhetoric continues to be perpetuated by expatriate workers at Atoifi to the current day.

Due to the remote location, no transport infrastructure, professional isolation and Christian superiority over the ‘heathen’, it became evident for the new post to be sustainable it would require someone with links to the local community to staff the
‘clinic’. The community nominated Esau Fo’ofafimae Kekeubata. Esau was a young man who, although born in the area had relocated to the coastal SDA village of Malo’u in Sinalagu in 1972 when about 7 years old. This move was initiated because his mother had pneumonia that had not responded to traditional medicine including sacrifice to relevant ancestors, so went to the coastal village of Gounabusu to access the government clinic there. While there she and her husband Kekeubata, who had been working in the Western Province for several years and returned to Kwaio when he heard his wife was ill, were convinced to relocate to the coast and become Christians. As a small boy Esau can recall how a group of approximately 20 coastal Christians came with Kekeubata to collect their family and belongings and carry them to the coastal SDA village of Malo’u. Esau was afraid of the people who were wearing clean clothes and did not cut their hair “We slept one night together and then went down to the coast, our houses, our gardens, our pigs were just left behind – abandoned”. Conflict erupted in Malo’u after one of Kekeubata’s kin was involved in a fight which caused the family to move again to the Roman Catholic village of Madafu on Uru Harbour to live with their relative Toloka. Six months later they settled at the SDA village of Wyfalonga to live with their relative Fiiafelo. Esau attended the local SDA primary school at Ibo for a year and a half, however was suspended from school after his kin from the Lafa asked for compensation from the family of a student who fell onto Esau and broke his arm. Like many other Kwaio in search of work Esau travelled to Western Province. He stayed with his father and started work as a labourer on a coconut plantation in 1979. In 1981 Kekeubata relocated his entire family to the Western Province. During 1982 Esau returned to Kwaio and eloped with a girl from Wyfalonga. He subsequently paid bride price, was married and returned to the Western Province later that year.

While in Western Province Esau’s ‘father’ (paternal uncle) Silas Nika came and stayed with him. Silas was an influential priest and mediated with ancestors on behalf of his kin. Silas taught Esau many traditional Kwaio “custom things”. “It was not only the good things he taught me, he also taught me the deviant things as well, like magic for stealing and breaking into stores” (Esau Kekeubata–5 Feb. 2004).40 Esau

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40 Please note: All direct quotes used in the rest of this chapter, and not attributed to a specific source, come from an interview with Esau Kekeubata on 5 February 2004.
maintained close links with his kin from the Lafea and worked with many of them on plantations. Esau became involved with his kin who were infamous criminals in Western Province and Honiara. His best friend Karisitoo was a well known criminal convicted for the murder of a European on Guadalcanal. Karisitoo subsequently escaped from Rove prison in Honiara and returned to his home in the Lafea, close to Kafurumu. Despite being a high profile convert to Christianity, his criminal ways continued and Karisitoo was killed in 2002 leading a mercenary group to kill the Guadalcanal militant leader Harold Keke on the Weather Coast of Guadalcanal. Esau was charged and appeared in court for several crimes prior to his call to establish the health outpost at Kafurumu. He was never convicted.

In December 1986, seven months after the cyclone, Esau and his family returned to Kwaio. Silas explained events and how they were happy with the assistance given. Esau was glad that “the government had finally recognised my people as my people had been forgotten until this time”. Esau’s family remained on the coast and Esau went to spend time with his ‘father’ in the Lafea. Esau realised that although he was born and belonged in the Lafea, because he had been taken away as a small boy he “didn’t know anything”. He lived with his ‘father’ Silas for 1987 and 1988, during which he “Studied the culture of Kwaio; to learn the taboo things and to sit down with the old men at the feasts and listen to their stories and learn from them”. Esau had a very inquisitive mind and although he had only 18 months of formal primary schooling he could read and write in English, Pijin and Kwaio and spoke six languages. He was a clear thinker and articulate with proven leadership qualities. He had one thing in mind—to help his people.

At the end of 1987 Esau decided he must do something for his kin and started to plan. He asked his community if they were happy for him and his family to stay with them in the mountains. He asked “What about all the taboo things that belong to Kwaio custom that you don’t want the Christians to be involved with?” They replied “you are our son, so you will be alright”. Esau went on “I am a Christian, if I come and stay here will you accept my lotu? (worship) They all had a hard think about it as they didn’t like all of the Christians”. Esau explained how he would set up his new settlement to parallel a Kwaio settlement, have a women’s area, a common area and a
taboo place, where a small church would be built. His kin, used the taboo place for talking with their *adalo* and he would use his taboo place to talk with his *adalo*. He explained “If I come with my family and don’t ask my *adalo* to protect us – then we will be sick, my *adalo* will not look after us”. He asked for a piece of land that their *adalo* did not frequent, and was offered an area on the Darisuri river a tributary of the Kwailafa River. “That wasn’t a flat area, it was really rough, but we accepted. Let’s go and stay. That is where we started our place”.

Prior to the establishment of Esau’s new settlement, he had a further discussion with the community leaders. He described his approach to me:

> For the life of a village, there are *fo’ota*, sacred pigs for sacrifice, if *adalo* see these in the village, they are happy and people will not be sick. But if my *adalo* sees one thing, he will be happy. That thing is a clinic. What if we can have a clinic?

At this time there was a satellite outreach clinic run from Atoifi every three months. “Go and come all the time is no good—we need to have a clinic here. If anyone is sick then they can become good. That is what I would like”. The community agreed and leaders went to Atoifi to ask for a permanent clinic in the Lafea. Esau did not join the delegation to request the clinic. The Atoifi administrators agreed to the idea but said “Who from Kafurumu will come and train to staff the clinic you want?” They suggested Esau and indicated he had been living with them for a year and a half and they trusted him to establish the clinic in the Lafea.

In the second half of 1988 Esau began his training at Atoifi hospital. Each morning he accompanied medical superintendent, Dr Chester Kuma on the hospital ward round. He then spent the next few hours in outpatient's department learning about dressings and simple treatments. Between 3–4 P.M. Dr Kuma would teach him western medical theory and treatments. After three months Esau was ready to return to the Lafea to gain practical experience, after which he returned to Atoifi for a further three months training. During his practical work Esau lived with his kin and learned relevant aspects of Kwaio culture. This included genealogies, traditional medicines, concepts of health including disease causation and principles of indigenous *gulanga* (healing). He became grounded in the social, cultural, spiritual and physical context he was
about to work in. At the completion of his training he stated “Even if I don’t have an in-depth knowledge of all things, at least I have an idea for me to start”.

**Operational Ethos of Kafurumu Clinic**

Although Kafurumu clinic was established as a satellite of Atoifi and therefore a Christian settlement, it was shaped in accordance with Kwaio principles of health to include the spatial organisation of the settlement. The clinic was based on the Kwaio concept of *to’oru leanga* (literally staying/living well), or wellbeing, rather than a western biomedical model. There was extensive consultation with the community about the placements of domestic buildings, the clinic and toilets. Esau had been studying Kwaio cultural determinants of health for almost two years and was able to negotiate with the community using Kwaio terminologies, Kwaio spiritual frameworks and Kwaio ideologies. There are three underlying principles of wellbeing which act as a foundation for all health activity at Kafurumu:

- *Wado* - Land
- *Falafala* – Custom/Tradition
- *Fufutanga* – Genealogy/Social Connectedness

Despite health services in the Lafea being initiated in the same Christian expansionist model as Atoifi more than twenty years previously, Kafurumu became unique in its operations. It was grounded in Kwaio concepts and realities of the community in which it was located were its foundation. This did not mean it was not a Christian endeavour, however one that was uniquely different to others in the history of the SDA mission.

Prior to constructing any buildings or establishing services, community leaders were consulted through the Kafurumu Baru committee which was set up to represent the community’s interests and guide development at the clinic. As a Christian settlement, Esau wished to erect a small church building. It was this decided this be placed at the upper end of the ridge to be consistent with the Kwaio cosmological principles of the sacred being on the upper edge of the settlement. The small church building was not
commenced until the chiefs were fully consulted and after some time agreed to proceed. The modest clinic building of sago leaf walls and roof was placed in the central part of the settlement, a gender neutral position. The toilets were placed in appropriate locations in designated men’s and women’s areas and the childbirth area in a separate area lower than the clinic.

The clinic was seen as a resource and a means to prevent sickness in the community rather than just a place to treat patients for their illnesses. A mixture of medical treatments (pharmaceuticals) and traditional or natural treatments (roots, leaves or herbs) was offered and clinic procedures showed a deep respect for the community in which it was located. An example of this respect is the disposal of waste from Kafurumu clinic. All waste is buried, not burned, as if waste was burned the smoke from the waste (particularly dressings containing women’s blood) would raise above the houses, the clinic, the head of men and of shrines. This would insult adalo who would withdraw their protection from the community and allow sickness to befall the community. Thus actions at the clinic can actually cause sickness in the community. Burying all waste from the clinic, in Esau’s words “Prevents sickness in the community”.

Initially 50–60 patients per month attended from the 37 hamlets in the Lafea. All patients were personally known to Esau and it soon became obvious when outbreaks of illness were occurring in particular hamlets. He was proactive and investigated the outbreaks and worked with the communities to address their causes. The philosophy of centralising social connectedness and Kwaio customs was at the core of community health initiatives “It is our own ways—if we don’t look after family and village, then we will get sick”. Esau did not stay in the clinic waiting for patients. He spent time in hamlets to address health needs because “looking at the source was important”. He attended feasts or other cultural events where health issues and initiatives were discussed and treatment administered. This provided opportunities to seek advice from leaders and holders of knowledge on particular topics to inform and modify approaches at Kafurumu. After several years the numbers of people being treated at the clinic dropped to 20–30 per month. Esau attributed this fall in numbers to the
proactive community health initiatives. Despite this it was evident the available flat land where the clinic was situated was too small.

Permission was sought to move the settlement to a larger portion of flat land at the junction of the Kwailafa and Darisuri Rivers. This was granted and in 1995 a semi-permanent clinic was built with a sawn timber frame and walls and corrugated iron roof. Services were expanded utilising culturally appropriate ways of practice until 2000 (see examples 1–3 below). During 2000 Esau and his wife were divorced and he remarried. As Esau was now a divorcee and his remarriage a ‘custom’ marriage rather than a church marriage, church policy dictated he be ex-communicated from the church and dismissed from employment by Atoifi. Esau’s cousin, John Silas, was trained as a replacement, however resigned after a number of months. Esau recommenced his role as village health worker in a voluntary capacity. Medication was supplied to Kafurumu by Atoifi and Esau continued his community health initiatives without being paid.

Although Esau left Kafurumu periodically to earn money to pay his children’s school fees, he continued to devise the expansion of services at Kafurumu. In 2002 plans were discussed to move the clinic and settlement to a larger site at Eritalana on a broad ridge above the Kwailafa River. The existing site, although flat was limited in size by the two rivers and the toilets were close to the rivers potentially causing pollution if the population expanded. Although Esau had initially located the toilets away from the rivers when he was dismissed from employment (although continued in a voluntary capacity) for divorcing his wife and remarrying, this changed. The church layman, with little understanding of health principles had relocated them close to the river. The new site would allow for future expansion and allow access to the clinic when the rivers were in flood. Work started on the new settlement in 2003 and continued in 2004 and 2005.

The following three examples describe how Kafurumu clinic operates within the Kwaio concept of to`oru leanga (wellbeing) and the three underlying principles of wado (Land), falafala (Tradition) and fufutanga (Social Connectedness).
Example 1: Mental Health Services at Kafurumu

When Kwaio bush people are physically or mentally ill the cause of the illness is believed to be ancestrally initiated (Keesing 1982:117–119). The approach to patients with mental health problems at Kafurumu is to place them within their social and spiritual context. The ancestors, (or category of ancestors), that “makes people crazy” are wild buru spirits that come from unspecified places. These are opposed to domestic spirits that are benevolent and used routinely. Akin describes buru spirits as one of the foreign spirits that have been ‘imported’ into Kwaio.

One type of female alien spirit called buru personifies this ethos [foreign, transient, asocial or antisocial, lacking in qualities most valued and exemplified by ancestral spirits]. Since the 1930’s buru have been purchased abroad by individuals seeking access to new and supernatural powers. Once back in Kwaio, the buyers have lost control of the spirits, with dreadful results. Multiple suicides, dwindling support from ancestral spirits, and the disintegration of mountain communities have all been attributed to uncontained wild buru. In recent years these spirits have become more active and have been blamed for a growing number of social ills. (1996:149)

The area surrounding Kafurumu has been severely affected by buru spirits with suicides and unexpected antisocial behaviour increasingly common. When people present to Kafurumu clinic with mental health conditions attributed to buru it is immediately acknowledged and centralised. Esau explained the approach:

Yes, it is true your belief, let’s not disrespect our customs and beliefs, but I want to look at one side–why does buru come? The buru won’t come if everything is good–there must be a link or reason that the buru came.

Social conditions in the person’s settlement are examined as are social circumstances that cause the person to worry or that may begin “something wrong in their mind”. This may be a person asking for shell money to attend a feast and being refused or having relationship problems. “The buru can’t actually read one’s mind” just see actions and responds. Thus social interactions and conversations that may affect the mental health of a person may “cause” the person to be in a state that is responsive for the buru to enter. “For that reason the buru will recognise that you have talked like that and see an opportunity to approach and possess the person. Buru will then spoil that person”. If the person is in a state of to’oru leanga (staying well) then there will
be little reason for the buru to affect that person. Thus “If we make something wrong in our communities, then it is not the buru, its starts with that person’s mind—that person’s thinking.” Esau explained the approach:

If people [staff] at the clinic do not understand this then it will be difficult to relate to the patients, and how will they be able to give appropriate treatment? If you just say ‘health’ is like this or that, it will be too difficult and we need to apply what the people know and their beliefs. Every time people come with any different kind of condition I have to relate back to this type of explanation to Kwaio custom, so they can understand. You have to relate to what they understand first before coming to a medical explanation. If you push along with ‘health’ explanations then people will not accept - we call it ‘white eye’ people will not know. You will just keep pushing and pushing, but the person you are talking to just has no idea about what you are talking about. So it is hard unless you know Kwaio custom and able to apply it to ‘health’ and then this will allow people to understand.

Example 2: The Kafurumu Water Supply—Incorporating Kwaio Cosmology in a Public Health Initiative

In 1999 a piped water supply was connected to the clinic settlement. This supplied water for the small community living at Kafurumu and patients and their families. Prior to the pipeline water was carried from a nearby water source.

During the planning of the water supply project it was clear that standard underground pipes, or pipes laid on the ground, were not appropriate for the location. If pipes were on or under the ground it would allow women step over them and ritually defile the water. This would make it impossible for ritually mature men to drink or otherwise use the water. To install a standard underground piped water system would mean men who drank the water would need to sacrifice between five to ten pigs to adalo to compensate for such a blatant violation of ancestral rules. If sacrifices were not made sickness would befall him or his family. This required an alternative to be conceptualised. The project was approved by the community when plans were made to elevate the water pipes to allow people to walk under them. This meant that instead of the pipe coming up from under the ground and the tap sitting on top of the pipe, the tap now hangs from the elevated pipe, supported by a frame. Elevated pipes now exist in the clinic settlement and anywhere along the route of the pipe that intersects a forest trail. This public health/health promotion project, had it not followed Kwaio
cultural rules, would have been perceived to bring more sickness and death to the community—indeed a death promotion project! Esau asserted “for everyone to be equal the pipes needed to be elevated”. If the pipes were under or on the ground only the women and Christians could drink the water, but as they are elevated it is used by all regardless of gender or religion.

Another reason the pipes were elevated was because of the social connectedness and obligations Esau has to his community. Had the pipes been on or under the ground everyone in the community would be consistently reminded that their beliefs were not respected. Such a constant reminder would make Esau feel ashamed that he had deliberately excluded a part of his community from a basic need in life, as he explains:

It was the community who worked hard in carrying the pipes and cement and materials into the mountains and everyone helped in building the water supply project and then if only my family and the Christian minority were able to drink from the system, and when the community from the surrounding area came and were unable to drink, then it would be a very shameful thing for me and my family. So this is why a balanced approach is needed, and the pipes need to be elevated – so everyone can benefit. Even very important men, when they come to the clinic will go straight to the tap and drink from it. This shows that they are very happy. What do they have to worry about? Because they know it is good water. Even if he drinks it his adalo will have no reason to be angry with him, as it is adalo who hold the power of wellness and sickness.

The alternative design of the Kafurumu water supply did not only consider the pipe with the incoming water but also the placement of the waste water drainage. If the waste water pipe were to run through the women’s menstrual area, or go near the women’s toilet this would displease adalo and exclude men from drinking from the tap.

So for that reason, when the water supply at Kafurumu was set up, the waste water was drained away from the bisi and the female toilet. If the community saw this was not occurring they would be very angry and not want to drink from the tap.

Thus the water supply was designed and constructed at Kafurumu. It continues today as a monument to the ‘balanced’ approach to initiatives undertaken at Kafurumu.
Example 3: Cultural Approach to Maternal Care—An Ongoing Challenge

An ongoing challenge at Kafurumu is the need for improved maternity services. As a male Esau is only able to perform simple antenatal procedures. This is of constant concern and Esau is acutely aware of the number of women who experience difficulties during delivery in the bush. Serious complications sometimes culminate in maternal and child death. There are numerous cultural barriers faced by women who wish to access maternity services at Atoifi which means very few babies are delivered there. Regularly medications have been organised to be given to women by untrained attendants. Separation of gender roles means Esau is unable to personally assess or treat the new mother.41

Esau became interested in the stories he had been told of his grandfather who was known for his love, compassion and affection for his wife and family. When Esau’s grandmother had given birth his grandfather was so concerned for her welfare he broke taboo and went directly to the delivery area to visit his wife and newborn. He used a protective magic in the form of the bark of a particular tree to protect him from ancestral wrath that would normally ensue after such a deliberate crossing of cosmological boundaries.42 When Esau’s grandfather first arrived at the delivery hut, the attendant was not there. On her return she was shocked to see her charge’s husband in the delivery area. He chided her for not attending to his wife as she was paid to do. He then returned to the common area of the hamlet with no ancestral wrath ever forthcoming, reinforcing the power of the protective magic. This intrigued Esau, who sought to discover more about the potential of this system.

Esau sought advice from senior women in the community on the appropriate ways to utilise the protective system his grandfather had used. Discussions with particular kin

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41 A young woman from the community is paid by the husband of the expectant mother to accompany her in the delivery area. She will be expected to assist with the physical practicalities of the new mother and baby but does not have any formal role in assisting the delivery of the baby. This entails gathering water from particular water sources and harvesting from particular gardens planted specifically for this time. The young assistant is unable to return to the hamlet for ten days after the birth of the newborn (the exact period of time differs from area to area, however it is between 7–10 days).

42 Keesing (1982:73) notes there are “magical and other ancestral means of circumventing normal rules. Thus some groups command magic that partly protects them against the massive contamination caused by maternal death in childbirth; and some groups command magic that allows them to enter the kaakaba (women’s latrine area) to steal pigs”.
groups who hold the knowledge has followed. Esau is also keen to utilise the attendants who accompany Kwaio women during childbirth. When the clinic moves to the new location there will be sufficient space to create and support a specific birthing area. Consistent with the philosophy of Kafurumu, maternity services will utilise resources and systems already in place in the community. Esau plans for the cohort of women currently paid as untrained attendants to be trained as traditional birth attendants to assist in the birthing process. These traditional birth attendants would go beyond the physical practicalities as they have always done to learn delivery techniques and associated skills to care for the mother and newborn. These traditional birth attendants will also be responsible to maintain gardens specifically used to feed women while in the birthing area. The future nurse at Kafurumu would be called to the birthing area in emergency situation. Esau envisages utilising the system his grandfather had used to allow female nursing staff go to the birthing area and return to the clinic on the same day without having to be away from the clinic for the requisite 10 days. This system would also allow male nursing staff and visiting medical staff to assist with birthing in emergency situations.

In a process encompassing mutual respect and understanding, Esau has had a far reaching impact on the people of not only the Lafea but the entire interior of Kwaio. Many people access services at Kafurumu who do not at Atoifi. Esau was one of the 60 chiefs to be recognised by the Provincial government in May 2000 and became the chairman of the Kwaio Fadanga (Kwaio Council of Chiefs) in 2005.

Although Kafurumu clinic is an example of centralising Kwaio concepts of health and counters the colonial methods and wholesale Christianisation of the past, it is only one small, relatively autonomous clinic in a remote location. It however serves, not only as a further example of the health, culture and Christianisation nexus in Kwaio, but provides an alternative to the model at Atoifi. As a result of my exposure to this anti-colonial approach and with an increasing understanding of the anti-colonial struggle in Kwaio I asked myself—is culturally appropriate health care able to be delivered on a larger scale or at Atoifi? This has been a question the Kwaio people had been asking themselves for the past forty years. My research in 2000 had documented the Kwaio community’s wish for a facility at Atoifi where they did not need to repudiate core
cultural or religious beliefs. Later that year Atoifi administration agreed to investigate such a facility (later known as the ‘bush ward’). To use an anti-colonial methodology—in the form of Participatory Action Research—seemed a ‘natural fit’ to investigate culturally appropriate health care at Atoifi, and to which we now turn.
4. Participatory Action Research—A Methodology for Action

In the initial chapters in this thesis I have described the background and context of the Kwaio ambitions for culturally appropriate health care at Atoifi. As described, the bush people’s response to the exclusion and injustice they faced was a recommendation to design, construct and operate a facility, where cultural and religious beliefs were not repudiated. This became known as the ‘bush ward’. This chapter outlines Participatory Action Research as an anti-colonial ‘methodology for action’ which was used to work towards this goal. The chapters that follow describe and analyse the contemporary events which took place between 2000 to 2006. They also outline the processes used with Atoifi staff and the Kwaio community to achieve the vision of the bush ward.

4.1 Participatory Action Research as Anti-Colonial Methodology

Although Atoifi is not formally in a colonial situation (the Solomons have been independent since 1978), much of the attitude and practice at Atoifi continues the legacy of colonisation. As Linda Tuhiwai Smith argues, the effects of the colonising society dominates and continues to “determine the shape and quality of their lives [the colonised], even after it has formally pulled out” (1999:7). Earlier chapters have outlined the historical context of culture, colonisation and Christianisation at Atoifi and how “colonialism was not just about collection. It was also about re-arrangement, re-representation and re-distribution” (Smith 1999:62). Choosing the most appropriate way to conduct research in this context is vitally important, as put forth by Fanon (1965:125):

It is necessary to analyse, patiently and lucidly, each one of the reactions of the colonised, and every time we do not understand, we must tell ourselves that we are at the heart of the drama—that of the impossibility of finding a meeting ground in any colonial situation.

This is particularly important given the part the Christianisation process plays in driving the colonial enterprise. As Smith (1999:78) asserts, “for missionaries there was a huge and exciting minefield of lost and fallen souls who needed rescuing. The savagery, abhorrence and ‘despicability’ of the natives challenged their very
vocabulary”. The situation at Atoifi necessitated working outside the colonial methods which had failed the Kwaio, and employing a methodology that challenged the patterns of the colonial past and present. As Smith (1999:61) emphasises research has a sordid history, since much of the colonial period was an era of “highly competitive ‘collecting’. Many indigenous people might call this ‘stealing’ rather than ‘collecting’” (Smith 1999:61).

The history of research is dominated by the scientific paradigm of positivism. Positivism operates from a set of underlying beliefs and assumptions derived from empiricism about how knowledge can be acquired and understood (Smith 1999:42; Gaventa and Cornwall 2006; Park 2006; Reason and Bradbury 2006). Scientific positivism however “comes up short as a vehicle for providing explanations for the socio-cultural aspects of human life” (Stringer and Genat 2004:20). Given the complexity of the social, cultural and religious issues at Atoifi, I knew my research methodologies would need to be fundamentally different from those of the past. A review of the literature led me to believe that Participatory Action Research (PAR) would honour all knowledges and allow me to have both Kwaio people and Atoifi staff as collaborators. PAR has at its core the principle that research occurs with and by persons and communities not on or to persons and communities (Wadsworth 2005; Reason and Bradbury 2006). It is collaborative and flexible and aims to address issues of importance to the ‘researched’ as well as the ‘researcher’. The distinction between the ‘research subject’ and ‘researcher’ is fundamentally different in PAR, since collaborative approaches imply critical partnerships (Baldwin 2006; Heron and Reason 2006; Reason and Bradbury 2006). Stringer and Genat elaborate on this distinction:

It says, in effect ‘Although I have professional knowledge that may be useful in exploring the issue or problem facing us, my knowledge is incomplete. We will [together] need to investigate the issue further to reveal other relevant (cultural) knowledge that may extend our understanding on the issue’. Expert knowledge, in this case, becomes another resource to be applied to the issue investigated and stands alongside the knowledge and understandings of other people whose deep and extended experience in the setting provides knowledge resources that might usefully be applied to the solution of the problem investigated (2004:27).
In PAR, the researcher is the catalyst or facilitator of a collaborative research process rather than an expert who does research (Wadsworth 2006). Participation, dialogue, respect and action are key to the process and the successes that result, making it a fundamentally anti-colonial methodology. Participation is a key to the process of consciousness-raising and becoming critically conscious of the socio-cultural reality in which one lives and how one lives in and with this reality. What Freire (1972:51) named “conscientisation” goes one step further, and refers to the process in which “men [and women], not as recipients, but as knowing subjects, achieve a deepening awareness both of the socio-cultural reality which shapes their lives and of their capacity to transform that reality”. Conscientisation is a foundation concept in PAR as “conscientisation is a joint project in that it takes place in a man [sic] among other men [sic], men [sic] united by their action and by their reflection upon that action and upon the world” (Freire 1972:75). PAR explicitly aims to work with people to develop their capacity for inquiry both individually and collectively, and to act towards changing unjust situations (Stringer and Genat 2004:4). In Kwaio and particularly at Atoifi this was an ongoing challenge due to the constantly changing research environment. I aimed to follow the direction of Kickett, McCauley and Stringer (1986 cited in Stringer 1996:23):

- You are there as a catalyst.
- Your role is not to impose but to stimulate people to change. This is done by addressing issues that concern them now.
- The essence of the work is process-the way things are done-rather than the results achieved.
- The key is to enable people to develop their own analysis of their issues.
- Start where people are now, not where someone else thinks they ought to be.
- Help people to analyse their situation, consider findings, plan how to keep what they want, and change what they do not like.
- Enable people to examine several courses of action and the probable results or consequences of each option. After a plan has been selected it is the worker’s role to assist in implementing the plan by raising issues and possible weaknesses and by helping to locate resources.
- The worker does not focus only on solutions to problems but on human development. The responsibility for the project’s success lies with the people.

PAR, as described by Reason and Bradbury (2006:1), resonated with me philosophically as a way to research with and by persons and not on or to them.

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43 A slightly different definition of conscientisation is given by Freire in his classic Pedagogy of the Oppressed (1996:17). “The term conscientisation refers to learning to perceive social, political and economic contradictions and to take action against the oppressive elements of reality”.

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Action research is a participatory, democratic process concerned with developing practical knowledge in the pursuit of worthwhile human purposes, grounded in a participatory worldview which we believe is emerging at this historical moment. It seeks to bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of pressing concern to people, and more generally the flourishing of individual persons and their communities.

PAR enacts inquiry that is fundamentally democratic, participatory, empowering and life enhancing (Reason and Bradbury 2006). These principles are also the foundations of two of public health’s leading international documents: the Alma Ata Declaration on Primary Health Care, ‘Health for All’ (WHO 1978a; 1978b), and the Ottawa Charter for Health Promotion (WHO 1986). What these documents and PAR have in common is that they privilege a health sector that is practically, socially and culturally acceptable; collaborative and accessible, and that encourages self-reliance and self-determination. This makes PAR a natural choice for public health research.

Although PAR may be a natural choice for researching public health, many health professionals are not always willing to fully participate with the people as this challenges deeply embedded power inequalities present in many health institutions and communities. Freire (1996:55) highlighted such situations, using the oppressor/oppressed dichotomy to describe those with/without power. His description could easily describe situations in health institutions, both service delivery and health education, including those at Atoifi who hold power over the recipients of their services. “Indeed the interests of the oppressors lie in ‘changing the consciousness of the oppressed, not the situation which oppresses them’, for the more the oppressed can be led to adapt to that situation the more easily they can be dominated”.

PAR is not just a technical pursuit, but explores the realities of people and communities being a part of their world, embodied in their world and co-creating their world. It explores extended epistemologies and inquires into the meaning and purpose of people’s realities (Chaudhary 1997; Cock 2005; Schön 2005; Bradbury and Reason 2006). Stringer and Genat (2004:22) state this is “at the heart of action research—the need to clarify and understand the meaning implicit in the acts and behaviours of all
people involved in events on which the research is focused". Phenomenology, the philosophical approach that explores the subjective realities of human experience, is used within PAR because “Phenomenology focuses on the need to get subjectively in touch with knowledge of people’s everyday experience, not so that we can explain it through our own systems of knowledge, but so that we can understand it in their terms” (Stringer and Genat 2004:24).

The concept that ‘Atoifi was in Kwaio but not of Kwaio’ had troubled me over the past decade. How could a major institution have survived for 40 years while being such an anathema to the community? The answer became clear when I realised that Atoifi had no need to be in and of Kwaio since it was in and of the church. The church and the processes of Christianisation and colonisation were the dominant discourses at Atoifi. Other discourses were secondary—those of the cultural integrity of the community, community health or medical ethics. In utilising PAR, I attempted to honour all knowledges and experiences of the divergent groups involved in the research and include all stakeholders in results and action achieved. I had the opportunity to use methodologies never before applied at Atoifi. Nonetheless, I had lingering questions regarding the methodology: Could I undertake research, and generate outcomes, that were in and of Kwaio and in and of Atoifi at the same time?


1. Participatory Action Research is not the usual thing social practitioners (academics and workers) ordinarily do when they think about their work.
2. Participatory Action Research is not simply problem solving. It involves problem posing, not just problem solving.
3. Participatory Action Research is not research done on other people. It is research by particular people on their own work, to help them improve what they do, including how they work with and for others.
4. Participatory Action Research is not a research ‘method’ or ‘technique’ for policy implementation. It does not accept truths created outside the community or truths created by researchers working inside the community who treat the community as an object for research.
5. Participatory Action Research is not ‘the scientific method’ applied to social (educational, agricultural) work. There is not just one view of the scientific method, there are many.

Stringer and Genat (2004:24) explain the limitations of phenomenology and the need to use it as only a part of the PAR process, (in this instance in a health care setting). “Phenomenology does not offer theory to explain and/or control practitioner/client interactions and behaviours, but rather plausible insights that have the potential to connect health professionals more meaningfully with the world of their clients and patients... A phenomenological perspective should not be interpreted as the best way to approach research, since it will sometimes be appropriate for practitioners and researcher to stand...
How could I acknowledge the dominant colonial-Christianisation discourse, but at the same time work apart from it? How could the research centralise the Other? Could it make a real difference for those facing the reality of exclusion and oppression? Chapters 5–8 describe the processes used, challenges faced and actions that resulted when undertaking PAR with Atoifi staff and the Kwaio community.

Emergent Questions from the Research Environment

This research emerges from prolonged experience at Atoifi and research undertaken in Kwaio in 2000. That research encompassed recommendations from the Kwaio community for a culturally appropriate health facility to be established at Atoifi. The research documented in this thesis responds to questions which emerge from the research environment, generated by significant community concern developed within the cultural and historical context described in the preceding chapters.

Reflecting on the research environment a number of questions emerge

Can the human impact of preventable death and disease be improved by addressing the injustice, oppression, exclusion and inequalities?

Can using an anti-colonial methodology counter a history of colonial methods that have failed the people of Kwaio?

Is it practical (or impractical not to) to use a participatory worldview of seeking meaning and purpose, practical being and acting and an extended epistemology in such a complex situation as Atoifi?

Do the use of multiple methods that emerge over time, and the cultivation of awareness of multiple realities, result in an appropriate methodological framework?

back and observe the situation objectively, assessing and evaluating events in unemotional and disengaged terms”.

46 In theory, PAR has the capacity to transcend seemingly oppositional viewpoints and paradigms because of its participatory approach. Bradbury and Reason (2006:7) discuss this: “A participatory view competes with the positivism of modern times and the deconstructive post-modern alternative—and we would hold it to be a more adequate and creative paradigm for our times. However, we can also say that it also draws on and integrates both paradigms: it follows positivism in arguing that there is a ‘real’ reality, a primeval givenness of being (of which we take part) and draws on the constructivist perspective in acknowledging that as soon as we attempt to articulate this we enter a world of human language and cultural expression. Any account of the given cosmos in the spoken or written word is culturally framed, yet if we approach our inquiry with appropriate critical skills and discipline, our account may provide some perspective on what is universal, and on the knowledge-creating process which frames this account”. The constant challenge for PAR at Atoifi was to develop appropriate critical skills and show discipline in using them throughout the PAR process.
Can the Christian and medical rhetoric (religious liberty and ‘health for all’) and the contradictory reality at Atoifi (exclusion from services because of religious belief) be challenged?

4.2 The Research Question

Out of these emergent broad questions comes the research question:

Can the Participatory Action Research process result in culturally appropriate health services for Kwaio bush people at Atoifi?

Why Is this Question Important?

The history of Kwaio, including Atoifi, has been one of conflict and confrontation between ‘development’ and a proud indigenous people unwilling to accept blatant dismissal of their traditional ways (Refer to the reference section for a list of Akin’s and Keesing’s writings covering this topic). For many, the process of ‘development’ has meant submission to western hegemony through the colonisation and Christianisation experience at Atoifi. The bush people have seen what development has to offer, yet choose to remain strongly committed to traditional ways and ancestral religion; they have been fascinated and charmed, but not deceived by ‘development’.

The assumption that development is always favourable, a movement from inferior to superior, worse to better, dark to light (Esteva 1992) has dominated at Atoifi. Unlike sections of the government (Gegeo 1998), the bush people have deemed this untrue, as well as the associated suggestion that they must repudiate core aspects of ancestral religion.

Participatory processes that incorporate Kwaio principles aim to enhance Kwaio community control. The adoption of inclusive and collaborative community-based PAR is intended to allow this project to serve as a tool for de-hegemonisation. The question then arises: can PAR live up to its rhetoric in a complex situation such as that

47 Antonio Gramsci (1971) described hegemony as the process of the ruling class not only dominating but maintaining control over members of society; “the entire complex of practical and theoretical activities with which the ruling class not only justifies and maintains its dominance, but manages to maintain the active consent of those over whom it rules” (1971:244). This active, although at times unconscious or involuntary consent, is what Gramsci called hegemony. The concept of hegemony has been used to describe the dominance of the western development discourse (Escobar 1995; Watts 1995; Gegeo 1998; Kamat 2002)
at Atoifi? If it is to do so, it must counter the sort of hegemony that Escobar has described: “The coherence of effects that the development discourse achieved is the key to its success as a hegemonic form of representation: the construction of the poor and under developed as universal, preconstituted subjects, based on the privilege of the representers” (1995:53).

How then does one endeavour to engage in the process of dehegemonisation? Malaitan David Gegeo (1998:28) suggests, “Dehegemonisation starts to take root where anchored in people’s epistemology, because it is when they create truth about something that they form a discursive framework on the basis of which they act”. Central here is PAR’s recognition and incorporation of all knowledges. To centralise Kwaio knowledges in the process is critical to putting to the fore indigenous epistemology: “a cultural group's ways of theorising knowledge” (Gegeo and Watson-Gegeo 2001:55). This approach has not informed policy or practice at Atoifi. PAR has a core foundation principle of an extended epistemology applied towards the emancipation of peoples (Fals Borda 1988; 1997; 2005; 2006; Zuber-Skerritt 1997; Reason and Bradbury 2006). This is to counter failings where, “Traditional knowledge has frequently been over-looked in the search by outside professionals to find solutions to development problems” (Brohman 1996:266). PAR calls for an epistemological turn to investigate alternatives to Anglo-European cosmology and positivist epistemology (Park 2006). Recent work on opposed epistemological approaches on Malaita has called for an extended Indigenous epistemology (Gegeo and Watson-Gegeo 2001; 2002). This is important, but Burt (2002) argues that a combination of all knowledges is required to articulate shared understandings. This is consistent with PAR, which honours all forms of knowledge in its pursuit for shared practical local outcomes (Pyrch and Castillo 2001). Through this approach, PAR can act as a tool of dehegemonisation.

Health professionals worldwide acknowledge the relationship between culture and health (Airhihenbuwa 1995; Huff and Kline 1999; Strathern and Stewart 1999; Helman 2001; Nichter and Lock 2002; McElroy and Townsend 2004; Trostle 2005; Joralemon 2006; Satcher and Pamies 2006). Many health programs, both in so called ‘developing’ and ‘developed’ countries fail because they do not encompass cultural concepts of health (Hahn 1999; Campbell, Wunungmurra and Nyomba 2005). Many
Preventive health programs that are anchored in culturally appropriate paradigms enhance and magnify the possibilities offered in progressive educational processes/approaches that embrace dialogic participation. This process of engaging teachers/interventionists and students/audiences in the production of meaning, value, pleasure and knowledge should be central to the mission of health promotion and education. It is only through such dialogue that varied cultural expressions and meanings are affirmed and centralised, and the production of cultural identity can be legitimating and empowering relative to promoting individual, family, community, and societal health (Airhihenbuwa 1995: xiv).

4.3 The Research Process

How the Research Question Was Addressed

To address the research question, a Participatory Action Research methodology was used. PAR centralises people’s reality in specific situations so people can reflect and take action towards bettering the situation. It needs to reflect, and respond to, the unpredictable and dynamic reality of the human experience which, because it so seldom follows a straightforward, predicable path, cannot be assumed to be a linear process. Numerous verbal and visual models have been used to represent the PAR process. They all attempt to signify the need to constantly reflect and act in a cyclical manner to gain a greater understanding of the situation and make progress towards

Figure 4.1: Basic Action Research Cycle

Action Research is not a neat and orderly process that progresses step by step, as cyclical models may seem to suggest. It requires constant recycling of activities and
reviewing of previous observations, reflections, plans and actions. For this reason, many action researchers expand on the cyclical model to create a spiral or helix (Kemmis and McTaggart 1988; Schmuck 1997; Wadsworth 1997b; McNiff with Whitehead 2000; 2002; McNiff, Lomax and Whitehead 2003; Stringer and Genat 2004; Altrichter, Kemmis, McTaggart and Zuber-Skerrit 2005). Some spirals are vertical (Kemmis and McTaggart 1988) and others horizontal (Stringer and Genat 2004). The spiral I have created to represent the PAR undertaken in this thesis (Figure 4.2) shows many smaller simultaneous/coexisting cycles nested within a larger spiral and resembles the oblique spiral presented by Zuber-Skerrit (2001). This represents research cycles that repeat constantly through time (past, present and future) progressively building on observations, reflections, plans and actions.

**Figure 4.2 Action Research Spiral**

In the action research cycles within the spiral I have shown two concentric cycles taking place simultaneously, what Dick (1998) calls ‘cycles within cycles’. This demonstrates a parallel theoretical and operational/practical objective during the PAR that allows consideration of the complexity of people and social systems. As the
operational/practical situation changes (partly due to the PAR itself), and external factors effect action, then theoretical, methodological and operational approaches need to be reflected upon and modified.

To illustrate the flexibility and responsiveness of the PAR process I have expanded on the above model to include two oblique arrows parallel with the action research spiral.

**Figure 4.3 Action Research Model**

These parallel arrows indicate the parallel use of research methods and approaches and alongside data analysis throughout the PAR process. The arrow on the left indicates various research methods and approaches that took place. These were emergent and not pre-determined. This has been essential for the survival of the research and attainment of results because of dramatic changes in the research environment (as outlined in the following chapters). Although I have included years
beside each of the action research cycles in the spiral, this indicates the progressive building of observation, reflection, planning and action through time rather than discrete cycles in each calendar year. Such a model (numerous cycles within a spiral) can be used to represent any part of the PAR process in the overall life of the project. Details of how this was done are explained both in the text and diagrammatically through chapters 5–7.

I have expanded the above model in figure 4.4 to provide detail showing how research methods and approaches emerge from the action research spiral over time through the research process.

**Figure 4.4 Research Method and Approach**

The model emphasises participation, affirmation of multiple realities and action that reflects the social and cultural situation as constant methodological imperatives. Data
collection occurs throughout the process, rather than having a distinct ‘data collection’ phase separate from initial literature review and subsequent data analysis. It also signifies that reflection on research methods and approach occurs throughout the PAR process and may differ at stages throughout in response to the changing research environment.

To complement this I have also expanded and given detail to the data analysis method arrow on the right-hand side of the model. Figure 4.5 shows that data analysis emanates from the action research spiral, emerging from the start and continuing throughout.

**Figure 4.5 Data Analysis Method**

![Data Analysis Method Diagram]

This is implicit, given that reflection, planning and action are core to the action research process. Reflection on the data must precede any action based on that data in
order to remain true to the PAR cycle. The participatory foundation of PAR allows involvement by collaborators in the collection, storage and analysis of the data. Figure 4.5 shows details of methods of data collection, storage and analysis within the overall action research process.

**Description of the Research Approach**

Six periods of fieldwork took place between June 2002 and June 2006. Data gathered built on a knowledge base established through the literature and a professional and personal relationships with Kwaio since 1992. As a result of having worked and undertaken research over this period (MacLaren 2000), a strong foundation of enduring relationships was developed. The PAR process resulted in a journey of discovery unfathomable at the initiation of the research.

Kwaio chiefs and hospital leaders were central to the success of the PAR. They either participated directly in the action group, focus groups, staff meetings and regional community meetings, or indirectly through the Kwaio Fadanga (council of chiefs) and Atoifi administration. Others participated in the action phase of the PAR process. Numerous collaborators, both at Atoifi and in the Kwaio community, were vital to the success of the research. Although they all have been important I would like to acknowledge the following:

**Atoifi:**

- Lester Asugeni, former lecturer at Atoifi School of Nursing. As a hospital administrator and community liaison officer he facilitated discussions with his Kwaio kin. His excellent oral and written skills in several languages were utilised as secretary of the Atoifi Support Committee (ASC), a body that acted as a medium for community input to Atoifi and was utilised as the action group for the PAR process. In 2005 Lester moved to PNG to undertake further study.
- Dr Lemuel Lecciones, Medical Director (2002 to 2005) and acting CEO (2003/4). Dr Lecciones made himself available and supported the research
process philosophically and practically by participating in ASC meetings, and provided organisational and logistical assistance.

- Julie Aengari, former principal of the Atoifi School of Nursing and current Dean of Health Science at Pacific Adventist University in PNG. Her insights and participation were essential throughout the PAR, including as a member of the research reference group.
- Nashley Vozoto was supportive of the PAR process as Head of Outpatients Department beginning in 2002. During 2005 he became Director of Nursing and has been instrumental to the success of the PAR process.

**Kwaio Community:**

- Esau Fo’ofafaime Kekeubata established Kafurumu clinic in the Lafea, a region deep in the Kwaio interior. He has authority in the Kafurumu area as a chief since 2000 and rose to become of chairman of the Kwaio Fadanga in 2005. His success in providing the first and only long-term culturally appropriate medical care in the Kwaio interior makes him a visionary and thoughtful leader. He has participated since the inception of the PAR process. Without his leadership the planning and action phases would not have occurred.
- Jackson Waneagea, a chief from the Sinalagu interior, has taught in the Kwaio Cultural Centre schools and is a key member of the Kwaio Fadanga and Atoifi Support Committee.
- John Aniwa’i Laete’esafi, past paramount chief (head of Kwaio Fadanga) and influential leader. Both Waneagea and Laete’esafi have collaborated with researchers on issues such as the Kwaio Cultural Centre (Akin 1994, Keesing 1992) and on health issues (MacLaren 2000). Laete’esafi has participated throughout the PAR from inception to the action phase.
- Sava Japhlet Maefe’ua, school teacher and Kwaio ‘anthropologist and historian from within’, was a valued collaborator and friend. He provided valuable insights into both bush and coastal communities. He was diagnosed with testicular cancer and died at Atoifi in November 2005, aged 35.
Having enduring relationships with these people meant the PAR was established in collaboration with them and others at Atoifi and the Kwaio community. Working within an indigenous framework required the acknowledgement and incorporation of traditional holders of knowledge. Because PAR is fundamentally a collaborative process responsive to needs identified by research participants/collaborators, it needed to utilise multiple methods to collect relevant and trustworthy data from a variety of sources on which to collectively reflect and plan appropriate action.

**Data Collection, Storage and Handling**

Data was collected through prolonged engagement with Atoifi and the Kwaio community and specifically through:

- Conversations
- Interviews – both structured and semi-structured
- Action Group (Atoifi Support Committee)
- Focus Groups
- Research Reference Group
- Atoifi Staff Meetings
- Public Meetings
- Participant Observation
- Relational and Experiential Knowledge
- Literature

**Interviews and Conversations:** Interviews are one of the principle ways of understanding people’s experiences and perspectives in action research (Stringer and Genat 2004:59). Throughout the PAR process interviews were conducted to gain experiences and perspectives on which to reflect, plan and act. These ranged from formal structured and semi-structured interviews recorded and transcribed in air-conditioned offices, to opportunistic conversations with people met on rainforest trails. Conversations to reflect on research data took place with individuals and groups in the ‘field’, and also with academic and professional colleagues.
**Action Group:** Participation in action research can involve various group processes, including an action group (Kemmis and McTaggart 1988; McTaggart 1991; Stringer 1996; 1999) which is particularly useful in PAR in health care (Koch and Kralik 2006). Initial discussions with Kwaio leaders indicated the Atoifi Support Committee (ASC)—a group formed in 2001 of community leaders to inform Atoifi of community issues and *visa versa*—should be used as the action group. To create another group was unnecessary since it would merely have mirrored the membership and purpose of the ASC. The research concern of how to provide health services for all Kwaio and practical action towards achieving this was incorporated into the scope of the ASC. Membership included both coastal and bush representatives, land and resource owners, and women’s, youth and hospital representatives. Meetings occurred on an ‘as needed’ and ‘as possible’ basis on Wednesday mornings at Atoifi (set to coincide with the weekly market at Atoifi). Some members walked 5 to 7 hours at attend. Other people participated as necessary, such as hospital nursing staff, European Union and AusAID staff and visiting church leaders.

**Reference Group:** A reference group was set up to critique my practice and approach as facilitator of the PAR process and to discuss the actualisation of praxis. McNiff and Whitehead (2006:85) recommend a group of critical friends who are professional colleagues able to give critical feedback and validate the research process. The group comprised Atoifi staff interested in the research process and outcomes. Eight people were involved, all Solomon Islanders, and comprised a mixture of male/female and Kwaio/Non Kwaio. At every stage of the PAR process both the data and process were reflected on in an attempt to remain flexible, participatory and responsive to the research environment.

**Focus Groups:** Focus groups were utilised during the PAR to investigate various issues because they “enable research participants to share information and experiences that ‘trigger’ new ideas or insights, and provide greater insight into events and activities” (Stringer and Genat 2004:69). Focus groups were used at Atoifi and mountain hamlets to review and provide feedback to the ASC on the design and protocols for the proposed culturally appropriate facility. Specific groups such as the
Kwaio Women’s Association or landowner groups were invited to participate in focus group/action groups.

**Public Meetings:** Public meetings were open community meetings with input encouraged from everyone. Meetings were announced at regional feasts and markets, and were held in both the Kwaio mountains and on the coast.

**Staff Meetings:** Atoifi staff meetings were utilised for data collection and to provide feedback on research progress, resultant learning and planned actions.

**Ethnography:** Ethnographic principles were embraced because the project required not a ‘random sample’ of the community but it involve people because of ‘competence’ in dealing with issues, ability as orators, and holders of knowledge (Bernard 1988:170). An ethnographic processes was used throughout because it is “particularly well suited to the study of a people’s religious beliefs and perceptions of health and illness because of its focus on culture” (De Laine 1997:1). Participant observation was included and incorporated Stringer’s (1999:71) list of important elements in the research setting: Places, People, Objects, Acts, Activities, Events, Purposes, Time and Feelings. This was recorded through field notes, case studies and photography. Prior to undertaking six field visits from 2002–2006, I lived and worked at Atoifi and spent considerable time in the Kwaio mountains. This provided a base of relational and experiential knowledge that was expanded upon throughout the research. Walking for days on rainforest trails, sleeping beside fires on hard-packed dirt floors and eating food from the mountain forests developed experiential knowledge impossible to articulate through words. Having Atoifi as my base also created new relational and experiential knowledge. While ethnography was an important method used in PAR, it was only one of the tools used because—as Smith (1999) highlights—much of the social research that has been undertaken with Indigenous peoples has had colonising effects. Importantly, people participated from all three geographical areas in Kwaio (Uru, Sinalagu and `Oloburi), and included specific interest groups (for example the Kwaio Women’s Association, church groups, hospital representatives and traditional landowners). This enabled the research to take
place with and by persons and communities, not on or to persons and communities (Freire 1996; Reason and Bradbury 2006).

**Methods of data handling and analysis**

1. Field notes and diary/journal.
2. Interview transcripts.
3. Audio tape recording.
4. Meeting minutes.
5. Photography.
6. Letters/ e mail with supervisors/peers

Data collected was incorporated into the action research process of Observe, Reflect, Plan and Act, and analysed through this process. The trustworthiness of data was ensured through triangulation. Details of specific case studies were checked as findings were returned to collaborators. Emergent themes were analysed throughout the research process using open coding, and recurrent themes were analysed and discussed in the action group. In this thesis the resulting data is recorded using a narrative form of data presentation.

**Presentation of Data**

**Case Studies**

The use of case studies has been a common method of presenting data in action research (Kemmis and McTaggart 1988 and Reason 1988) and is frequently used in PAR in health care (Hart and Bond 1995; Stringer and Genat 2004; Koch and Kralik 2006). Case studies in this thesis come under two categories:

1. Documenting people’s interactions in accessing health care services at Atoifi. These are stories through which to share the human reality of the decisions the Kwaio face in accessing health services.
2. Experiences of myself and others negotiating the complex social, cultural, spiritual, political, economic and geographical situation at Atoifi and in Kwaio.

Case studies are used to share stories of human experience in an attempt to “understand what is happening in social situations and negotiate meaning” (McNiff and Whitehead 2006:40). They are intended to tell the stories of those experiencing injustice in their community and the process of addressing the injustice.

**Narrative**

The narrative mode I have chosen for this thesis tells the story of the PAR process to achieve culturally appropriate health care at Atoifi, and my understanding of the context. The thesis includes stand-alone case studies to explain specific situations and presents my personal account of the research journey. Narratives are useful because they “tell the processes of coming-to-know, and share people’s thinking, and they are generative, because they show the potential for further development” (McNiff, Lomax and Whitehead 2003: 27). This is a challenging task when “the person speaking sits inside the situation being described” (Brown and Jones 2001:62). The PAR process fundamentally changed the situation at Atoifi, and as such the narrative in the thesis is my experience of that change. Because people experience change differently, this thesis is not intended to present a series of objective facts, but rather a journey through and reflections on the changes precipitated by the PAR process.

This thesis is a description of the history of Kwaio and Atoifi as well as the PAR process and strives to accommodate the richness of description. The following methods are used to present the data.

- **DOCUMENTING:** Case studies of Kwaio people’s interactions with Atoifi
- **PARTICIPATION:** Utilising the Atoifi Support Committee as the ‘action group’ to collaboratively discuss the issues of exclusion from services, potential practical solutions and ways of achieving these solutions. Notes and minutes from the Atoifi Support Committee are used throughout.
• **OBSERVATION:** Participant observation (and interaction) through case studies to explain the complex social, cultural, spiritual, political, economic and geographical research context.

• **RECORDING:** The process of the PAR journey through the use of a narrative form of writing.

**Validity and Trustworthiness**

PAR is a naturalistic form of inquiry which seeks to construct holistic understandings in complex and dynamic environments. This can provide powerful understandings and create new knowledge on which to act to transform situations. This, however, is mostly specific for the particular situation and environment in which PAR is undertaken. As the situation changes, the understandings and knowledge created may be inadequate for the new environment and thus a new PAR process (or cycle) must be undertaken to respond. This makes knowledge contextual and fluid. Stringer and Genat (2004:49) explain this as: “we are not looking for ‘truth’ or ‘the causes’, but ‘truths-in-context’”. This is why I describe the PAR process and my journey through it. Others’ experiences of the PAR process may have differed, hence the importance I have placed on recording “the journey not the map” (Grootjans 1999:54).

Because the nature of PAR is essentially subjective and local, procedures to assess the validity of PAR differ from other forms of positivist research. Most action research texts devote whole sections to discussing rigour, validity and ‘trustworthiness’ of action research, indeed entire books are devoted to this topic, including Schwalbach (2003). Validity is a question of quality, and a prerequisite to quality is adherence to ethical principles and protocols. The following were incorporated in this research:

• **Ethics Approval:** Several levels of ethics approvals were granted namely:

  o Atoifi Adventist Hospital Chief Executive Officer letter of support, March 2002
  o Kwaio Community Chiefs and Traditional Leaders letter of support, April 2002
Ethical Principles: Collaboration and participation underpin this research and were present throughout. I was guided by ethical principles outlined by Smith (1999:120).

- A respect for people
- The seen face, that is present yourself to people face to face.
- Look, listen… speak
- Share and host people, be generous.
- Be cautious
- Do not trample over the mana of people
- Don’t flaunt your knowledge

Ethical Consent: The process of obtaining informed consent differed from mainstream qualitative research. Most Kwaio bush people are not sufficiently fluent in written language to make written consent forms practical. Interpreters read consent forms and plain language statements to participants. Participants’ responses were then recorded by the interpreter. The principles that consent is voluntary, competent, informed and understood were central (consistent with Section 18.1 Griffith University Guide for Research Involving Human Participation). As many of the participants did not have the capacity to phone or email the university directly, they were advised to direct complaints to Lester Asugeni at Atoifi. Many in the community used him as an intermediary in similar situations at Atoifi, and Lester was in an ideal position to act in this role. He had the capacity to translate and contact the university on behalf of the complainant if necessary.

Gender Issues: Although Malaitan societies are patriarchal, Kwaio women have had a voice on many issues affecting their lives, including health services delivered at Atoifi (Akin 1993; Keesing 1987, 1989, 1992; MacLaren 2000). The Atoifi Support Committee action group had a predominantly male membership, however the Kwaio Women’s Association, specific bush women
with social/cultural authority and female hospital staff all participated throughout the PAR process. A gendered approach was taken, with both men’s and women’s knowledge and participation central to action in providing culturally appropriate health services for both men and women.

- **Feedback and Member Checking:** By the very nature of PAR, knowledge and action created through the process is shared. Feedback occurred throughout the research process. This included reviewing in-depth interviews or field notes with relevant individuals and discussing questions that emerged. Prior to initiating action or using information from a group in a public forum it was rechecked with the group. This was done, where possible, during fieldwork or, between periods of fieldwork, through emails with Atoifi. All case studies went through a ‘member checking’ process during a field visit in July 2005 undertaken specifically for this process. I walked to the hamlets of the subjects in the case studies to read (most were unable to read English and so this involved translating into Pijin) the case studies and ask for final consent. Consent had been granted when initially documenting the case studies, however during the feedback people were given the opportunity to withdraw this consent, request anonymity or change any of the detail that had been recorded. None of the research collaborators withdrew their consent and all confirmed the use of their names be used in each case study. Most requested that more detail to be included in their case study. During the feedback the research process and results were discussed and reflections sought. A final copy of this thesis will be given to the Kwaio Archive currently planned for Kwaio anthropological and historical research data. This archive is proposed to be at Atoifi.

**Trustworthiness**

Stringer and Genat (2004) use principles outlined by Lincoln and Guba (1985) to ensure trustworthiness in action research in health care. Four principles used in this research are:

- **Prolonged Engagement:** The principle of prolonged engagement, that is, an enduring relationship with Atoifi and the Kwaio people since 1992, underpins
the PAR process. The concept of a culturally appropriate facility was not formed from abstract theory or external influence, but was rather a concrete reaction from a people facing injustice. This research was initiated to act as a catalyst to collaboratively document the context, the PAR process and action to face that injustice.

- **Persistent Observation:** Merely being present in a research context over time is insufficient to establish credibility, validity or trustworthiness. A process of engagement characterised by systematic observation and documentation is essential. Letters, journals and emails collated since the early 1990’s have provided a richness and intensity. This has been further supplemented by collecting reports, articles, academic papers and media reports about Atoifi, Kwaio, Malaita and Solomon Islands.

- **Triangulation:** The research used triangulation of data from at least three of the following sources to ensure the trustworthiness of findings:
  - Documentary evidence and literature, particularly from history, anthropology and public health
  - Semi-structured and unstructured interviews from qualitative research, both individual and group
  - Participant observation from anthropological research
  - Collaborative inquiry in the form of PAR

While these sources form the foundation of the research, they are not exhaustive. The research context is far too complex to limit data sources to these. Some data used predates the formal ‘research process’ by almost a decade, in the form of my written letters, conversations and lived experiences. Likewise, data continues to be collated through conversations/emails/letters and meetings with university staff and students, Atoifi staff and students, anthropologists, church leaders, past hospital employees (both national and expatriate), technical experts and community members. This supplements news/media reports and academic literature to become an ongoing process of data collection and reflection towards a greater understanding of culturally appropriate health care in Kwaio.
Stringer and Genat (2004:53) add two further measures of validity and trustworthiness for PAR in health care as indicators of quality for action research in Kwaio:

- **Participatory Validity:** The credibility of research is enhanced by participation throughout. The degree of participation in the research process with numerous people walking on rainforest trails for up to a day, and being out of their hamlets and villages for days on end, indicates participatory validity is a valuable indicator of quality and appropriateness. Had people chosen not to participate in the PAR process this measure would have raised questions about the validity of the process.

- **Pragmatic Validity:** This measure goes one step further to indicate the validity and trustworthiness of the research through practical outcomes achieved. “High degrees of credibility are evident as the understandings that emerge from the processes of inquiry are successfully applied to practical actions” (Stringer and Genat 2004:53). This measure is central to the PAR process as it strives for practical action to attain culturally appropriate health care in Kwaio. Its credibility should be judged against this measure.

**Further Guiding Questions on Validity**

Bradbury and Reason (2001:454) have created a list of “issues as choice-points and questions for quality in action research,” and these have informed the research. I constantly reviewed them throughout the PAR process, and aimed to achieve them.

Bradbury and Reason (2001:454) ask—is the action research:

- Explicate in developing a praxis of relational participation?
- Guided by reflexive concern for practical outcomes?
- Inclusive of a plurality of knowing?
  - Ensuring conceptual theoretical integrity?
  - Embracing ways of knowing beyond the intellect?
  - Intentionally choosing appropriate research methods?
- Worthy of the term significant?
- Emerging towards a new and enduring infrastructure?
4.4 Summary

The research described in this thesis follows a participatory action research process that utilises an eclectic collection of research methods appropriate for the research environment. The process emerges as a naturalistic way to address the research concerns and research questions that have emerged from the research environment. I have declared from the outset that the PAR process is an anti-colonial methodology, but there is nonetheless a risk that the research, if not thoughtfully reflected on, may continue the colonising process which has characterised health services at Atoifi. If the research did not incorporate a method of collaborative research based on decolonising methodologies, there was a risk colonial processes might be continued (Regehr 2000; David 2002; Cooke 2003). To protect against this, lessons which make PAR an anti-colonial methodology from Pyrch and Castillo (2001:384) have been heeded throughout:

(1) PAR is essentially practical in that it accesses local resources and encourages self-reliance
(2) PAR honours all forms of knowledge
(3) PAR is based on trust, an essential part of the dialogue
(4) A sense of community is an integral part of PAR
(5) Through the creation of trust and community, PAR builds self-awareness… Sharing different points of view, styles, philosophies and dispositions in order to learn … and put these learnings into action.
(6) PAR demands time.
(7) At all times and at all points we are required to translate knowledge into action.
5. Culturally Appropriate Health Care at Atoifi—the Action Research Response

*If we have faith in men, we cannot be content with saying that they are human persons while doing nothing concrete to enable them to exist as such* (Freire 1972:83).

This chapter outlines the Participatory Action Research (PAR) process used to explore culturally appropriate health care at Atoifi between June and December 2002. It records and reflects on the PAR process and describes the complex research environment through a series of case studies.

On Arrival at Atoifi in June 2002 for the initial six months of fieldwork it was obvious that colonial policy and practice was continuing. The two years since my 2000 research had been tumultuous for both the country and Atoifi, for different but interrelated reasons. The ‘atmosphere’ on campus was palpable. Before initiating any planning or action it was essential to individually and collectively observe in order to gain insights into the contemporary situation at Atoifi and reflect on implications for my research. This initial step in the PAR cycle was essential to re-establishing relationships. In what follows I describe my observations of, and reflections on, the context in 2002 and plans and actions towards culturally appropriate health care. Key lessons and reflections are included throughout the chapter and expanded in Chapter 8.

As stated in chapter 4 an **Observe-Reflect-Plan-Act** cycle, expanded into a spiral was the framework used in the PAR process. Diagrams presented in this and the following chapters locate the narrative in the PAR spiral, and illustrate how the PAR process moved through the spiral. The diagrams show the dates on which the events occurred and highlight the part of the cycle described. For example, in diagram 4.1 the Observe and Reflect parts of the spiral are highlighted in bold and the Plan and Act parts are in light text.
5.1 Atoifi 2000–2002: Observations and Reflections on a Period of Rapid Change

This section describes the initial OBSERVE and REFLECT stages of the 2002 fieldwork. Data was collected through participant observation, and formal and informal discussions with individuals and groups. Data was recorded in field notes, a journal, minutes and notes.

The period since 2000 had seen a rapid expansion and upgrading of physical infrastructure on the Atoifi campus with the new expatriate CEO securing funds from multiple sources for projects. While Atoifi rapidly expanded the rest of the country was in rapid decline. The ‘ethnic tension’ had enveloped the country with continuing social, political and economic upheaval. The June 2000 coup d’etat had forced the Prime Minister to resign and the Malaita Eagle Force (MEF) engineered the election of his successor. When I arrived in June 2002, the social, political, economic and security decline was so severe that many schools, clinics and hospitals were barely operational or in some cases not functioning. For example, in the later months of 2002 the national referral hospital in Honiara was only working four hours per day. Some provincial hospitals had no fuel to run generators. In the context of national decline Atoifi was providing full services and expanding. The people of East Malaita were proud of this, particularly the Kwaio people. A people historically seen as last on the ‘development scale’ of Solomon Island peoples now had the only fully functional hospital in the country.
The expansionary phase of 2000–2002 at Atoifi was characterised by the staff’s ability to access imported goods that came in containers of hospital cargo. Never before had staff and the coastal community had such access to consumer goods directly from abroad. Goods imported directly to Atoifi were available at cheaper prices than in Honiara because of import duty exemptions and bypassing wholesalers. Atoifi became known as a place where solar panels, batteries, whitegoods, kitchen appliances and power tools were available. People heard business transactions replacing health dialogue on the HF radio, and for some this raised the question: “waswe infala bisinis nao?” (‘are you a business now’).

Supplier induced demand on campus created an environment of competitive materialism. Staff went into increasing debt to acquire goods. This burden of debt increased as the price paid for goods increased when the Solomon Dollar decreased in value in relation to international currencies because of the ongoing ‘ethnic tension’. This was compounded when staff salaries decreased because of the non-payment of government funding to Atoifi (Although Atoifi is operated by the SDA church, the Solomon Islands government provides significant funding, including staff wages). Some in the community were dismayed at the sudden influx, while others swelled with pride that so much ‘cargo’ was coming. Ross (1978:196) described the SDA church in North Malaita a generation earlier as “in effect a European sponsored cargo cult.” I wondered if the materialism that had gripped Atoifi was a recursion in process.

48 HF radio conversations can be heard by anyone who has access to a HF radio. For most rural schools, clinics or government stations this is the only way of effective communication between each other and Honiara, and thus conversations can be listened to by anyone tuned to the particular frequency. People from across the country used this system to call Atoifi inquiring on prices and availability of imported goods.

49 So-called cargo cults have been found in many parts of Melanesia over the last century (Jebens 2004; Lindstrom 1993; Worsley 1968). Many areas have experienced the rise and fall of groups that believed that different messianic individuals, groups or organisations would come and disperse large amounts of ‘cargo’ to them, requiring little or no input of their own. This ideology is spread across many groups and has historically taken various forms. There have been individual ‘cult’ leaders. For example reports during 2003 described a cargo cult formed around the militant leader Harold Keke, whose followers on the Weather Coast of Guadalcanal believed he would return giving each of them $100,000 (PF Net News 23 Oct. 2003). In another case the focus was on groups, such as the American military during World War II who came bearing gifts. More recently there has developed a handout, foreign ‘aid’ mentality that some commentators argue has its roots in the Melanesian cargo cult mentality (Hughes 2003; see also PF Net News 26 Feb. 2004). Although the situation at Atoifi did not have a messianic character, many staff were affected by this underlying ideology when there was a sudden inflow of goods in an area historically isolated from such wealth. The CEO was certainly a powerful figure, in part because of his control of incoming goods. David Akin, cautions about using the label ‘cargo cult’
Discontent with purchases arose when goods started to break, malfunction or otherwise require maintenance. Many electrical appliances proved unable to cope with conditions of high heat, constant humidity or power frequency and voltage fluctuations. Goods (plant, equipment and appliances) purchased in Australia were often not models stocked by Solomon Island suppliers, and thus spare parts were unavailable. Much of the maintenance, purchase of parts or upgrading could only be done in Australia, organised through the hospital management. Donated goods and materials also arrived in containers, and were often sold. A number of donors ceased supplying goods and materials to Atoifi when they became aware of this. Many second hand goods had short life spans, particularly in the harsh tropical environment. The number of discarded goods grew, often thrown into the harbour from the end of the wharf.

I observed a paradoxical situation at Atoifi. As people purchased more consumer goods—particularly electrical appliances and ‘time saving’ devices such as electric frying pans or microwave ovens—the less they were able to use them. Atoifi’s electricity generation capacity was limited by its hydroelectric system and backup diesel generator. With the sudden increase in demand, the electrical system overloaded and periodically failed. As the system failed the frequency and voltage often went outside specified operational limits of appliances, resulting in their malfunction. Time-saving appliances caused the electrical system to fail, which forced staff to revert to time-consuming ways of cooking. For me, this was a clear lesson in the perils of unsustainable development.

Much of the cooperation and collaboration between staff on campus was replaced by competition. Material goods had always been a feature of Atoifi. As the only centre of ‘development’ in East Kwaio, people in the community often referred to Atoifi as as it carries connotations of religious fanaticism and illegitimacy: “It is important to point out in regards ‘cargo cults’ that the concept has often been used by Europeans to delegitimise anti-colonial political activities. Legitimate political actions are thus recast as dangerous religious fantasy and fanaticism that requires colonial or government repression. This occurred on Malaita during the post-war Maasina Rule movement. Caution is called for”. He explained further “it is a loaded term that has been misused a lot. Even just common "greed" among Melanesians is too often labelled "cargoism" or "cargo cultism" even when they are just coveting things like Europeans do. It mystifies people unnecessarily” (personal communication Nov. 2006).
‘town’. It was one of the main conduits through which new goods, people and thinking were introduced to the community. However the pace at which this was happening had clearly increased. Staff could now place orders for goods directly imported to Atoifi. The lower prices enabled staff ordinarily unable to access luxury items to purchase them. This led to a number of situations where a staff member would order a particular item but be unable to purchase it immediately it became available. When it was sold to another staff member, angst grew as staff saw ‘their’ ordered item sold to someone else. Some preferred debt to this situation. The purchase of goods meant less cash was available for other uses. A common experience for many Solomon Islanders earning a moderate to good wage is the expectation from extended family they will contribute toward expenses—particularly school fees—beyond the reach of village people. This was particularly the case during the ‘ethnic tension’, when there was an almost complete collapse of the economy and few people were being paid a regular full-time wage. Staff faced a decision between upholding family and cultural obligations or using funds for consumer goods.

Since the influx of goods was facilitated by the expatriate CEO the maintenance of a good relationship with him was paramount to individuals maintaining their supply of goods. The colonial management style—authoritative, autocratic, abrupt with a propensity to micro manage—was tolerated and condoned, in part because of access to goods. When allegations of misconduct surfaced, some staff showed hesitation to condemn it, due, in part, to the adverse effect this may have on the inflow of goods and continued development of infrastructure at Atoifi.

**Ongoing Development—A Continuation of Colonial Practice and Attitudes**

The historical disrespect and disregard for Kwaio culture continued at Atoifi. The hospital’s expansionary phase included plans to extend the administration offices and increase the size of the conference room. This included the expansion of the *tuusitori* section directly above the small trading store. These plans progressed with the full knowledge of the history and angst caused when the original *tuusitori* was built twenty years earlier.
The change to a more business focus in 2000–2002 included the pursuit of a new retail and wholesale strategy. The strategy included the expansion of retail services on campus and wholesale services for small village stores. Meetings were held with the operators of village stores, which secured in principle agreements that a wholesale outlet would be supported. The wholesale business started in 2001/2 with large quantities of basics such as rice, flour, tinned fish, noodles and biscuits shipped to Atoifi and on-sold in bulk. Venturing into the new area of wholesale supply was not without its challenges. Systems in place were not initially as robust as required. Customers had to pay for goods at the business office and take receipts to the security guard to release the goods from storage. When the business office ran out of official receipts they were written on small squares of paper. A number of forged receipts were presented to the security officer, who released goods. Despite several such incidents in which the hospital lost significant amounts of goods, the wholesale outlet continued.

To realise the potential of the retail and wholesale strategy a new building was proposed at the main campus entrance. The Adventist Health Association (AHA) in Brisbane became involved to raise funds for the project. A project proposal was written and submitted to Adventist Development and Relief Agency (ADRA) Solomon Islands. Several designs were proposed, with a three-story building favoured; the ground floor for storage and wholesale transactions, the second floor for retail and the third floor for accommodation units. The three-story plan was culturally inappropriate for all the same reasons as the *tuusitori* was. Not only would food items that had been on the lower floors not be eaten by bush people, but they would also be barred from entering to purchase non-food items. Bush people would be unable to eat wholesale goods distributed from the ground level to village stores.

A number of people, including myself, approached the CEO to discuss the implications and alternatives of the plan. Social, cultural and religious implications of the three-story were outrightly dismissed. I was told that despite knowing the history of the *tuusitori* and its ongoing negative repercussions the CEO would ‘plead ignorant’ to the cultural implications of the plans if further questions were asked. It was argued that the economic efficiency of building a multi-story building to house all
three functions on different levels outweighed any cultural concerns. A willingness was shown to intentionally go against advice given by the community liaison officer who had explained the negative implications of the design at length. Although alternative plans were discussed and arguments forcefully put, they were rejected.\(^{50}\) When I supplied information on cultural safety (Williams 1999) it was met with a dismissive “yes—that is one approach”. The design for the three-story building was approved by hospital administration and plans for construction proceeded. When ADRA became aware of the implications they reviewed their support for the project in order to uphold their mission to have equitable partnerships with communities (ADRA 2002). Plans were changed to remove the third level, which contained the accommodation units. The project was put on hold in October 2002 after the CEO was dismissed by church administration. The project re-started in early 2003 when a replacement arrived at Atoifi.

**Reflection**

The continuation of colonial attitudes and practice at Atoifi was overruling any cultural or religious beliefs of the bush people. The willingness to pursue the extension of the *tuusitori* and store project with full knowledge that it would violate core religious and cultural beliefs of the bush people was a typical example. The project proposal demonstrated how Atoifi was *in* Kwaio but not *of* Kwaio. It added to the argument of the bush people that development required Kwaio to relinquish their culture and religion, and as such was antisocial. The store would be the only option to purchase food items for hospital patients on campus. The hospital does not provide food for patients while admitted but is the responsibility of the patient’s family. Families from places too far away to collect food from their garden’s purchase food from the store at Atoifi. The argument that it is unjust to exclude people from the

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\(^{50}\) Hospital employees who were expected to work on the projects were fully aware of the cultural inappropriateness of the proposed extension and three-story building. They stated they had little choice but to follow the administration’s directives, and that they would complain amongst themselves but continue on the project knowing there would be a problem in the community well after the decision makers went back to their own countries. In a situation of general economic breakdown and unemployment of approximately 90 percent, a job was precious and workers feared being seen as trouble makers by administration. They could easily be replaced by one of the many unemployed workers waiting for jobs.
ability to purchase food in a way that does not require the relinquishment of culture was ignored. AHA were unaware of the cultural and religious significance of the project. Their advertising material outlined the development at Atoifi in glowing terms and benefits to the hospital and community. AHA leadership exhibited an evangelical zeal which negated any examination of negative social or cultural implications of their ‘development’ projects, and precluded any critical analysis of community benefits.

The recalcitrant colonial attitudes of expatriates at, or supporting, Atoifi was a major factor influencing the contemporary research environment and had the potential to undermine any participatory approaches undertaken in the PAR process. This was discussed at length with key collaborators and advice sought on ways to use inclusive, participatory processes.

Further Issues at Atoifi

Concomitant to the influx of goods on campus, research collaborators described a decrease in spiritual focus on campus. Atoifi had a reputation across the Solomons for two things: the dedication and quality of staff and the spiritual atmosphere there. Numbers at prayer meetings had declined since 2000 with some attributing this to the decline in unity. Rivalries had always been present, but a ‘spiritual safety net’ was perceived to mitigate these. With a lesser spiritual focus on campus, rivalries were perceived as worsening.

The decline in unity was also attributed to a weakened chaplaincy service. A decision was imposed on the chaplain by administration in 2000 to relocate from the administration office to a renovated room in the hospital wards. Many staff did not welcome the decision to relocate what was ‘God’s representative’s space’. When the chaplain’s term was completed he was replaced by a pastor who came out of retirement from the Western Province. The chaplain was friendly and experienced, but operating in an ‘acting’ capacity meant many of the programs led by the previous chaplain ceased. The coincident (interrelated) spiritual decline and materialistic
incline at Atoifi had implications for the PAR and needed to be reflected on and incorporated in the PAR process.

The perpetuation of a colonial attitude at Atoifi which included the need to assert and maintain unwavering power and control over Atoifi’s campus was an ever present reality. This was exasperated by the religious authority held by many of the senior managers who held local campus church leadership roles and membership of corporate church administrative committees. Staff who disagreed with the expatriate CEO’s authoritarian approaches had difficulty sitting through church sermons where they faced accusations of dishonesty and disloyalty to leadership. The situation was so dire that some staff chose not to attend services when he officiated. This was a significant sign of discontent in a context where spirituality and worship is a collective practice and experience. Staying away from a service at the Atoifi campus church denied the collective spiritual experience that underpinned the atmosphere, unity and history of Atoifi and served as a significant statement of no confidence.

**Reflection**

When I arrived at Atoifi in June 2002 I found the campus had changed dramatically in the previous two years and many staff were deeply discontented. I could ‘feel’ the place was different as soon as I arrived. It was hard to articulate but I could tell there ‘was something not quite right’. It was soon clear the spiritual environment was very different and materialism had gripped the campus. The legacy of the colonial and Christian enterprise, used with such success (from the perspective of the coloniser) at Atoifi continued to assert control over almost every aspect of life on campus. This was a major challenge on my arrival as I was intending to use a specifically anti-colonial methodology and be participatory in approach. To include, indeed centralise the perspectives of the Other in the process to achieve a culturally appropriate health facility at Atoifi would not be easy given historic and ongoing events at Atoifi.

The complex and tangled situation at Atoifi could not be isolated from the broader environment. As outlined in chapter 1 this was also a turbulent period within the history of communities across the Solomon Islands.
A Period of Rapid Change: Solomon Islands Society 2000–2002

Since the beginning of the ‘ethnic tension’ on Guadalcanal in 1998, subsequent return of 20,000 Malaitans to Malaita in 1999, coup d’etat and Townsville Peace Agreement in 2000, Solomon Islands society had to cope with rapid and ongoing social change (Fraenkel 2004; Moore 2004). A common phenomenon was the slipping influence of village leadership. This was mirrored in the overall unhappiness and uneasiness with leadership in many institutions of Solomon Islands government and civil society. With much of the economy crumbling and a dearth of political leadership, young educated people had little chance of gainful employment or career development. Many people who fled violence in Honiara returned to villages they had not visited for many years. Some children and young people were going ‘home’ for the first time. This sudden influx of people put pressure (housing, land, garden, social, economic) on communities across the country, and particularly on Malaita where population densities, especially on the coast, were already high. Many people, most notably the younger generation, had to negotiate a village system of decision-making they had little experience with or appreciation for. People arrived in rural villages with a young population and few ‘development’ or career prospects. With Honiara in chaos, so slid hopes for progression from their current state. Many young rural people saw their education and career possibilities diminish before their eyes. People exposed to systems of interacting with others in town and through video or television encountered a reality vastly different and often antagonistic to the system of village ideals and action. Life in an urban environment meant many of the traditional village ‘checks and balances’ were different in terms of who, what, when and how people could interact.

Young men had been drawn to the adrenaline and excitement of the armed militia, particularly those from Malaita and Guadalcanal. Several acquaintances of mine dropped out of high school to enter the excitement of the life of a militant. With the signing of the Townsville Peace agreement and the end of open hostilities in 2001, many ‘ex-militants’ were recruited into the Royal Solomon Islands Police Force as ‘special constables’. They received basic training and worked in a force that was
Chapter 5: Culturally Appropriate Health Care at Atoifi—The Action Research Response

intrinsically corrupt and involved in the coup d’etat in June 2000. Many continued
criminal and thuggish behaviour, however, from within a force that could protect
them. Others not recruited into the police force formed gangs who stole and extorted
money at will. Others melded back into society, both in Honiara and in home villages.

Ex-militants had a profound influence on authority structures. They brashly continued
criminal behaviour in Honiara knowing the police would do nothing. On returning to
home villages they were met with various receptions from differing groups. Many of
their peers saw them as heroes and wanted to be told stories of heroics from afar.
Others, however, were concerned with the new influences in the villages and the high-
powered guns that accompanied them. As young men with big egos and high-powered
guns they had instant profile and importance. They asserted their authority on matters
where it was not warranted, due to the presence of guns (Fraenkel 2004:128).

Domestic disputes, drunken brawls and land ownership disputes were all influenced
by young men with guns. While not the case in every village, it was in many. Young
men without guns could call on friends or relatives with guns to assert authority. As
these young men were now a ‘force to be reckoned with’ in local villages they were
often a direct threat to village authority. Some communities dealt with such
individuals and returned weapons to authorities, but not others. People began to
question the power and authority of village chiefs given their alleged involvement in
some untoward incidents. The influence of ex-militants on local and national affairs
was clear. Political and church leadership was also in question for involvement in, or
choosing to ignore, behaviour deemed unacceptable in the past. People were fully
aware that national political leaders were involved with shady and often corrupt deals,
including the office of Prime Minister. People spoke openly about the untrustworthy
nature of political leaders (Roughan 2002a; 2002b; 2003a). Questions were also raised
of local church leaders accused of making false claims to the government.

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51 Prime Minister Sir Allen Kemakeza was accused of instructing militia leaders not to hand over
weapons during amnesty periods set up by his government (People First Network News 7 Aug. 2003).
Finance Minister Snyder Rini was removed from office in a reshuffle in early August 2003, after
allegations of corrupt dealings and misuse of funds within his department. Investigations undertaken
by RAMSI led to numerous government officials and four members of parliament being jailed for
criminal behaviour, with several more under investigation (Roughan 2003b; ABC 2004c; People First
Network News 25 July. 2005, 18 Feb. 2005). Senior police were also charged and jailed (People First
compensation fund for property lost or destroyed during the ethnic tension of 2000. This all led to a lack of respect for leadership in different institutions of society. It was clear powerful groups with vested interests, such as the MEF and their supporters, were able to influence decisions of community leaders. This led many in the community to question leaders in positions of authority.

**Example – The Illusion of Leadership**

An example of the lack of trust and respect for leadership was evident when I attended an official amnesty ceremony at Atoifi in October 2002. I recorded the following note in my journal:

Amnesty for combatants in the conflict – There was a ceremony (attended by Police officials and Peace Monitoring Council leaders) at the front of Atoifi, with great fanfare, to officially give amnesty to people in the community, who had been deemed ‘weapons free’ and thus would not be charged for any offences during the tension. The irony was that one of the men to be given a clean slate and to be presented a certificate to state this was actually missing on the Weather Coast – one of the ten missing Kwaio men [who had gone to kill Harold Keke]. When his name was announced, there was a murmur through the assembled crowd. This left the ceremony with an air of farce. Some window dressing that had been shown up as just that. To add to that farce, the MC who had given a monologue regarding guns and handing them back was shooting birds at the back of his house only a matter of hours after the ceremony, with his personal gun he keeps in his house (not a high powered ex police gun, but the irony, never the less, was not lost!).

The community were well aware of who did and did not have weapons. They also knew the people involved with criminal elements. Despite this the ceremony went ahead, being led out by officers of the police force (tarnished by the involvement in the 2000 coup d’etat and unable and/or unwilling to maintain law and order in the country), the National Peace Council (a team with powers to observe and report only) and local leaders who obviously did not follow their own counsel. The community realised that despite what the leaders had said in the ceremony, there had not been, nor

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52 There was discontent in the community since some people employed by Peace Monitoring Council were educated, and could speak, read and write English, but were not seen as leaders in their communities. This follows a pattern described by Akin (1993:144) in the early 1920’s when the government under District Officer Bell developed a system of headmen and constables. “Many of those chosen were not recognised leaders, but were selected for their willingness and sometimes their sophistication in western ways… Some headmen took advantage of their positions to wield tyrannical power, particularly in East Kwaio”. Some of those employed to link the Peace Monitoring Council to the community were themselves involved in the violence and many retained their own guns.
was there likely to be, a wholesale round-up and charging of ex-militants or their collaborators. All of this created an illusion of leadership, however was just that—an illusion with little resemblance to the reality of the situation on the ground.

5.2 Participatory Action Research at Atoifi: June–December 2002

The following section is a description of the REFLECT and PLAN stages of the 2002 fieldwork.

Figure 5.2: Reflect and Plan in 2002 Action Research Events Spiral

To plan the research approach I met with my main research collaborators. The long-standing issue of how to provide culturally appropriate health services at Atoifi, in the rapidly changing and tumultuous context was discussed. On my first day at Atoifi one of my friends and collaborators from the bush asked for assistance to write a letter to the police department; He was able to write both Kwaio and Pijin but the letter was required in English. As a chief he had been involved in the investigation and resolution of a murder earlier that year. He hosted police who had not respected Kwaio culture and violated his hamlet and ancestors by using toilet paper there. My

As the fieldwork was to take at least six months, I was accompanied by my wife Michelle and our two sons, Hamish, 23 months, and Lachlan, 8 months. Having my family with me meant the interactions I had with members of the community were quite different than in the past, when I had not had the expectations and responsibilities of fatherhood to uphold while undertaking fieldwork. My ability to spontaneously attend community events at short notice was limited. On the other hand, the richness of interactions and experiences with my family created opportunities to observe and reflect on social and cultural situations that would have been impossible without my family.
friend had become very ill and only after sacrificing several pigs to his adalo had recovered. He wrote to the police to request reimbursement of his costs to source and sacrifice the required pigs to heal his illness caused by their violation of Kwaio custom in his hamlet. On reflection I became aware that although there were numerous frameworks, theories and explanations of both the research process and the rapidly changing contexts, both at Atoifi and the country as a whole, to move forward I would need to remain grounded in the reality of the people for whom I was there to work with. Colonial and Christian processes were continuing. How could I act as a catalyst and facilitator of dialogue between the bush people and hospital administration? Could PAR address the exclusion faced by the bush people and pursue practical solutions for improving the health of the community? I proceeded to use multiple approaches appropriate for the specific context I found myself in. The first four approaches used were:

- **DOCUMENTING:** Case Studies of Kwaio people’s interactions with Atoifi
  - Case Study 1: Fa’amolaa: A Case of Limited Access to Health Care Services
  - Case Study 2: Riuafu: A Case of Living with Disease
  - Case Study 3: A Case of Exclusion and Death
  - Case Study 4: Laete’esafi: A Case of Exclusion from Services

- **PARTICIPATION:** Utilising the Atoifi Support Committee as the ‘action group’ to collaboratively discuss the issues of exclusion from services at Atoifi, potential practical solutions and ways of achieving these solutions.

- **OBSERVATION:** Through participant observation (and interaction) document case studies which are relevant to explaining the complex research context.
  - Case Study 5: Ethnic Tension and Health Services
  - Case Study 6: Malaitan Social and Cultural Determinants of Health
  - Case Study 7: Complexity and Simplicity—The Italian Incident
Chapter 5: Culturally Appropriate Health Care at Atoifi—The Action Research Response

- Case Study 8: Conscientisation—The Process in Action

*RECORDING:* Through writing the narrative of the PAR journey

At every stage of the PAR process reflection constantly revisited both data and process to remain flexible, participatory and responsive to the research environment.

*DOCUMENTING:*

The following are case studies demonstrating the reality Kwaio people face in accessing health services at Atoifi.

**Case Study 1**

*Fa’amolaa: A Case of Limited Access to Health Care Services*

I met Fa’amolaa one afternoon in June 2002 on the verandah outside the medical store. He had just had his dressing changed on a large tropical abscess in the middle of his back which had recently been incised and drained. He was sitting talking to friends and relatives. This in itself was not an unusual sight—that of hospital patients sitting on the verandah, but Fa’amolaa was different from the average patient. He was from a hamlet four to five hours walk behind Atoifi and chose to uphold Kwaio religion and customs. His story was typical of many of his kin. He would be defiled by entering the outpatient department as it is located in the understory of the two-story building. If he chose to enter the outpatient department he would face negative consequences from *adalo* for which he would atone through sacrifice. Fa’amolaa did not have the requisite number of pigs and as such was unable to present himself to the outpatient department to treat the large abscess on his back for the past ten days. When he arrived at Atoifi he requested to be seen by outpatient staff outside the building. The doctor examined Fa’amolaa on the verandah and indicated the abscess needed to be opened, drained, cleaned and any dead tissue removed. This surgical procedure would usually be performed in the operating theatre. However, the operating theatre is adjacent to the female ward and gynaecological procedures occur there. Fa’amolaa requested he have the procedure on the verandah. The doctor agreed and performed the procedure there. Instead of being surrounded by hospital staff in the operating theatre he was surrounded by curious onlookers as the procedure took place in the public space.

Fa’amolaa was requested to be admitted to the male ward for twice daily dressing changes and antibiotic treatment. The ‘cost’ of this in pigs to be sacrificed to *adalo* was too great for him. He stayed in a nearby village, in a house specifically constructed for visitors from the Kwaio mountains, and walked to Atoifi every day to have his dressing changed and monitor his progress. It was on one of these visits to the hospital that I met Fa’amolaa. He told me he would have liked to have come earlier to the hospital, and not leave the abscess get so large, but he knew he would face problems getting help at Atoifi because he was a ‘kastom man’. He also knew his recovery was taking longer than usual because on days of torrential rain he did not walk to Atoifi and did not have his dressing changed as regularly as recommended.
Fa’amolaa had his dressings changed on the verandah for a month before he was well enough to return to his hamlet in the mountains. He often waited until staff were finished their other duties before being attended to. He collected all the old dressings and waste and disposed of them himself. He was afraid his blood and body fluids would be disposed of in the same place as the waste from the maternity ward.

I visited Fa’amolaa in his hamlet two months later. He had fully recovered. He stated his wish that medical treatment not be so difficult or distant from his mountain home.

Atoifi does not have a system to provide even basic on-site health services to bush people. It is on a case-by-case, *ad hoc* basis. Bebea Animae, a senior man from a hamlet near Fa’amolaa’s took advantage of the doctor’s presence that day and had a stick removed from his foot that had entered the webbing of his big toe and was protruding from the top of his foot. This procedure also occurred on the verandah.

**Case Study 2**

**Riuafu: A Case of Living with Disease**

In July 2002 a Kwaio nurse introduced me to Riuafu. He was an elderly gentleman from a hamlet five hours walk into the mountains. He was admitted to the male ward and was recovering from an operation to repair a scrotal hernia. His condition allowed a portion of intestine to move into the scrotum. This caused constant pain and his scrotum was the size of a coconut. In the preceding months he had increasing pain and a decreased ability to walk.

After talking with Riuafu about his experiences of accessing services at Atoifi I asked him when his condition started. To my disbelief he told me it had started in 1962. He had been working as a labourer on a coconut plantation in Yandina, lifting bags of copra, when he injured himself. He was too ashamed to go to the nurse to explain his condition and thought he would recover. Being in too much pain to work he left the plantation in 1963 and returned to Kwaio. I asked him why he had not sought medical help from Atoifi in the previous 40 years. He told me he was a *kastom man*, and as such did not want to defile himself by entering the hospital. He did not have enough pigs to sacrifice if he did defile himself and so never came to seek treatment. The ‘cost’ for him was too high and had endured the condition for 40 years. In recent times he was unable to walk and had been unable to work in his garden for many years. He decided he must go to Atoifi. Although he would defile himself at a significant cost, he had reached a stage where he had to do this. When one of his pigs gave birth to a large litter of piglets he consecrated three of them to the ancestors and fed them up to a size worthy of sacrifice. He sacrificed a total of six pigs (the further three being bought with shell money*) prior to coming to Atoifi and was planning on performing several more sacrifices on his return**.

Riuafu demonstrated the willingness of the bush people to carry a huge burden of preventable/treatable disease because of the ‘costs’ of accessing services at Atoifi. His case is not isolated—his brother had chronic severe abdominal pain, and although he was urged by family members to go to Atoifi he was unable to defile himself by entering the hospital. Riuafu’s brother-in-law died in early 2002 after two months of vomiting blood. He had not sought treatment at Atoifi because he was a *kastom man*.

* The initial six pigs sacrificed were of the following value (Kwaio shell money and 2005 equivalent Solomon Island dollars). The three small pigs were his own, the others purchased:
size of pig | Kwaio shell money denomination | Solomon Dollar equivalent
--- | --- | ---
3 small pigs | foo`aba | ($50 each)
1 moderate sized pig | fa`afa`a | ($200)
1 moderate/large pig | nima`ae | ($300)
1 large pig | baani`au | ($500)

** I visited Riuafu in his hamlet of Baleka in July 2005. He explained that on returning home he sacrificed a further six pigs. On this occasion he bought three smaller pigs and sacrificed three of his own large pigs. The larger pigs were required from his own hamlet, since this would respect his *adalo*, who would provide protection into the future for Riuafu and his family. It had taken him three years to rebuild the number of pigs in his hamlet to what it had been prior to him going to Atoifi. Since returning he had fully recovered with no ongoing pain or other health problems.

The pigs sacrificed were of the following value:

<table>
<thead>
<tr>
<th>size of pig</th>
<th>Kwaio shell money denomination</th>
<th>Solomon Dollar equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 pig</td>
<td>foo`aba</td>
<td>($50)</td>
</tr>
<tr>
<td>1 pig</td>
<td>genilabi</td>
<td>($100)</td>
</tr>
<tr>
<td>1 pig</td>
<td>sauoru</td>
<td>($150)</td>
</tr>
</tbody>
</table>

the following three pigs were raised in Riuafu’s own hamlet

<table>
<thead>
<tr>
<th>size of pig</th>
<th>Kwaio shell money denomination</th>
<th>Solomon Dollar equivalent</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 pig</td>
<td>fa<code>afa</code>a</td>
<td>($200)</td>
</tr>
<tr>
<td>1 pig</td>
<td>nima`ae</td>
<td>($300)</td>
</tr>
<tr>
<td>1 pig</td>
<td>baani`au</td>
<td>($500)</td>
</tr>
</tbody>
</table>

Case Study 3

A Case of Exclusion and Death

During August 2002, Esau Kekeubata described a family in the area close to Kafurumu clinic. He had visited the family continuously over the previous month and recorded the deaths of a mother in childbirth, an old man with chronic illness and a middle-aged man with an acute case of vomiting blood. He had urged each to go to Atoifi but each refused. They all indicated they did not have sufficient pigs to sacrifice upon their return and were unable to manage the ‘cost’ associated with entering Atoifi. Esau offered to contribute two pigs towards the cost if the expectant mother with complications went to Atoifi. This was refused since they did not have an additional ten pigs to sacrifice. The mother died in childbirth. Within a one-month period four people from one family died.

Case Study 4

Laete’esafi: A Case of Exclusion from Services

I met my long-time friend Laete’esafi early one Saturday evening in front of the Atoifi School of Nursing. It was July (2001), the rainy season, with torrential rain falling for much of the day. Laete’esafi had been walking the whole day through the rainforest, taking several detours because of flooded rivers, with his wife Taawai carrying his 18-month-old son. His son was very weak and had lost weight over the past week. He told me he had not and would not be
taking this son to the outpatients department that night for several reasons. Firstly he, as a man from the bush, was unable to enter the outpatient department since it was located under the two-story section of the hospital. If he were to take his son there this would cause sickness and/or death in his community.

I asked if his wife was able to take his son to outpatients. He told me she was able to enter the outpatients department, but could not speak Pijin. There were often no Kwaio-speaking staff rostered on to particular shifts and non-Kwaio staff had no formal training in Kwaio language. Past experience told them this was a very difficult situation and one they wanted to avoid. A further reason they did not take their son directly to the hospital was because of the experiences of many of their kin. Despite a sign above the door of the outpatients department stating “Big Sick Anytime”, staff often scolded patients for leaving their attendance until after hours. This problem was magnified when the mother of the child and staff were unable to communicate in a common language. Despite walking for an entire day on steep rainforest trails in torrential rain with a sick child, Laete’esafi and his wife Taawa’i felt they were unable to seek medical attention that night. This left them having to find shelter for the night. Atoifi does not provide accommodation for village people travelling to Atoifi to seek treatment. Laete’esafi, Taawa’i and their son initially stayed on the verandah in front of the medical laboratory, however this soon became wet as windy squalls pushed rain into the area. They then found sheltered spots under the eaves of several buildings to spend rest of the night. They moved regularly as the weather changed direction, causing their resting place to become wet. Laete’esafi was unable to cook for his family as the kitchen is located adjacent to the maternity ward, a women’s area, excluding men. The family spent the night cold, wet and hungry. The following day the child was attended to at outpatients by Kwaio-speaking staff and hospitalised. Laete’esafi was unable to visit his son in children’s ward since it was adjacent to the maternity ward. This situation had been faced by Laete’esafi and Taawa’i on many occasions over the preceding years with their five children. Personal relationships with particular nurses had sometimes mitigated this, but the situation faced by Laete’esafi and family that night was the norm*.

That night there were pets on the campus that were warm, dry and well fed. Staff had spent most of the day on which Laete’esafi and Taawa’i carried their son to hospital in church praying for the sick and needy in the community.

* In February 2004 Laete’esafi endured a large boil on his upper thigh for several weeks. Despite visiting the hospital campus on several occasions during this time, he did not seek treatment from the outpatients department. His boil was eventually lanced and drained on the verandah at the front of the hospital after the doctor, with whom Laete’esafi had established a friendship, happened to see him on campus and examined his leg.

In July 2005 Taawa’i’s grandson was taken to Atoifi for treatment after a weeklong illness. Although the child’s father carried the child to Atoifi (a walk of over five hours), the child’s teenage female cousin took the child into the outpatient’s department since he was not able to enter the building. The child’s cousin had no formal education and spoke Kwaio language and no Pijin. The teenager was unable to explain the child’s condition adequately to nursing staff, nor understand the diagnosis or treatment plan explained by the nurse. She returned the child to his father with a small bag of medication. The father returned to his home unable to ask questions to hospital staff directly and unaware of the diagnosis, treatment plan or prognosis.
Reflection

The above four case studies place a human dimension to the issues outlined in the previous chapters. Three of the four involved my personal friends, which underscored the issues for me. The injustice highlighted in these studies is in stark contrast to the concept many staff perpetuate that Atoifi is a ‘light on the hill’. The barriers faced by the bush people are real and ongoing. Despite the mantra of health professionals seeking ‘health for all’ (WHO 1978), this was not the case at Atoifi; it was, rather, ‘health on our terms’. These cases are not isolated. They are a snapshot of a broader reality bush people have faced for forty years. My question was, could there be change and could there be services for all. Could the collective participation of all stakeholders really make a difference?

PARTICIPATION, OBSERVATION AND RECORDING:

The following section outlines participation, observation and recording that took place during the 2002 fieldwork.

The Atoifi Support Committee

On arrival at Atoifi I met with Lester Asugeni, Atoifi’s Cultural Liaison Officer, and he told me the ‘Atoifi Support Committee’ (ASC) had recently been formed, consisting of community leaders and acting as a link between the hospital and community. Committee members represented Kwaio hospital staff, and both coastal and bush communities. There were representatives from landowners groups, Kwaio women’s groups and youth groups, with Lester as secretary. The formation of the ASC was a significant step forward in the dialogue between the hospital and community. We agreed to utilise the ASC as the ‘action group’ to discuss the proposed culturally appropriate facility, which had become known as the ‘bush ward’. The ASC was pivotal as the ‘action group’ to facilitate the conceptualisation and planning of the ‘bush ward’ and monitor the construction and ongoing operation of the facility as it included all key stakeholders.
The logistics required for the ASC to meet regularly were challenging. Many members lived up to a day’s walk from Atoifi and others had to travel long distances by canoe. Meetings were scheduled around existing events at or near Atoifi. Most meetings were held on Wednesday mornings to coincide with the weekly market. Notice of meetings was given to members in advance. Participation in the ASC was rather loose, and some leaders participated only if they deemed the issues important; others stayed away. Many members did not attend every meeting. Social and cultural obligations and responsibilities meant it was impossible to attend all meetings. The advantage of having different community leaders periodically attend ASC meetings meant wider input and viewpoints, but the irregularity of attendance made maintaining a quorum for continuity a challenge. A core group of approximately six people attended most meetings and their influence and vision carried the momentum forward.

The first formal meeting with the ASC as action group was planned for Wednesday 3 July. This was postponed for a week because of a large community meeting held at Atoifi discuss the Kwaio response to the ten Kwaio men missing, reportedly killed, on a mercenary trip to kill Harold Keke on the Weather Coast of Guadalcanal. (For more detail on this incident and the allegations of involvement of political leaders, including the member for East Kwaio Alfred Sasako and Prime Minister Allen Kemekeza, see Fraenkel 2004:141–142). I took this opportunity to meet with people I had not seen since arriving and explained in a non-formal environment the PAR process and how it was envisaged to guide work towards designing and building the bush ward. The first meeting of the ASC as action group was held on Wednesday 10 July 2002.

In preparation for the ASC meetings talks were held with Lester Asugeni and the CEO to discuss a broad framework to progress the research project. The following framework was agreed to as a guide for progress.

54 These markets, held at the Atoifi wharf, draw people from a wide geographical area, both mountain and coastal, to trade produce and goods. This was also the busiest day of the week for the hospital because antenatal, child health and other clinics were run to coincide with the increased numbers of people visiting the area. The several hundred people who congregate at Atoifi each Wednesday morning have a choice of activities from listening to the hospital staff proselytise and present health education talks on the hospital lawn, to gambling on the wharf.
Chapter 5: Culturally Appropriate Health Care at Atoifi—The Action Research Response

First Phase:
- Conceptual approach
- Philosophical foundations
- Collaboration with community groups and representatives
- Draft Plans and Drawings
- David MacLaren to facilitate this through PAR process

Second Phase:
- Formalising plans and drawings
- Involve outside assistance – technical and economic if needed
- Preparation of funding proposal if needed
- David MacLaren to assisting where necessary – becoming more peripheral

Third Phase:
- Formally seeking funding – submission of proposal jointly supported by Atoifi and ASC to funding bodies if needed
- Participatory policy development with staff and community
- David MacLaren assisting where necessary – becoming more peripheral to project management team based at Atoifi

Fourth Phase:
- Project implementation (construction of facility)
- Project management team based at Atoifi leading project (Joint between Atoifi and community)

Fifth Phase:
- Facility operational - ongoing monitoring and evaluation of facility.

Although this broad framework may appear prescriptive and predetermined, it was, rather, a way to conceptualise the project moving forward and was drafted to be flexible and responsive to ASC decisions.

ASC as Action Group: First Meeting, 10 July 2002

On 10 July, the day the first ASC meeting as action group was planned, a chartered plane landed at Atoifi to transfer a patient from the National Referral Hospital in Honiara. On arrival I discovered the patient was Esau’s son, Tome, who had been stabbed in Honiara two days previously and was being transferred for security reasons. The complex ethnic, security and health service issues present in the Solomon Islands were all influences on the situation and exemplified, even before the action group’s first meeting, the need for a flexible research approach.
**Case Study 5: Ethnic Tension and Health Services**

On Monday 8 July, Tome Kekeubata was leaving a store owned by his Kwaio kin in Honiara when he was attacked and stabbed several times in his abdomen and neck by two men from the To’obaita region of North Malaita. Tome was an innocent victim of an inter-ethnic conflict with its roots in an event Tome had no involvement with. Several days prior to the attack, two of Jimmy Rasta’s (MEF commander) militiamen from To’obaita had been drinking at a hotel in Honiara. The security guard at the hotel was from Kwaio. The two MEF militiamen swore at the guard, saying he and his people were rubbish because they were from Kwaio and the ten Kwaio men reportedly killed on the Weather Coast on a mercenary trip to kill Harold Keke had no idea how to fight. The Kwaio security guard informed a number of Kwaio kin who then returned to the hotel and confronted the two men. A fight ensued in which one of the To’obaita men was killed and the second injured. Relatives of the murdered To’obaita man sought revenge for his death and randomly selected and attacked Tome because of his Kwaio ethnicity. Tome was taken to hospital where a large number of Kwaio people later amassed. At the same time a large number of To’obaita people were at the hospital visiting their relative involved in the fight. The almost non-existent security in Honiara made this a volatile situation and many people fled the hospital fearing a further outbreak of violence. This was not an unwarranted fear—previously Malaitan militia had shot dead Guadalcanal militants in their hospital beds. The police were called, but on arrival they themselves were afraid for their own safety and left. The To’obaita people carried their relative over the hospital fence and into the back of a waiting truck to flee. Tome’s extended family discharged him from hospital and chartered an aircraft to transfer him to Atoifi, where he would be safe. Funds gathered from relatives covered the expense.

This created a potentially volatile situation at Atoifi, particularly for staff and students from To’obaita. Atoifi administration, concerned for their safety, decided staff and students from To’obaita needed to leave the campus and stay in a neutral location until the situation settled. As soon as Esau arrived on campus from Kafurumu he assured everyone there would be no retaliation by his kin towards the To’obaita staff on campus, although he would be claiming compensation from the To’obaita people in Honiara who assaulted his son. This compensation was to cover expenses incurred due to the incident. (This compensation was later collected by Esau’s relatives at the same time they presented compensation to the relatives of the To’obaita man who had been killed). Tome was admitted to Atoifi and recovered after several weeks.

I was full of anticipation for the day. It started with an unexpected event and associated tension on campus. Seven members attended the meeting. I was disappointed more did not attend, but there was a mortuary feast in the mountains, a meeting of the Kwaio Women’s Association at Sinalagu, a women’s representative from the bush communities had a sick child, and the Peace Monitoring Council were on the hospital campus to monitor events after the incidents between the Kwaio and To’obaita in Honiara. There were also many informal meetings on campus to discuss both the recent confrontation in Honiara and the Weather Coast incident. Despite the meeting being attended by only a small number of leaders, it was productive.
Members contributed well and were keen to progress with the idea of constructing a ‘bush ward’ at Atoifi. They emphasised the ward was something they had desired for many years, and that they saw this as their opportunity to advance their cause. The medical superintendent, also attended. This gave confidence to members of the ASC that the administration was committed to the process.

Those in attendance immediately started to discuss the logistics of making the ‘bush ward’ a reality. Topics discussed included:

1. **Location**: a section of land behind the workshop was deemed appropriate.
2. **Medical procedures to occur within the facility**: all procedures excluding obstetrics and gynaecology.
3. **Outpatient Department/Simple Operating Theatre Complex**: to be included in ‘bush ward’.
4. **Male/Female Buildings**: They needed to be separate, but could have a walkway connecting them.
5. **Toilet/Shower Facilities**: A waterless toilet system to be included in buildings separate from the male/female buildings. Shower facilities can be inside the male/female buildings.
6. **Kitchen**: Two kitchens, one for males and one for females.
7. **Guardian Accommodation**: An open community facility for sleeping and community meetings and health education/promotion programs.

**Reflections on the Initial Meeting**

The summary indicates that the committee was immediately keen to discuss the reality of the bush ward. Having the medical superintendent in the meeting added a sense of organisational commitment, and raised hopes that issues raised would be listened to and common solutions sought. I left the meeting feeling the process was robust and valuable and had a real chance of significant movement in the future. The day had also been a reality check regarding the PAR approach in such an unstable and volatile situation. There was still an air of anticipation around the campus about possible violence between the To`obaita and Kwaio people, and uncertainty over the
Weather coast incident and its implications. Despite these events I was optimistic that the initial meeting of the ASC as action group in the PAR process had proved that progress could be made despite such a complex and constantly changing context.

ASC as Action Group: Second Meeting, 17 July 2002

Because there were fewer conflicting events going on in the community 14 members were able to attend the second meeting. A summary of the discussions follows:

1. **Review of Previous Minutes:** The previous minutes were agreed upon and all decisions confirmed.

2. **Maternity Services:** Women are not coming to Atoifi to deliver their babies, due, in part, to having no *bisi* on campus. A *bisi* needs to be included in the bush ward.

3. **Physical Layout:** Discussions were led by Esau Kekeubata and Adam Faeni (ASC member and SSEC pastor) regarding the physical layout of the buildings on the proposed site. The design reflected the layout of a Kwaio settlement. Internal design of buildings would be led by medical staff at Atoifi after the overall layout was agreed to including siting of toilets and the like.

4. **Toilet Facility:** A small building to be included at the boundary of the female toilet area where women will leave their clothes prior to entering the toilet. Washing hands for both male and female will occur at a tap and basin on the external, and not the internal wall of the toilet block.

**Reflection**

After only two meetings the ASC had produced a draft sketch of the bush ward and its location and discussed the facility becoming operational. The greater number of people who participated was heartening as was the general support from coastal and bush communities. There had been movement towards the need for a *bisi* for bush women. Honouring all knowledges had allowed people from disparate groups to have
an equal voice and had enabled an amazing shift to occur, one that would have been almost impossible had the ASC not been utilised, and a respect for all centralised. Although the PAR was the catalyst to discuss and document the issues, the consensus reached at these meetings was an example of a participative and collaborative process. Details were discussed and members of the ASC agreed through a consensus process prior to decisions being finalised. There were lengthy discussions over particular points, yet common ground was always reached. Given the ease with which many of the issues were resolved and the speed at which the draft sketch was produced, I wondered if the action phase would be equally speedy. Knowing the complex environment we were working in, I had my doubts.

**Opportunities for Community Visits**

I had been invited by some members of the ASC to visit their hamlets and took the opportunity to attend a mortuary feast hosted by a close friend. This allowed me to visit Fa’amolaa, whose story I had documented some weeks earlier (case study 1). My presence at Kwaio cultural events showed my genuine desire to engage with the community and my willingness to attend community gatherings to discuss the bush ward. My presence was announced at the feast, which allowed me to discuss the bush ward with people who would ultimately utilise it. I discussed the content of recent ASC meetings with those unable to attend and documented additional issues that community members raised. Most of this was done around a fire were taro was roasted into the night.55 There was widespread support and appreciation for the process to work towards practical solutions to address the barriers faced by the bush people at Atoifi. It was satisfying to find that issues outlined by the community during my research two years earlier were being used as a base for the PAR. I left the feast

55 Discussions not only covered the bush ward but also interactions of coastal Christians and those upholding ancestral religion in the mountains. Two senior men said that their ancestral religion was much like Moses in the Old Testament, except they sacrificed pigs instead of sheep. A long monologue ensued from a senior figure who stated Christians’ behaviour did not live up to their rhetoric, and that although he had Christian brothers and cousins they were not kind to him and did not share with him. Christians, he continued, say that God leads them while the devil leads those upholding ancestral religion, but he saw it as the other way around: ‘maybe God leads us and the devil tricks them’—since they don’t think of others or their families and ‘that is not the way of God’. I have had numerous coastal Christians admit to me that they are not nearly as generous, sharing or thoughtful as their ‘heathen’ relatives in the mountains.
confident that although much of the detail was yet to come, the goodwill towards the project was another indicator that the bush ward was achievable.

**An Assumption Proved Wrong**

On my return to Atoifi I was confident of the commitment of the bush community and ready to engage in a closer way with Atoifi staff. I met the Principal of the School of Nursing, and we talked in detail about the bush ward project and PAR. It was soon evident she was not fully aware of the research or the process behind it. Prior to arriving at Atoifi I had sought, and received in writing, authority to undertake research from both the Kwaio Chiefs and Atoifi’s CEO. I assumed the administration committee, including the principal of the School of Nursing were aware of the purpose and scope of the research. This assumption proved wrong. The principal expressed her disappointment at not being fully informed and at how some staff were antagonistic towards me being at Atoifi because they were unaware of the purpose of the research. My family and I had been on campus for over a month and I had worked closely with members of the ASC to ensure the process was as participatory and inclusive as possible. In my zeal to have the ‘community’ participate in the process I had neglected to check my assumption that Atoifi staff were fully aware and involved in the research. Since a number of Kwaio staff were on the ASC, the problem did not become apparent until I discussed the research in detail with non-Kwaio staff.

**Reflection**

An entry in my journal expresses how I felt:

> I was really sad when I heard this, as I have neglected the hospital staff by concentrating on the bush community… on reflecting on the past few weeks I can see how the hospital staff could see this as another top down project where they have very little say… they are the front-line workers who will be staffing the ward and need to feel they have a say in how it will be planned, built and managed. I feel ashamed something so obvious has been overlooked and people have these feelings towards me and the project.

The flexibility of PAR allowed me to respond to the situation.
Ensuring Full Participation

The following Wednesday, instead of an ASC meeting a staff meeting was held with clinical staff to fully explain the research project, and the process through which they could participate. The flexibility of PAR and the constant reflection on action was explained. Their own example of not feeling a part of the process was used to explain why assumptions should constantly be reflected upon and challenged. Questions and concerns about the research project were discussed. Numerous staff stated the meeting allowed a clearer understanding of the bush ward project and how they could participate. A major concern raised was the impact the facility would have on practice and how they as individuals and collectively did not have the skills to adequately understand Kwaio bush people. They were afraid of being asked for compensation if they broke Kwaio cultural or religious rules. This was another example of how Atoifi was in but not of Kwaio. Staff, some who had been resident at Atoifi for over a decade, expressed that they were unsure how to interact and provide culturally appropriate services for the people they had come to serve and whose land they lived and worked on.

A major concern raised in the meeting was that to provide culturally appropriate services for non-Christians would ‘encourage heathenism’ at Atoifi. This was deemed unacceptable because Atoifi had been established and operated as a ‘Christian campus’. Many thought the maintenance of the Christian status quo outweighed any health benefits for a community that chose to retain ancestral religion. Given that the objective of many hospital and church hierarchy was to convert ‘heathen Kwaio’ to Christianity, it was argued that to provide culturally appropriate health services that respected Kwaio culture and religion was counterproductive to this aim. There were numerous celebrated examples of bush people who had relinquished Kwaio religious beliefs to access services at Atoifi and become Christians. To provide a facility to

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56 This also extended to converting Christians of other denominations to Adventism. During a visit in July 2005 there was discussion on campus about why Atoifi Hospital had been so ineffectual in converting the surrounding SSEC and Catholic villages to become SDA.

57 Although some people from the bush did become Christian after relinquishing Kwaio ancestral religion by accessing services at Atoifi, this did not mean they automatically joined the SDA church. More pragmatic factors than theology influence the Christian denomination a person will choose after relinquishing Kwaio ancestral religious beliefs. In most cases it means leaving mountain ancestral land and living in a coastal Christian village. People will choose to live with their kin, whatever
allow Kwaio to uphold ancestral religion meant they would not be forced to relinquish traditional beliefs and there was less chance of Christian conversion—the bush ward challenged a core objective of Atoifi. On a personal level, some staff saw the health benefits of a change in practice for the bush people, but the Christian paradigm that dominated Atoifi was not easily challenged.

Two days later a similar meeting was facilitated for non-clinical staff. I was surprised at the open discussion about the ‘one-sided’ nature of policy and practice at Atoifi and the need for a ‘balanced’ approach to include the community. One staff member commented that if a participatory and balanced approach was to be used it would be necessary to leave particular senior managers with colonial approaches out of the process since they would take over and make decisions for people not with people. Concerns about ‘encouraging heathenism’ as described above, were also expressed. Concerns about ‘outsiders’ using Atoifi’s resources was also raised. An Australian was in a nearby village to assist the local SSEC pastor translate the Bible into Kwaio language and he was using hospital computers and printers. Suspicions were expressed because he had not introduced himself to all the staff and had created mistrust of his project. This was a real lesson for me. I had gone to considerable lengths to work with the bush community, and staff on the ASC, but because of my assumption that Atoifi staff had been informed about the project, along with my familiarity with Atoifi, I had inadvertently not involved all stakeholders.

Soon after this I instigated a research ‘reference group’ to monitor the research process and to advise on appropriate strategies. I had always intended to set up a research reference group, but in my haste to engage the bush people it was never formulated. The reference group was comprised of clinical and non-clinical staff from a range of ethnic groups across the Solomons, and proved invaluable as a guide for the research process. This ensured that I, as a researcher, would act as catalyst and facilitator for action, and be able to respond to the complex research environment. It also made me accountable for working with and for the community, not on and to them.

denomination they may be, and adhere to their denominational beliefs. Those living in the mountains are acutely aware of this and are unwilling to leave their land and religion to become a Christian and live on someone else’s land, in a village that is constantly feuding.
A further meeting was held with senior nursing staff to discuss the bush ward project, provide a brief on ASC decisions and extend an invitation to participate in future ASC meetings. I was asked numerous questions I was unable to answer because there were more appropriate people in the community to answer the questions (and due to my lack of cultural knowledge!). My inability to answer these questions was a good outcome that reinforced the need to participate with the ASC and ask questions directly to the holders of the relevant knowledge. It also reinforced that PAR was not a process that I could lead alone—it was a collective, participatory approach to decision making, which honoured the knowledges of all who participated. I should note here that some staff were unwilling to participate. They wanted to be informed of discussions and outcomes, but not to engage directly with community representatives. One senior staff member in particular was hesitant. He was a very conservative Christian and acknowledged that many people in the community did not like him because of his direct manner and close associations with senior management who perpetuated the colonial approaches of the past. Having to sit as an equal with those he had antagonised, to discuss mutual understandings and progress towards culturally appropriate health services for non-Christian Kwaio was very challenging for someone who had spent the past decade attempting to convert the bush people to his brand of Christianity. After extended indecision he chose to participate.

ASC as Action Group: Third Meeting, 7 August 2002

Since the previous ASC meeting there had been meetings of community groups in hamlets across the mountains and staff meetings on campus. Representations from clinical and non-clinical staff attended the ASC meeting. The president of the Kwaio Women’s Association attended, which broadened the committee’s representation. A summary of the discussions follows:

1. Site Plan and Internal Design of Buildings: Site plan confirmed that orientation of buildings conformed with Kwaio custom. Continued and ongoing discussion surrounding internal design of buildings
2. **Bisi:** Confirmation of the need for a *bisi*. Maintenance to be done by hospital workers.

3. **Policy/Procedure Implications for Staff:** Discussions surrounded implications of no internal toilets in the bush ward for nursing staff procedures.

4. **Simple Theatre in OPD Complex:** For minor procedures only, major procedures to be undertaken in the main theatre in the existing hospital.

5. **Clothes:** Clothes that are currently given to new mothers in the Obstetrics Ward are discarded prior to returning to hamlets because nothing from the delivery area can be taken back to the hamlet. These clothes need to be kept in the obstetrics ward, washed and reused for the other mothers who are admitted.

6. **Electrical Supply:** Electricity from the main switch to both male and female buildings approved. Female toilet and *bisi* to have independent power supply, for example a solar system.

7. **Building Materials:** Facilities staff recommended brick construction rather than timber and heavy duty fittings since these were more durable and robust.

8. **Water Supply:** Water pipes to be elevated to allow all people to access drinking water, as at Kafurumu Clinic (see chapter 3)

**Reflection**

Positive outcomes from this meeting included the support given by the president of the Kwaio Women’s Association. This Christian woman not only approved the direction and detail of the bush ward, but commented that this was the first time such a participatory approach had taken place for project planning at Atoifi. All details of the bush ward planning process to date were confirmed as being culturally appropriate. A consistent theme throughout the meeting was that bush people were happy that core Kwaio religious beliefs were centralised in planning, for example, men’s and women’s areas, toilets and water, but there were a multitude of Kwaio religious rules that would need to be compromised for the project to proceed. Bush leaders constantly reiterated that because the planned facility was on the hospital campus not all Kwaio rules were possible to uphold, but core beliefs were centralised sufficiently to progress. Had the facility been planned for the mountains, then numerous other rules would require to be incorporated. A pragmatic approach was
taken by the ASC in planning the bush ward at Atoifi. This was not the first time that the Kwaio had faced these issues when planning ‘development’ projects, as Akin (1993:468) noted:

Though Kwaio religion presents a challenge to those who would attempt to introduce development schemes to the area, it is not an insurmountable one. Kwaio have shown themselves willing to compromise when they feel a project genuinely is geared towards their interests. For example many ancestral rules were bent or ignored to facilitate the running of the Kwaio Cultural Centre at Ngarinaasuru from 1979–1983.

It was becoming clear that the first phase of the PAR process was almost complete. Philosophical foundations had been established, draft plans had been made, and collaboration with community groups and representatives was taking place.

A number of chiefs (both coastal and bush) did not attend the ASC meeting on 7 August because of a major issue in the community. Such events were a constant reminder of the need to reflect on the research process and assure that the process acknowledged the reality of the social and cultural situation. The situation is described below:

Case Study 6: Malaitan Social and Cultural Determinants of Health

In early August 2002 a young man from Uru was admitted to Atoifi with a clinical diagnosis of stroke. This case however had deep social and cultural implications beyond the immediate medical diagnosis. Several weeks earlier he had been in a group of young men from Uru who travelled by motorised canoe to South Malaita to participate in a compensation ceremony. One of their female kin from the village of Canaan had been seduced by a young man from South Malaita. The situation was to be resolved by the young man’s family giving shell money as compensation to the family of the young woman. The compensation ceremony went as planned and the young men from Uru stopped near Maanawai in East ‘Are’are on their way home. There they stole four pigs, killing three and taking one alive, and returned to Uru. When the ‘Are’are people became aware of the stolen pigs they made a curse by an ancestor to chase after the thieves and make them sick until one eventually died. Soon after, one of the young men involved noticed a kurukuru (pigeon) constantly following him. When others also noticed the kurukuru questions were asked about his activities, and it was felt that this sign must mean he had done something wrong. Soon afterwards he became ill, was taken to Atoifi and received a diagnosis of stroke. When he fell ill he confessed to being involved in stealing the pigs from ‘Are’are, after which he steadily regained his health. The Uru chiefs gathered to discuss compensation to present to the ‘Are’are people for them to call back their ancestor so the young man could recover.58

58 Some mountain chiefs have stated that the coastal Christians do not know Kwaio customs in enough depth to prepare for stealing pigs, or how to spiritually ‘protect’ themselves from their victims’ ancestors.
In the proceeding days the young man’s condition improved. He was given ‘custom medicine’ to help his recovery and protect him from further spiritual inflictions. A week later he rapidly deteriorated and died at Atoifi. There was great commotion at Atoifi as his father’s kin became angry at his mother’s kin, since all the young men involved with the pig theft were his mother’s kin. The father’s kin asked compensation from the mother’s kin because their actions had led the young man to be involved. A tense situation was alleviated only after the body was prepared by hospital staff and the relatives left Atoifi, still in passionate debate.

Moving Forward on the Bush Ward

To progress to the second phase the plans needed to be formalised, which involved outside technical assistance and funds. I had been in contact with both the European Union (EU) Microprojects Program Office and AusAID funded Community Peace and Restoration Fund (CPRF) Office in Honiara. They were both keen to assist. A request for technical assistance was submitted to the EU by the ASC. The program manager assigned an engineer to assist with technical aspects of the project proposal and preparation for submission. The Program Manager stated they were unlikely to fund the entire project and recommended to liaise with other organisations for co-funding. CPRF was contacted and arrangements made for the East Malaita representative to visit Atoifi to meet the ASC.

As logistics for the technical aspects were being organised, further discussions were held with key stakeholders and case studies recorded. Given it was the rainy season on East Malaita, logistics were even more difficult as people could not travel easily to and from Atoifi.

Family Issues and Fieldwork

The week of 19–23 August 2002 was a tumultuous one on many fronts, particularly on a personal and family level. The first tumult was a violent incident with five visitors to Atoifi (see case study below). The second was the health of both of our boys. Lachlan our ten month old, was having severe reactions to insect bites. He was learning to walk and crawled on the floor of our house most of the time, which exposed him to small red ants, a ubiquitous part of life at Atoifi. His skin was covered
in bites, several of which had become large pussy sores which required antibiotic therapy. He was very uncomfortable, not sleeping well and generally miserable. Hamish, our two year old, was not bothered by the ants, but started spiking fevers which were diagnosed as *plasmodium falciparum*—malaria. Our best attempts to prevent the boys from being afflicted by tropical infections had failed.

Being accompanied by my family presented opportunities to learn not available in my previous visits. When both boys became ill people offered numerous explanations of why they had become sick. There were three main ones: First that we had taken the boys to different villages in the area and that *adalo* always affect children the first time they enter a new area; this can range from inability to sleep to acute illness. 

Second, we carried the boys on backpacks to the market each Wednesday morning. Since they were on our backs and not our fronts, people could touch them or give them things and as such they could, again, be affected by their *adalo*. The third main explanation was that they slept in separate bedrooms, and not with Michelle and I in our room, and so *adalo* could enter their rooms unbeknownst to us and afflict them.

These explanations came not from bush people but from Christian nurses at Atoifi. Few suggested insect vectors were responsible. We decided to return to Australia, an environment where they could recover. I accompanied my family to Australia and returned two weeks later to continue the PAR. The events of that week are recorded in the following case study:

**Case Study 7: Complexity and Simplicity—The Italian Incident**

**Background**

Early in August 2002 I was informed by a bush chief that a group of Italian doctors would soon visit Kwaio. He had little information about them, just that they were to visit, wanted to visit bush hamlets and could potentially assist with health services in the bush. Maenaa’adi was organising the trip from Honiara, but would not personally accompany them (he was in Honiara negotiating with the government over compensation for the Weathercoast incident). Lester Asugeni and I were asked to talk with the group prior to them going into the mountains to assess their objectives in coming to Kwaio and how they could assist health services.

The group flew into the airstrip on Thursday afternoon 15 August. There were two male doctors, one accompanied by his wife, and a male and female teacher. They did not visit the hospital. From the airport they walked the 45 minutes to the Catholic village of Loo’ama accompanied by their guide who was from there but lived in Honiara. The five had been a part of a larger group of volunteers with the Don Bosco organisation, a Catholic organisation
operating a school at Henderson, Honiara. They had just completed a medical tour of rural Guadalcanal that had not had medical services since 2000 because of the ethnic tension. There had been radio announcements explaining the movements of the group, and that they were there to provide medical assistance.

The group’s primary purpose in coming to Kwaio was a short adventure, to see first hand Kwaio culture and travel to an area rarely visited by tourists. They did not have large amounts of medication or supplies, since this was not their purpose in visiting Kwaio. The remainder of the medical team had travelled to the Western Province to go diving.

Because of the heavy rain falling when the group landed at the airstrip they bypassed Atoifi to go directly on their adventure. Over the weekend I was informed that the group had not ventured far into the mountains, spending their first night in Loo’ama before going on to a bush hamlet and then to Sinato’oana, a SSEC village. They were due to arrive at Atoifi Monday morning to catch the Monday afternoon flight to Honiara.

The Incident

Early Monday morning I was met by Jimmy Ri’ifana (also known as Silas Laefiwane), a young man I had got to know over the preceding months and who had acted as a guide on a previous trip into the Kwaio mountains. Some of his cousins were angry with the group in the Kwaio mountains. He explained people were puzzled they had not coordinated with Atoifi when offering medical services, that some people had not been given medicine when they had requested it, and that they had not respected people in the bush hamlets by taking toilet paper from the toilet back to the main house, and had taken photographs of women without the consent of all in the hamlet. All of this was exacerbated because none of the group could speak Pijin and only one English. The Italian accent made it difficult for people to understand. I suggested Jimmy talk with Lester Asugeni, who recommended writing down the concerns and passing them to Maenaa’adi since he had organised the group’s visit. Jimmy seemed satisfied with this and after writing the points with Lester he left Atoifi.

Late Monday morning the group arrived at Atoifi to check in for their flight. Airport staff in Honiara had gone on strike that day and the flight had been postponed. A few hours later the flight was cancelled until the following day and possibly the day after. When I met the group they explained they had stayed in Christian villages on all but one night and when in the bush hamlet had asked permission before doing anything. Numerous people had come to them with medical conditions. They treated them with the few simple medications they had. The doctors in the group had told some patients with chronic conditions they did not have any medications to help them. They had taken video footage and photographs of people and hamlets they visited. The group assured me they had asked permission of the people present prior to any photography.

On realising the flight was cancelled the expatriate CEO was asked where the group could be accommodated. I indicated the group would be welcome in our house. The response was that the group looked like dirty people, it was unclear where they had been or what they had been doing and did not want them to stay with our family (I discovered later, that one of the doctors was a specialist in public health and chief hygiene officer for an entire province in Northern Italy and the second doctor was a surgeon from Milan). Two of the Italians were instructed to stay in the hospital ‘private ward’, a basic facility with two beds and a shower/toilet. The other three were to sleep on the floor of the antenatal clinic, a room within the maternity ward. No access to cooking facilities was offered. On hearing this, I checked with the community liaison officer if it was appropriate to accommodate visitors there. He
stated it was inappropriate for the group to stay in the maternity ward. The group was then invited to stay with my family. Two of the group decided to sleep in the private ward, the others in our house. There were no indications that afternoon or evening that the issues raised by Jimmy earlier that day needed further discussion.

Challenges were also being experienced on the family front. Hamish our son was experiencing fevers and was generally lethargic. He was tested for malaria twice, both results returned negative. The main campus water supply burst leaving no running water. Despite constant rain, electricity from the hydroelectric plant was intermittent at best and off most of the time. The backup diesel generator had broken down.

The following morning a group of approximately twenty Kwaio (both bush and coastal) came to our house wanting to speak with the group. The community liaison officer was called to liaise between the Kwaio group and Italian group. They discussed the issues raised by Jimmy the previous day. They stated their unhappiness at the anticipated medical team in fact being tourists, who just happened to be doctors. The issue of taking toilet paper into the kaakaba and back again was major. Taking photographs and video footage was also a concern. They asked ‘If these people are not on an official medical tour why are they taking photos and video? Who would profit from them, and was this ‘stealing’ Kwaio custom?’ The decision to allow the photographs taken of women was not agreed to by all the men of the hamlet, with those not present angry. Ronnie, a young man from Gounaabusu in Sinalagu, who ran a small tourist lodge and worked closely with surrounding communities, quickly saw misunderstandings on both sides and attempted to clarify the situation.

Lack of information, mixed with misinformation, made for a confusing situation for both sides. During the discussions a message came that the airport strike had ended and the plane would soon arrive. This put pressure on an already tense situation. The young Sinalagu man attempted to conclude the discussion by suggesting reporting all the issues to Maenaa’adi when they all (he, too, was to fly to Honiara) arrived in town. The group then walked the three minutes to the office to check in. The Kwaio group followed, clearly unhappy with the situation as it stood.

After checking in, the Italians walked to the awaiting four-wheel drive and trailer (transport for passengers to the airstrip approximately 2 km away). Voices began to become angry and several men began to demand compensation in the now growing and increasingly angry crowd. Individuals started to shout that the Italians were there to steal their custom and become rich when they sold the pictures and video. Others joined in, supporting the compensation claim. The plane then landed, heightening tension. Naasusu, a young man from the mountains, and Maenaa’adi’s nephew, demanded the Italians leave their photographic equipment behind and delete all their video footage before leaving. The Italians, clearly worried, opened a camera and pulled the film out for all to see. Others in the crowd told the Italians to get into the vehicle and sort the situation with Maenaa’adi when they arrived in Honiara. Naasusu and his supporters wanted nothing of this and stated they were not letting the group leave Kwaio until Maenaa’adi returned to Kwaio to resolve the situation. At this a number of the crowd told the group to give SBD1 000 compensation for the toilet paper issue and they would be able to board the plane and remedy the situation in Honiara. Hearing this, Naasusu, who had demanded they stay until Maenaa’adi return, swung his bush knife at the group’s leader, striking his shoulder with the back of his knife. People ran in all directions. The Italians were hurriedly taken into the office for their protection. I ran to the back of the building, not knowing what would happen next. Was I in danger? Was Naasusu so angry that

59 Since there was an item that was taken from the kaakaba, an abu place, to the ifi, a mola place, this transgressed Kwaio custom, and several pigs would have to be sacrificed to atone with ancestors for the error. Compensation was demanded to cover this expense.
he could not distinguish between Europeans? Was he going to take his anger out on anyone associated with the group? Was I seen as being implicated because the group had stayed at my house? Kwaio friends ran to the house and told Michelle and the boys to stay inside. I asked several Kwaio friends if I or my family were implicated. All said I had nothing to fear since Naasusu was very clear who his problem was with and it certainly was not my family or me.

The plane sat at the airstrip for twenty minutes. Waitlisted passengers were hurriedly checked in and taken to the plane. Naasusu had achieved his goal: the Italians had not left. He then sat under a nearby tree. The pressure was off, the tension dropped and there was time to negotiate. A Kwaio delegation explained to the Italians the demand for SBD1000 compensation still stood, and they agreed to pay. On arriving in Honiara the passengers informed Maenaa’di of the incident. He radioed Atoifi and spoke to Naasusu and others involved. He informed Naasusu they must allow the group leave Atoifi since they had paid the compensation demanded. He instructed Naasusu that to uphold Kwaio custom he would have to pay compensation to the Italian man he had injured. Blood had been drawn and compensation had to be paid. A number of chiefs present gathered *bata* (shell money) and presented four *lousu’u* (a length of shell money measuring from the tip of the thumb to the mid bicep, or about 45 centimetres) to the Italians to complete the compensation ceremony.

Naasusu informed the crowd the group could return to Honiara. A special flight was requested. The plane arrived at 3 P.M. The group boarded without incident.

At 4pm a repeat malaria test for Hamish returned positive. We had tried so hard to prevent this but in an environment with such high malaria prevalence it was almost inevitable. Half an hour later a group of friends from the mountains arrived. They had come to exchange a bag of taro for a bag of rice. I was honoured by the interaction with a smiling, gentle old man so happy that we were exchanging goods. At the same time, I was struck that this old man was Naasusu’s uncle. I was so comfortable and honoured now while only hours earlier I was running in fear for my life. The emotional rollercoaster continued, our little boy so precious and wonderful, lying feverish, convulsing, the fear, anger and confusion we all had felt that day and now this warm human interaction. What were we doing here? Sometimes it is all too hard! Michelle and I decided that for our boys to fully recover they needed to return to malaria-free Australia.

**Reflection**

I continue to reflect on the events of that day and week. The following is but a short list of reflections:

- Was this a situation of miscommunication, cultural misunderstanding and bad luck or something more sinister? The lack of communication with the Kwaio only having basic English and the Italians having no Pijin and limited English was significant but was this something much deeper, and if so what were the implications for the bush ward project? Was the PAR robust enough to deal with inevitable cross-cultural miscommunication?
Chapter 5: Culturally Appropriate Health Care at Atoifi—The Action Research Response

- What is the incidence of this type of situation ‘almost happening’? Had the plane arrived on schedule would this incident have occurred? Was I stumbling through ‘just’ avoiding such incidents or was the PAR embedded in the community sufficiently that this type of incident was unlikely to occur?

- The importance of being an outsider but having links with the correct people/organisations struck me. The Italians did not make themselves known or ask advice at Atoifi prior to going into the mountains. This was critical because many people (including me) had thought the group of ‘doctors’ was there to provide medical assistance. Had the group first gone to Atoifi and clarified that they were adventure tourists and not there to provide medical assistance would the outcome have been different? This made me reflect—were all relevant groups included in the PAR? I had already learned the Atoifi staff had not been included sufficiently, were there others that needed to be included?

- The deeply held view of many Kwaio that outsiders ‘steal’ custom and become rich from the proceeds is a major factor in the suspicion of outsiders. Suspicion had grown quickly against the Italians. Some Kwaio believe Roger Keesing was exceedingly rich because of his publications on Kwaio custom. Would this be a significant factor for me as an outside researcher? Would the participatory and collaborative processes of PAR be able to counter this and allow the ‘action’ from the research be a shared goal?

- How then does one engage with limited timeframes? Maybe the answer is that you cannot, because the outcome may be so detrimental to yourself, the community and others who follow? However, the alternative was a situation that occurred only weeks earlier when a young American medical student had accompanied me to some of the same areas the Italians had visited. During this visit many of the same cultural issues were discussed and photographs taken, however with no resulting violence or aggression. The student was a keen learner and enthusiastically shared his experiences in Africa where he spent his childhood. His was not an extended relationship with Kwaio, but a very positive one. How much of that was because of his connection with Atoifi or reflection/extension of my relationship with Kwaio? I reflected on the
contradiction of my role—as an outsider but at the same time an insider; a bridge
between two realities when I do not fully belong to either. Additionally, during
our trip we had been guided by a chief with authority on the geographical,
cultural and spiritual location. Had such a chief accompanied the Italians would
the situation have been different? Although many of my questions could not be
answered definitively, I continued to reflect on them throughout the PAR.

- Were the violent actions of that day a young man defending his people, his
custom and his honour or merely violent extortion, kidnapping, deprivation of
liberty and assault? How does one describe such an event? Is it to be another
example of history being a subjective view of the presenter, whether from the
Kwaio, the Italians, Atoifi staff or me writing this thesis? Can this event ever be
viewed objectively? I feel the situation is all of the above, so how can I
objectively describe the situation? Is this possible and how do I write and reflect
on this situation? Does the fact that Naasusu was known to smoke marijuana and
was alleged to have been using it the morning of the incident detract from his role
in defending custom and his people? Does this fact swing the pendulum more
towards this being extortion and assault? Is it even appropriate to make such
assertions?

- The group’s guide had secondary rights over land at Atoifi. While legal leases
have been signed, there was a possibility that he may hinder the building of the
bush ward because he was diminished by the incident. He was angry the bush
people had demanded compensation for things that occurred while he was guide,
and these people were to benefit from the proposed bush ward. I was assured this
was a minor problem, but given the history of conflict over land at Atoifi this only
added to the complexity of the situation.

- I felt a range of emotions: I wanted to go home, I was confused, angry (at both
parties) and disappointed. I had approached the research process from a position
of social justice. Social justice projects are by definition difficult. If they were not
they would have been done already! If the situation was simple, the living
conditions easy and the future predictable I would not have been there. These
events were a reality check of the difficulty in working with and for people not
just on or to people. While working with people there are situations that frighten, anger and confuse. If one was to work on or to people this complexity would be diminished, stolen from the richness of the situation. This statement is easy to write but hard to live!

The PAR Process Continues

The following section is a description of the PLAN and ACT stages of the 2002 fieldwork.

Figure 5.3: Plan and Act in 2002 Action Research Events Spiral

When I returned to Atoifi after leaving my family in Australia I found volunteers from the mountains had cleared the site for the bush ward. This was a moral booster for the ASC, staff and community and proved a focal point and evidence that movement was occurring from words to action. Soon after the East Malaita Community Peace and Restoration Fund (CPRF) coordinator visited Atoifi and met the ASC and key staff.

ASC as Action Group: Fourth Meeting, 2 October 2002

The CPRF coordinator explained the potential of CPRF involvement and expectations of community participation to the ASC. Several members of the hospital administration committee attended, but a number of community representatives could
not because a chief in the Lafea had died two days earlier. A summary of the meeting follows:

1. **CPRF:** The mandate and activities of CPRF targeted at health and education projects for youth, women and displaced people from the ethnic tension was explained. The community needed to be involved to plan the project and the natural resources (sand, gravel, timber) for any buildings needed to be donated by the community. A gender balance was required for planning and implementation.

2. **Skilled Labour:** Concern was raised about the supply of skilled labour. A decision was made to negotiate this as either the responsibility of CPRF or the hospital’s contribution at a later date.

3. **Roles of ASC:** The CPRF coordinator was keen to clarify the roles and responsibilities of the different communities (bush and coastal) in the project planning that had occurred and how this would continue in the future for project sustainability.

4. **Negotiation of Cultural Rules:** There was considerable discussion between coastal and bush leaders and hospital staff about procedures in the bush ward. It was emphasised by bush leaders that because the bush ward was planned for the hospital campus many rules normally applied if it were in a Kwaio hamlet would not be enforced. There were, however, fundamental precepts of Kwaio religion and culture that were not negotiable and must be upheld in the new facility. Two examples were given. Firstly, a senior priest had recently visited the female optometrist, requiring her, as a woman, to hold his head to administer treatment. This was accepted by the priest since it was necessary for the procedure. A woman holding his head in other situations would not be acceptable. The second example regarded the proposed *bisi* and female toilet. Bush chiefs accepted that maintenance would be done by male workers at Atoifi. Again this would be unacceptable in a mountain hamlet. Fundamentals of Kwaio custom such as women menstruating in men’s areas were not negotiable, but other things that were negotiable were discussed and procedures explained—why they were or were not acceptable.
Chiefs present made an appeal for all other leaders to talk with their people and to request that they all work toward the goal of a specific ward for the bush people.

**Reflection**

This meeting was successful on several levels. The ASC could observe that progress had been made with a potential donor visiting the site and meeting the ASC. The process also allowed members of Atoiﬁ administration to observe how the bush chiefs were flexible and keen for the project to progress. Some had perceived the chiefs as obstructionist to any projects the hospital put forward. They now observed the chiefs’ genuine attempts to progress within their religious system. They saw how the chiefs stood up for the fundamental rights of their community while simultaneously demonstrating flexibility wherever they could. The meeting was also a watershed in the support given to the project by Julie Aengari, the Principal of the School of Nursing who attended the ASC for the first time. That evening a general staff meeting was held to discuss numerous issues at Atoiﬁ. Julie stood and became very emotional when she described the ASC meeting and gave her support for the need to provide services for the bush people at Atoiﬁ. Until that time she had been sceptical of the need for such services. Her participation in the ASC meeting earlier that day had changed her and now she fully supported the bush ward project. The following case study describes this:

**Case Study 8: Conscientisation—The Process in Action**

The following case study outlines my observation of the process of conscientisation during the PAR process.

In October 2002 my friend and colleague, Julie Aengari, the Principal of the School of Nursing, an influential member of the Atoiﬁ hospital administration, became an ardent supporter of the bush ward project. Prior to this she had been a sceptic on the need for such a facility. She was one of the most formally educated and experienced members of staff, having lived and studied in Solomon Islands, Papua New Guinea, Fiji and Australia. She had a long history with Kwaio since she had worked periodically at Atoiﬁ over two decades and had family members holding senior medical and management positions in the 1980s and 1990s. Her father had been employed by the SDA church throughout the Pacific. Her mother is a strong woman and a leader in her own right. Both her parents come from the Western Province, a region that follows a matrilineal system, where land and resources are passed from mother to daughter. Julie inherited many of the qualities of her mother.
We had engaged in many in-depth discussions during my time at Atoifi including Western hegemony, particularly in education, and different models of health care delivery. Her initial view was shared by many at Atoifi—that bush people are strident obstructionists who oppose Atoifi initiatives on ideological grounds, stances that negate health benefits for their community. The general view held at Atoifi was that change needed to come from the bush people, despite forty years of evidence that the hospital did not meet their needs.

However, by October 2002 Julie was an ardent supporter and spokesperson for the need to provide culturally appropriate health services. The process I observed of transformation from sceptic to supporter I believe to be what Freire (1972, 1996) described as Conscientisation.

How Did Conscientisation Occur?

- Very simply by participation in the process. As a member of the hospital administration Julie had been invited to participate in an ASC meeting to discuss the proposed bush ward. I had also requested she be a member of my research reference group as someone whose opinion I respected. Though this in itself was very simple, the impact was profound. Julie was in contact with bush people almost every day in an informal way, buying produce at the market, and them walking past her house and school. She now was a part of a collaborative process of participation to discuss ways forward to provide culturally appropriate health care. By collaboratively exploring a shared future, the bush people could no longer be an intellectual abstract. No longer could their humanity be hidden behind the labels given them. They now were equals, human beings with whom dialogue was a prerequisite. Their input, knowledge and opinions were given equal importance when discussing the project. This interaction and process had a profound effect. The initial steps towards conscientisation.

- Through this dialogue Julie found the bush people genuinely trying to find the best solutions to the situation they found themselves in. They were not purposely being obstructionist or antagonistic to the process of change. People who were perceived as lagging on the scale of progress showed themselves more flexible in their genuine search for a solution than many regarded as ‘developed’ and ‘educated’. It was obvious that those who viewed themselves as further along the progress scale were stuck in their belief that their way was the only way. They were stunned to see people, fellow human beings, genuinely looking for solutions that they, the progressives, were unable to conceive themselves. This realisation proved a watershed and she became aware that change was possible, and needed, on all sides and long held views would need re-examining.

- The research reference group examined the influence of theoretical frameworks on the research process and practical outcomes. We discussed praxis, (that is, theory + action = praxis) and what that meant for PAR and action with the bush people. In discussion about the application of alternative knowledge and beliefs of the ‘other’, we analysed what it actually meant to honour all knowledge in PAR, whether one actually believes it or not. This led to a re-examination of the dominant view at Atoifi that doing anything for the bush people would ‘encourage heathenism’. Discussion also covered the theory of religious liberty, a foundation of the SDA church that ensures the right of individuals and groups to uphold their religious beliefs. This principle ensures the rights of all faith groups to co-exist with no one group having the right or authority to force another to conform to their beliefs. The reference group discussed what this meant for PAR and how it may influence the bush ward. This was an excellent learning experience and assisted in recommending appropriate methodologies, frameworks and approaches to PAR. The question was posed: what does praxis actually look like at Atoifi? The impact of analysing the reality for many at Atoifi and “learning to perceive social, political, and
economic contradictions and to take action against the oppressive elements of reality” (Freire 1996:17) continued the process of conscientisation.

- Participative action began the conscientisation process. Becoming aware of the contradictions and negative implications of the reality for many at Atoifi, had stimulated a growth in critical consciousness. This process not only enabled Julie to become an ardent supporter of the project, but very emotional at what she was now conscious of. She had begun a process of individual liberation through becoming critically conscious. She had become aware of the theory, the contradictory and oppressive reality for the bush people at Atoifi, and was supportive of action to address the situation. I questioned—how can this be expanded to encompass the collective liberation of others at Atoifi and in the community? Can PAR be a catalyst for this on a broader level?

**Staff Meetings and Historical Events: 4 October 2002**

Friday 4 October and the subsequent days became historical for Atoifi (this, incidentally, was 75th anniversary of the Bell assassination at Gwee’abe, at Sinalagu). The day started with the arrival of a Canadian journalist on a journey to retrace the footsteps of his great-grandfather, who as Anglican Bishop had sailed through the Solomon Islands in the 1890’s.

A meeting of clinical staff was held, and each department was invited to compile a list of questions to specifically ask Kwaio chiefs on the ASC. This process provided a mechanism for staff to engage with community leaders. The questions and responses were a basis to formulate policy and procedure for the bush ward.

The day also saw the arrival of the President of the Trans Pacific Union Mission (TPUM)\(^6\) who held the chair of the hospital board. He came to investigate allegations made against the expatriate CEO. Within an hour of arrival a hospital board meeting was convened and a staff meeting called for 5pm. During this meeting staff were informed the chairman of the board would assume hospital management responsibilities until allegations were more fully investigated. On Monday afternoon, 7 October, a further staff meeting was called to inform staff of the CEO’s dismissal and that he would be escorted from the campus the following day. Although there was

\(^6\) This is the administrative unit of the SDA Church covering the island nations of the South Pacific, excluding the French-speaking nations.
little surprise at the outcome, there were major ramifications across the campus, including for the bush ward project. Although the CEO had not been intimately involved, nor attended any ASC meetings, and despite admitting he was willingly ignorant about many cultural issues, he was broadly supportive of the bush ward project. As Atoifi was not working within a strategic plan, his successor might or might not support the project. The Medical Director was assigned increased management duties until a replacement could be recruited. The dismissed CEO was escorted from the campus by the chair of the hospital board on Tuesday, 8 October, on the scheduled flight to Honiara. He connected to a flight to Australia on the same day.

Case Study 9: How the ‘Investigator’ Can Fail to Find Knowledge Everyone Has

I was originally contacted by Charles Montgomery in early 2002. His great grandfather, Henry Montgomery, as the Anglican Bishop of Tasmania and had travelled through the islands of Melanesia in 1892 and 1906. Charles planned to retrace the route of his great grandfather to investigate the impact of Christianity/the Christian Church on local people and cultures.

In late September I received a radio message from Montgomery in `Aoke. He was, after four months of touring Vanuatu and Solomon Islands, scheduled to visit East Malaita. I indicated I could organise interviews and that he could stay at my house. He arrived early Friday morning, 4 October, after catching a ride in a police canoe from Atori, a government station approximately 15 km north of Atoifi. While eating breakfast with him an aeroplane landed carrying the chairman of the hospital board. Despite meeting the chairman and many Atoifi leaders, Montgomery was not told of the reason for the chairman’s visit.

I organised interviews for Montgomery including with the paramount chief. He spent time in surrounding villages and interviewed both Christians and those maintaining ancestral religion on their views on the impact of Christianity and the mix of traditional and introduced beliefs. On Friday and Monday evenings, 4 and 7 October, there were general staff meetings facilitated by the hospital board chairman who informed all staff of the process and decisions made. I was to fly to Honiara on Tuesday, 8 October, to connect to Australia later that day to be in Australia for my son Lachlan’s first birthday. The chairman, Montgomery, and the dismissed CEO were also on the flight to Honiara.

Despite coming to Kwaio with the explicit intent to investigate the churches’ impact on local people and culture, Montgomery left Atoifi having not been told of the dramatic situation that had just unfolded (see Montgomery 2004: 177-212 for an account of Montgomery’s time in East Kwaio).
Reflection

- Despite discussion with hospital leaders, spending time in surrounding villages and an interview with the paramount chief, no one mentioned this dramatic situation to Montgomery. The situation was clearly relevant on numerous levels. An expatriate CEO of the largest Christian institution in Kwaio, was dismissed and yet no one mentioned it. This prompted me to think: Are such things too difficult to talk about to strangers or was there just no need for this person to know? Was this question relevant for the PAR process?

- Montgomery did not know what ‘normal’ behaviour was at Atoifi. He did not know that it was abnormal to have a staff meeting at 5pm on a Friday afternoon, or to have groups from surrounding villages loitering on campus waiting for news from such meetings. He was also unable to perceive less tangible, though very important things, such as a collective feeling of an ‘air of anticipation’ that made tensions high. Due to his lack of history he was unable to perceive this tension. Leaving on the same plane with a large number of people at the airstrip to ‘farewell’ the dismissed CEO, either in a desire to see him go or a paradoxical Melanesian show of respect for a leader (even a leader dismissed under such circumstances) was not significant as he did not have a comparative context to place it within.

- The principle of relationship prior to the sharing of information/knowledge is significant, and links to the concept of epistemology. How knowledge is created and transferred, to whom and by whom, must be reflected upon in PAR. Outsiders’ who wish to access knowledge without an understanding of the epistemological roots of that knowledge will struggle even when everyone in the community has that knowledge, a central reason anti-colonial methodologies such as PAR are required in such situations (refer to Gegeo’s (1998; 2001; 2002) work on epistemology in neighbouring Kwara’ae). In a larger sense, this is a key reason why colonialism itself so often failed in the British Solomon Islands Protectorate. This also highlights the importance of prolonged engagement and persistent observation with a place and people. One can gain deep insights into
relationships, norms and the historical importance of events only through prolonged engagement and persistent observation.

- This was a historical moment for Atoifi. A moment where the ‘people’ used a collective voice against the ‘oppressor’. Despite a colonial history of submission to Europeans, church history and power, respect for leadership, economic domination, professional domination, social domination and the culture of silence surrounding misconduct within church organisations, people chose to act. Because of this multi-layered, complex situation those who did stand and give evidence showed great courage. The ability as a Solomon Islander to fearlessly stand against an expatriate church leader, in an environment of domination (not to mention isolation) was historical. I am unaware of this happening previously at Atoifi.\textsuperscript{61} The importance, indeed the occurrence of this historical action was never raised with Montgomery.

- This leads to the inevitable question; what might I have missed that is so obvious to those around me? Where have I stumbled through situations unaware of the historical importance of what everyone else can see? Is there a gaping hole in my data and analysis that makes my study deficient? Is the participatory approach which includes member checking enough to fill such gaps, or is some other method needed? Was it my role to expose the unfolding situation to Montgomery as an outsider with a view of the inside, but not actually being an insider? Was I being negligent to him or merely acting in an ethical way to honour my friends at Atoifi who were hurting? Was it my role to explain the situation to Montgomery, or anyone else for that matter, if I had been asked—if people had known the questions to ask?

- After this incident I made a conscious effort to constantly reflect and not assume the picture I saw was the same picture others saw.

\textsuperscript{61} Steley however lists two European SDA missionaries dismissed earlier in the Solomon Islands in 1922 and 1937 (1983:279–281). Hilliard (1978) records a number of Melanesian Mission missionaries being dismissed throughout its history.
Technical Assistance: 29 October, 2002

Despite the upheaval caused by the dismissal the PAR continued. The EU Microprojects Office in Honiara responded to a request for assistance with technical aspects of the project preparation, and sent an engineer to Atoifi to survey the proposed site and prepare technical drawings. The engineer arrived and met facilities management staff and charge nurses from all departments. The overall layout and spatial organisation of the bush ward complex had been agreed on by the ASC, although the internal design needed to be completed. A group of seven senior nursing staff met with the engineer and discussed the internal design to incorporate technical and space requirements. The size of facilities, procedures to be undertaken, storage, nurses’ station, lighting and bench space were discussed. This began the process to transform the sketches the ASC and staff had created into formal drawings usable for further technical, logistical and financial planning. The engineer returned to Honiara and worked towards the production of formal technical drawings of the bush ward.

ASC as Action Group: Fifth Meeting, 6 November 2002

A historical meeting of the ASC occurred on 6 November with twenty-two chiefs, community leaders and staff. For over three hours health service provision at Atoifi was discussed. The meeting was attended by Dr Percy Harold, Associate Health Director for SPD, who was visiting Atoifi in the aftermath of the dismissal. Representatives from all departments attended to discuss the lists of questions formulated with their colleagues over the preceding weeks. Attendees were challenged to collaboratively conceptualise and develop policies and procedures for the bush ward. This meeting was the first time senior staff had an opportunity to sit as equals with community leaders. It was evident that bush leaders were flexible in their approach to the proposed ward. They explained at great length how they were willing to compromise where they could, and why they were unable to compromise on issues of core religious beliefs. Questions covered issues from ‘Can a female nurse attend to a male patient?’ to ‘What custom medicine will be used?’ to ‘Will they accept prayer in the bush ward?’ Esau Kekeubata, a key member of the ASC with deep knowledge,
understanding, appreciation and respect for both worlds, explained nursing issues to
chiefs and cultural issues to nursing staff.

Reflection

This was a defining moment in the history of Atoifi because staff were able to enter
into dialogue with community leaders and mutually negotiate a common way forward.
All attendees engaged in the process with obvious good will. There was a collective
willingness to move forward and address the issues raised. The Associate Health
Director spoke on behalf of church administration and indicated the historical nature
of the meeting. Two influential chiefs thanked everyone involved in the dialogue and
urged that it continue. Staff in attendance were able to observe and engage in the
process of negotiation for new policies and procedures for the bush ward. Through
this process staff saw chiefs’ genuinely attempt to progress, and that they pursued the
best outcomes for their people, rather than being obstructive or unwilling to change.
The mutual process of genuine dialogue showed both sides that there were numerous
areas where positive outcomes could occur with a collective understanding and
willingness to progress. The meeting was another example of the participatory
approach, central to PAR, that had been successfully used a month earlier when
members of the Atoifi administration committee met with the ASC leading to the
conscientisation process outlined in case study 9. It was hoped the momentum for
change could continue and the participatory approach could lead to concrete action for
the bush people.

More Family Issues

In the early afternoon of 6 November, soon after the successful meeting had
concluded, I received a call on the satellite phone from my wife Michelle in Australia.
She explained our son Lachlan was to be admitted to hospital with a large abscess on
his buttock. This abscess had been present since leaving Atoifi more than two months
previously and was getting worse despite treatment. A call to the travel insurance
company confirmed I could return to Australia to be with my family. The next
morning I flew to Honiara and on to Australia that evening. There were no ASC
meetings scheduled for the following three weeks, although preparation was needed for the EU Malaita Province Coordinator and engineer to visit in early December.

**Reflection**

The emotional rollercoaster could not have been more stark. After the high of a very successful ASC meeting and the genuine good will shown by both sides, I had thought this might be the start of something new for Atoifi, a genuine and ongoing dialogue between the Atoifi staff and the Kwaio community. To be a catalyst in this process was hugely satisfying and I held high hopes for the future. At the peak of this almost euphoric state I received the call about my son who was en-route to hospital. The realisation that my son was gravely ill because he had accompanied me in the process to achieve change at Atoifi (and had to return home to Australia prematurely due to illness) was a deep low. The push-pull factors and personal consequences of undertaking PAR in a situation such as Kwaio were very real.

**Return to Finalise the Project Proposal**

After two and a half weeks in Australia with my family I returned to Atoifi. The project proposal was almost completed, and awaited only the materials list and costs and final community approval prior to submission to hospital administration for approval and submission to funding organisations (EU Microprojects Program and CPRF). I timed my return to coincide with the visit by the EU engineer and his Malaita Province Coordinator to present the technical drawings to the ASC and explain their procedure for completion of the project proposal. The scheduled visit on 27 November was delayed for a week, but I collected a copy of the drawings while in transit in Honiara en route to Atoifi.

**ASC as Action Group: Sixth Meeting, 4 December 2002**

Spirits were high when the two EU representatives met with the ASC and staff, and 14 members attended the ASC. The EU delegation stated three reasons for their visit:
• To view the community support for themselves

• To confirm the plans and layout of the bush ward

• To explain the expectations of the community contribution to the project (25 percent of inputs were to come from the community—this could be in the form of labour, timber, sand or gravel)

A major issue discussed was that beneficiaries of the project lived in the mountains up to a full day’s walk from Atoifi. These beneficiaries could supply labour for the project, but although they had suitable natural resources (timber, gravel) it was not logistically possible for them to supply them due to distance and terrain. Resource owners near the project site were not beneficiaries of the project, but were expected to contribute, and these landowners had faced four decades of constant requests to contribute to projects at Atoifi. Most of their trees had been cut down and they were unable to contribute. Community leaders from Sinalagu and `Oloburi indicated their willingness to contribute resources, but transportation would prove expensive. Plans were made for Lester Asugeni and myself to consult community leaders the following week at Sinalagu and `Oloburi as a part of a wider community consultation prior to submitting the project proposal.

The engineer presented the technical plans, which the ASC approved with no objections. A commitment was made by the EU to compile a materials list with associated costs to be forwarded to the ASC by early January. This would allow the proposal to be submitted to the Atoifi Administration Committee by mid-January, then to the EU Microprojects Office for their funding meeting in February. A site visit was undertaken with the EU engineer and coordinator and ASC members. The location was confirmed.

62 Resources had been under particular strain since 1999/2000 when many people had returned to their home villages from Honiara because of the ethnic tension. The small tracts of forest on the coast are steadily being diminished, cleared for timber to build new houses and to open new tracts of lands for gardens. This exacerbated coastal resource pressures already being felt from a population that was steadily increasing through natural growth and the Christianisation process (i.e., as people descended from the mountains). Forest had been cleared from the catchments of the small river that powered Atoifi’s hydroelectric system, and this decreased the river’s water flow and water availability for the generator, exacerbating power supply problems.
Reflection

Although there were still significant issues regarding natural resources for building the bush ward, there was a feeling that these could be overcome. Staff and ASC could see the EU support and commitment to the project. The draft plans of the bush ward complex allowed all involved to see that planning had led closer to the bush ward becoming a reality.

Community Meetings

A round of community meetings to present the bush ward complex plans was undertaken from 5–10 December. Meetings were held at Kafurumu in the Lafea (10 men and 5 women in attendance, at Baelanubu (25 men, 10 women) and at Faunuariri in the mountains behind Sinalagu (20 men, 9 women), all facilitated by Esau Kekeubata. Further meetings were held at Gounaabusu on the Sinalagu coast (42 men, 22 women), and Kingston on the `Oloburi coast (5 men, 3 women), facilitated by Lester Asugeni. Although formal community meetings were held in each of these hamlets and villages, that I slept in each hamlet or village either the night of, or the night prior to, the meetings allowed me to have many informal and in-depth discussions of the issues.

Plans and expectations of the community contributions were presented to each meeting. Those in the mountains pledged labour and those on the coast resources. At all meetings in the mountains, leaders also pledged resources, but the logistics of transporting these to the coast meant this was impractical. Although the leaders on the Sinalagu and `Oloburi coast also pledged resources, they faced similar resource pressures as the Uru coastal residents. However, Atoifi had asked them for contributions less often due to their greater distance from the hospital. Issues of separation of men’s and women’s areas were confirmed, particularly the placing and use of dry toilet systems, water tanks for drinking and a separate power system for the *bisi*. 
Discussion also covered policy and procedure for the bush ward. Two areas were of particular concern:

- Significant time was spent at the Baelanubu meeting in discussion about procedures for mothers visiting the antenatal clinic and after delivery in the maternity ward. Mothers do not take their child’s health record book from the maternity ward to their hamlets but leave them on the coast (as outlined in chapter 1). These books are often lost or destroyed before mothers collected them. When women presented without the records midwives at Atoifi often complained at the carelessness of the bush women who ‘did not know the importance’ of the documents. On interviewing the midwives at Atoifi, none of them were aware of the cultural significance of the child health record book coming from the maternity ward, nor the system of mothers leaving them with relatives in coastal villages. The bush women recommended that a child’s health records could be retained in the outpatient’s department or female ward. This would negate the need to have a relative care for them.

- A further recommendation was that when the antenatal clinic is conducted inside the *bisi* that medication be dispensed through the outpatients pharmacy. This would negate the possibility of taking medication from an *abu* place—the *bisi*, to a *mola* place—their house in their hamlet.

Discussions also covered security issues, and suggestions were made that the community pay an influential leader to curse or decree over the new facility that if anyone was caught stealing they be responsible to that leader, rather than hospital leadership. This was to cover both the mountain and coastal communities; that is, both young men from the mountains and ‘backsliders’ from the coast.

**Reflection**

The round of community meetings prior to the project proposal being finalised went very well. Although new issues were raised, there was nothing to fundamentally change the plans. Policy and procedure development was needed, but this was an ongoing process that needed to be undertaken through dialogue between the
community and Atoifi staff. The community meetings were held in often difficult circumstances at the same time as other significant events. For example, the father of one ASC member was gravely ill while he was hosting a community meeting. Nonetheless, despite such diversions the number of people participating, including many who walked for several hours to participate indicated broad project support.

Proposal Finalisation

The following section is a description of the ACT stage of the 2002 fieldwork.

Figure 5.4: Act in 2002 Action Research Events Spiral

Because the Christmas and New Year holiday season was about to slow the process, the ASC secretary Lester Asugeni agreed to liaise with the EU office while transiting through Honiara en route to his wife’s village for holiday. I returned to Australia the week before Christmas content that the proposal was near completion and the last six months of PAR had been participatory and reflective. It was putting knowledge into action and addressing an issue of practical need in the community. There were a number of obstacles yet to overcome, but the project had momentum and tangible outcomes seemed near.

Reflection

The initial aim of the PAR process in 2002 was to collaborate with hospital and community leaders to investigate the establishment of a culturally appropriate facility on the Atoifi Hospital Campus for and with the Kwaio bush people. This was to
provide a research base to inform the action phase and inform policy development for the facility. Specific outcomes planned with collaborators during the fieldwork to be achieved by December 2002 were to:

- Re-establish contact with community/hospital staff
- Establish collaborative groups
- Identify key issues through a collaborative process
- Use issues to inform the physical planning process for facility
- Establish ongoing evaluation of plans
- Record case studies of individuals’ experiences at Atoifi
- Describe the social, cultural and historical context of Atoifi
- Secure community support for project
- Secured hospital staff support for project
- Complete a project proposal with building plans and costings
- Liaise with funding agencies to secure funding
- Liaise with other relevant agencies/organisations to secure support, for example the Kwaio Development Association
- Liaise with hospital staff and community leaders to investigate policy and procedure formation for the new facility
- Liaise with hospital staff and community leaders to investigate ongoing management issues for the new facility

As of December 2002, most of these outcomes had been met or were on their way to being met. A collaborative and participative process had resulted in collectively observing, reflecting and planning. The action phase was in preparation and despite several organisational and logistical challenges the future was promising.

**Natural Disasters and Delay**

While the project proposal was at the cusp of completion, it was affected by two cyclones in the far east of the Solomon Islands. One of them, Zoë, a category 5 storm (The most severe category, with winds above 280km/hr) passed over Temotu
Province from 28–30 December 2002, and almost completely destroyed the islands of Anuta and Tikopia. An international response followed which provided immediate aid for the islands’ residents, who had survived by hiding in caves. Aid focused on rebuilding and establishing new gardens. The EU microprojects office, like many other aid and development organisations, became involved in coordination and provision of assistance to the people of Temotu, particularly Anuta and Tikopia. Many existing projects, including the bush ward, were postponed because of the disaster relief and the arrest and conviction for fraud of the EU Microprojects accountant.

During February 2003, Lance Gersbach, an accountant living in Newcastle with experience in church administration in the Pacific, was recruited to Atoifi as Business Manager. There was regular communication between members of the ASC, the acting CEO and myself with the EU in February, March and April, but their commitment to the disaster relief projects caused delays for the bush ward project. Frustration mounted given that the proposal only required final input from the EU. The proposal was still incomplete when a tragic event in May 2003 changed Atoifi forever.
6. A Situation Forever Changed—May to July 2003

The previous chapter has outlined the PAR undertaken at Atoifi and the complex situation in which the research progressed between June 2002 and early May 2003. The action phase of the project was delayed because of the EU Microprojects program’s ongoing response to cyclone Zoe in Tikopia. While waiting, frustrated at the delay and loss of momentum, a tragic event engulfed Atoifi and changed it forever. This chapter describes that event and its aftermath.

The following is a description of the OBSERVE and REFLECT stages of May to July 2003. Although the ASC was not formally involved as the ‘action group’ in this phase of the PAR, many of the ASC members were central in the participatory processes which occurred. How the ASC was re-engaged as action group is described.

Figure 6.1: Observe and Reflect in May—July 2003 Action Research Events Spiral

6.1 A Situation Forever Changed

I received a phone call at 6 P.M. Sunday, 18 May at my home in Brisbane from a friend whose father was a senior church administrator in the Pacific. She had just been informed of a tragic incident at Atoifi and requested to pass on the information by her
father. She relayed the news that Lance Gersbach, the newly arrived business manager, had been beheaded earlier that afternoon while digging the foundations of the new store. I was in disbelief and my heart raced. I immediately asked for more information: who was involved and what were the circumstances? Those details were not available. My immediate reaction was to ask who the perpetrator was and why the murder happened. My mind began to run and think through possible scenarios. In the initial stages with very limited information I was unsure what the possible scenarios were. I thought through the following:

- Was Gersbach’s murder on the site of the new store significant? Was the store still to be three stories and thus culturally inappropriate? Over the ensuing days news reports from Atoifi through the Police spokesperson indicated some Kwaio were unhappy with multi-story buildings, as it violated custom. Had this project, backed by AHA in Brisbane been so ill-conceived that it had ended in disaster? Had the previous CEO’s propensity to willingly ignore cultural advice and feign ignorance led to a man’s life being taken? This however would be a dramatic reaction to a small project given the history of continual violation of Kwaio culture at Atoifi. Was it the straw that broke the camel’s back?

- Was it a land dispute? This theory was widely reported in the Solomons and international media over the following week. If so why had Gersbach been targeted? Was the land on which the building was to be constructed in dispute or was it just a focal point? Had there been negotiations with landowners that had created enmity to such an extent that this was the outcome? Was this the December 1965 Dunn incident all over again? There had been continuous quarrelling between parties over land rights at Atoifi since the mid 1960s. Had one of the aggrieved parties resorted to such violent means? Early media reports suggested such a scenario.

- Was the murder a result of Gersbach’s ‘tightening up the system’ after the accounting practices of the previous CEO? Had his involvement in reining in spending and management practices angered someone to the degree that this was the result? Were there debts that had to be collected
or general anger at the change in leadership and direction at Atoifi? Had an individual or group ‘lost’ so dramatically by the change in leadership and management that they resorted to violence? There had been a history of dramatic change in leadership and management in the past, but it had never led to violence.

- Was it a simple case of mistaken identity? Had the murderer just become aware of the allegations which led to the dismissal several months previously and come for revenge? Had revenge been taken on the wrong person?

- Had Gersbach insulted someone (intentionally or unintentionally) to such a degree that this was the outcome? Had he been informed of the appropriate cultural norms to follow? This was unlikely, since Gersbach had a reputation as a considered, introverted, quiet man.

- Was the perpetrator from Kwaio? This was the immediate assumption because it happened in Kwaio, but could the perpetrator be from another language group? If so, what was the significance?

- Was the perpetrator a patient with a mental health problem in a psychotic state? There had been several violent incidents at Atoifi in previous months involving mentally ill patients and staff.

- Was the murder a symbolic strike at the head of Atoifi as an organisation or was it just a case of Gersbach being in the wrong place at the wrong time?

- Was this a trigger for further violence and would staff, expatriate or local, be targeted in the future?

- Was it a combination of all of the above or something totally different? What was the future of Atoifi and health services in the area?

As I pondered these questions I felt deep sorrow. What would the future hold? Would Atoifi recover? I also had anxieties. Personal anxieties: my family had lived in a house just 20 metres from the murder site; anxieties for friends at Atoifi living
through the experience; for the organisation, over how the hospital and health services would face this challenge; and professional/academic anxieties: what would this mean for the research process and outcomes? The bush ward proposal was not yet finalised. The EU was still involved in disaster relief with the technical drawings not yet complete. Would they continue to support the project? It was a time of emotions, from fear to sorrow to anger to sympathy. Had I erred in judgement by choosing to work with a group of people feared for their fierce, often violent behaviour? Or was this a time to facilitate the voice of Kwaio to be heard by those who needed to hear? Was this a time, more than ever before, when the voice of Kwaio needed to be heard to counter negative stereotypes that would inevitably come to the fore?

Over the following week I was anxious to know the circumstances of the murder. It was impossible to contact Atoifi directly since the satellite telephone was not working. Media reports appeared stating there was a land dispute and the Kwaio were unhappy with the multi-story building proposed for the new store. I made contact with colleagues in Honiara, although they had only scant ‘on the ground’ and mostly second-hand accounts of events. I contacted the Health Department of SPD in Sydney and offered my assistance. I was contacted by the chairman of the hospital board from Fiji. He was keen to consult widely to gain other insights, including mine because of my recent research with Atoifi and the Kwaio community. Because the telephone was not working there was little direct information from Atoifi. Accounts of events varied dramatically from Honiara. The medical superintendent, who was Acting CEO, was on annual leave in his native Philippines. On hearing of the incident he called me in Brisbane on 20 May after his unsuccessful attempts to contact the board chairman. My understanding of the circumstances surrounding the murder emerged over the next several weeks as I spoke with people, and became clearer during my June 19 to July 4 visit to Solomon Islands and subsequent media reports and court documentation.

The Incident

The following description of the circumstances leading up to and subsequent to the murder of Lance Gersbach on 18 May 2003 are based on numerous conversations, interviews and group discussions held from May 18 to July 18 2003. This account is
not definitive, and my reflections are a subjective analysis of the data gathered. What is recorded here is consistent with accounts delivered during the murder trial and documented in the court ruling (Brown 2003), as well as media coverage of the incident, however the following should not be used for legal purposes.

**Lance Gersbach**

Lance Gersbach was a quiet father of two. He accepted the position of business manager in February 2003. As accountant, his role was to stabilise the budget after a period of rapid expansion and unorthodox management, and to create a business system for Atoifi’s future operations. He had most recently worked in Newcastle in New South Wales, Australia, and had experience in hospital financial systems in the Pacific, namely, Sopas Adventist Hospital in Enga Province, Papua New Guinea and Auckland Adventist Hospital in New Zealand. During his short time at Atoifi he became known by staff as a sincere man who loved to keep fit and cared deeply for his family. Gersbach was an introverted, quiet, humble man who was considered in his movements. Those who worked closely with him told of a man with a dry sense of humour who was enjoyable to work with. Many staff noted how much time he spent with his family.

**The Suspects**

Silas Edi Laefiwane is a young man I first met in 2002. He introduced himself as Jimmy Ri’ifana and that is the name I knew him by (It is not uncommon for Kwaio to have several names which they use interchangeably). Our friendship strengthened when I established a relationship with his uncle, Fa’amolaa (Case Study 1 Chapter 5). Silas was a confident young man who was always keen to talk. When I first met him I was eager to cultivate relationships with younger men from the bush since I had mostly dealt with chiefs or leaders. I wanted to get to know Jimmy and learn about his life and issues of concern to him. He would often call to visit when attending the weekly market. We established a system where his extended family supplied my family with taro in exchange for rice—Many of Jimmy’s family did not engage in the
cash economy and they found it difficult to purchase commodities such as rice. I would purchase a twenty kilogram bag of rice to trade for a twenty kilogram bag of taro from his family. This was done in an *ad hoc* manner depending on availability of taro from gardens and rice from the store.

As part of the PAR process I visited hamlets in the mountains to interview people and attend cultural events. On one occasion I was accompanied by a medical student on a six-week practical at Atoifi. We arranged for Laete’esafi to guide us into the mountains and Jimmy to guide us back through several hamlets to examine patients unable to enter Atoifi for cultural reasons. During this trip we were informed that Jimmy was known locally as ‘Jimmy Marijuana’, a fact confirmed on a visit to his hamlet. An extended discussion ensued on the advantages and disadvantages and medical, social, cultural and legal implications of marijuana use. He had used marijuana for some time and had several altercations with police in Honiara over it. He had also done time in Rove prison in Honiara for possession at least once.

Although Jimmy was involved with introduced substances such as marijuana, he also upheld ancestral religion. Despite being a young man Jimmy had started to sacrifice pigs, something many men his senior had not yet begun. This meant he was periodically *abu* and restricted from engaging with his peers. He was unable to enter our house (nor any other that a potentially menstruating female was in) nor accept food that a female had prepared. On one occasion he guided me to a friend’s mortuary feast but was unable to enter the hamlet because his family was observing a period of mourning after his cousin’s baby had died several days earlier. He was also a member of an extended family known to be effected by *buru* spirits. *Buru* are foreign and malevolent, and induce antisocial and unexpected behaviours in people they possess. Jimmy had scars on his arms and legs where he had stabbed himself while possessed by a *buru* (for information on *buru* spirits see Akin 1993: 636–648 and 1996:147–171).

Jimmy was a man in which many contradictions played out. One of these was his outward appearance and his passionate belief in ancestral religion. He dressed in Afro-Caribbean-style clothes, and was often seen in long cargo pants, a tight singlet, a
reggae-style hat and dark glasses, and yet he was abu and upheld sacrificial practices. This adherence to Kwaio religion meant he was unable to access health services at Atoifi. On one occasion I asked why his hand was bandaged with crude bandages of calico. His hand had been burnt several days earlier and was covered in numerous pussy lesions. When asked why he didn’t go to outpatients to seek help he laughed and said was unable to go under the tuusitori. His concern for Kwaio culture extended to his broader community. In August 2002 Jimmy came to me expressing concern over a group of Italian doctors in the mountains (Case Study 7 Chapter 5). This young man was negotiating his way in a world of tradition and custom interacting with a world of ‘modernity’ and ‘development’.

Naasusu Tome is a ‘cousin’ of Jimmy Ri`ifana who I knew by association rather than personal relationship. Naasusu was a regular visitor to Atoifi. On several occasions I had talked with groups of young people, including Naasusu, outside our house while waiting for market to finish, the irregular ship to arrive, or after trading taro with his aunts or uncles. He was an introverted young man, less likely to initiate conversation than Jimmy.

Naasusu, like many of his family, was known to be affected by buru spirits. These spirits would make him do unexpected and unusual behaviours. He would disappear into the bush for days at a time and have no contact with people. At times he was distant and vague, and sometimes reciprocated greetings with a blank stare. This was an unusual reaction in the cultural context where one would acknowledge someone else as they walked by, even if only with the raising of an eyebrow or some facial expression. Informants described Naasusu as prone to paranoid delusions. On occasions he thought that people or animals had come to attack him. These behaviours were attributed to buru spirits and had started affecting him in his late teens. Some informants described his behaviour as influenced by buru spirits, some as paranoid and others used both of these descriptors interchangeably.

Naasusu was known to be in Jimmy’s group of marijuana users. He often had a glazed look in his eyes when at Atoifi. He became well known at Atoifi after he struck the leader of a group of Italian tourists with his knife in August 2002 (Case Study 7
Many in the community perceived marijuana to be a significant factor influencing his behaviour. Despite his history of antisocial behaviour he was most often in a normal state when at Atoifi.

**An Incident of Public Humiliation**

Small trading ships were often chartered by Atoifi to transport goods for health services, retail store and staff needs from Honiara. Atoifi’s long-serving Facilities Manager Ray Jack (from Lau Lagoon in north Malaita) would routinely organise the procurement and transport of the goods. If the ship was not full East Kwaio people often utilised the opportunity to return home. Space was in demand because of the infrequent passenger and cargo shipping to East Malaita. The April 2003 charter was no different.

During April 2003, Jimmy Ri’ifana was in Honiara and looking for passage to Atoifi. He heard of the imminent departure of the Atoifi charter and saw this as a way to return to Kwaio. Jimmy boarded with his bag, requesting passage to Atoifi. Ray Jack, overseeing the loading of the ship asked if he could pay for his passage. An argument ensued after Jimmy stated he did not have enough money to cover the fare. Ray told him there would be no passengers that did not pay full fare and it was not his decision but that of the business manager. Ray threw Jimmy’s bag onto the wharf. This publicly humiliated Jimmy on the crowded wharf. Jimmy allegedly remarked ‘no problem you will get your fare’ as he walked off. He went to his relatives and secured funds for an air ticket to Atoifi the following day. On arriving at Atoifi Jimmy returned to his home in the mountains.

A month later Atoifi chartered another ship to transport goods both to and from Atoifi. The ship arrived at Atoifi wharf on Tuesday 13 May. As usual when the ship arrived at Atoifi the maintenance workers loaded and unload the cargo. This continued into the night with timber being loaded for transport to Honiara. During the loading Jimmy and Naasusu boarded the ship and made demands of Ray Jack. Jimmy stated that in light of the refusal of passage on the ship a few weeks earlier Ray Jack was to leave Kwaio permanently. He stated that if he did not leave within five days he would kill
Ray. Kwaio workers took the two away and tried to talk with them to defuse the situation. Lester Asugeni was called and offered them $20 as compensation to cover the insults that acted as catalyst for their anger and threats. When the ship was loaded it returned to Honiara as scheduled, with Ray Jack aboard as originally planned.

### 6.2 Sunday 18 May 2003

Sunday 18 May, was a like any other Sunday on campus. A small number of patients came to the hospital to seek treatment, villagers brought food for their friends or family admitted to hospital and staff used the day for chores or garden work. The medical superintendent was on annual leave, his position covered by Dr Bruce Hands (an Australian) and Dr Arnold Raubenheimer (a South African). Dr Brian Senewiratne, a clinical Associate Professor of Medicine from Brisbane, had arrived two days earlier to deliver a series of lectures at the invitation of Dr Hands. That morning Dr Senewiratne gave a lecture in the School of Nursing. Most nursing staff not on duty attended with others including Lance Gersbach.

Prior to Gersbach attending the lecture he worked on the foundations of the new Atoifi store. Joshua Anisi, Atoifi’s mechanic and relative of Ray Jack, used the backhoe to excavate the site. Both men had worked alone on the site. At Approximately 11:30 A.M. Fraser Alekevu, the hospital accountant, came to help Joshua. As Fraser walked past the house before the building site (This house was used for visitors to the campus and my family and I had stayed there during 2002) he noticed Naasusu sitting under a tree watching Joshua work. Joshua, too, had noticed Naasusu watching him and had smiled but received no response. Although Fraser was the accountant he was keen to learn new skills and requested Joshua to teach him to operate the backhoe. The two worked together for about half an hour until Joshua saw one of his relatives from East Fataleka walking towards the hospital. He left Fraser in control of the backhoe and accompanied his relative to the hospital, and Fraser worked on the site alone. Joshua returned and they worked together on the backhoe. After the morning session of lectures was complete Gersbach returned to his house and then on to the building site at approximately 12:30 P.M. He began manually digging where the backhoe was unable to reach to clean the rough edges of the trench.
As they worked the backhoe transmission seized because of a lack in transmission fluid. Both Fraser and Joshua left Gersbach and walked to the workshop to find more fluid. This took some time because they had to ask Lance’s wife Jean for Ray Jack’s keys to the workshop (Ray Jack was still in Honiara and had left his keys for the workshop with the Business Manager). The two then continued to the workshop 400 metres away.

As staff returned to the School of Nursing for the afternoon lecture Stewart Lota, who lived near the building site came running to the School of Nursing and shouting “olketa kilim Lance”, literally “they have killed Lance”. There was initial confusion as in Solomon Pijin the word ‘kilim’ does not necessarily translate to the English word ‘kill’ but can also mean to ‘fight’ or ‘wound’. As staff ran the 100 metres to the building site they were unsure what they would find. Some thought he might have been involved in an accident with the backhoe, or become involved in a fight. As they ran to the site they saw Gersbach slumped in the trench he was digging. Some initially thought the side of the trench had collapsed and covered his head. Raubenheimer arrived at the scene together with Benjamin Polosovai, the Deputy Director of Nursing. Raubenheimer instructed staff to run and get a stretcher and the ambulance. It was immediately obvious that this was not an accident. Gersbach had been decapitated with a single clean cut. In minutes a large crowd assembled around the site with people wailing and crying.

The Australian volunteer hospital chaplain, Wolfgang Kissener, was quickly on the scene. He immediately went to Gersbach’s house and informed his wife Jean and his two daughters what had occurred. They were stopped from going to the scene or viewing the body by Atoifi staff. They were advised to stay in their house until the situation was clarified.

Benjamin ran with the stretcher accompanied by Nashley Vozoto, Charge Outpatients’ Nurse to the scene. Nashley had run to the workshop to get the ambulance. While there he informed Fraser and Joshua, who both greeted the news with disbelief as they had left the building site just minutes before. When the stretcher and ambulance arrived Gersbach was lifted onto it and covered with calico while he
was transported to the hospital. Gersbach’s body was not wrapped nor was it prepared as normal, since it needed to be examined by police. This caused great concern among nursing staff who were unable to prepare the body of their manager in a way they saw fit and were trained to do.

The crowd grew and started to ask questions about the perpetrator of the crime. Staff, patients and guardians were all shaken and confused. Not knowing if this was an isolated incident or if further attacks would come, patients immediately began to discharge themselves. All but the critically ill fled the hospital in the following few hours. Nursing staff panicked, and in the chaos medications were given incorrectly or missed. Most of the nursing staff felt insecure in the wards and fled to their homes. As people from surrounding villages arrived on campus community leaders began to ask who had seen what. No eye witnesses came forward and people began analysing who and what they had seen that day.

As the satellite phone was down, the only communication was via HF radio. A radio call was made to Solomon Telekom requesting they ring the SDA administrative officer at her home in Honiara to inform her to radio Atoifi urgently. This took approximately 30 minutes to establish communication with SDA administration in Honiara. Staff at Atoifi explained events and requested the Australian High Commission in Honiara be informed. The Australian High Commission, SDA headquarters and Solomon Islands Police were all contacted. Two aircraft were chartered and landed at Atoifi between 4 and 5 P.M.

In the time the aircraft took to arrive medical staff had examined Gersbach’s body and documented the injuries. The wound indicated a single swing of a knife from behind at the neck to the front of the throat. It had resulted in immediate death. They consoled themselves that although it was a horrendous death, it would have been swift, to the extent that Gersbach would not have known what occurred. He was known to remain focused on his task even if there was activity or noise in the area.

Leaders from surrounding villages suggested the community provide a security force for the campus to ensure no further attacks. The entire community was shocked at the
murder and searched for an explanation to why it had happened. From the outpouring of emotion and grief it was obvious it was an isolated incident with no knowledge of any potential attack in the community. Several leaders showed an unwillingness to accept that the perpetrator was from Kwaio, and stated there were people from other parts of Malaita and the whole country present at Atoifi that day. This idea was swiftly dismissed as all non-Kwaio had alibis. Within hours hundreds of ‘community security officers’, men armed with knives patrolled the campus. This was despite the fact that, historically, Kwaio murderers have not returned to the scenes of their crimes.

When news arrived that an aircraft was on its way to bring police, retrieve Gersbach’s body and evacuate Jean and family, others also decided they too should leave. Jean Gersbach did not want to leave Atoifi until she could connect with a direct flight back to Australia. She did not know anyone in Honiara and felt her friends at Atoifi could support her until she could return directly to Australia. This choice was taken from her when officials from the Australian High Commission and TPUM stated they were evacuating her and the two girls to Honiara that afternoon. Both Fraser and Joshua decided to leave for their personal safety after they gave statements to authorities. They both identified Naasusu as sitting under the tree overlooking the site just prior to the murder and wanted to nullify any attempts to interfere with them as potential witnesses or other payback. Dr Senewiratne also chose to fly out. All other staff, both national and international, chose to remain despite the fear and uncertainty people were experiencing and that the Australian High Commission had chartered the plane to evacuate Australian citizens.

The aircraft arrived with police, SDA administrators and Australian High Commission officials. Lester Asugeni, the community liaison officer was in Honiara and also flew back. Lester was installed as acting CEO. As a Kwaio, he could make sense of the situation and decipher information from the hospital as an institution and the community. Another significant reason Lester Asugeni was installed as acting CEO

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63 There had been no permanent police presence at Atoifi or its immediate surroundings since the beginning of operations at Atoifi. Police come from the nearby government station of Atori, approximately 40 minutes away by motorised canoe, or by plane from Honiara. This changed in 2004 when a police post was built at Atoifi, 50 metres from the murder site.
was that the medical superintendent and acting CEO was on annual leave; the business manager, the next person in line, was dead; and the accountant was leaving due to safety concerns. This meant that Lester was not only a Kwaio with administration experience, but one of the only experienced administrators on campus. Fear gripped staff and many indicated apprehension at staying at Atoifi. Gersbach’s body was driven to the airstrip in the ambulance and the aircraft took off just on dusk. Returning to their homes, many staff immediately packed their belongings, unsure of the future and unwilling to stay. Staff were aware of the agreement that stood between the hospital and community after the 1965 murder of Brian Dunn that stated that a further murder on campus would close the hospital. Numerous staff saw this incident as breaking that agreement. The majority had been on campus when Naasusu had attacked the Italian doctor and were aware that he was the prime suspect. As patients fled the hospital, staff too were unsure of Atoifi’s future. There were accounts of staff leaving the hospital with medication, equipment and anything else of value—knowing the hospital might close, they feared looting.

A senior nurse recalled to me that he knew of the 1965 agreement and, as many others did, thought the hospital would close. Despite this, he worked the following day to serve the few patients who remained. Two days after the incident he recalled being particularly ‘hit hard’ by the enormity of what had occurred. He was unable to think clearly and could only think about the Italian incident. He had been only 5 metres from Naasusu when he swung his knife and gashed the Italian (and I had been standing beside him). This played on his mind and he was unable to work for a week. The impact on the mental health of staff was significant. Numerous staff I interviewed indicated they were unable to remember Gersbach as a whole person, but rather only as a head and body in two parts. This was only remedied after seeing a photograph of him as a whole person. Others had physical reactions which included an inability to sit down with their back and neck exposed to people coming from behind. Due to the geographical isolation and lack of transport and communication infrastructure, social support that extended family could provide was limited, particularly for non-Kwaio staff. Administration allowed staff and students to take leave and depart the tense situation at Atoifi.
6.3 The Aftermath of a Tragic Incident

Lance Gersbach’s murder had an immediate and dramatic affect on everything at Atoifi—not only the security of patients, staff and campus residents but also the logistics for continued health services. Then there was the 1965 agreement. This loomed over the staff and community, who knew this could be the catalyst for Atoifi to close. Recognising the enormity of this potential outcome, Silas Lounga and other chiefs took action to ensure staff would not leave. He presented a shell money valuable, fa’afa’a, to hospital administrators in an interaction known as batani kwairuinga’a ania. The four strings of shell money were a representation that the community wanted staff to remain. Despite this gesture of good will, many staff wanted to leave because the perpetrator/s were still at large.

Members of the Royal Solomon Islands Police Rapid Response Force were among the first police to arrive. In the first days police and media statements indicated the murder may have been associated with a land dispute or the multi-story store design (Coutts 2003, O’Callaghan 2003, O’Callaghan and Walker 2003). Within a few days two suspects for the murder were named: Silas Edi Laefiwane (a.k.a. Jimmy Ri’ifana) and Naasusu Tome. Chiefs and police made contact with them in their hamlets. Accounts differ on details, but it is clear that after an initial period of discussion both agreed to give themselves over to authorities. Within a week both Jimmy and Naasusu, accompanied by several chiefs and community members, walked the several hours to Atoifi to hand themselves over. As the group neared Naa’au, the last village before the airstrip, Naasusu became agitated and bolted into the bush. He stated he was afraid he would be killed while in custody. Jimmy handed himself over to authorities, was flown to Honiara, questioned and charged.

The subsequent weeks were tension filled, both in the community and at Atoifi. Delegations of chiefs and unarmed police visited Naasusu’s hamlet and discussed issues with him and his family. There were several attempts to have Naasusu give himself up in a peaceful manner. On several occasions he started to walk down to give himself up only to become severely agitated and turn back. A number of chiefs stated they were in a difficult situation because of Naasusu’s history with buru spirits. As no
eyewitness had come forward those involved in handing Naasusu to government authorities had to treat him as a suspect and not the actual murderer. That buru spirits had made members of Naasusu’s family commit suicide (including a cousin, just months previously) was also a factor. If Naasusu was forcefully handed to authorities, placed in prison and subsequently committed suicide prior to being convicted in court, his death could be blamed on the person that forcefully handed him to authorities. Compensation might be claimed against those responsible for Naasusu being in prison. Had there been an eyewitness to the event chiefs would have been at liberty to pursue the matter in a more vigorous manner. Chiefs involved had worked together to apprehend and hand over another murderer to police in the Sinalagu interior a year earlier. In this case there had been eyewitnesses and chiefs could boldly pursue the matter. This was not so in this case and a more considered approach was taken.

As time progressed and Naasusu remained free, staff grew increasingly concerned about safety, and the apparent lack of ability of the police or chiefs to apprehend him. This caused many more staff to leave. Workload fell on staff who remained, the majority of whom were Kwaio or married to Kwaio. Although many Kwaio staff understood their colleagues’ need to temporarily leave, some were angry at rumours about the lack of security. Atoifi was in a paradoxical situation, the campus was actually safer than at any time in recent history. Not only were forty security guards on duty at any given time, but all staff and visitors were acutely aware of any suspicious or unexpected behaviour. When staff cited security concerns and left many Kwaio staff were disappointed. This was amplified when several Kwaio staff took leave as well. Those Kwaio staff who did take leave were married to non-Kwaio and as such had responsibilities to others outside of Kwaio. In a time when the Kwaio saw the need to demonstrate their capacity and will to carry the hospital through a crisis and show the country they wanted to keep it operational, some felt betrayed. The collective shame felt by many Kwaio was immense, with one of their own as the prime suspect for the murder of a hospital leader and a guest on their land. Many felt

64 Despite this, people were staying away from the hospital because of their security concerns. One such situation occurred during an acute outbreak of food poisoning in the Kwaibaita valley, three hours walk from Atoifi. The outbreak occurred at a school fete where fish purchased from the provincial capital of Aoke was prepared for the community. Reports that reached the hospital indicated several hundred people were afflicted by acute vomiting and diarrhoea, and at least one person died. Despite this outbreak not one person came to the hospital for medical attention.
the pain from barbed comments about Kwaio that were being spoken. With a history of Kwaio perceived as backward and the least ‘developed’ area of Malaita, the derogatory comments caused deep emotional scars. This exacerbated divisions between staff that had grown in previous years.

Conflict on campus was reflected by conflict in the community. The community began to question the ability of their leaders to make accurate and swift decisions, and there was ongoing debate over the best way to resolve the situation. As discussed in Chapter 5, this was in the context of a trend occurring across the country toward questioning leadership at all levels of society. Because bush people were centrally involved, many Christians called Kwaio custom to question. This was a continual point of contention as some custom practices proposed by both coastal and bush leaders were perceived as a screen to hide behind. Others were concerned at custom being twisted to suit the best outcome of the suspect. Allegations were made that customs were being manufactured to suit the situation. Many of these allegations were scoffed at by the bush people, who saw coastal people to have little understanding of Kwaio tradition though they made confident statements as if they were experts. Some alleged that Maenaa’adi, as paramount chief, was unable to act in the best interest of Kwaio as a whole because he was related to the suspect. This led to questions concerning his leadership and his motives for delaying Naasusu’s arrest. Maenaa’adi had explained the need for sacrifices to be performed which would clear the way for Naasusu to be handed to police. This was perceived by some as a misuse of custom in order to postpone Naasusu’s arrest. Elements within the Kwaio community saw these delays as unacceptable, and groups of coastal Christians planned to respond to the inability of the police by setting up an armed group to apprehend Naasusu themselves. Some claimed they were prepared to use firearms if they faced resistance. Similar ideas circulated among ex-militants in Honiara. None of these scenarios eventuated, but they exemplify how leadership on all levels was being questioned.

With the 1965 agreement present and Naasusu still free, the possibility of Atoifi closing deepened. This was a matter of logistics as much as principle. As the number of staff at Atoifi decreased, so too did the ability to keep the campus operational. The staff shortage included key staff such as mechanics and accountants as much as front
line nurses or medical staff. As the likelihood of closure increased, so the pressure on Naasusu’s family increased. This pressure heightened when some coastal Kwaio threatened to claim compensation from Naasusu’s family if anyone died from an illness that could have been treated had the hospital not shut down. In such situations it would be deemed that Naasusu was the direct cause of the hospital closure and thus the direct cause for the illness not being treated. This would then allow the family of anyone suffering a preventable death to claim compensation for the life. This would raise the already significant social upheaval to a new and more volatile level.

Pressure was also mounting on the international front. The Australian Foreign Minister condemned the killing and called for those involved be brought to justice (The Australian 20 May 2003). Australia was also making final preparations to lead the Multinational RAMSI. Leaders in Australia and New Zealand emphasised the capacity of RAMSI to re-establish law and order and investigate un-investigated or unsolved crimes. The news of the impending arrival of Australian troops conjured memories of the 1927 punitive expedition led by the Australian navy after the killing of Bell. This event looms large as the most significant landmark in the history of East Kwaio. Life was significantly changed for most Kwaio and the punitive expedition is used as a reference point for most contemporary political events. Many older Kwaio who grew up in the aftermath of the 1927 social upheaval indicated their unwillingness to relive this should RAMSI be dispatched to apprehend Naasusu. This was heightened by the knowledge that Australia had recently been involved in the invasion of Iraq, and the level of training and weaponry they would bring. Although there was no official announcement from Canberra that this was a possibility, members of the Kwaio community felt that it was.

As weeks passed staff morale slipped further and more indicated their desire to leave. Senior church officials visited to assess the situation, talk with staff, chiefs, government officials and diplomats. The security and logistics of continuing services were discussed. There were real fears that Atoifi could not remain operational because of insufficient staff despite the desire to maintain services. The date of Monday 16 June was set after which the hospital would revert to ‘clinic only’ status if the suspect was not apprehended. This meant suspending all inpatient services and providing staff
transport to Honiara by ship. As these decisions were being made Dr Senewiratne wrote an article in the Solomon Star urging the church not to close the hospital. He alleged church leaders were placing undue pressure on the suspect to confess.65

**The Suspect Arrested**

Monday 16 June arrived and Naasusu was not in police custody. This initiated the hospital to revert to clinic only status, after which emergencies only were treated. All inpatients were discharged and all inpatient and auxiliary services ceased. A ship was organised to arrive that day to transport staff who wished to leave, and their goods to Honiara. The ship was delayed until Wednesday 18 June. Many staff were unsure when or if ever they would return to Atoifi, or if the 1965 agreement would mean the hospital would permanently close. Many took their possessions with them since they had no faith in the community security to prevent looting of staff houses in the event of the hospital being declared permanently closed and staff members not able to return to pack and transport their goods.

A senior police officer with links to Atoifi and to Naasusu’s family, flew to Atoifi on Monday afternoon. He lived and worked in Honiara but came from the SDA village of `Abitona across Uru Harbour from Atoifi. His father was a church and community leader and had been central in establishing Atoifi in the early 1960s. Naasusu’s mother was a relative of his, and this allowed him to interact as both police officer and family member. He also came as member of the Kwaio Development Association (KDA), a group of professionals representing Kwaio people in Honiara. The Kwaio community in Honiara wanted to send a message to Naasusu’s family that a quick resolution was required to end uncertainty at Atoifi. They raised funds after news reached Honiara that Naasusu’s family had exhausted their resources and were no longer able to perform further cultural requirements. This was perceived by some as an excuse to delay handing Naasusu to police. Funds from the KDA would be used to

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65 This allegation came after a comment by the chairman of the hospital board that if the suspect were to give a full confession it would provide a safer environment for the staff to continue work. A confession would mean that, in the event of the suspect being found guilty, it would not be done based on the testimony and evidence given by a staff member. It was feared that if a staff member were to give the crucial evidence that led to conviction then his associates might seek revenge, and the work environment at Atoifi would consequently continue to be unsafe. It was not intended to pressure the
purchase pigs or other requirements if this reason was given for not handing Naasusu to police. Many Kwaio were afraid of the repercussions of forcefully handing Naasusu to police because of the potential that *buru* spirits would make him commit suicide in custody. The money was to cover this excuse should it be used. That is, it could be used as a forward ‘compensation’ to cover that possibility. The police officer walked to Naasusu’s hamlet on Monday evening, arriving after dark. He told everyone he was staying until the situation was resolved and would not leave without Naasusu. The family was told to perform any final cultural requirements that night as it was his intention to leave with Naasusu the next morning. Discussions ensued into the night and although different accounts conflict in detail, Naasusu gave himself up early the next morning (Tuesday 17 June).

On Monday afternoon, 16 June, a group of heavily armed police from the field force division massed at Atoifi. In the early hours of Tuesday morning they walked to Naasusu’s hamlet and surrounded it. Some accounts have it Naasusu had already laid his knife on the ground and agreed that he walk out together with the police officer while others state that he only gave himself up when he realised his hamlet was surrounded. In any case, Naasusu came over to police without hostility or violence, and the group proceeded down the mountain. When Naasusu arrived at Atoifi there was relief not only within the staff but also the community. Naasusu was flown to Honiara, questioned and charged.

After the arrest, claims were made this had only happened after payoffs to his family. This yet again was an example of questioning of leadership that pervaded Solomon Islands society at this time. Many at Atoifi and the broader community had known of the funds raised by KDA and perceived it as a direct ‘payoff’—none of the money was used to aid cultural requirements. A small amount of money was handed to Naasusu’s parents as police were to leave the hamlet to cover costs of hosting them.66

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66 This gift was perceived by some as a bribe to facilitate Naasusu’s arrest. Allegations of bribery were vehemently denied and dismissed by Maenaa’adi, as outlined later in this chapter.
Staff at Atoifi now had to make a difficult decision. Naasusu had been arrested and was in custody. They had packed their possessions and were physically and emotionally ready to board the ship. Had the ship arrived the previous day the vast majority would have already left, and they knew it was scheduled to arrive the next day. They were also aware that the next week Health Director for SPD was coming to Honiara, and possibly, but not definitely, to Atoifi. The Acting CEO, was attending church administrative meetings in Fiji and was scheduled to arrive in Honiara to meet with the SPD Health Director and staff to discuss the way forward for Atoifi. I had been requested to accompany the Health Director on his trip and act as a liaison between him and the community. Staff were eager to attend these meetings and participate in the collective decision making. Though most staff were about to leave, Dr Raubenheimer declared Atoifi open again and ready to admit inpatients. Administrators had stated that the lack of arrest was the block to hospital services continuing, and now this block had been removed—they wanted to reopen. This left many staff in a bind because they wanted to support the hospital but were emotionally ready to leave. They remained uncertain of security implications of the arrest and if they would ever return to Atoifi. To add to the complex situation, many staff had planned to attend the wedding of two registered nurses from Atoifi in Honiara on Sunday 22 June. Coincidentally, the groom, Kelvin Jack, was the son of Ray Jack who was involved in the original incident on the ship. Kelvin left Atoifi for his own safety soon after the link was established between the murder and his father. Most non-Kwaio staff chose to board the chartered ship. The ship arrived in Honiara on Thursday evening 19 June, the same time I arrived in Honiara from Brisbane. I flew into Honiara several days prior to the Health Director so I could talk with the acting CEO, staff and Kwaio residents in Honiara. This allowed me to gain a deeper understanding of the situation prior to the Health Director’s arrival.

Securing Atoifi Campus

Leaving possessions behind was not an easy decision for staff because of questions of the honesty and loyalty of community security officers. As noted, on the evening of the murder community leaders had come together and organised a ‘community security force’ to secure property and ensure personal safety for staff and patients.
Over the ensuing days the force became more organised with shifts of forty men on duty at any one time and four ‘bases’ built. These ‘bases’ were built from sheets of corrugated iron secured to a crude frame and located at the four main entrances to the campus. The security force cooked, ate and slept in these bases and monitored people coming into and out of the campus. Men from Sinalagu and Uru maned the bases alternatively for a week at a time. Men gave their time voluntarily and their home villages provided food. Their tasks were to patrol the campus to monitor suspicious behaviour or activities and ensure no knives were carried onto campus. People’s bush knives were collected as they entered the campus and returned as they left. The security force was identifiable by white headbands (strips of cloth) on which ‘security’ was written.

While the security was appreciated, many staff had suspicions about the force. Staff argued anyone could write ‘security’ on a piece of white cloth and wrap it around their head, leading to constant suspicion over who was or was not a genuine security officer. As members of the force came from different villages, it was difficult for staff to know who should or should not have headbands. Young men were given the responsibility of securing the campus, but given no training in appropriate practices of a disciplined force. Lines of authority were initially questioned as it was unclear who the force reported to; was it the police, who now had a presence on campus, the hospital CEO or administration committee; did they have the authority to apprehend anyone who acted suspiciously or merely to report to police and/or hospital administration? The force’s willingness to provide a constant presence for the required length of time until stability returned was also questioned. It was also unclear if the force would request (or demand) payment in the future. While these questions were discussed, a sense of uncertainty shrouded the security force. Some of the young men on the force were teenagers who were suspects for previous thefts on campus and were now being given responsibility to ensure security on campus. This was of particular concern when small numbers of items were reported missing around people’s homes and some women stated they were uncomfortable with their presence. This was exacerbated when some claimed that a number of security guards were ‘peeping toms’ who sat outside the windows of dormitories and staff houses peering through windows at women inside.
In light of the nature of the murder and uncertainty over who were genuine security guards, other staff had issues with security guards carrying knives. As time progressed and Naasusu was not apprehended, some staff worried that close relatives of his were members of the security force and might have passed information to his family. Others questioned the motives of the security guards, particularly after Naasusu had been arrested, given indications that some community leaders were raising funds to pay the security force. This increased concerns over raised expectations and the implications of those if payment did not eventuate. Many Kwaio staff were less worried because they knew or were related to the security guards, and thus knew their motives. But this did not apply to many non-Kwaio. While community leaders were aware of staff concerns, they too were pensive about the situation. They made deliberate decisions to give responsibility to young men who had questionable histories. Their role was now to secure the campus and ensure that there was no stealing. This change in role gave a different perspective as young men saw the hospital as a place to protect and have ownership of. If anything was stolen these individuals would be the first to be scrutinised, and they knew it. There was pressure from the broader community to show they were capable of the responsibility given them. The force was also in a paradoxical situation because although they could monitor events they had no authority to act on any incident or apprehend anyone for an offence. They were also unable to deal with situations involving staff.

On one occasion I was sitting in one of the tin shacks called ‘bases’ late at night talking with security guards. They stated there were a number of individuals in the security force with questionable pasts who had experienced a paradigm shift with the responsibility they had been given—they now saw the hospital in a totally different light. They had initially seen the hospital as a foreign institution with little local ownership. The historical lack of social connectedness had made Atoifi easy pickings for thieves. Now that they were responsible for securing the hospital they began to feel a sense of ownership and guardianship of the campus for the first time. There has been a long-term pattern to assign expert thieves to security in Kwaio, including during Maasina rule in the 1940’s. More recently, in the early 1980’s, the head of the Kwaio Fadanga Security was one of the most famous Kwaio thieves in history. The
feeling behind this is that they, better than anyone, would be effective in spotting, preventing, and detecting criminal behaviour. David Akin (personal communication, Nov. 2006) explained the implication of Atoifi being in, but not of Kwaio “Kwaio thievery is often not as anonymous or opportunistic as in our society, but is a social crime—an attack on the victim who is seen to be either unconnected or connected in a hostile sense. I have told people at Atoifi before that one reason thieves target the hospital is that it is viewed as a hostile presence, due to their dismissive attitude toward the bush community”.

Several incidents occurred that made staff and security suspicious of each other.

Example 1: A Late Night Request

In the early hours one morning, while the prime suspect was still at large, there was a noise at the front of one of the international staff’s house. Two single female office workers were staying with the female staff member while her husband was attending church meetings. They looked through the window to find the head of security accompanied by several others wanting to talk with one of the office staff who was also, acting store manager. The office worker, herself from Kwaio, asked what they wanted. They told her to open the store and supply them bags of rice as he and his men were hungry. The office worker was angry with such a request at 1 A.M. and told him it was inappropriate and unreasonable and to organise his requirements during working hours. He insisted the store be opened, however he was reminded how unacceptable it was to make a scene at the house of an international staff member as ‘visitors from another place’ particularly in the tense situation. He became angry and shouted aggressively and pounded the side of the house with his knife. The international staff member was afraid and felt threatened not knowing who was shouting or their intentions. Since Kwaio language was being used, she could not understand the conversation nor what was happening. The head of security was eventually convinced to talk with the community liaison officer, after the office worker refused to succumb to pressure to open the store. The Kwaio office worker was not overly perplexed because she personally knew the man and it was not uncommon for her to have requests to open the store after-hours. She also knew that the security force were fellow Kwaio people serving the hospital and as such she had the social and cultural understandings that the request was not as unreasonable as outsiders may perceive. The international staff member, however, was shaken and was left unsure of the motives and action of the head of security, and the discipline or trustworthiness of the security force.

Expatriate and Non-Kwaio staff had ongoing concerns about security. Not knowing the identity of all of this armed force caused unease. An example of this occurred late one night while one of the doctors was walking from the hospital to his house and heard footsteps. He turned to see a group of young men carrying knives following
him. Assuming they were security, which they were, he asked them to walk in front of him. The group had been legitimately concerned for the doctor’s safety and wanted to escort him to his house, however their actions were viewed with suspicion. Following this incident security officers were requested to patrol in groups, unarmed.

**Example 2: Acts by Both Staff and Security**

It was not only staff who had apprehensions about the security force. Security people knew that hospital property might be at risk from staff as well as community. The security force had the power to inform police of suspicious activity, but not to act directly. The ambiguity of the security force’s position was ever-present. Late one night security observed a hospital employee returning to his house from the workshop with several large boxes. This in itself was not unusual under normal circumstances, but given the situation it was deemed suspicious. Tension was present with some staff who left the campus (temporarily or permanently) being accused of taking hospital property. Such charges were difficult to prove because of the lax documentation of hospital equipment. Simple inventories or equipment lists were not maintained or were nonexistent. Because of the rapid influx of goods in the preceding two years the problem was particularly acute. Similar goods and equipment had been procured for both hospital use and private individuals, and this meant it was often not obvious or possible to determine who owned particular equipment. The fall in staff morale and increase in the competitive nature of staff interactions meant a rise in scepticism towards some who claimed equipment as their own. Given this, when workers were seen carrying boxes from the workshop at 10 P.M. doubts arose within the security force. Those involved had been accused of claiming hospital property as their own some months previously, further raising suspicions. The security force were aware many of the goods accumulated at Aloi had contributed to Atoi’s advancement and could be removed by non-Kwaio people as they left. This concern was not only theoretical. Many of the security force had seen many goods illegally taken from Honiara during the return of Malaitans in 1999 as people took advantage of the breakdown in law and order. During that time cars, vans and trucks, often laden with goods, were stolen and driven onto ships bound for Malaita, particularly those going to the northern end and western side of the island. The security force did not want such actions to occur at ‘their’ hospital. Suspicions were heightened the next day when those seen with the boxes the previous night drove to the wharf and loaded boxes into a waiting canoe.

This incident sparked an immediate response by the head of security. He made a public announcement at the weekly market that his security force were to block the road to the wharf and search all boxes taken off campus. Staff were outraged at the thought of the security force opening their boxes in public to search for hospital property. Questions were raised as to how the security force—village residents from the community—would discern what was and was not hospital property. This was of particular concern when staff were unable to document ownership, as was often the case. There was alarm at the volunteer security force’s claim to have the authority to take such actions. No standards to ensure fairness were outlined. The force were concerned about a small number of individuals but did not want to target only them, and they therefore stated that they would search everyone. They alienated most of the staff in the process. Although the security force temporarily blocked the road, no
boxes or bags were ever searched. News of the incident soon reached Honiara, where rumours abounded of Kwaio villagers acting as judge, jury and prosecution, pronouncing sentence on what was or was not hospital property prior to staff being allowed to leave the campus. Rumours also circulated that security officers were themselves living in staff houses and looting those left unattended, although none of these events ever occurred.

**Decisions**

The two weeks from 16 to 30 June was a time of conflicting signals and emotions. The hospital reverted to clinic only status on Monday 16 June; Naasusu was apprehended on 17 June; and the hospital started to re-admit inpatients on 18 June, the day most remaining non-Kwaio staff left by ship. This left an air of uncertainty over the hospital’s future. Atoifi found one of its demands met—the prime suspect was in custody—but when staff left the following day it undermined statements from hospital administration that services were being re-established. Confusion surrounded the level at which decisions were being made. In fact, local leadership and administration at Atoifi, and church administration in both Fiji (TPUM) and Sydney (SPD) were all involved.67 I was concerned that the voices of the Kwaio people needed to be heard, and was unsure if this was happening, particularly at TPUM and SPD. The week also saw the mid-year meeting of the TPUM executive in Fiji where a report from Atoifi was presented. The executive decided that, if at all possible, Atoifi would remain open.

The TPUM executive, in collaboration with the Health Department at SPD, made a decision that staff and community should be involved in future planning for Atoifi. Meetings were planned to discuss the way forward and alternative community health models for the medium- to long-term. The executive proposed a staff ‘retreat’ to bring together staff for collective debriefing and to reconcile internal differences, prior to the return of full services at Atoifi. Before this a series of meetings were to be held in Honiara and at Atoifi for staff to discuss immediate issues regarding the hospital’s

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67 The Trans Pacific Union Mission (TPUM), based in Suva, Fiji, is the administrative unit that manages church business in the South Pacific Island Countries excluding New Zealand and the French-speaking countries. The hospital is owned and operated by this administrative unit and the President of the TPUM is also the chairman of the Atoifi Hospital Board. This is one of four ‘unions’ that make up the South Pacific Division (SPD) that has offices in Sydney. While many of the institutions (schools,
continuation. I was asked by the chair of the hospital board, to help the SPD Health Director to facilitate these meetings.

The following is a description of the **REFLECT** and **PLAN** stages of May to July 2003.

**Figure 6.2: Reflect and Plan in May—July 2003 Action Research Events Spiral**

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**Staff Meeting Honiara**

The acting CEO arrived in Honiara from Fiji on 19 June, the day after I arrived. Community health and primary health care models of service delivery had been discussed at the regional meeting and needed to be examined with staff and community as an alternative in the future. The SPD Health Director arrived in Honiara on 24 June. Discussion about the situation quickly turned to the implications of the 1965 agreement which followed Brian Dunn’s murder. This was also a central discussion point during the staff meeting the next day. Fifty-two staff and students—many of whom had left Atoiifi soon after the murder, others who had recently...
arrived—met to discuss the situation and potential ways forward. Questions that were discussed included: ‘What are we to do with the 1965 agreement? Are we people of our word who uphold agreements? Does the community expect us to uphold the agreement? The assemblled group was asked to ponder: ‘If we are not seen to uphold the agreement, will the hospital and church loose respect from, and our respect for, the community’? Would this lack of respect mean a lack of effectiveness in delivering services? Many staff found themselves in a bind. They wanted the hospital to continue, but were aware that the 1965 agreement needed to be honoured. A senior staff member asked, ‘If the hospital was closed, would it be permanent or temporary?’ This became the key question discussed regarding whether to uphold the agreement or continue services. It was stressed that whichever course of action was taken consequences needed to be carefully thought through and discussed.

The nature of the 1965 agreement and its implications for the current situation needed to be analysed. The 1965 agreement had been made in the context of a new institution constructed in a region known for its history of hostility to outside ways. Brian Dunn’s murder was understood to have resulted from conflict between two groups in a dispute over land at Atoifi. It was deemed at the time that if Atoifi was to be completed then the community needed to assure the hospital support and prevent further murders. Church leaders were unsure of the level of support for the murder within the community and needed to work to negate the possibility of future murders. Agreement was subsequently reached that if any further murder occurred the hospital would close, with services moved to an alternate location. This opened the possibility to ask: Is the nature of the 1965 agreement relevant to the 2003 situation? Some opined that the agreement should be upheld regardless of historical context. Others saw the situation of Gersbach’s murder as dramatically different to that of Dunn’s. It was clear the suspect in the 2003 murder was an individual with a history of unstable, anti-social behaviour. The huge amount of community support for the hospital was manifest by the abhorrence felt and the voluntary community security force. The institution now had a history of almost forty years with the community and so the response could be more mature given the passage of time and understandings that had developed. It was decided the agreement needed to be conceptualised in this way, as a document meant to assure the establishment of a new institution in an area known for
its hostility. Was it, then, still relevant? Considerable discussion about the difference in the two situations followed. It was decided the 1965 agreement had not been superseded or replaced and as such needed to be honoured. The older agreement could, however, be honoured by a temporary closure, during which time the staff could participate in a ‘retreat,’ after which the hospital would resume full services. Another strong argument was put that Atoifi had not operated to its full capacity from the time of the murder, with a period with no inpatient services. Did this amount to a technical ‘closure’ of the hospital, and fulfil the letter of the agreement? On the other hand, the technical closure had been a reaction to the suspect being at large rather than a principled stand to uphold the agreement. During discussions it was obvious that staff and students wanted the hospital to continue to operate, but the agreement needed to be honoured. The concept of a staff retreat to collectively debrief, reconcile and return united was also agreed to. Two recommendations were passed from the meeting:

1. The 1965 agreement must be upheld and the hospital closed, but only temporarily.
2. A retreat should be held for staff to debrief, reconcile and focus on the future of Atoifi.

Staff Meeting Atoifi

Immediately after the three-hour meeting, the Acting CEO, Health Director and myself boarded the plane for the 35-minute flight to Atoifi. I had flown this sector often and was usually full of excitement at returning to Atoifi. This time was different. I had spent the previous six days in Honiara talking with people, some with negative impressions of the situation and predictions of further violence. I had also talked with staff recently arrived from Atoifi, some who were so fearful they pledged never to return. The collective apprehension and uncertainty at the meeting that morning also made me anxious. There were numerous questions in my mind. Would my personal safety be at risk? Some stated clearly that I would be in danger while others stated I would be totally safe. Would staff and community perceive me as neutral, or as aiding and/or siding with the church administration? Would the non-
Kwaio staff perceive me to be biased on the side of the Kwaio? Would I have a positive effect on any outcomes that emerged for Atoifi? These uncertainties swirled in my head during the flight. My thoughts were also with my wife and two boys in Australia. Was I unwise to go into a potentially dangerous situation, given that I now had responsibilities greater than myself? Was I being irresponsible and showing a lack of judgement as a father and husband? The usual 35-minute flight turned into a two-hour venture as we flew first to Fera in Isabel Province and to ʻAoke. This gave still more time to mull. As we left ʻAoke a storm front was obvious along the east coast, and we approached Atoifi in increasingly stormy conditions. The pilot circled looking for a break in the clouds, but after several minutes the aircraft had to return to Honiara.

Being unable to land at Atoifi evoked a strange feeling—was this a sign we were not meant to be there? I dwelled on my family and was apprehensive about going to Atoifi. On reaching Honiara I could have easily decided to go back to Australia. I tried to make sense of the stories I had been told, both positive and negative. I knew the hard decisions that lay ahead and that the future of the hospital depended, in part, on the meetings planned for the following days. When we landed in Honiara an Atoifi staff member who had left Atoifi soon after the murder, who we met at the airport, commented, ‘Mi ting olketa Kwaio rausim iu fala?’ (I thought the Kwaio had chased you all away). This shook the already fragile foundation on which I felt myself standing. The flight was rescheduled for 6 A.M. the following morning. That night I hardly slept, thinking through the sometimes contradictory information I had and the myriad of potential outcomes. The next morning we made an uneventful landing at Atoifi.

When we arrived I was almost instantly at ease. Familiar faces from surrounding villages milled around the edge of the airstrip. Chief Silas Lounga, a long time friend, greeted me with his usual smile. The tractor and trailer sent to collect us was late which left a few minutes to gather thoughts. The familiarity of the location eased my anxiety. I had built in my head a place dramatically different in many senses from the one I had known. The impact the murder had on me cannot be overstated, but the familiar environment reassured me. One of the immediate differences I observed was
that not a single person was carrying a bush knife. Knives had seemed an ever-present reality in Kwaio and it now seemed bizarre that nobody carried one.

The short trip to the hospital was peculiar, too, as I entered a situation I had been fixated on trying to make sense of over the past six weeks. I had been an intermediary and facilitator previously at Atoifi, but never under circumstances like these. It was eerie driving past the murder site circled with police tape, and the broken down backhoe still unmoved within. Opposite was a rough shelter of corrugated iron, a ‘base’ for the security force, and it was strange to see many men I knew wearing their white headbands. I had been told so many confusing things about the security force that I had forgotten that many of them were my friends, with familiar human faces. The label ‘security force’ was replaced by names of individuals—Dioni, Diaki or Demesi. Some had told me in Honiara that there was no real or imminent threat to staff or hospital, and that the security was a symbolic way to show community support for Atoifi to ensure that it remained open. This was certainly how it now ‘felt’ to me. There was no air of imminent danger in the actions of the security force. This put many of my apprehensions at ease and helped to place the information I had gathered in Honiara of Naasusu’s family being angry and looking for revenge into a context. I saw no evidence of this in the actions of the security.

Atoifi was very quiet, with only 15 people admitted and few people on campus. Although the police coordinated the security force there were ongoing concerns about their role and responsibility to staff. An indication of change on campus was just near the door of the CEO’s office door—a personal protection aerosol can. The police briefed the SPD Health Director on how Naasusu had been apprehended and the current situation. They proposed a contingent of community constables be trained and stationed under trained officers at Atoifi.\(^{69}\) The briefing included a statement that there was no evidence of any imminent threat to property or people at Atoifi.

\(^{69}\) This never eventuated. The police force had had mixed success with community constables, particularly with many former MEF militants using their roles to continue criminal activities. With the imminent arrival of RAMSI and changes that would eventuate, senior police in Honiara did not want to recruit community constables for Atoifi.
That afternoon and evening two meetings were held with staff. Those who remained were primarily Kwaio and their spouses, but there were a small number of non-Kwaio staff. The feeling in this group was quite different from that of the Honiara staff meeting. This group saw themselves as remaining to keep the hospital open, and had worked for the good of the hospital and the community. A number of nursing staff had not had a day off in over a month. Raw emotion was shown by some Kwaio staff related to Naasusu who shouldered collective shame for what had happened. They saw it as their responsibility to host visitors to Kwaio, and the murder meant they had failed. The anti-Kwaio rhetoric and rumours in circulation were also taking a toll. The uncertain future of Atoifi was clearly an agonising issue for many. During the meetings the administrators explained their roles, and why I had been requested to assist. The recommendations from the previous day’s meeting in Honiara were outlined.

Staff were keen to discuss the 1965 agreement and its implications. Some indicated the need to honour the agreement, but to also have Christian compassion, meaning they felt the closure should be temporary. Others argued the hospital in its current state of operation was effectively closed, and thus temporary closure to honour the agreement had already been fulfilled. Others articulated that reconciliation had already been achieved between a number of people on campus and thus there was no need for collective reconciliation at a retreat. It was explained to the staff that the temporary closure and retreat were a chance for the entire staff to leave the campus to focus the collective mind on what had happened and to look to the future in a united manner. It was obvious there were tensions between staff who remained and those who had left. A suggestion was put that those who had left participate in the retreat prior to their return, and that the entire staff then participate in a Christian ‘revival week’ to allow internal reconciliation.70 It was then reinforced that everyone needed to be realistic and respect those who had chosen to leave, and that it had only been natural for those from Kwaio to remain. It was stated that the retreat would not be wholesome or unifying if it did not include the entire staff, given that the objective

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70 This suggestion was not wholly attributed to the rift felt between those who remained on campus and those who had left. There was apprehension that if all staff were to leave the campus and ‘outsiders’ were to temporarily provided emergency medical services and secured the campus this would be unsatisfactory.
was to reconcile and share a future vision. Other staff said the retreat needed to be long enough to allow time to get to the bottom of deeper issues—a short retreat would be inappropriate. After some discussion, those staff initially hesitant to participate began to see the merit of the retreat. The ‘revival week’ idea was still preferred by some, but after considerable discussion a consensus was found: The hospital would remain as a clinic until a retreat was held, during which the hospital would be closed; on return from the retreat the hospital would ‘reopen’ with a renewed focus in a spirit of unity.

The next day meetings were held with community representatives including a large number of coastal and bush chiefs and representatives from Christian denominations. The Health Director explained his role and explained that he had chosen me as a mediator and link between the community and the hospital/church administration. He utilised me as a resource to explain and expand on issues for him throughout his visit, to link him with appropriate people, and as an interpreter. Several senior community leaders stood to express their dismay at the situation and the community appreciation for services Atoifi delivered. They stated their collective support for the hospital and how they had been deeply affected by the murder. One leader apologised on behalf of the community for the deaths of both Brian Dunn and Lance Gersbach, and stated that all parties needed to learn from the mistakes of the past to assist in moving forward. Laete’esafi attended as the representative of the bush people. He stated that although there had been a history of antagonism between the bush people and Atoifi, they too had seen and experienced benefits from the hospital. He continued that although Atoifi was in Kwaio, throughout its history it had failed to recognise issues important for the bush people. Although he was happy that I was involved, he expressed dismay that it had taken an outsider to come and listen to the bush people, become aware of the difficulties in accessing health services, and advocate change. He explained that when he heard of the murder his initial thoughts were that Atoifi would close. When he heard of the meeting to discuss the way forward he was eager to participate and support the process.
Benjamin Isafi, son of the principal land owner who had negotiated the land deal with government and church administrators in the early 1960s, stood and spoke. He started with a parable:

This land is like a girl. The founders of the hospital had travelled looking for a girl to marry. They finally arrived here and saw the girl they wanted to marry. The church asked for the girl and the father agreed. Now the girl is married and we see how good she is and how she has nurtured and developed. We are now sad that a person possessed by an evil power destroyed this. How can we allow this place to finish? But if the parent wants to take the girl then what can we say?

This short oration was a powerful statement about the potential closure of the hospital and the importance of the hospital to the community.

The SPD Health Director began by posing the question: ‘Are we a people who don’t uphold an agreement?’ After some discussion he went on: ‘At the same time, we don’t want to be derailed by one person’. He explained that to uphold the agreement there would need to be a closure. This however would be temporary after which there would be a ‘rebirth’, a reopening and a new future for Atoifi. At this reopening it was envisaged that a new agreement would be signed between Atoifi and the community. This agreement would address issues relevant to both Atoifi and the community and signify a process of reconciliation between them. He explained that he was new in his position, although was aware the hospital had not always respected local people. He stated his disappointment at this and that he was looking forward to a better relationship. He proposed a future based on a new agreement, put forth as a marriage rather than an authoritarian legal document that favoured one side at the expense of the other. The community would uphold its side through a respect for the culture of the hospital governing issues such as carrying knives, smoking and stealing on campus, as well as cooperation with law enforcement agencies in the event of serious incidents on campus. Atoifi would uphold its side through a respect for the culture of the local community, and operate accordingly. A pastor of a local church agreed to the concept but indicated that the deadline given for the suspect to be handed to police had created potential for further incidents. This was acknowledged, but it was pointed out that having the suspect at large had caused staff to leave which made it impossible for the hospital to function. After some discussion the concept of the staff retreat was
outlined. The function was explained as a chance for all staff to leave the campus, focus on the future and return for the reopening. Explanation was given in detail about how the retreat was not to run away because staff were afraid, but rather that staff needed to be together and focus prior to returning together to start anew. A quorum of chiefs was invited to remain behind to specifically discuss issues for the new agreement.

This quorum raised issues ranging from the bush ward and services for the bush people to the incorporation of culturally appropriate procedures. An equitable system for accessing outpatient services and payment for those services was also discussed. During the meeting it was revealed that many people from the bush were afraid of the repeated costs involved in follow up treatment for particular conditions. This stopped people coming to the hospital in the first place, which allowed the sickness to progress into severe disease. When people did finally present, staff would chastise them for not coming earlier. This was a humiliating experience dreaded by many bush people. Law and order was also discussed, including the role of police stationed on campus, as well as the potential for further violence or payback by associates of the accused. This was addressed by recalling incidents from the recent and distant past where suspects had been arrested and sent to court with no retaliation. This included a recent murder in 2002 involving two Kwaio families where the court had imposed an extended prison sentence for the perpetrator and there had been no retaliation. Chiefs were invited to think through the issues for a further two days and return on the following Monday for a further meeting.

The weekend was eerily quiet at Atoifi with very few people on campus. Staff pondered issues and prepared for further staff meetings. Chiefs returned on Monday and discussed the issues to include in the draft agreement prior to it being distributed for review. A core issue raised covered employment of Kwaio staff. There was a perception in the community of a bias against Kwaio staff being employed and Kwaio young people being accepted to the school of nursing. Allegations were raised of people from other language groups taking the positions for which there were qualified Kwaio. A long discussion ensued about positive and negative discrimination towards Kwaio workers. The hospital’s mandate to serve the people of East Malaita as well as
the entire country was discussed. Those in attendance were challenged to think of the hospital as an asset of the nation, not owned by Kwaio, but with Kwaio as its custodians. This included the school of nursing which had a mandate from the government to accept students from the across country. There was support from a number of senior bush chiefs of the concept of employment on merit, and examples of private companies or plantation workers chosen on merit rather than ethnic origin were sighted. Nevertheless, some coastal chiefs remained sceptical. There was a call for those present to nominate Kwaio people to fill vacant senior positions, including doctors, accountants, teachers and the business manager. The meeting fell quiet on the realisation that there were senior positions available for suitably qualified Kwaio, but no Kwaio had applied.

Another core issue raised was law and order and the need for both staff and community to respect it. Channels of communication between staff and community were discussed and the need for new ways to communicate. Incursions onto Atoifi land was an important topic for many staff. Over the past several years members of the surrounding community, some casual workers at Atoifi, and others members of the general community had used land within the hospital lease to grow gardens and in some instances to build houses. This was an intrusion on land they had no legal right to use, but little had been done to address the issue. Safety standards were flouted with houses on hospital land within 100 metres of the airstrip. This breached aviation regulations making the hospital accountable for any accident that might occur. Another significant issue was voiced by students and junior staff that felt pressure from family members and relatives in the community to provide them with medication without proper consultation processes. Administrators promised to address this and to issue procedural guidelines. The proposed temporary closure and retreat was announced to occur from 23–27 July. The reopening and reconciliation ceremony would take place on Monday 28 July. It was explained that I had been asked to compile a list of issues raised in the meetings over the past days and summarise them into a working document for consultation. This would be presented to staff and community members in two-days time, on 2 July. There would then be a period of 14 days for the community and staff to review the draft document and make any recommendations for changes. This would then be worked into a final agreement to
be publicly signed during the reconciliation and reopening ceremony on 28 July. In both the staff and chiefs’ meetings all parties urged that the agreement was more than a mere piece of paper, and that all involved needed to be aware of the document’s seriousness and implications. Attendees urged that a copy of the draft agreement be sent to Kwaio elites in Honiara for their input.

That afternoon the Health Director flew to Honiara and connected to Australia. I spent the following two days on the document, which consisted of a preamble and several principles that staff and community would agree to uphold. After each principle there was a list of action points that were indicators of achievement.

The following Principles were proposed for the staff and students:

- To respect all people as equal regardless of religion or ethnic origin and to honour cultural differences and beliefs.
- To provide services to all sectors of the Kwaio community including the Kwaio traditionalist.
- To provide employment opportunities to the surrounding community in an equitable manner.
- To provide accessible and effective means of representation and communication between hospital and community.

The following Principles were proposed for the Kwaio community:

- To uphold the rule of law and order in dealings with the hospital.
- To respect hospital campus, staff, property and land.

In discussions with staff and community leaders there had been suggestions that the land at Atoifi be given to the church as ‘compensation’ for the two murders there. There were claims and counterclaims by different people asserting that they knew Kwaio and Malaitan tradition surrounding gifting land under such circumstances. It was decided very early that this would be left out of the agreement since there was no clear consensus on this contentious issue.

Over the preceding week at Atoifi I had realised the security situation was not nearly as fragile as I had been led to believe. When I spent time with the security force it was
obvious they were not expecting any major incidents. The second thing that eased my concern in a very peculiar way was a conversation I had with a senior figure from the bush. He stated that Naasusu’s family were not feeling any antagonism towards the Atoifi staff nor were there plans for retaliation for his arrest. As he was a close relative of Naasusu, this confirmed what I had been observing. He went on to explain there had been trouble in their extended family when a man had ‘gone crazy’ and had sex with three women in the previous two days. This had heightened tensions in the bush and he wanted Maenaa’adi to return from Honiara to quickly resolve the problems in their community. Relatives of the women had wanted to kill the perpetrator for his sexual indiscretions but this did not eventuate and the chiefs found non-violent solutions. In a strange way this story made me feel better about the situation at Atoifi, because a serious situation with emotions running high, which historically would have ended in violence, was resolved through non-violent means. This served as a further indicator that the likelihood of retaliation towards the hospital staff for Naasusu’s arrest was remote.

Approximately 25 chiefs, mainly from Uru, gathered at Atoifi on 2 July for a presentation of the discussion document. Lester Asugeni, as a hospital administrator from Kwaio explained the draft agreement in detail. Issues for the hospital and community to address were fully explained. A temporary facility for the bush people on campus was discussed, including the provision of a *bisi*. The medical superintendent indicated this project could begin immediately, with the possibility of some structures being started before the reopening on 28 July. No one was given direct responsibility to pursue this and so nothing was initiated. He explained the process of a primary health care approach, which included village health committees and preventative programs that addressed what he called the ‘building blocks for health,’ rather than merely being a curative institution.71 This concept was well

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71 In early 2003 the medical superintendent planned to initiate a change in focus at Atoifi from the dominant clinical curative approach to a Primary Health Care (PHC) approach. Atoifi linked with the AusAID-funded Health Institutional Strengthening Project and started a PHC team of nursing staff who worked in outpatients, immunisation and tuberculosis programs. These staff had contact with community members either at the hospital or in villages and had an understanding of many of the issues that concerned them. The PHC teams were to make links with individual villages and undertake initial research into basic conditions for health including water and sanitation, nutrition and living conditions. This information was to be included in planning the proactive health programs for each village/community. This was a change in direction for the services provided at Atoifi and there was a degree of resistance from nursing staff who had a curative, hospital-based paradigm. Planning for this
received by chiefs who agreed it was a more appropriate way to address health for their people. How to approach serious incidents in the future and how this agreement would supersede past agreements was discussed. The need for this to be explicated in the document was emphasised. It was decided the draft should be circulated in the community and feedback sought in two weeks. At the end of the five-hour meeting it was confirmed the reopening and signing of the new agreement would be on Monday 28 July.

Follow-up Meetings in Honiara

Late that afternoon the medical superintendent and I flew to Honiara. I was encouraged and positive about achievements over the past week and optimistic that there was a clear way forward. When we arrived in Honiara we were met by staff who felt uncertain about their futures. We asked how many staff houses had been ransacked or occupied by village people. This saddened me. Rumour had circulated that the Kwaio had chased staff from the campus, and that they had been forced to take refuge on Leli Island. It was unclear whether this was a misinterpretation of the plan for the future retreat on Leli Island or a more sinister attempt to twist the truth.

The following afternoon we met staff and students in Honiara to review outcomes from the Atoifi meetings and explain the concept of the new agreement between the hospital and community. The draft agreement was presented to the fifty-two staff and students present, and feedback was invited. The staff were urged to address issues among themselves prior to the retreat and the reconciliation/reopening. Discussion eventuated about culture and the perceived use and misuse of culture at Atoifi. A number of non-Kwaio staff appealed to the Kwaio staff to tell them if their actions were antagonistic towards Kwaio culture. Many Kwaio staff responded that they had been raised in coastal Christian villages and needed themselves to be taught Kwaio culture. Staff were urged not to see culture as a barrier but as a facilitating factor in

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was taking place when the murder occurred. The village health committees were proposed to be called To’oru Le’anga Committees, or “TLCs” (to’oru le’anga being Kwaio for ‘staying well’). On the coast they would be based around church organisations and in the mountains around chiefs and kin groups.

72 This was a very interesting passage in the meeting since culture was being discussed as a thing that could be ‘put in a box’ and had definite unchanging boundaries, a set of rules that once ‘learnt’ could
the delivery of services. Senior staff added that the hospital needed to create and strengthen protocols that respected culture in a systematic way rather than following the current ad hoc manner. Several staff were concerned that Paramount Chief Maenaa’adi had not been involved in the creation of the agreement. This had twofold importance. Firstly, as paramount chief his involvement would add legitimacy to the document. Secondly, as Naasusu’s uncle he was closely involved with the relevant family politics and staff had feared of retribution after Naasusu’s arrest or any jail sentence he might receive. Staff requested Maenaa’adi to address them to give a clear assurance of safety in the future. Staff indicated that there was fear in people’s minds about their return to Atoiﬁ, whether substantiated or not, and an unambiguous statement from Maenaa’adi could help to clear this away. Staff were assured there would be an attempt to meet Maenaa’adi that night. The meeting adjourned with an invitation to provide feedback on the draft agreement, and staff were instructed to return to Atoiﬁ prior to 22 July. This would allow participation in the retreat from 23–27 July and the reconciliation/reopening ceremony on 28 July.

That same evening the Kwaio Development Association (KDA) held a scheduled meeting in Honiara at which which Maenaa’adi had attended. By the time the medical superintendent and I arrived at the venue of the KDA meeting it had finished with only the association’s secretary remaining. It was requested that the KDA provide Atoiﬁ feedback on the draft agreement and to contact Maenaa’adi requesting a meeting. I was driven to the airport directly from the meeting to fly home to Australia.

Reflections on the Rapidly Changing Situation

When I returned to Australia I was physically and emotionally drained. Only after returning could I begin to reflect on the situation and the implications for the PAR:

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be addressed, rather than a constantly evolving pattern of behaviours based on values or principles that need to be approached in a respectful way.

73 The trip had drained me on a number of levels, not only from my entering the unknown after a violent incident, but also leaving my family. I also had to contend with a member of my thesis supervision panel not supporting my trip and urging the head of school to write to me that they would not support my involvement (after this incident we mutually decided to review my supervision panel and replace this member). I did have the support of my primary supervisor who had visited Atoiﬁ
Chapter 6: A Situation Forever Changed—May to July 2003

- The aftermath of the murder emphasised the lack of understanding between Atoifi and the community, the result of decades of non-dialogue. After the murder there were no mechanisms in place through which the community and hospital leaders could enter into dialogue. This created suspicion and ongoing instability. Although community meetings were facilitated, they were an *ad hoc* response and not a part of a greater engagement with the community. They occurred at Atoifi, with community leaders expected to travel there. I reflected on the PAR process and the potential for participatory methods to create a mechanism for dialogue and mitigate future confrontations. I was unsure if staff would be willing to participate with the bush people when the staff was angry, and felt unsafe and unsure of the future. Would they be willing to be culturally sensitive and support the bush ward when the murder suspect was from the bush? What did this mean for any action from the PAR?

- I also reflected on the difference between the ‘silent’ deaths – the results of exclusion from Atoifi and the more spectacular death by murder? Which one makes us sit up and take notice? Which one will lead to policy and practice changes? Which will stimulate sustainable development? Will either stimulate a mechanism for ongoing dialogue between the hospital and community? Would the new agreement act as the first step towards ongoing dialogue, or would it be forgotten as the colonial and Christian paradigms continued to dominate?

Minor changes were made to the agreement after feedback from community, staff and hospital/church administrators. Maenaa’adi met with the medical superintendent the following week. He had never met the paramount chief before and had been led to believe that Maenaa’adi was a difficult person and would be a challenge to work with. He commented “Maenaa’adi is the complete opposite of the difficult person portrayed” after they met. Maenaa’adi stated his support for Atoifi to operate in a free and safe environment. He stated there would be no retaliation or payback nor was there any reason to do so. The situation with the money at the time of the arrest was also clarified. Neither he nor Naasusu’s parents had asked for any money—rather the

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during my 2002 fieldwork and realised the links I had with the community and the importance of acting in the role that I did.
Kwaio elites had wholly organised its presentation. This had given the family a bad image. This conversation gave Atoifi’s administration confidence to move forward toward the reconciliation/reopening.

The following is a description of the **PLAN** and **ACT** stages of May to July 2003.

**Figure 6.3: Plan and Act in May—July 2003 Action Research Events Spiral**

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### 6.4 Reopening and Reconciliation

By the end of July the majority of staff had returned to Atoifi to prepare for the retreat and reopening ceremony. Despite initial indications that a number of international church leaders would attend the SPD Health Director was the only international church leader to attend. The retreat was scheduled for Leli Island, a coral atoll 45 minutes from Atoifi by motorised canoe, over five days from 23–27 July, but torrential rain delayed the start by two days. Staff participated in sessions which included planning for the future, examining improvements for both staff and patients, culture and customs of Solomon Island groups and the need for culture to be respected in both service delivery and staff interaction. Many staff reconciled their differences,

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74 The family’s image was also being tarnished by misinformation in Australia. Only two days after returning from Atoifi I attended a meeting of the Adventist Health Association (AHA) in Brisbane. Dr Bruce Hands, a member of AHA, presented his experience at Atoifi. He used emotive language and described the bush chiefs as ‘hot headed’ and insinuated direct involvement by calling the two suspects the chiefs’ ‘henchmen’. This stereotypical colonial description of the situation misled the audience into believing the there was no cooperation or willingness to move forward by the bush leaders. I explained how I had been involved in a dialogue with the chiefs. Many present were interested in hearing another perspective on the situation.
but concerns were raised over the limited time for the retreat. The overall feeling was that the retreat had been useful to focus staff and prepare them to return for the reopening and resumption of full services. Staff who participated in the retreat signed a statement stating:

As an employee of Atoifi Adventist Hospital I agree to provide the best possible service to all people being respectful of their race, culture and religion. In my contact with fellow staff, administration, community and patients, I will reflect love, compassion and care Jesus Christ has shown me.

Approximately 2,000 people gathered at Atoifi on Monday 28 July to witness the official reopening ceremony. A number of officials attended, including several national and provincial members of parliament, the Deputy Premier of Malaita Province, the local Police Superintendent and numerous church leaders. Thirty Kwaio chiefs took part. During the ceremony hospital administrators and community leaders signed a memorandum of understanding based on the draft agreement. The signing was followed by the presentation of shell money from Kwaio chiefs to hospital administrators to signify that there would be no retribution. The reopening ceremony signalled the return of full hospital services after two and a half months.

This was a significant period in the history of Solomon Islands as four days earlier (24 July) the international RAMSI troops landed in Honiara to secure law and order. The initial deployment of several thousand troops and police officers from ten Pacific countries removed more than 3,500 firearms across the country and re-established a viable police force and aspects of the public service. There was an awareness campaign to communicate that RAMSI would investigate crimes across the country. RAMSI’s arrival increased the likelihood of a police post at Atoifi. Some members of the Kwaio community who remembered the punitive expedition after the Bell killing in 1927 were concerned about the intervention force. They worried that history might repeat itself in the aftermath of Gersbach’s murder.

**Reflection**

Atoifi had confronted one of the darkest periods of its history from May to July 2003. It came to the brink of closure, but then stabilised and resumed services. It faced the
challenge of moving forward into an uncertain future. Had the events of the previous three months changed the situation so dramatically that the bush ward project could not continue? Had all the work of 2002 been undone? Would the PAR process be able to continue? Would it be the only way to continue? Would the whole project need to be re-examined in light of the dramatic change in situation? Would the community and Atoifi live up to the agreement they had designed? Despite the return of full services, the future was still tentative, particularly regarding services for the bush people.

The events of May 2003 dramatically changed the situation at Atoifi and the resultant instability meant the action phase of the PAR was not possible as originally planned. For the research to continue it needed to be flexible and adapt to the changed context. The next phase of the research became one of documenting and reflecting on the changed situation. The following chapter documents how the project adapted to achieve its goals.
Chapter 7: Moving Forward in a Situation Forever Changed—July 2003 to December 2005

The previous chapter outlined the 18 May 2003 murder, instability, closure and re-establishment of services at Atoifi. This chapter will describe how services at Atoifi moved forward and how the PAR correspondingly adapted. It will outline parallel events over the time period July 2003 to December 2005. The diagram below outlines the sections and data presented in this chapter.

Figure 7.1 Structure of Chapter 7

The PAR process entered into a new observe-reflect-plan-act cycle with the resumption of services at Atoifi in July 2003. The following section is a description of the OBSERVE and REFLECT stages of the PAR during July 2003 to December 2005.
7.1 Atoifi Resumes Services

Despite Atoifi reopening and resumption of services on 28 July 2003 significant issues remained. Unsubstantiated rumour reinforced insecurities felt by many non-Kwaio staff. Normally inconsequential events were interpreted in ways which often misrepresented the situation or people involved. Although staff participated in the retreat distrust grew, particularly between Kwaio and non-Kwaio staff. Kwaio staff, aware that further violence was highly unlikely, became frustrated at the insecurities of their non-Kwaio colleagues. The lack of senior management on campus was also destabilising. The Medical Superintendent also held the positions of Acting CEO and Acting Business Manager. As the only doctor, his clinical load allowed him little time for administrative duties. When those duties were undertaken they often took him to Honiara or Fiji, leaving the hospital without a doctor. Both community and staff became concerned about a hospital without a fulltime resident doctor. The accountant, as a witness in the murder trial felt unsafe at Atoifi and worked from Honiara. The facilities manager who had been involved in the incident on the boat, did not return. The school of nursing was short-staffed; and its principal was in Australia undertaking postgraduate study. The chaplain’s position was also vacant. This meant most of the positions which comprised the administration committee were vacant or those who held them were not on campus. Lack of senior management meant there was little
leadership or stability, and staff complained that they were working aimlessly, unaware of the future direction.

The tenuous electrical supply added to discontent. In late June 2003 lightning struck the hydroelectric generator and burned out sections of the electrical system. Of the two backup diesel generators, one was down for maintenance and after some time the second broke down. The mechanic who was to testify at Naasusu’s trial had not returned to Atoifi. Emergency power was supplied to the hospital (mainly the operating theatre) by a single small portable generator. Staff houses remained without power. Numerous staff interpreted the lightning strike and subsequent lack of electricity as a ‘spiritual sign from on high’ that things were ‘not straight’ among them and issues still needed to be addressed.

The internal situation was complicated by concerns of external influences including staff who had maintained contact with the CEO dismissed the previous year. The willingness of all staff to collaborate in a shared vision for Atoifi was in question.

These issues were compounded by the uncertainty and emotion of the imminent trial in ‘Aoke. The trial was adjourned in August while the alleged weapon was sent to Australia for forensic testing. A number of staff and community members were due to testify, causing apprehension on campus. Tensions escalated between Kwaio and non-Kwaio as perceived bias for or against the defendants challenged professed commitment to Atoifi. Kwaio and non-Kwaio alike openly discussed their desires to leave. A number applied for work in Honiara or abroad, and though most remained some did leave. Staff numbers slowly returned to normal as more people were recruited and the situation stabilised. Throughout the second half of 2003 services continued at Atoifi and small primary health care initiatives were undertaken in the community. This approach was not uniformly supported since some staff who desired stability saw more change. Rumours persisted about the desire of Naasusu’s family to interfere with staff, despite their having stated otherwise. Rumours also persisted that all of the murders of outsiders by Kwaio had been perpetrated by Naasusu’s tribe, and that this would continue into the future. Ironically, the kin group of Basiana (Bell’s killer) were among those working closest with Atoifi through the Atoifi Support
Chapter 7: Moving Forward in a Situation Forever Changed—July 2003 to December 2005

Committee, and were involved with drafting the new agreement signed on 28 July. A number of influential men from this group had positive ongoing involvement with Atoifi. Conspiracy theories also circulated of strong sentiments against Europeans.

The Suspects’ Trial

Uncertainty and apprehension continued into 2004 and the trial. The Australian High Commission in Honiara recommended Australian citizens not remain at Atoifi during the trial process, and two Australian volunteers were relocated to Honiara. It was held in ‘Aoke in March 2004 and a number of Atoifi staff testified. The presiding judge, Justice John Brown, was a European. A number of people who gave evidence told me they were unhappy when he misinterpreted their statements. Testimony was given in English or through an interpreter from Pijin into English. There was no jury and the judge was the sole arbiter. The judge claimed that some witnesses had changed their stories or that they were inconsistent with their answers to questions on particular points. He stated, “For prosecution evidence perhaps language used was rather not clear to the Defendant’s Solicitor” (Brown 2003:12), but went on to say, “Fraser had embellished his story” (Brown 2003:16). Fraser claimed he had remained steadfast to his original statement and that misinterpretation of his language had caused the judge to make this statement. The judge stated, “it was made plain that the police statement was given in pidgin, recorded in English” but went on to state “the cross examination left me with the distinct impression that the evidence given in court by Fraser differed in these material respects, from the earlier statement to the police. In other words, Fraser had embellished his story” (Brown 2003:16). Fraser refuted this statement and claims to have given identical statements to both police and the court. He claims the judge had misunderstood his statements given in court using English, particularly when he had answered double negative questions. He explained to me that he would have been able to express himself more exactly and have faith his testimony would be understood if he had been able to articulate himself directly to the judge using Pijin, or his mother tongue, rather than having his words translated by a third party into English. The government prosecutor, was a Solomon Islander from the Western Province. He did not visit Atoifi during the preparation of the case, and those who attended the trial said he was disorganised and his approach was unconvincing.
The case presented was based on circumstantial evidence. The prosecution claimed Naasusu had confessed to a family member, a ‘high priest’, although no such office exists within the Kwaio religious system, and that he had given a statement to police during the investigation. This witness was called before the court, but did not attend. A police contingent from Atori visited the man’s hamlet in the Kwaio mountains, but he was not found. The prosecutor sought an adjournment to have time to make contact with the witness and have him attend court. The adjournment was granted and police were sent to the Kwaio mountains to forcibly take the witness and facilitate his attendance in court. He was never found by police and never testified.  

Relatives of Lance Gersbach, Naasusu Tome and Silas Laefiwane all attended the trial. A number of hospital and church administrators stated they felt the defendants’ relatives attending was a form of intimidation. As the trial progressed it became evident that both the prosecutor, from the Western Province, and the judge, a European, had limited understandings of Kwaio or Malaitan cultures. Several statements were recorded in the final judgement including “There is an underlying thread, relating to customs or traits of the Kwaio, which hasn’t been explored in this trial but which I venture to suggest is of great importance and most probably would affect how I should treat the evidence of these Kwaio people” (Brown 2003:13). Neither man understood Kwaio culture enough to make sense of evidence presented: “All this manner and attitude as I have recounted obviously means something to these Kwaio youths and the two accused watching, quite unlike what it means to me” (Brown 2003:12). The judge did seek background information on Kwaio culture to give a foundation on which to interpret testimony. “Clearly the Kwaio have been the subject of anthropological interest as recently as the 1970’s. Solomon Islands (Lonely  

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75 See People First Network, 16 March 2004. Rumours had circulated at Aotifi that Naasusu’s family had threatened this person if he testified. Informants from the mountains indicated that he had escaped prison in the early 1980s, and had since lived quietly in his mountain home. He was aware that two of the major RAMSI objectives in the Solomon Islands were to confiscate guns and catch escaped prisoners, and was understandably afraid of being recaptured in ‘Aoke if he appeared in court.

76 Despite a statement in the SDA publication Record (Stacey 2004:5) that “Representing the Adventist Church were Pastor George Fafale, and Teddy Kingsley, the president and secretary-treasurer of the Malaita Mission, Pastor Martin Losi, the president of the Eastern Solomon Islands Mission, and Pastor Titus Rore, the associate education director for the Trans-Pacific Union (TPU)” and “Pastor Bruce Roberts, also attended the trial in his role as president of the TPU”, only one of these men attended the trial regularly.
Planet Publications) at 207 says that Roger Keesing spent much of the 1970’s in east-central Malaita studying the life of a Kwaio chieftain” (Brown 2003:12). None of the scores of articles, chapters or books written about Kwaio were mentioned in the judge’s final statement despite Kwaio being the most extensively studied and written about group on Malaita over the past forty years, including many publications over the past five years. Anthropological insights used in the final judgment were drawn from a book written for adventure travellers. The judge stated “I have no idea what moves the collective will of the Kwaio; it may be the terror of retribution invisible to the human eye caused this outward manifestation of an inward fear, but who am I to say, in the absence of knowledge or argument” (Brown 2003:12).

**No Case to Answer**

When the prosecution was unable to produce the key witness the judge asked them to summarise the case against the accused. Circumstantial evidence was presented but no direct evidence that linked the accused to the crime. Naasusu’s history of mental illness/buru possession and drug use was not raised in court. The defence proceeded with a submission that stated that because there was no direct evidence that linked the two accused to the murder they had ‘no case to answer’. On Friday 2 April judge John Brown stated ‘Very good reasons for suspicion are not enough’ (Brown 2003:22) and upheld the ‘no case to answer’ submission. The two accused were acquitted and discharged.

The court ruling, although not unexpected, caused services at Atoifi to be reviewed. Staff and administrators were unsure of the implications of having the two acquitted men released into the community. The prosecution immediately stated it would appeal the decision, and ordered the arrest of a Kwaio chief who allegedly prevented the Kwaio priest from testifying. The Chairman of the Hospital Board stated he wanted the hospital to remain open and the Associate Health Director of SPD said he believed that by working with Kwaio chiefs, assurances could be provided for security to allow Atoifi to continue to function (Stacy 2004). Community members who had initially queried the decision of hospital administrators to pursue the legal route only, and not a Kwaio cultural model, openly restated their queries. The court system had produced a
ruling that left the Gersbach family, Atoifi staff and the broader community openly stating that there had been no ‘natural justice’ produced through the legal system or ruling. Questions were raised as to why the legal system had been wholly relied on. Because the court had ruled on the case, Kwaio chiefs were unable to pursue the matter further since their cultural system had not been used from the beginning and to do so would constitute double-jeopardy. This led to the questions of ‘how would justice be done?’ not only for the Gersbach family, but also for the community, and if/how the perpetrator/s (whether the two men tried or others) would face consequences for their deeds? Because Kwaio justice is based on normalisation of relationships, often through compensation and exchange, how could the broad relationships between the hospital and community be normalised? The judgement produced by the legal system did not allow this to occur.

Having the two suspects released also raised security questions. If Naasusu and Silas were the perpetrators, what were the implications of having them in the community? Was there a potential for further crimes? On the other hand, if they were not the perpetrators, then who had committed the crime, and what were the implications of not knowing? This was of great concern for Atoifi staff and the general community. The release of the two men further exacerbated the splintered relationships of Kwaio and non-Kwaio at Atoifi. Questions about the future of the hospital were again raised as uncertainty and instability became apparent. Naasusu initially stayed in his mountain home after his release, but he did visit the hospital campus on occasions. I met Silas in Honiara on two occasions in 2005 and again in 2006. He was working as a labourer in a trade store.

Continuing in Uncertainty

Hospital and church administrators had decisions to make in light of the court decision. Internal disunity, low staff moral and numerous vacant senior management positions all exacerbated the lack of leadership. Some employees were expected to perform beyond their levels of experience. The financial situation at Atoifi had also deteriorated. Although the hospital had financial support from AusAID, resources
allocated by church administration began to decrease. Although hospital administrators had signed the community agreement nine months previously, there was no significant movement to address the commitments within the agreement.

Atoifi’s future was dependent on local, national and international issues. The lack of police presence at Atoifi was a concern, but when placing a police post there was discussed some leaders raised concerns over church-state separation. The police post would be a government responsibility, but built on land leased to the church for health services and seemed incongruous to some leaders. This reflected a deep mistrust and antagonism towards the government despite the widespread agreement of the need for a police presence. The blurred boundaries between ‘mission’ and ‘government’ made many anxious. This reflects the unique situation at Atoifi, where although the hospital is a church-run health institution it is the only major infrastructure within East Kwaio. Shipping services, air services, communication, post, banking, retail and wholesale services are all offered on the hospital campus. Some of these are church operated, while others are agencies for government owned enterprises. A police post would be the first direct government service run independently of hospital administration but on the hospital campus. The reality was that RAMSI and the multinational Participating Police Force (PPF) had been successful in Honiara and planned to establish police posts around the country. Atoifi was the obvious location for East Malaita.

**Reflection**

Decisions needed to be made. Would the hospital remain open? Would this be an opportunity to expand or would services decrease? Was this an opportunity to shift from the historically curative focus to a broader preventative community one? Would the hospital remain fully functional or would the administrators decide to revert to a simpler clinic status, where expatriates or people from other ethnic groups were no longer required? This was a suggestion put forward by some non-Kwaio staff, but were quickly rejected as unacceptable by administration. The agreement signed by staff and community leaders to ‘reopen’ the hospital had been seen as a foundation or ‘roadmap’ to move forward, but almost a year later there was no significant movement (or systems in place) to address the commitments in the agreement. Now
that the two acquitted men were back in the community, some at Atoifi perceived this as a breach of the agreement—that the ‘Kwaio community’ should uphold the rule of law. This point was challenged by others who stated the government legal system had run its course and a ruling had been achieved. It also challenged the perception held by some at Atoifi that the ‘bush community’ was responsible for and had the ability to, by signing the agreement, over-rule the government legal system. In particular if people charged for a crime at Atoifi, were not found guilty, but the popular belief was they were.

The government legal system may not have produced ‘natural justice’ from a personal, community or organisational perspective, but the system had produced a ruling. From the hospital, there were still no specific services for the bush people, or any significant reform implemented to allow service delivery for all Kwaio at Atoifi. There had been no measures, even temporary ones, put in place for bush people on campus (there was, however, an agreement in principle that Kafurumu clinic should expand). This raised the question of the organisational commitment for the new agreement and placed further uncertainty over the future of Atoifi.

The discussion, perception and discourse of the agreement at Atoifi opens a plethora of issues and interpretations, of which I just start to explore here. Although, as recorded in chapter 6, the agreement had been established as a broad moral agreement—compared to a marriage commitment for a shared future (knowing that things would not always be perfect!) rather than an authoritarian legalistic agreement—some interpreted it as the latter. Interpretation in this way was problematic. An initial overview of the categories of Atoifi “staff and students” and the “Kwaio community” seem primarily to be two distinct groups. However, if the agreement were to be interpreted in a legalistic way defining them becomes difficult: Would a Kwaio person on staff be categorised as “staff” or “Kwaio community”, and who would they be responsible to if they were to not comply with an aspect of the agreement? Does the “Kwaio community” mean everyone who has some Kwaio heritage, whether resident in Kwaio or not? Are “Kwaio community” leaders responsible (or should they be expected to be) for the behaviour of people with Kwaio heritage who may be temporarily visiting Atoifi from Honiara or other parts of the
country? What if they are from another part of Kwaio where the particular leader has no legitimate authority? A further problem with the agreement being interpreted legalistically is that “Atoifi” and the “Kwaio Community” are completely different kinds of entities. Atoifi is a coordinated, fully integrated entity with a board, formal institutional structures, administrative officers, professional leadership, policies and personnel. It is a member of a worldwide faith-based organisation with access to professional support and wealthy funding institutions. The “Kwaio community” has none of these features or structures and has a non-hierarchical, fragmented social order. For these reasons alone interpreting the agreement in a legalistic way exposes fundamental problems. That there were never any mechanisms proposed to review the agreement or attain its goals further highlights these problems if interpreted legalistically. This all means that the agreement needed to be interpreted as a moral agreement—which it was designed to be. This negated the need for it to be viewed as a rigid set of rules to prevent or punish specific crimes, but rather a symbol and a basis on which both parties (with all the definitional difficulties acknowledged) could discuss the future. As a moral agreement, it had the potential to act as a vehicle through which much deeper, longer-term Atoifi—community relations could be discussed. There was, and still is, a need to be clear about the great value of such a moral agreement between Atoifi and the Kwaio community. It is important to be clear about what the agreement was/is, but also what it was not/is not and cannot possibly be.

The Atoifi Police Post and Potential Stability

In early May 2004 hospital administrators announced the construction of a joint Participating Police Force—Royal Solomon Islands Police post at Atoifi, to be completed by July. International and local police would be posted at Atoifi. A self-sufficient police post and accommodation for the officers was built on the lower end of the campus.

Numerous dignitaries gathered on 9 July 2004 for the opening of the post, including the Commissioner of Royal Solomon Island Police Ben McDevitt and President of SPD Pr Laurie Evans. During the opening Pr Evans stated, “The Adventist Church has
given and is continuing to give serious consideration to its future here. Our 37 years of operation has been at some considerable cost with some unresolved questions still demanding answers” (SIBC 10 July 2004). This statement caused unease among many staff and community leaders. Bush chiefs wanted to respond to the president and discuss the situation in detail. Coastal chiefs blocked bush chiefs from talking because they did not want them to raise contentious issues that might cause the church leaders to close the hospital. Coastal chiefs gave broad statements to church leaders that glossed over many underlying issues, and bush chiefs were unhappy that they were not given a chance to explain and clarify issues.

The President announced that a new business manager and CEO would soon be recruited. This, added to two Filipino doctors who had recently been recruited (a husband-and-wife team), and indicated that church administration was supporting Atoifi, at least for the short term. The major financial commitment to recruit these vacant posts meant there would be senior staff to manage and lead the organisation. Despite misgivings over the president’s statement and the bush chiefs being prevented from responding, the commitment of new senior staff was welcomed. Issues remained to be resolved but the immediate future was secure and programs could now be planned and implemented.

Late in 2004 a new Business Manager from Tonga, and a new CEO from Australia, were employed. In January the Director of Nursing left to undertake further study in PNG and was replaced by Nashley Vozoto. Nashley Vozoto had worked in various rural clinics across the Solomons and had a broad understanding of community health issues and the need to work closely with communities to address their needs. With senior management positions filled a fresh look at the situation occurred and new systems planned. One of the objectives of senior management was to ensure that a robust hospital board be created to provide strategic direction. A strategic planning process was initiated with the intention to produce a plan for Atoifi’s future to counter the ad hoc planning which had characterised the past.

With the arrival of new senior management came debate over the primary purpose of Atoifi. The new CEO was of the opinion the hospital was primarily a health service
for the community and only secondarily an evangelical tool of the church. He also supported a PHC approach. This meant that indicators of success or failure should be health indicators, not numbers of converts to Adventism. His opinion was challenged by those who saw church expansion as the primary purpose for Atoifi’s existence, with health outcomes as a welcome, but secondary outcome. Despite this, an article in the SDA journal Record on 21 August 2005 was headed ‘Hospital Connecting with People.’ It outlined an initiative led by Atoifi’s chaplain and implemented by the nursing staff to ‘Help a friend to meet my friend Jesus’. The article did not mention health indicators (Nash 2005a). This debate has been ongoing since the establishment of Atoifi.

During the first half of 2005 preparations were finalised to install a telephone system. The project had started three years earlier but like most projects at Atoifi it faced major delays in the uncertainty of 2002–2004. In June 2005 Atoifi was linked to the Solomon Telekom system. This enabled for the first time telephone, email and Internet access for staff and students.

A major review of the church’s support for Atoifi was initiated in September. This ‘Atoifi Commission’ is a wide-ranging review to examine all aspects of the hospital’s operations, ranging from financial viability, medical services and security, to the hospital’s ability to fulfil the ‘evangelical commission’ of the church. Members from local church administration, TPUM and SPD are involved. Findings will influence the church’s support for Atoifi hospital. At the time of writing no findings have been released.

**Reflection**

Despite staff participation in the ‘retreat’ and Atoifi reopening, internal conflict had the potential to cause the organisation to implode. What did this mean for the PAR process and services for the bush people? During this time of uncertainty organisational and personal survival were at the forefront. There was little room for
change, particularly for a group from which the alleged perpetrators had come. The lack of understanding and communication between Atoifi and the community was ongoing, a symptom of a long period of coexistence without genuine dialogue. Thus the behaviour of both sides was interpreted with limited understanding. Given the situation, would the bush ward project be possible? Would the perceived lack of justice dictate an unwillingness to provide specific services for the bush people? Did perceptions that aspects of the reopening agreement had failed to be upheld compromise participation in the process forward? The bush ward hung in the balance.

The following is a description of the PLAN and ACT stages of July 2003 to December 2005 and the parallel events that occurred. It outlines how many of the above questions were incorporated into planning and action.

Figure 7.3: Plan and Act in July 2003—December 2005 Action Research Events Spiral

7.2 Parallel Events (I): The Bush Ward Project Stumbles

As outlined in Chapter 5, the EU Microprojects staff had worked closely with the ASC to produce formal drawings including a materials list and associated costs, but
this was delayed due to the Cyclone Zoe disaster response. They had not returned to the bush ward project. In May 2003 after news of Atoifi’s uncertain future the EU office suspended work on the project. In June 2003 I met with EU staff to inform them of the agreement between the community and hospital. Assurances were given that work would recommence once it was clear the hospital would continue. Despite the hospital reopening, work on the drawings did not progress. Repeated requests for a completion date were sent. A similar reply came on each occasion—they would come in the near future. By February 2004 the plans, materials lists and associated costs had still not been completed. It was hoped the proposal would be submitted to the hospital board to consider in light of the agreement signed at the reopening ceremony. The instability and uncertainty over staff safety prior to the trial meant a decision to progress from the board was improbable, but having the proposal submitted would allow the project to be considered as soon as the situation stabilised. Given that there was no apparent trigger for the EU office to complete the work, a different approach was pursued.

The Managing Director of Hocking Joinery and Construction in Honiara was approached to complete the work started by the EU. He agreed, with the support of the EU office. During February 2004 the EU office passed the drawings to Hocking Construction to complete. The drawings, materials list and associated costs were almost completed in early July. The Managing Director knew that a statement on the future of Atoifi would be made by the SPD President at the opening on the police post on 9 July. The statement that assured recruitment of new senior management staff at Atoifi gave confidence to progress with the project. Some initial drawings and a list of materials and associated costs were forwarded to Atoifi in August 2004. These awaited review by the new senior management team who arrived later that year.

**Reflection**

The delays in the drawings and materials list could have been multi-factorial. Legitimate logistical reasons dictated the EU office was preoccupied with urgent projects, such as disaster relief and reconstruction after the two cyclones. The unstable security situation and apprehension over the trial outcomes were ever present. Despite
contact on several occasions that urged completion of the drawings they were not completed. I asked myself if there were feelings held by some Solomon Islanders in the EU office that the Kwaio had forfeited their chance of the project because of the murder? Was there a feeling that to provide services for non-Christian people was a retrograde step that encouraged ‘heathenism’ in Kwaio, and that they should instead pursue projects to ‘advance’ the country into the ‘modern’ age? This was never verbalised in that office but was in almost all other government and NGO offices where I had discussed the project in Honiara. Although these were questions that could not be directly answered, they lingered in my mind.

Given the events of the two years since the PAR had begun it was important to refocus and work toward outcomes for service delivery for the bush people. However, was it time to rethink the ‘bush ward’ concept? Had the situation changed so dramatically that the project needed to be fully reviewed and perhaps reconceptualised? Given the struggle at Atoifi to maintain current services, would there be support for expansion to provide still more services? Did the scale of the project need to be changed? How was the bush ward project to continue in this context and would the PAR process be able to produce an outcome in the complex and dynamic situation?

7.3 Parallel Events (II): Towards a PHC approach

Discussions about the move from an acute curative model to a PHC model took place in parallel to other events. A PHC team was created to investigate the potential of a network of village health posts staffed with Village Health Workers, supported by regional clinics staffed by registered nurses. This system was envisaged for both coastal and mountain areas. This could work in the mountains if Kafurumu Clinic was upgraded to a registered clinic status and staffed by registered nurses. This system would see patients initially visit a village health post, referred to Kafurumu for the next level of care if needed, and finally referred to Atoifi if a doctor’s review was necessary. Kafurumu would also function as a centre for proactive health initiatives, investigate disease outbreaks, and would manage immunisation programmes.
Since starting at Atoifi in 2002, the medical superintendent had not visited the Kwaio mountains. He had wanted to, but with ongoing security concerns and increased workload had been unable to.\textsuperscript{77} I informed him that I planned to visit Kafurumu in January and February 2004, and so he and an immunisation team visited during that time. We left Atoifi in the late morning and arrived at Kafurumu after dark. In darkness, over the steep and rough terrain, the doctor had to proceed carefully due to his inexperience with the forest trails and needed to be carried in particularly treacherous locations. The difficulty he experienced left a lasting impression on him about the need for more accessible health services for the Kwaio bush people. Kafurumu clinic had not hosted a doctor for several years, and the following day was filled with treating patients. That evening Esau hosted a meeting of chiefs from across the mountains to discuss the past and future of health services at Atoifi and in the mountains. Dismay was expressed at the lack of even basic services in the latter. A request came from chiefs for more village aid posts, particularly in the Sinalagu interior where the greatest population live. The medical superintendent explained the PHC approach and his plans to expand Kafurumu and post registered nurses to the clinic to compliment the village health worker. This would allow Kafurumu to improve services and address the ‘building blocks’ of health (to use his terminology). The chiefs agreed, but requested that there be services in their areas also. The system to fund and allocate resources for particular ‘catchment areas’ was explained. The villages in the immediate surrounds of Atoifi and the hamlets near Kafurumu were in the ‘catchment areas’ and received government funds through Atoifi, but other areas would not.

That only some areas in Kwaio were official ‘catchment areas’ for Atoifi was news to the chiefs. Those outside the Atoifi catchment areas were theoretically provided services by government clinics and hospitals. Chiefs thought that their people were in the natural catchment areas for Atoifi. Although the catchment area was a model to fund and allocate resources, some chiefs saw it as a tool of oppression. Some of the chiefs started monologues of anti-government rhetoric and sighted this as yet another example of government not recognising or providing services for Kwaio. It was

\textsuperscript{77} Late in 2003 he had planned to visit Kafurumu but was advised against it on security reasons by RAMSI police, despite the chiefs’ assurances that he would be safe.
explained that Atoifi was prepared to provide services for the entire Kwaio mountains, however a statement from the chiefs of the community’s desire for this was needed, accompanied by a population list.\textsuperscript{78}

An ongoing issue was the lack of accommodation for families of patients at Atoifi. The draft plans for the bush ward included family accommodation. The medical superintendent suggested a system used in his native Philippines of small bungalows with a room for patient treatment and the remainder for family accommodation. This allowed social and practical support for the patient, especially important when meals and much of the personal care are provided by the patient’s family. Discussions continued with Esau and the Kafurumu Baru Committee to explore the incorporation of such an initiative into the expanded Kafurumu Clinic.

The following day the Atoifi party visited the site of the proposed expanded clinic complex thirty minutes walk away. Expansion was impossible at the existing site at the junction of the Kwailafa and Darisuri rivers because of limited flat land. When Esau consulted extended family who had collective ownership of the land he was granted authority to build a new settlement to include a clinic and housing for staff employed there. A nearby waterfall was a potential site for a small hydroelectric scheme. Work had started on the site with volunteers from the community providing labour.

If the PHC approach proved effective more people would be treated in the mountains. This was a chance to rethink services for the bush people at Atoifi. The expansion of Kafurumu provided an option to build a smaller bush ward at Atoifi. This would acknowledge the dramatic changes at Atoifi and enable a smaller, more modest

\textsuperscript{78} The medical superintendent had indicated a census of the population was required. He was quickly reminded by David Akin, who attended the meeting and translated for him, that the word ‘census’ had a particular Malaitan history and was politically charged. Beginning in the late 1940s the colonial government had used censusing as a part of its campaign to suppress the Maasina Rule movement. Government officers and police jailed thousands of men who protested colonial rule through civil disobedience by refusing to census. The 1999 government census had not fully covered Kwaio. In one area alone at least seven hundred people were left uncounted. This meant there was no accurate population data with which to plan services.
project to progress. Modest PHC initiatives started on the coast, though there was little movement in the mountains.

Reflection

The PHC approach allowed alternatives for the proposed bush ward at Atoifi to be considered. The bush ward had been conceptualised when curative focus dominated at Atoifi. It was initially decided to construct the bush ward at Atoifi and then expand to other areas of Kwaio. Discussion about a PHC model with the potential to expand Kafurumu gave the option to reduce the size of the proposed bush ward. A counter to this was that despite the PHC discussion there was little action. Did the limited action on the PHC approach indicate that it was just too hard, given the unstable and unpredictable context? Did organisational survival at Atoifi mean the retention of the ‘way things had always been done’, even if this did perpetuate an inequitable and unjust system? Was the PHC discussion mere rhetoric with no real resources allocated to realise them? An example was the authorisation to build a temporary bisi at Atoifi in both October 2002 and June 2003. The bisi was never built. Would the new senior management team support PHC initiatives in the bush or maintain past policies? Those involved in the PAR needed to consider whether the bush people were now even more alienated from Atoifi because the language of participation was being used in PHC but with no resultant action? These were all ongoing challenges for the PAR process. They also had to be addressed in light of parallel events.

7.4 Parallel Events (III): Leadership in the Bush

During November 2003 Esau Kekeubata and I were notified that two abstracts we had co-submitted to the International Union for Health Promotion and Education (IUHPE) World Conference in Melbourne had been accepted. The theme of the conference was “Valuing Diversity, Reshaping Power: Exploring Pathways for Health and Wellbeing,” which reflected exactly how Esau approached services at Kafurumu. The
following January I travelled to Kwaio to work with Esau on our presentations and organise logistics of travel.\textsuperscript{79}

We discussed logistics and requirements of presenting at an international conference. It was difficult for me to know where to start. We were a day’s walk into the rainforest clad mountains of Malaita and were preparing to present at an international conference in a city of 3.5 million people in Esau’s sixth language. We started with the documentation. I passed Esau the letter of offer with the letterhead “18th World Conference on Health Promotion and Education”. Esau later stated he was almost overcome when he saw this. He had little formal education, worked in the mountains, set up his health service for and with the community, and worked in a very isolated environment. Many aspects of his work were outside any formal regional or national system and he had never travelled outside the Solomons before. Now he was accepted to talk about his work at an international conference. He said there were other people with more education and higher positions at Atoifi more qualified to present at such a conference. I assured him that those at the conference would welcome his unique approach to health services. After his initial apprehension passed Esau and I together prepared the presentations. We discussed the opportunity of attending the ‘pre conference’ Maori Health Promotion Hui (Maori ‘meeting’) at the University of Auckland in New Zealand. This would be an excellent opportunity to learn how fellow Pacific Indigenous groups were negotiating the links between culture and health. I had lived in New Zealand and worked in the health care system there in 1996 and 1997 and was aware first-hand of the importance Maori culture was given in the health sector in that country.

\textsuperscript{79} My trip to Kwaio in late January/early February 2004 coincided with friend and colleague David Akin’s visit there. Akin and Laete’esafi stayed with my family and I in Brisbane in January. Akin, based at the University of Michigan, was working on a project with the University of California at San Diego Melanesian Archive to repatriate a copy of Kwaio materials to the Kwaio people. Akin met Laete’esafi (who had flown from Solomon Islands) at my home in Brisbane to work on details of the project prior to their return to the Solomon Islands together to pursue arrangements for the return of the archives, and to hold several community meetings on the subject. They also visited the Queensland Museum and assisted the curator of the Melanesian section to review their Malaitan collection, including Kwaio materials. Being an artist himself, Laete’esafi sold some weaving and other art work to the museum for their Kwaio collection. While Akin and Laete’esafi were in Brisbane we also met with Clive Moore, a historian who has documented nineteenth-century ‘blackbirding’, or labour recruitment, throughout Melanesia and especially on Malaita. He works closely with the Fataleka people of East Malaita (see Moore 1985; 2004).
Esau discussed his invitation with community leaders to gain authority to talk about Kwaio health issues at the conference. He first consulted his father Kekeubata, who explained his expectations for Esau as a community representative talking at an international conference for the first time. We visited a feast given by Laete’esafi to honour and farewell David Akin, who was leaving after a month together in both Australia (staying with me) and the Solomons. Esau consulted with chiefs and leaders gathered and was granted authority to speak about Kwaio. The following day we were hosted by Maenaa’adi, paramount chief of Kwaio. Esau discussed the trip with Maenaa’adi and also sought his authority to speak about Kwaio. Maenaa’adi indicated his desire, on Esau’s return, to include him in a group of advisors on Kwaio community matters, particularly health. This was a huge boost for Esau’s confidence and increased his standing in the community.

Esau arrived in Australia on 13 April 2004, after six months of planning. Presentations were finalised in the next few days prior to leaving for Auckland. The Maori Health Promotion Hui was held at the Waipapa Marae on 19 and 20 April. The Marae is set on the University of Auckland grounds as a working pan-tribal marae to promote the study and advancement of Maori issues. Maori cultural protocol is upheld and all visitors are welcomed and interact following Maori protocol. Esau stated he

80 This was an uneasy experience for me as it was the first time I had been in the mountains since the May 2003 murder. I was on the land of the families of both suspects who were in custody. The last time I had visited Maenaa’adi’s hamlet was with Jimmy Ri’ifana (Silas Laefiwane), who was now in custody. His hamlet was only about a minute’s walk from Maenaa’adi’s and I would be spending the next twenty four hours with his and Naasusu’s families. Given my knowledge of the incident, that I was associated with the hospital and a wantok of Gersbach’s made me apprehensive. I didn’t really know what to feel, whether it was fear, or apprehension, or sorrow given the events of the past year. I was however feeling safe knowing I was under the authority of Maenaa’adi, the paramount chief and accompanied by Esau. I was also known by most people in the immediate area. I had stayed in a number of the surrounding hamlets previously and I had traded taro with several of the families while we were at Atoifi in 2002. I soon became relaxed when I started to see old friends. This was a similar reaction to when I had flown into Atoifi in June 2003 immediately after the murder. This was particularly so when Jimmy’s mother came to me with a big smile, shook my hand and talked about the last time I was in her community and my family. This put me at ease, as seeing my friend Silas Lounga at the airstrip at Atoifi had six months previously. I was however uneasy when I saw Naasusu’s brothers enter the hamlet, all bearing knives (which, of course, was very normal). Although I knew I was in no danger their presence did have an impact on me. As the afternoon progressed and more people gathered I felt more at ease. A night of feasting and music with the community made me realise my initial reactions were not based on any current dangers.

81 Esau had almost missed his plane after being held by RAMSI police in Honiara earlier that day. He had been celebrating his imminent departure with his extended family the night before, when a bottle of home brew, ‘kwaso’, had been placed in his bag. On entering the New Zealand High Commission to collect his visa on the day of his departure, his bag was searched and the illegal kwaso found. Police
was impressed that culture was respected at a university in the centre of a large city, and also to find educated, professional people who respected and upheld cultural tradition. His experience in the Solomon Islands was that to engage in any form of education or development required relinquishment of culture to engage in a process of modernisation that rejected notions of indigenous culture. In New Zealand he saw people along the path of ‘development’ who not only respected culture but centralised culture within everyday professional practice. After the welcome in Maori language, the keynote speaker gave an overview of Maori health and approaches to Maori health promotion. This centralised cultural understandings of health and differentiated it from western models. The ability to listen and engage with an Indigenous group as they strived for the health of their people was a powerful experience for Esau.

Esau and I then travelled to Melbourne for the IUHPE conference. The opening ceremony was a spectacular event which started with a traditional Indigenous welcome to land by traditional Aboriginal owners. After the ceremony Esau was surprised that he was sought out by a number of people who wanted to meet him after seeing his details on the list of participants. The producer of Radio Australia’s ‘Pacific Beat’ program sought out Esau for an interview, to which he agreed and which took place the following day. It was broadcast across the Pacific region.

The first of our conference presentations was titled ‘Preventing Conflict: Is There a Role for Health Promotion?’ The chair of the session, the AusAID health advisor for the Pacific, introduced Esau and told the audience they were to experience a unique grassroots perspective from a person who had travelled from his home country for the first time. Esau outlined how Kwaio understand holistic frameworks of health. He explained how these frameworks can be used to understand and minimise conflict in the present and future. On completion of the presentation the head of the department of health in Vanuatu publicly praised Esau and stated Pacific Island countries needed to ground themselves in the reality of the grassroots existence of its peoples, and that Esau’s presentation was an excellent example. One of the many people who approached Esau after his presentation was the regional director for North America of
IUHPE, who invited Esau and I to present at an international conference in Canada later that year (Esau did not attend this because of the tight time frames involved). This was a massive boost for Esau, who had been told at Atoifi that there were better people to attend an international conference—“what would a man from the bush know, who has no education?” “Let someone attend who has education and knows what they are talking about”. When these comments came from Atoifi, I had assured Esau that we would revisit them after his presentations. I was confident they would be proved wrong—and they were!

Our second presentation ‘Incorporating Diversity in Health Planning: An Example of Negotiating Common Ground in a Complex Environment’, was likewise well received. This presentation covered how Esau negotiated with the community to construct a water supply at Kafurumu that acknowledged traditional Kwaio theories of health and disease see example 2, Chapter 3. An article on Esau’s work was placed in the conference news bulletin and several people asked him to autograph the accompanying picture. Esau was invited to a ‘meet the luminaries’ lunch during the conference where he met numerous national and international leaders in public health.

The following week Esau and I attended a satellite IUHPE conference on ‘Settings for Health Promotion’ in Brisbane. During a discussion group, ‘Indigenous Issues in Health Promotion’ (which had input from health workers from Australia, New Zealand, Canada, South Africa and Ireland), Esau explained how Indigenous Kwaio frameworks were used. This was particularly well received by the Australian Aboriginal participants. We also visited an Aboriginal Community Controlled Medical Centre which provides services specifically for Indigenous Australians. Once again, Esau observed another Indigenous group who faced similar issues to Kwaio and were proactive in the provision of culturally appropriate health services.

Later that week Esau presented a talk at a local SDA church in Brisbane. A member of the church, a health professional in a strong financial position, was interested in Esau’s plans for the expansion of Kafurumu Clinic. Esau explained how he had natural resources, including trees, but that a chainsaw to selectively fell and mill trees into timber would allow the project to progress. Unaware of this individual’s support
for grassroots projects, Esau was surprised when he was offered sufficient funds for a new chainsaw, spare parts, transportation and operating costs. The donor also indicated his willingness to support further projects, a catalyst to investigate a simple hydroelectric system.

The most suitable hydroelectric system (low maintenance, small volume of water used, able to be carried to remote locations) was manufactured by the Rainbow Power Company in Nimbin, in northern New South Wales. Electricity generated was stored in a battery bank which supplied a 12 or 24 volt system. The system had capacity for lighting, radio and vaccine fridge at Kafurumu clinic and numerous houses in the settlement. When we visited Nimbin we also saw a working example of a dry toilet system. These systems had been discussed as an option for the bush ward and new clinic at Kafurumu but there were no examples to view in the Solomon Islands. Seeing the simply built system was an indication that the principle could be used at Kafurumu and constructed locally.

Esau and I were invited to attend a ‘brainstorming’ session with the Health and Conflict Research Project team at the University of New South Wales in Sydney. This session helped the research team gain perspectives from Solomon Islanders involved in health who had lived through the ethnic tension. Other Solomon Islanders living or studying in Australia also participated. Esau was surprised that a prestigious academic institution would seek his input, and commented, “I have only eighteen months schooling and I am now to give advice for a university research project”. After the three-hour meeting Esau was again surprised to be asked further questions by professors from the Sociology and Anthropology Departments. This was another boost for Esau’s confidence and an example of what I had assured him months earlier at Kafurumu when we were planning the trip. Many at Atoifi saw Esau as not educated enough and working in a remote place that nobody cared about and had been

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82 Esau purchased a Stihl 090 chainsaw the biggest, most powerful and suitable chainsaw on the market. Esau had used this model previously when he had worked in logging camps.
83 Nimbin is known as an area were people attempt to find sustainable development, ranging from permaculture to renewable energy. To see Australian people actively choosing to live simply, using alternatives that were sustainable and rejecting materialism, encouraged Esau. He saw an alternative to the path of ‘development’ that many of his fellow Solomon Islanders had chosen, and saw ‘development’ pursued in a sustainable way that did not necessarily mean conforming to the
vocal in their negative opinions of Esau’s inability to interact with professionals in Australia. Esau had been surprised when I told him people would seek him out and want to ask his opinions as his approach to health was so innovative and important in the Solomon Islands. After the UNSW meeting we laughed as we recalled my predictions several months earlier.

While in Sydney Esau and I meet with the Health Director of SPD. Esau shared his hopes and fears about Atoifi and the Kwaio community. He presented his perspective as a bush leader on the May 2003 murder and its impact on the Kwaio community. Discussions about justice for both the victim’s family and the community after the ‘no case to answer’ ruling ensued. Esau was honest about the impact of the historical lack of respect for bush people at Atoifi and resultant exclusion. He became emotional as he asked church officials to continue support for Atoifi and support expansion in a respectful and culturally appropriate manner. Esau was given a commitment that the Health Director believed in Esau and Kwaio and that he would do what he could to assist to stabilise Atoifi’s future.

This was a historical moment for the Kwaio bush community. A community representative had direct access to decision makers at the highest levels of the SDA church in the Pacific. The significance of this was acknowledged by both parties. The meeting concluded with a feeling of mutual understanding.

Esau returned to Solomon Islands on 1 June 2004 and soon after to Kafurumu. Returning with the new chainsaw allowed an immediate start on timber production for the new clinic and settlement. Planning for the new hydroelectric scheme also started. Esau attended the opening of the new Atoifi police post on 7 July 2004 where the SPD president announced a new CEO and business manager were being recruited. Although Esau welcomed this, he was disappointed at the president’s statement that “The Adventist Church has given and is continuing to give serious consideration to its future here. Our 37 years of operation has been at some considerable cost with some unresolved questions still demanding answers”. He was also unhappy that coastal mainstream. He also reflected that development could be small and simple and appropriate for the environment and did not necessarily need to be on a large scale.
chiefs had blocked bush chiefs from publicly responding to the statement, as referred to above. Bush chiefs had been disturbed when coastal chiefs, many of them born and raised as Christians, made statements on Kwaio tradition that did not reflect the reality of tradition as they lived it.84

Three weeks after the announcement of the new CEO Esau was informed that it was the SPD Health Director’s own brother-in-law who had accepted the position of CEO. Esau was asked to inform the community that his pleas had been heard and that the Health Director was supportive of one of his own family members taking the position. Esau appreciated the significance of this response, indicating as it did that a voice from the grassroots had been heard and acknowledged. While Esau awaited the new CEO he continued to work closely with the community to plan the expansion of Kafurumu clinic.

Reflection

Despite Atoifi’s uncertain future, Esau’s leadership role in the bush increased. This was accelerated by his involvement in the international conferences. Visiting other Indigenous groups addressing health issues in their communities using cultural frameworks influenced Esau to continue his initiatives. The derision by those who perceived him as an uneducated bush man who would make a fool of himself spurred him to prove his worth. His humble but confident manner won admiration and enabled the voice of grassroots Kwaio to be heard in international forums. His conference presentations, invitation to UNSW and meeting at SPD demonstrated not only his ability to interact with people in locations different than his own, but to excel in these environments. This was important for the PAR process and the sustainability of any action. His initiative and ability to network enabled him to continue the project despite dramatically changing local events. Facilitating Esau’s trip to Australia and New Zealand allowed me to be a catalyst in enabling him to continue his leadership

84 An example was when coastal chiefs stated they would work within Kwaio tradition to find the perpetrators of the murder and bring them to justice. This assumed the murder had a culturally sanctioned mandate and that chiefs knew who the murderer was. It also assumed that after the legal justice system had reached its verdict that chiefs could now start from the beginning and achieve another outcome.
and innovation through this experience. Would having a revolutionary leader who was growing in stature be enough to move the process forward for the bush ward? He had proven he was able to establish and operate Kafurumu clinic in a location where services had never been before—would he now be able to lead a similar process at Atoifi?

The following is a description of the ACT stage of July 2003 to December 2005 as a culmination of all parallel events which occurred over this time.

**Figure 7.4: Act in July 2003—December 2005 Action Research Events Spiral**

![Diagram showing the ACT spiral with steps Observe, Reflect, Plan, and Act, and Data Analysis Method and Action Research Method]

### 7.5 Towards Realising the Bush Ward

The arrival of new senior management at Atoifi in January 2005 allowed an opportunity for reflection on organisational processes and plans, including the bush ward. In preparation for the arrival of new senior management Esau coordinated a series of community meetings in the mountains in late 2004 to discuss the future of the project. The outcome was a total rethink of the project in response to the events of the previous two years. It was collectively decided that a more modest facility would be planned, with the potential to expand in the future once the bush ward was established.

Soon after the new CEO arrived he met with the ASC. Esau presented the idea of a small, modest facility constructed of local materials to the CEO, Business Manager
(BM) and new Director of Nursing (DON). Esau had been chosen as chairman of the Kwaio Fadanga for 2005 and thus spoke as not only health worker and chief in the Lafe'a, but also as representing the views of the broader Kwaio community.\textsuperscript{85} The CEO, BM and DON indicated their support for the new approach and their willingness to work collaboratively with the ASC and Kwaio Fadanga to achieve better outcomes for the Kwaio people. During the meeting concerns were raised that the membership of the ASC had been handpicked in the past. Therefore, a process was initiated to have geographic and religious representation nominated from relevant groups within the community (rather than from Atoifi), a move towards a more representative committee.

A further round of community meetings was held in the mountains and the new approach clarified. Consensus was reached to construct a building measuring 10 x 6 metres with timber floors and walls and a sago palm leaf roof. One end was to be a large open room, with men admitted to one side and women on the other. The other would have two further rooms, one for patient consultation and the other for treatment. A kitchen built from natural materials would be constructed adjacent to the bush ward for use by both patients and guardians. The bush ward was proposed to be built on a flat piece of land approximately 50 metres from the new Atoifi police post and adjacent to the mangrove forest. There were several major reasons this site was chosen in preference to the original bush ward site 400 metres away behind the workshop.

1. **Safety**: There were ongoing safety concerns held by staff at Atoifi. Having the bush ward close to the police post would ease these concerns, particularly at night. Police could provide escorts if needed and be in the bush ward in seconds in the event of any incident. The police would be close to the bush people and, though this was unnecessary regarding the vast majority of bush

\textsuperscript{85} A part of Esau’s increased leadership in the community included an initiative to publicly state that Kwaio leaders and chiefs were not a part of the Malaita Separatist Movement, a rebel group established in early 2005 calling for the resignation of Prime Minister Sir Allan Kemekeza. The militant group was claiming to represent all of Malaita (Iroga 2005).
(and also Christian) people, it would allay staff fears and minimise any chance of criminal behaviour.

2. **Toilets:** The bush ward adjacent to the mangrove forest would allow both patients and their families easy access to designated male and female areas of the mangrove forest to use as toilet areas. Plans for the future construction of waterless toilet systems were discussed.

3. **Infrastructure:** The site is close to the existing electricity supply and other infrastructure such as road and wharf, facilitating construction and maintenance. The site had been levelled and cleared several years earlier. This allowed construction of the bush ward to proceed. The area was large enough for an adjacent kitchen and to allow future expansion.

As part of the bush ward project a *bisi* was also to be built. This would not be near the bush ward, but adjacent to the hospital’s maternity ward. It would measure 6 x 4 metres. The DON and maternity staff agreed that antenatal clinics for bush women could be operated within the *bisi*. It would also function as a facility where women could stay after discharge from the maternity ward, and likewise women admitted to the bush ward during their menstrual periods.

The community agreed to a totally new approach to funding and resourcing the project. Instead of working with external groups for both technical assistance and funding, the project would be wholly funded and supported from within Kwaio. As the building was now to be designed and built by Kwaio people, an agreement was reached that each person in the Kwaio mountains contribute one dollar each towards the project. This raised several thousand dollars to start the project. An initial idea to roster workers from across Kwaio to construct the buildings was deemed logistically impractical and thus local Kwaio builders were hired. Arrangements were made with chiefs in each of the administrative regions in the mountains (Kafirumu, ´Ailai, Lage´efasu, Fanuariri, ´Alalau and Bina) to collect contributions and deliver them to the administrative office at Atoifi. Two Kwaio builders were contracted in May 2005. Each administrative area was also asked to donate raw materials such as lawyer cane.
Because of a lack of available sago palm leaf for roofing in Kwaio, 240 panels of sago palm leaf were purchased from Lelisia in nearby Kwara’ae.

Esau, as project coordinator, chose to pursue this approach for two main reasons:

1. **It was responsive to the new situation.** The situation at Atoifi had dramatically changed in the previous three years since plans were first envisaged. Events over that period dictated a fundamental rethink of the bush ward project. Esau and the ASC knew the original concept of a large facility was unlikely to proceed in the current context and so a change in direction was required.

2. **It represented sustainability and community ownership.** Esau had observed that numerous projects throughout the Solomons fail because of a lack of community ownership. In his recent trip to Australia and New Zealand he had also observed that despite the dominant development paradigm there were groups striving for local, sustainable and culturally appropriate solutions. Numerous health professionals in Australia and New Zealand had encouraged him to continue to pursue local solutions in his community. This followed Esau’s unease at some recent projects in Kwaio. Several years previously ADRA had installed a water supply project to supply all major villages in Uru Harbour. A number of villages no longer had water because pipes had been cut for use in local ‘bamboo bands’. Esau’s experience was “ADRA came and funded the system, but the mentality of the people said that other people came and built it here and they have no ownership”. Leaders did not want this to be the case with the bush ward. Ironically, one of the local bamboo bands that performed at the opening of the Atoifi police post in July 2004 used stolen water pipes from the AusAID-funded, ADRA managed water project. Many of

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86 ‘Bamboo bands’ are made up of young men dancing while blowing panpipes made from bamboo. These are accompanied by other young men beating the end of larger diameter lengths of bamboo with a rubber thong to produce the base sound. Large diameter lengths of bamboo were being replaced by lengths of PVC pipe taken from the water supply. This was a phenomenon across the country, with articles in the national newspaper such as ‘Warning for PVC Pipe for Music’ (*Solomon Star* 3 Mar. 2005).
the assembled dignitaries had been indirectly involved in the project, including Australian government officials and a member of the board of ADRA.

Leaders decided if money, resources and effort came from the community, then responsibility for the project would follow and leaders and community members would be held more accountable. Esau urged that in order to ensure community ownership of the bush ward people must feel “hem blo mifala”—’it belongs to us”. Esau had been urged by some to make a specific request for money from the provincial or national members of parliament. He rejected this since he did not want the community to perceive that the money had come from the ‘government’ or ‘donors’ rather than from within the community. He had also rejected promises of funding from candidates standing for the 2006 national election. Commenting, “politicians always lie”, Esau recalled numerous projects promised but not delivered by political candidates and other politicians. Again Esau did not want funding to come from outside the community leading to the bush ward being claimed or seen as ‘politician X’s’ project. A government run clinic in West Kwara’ae had been burned down several years earlier by the supporters of a provincial politician after he lost an election since it was perceived as being ‘his’ clinic because he had secured funds to establish it. Esau deliberately decided to distance himself and the project from any political manoeuvring. Because the government had historically provided very little for bush people in Kwaio, politicians would be very keen to claim any involvement in the bush ward project as evidence that they were working for the bush people, particularly in the 2006 national election campaign.

The new CEO was supportive of the PHC approach despite the limited action. However he soon realised that Kafurumu had never been set up as a registered aid post or clinic and thus did not operate under proper authority.\(^{87}\) Although Esau served

\(^{87}\) Kafurumu operated in a unique manner due to the innovation of Esau’s approach to deliver health services, however in the mentality of those at Atoifi it was established and supported as an evangelical tool, not just a medical aid post. Despite being a celebrated evangelical tool of Atoifi, the establishment of Kafurumu has resulted in few conversions to Adventism. Thirty-six people reside at Kafurumu. Many of them were SDA prior to settling there or are old widows or children. There has been no significant growth in the past decade despite the rhetoric about health services leading to conversions.
in a voluntary capacity at Kafurumu, Atoifi had supplied medication and equipment.  

Because one of the objectives of the new CEO was to ensure proper systems were in place, discussions were held with the DON and Esau. It was decided that the Malaita Province Health Services would be contacted to seek support for the registration of Kafurumu clinic as a Rural Health Centre. This would allow financial and staff support to come from the province and logistical support and reporting requirements would continue to be administered from Atoifi. In the interim Atoifi could not continue to forward supplies to Kafurumu. While disappointed at this temporary cessation of support Esau understood and continued to work with the new management at Atoifi. In early July 2005 the East Malaita coordinator for Malaita Province Health Department, visited Kafurumu, met with the Kafurumu Baru Committee and visited the site of the proposed new clinic. He stated the Kafurumu Baru Committee were proactive in supporting Kafurumu clinic, they had existing links with Atoifi, and had expansion plans. These factors, and that other health facilities were all far away, meant support was likely from Malaita Province. He collected population data for the surrounding community and submitted a report supportive of Kafurumu becoming a registered Rural Health Centre.

Although the cessation of services at Kafurumu affected the morale of the community and those working on the new clinic building, Esau remained focused. While the expansion of Kafurumu was supported by the previous Acting CEO, no financial or support systems were in place. Esau and the Kafurumu Baru Committee saw the future in more coordinated approach between the community, Provincial government health system and Atoifi. If Kafurumu was expanded to a Rural Health Centre with a fulltime RN then less people from the bush would travel to Atoifi for treatment. This would support the move towards a modest bush ward at Atoifi.

Over the same time period other denominations, with no health services, have outgrown the SDA settlement. Nearby SSEC villages established in 2004 and 2005 have almost fifty residents, and a Roman Catholic settlement established in 2001 has forty. This supports Steley’s analysis that evidence does not support the SDA rhetoric that health services increase conversions to Adventism in the Solomon Islands (1983, 1989).

Esau had been dismissed from employment in 2000 after divorcing his wife and remarrying. As his remarriage was a ‘custom marriage’ and not a church marriage, he was deemed unfit to be employed by Atoifi as a church organisation. Although Atoifi did not pay Esau to continue his service to the community, they did continue supplying him with medical equipment and pharmaceuticals to continue the service.
On a field visit to Atoifi in November 2005 I travelled through `Aoke and met with the Provincial Director of Health, the Director of Primary Health Care and AusAID-funded Australian Provincial Primary Health Care advisor. These men had received the report on Kafurumu, but there had been little movement and no feedback had reached Esau or the Kafurumu Baru Committee. I then travelled to Atoifi and Kafurumu. Esau and I returned to `Aoke where Esau met the provincial health officials. Esau and I met with Atoifi DON en route. Esau explained his intention to meet with the Provincial health officials and discuss the next steps in the registration of Kafurumu clinic. The DON indicated his ongoing support for the expansion of Kafurumu and his willingness to work collaboratively with both Esau and the provincial health services to achieve this.

This was the first time Esau had directly met with decision-makers from the provincial health department. He was well received. Esau remained in `Aoke after my departure and worked with the Director of Primary Health Care and his advisor to draft a proposal for the future expansion and development at Kafurumu. In early 2006 the Provincial Director of Health officially ‘signed off’ on the proposal, and it had passed through provincial administrative procedures. It was then submitted to the national Ministry of Health for final approval. Throughout this time, work continued at the new Kafurumu site. Two buildings were completed by December 2005 and two more in early 2006.

Throughout the restructuring of support and funding mechanisms for Kafurumu, community consultation continued regarding the new approach to the bush ward at Atoifi. Esau met with the CEO and DON and detailed the proposed plans and approach. Both agreed with the direction and committed to operationalising the bush ward with equipment and staff as soon as the community constructed the facility. The DON met with nursing staff to explain the new proposal. Although there was general agreement for the establishment of the ward, the DON realised he needed to address attitudes of staff towards patients who would use the bush ward. This was a part of a greater initiative to improve nursing practice and competencies through an emphasis on ethical practice. Because of isolationist policies of the past and the previous emphasis on converting patients to Adventism rather than professional standards, core
ethical nursing practice needed to be addressed. The new DON was to tackle this issue. Initiatives included one by the School of Nursing to incorporate Kwaio culture as a core component of students’ training and staff in-service training. Esau was invited to deliver lectures to students in June 2005 on Kwaio culture and its implications to health care, with plans made for this to continue and expand. Esau requested Laete’esafi to be involved with future lectures at the school of nursing because he himself was not always available. Laete’esafi was willing to deliver the lectures on Kwaio culture, but I was struck by his response when he said “I hope they are not afraid of me”. This simple statement crystallised the situation at Atoifi. Despite the presence of Atoifi in Kwaio for over four decades, there was still no underlying trust between Atoifi and the community. Laete’esafi was an international traveller, past paramount chief, orator and upholder of Kwaio religion, he had been intimately involved with the ASC and worked closely with administrators on the reopening of Atoifi in July 2003, and yet he perceived that students saw him as someone to be afraid of.

With senior management in place, a reality was emerging that encompassed a systems approach to administration which incorporated dynamic, considered and flexible leadership from the bush. Small steps were being made towards the bush ward becoming a reality. In May 2005 site preparation started and materials were ordered. Funds had been raised and relationships between Atoifi administrators and Kwaio leaders were being strengthened. With materials already on site, another delay slowed the project: the owners of the land adjacent to the bush ward site were unhappy and stopped the project. Their pigs foraged on the land directly below the bush ward site and would often stray onto the land adjacent to the bush ward. Landowners were afraid their pigs would be too great a temptation for the bush people to steal. Several leaders unsuccessfully talked with the landowners and attempted to convince them to withdrawn their opposition. A stalemate continued over several months. Esau discussed the situation with the landowners several times until finally a resolution was reached in early October.

The situation was resolved based on the Kwaio concept of relationship. Esau reminded the principle landowner of the good relationship his father, who had died
earlier in 2005, had with the bush people throughout his life, and the mutual respect that characterised that relationship. He had provided a house in their village for bush people who could not stay at Atoifi. Because of this long and strong relationship there had been no problems between the bush people and their family in the past. Esau impressed upon the man that the bush ward project needed to be seen in this light. If the bush ward was stopped because of fear of theft this might sour relations between his family and the bush people. The bush people knew exactly where their pigs were and had ample opportunity in the past to steal them but had never done so. Given this history, there was no good reason to oppose the bush ward. Soon after this conversation opposition was withdrawn and the project recommenced.

During the stalemate other community factors worked towards the project proceeding. Each national politician has a Rural Constituency Development Fund (RCDF) to use at their discretion for development projects in their constituency. The member for East Kwaio distributed cash to his constituents in some areas rather than funding specific development projects. The leaders of each of the seven administrative regions in the mountains received SBD5000 to either use for community-based projects or distribute to each individual in their region. Many community commented on the irony that this was the first time this had been done in many years and was only months prior to the national election. Some leaders wanted to pool the funds for community projects, while others wanted to distribute the cash evenly to the people. The funds were in the end distributed evenly, but prior to the funds being shared out the first SBD300 from each region was donated to the bush ward, for a total of SBD2100. As noted earlier, Esau had specifically rejected funds from politicians previously. However this money was not viewed as political money for the bush ward since it had been given to the community to use as they wished, and the community had decided to use part of the money for the bush ward. This was perceived as different from taking money directly from a politician or donor specifically for the project. The community had the discretion of spending the funds as they wished. This fulfilled Esau’s wish for community ownership and sustainability.

By September 2005 over SBD4000 had been raised from the community and Atoifi donated a further SBD2000. When the opposition from landowners was resolved,
building re-started in late October. The frame of the bush ward was completed in mid-November and the sago palm thatched roof in December. Construction then slowed over New Year holiday. The foundations of the *bisi* were started in December.

In late November Atoifi’s CEO attended church administration meetings in Fiji. During those meetings the church administration decided that due to security concerns they no longer supported an Australian CEO remaining at Atoifi. A number of events culminated in this decision. The CEO’s primary focus on the health system at Atoifi and secondary focus on evangelical outcomes caused a number of church leaders to disapprove of his leadership and actively lobby against him continuing in the position. In the day preceding the committee sitting (28 November 2005) the front page of the *Solomon Star* newspaper read ‘Sasako warns Australia over Atoifi’. The article linked Atoifi’s fickle funding from both church and government, the likelihood the church would withdraw support from Atoifi, a survey distributed at Atoifi to gauge staff perceptions of safety and a letter the MP for East Kwaio, Alfred Sasako received from the Australian High Commissioner in which he claimed no development would take place in East Malaita if community leaders did not find those responsible for the murder of Lance Gersbach. The imminent 2006 elections required the article be read from a political perspective. Although the article ended with the statement “Mr Sasako appealed to the students and staff to ignore the politics being used to scare them away”, the result, in part, was the opposite. In December 2005 the Business Manager completed his contract and left Atoifi. After ongoing antagonism between the medical superintendent and nursing staff throughout 2004 and 2005 he was was requested to leave Atoifi in early 2006. Despite further change in senior management, and reignited security concerns, the bush ward project continued and construction progressed. Esau continued to work constructively with the DON.

The PAR process had become a grassroots initiative working independently. I had moved from being a catalyst to having a support role. The PAR process which started in 2002, and envisaged the construction and operation of the bush ward, had persevered through a dramatic time in Atoifi’s history and had to undergo significant changes to adapt to the new situation. The process had been difficult and at times seemed doomed, but the outcome was now at hand.
Reflection

Was this now the final stages of the PAR process? Were outcomes of the project now independent of me as a researcher? I had always hoped to be a catalyst for change and for the project to be taken and led *by* Kwaio *for* Kwaio. Had the events of the past two years clarified the fact that for the bush ward project to be sustainable it truly needed to be *in* and *of* Kwaio, and that it had to return to the grassroots to become a reality? This was a tough situation for me as a researcher. I had lived and breathed this process and project for the past four years and on a visit to Kwaio in July 2005 I observed the momentum, grassroots support and potential for the bush ward to become a reality, though this had seemed almost impossible during the previous two years. I was satisfied on a theoretical level that I had been a catalyst but it was difficult on a personal level to ‘let go’ of the project and any outcomes that might eventuate. The process had taken a vastly different direction than first envisioned. I had tried to be flexible and responsive to the situation at hand and work with appropriate stakeholders at appropriate times. This had not come without personal costs: both of my children had suffered serious illness in 2002 and I had left them to return to an uncertain, potentially dangerous situation in 2003. There had been periods of self-doubt and pessimism about what, if any, outcomes would be achieved. Visits to Kwaio in 2004 and 2005 deepened the personal commitment and passion I had for the project as the potential increased for the bush ward to become a reality. This same commitment and passion now made it difficult to stand back and watch others pursue the project. This had to happen for the project to be a sustainable, grassroots, bottom up project that addressed issues of social justice and human rights, but this did not make ‘letting go’ any easier. It was only after I observed Esau leading the process and using networks and approaches that grounded the project in the reality of the current situation that this theoretical desire became a personal reality. When this occurred it was personally liberating. I did however ask myself: What if there hadn’t been such a positive outcome—would I have been able to ‘let go’? A question I continue to ponder. As catalyst, I was there to trigger and support the process. The outcomes that eventuated have, however, confirmed the validity of the process. It was personally satisfying to know that a process was now in place—quite independent of me as a
researcher and reliant on the agency of the local community—to achieve the outcome
discussed by so many people in Kwaio for four decades. It was also gratifying to
know that the PAR process had enabled this, and that the flourishing of humanity
could be enhanced through that process. The bush ward was not yet a reality, but it
was closer than ever before. It was not at an end—the next phase was just beginning.
Chapter 8: Participatory Action Research as Anti-Colonial Methodology—Some Thoughts

8. Participatory Action Research as Anti-Colonial Methodology—Some Thoughts

This chapter is a discussion of the Participatory Action Research undertaken in Kwaio to produce this thesis. It cannot be an exhaustive analysis of the context or events which took place, nor can it be a comprehensive exploration of the themes that have developed and continue to emerge. The reason for this is twofold. First, that the scope and limitations of this thesis do not allow for this, and second, that I continue to learn, reflect and act on the knowledge created through this research. This learning, reflecting and acting will persist in the years to come as I participate further with the Kwaio, encounter and create new knowledge and explore new theoretical approaches. What this chapter presents is my first steps on that journey.

8.1 Colonial Order and Anti-colonial Struggle at Atoifi: A Methodological Imperative

This research has produced a number of ‘ah ha’ moments when theoretical and practical clarity has emerged. One of the most important of these challenged a key assumption on which the research was based. I had realised early that Atoifi was not in and of Kwaio but in and of the church, but I did not recognise the extent to which this perspective had required subjugation of the health paradigm. While engaging in the research and reflecting on events it became obvious that the dominant discourse at Atoifi was not that of health but rather of colonisation and Christianisation. This seems clear when presented in a historical perspective, but when I first confronted this realisation I was stunned that a health care institution would not have health as its dominant paradigm. I had approached the research with an assumption that health was the dominant paradigm which informed practice—a paradigm in which I had been educated in both technical and community perspectives. Although aware of the colonial and Christian impact, I had naïvely assumed that health was the paradigm that informed Atoifi medical practice, and that therefore it was through this that culturally appropriate health care could be approached. When I realised the actual situation, I was forced to rethink my approach and reassess the complexity of research into the provision of culturally appropriate health care. The primary purpose of Atoifi’s very existence had been ambiguous from its beginning, and had oscillated
between health and evangelical indicators. The later had been dominant. Although Steley (1990:504–507) claims that Adventists’ primary motivation for involvement in medical work moved from evangelical to humanitarian by the 1970’s, the history of the past four decades shows this not to been the case at Atoifi. Both health and evangelical processes had resulted in the reordering of time, place and space within the colonial and post-colonial process. Realising this helped me understand what had puzzled me for so long: how could Atoifi be a health care institution, yet fail to respond to the level of preventable ill health in the community? Understanding the role Atoifi played in the colonial-Christian enterprise clarified this. It also allowed me to understand why so many Kwaio bush people had refused medical treatment at Atoifi for over 40 years.

The history of Kwaio over the past hundred years, as outlined in chapters 2 and 3, reveals a consistent theme of ongoing anti-colonial struggle to uphold cultural autonomy. Franz Fanon (1965:121–145) analysed how the colonised in his own native Algeria refused medical care provided by the colonisers. This was part of their anti-colonial struggle, even although they very much wanted the benefits of medical care. Europeans in Algeria, much as in Kwaio, saw refusals to utilise medical services as ‘primitive ignorance’ rather than political statements. Because the health care system was a part of the colonial enterprise it could not be separated from it, and as such, was perceived as politically ‘polluted’. The Algerians, like the Kwaio, did not reject hospital services because of a fear of the technological (though they often feared the technician), or of being away from home, or because they relied on traditional medicines, but because it was the hospital “of strangers, of the conqueror” (Fanon 1965:125). The dismissive and hostile attitudes towards the bush people, in the very act of providing health care at Atoifi has resulted in the community perception that the hospital is not their own, but a part of the colonial and post-colonial apparatus which Malaitans have a history of resisting (Akin n.d.; 2004; 2005; Babadzan 2004). Being a part of the Christian apparatus adds a level of complexity, but readers should recognise that many Christians, too, have been unhappy with Atoifi’s approach, as outlined by David Akin: 89

Christians as well as non-Christians are sometimes angry over Atoifi policies of divisiveness and insensitivity, though they may be more reluctant to say so openly. They are not just an insult to bush people but to all Kwaio and to some degree all Malaitans, and they define Atoifi clearly as being a continuation of the colonial order of unquestioned European cultural superiority, a mindset that all Malaitans detest and will resist at some point. Atoifi has long and repeatedly defined itself as part of the establishment, above and superior to Malaitans. Malaitans have a long tradition of fighting against this. The prime display of this self-definition, just as it was for colonial officers, is an open show of lack of respect for local people (personal communication, October 2005).

This allowed me to place the resistance of Kwaio to using the hospital—such as my friend who had endured a scrotal hernia for 40 years (Case Study 2, Chapter 5)—into a broader historical and political context. It would be easy to dismiss such a case as a ‘conservative’ and ‘primitive’ individual inhibited by his anachronistic taboos if one did not understand that it is inextricably intertwined in the larger historical and political context. When this is realised, it becomes harder to dismiss Kwaio actions, and their attitudes become more understandable. This is something most Atoifi staff and administrators have historically remained oblivious to.

Fanon (1965:122) could have been describing the situation at Atoifi when he told of Algerian attitudes to the colonial health system:

> Reduced, in the name of truth and reason, to saying “yes” to certain innovations of the occupier, the colonised perceived that he thus became the prisoner of the entire system.

Kwaio refusal to become prisoners of the colonial system lies behind the history of their exclusion from, and antagonism towards, health services at Atoifi. It is important to underscore that most people who refuse services at Atoifi are only too happy to avail themselves of medical services at Kafurumu, where they and their beliefs are respected. Further, as Akin (n.d.;1993) notes, Malaitans have eagerly sought western medicine care since the nineteenth century, and calls for it were a consistent demand of the Maasina Rule anti-colonial movement during the 1940s and 1950s. It can thus be seen that it is something at Atoifi, not Kwaio ideas about western medicine, that is the crux of the problem, the reason people refuse its medical services. Fanon (1965:131) argues that ambivalence towards medical treatment continues even when medical staff belong to the dominated people, because such staff are “tacitly rejected into the camp of the oppressors”, because they have taken on the characteristics of the coloniser. A common term used across the Solomon Islands for such a person is a
‘coconut’—black on the outside, but white on the inside. Keesing (1989b:28) comments that the colonised have “incorporated and internalised conceptualisations and semiology of colonial discourse at the level of thought, ideology and political praxis”. This exemplifies the situation at Atoifi with many (Christian) Kwaio on staff, and explains the broader political stance that the bush Kwaio hold to in rejecting health services.

Because Christianisation at Atoifi is a continuation of the colonial enterprise, it also takes on colonial characteristics—the characteristics of the oppressor. The colonial project is about establishing a dominant colonial order. It strongly resists negotiation or any actions towards changing that order. This has been a historical reality at Atoifi despite knowledge (by some) of Kwaio cultural rules, and the fact that the impact of deliberately ignoring them is evident on a daily basis. PAR gave me the licence to work in a way contrary to this history and, not only allowed, but centralised the collective negotiation of new personal and social realities. One of the books that most influenced my thought and practice (as it has for many action researchers) and gave me frameworks to make sense of the Atoifi situation was Paulo Freire’s classic *Pedagogy of the Oppressed*. Although its topic is about educating peasants in South America, the book’s principles and frameworks are directly applicable to Atoifi. The following quote helped me to understand the colonial dynamics at Atoifi and the hospital’s continued resistance to change over the past 40 years:

Indeed the interests of the oppressors lie in ‘changing the consciousness of the oppressed, not the situation which oppresses them’, for the more the oppressed can be led to adapt to that situation the more easily they can be dominated. To achieve this end, the oppressors use the banking concept of education in conjunction with a paternalistic social apparatus, within which the oppressed receive the euphemistic title of ‘welfare recipients’. They are treated as individual cases, as marginal persons who deviate from the general configuration of a ‘good, organised, and just’ society. The oppressed are regarded as the pathology of the healthy society, which must therefore adjust these ‘incompetent and lazy’ folk to its patterns by changing their mentality. These marginals need to be ‘integrated’, ‘incorporated’ into the healthy society (Freire 1996:55).

This summed up the situation at Atoifi. Those creating hospital policy and implementing practice (as the colonial/Christian oppressor) showed no interest in changing the oppressive situation faced by the bush people. The focus was on changing the consciousness of the bush people so that they would submit to the
colonial order, and on making them learn the European culturally conditioned and sanctioned understanding of Christianity (for an analysis of this within the Anglican Melanesian Mission in the Solomon Islands, see Hilliard 2005:195–215). When Kwaio people refused services at Atoifi, alternative services were not provided to address their needs. Instead, evangelical programs were broadcast over loudspeakers as people sat under trees on the hospital grounds. If the Kwaio would only conform to the colonial/Christian order, then there would be no need to alter practices or attitudes at Atoifi. Freire’s next paragraph addressed this approach:

The truth is, however, that the oppressed are not ‘marginals’, are not people living ‘outside’ society. They have always been ‘inside’—inside the structures which made them ‘beings for others’. The solution is not to ‘integrate’ them into the structures of oppression, but to transform the structures so that they can become ‘beings for themselves’. Such transformation, of course, would undermine the oppressor’s purposes; hence their utilisation of the banking concept of education to avoid the threat of conscientisation (1996:55).

PAR has this principle as a foundation, as it strives for personal and social change. This challenges the established order—the status quo. This is confronting for many at Atoifi who have shown a limited ability to perceive and treat bush people as fully human in and of themselves, beyond labels such as ‘heathen’ or ‘primitive’. I have had multiple conversations with Atoifi staff who emphasised that to work with bush people was a retrograde step, one that was backward for Atoifi since it would ‘encourage heathenism’—the antithesis of Atoifi’s very existence. All the bush people needed to do was submit to Atoifi’s policy and practice and learn the appropriate (Christian) spiritual frameworks and behaviours. To truly engage with the bush people was never pursued because they were the Other. McLaren portrays those prone to conceiving people or groups as Others as reflecting the characteristics of paranoia:

The external world is endowed with the subject’s own worst qualities and characteristics. The process sustains the illusion or fiction of the subject’s internal economy or the ‘I’. Whereas the ‘I’ is perceived as good, everything outside the ‘I’—perceived as external to this ‘I’—is regarded as the repository of destruction, and where the subject expels its own impropriety and vomits up its turmoils … the ego is cut off from the historical memory of the larger social order as well as from the capacity for imaginative production, since it cannot admit to or acknowledge the illusionary nature of the world that it has created. The paranoiac cannot recognise the outside world as his or her own creation. The outside world can only be reacted against, not responded to (2000:30–31).
The situation at Atoifi prior to the PAR process was much like this. The ongoing internal rhetoric of Atoifi being a ‘light on the hill’ perpetuated the light/dark dichotomy. Those in the light had it all; those in the dark had nothing. Whether conceived through a colonial or Christian paradigm, or both, the outcome was the same—the Other was different, inferior and needed to change to be like I. Historical policy and practice at Atoifi was to react against the Other, not respond to them, and certainly not with them. The objective was to transplant a totally new way of living, so why accommodate the community’s wishes? Again, PAR was a direct challenge to this. Freire (1996) highlights that in situations such as this the oppressed cannot be liberated from oppression by the oppressor, but rather, sooner or later, the “less human” oppressed will struggle against the oppressor who made them so. If the oppressor does attempt to liberate the oppressed this will take the form of false generosity:

In order to have the continued opportunity to express their ‘generosity’ the oppressors must perpetuate injustice as well. An unjust order is the permanent fount of this ‘generosity’, which is nourished by death, despair, and poverty. That is why the dispenser of false generosity becomes desperate at the slightest threat to its source (Freire 1996:26).

True generosity consists of struggling against the situation that oppresses and perpetuates despair. This cannot be done by the oppressors since it undermines the very structures which give them power to oppress and distribute false generosity. Freire (1996:36) asserts that making “the oppressed the objects of humanitarianism, itself maintains and embodies oppression. It is an instrument of dehumanisation.” The history of Atoifi shows that hospital policy and practice did not have the capacity to change the oppressive situation for the bush people. The hospital did not want to address the situation and so it did not. Freire (1996:27) asks the question: “Who are better prepared than the oppressed to understand the terrible significance of an

90 Freire (1996:114-115) comments on such a dichotomy, referring to it as “One of the myths of the oppressor ideology: the absolutising of ignorance. This myth implies the existence of someone who decrees the ignorance of someone else. The one who is doing the decreeing defines himself and the class to which he belongs as those who were born to know; he thereby defines others as alien entities. The words of his own class come to be the ‘true’ words, which he imposes or attempts to impose on the others: the oppressed, whose words have been stolen from them. Those who steal the words of others develop a deep doubt in the abilities of the others and consider them incompetent. Each time they say their word without hearing the word of those whom they have forbidden to speak, they grow more accustomed to power and acquire a taste for guiding, ordering, and commanding. They can no longer live without having someone to give orders to. Under these circumstances, dialogue is impossible.”
oppressive situation?" It is from this base that Freire’s participatory models arise and act as a philosophical base for PAR. As emphasised throughout this thesis, it is an approach that must be forged with and not to the oppressed. The oppressed must perceive the reality of the situation not as a situation from which there is no exit, but one which they can transform (1996:31). The beginning of the struggle of the bush people against the repudiation of Kwaio religious and cultural integrity was, in the first instance, to realise that there was another option and change was possible. Prior to planning for the bush ward there was a collective realisation in Kwaio that the oppressive situation at Atoiﬁ could be transformed. To address this, through PAR, required more than just struggling against the situation, since the situation was not going to be transformed by chance; it required praxis—“reflection and action upon the world in order to transform it” (Freire1996:33). These must be deliberately linked as the sacrifice of action leads to mere verbalism and the sacrifice of reflection to mere activism Freire (1996:68). Reflection, action and transformation (by and of myself and fellow actors in the PAR journey) has been recorded throughout this thesis.

8.2 Lessons Learned while Undertaking PAR

The following list of lessons learned is an initial attempt to understand PAR as used to work towards attaining culturally appropriate health care in Kwaio.

The Importance of Participation

As documented in Chapter 5, when the PAR process was initiated in 2002 I was very keen to work in solidarity with the ‘oppressed’ Kwaio bush people. This meant re-establishing relationships and networks with Kwaio people to work together, through the Atoiﬁ Support Committee, to address the problem of obtaining culturally appropriate health care. In my eagerness to work with the Kwaio people and document their issues I paid inadequate attention to the other major group required for action—the hospital staff. Being faithful to the PAR principle of honouring all knowledges required that Atoiﬁ staff, too, be involved in the process and action. My initial work was almost exclusively with Kwaio, but I quickly realised the need to include Atoiﬁ staff from the beginning. Working collaboratively was essential for a
collectively negotiated and agreed upon action process. The PAR process could not be of Kwaio, nor of Atoifi, but needed to be a collective conversation which allowed all stakeholder’s involvement in a collective decision making process. Solutions needed to be, as Freire stresses, dialogic in nature. Pyrch and Castillo (2001:380–381) liken this to the *ganma* metaphor used by Indigenous people of Arnhem Land in the Northern Territory of Australia, where a river of water from the sea and a river of water from the land mutually engulf each other in a common lagoon. At the coming together of the two bodies of water foam is produced which represents new knowledge. The PAR needed to be, not merely about planning activities, but as through the process of *ganma*, about preparing for surprise, unexpected lessons, and reassessment of what one thought that one knew. Once I realised this and the PAR process adapted, further stakeholders were included.

The importance of participation was a crucial lesson for me. It was only through participation that dialogue took place between staff and bush people. The vehicle for that dialogue, the ASC, was a foundation where issues of practical importance for both Atoifi and the bush people were discussed. Questions of significance and consequence were posed about practical issues of culturally appropriate health care for Kwaio. The diversity of knowledge among ASC members allowed the creation, through interaction and integration, of a new, more complex and nuanced knowledge base for action. This was true to the PAR philosophy of sharing, respecting and incorporating difference as a base for action (Wadsworth 2005; Heron and Reason 2006; McNiff and Whitehead 2006; Reason and Bradbury 2006). It was only through participation that this ‘collective knowledge’ was created, enabling planning decisions to be made. This confirmed to me that PAR is not about discovering ‘the answer’, but about collectively ‘creating knowledge’ (with all its uncertainty and ambiguity) for the context on which relevant action can be taken to change the social order (Reason and Bradbury 2006; McNiff and Whitehead 2006). This confirmed PAR as fundamentally different to past methods which had resisted negotiation or action towards changing the colonial/Christian order. Participation was not in formal ASC meetings alone but also through a consultation process which included open meetings held throughout Kwaio. This consultation extended participation to include the
community at large in a broader more ‘democratic’ approach (Reason and Bradbury 2006). General staff meetings at Atoifi were another important forum for participation, particularly by those not directly involved in ASC meetings.

The importance of participation was underscored in the aftermath of the May 2003 murder. Until the initiation of the ASC, dialogue between the community (particularly the bush community) and Atoifi had either been non-existent or dysfunctional, characterised by distrust and confrontation, and top-down authoritarian processes (consistent with the colonial/Christian established order). In an attempt to envisage a new way forward in the chaos after the murder, church leaders saw the advantages of a participatory methodology and utilising the goodwill that had been achieved through the PAR process. After the tragedy it was clear that non-participatory methods had failed to create any sense of a shared, common future at Atoifi nor gave any mechanism to negotiate these shared futures in such circumstances. Despite this recognition, participatory processes were not sustained at higher administrative levels in the medium or long term (to the degree required for church administration—community leadership dialogue to be effective). The chance was missed to build on the initial positive outcomes of the new agreement and reopening of Atoifi in July 2003. Dialogue suffered at this level and as a result a relationship characterised by distrust and dysfunction continued through much of 2004. I observed how participatory processes must be ongoing in order to build relationships and trust—precursors to shared understandings.

The dramatic turn the PAR took after the May 2003 murder has been recorded and reflected on in chapters 6 and 7, and how plans for a large bush ward were modified to pursue a more modest facility. Participation was the key to the sustainability of the process. Leaders involved in the ASC, in collaboration with the communities they represented, restructured the project as a more grassroots one, more achievable in the new context. Participation was at the core of the new project—this included requests that community members financially contribute. This represented community support

91 I use the word and concept ‘democratic’ as a broad term which refers to the views of ‘the people’ to be included in decision making. I do not use it, as it most commonly used, as a narrower political term.
for what had now become ‘their’ project. This ultimately gave the PAR process participatory and pragmatic validity.

The Importance of Flexibility

The importance of flexibility and responsiveness to change was another important lesson learned throughout the PAR process. As noted, PAR had to have the flexibility to respond to the dynamics of the context. My realisation that Atoifi staff were largely being left out of the initial stages of the project required a response that was not only reflective and reflexive, but one flexible enough to respond to lessons learned and new knowledge created in ‘real time’. PAR showed it could respond to dramatic changes in the research environment. During the research the situation across the country was highly dynamic given the ethnic tension had caused social and cultural rules to be challenged. PAR provided an inherently flexible methodology. The response to local Atoifi dynamics and change of leadership in 2002, 2004 and 2005 also proved PAR was flexible enough to incorporate new people and their views. The methodology most clearly displayed its ability to be flexible when the context changed so dramatically in May 2003. Key to its ability to achieve action was its capacity to pause, reassess and adapt when Atoifi faced closure in 2003 and ongoing instability in 2004. This is perhaps clearest in the shift from a process driven primarily by me as researcher based at Atoifi in 2002 to a grassroots project, driven and owned by the community by 2005. The methodology showed an ability to accommodate the changed context and to utilise different networks and groups when and where necessary. In the end, the research question, process and outcomes became primarily in and of the context, not in and of me, the researcher.

Dealing with Complexity

A further lesson learned through the PAR process was the importance of acknowledging, valuing and incorporating complexity. Where much positivist research (in public health—primarily epidemiology and other quantitative approaches) supports a notion of controlling variables and bias, qualitative research
generally and PAR specifically do not—rather, PAR aims to include a suite of methods able to respond to and incorporate the complexity. As Hammar notes in his HIV/AIDS research in PNG:

I argue that some objections of bias are not as serious as they may appear. And anyway, sampling and other forms of bias are good, not bad, insofar as social systems themselves are biased. It makes more sense to accept and roll with bias instead of trying to hide or apologise for it (2005:4).92

Positivist science has been critiqued by numerous thinkers including seminal work in the area by philosopher Karl Popper. Popper’s work has influenced both the physical and social sciences for almost a century and included significant criticism of Marxism (Popper 1960;1966;1980;1989). Popper rejected the orthodox view of scientific method that theories could be verified and thus ‘proven’ through confirmatory experimentation or observation, but asserts they are maintained only until they are disconfirmed or ‘falsified’. This falsifiability is most important at a methodological level (Magee 1982:23). This assumes that to advance science one must strive to disprove one’s theory and by discovering one’s errors advance theory and practice rather than prove oneself to be right and thus stay in control (Friedman 2006:134). Others such as Donald Schön have described the distance between social science theory/research and practice. Schön used a metaphor that researchers and practitioners can be on “high ground where [they] can solve relatively unimportant problems according to prevailing standards of rigour or…descend into the swamp of important problems and nonrigorous inquiry” (1987:3). Schön (1983;1987) attributed this to the dominance of technical rationality which has worked well in some fields but renders knowledge produced by theory, or the application thereof, of limited use to practitioners. Social practitioners must function in ‘real time’ and so application of theories produced by positivist science where conditions and variables have been controlled, distance maintained to ensure objectivity and all requirements completed in full are difficult to reproduce where variables and conditions are all changing at once (Friedman 2006:132). Added to this is that ‘professional elites’ that produce theory have their own language to talk with each other on the high ground which is far removed from practitioners facing real world problems in the ‘swamps’ (Schön 1983). “Thus, the rules that produce valid positivist explanations of social problems cannot
produce the knowledge needed to do something about them” (Friedman 2006:132). This leaves those of us in the ‘swamp’ of important and complex problems to use alternative ways of producing relevant knowledge on which to act in ‘real time’. PAR is such an alternative to produce relevant, practical knowledge in a dynamic and complex environment.

Throughout the research I attempted to embed the research process, including the research concern and research outcomes, within the complexity of the research environment. Although this was difficult in practice, it was the most prudent approach to negotiate the ‘swamp’ of important and complex problems, and remained true to the project’s overall anti-colonial approach. The extensive description of the cultural, colonial, religious and political impacts on health and health services have explained some of the levels of complexity PAR had to acknowledge, understand and incorporate to produce action. The historical descriptions act as a basis for understanding the narrative and contemporary case studies throughout chapters five, six and seven. Grasping the ongoing situation and the need to incorporate its dynamism and complexity within the research process in ‘real time’ was crucial to success. The May 2003 murder demonstrated the multiple layers of intricacy and the need (and ability) of PAR to respond through observing and reflecting on the situation, and re-invent itself—an adapted methodology used to continue in a modified and more appropriate form.

The possibility that PAR will have to re-invent itself in ‘real time’ in response to the dynamic and complex research environment creates inherent risks for the researcher. Several academics have advised me they do not recommend using PAR for public health research, particularly for doctoral research. Processes, timeframes and outcomes are unpredictable because of the researcher’s inherent need to be flexible, to reflect on and be responsive to, ongoing complexity in the research environment. This is something that public health methodologies which use more rigid research methods and tools, in the positivist tradition, may find difficult. It also means that both data and process must be reflected on (collectively and repeatedly) throughout the research.

See also Hammar 2004 for a discussion on the need for multiple and flexible research methods in a complex Melanesian situation.
to achieve appropriate action. The researcher is not just to objectively record empirical results to be analysed and potentially applied at some future time, but works with people in the research environment from an explicit value base in ‘real time’ (McNiff and Whitehead 2006:24—36). The number of recent texts published on the use of PAR in health/public health exemplifies the usefulness of this approach and the need to use methodologies additional to those based on scientific positivism (Hart and Bond 1995; Winter and Munn-Giddings 2001; Minkler and Wallerstein 2003; Dick 2004; Stringer and Genat 2004; Koch and Kralik 2006). This however may render established academic structures and processes including timelines, written material and funding arrangements non-responsive or irrelevant to the local level where the research is actually taking place. Levin and Greenwood (2001:103) state the dissonance between PAR and universities in emphatic terms: “The institutions [universities] that claim the position of the premier and most advanced knowledge producers in society frustrate learning and social change in most of their internal processes and in their articulation with the surrounding community”. Because a doctoral thesis must conform to academic requirements a dissonance is created. Academia could be described as colonial because of its “roots in institutional designs created centuries ago…based on a particular understanding of the ontological and epistemological foundations of the conventional scientific project” (Levin and Greenwood 2001:103). PAR on the other hand could be described as anti-colonial because it specifically calls on alternatives to Anglo-European cosmology and epistemology to be inclusive of broader methods and knowledges (Park 2006). This exacerbates the tension between academia and PAR—Hall summarises:

Participatory research originated as a challenge to positivist research paradigms as carried out largely by university-based researchers. Our position has been that the centre of the process needed to be at the margins, in the communities, with women, with the people of colour and so forth. Our experience has been that it is very difficult to achieve this kind of process from a university base. (2001:176)

Throughout this research there was a tension between the fluid and unpredictable research environment and the less-fluid structure of written material, completion dates, and travel (at times in uncertain security situations) and scholarship funding.93

93 Levin and Greenwood (2001:103) state that “Universities, as institutions charged with the generation and transmission of knowledge, have created a variety of conditions inimical to the practice of action
The dramatic changes at Atoifi after the May 2003 murder made academic timelines or outcomes of little relevance to the practicalities of addressing the need for culturally appropriate health services at Atoifi. The events of 2003–2005 became a fundamental part of PAR as co-agents for change incorporated and responded to the realities of the complex and dynamic context. It was not until this occurred that the bush ward became a reality and the ultimate goal of the PAR achieved and recorded in this thesis. This confirmed to me that PAR is about a flexible and responsive process in the local (often complex and at times chaotic) context and outcomes that emanate from that local context. Brulin explains that PAR goes beyond applied research (applying techniques to solve problems using theories produced by pure science), to bring about practical knowledge and change during the research itself. It fuses the two into a single participatory (in this case emancipatory and anti-colonial) process—it is about working developmentally:

Action research differs from traditional research (modern and postmodern) in its capacity, through its direct contact with and practical knowledge of development processes, to reflect on the dynamics of these processes. It is not just empirical results that are possible to codify but tacit and practical knowledge is also brought into science. In action research knowing that and knowing how are not separated. Action research is not just describe, understand or explain, it also creates knowledge through direct participation in different development processes. Action research means a wider concept of knowledge than traditional research. Besides taking part in the development process, the action researcher analyses and processes and reports to the scientific society. They bring practical knowledge about development processes into a field of academic knowledge hitherto very much ignored by the established research society (2001:440).

This does not mean that predicted outcomes are mutually exclusive to PAR. Rather it means that outcomes that are strived for, in this case the bush ward, incorporate the local complexity and that the research shows an ability to respond to unpredicted events and modify itself accordingly. The PAR outlined in this thesis confirms that outcomes eventuate through praxis—as people strive to address injustice and struggle for a better world in which to live. This makes some academic expectations problematic and of little relevance to people engaging in praxis if the academy does not show an ability to respond to local complexity. Levin and Greenwood (2001:104) argue that although universities should be the most obvious institutions to support action research, and the resultant knowledge production and social change, they are
often not because they are generally unresponsive to their surrounding communities. Pausing to reflect, revise and re-envision, as happened in 2003 and 2004 may be perceived by some as inaction, but is an essential element of praxis, as Freire outlines:

Those who through reflection perceive the infeasibility or inappropriateness of one or another form of action (which should accordingly be postponed or substituted) cannot thereby be accused of inaction. Critical reflection is also action. (1996:109)

How to acknowledge, value, incorporate and respond in the ‘swamp’ of important and complex problems through PAR was a valuable lesson learned.

The Researcher as Catalyst

One of the philosophical reasons I was attracted to use PAR, was, as I have emphasised repeatedly, the centrality of a research process with and by persons, not on or to them. I always perceived myself as the catalyst for the PAR process and constantly described myself as the ‘facilitator’ of the research process, rather than as a ‘researcher’ while in Kwaio. I did not want to maintain the colonial order and position myself as the ‘expert researcher’, through whom all knowledge needed to be validated or incorporated (an ongoing consideration and delicate balancing act while writing this thesis). Although I was careful to do this, I was concerned in 2002 that although I was the catalyst I was also holding the process together. These concerns were alleviated after the formation of a research ‘reference committee’ at Atoifi that advised on both the research process and its practice.

When delays occurred in early 2003 my concerns again grew that I had taken on a leadership role that should be held by a member of the ASC or Atoifi administration. My role to work with and not on or to people needed to be carefully and constantly examined because I had the potential to dominate from within, and Freire outlines:

The fact that certain members of the oppressor class join the oppressed in their struggle for liberation, thus moving from one pole of the contradiction to the other. Theirs is a fundamental role, and has been throughout the history of this struggle. It happens, however, that as they cease to be exploiters or indifferent spectators or simply the heirs of exploitation and move to the side of the exploited, they almost

following my decision to travel to Atoifi only weeks after the May 2003 murder.
always bring with them the marks of their origin: their prejudices and their deformations, which include a lack of confidence in the people’s ability to think, to want and to know. Accordingly, these adherents to the people’s cause constantly run the risk of falling into a type of generosity as malefic as that of the oppressors. The generosity of the oppressors is nourished by an unjust order, which must be maintained in order to justify that generosity. Our converts, on the other hand, truly desire to transform the unjust order; but because of their background they believe that they must be the executors of the transformation. They talk about the people, but they do not trust them; and trusting the people is the indispensable precondition for revolutionary change. (1996:42)

I had been careful to allow members of the ASC to develop their own analyses and plan the bush ward using their knowledges, but my concern lingered about the most appropriate way I, as the catalyst, was to participate. When the situation changed after the murder in May 2003, it became evident that my primary role was as a catalyst or facilitator. My invitation to assist the SPD Director of Health to facilitate dialogue between the church administration and Kwaio community solidified my facilitating role and the PAR process. Although church administration sought information, I was not asked to speak or plan on behalf of the Kwaio, but rather to facilitate discussions with them that would collectively move the process forward. This demonstrated that people saw my role as a facilitator of change, and their recognition that I had attempted to work in a collective and respectful way to incorporate multiple knowledges and perspectives. It also demonstrated that there were no pre-existing mechanisms at Atoifi that could be used to address such issues.

Although I describe myself as a catalyst I continue to feel the presence of an insider/outsider dichotomy; on some levels I am an insider, on others an outsider, but I never really belong to either. I had worked at Atoifi as staff from 1992—1994 and as such intimately knew the workings, attitudes and culture of the institution. I have also had a relationship with the Kwaio people since 1992. Since 2000 I have been involved in the process to document and present the barriers to access at Atoifi and a potential ways to address them. Because I have intimate knowledge and experience with both Atoifi and the Kwaio, I have characteristics of an insider. Being an Australian researcher, however means I never fully belong to either Atoifi or Kwaio. Despite this, I have been given the identity by many (and often feel) as ‘belonging to Atoifi’ and/or ‘belonging to Kwaio’. This uneasy dichotomy remains a part of the reality of my relationships with Atoifi and Kwaio. Although this dichotomy may be problematic
on some levels it is able to be incorporated into PAR, particularly in the new focus of ‘self-study’ that is emerging in action researchers in recent years (Niff and Whitehead 2006). This approach asks “How do I hold myself accountable to myself and to you?” through the PAR process (Niff and Whitehead 2006:11). This also allows a question such as “How do I improve what I am doing?” to be answered through two related and parallel processes. The first process is what is happening in the social situation under investigation, that is ‘out there’. The second process is what is happening in my own thinking, that is ‘in here’ (McNiff and Whitehead 2006:30). This approach allows simultaneous positions as *I* and *we*, where *I* can retain a unique individuality, but be in collaboration with other *I*s to make a collective *we*. This has been a characteristic through this thesis—a parallel description and reflection of myself in the process and the social, cultural, historical, political, and religious situation at Atoifi. The thesis intertwines both of these perspectives throughout. Considerable judgement is required to negotiate these processes, however using them allowed me to describe and reflect on my own thinking and action as I attempted to distance myself as an ‘executor of transformation’, to trusting the people as they strive for revolutionary change.

The continual reflective processes in PAR allowed me to constantly review my different roles. One of my most significant lessons was when the journalist stayed at Atoifi during a tumultuous time and witnessed the dismissal of the CEO under extraordinary circumstances, but was unaware of what he had observed (Case Study 9, Chapter 5). This had a profound effect on me. It made me revisit my assumptions of what I myself observed and just how much I might be missing at both the institutional and community levels. Although I had many characteristics of the insider (and assumptions of insider knowledge), I would always be an outsider engaging with Atoifi and the Kwaio community—belonging to neither but yet an essential part of the PAR process. This underscored the need for me to be a catalyst for, rather than executor of, change. The bush ward had to be the peoples’ project if it was to be credible and sustainable and address the real issues faced by the community on a daily basis. In the aftermath of the May 2003 murder the re-envisaging, and ultimate construction of the bush ward took place without me, allowing me to see myself as the catalyst rather than executor of change. Despite this, it was difficult to ‘let go’ of a
project that had taken over my life. Friends and colleagues questioned my sanity in pursuing such a complex and uncertain research project for my doctoral thesis. My family followed me to Atoifi in 2002 but returned to Australia because of ill health. Continued travel to Atoifi and Kwaio throughout the period of security threats and institutional chaos demonstrated my commitment to the process, but made it difficult to ‘let go’ of the project’s outcomes. On a theoretical level, I knew that “the responsibility for the project’s success lies with the people” (Kickett, McCauley and Stringer 1986 cited in Stringer 1996:23). Only when I realised that the process had resulted in success (i.e., the bush ward’s construction), was I able to ‘let go’ in a fuller sense. The process of ‘letting go’ must include not only critical reflection on the PAR process, but on myself and others as actors within the process and who fundamentally shape the process. This is consistent with the ‘self-study’ approach emerging within PAR. This takes considerable self-reflection when making the decision to ‘let go’ from the best available evidence from within the process and an understanding of my personal impact (and limitations) as catalyst and agent for change. The ability to be a catalyst for Esau to engage on an international level was also satisfying both professionally and personally. Esau’s engagement with a global audience, and that he thrived in doing so, empowered him to continue his struggle and receive support from around the world. This aspect of the project finally allowed me to “not focus only on solutions to problems but on human development.” (Kickett, McCauley and Stringer 1986 cited in Stringer 1996:23). I discuss this further in the next section.

The Importance of Leadership

The importance of dynamic and reflective leadership was a further lesson learned throughout the PAR process. This was brought home to me though working with Esau and observing his participatory leadership style. From my earliest dealings with him in 1992 I observed his humble yet determined approach to leadership through which he was in continual dialogue with his people. This was not a façade that he used to direct or communicate to the community, but a truly participatory and collaborative dialogue with the community. The process of leading any community health project involves collaboratively identifying needs and using frameworks, both theoretical and practical, that are in and of the community:
If they [leaders] are truly committed to liberation, their action and reflection cannot proceed without the action and reflection of others...It is absolutely essential that the oppressed participate in the revolutionary processes with an increasingly critical awareness of their role as Subjects of the transformation (Freire 1996:107–108).

Throughout this thesis I have highlighted examples of this in both the establishment and operation of Kafurumu clinic, and the planning and then re-envisaging and construction of the bush ward. Esau showed determined leadership both in the ASC and the broader community in establishing the bush ward through a complex and unstable period. This stemmed from his own conviction, reflection and knowledge that he had already led a process that had transformed history by establishing and operating Kafurumu clinic over the previous two decades. This enabled him to work with his community and transform the bush ward project from what was initially a large project requiring extensive external technical and funding support to being a grassroots peoples’ project. The grassroots could now directly participate in transforming the oppressive situation they faced. Freire could be directly describing Esau in the following passage:

The revolutionary leaders must realise that their own conviction of the necessity for struggle (an indispensable dimension of revolutionary wisdom) was not given to them by anyone else—if it is authentic. This conviction cannot be packaged and sold; it is reached, rather, by means of a totality of reflection and action. Only the leaders’ own involvement in reality, within a historical situation, led them to criticise this situation and to wish to change it (1996:49).

I included Esau’s personal history in Chapter 3 to demonstrate this aspect of his character. It was only because of who Esau is, where he belongs and his personal response to the historical situation that allowed him to reflect on the reality and, through a critical consciousness, strive to change it. Through this process Esau has become an example of the internal capacity to transform the conditions which cause oppression—an essential requirement for leadership: “The oppressed must be their own example in the struggle for their redemption” (Freire 1996:36).

This extended to Esau’s ability to present his peoples’ story of struggle to a global audience. Again, the Kwaio people made a collective decision to allow Esau to engage in this way. Prior to leaving the Kwaio mountains he gained authority through
numerous community meetings to speak about Kwaio. Sharing his participative processes with a global audience empowered him as a leader to believe more strongly in the community-based participatory processes, and see it as part of a global movement. Despite comments from some Atoifi staff that such an uneducated man before such an audience would make a fool of himself and his community, the trust his people granted him was repaid. A strength of Esau’s presence in Australia and New Zealand was that he constantly reminded his audiences that he spoke not as an individual but with the authority given him by his people. Esau’s travel represented a clear shift in the power dynamics in health care in Kwaio. This was the first time a person from the Kwaio bush had spoken at a global health conference to personally explain the Kwaio struggle. Previously I, as an outsider with an understanding of the inside, had been an advocate on behalf of the bush people on the need for culturally appropriate health care. The dynamics changed, however, when Esau, as community leader, began to directly engage with a broader global audience. This allowed a further shift towards more Kwaio control in the change process and empowered Esau to strive further in his participative process to bring about better services at Kafurumu and the bush ward. This is not only an example of the collaborative nature of PAR and how the knowledge and action created in the ‘swamp’ of everyday reality is of interest to a broader audience, but that the differentiation between ‘researcher’ and ‘researched’, ultimately means little in PAR. Esau engaging with a global audience is a further indicator of the concept of co-agents for change in PAR that goes beyond the ‘researcher’. This strengthens the perspective that PAR is done by people who see themselves as agents for personal and social action—who challenge the status quo and realise that a better future is possible.

I also learned from the leadership of Nashley Vozoto, DON at Atoifi in 2005. His ability to work within the institutional constraints of Atoifi but at the same time be in solidarity with the bush people made him, also, a revolutionary leader. Being from another province (Choiseul) meant that he needed to be purposeful in his leadership

94 Subsequent to the bush ward being completed Esau has spoken at the University of New South Wales, James Cook University and presented at an International Mental Health and Wellbeing conference in Cairns in September 2006. He has been invited to present keynote addresses on community action for health at the International Union for Health Promotion and Education World Conference in Vancouver, Canada in June 2007 and on social movements for health and wellbeing at the Australian Research Council Asia Pacific Research Network conference in Melbourne in July 2007.
and inclusive of all local groups. His articulation of the need to utilise both Melanesian and Western approaches to both process and outcome demonstrated his trust in both the Kwaio people and Atoifi to collectively address the need for culturally appropriate health care. Had he been non-cooperative, it would have been much more difficult for the bush ward to progress. His trust that Esau had the capacity to resolve the land dispute delaying the ward demonstrated his recognition that Kwaio processes could achieve mutually beneficial outcomes. As Freire (1996:48) states: “It is necessary to trust in the oppressed and their ability to reason. Whoever lacks this trust will fail to initiate (or will abandon) dialogue, reflection, and communication, and will fall into using slogans, communiqués, monologues, and instructions”. One of Nashley’s ongoing challenges will be continuing participatory approaches to create appropriate and inclusive policies and practices for the bush ward.

**Conscientisation as Experienced in this Project**

The fundamental role of conscientisation as a foundation for PAR was an ongoing lesson for me throughout this research. Although I have only documented one case study of the conscientisation process in the thesis (Case Study 8, Chapter 5), this process occurred with different individuals and groups, including myself, throughout the PAR, albeit at different times and rates. It is a foundation for reflection and action, without which PAR is an impossibility. Although the oppressors reject conscientisation as anarchic and fear the risks of transformation, it is essential in action against the oppressive elements of a given situation. It leads to liberation and freedom (Freire 1996:17; Shor and Freire 1987:53–74). In the case study I have documented the process of conscientisation in one individual, but I continue to contemplate whether it possible to have a collective conscientisation? Is this already happening in the Kwaio bush? Alternatively, might people at Atoifi or in the bush feel threatened by conscientisation taking place?

They confuse freedom with the maintenance of the status quo; so that if conscientisation threatens to place that status quo in question, it thereby seems to constitute a threat to freedom itself. (Freire 1996:18)
Individuals have experienced conscientisation, and others are experiencing it in their own ways and at their own pace. I continue to ask myself—have there been enough people involved with the bush ward for it to be a symbol of the transformation of an oppressive situation? Will the status quo remain at Atoifi, with the bush ward remaining merely an aberration? Will it be perceived as a thorn in their side? Will the situation be as described in other locations:

The elites are anxious to maintain the status quo by allowing only superficial transformations designed to prevent any real change in their power of prescription. (Freire 1972:66)

A question for the future will be: Has the bush ward only been a superficial change or has it instigated significant change at Atoifi?

### 8.3 Love in Participatory Action Research

So far in this chapter I have established that PAR has the capacity to be emancipatory, flexible, reflective, able to deal with complexity, inclusive, participatory and rejects Othering by redefining relationships between researchers and the researched to be co-agents for change. I have outlined examples of each of these and how they fit within the PAR literature. However, as it stands this is merely a glorification of PAR and its application in working towards culturally appropriate health care in Kwaio. What I now turn to is what I have personally learned that may contribute to others who use PAR in the future. It is obvious in this thesis that the writing, philosophy and example of Paulo Freire has had a profound impact on the way I view, and act within, the world. I have directly applied his works to the situation at Atoifi to allow me, not only to understand through his theoretical constructs, but to be involved in practical forms of action to address injustice. The work of Paulo Freire stands as a philosophical foundation for PAR, something most PAR texts emphasise. One of Freire’s fundamental concepts which he embeds within the fabric of his participatory and emancipatory philosophy is that of love. Love cannot be separated from other aspects of an action researcher as an agent for personal and social change as it underpins and acts to bind together the other important foundations of PAR. Let me give an
example—an essential foundation of praxis for social change is dialogue, and a fundamental of dialogue is love. Freire explains the nexus between these concepts and their importance for PAR.

Because love is an act of courage, not fear, love is commitment to others. No matter where the oppressed are found, the act of love is commitment to the cause—their cause of liberation. And this commitment, because it is loving, is dialogical. As an act of bravery, love cannot be sentimental; as an act of freedom, it must not serve as a pretext for manipulation. It must generate other acts of freedom; otherwise it is not love. Only by abolishing the situation of oppression is it possible to restore the love which the situation made impossible. If I do not love the world—if I do not love life—if I do not love people—I cannot enter into dialogue (Freire 1996:70–71).

In this passage Freire not only lists the characteristics of love, but that dialogue, without which PAR cannot exist, in impossible without it. This aspect of dialogue and its inextricable intertwining within PAR had an intense effect on me. Although love is so central to Freire’s approach, this has not been explicitly carried into the overt vernacular of PAR. Both McNiff (2002) and Whitehead (2005) plainly state that love is a core value in their life and work, but in their 2006 book “All You Need to Know About Action Research”, love does not appear in the index, nor in the section on values in action research. Despite an extensive discussion of respect, love was not mentioned. I believe, and it is clear Freire also did from his quote above that love underpins respect, and it is my conclusion that this should be overtly stated and not just an implicit unstated assumption. Reason and Bradbury’s 2001 “Handbook of Action Research: Participative Inquiry and Practice” discusses love in only three of its 47 chapters. Love is mentioned in two of the 34 chapters in the 2006 abridged edition. I assumed love would be a concept which would resonate with action researchers in health, but the recent texts of Stringer and Genat (2004) and Koch and Kralik (2006) (who explicitly have health care in the title of their book—is there not a link between care and love?), do not list love in their indexes. It is because of the profound effect Freire has had on me, the ontological base which informs my practice and the paucity of discussion of the concept of love in PAR, particularly health, that I highlight and reflect on the concept here.

I attempted to establish my PAR practice so the manifestations of love could emerge. At its most basic, my PAR practice was to show love towards others with PAR used to liberate an oppressive situation. This went beyond respecting people and their
opinions to honouring them and sharing a commitment to personal and social action. This type of love, as Freire commented above, is an act of courage, is dialogical and must be an act of freedom. It cannot be sentimental or manipulative. It is through such love that relationships were founded, and through which Atoifi staff and the Kwaio people were honoured. This allowed us to exist as fellow agents of personal and social change. While this may be seen as taking the moral high ground, it does, in fact, present a paradox for PAR. Acting in such a way served to potentially threaten the PAR, but at the same time was essential for it to function. That is, this love must be an act of freedom, and generate other acts of freedom. This means it cannot be controlling and must allow other co-agents (individual or collective) in PAR to explore and enact their choices in their journey in personal and social action. This acknowledges that personal pain may be the result of a co-agent’s choices that do not reflect my own. This acknowledges a deeper level of engagement and consequent pain than merely through a respect of one’s co-agents in PAR. It goes to the level of relational knowledge and action. Park (2006:87) claims relational knowledge based on love is the real basis for solidarity and community and forms one of the cornerstones of human rationality. This allows for deeply knowing ourselves and knowing others *in action together* to transform oppressive situations. The personal pain and confusion that I felt when the leader of the Italian group was attacked (Case Study 7, Chapter 5) and when I learned of the murder in 2003, are clear examples of the personal pain and difficulties of the love required for commitment and solidarity to the Kwaio people (this is not to perpetuate collective liability for an individual’s act—merely reflect the personal pain and confusion I felt). Love needed to be an act of courage to return to Atoifi and remain committed to action to address the oppression there. Facing oppression at Atoifi in solidarity with the Kwaio people who daily experienced their culture and religion being purposefully rejected and desecrated also caused pain for me. This was exacerbated when documenting the rejection and desecration and Atoifi staff resisting initiatives that challenged this. To continue in solidarity with Atoifi staff and the Kwaio community was essential to continue dialogue, but it was also dangerous and it certainly required courage. In maintaining love through the difficult times at Atoifi lay the paradox of the danger, yet essential nature, of love in PAR. Staying in solidarity with both Atoifi staff and the Kwaio people through love confirmed PAR was being used as an anti-colonial methodology. For me to be in
solidarity only occurred when I stopped categorising people as the Other or ‘abstract categories’ and started to treat them as fellow human beings who live in an unjust social order and with whom I could risk an act of love.

True solidarity is found only in plenitude of this act of love, in its existentiality, in its praxis. To affirm that men and women are persons and as persons should be free, and yet do nothing tangible to make this affirmation a reality, is a farce (Freire 1996:32).

Maintaining love, and through this dialogue and praxis, PAR held the potential to not only help to liberate the Kwaio bush people but also those at Atoifi. This was evident when staff entered into dialogue with Kwaio chiefs through the Atoifi Support Committee, resulting in the process of conscientisation (see Case Study 8, Chapter 5). One of the difficulties, however, is the Christian rhetoric of Atoifi being a ‘light on the hill’ and correspondingly all other places being in darkness. This dichotomy negates the possibility of love in and of the Other. Freire called this sectarianism and stated: “Sectarianism mythicises and thereby alienates…Sectarianism in any quarter is an obstacle to the emancipation of mankind.” He continued that sectarians close themselves into a “Circle of certainty from which they cannot escape” (1996:19, 20). Sectarianism and other forms of fundamentalist practice may lead to what the philosopher Karl Popper (1966) called a ‘closed society’ where energies are devoted to maintaining established regimes and the status quo. Because PAR is about improving personal and social situations—it is about the creation of more open societies. This poses a problem for fundamentalists who do not believe their practice needs improving. Many Kwaio Christians have privately acknowledged that in many circumstances bush people show more love than Christians. Collective rhetoric however determines practice which means that love is defined as coming from ‘the light,’ and this is by definition Atoifi (through the SDA church). As such, dialogue has been historically undermined and no praxis could be initiated from Atoifi. This serves to confirm Freire’s assertion that the oppressed cannot be liberated by the oppressor, but need to work from within. The PAR process using Freire’s concept of love in action to abolish situations of oppression, gave a forum to advance. This process, initiated by the bush people’s knowledge that there was a better way to deliver health services, provided a mechanism through which they and Atoifi staff could begin dialogue. The dialogue explored the oppressive situation and began the personal and social action that was needed to address it.
Freire (1996:26–32) warned of the threat of the oppressed themselves oppressing as they strive for liberation as the “very structure of their thought has been conditioned by the contradictions of the concrete, existential situation by which they were shaped” (1996:27). A part of that conditioning is the situation where “to be is to be like the oppressor” (1996:30). Keesing (1989b:25) reminds, “the dominated reproduce the conceptual and institutional structures of their domination, even in struggling against it”. This poses the question: is the bush ward really an anti-colonial and counter hegemonic statement when the structures and systems of the dominant health provider continue to be used? Is the bush ward going to be so radically different from anything previous at Atoifi that it will be a seminal event in and physical symbol of Kwaio anti-colonial struggle. Do they have no alternative but to use the institutional structures of their dominators, given that these are the only means of consistently delivering health services to Kwaio?

When I first went to Atoifi in 1992 I learned the ‘abstract categories’ into which I myself placed the bush people. But when I engaged with bush people, became their friends, started to understand their lives and dared an act of love to join their struggle for culturally appropriate health care, these ‘abstract categories’ became nonsensical. The sectarian construction of them also became nonsensical. I was able to love them for who they were, not who I (or others) wanted them to be. I came to understand how the situation at Atoifi was perceived by the bush people as one of colonial and Christian oppression that led to the rejection of health services. I also needed to understand that many people at Atoifi perceived themselves as liberating the ‘primitive’ bush people from their darkness. PAR has allowed me to go beyond understanding the delivery of health services at Atoifi through the health paradigm alone. It has allowed me to understand and incorporate greater levels of complexity at Atoifi into my research methodology. It also allowed me to utilise Freire’s concept of love in action to face oppression. This enabled me to better work with people at Atoifi and the Kwaio community towards achieving culturally appropriate health services.

I do however continue to ask myself: Is the bush ward a denunciation of the dehumanising status quo at Atoifi? Has it transformed the situation and as such the
human experiences of the bush people in accessing health care? Will it remain something to be resisted by Atoifi policy and practice? Has there been sufficient participation of staff at Atoifi to initiate a collective conscientisation process? Will the realisation that an alternative is possible improve health services for the bush people? Once the bush ward is operational, is the fact that staff will be faced with an alternative to the status quo be enough to change policy and practice, and will “bush people” no longer be an ‘abstract category’ but fully humanised? Will this cause a collective process of reflection on which to act? Freire (1972:78) states, “Critical consciousness is brought about not through an intellectual effort alone, but through praxis—through the authentic union of action and reflection”. But will the action required to deliver services at the bush ward cause an authentic reflection that will lead to praxis? Will the participation that is required in order to staff, manage and review policy and procedures at the bush ward lead to a deeper understanding of the contradictions present, and lead to conscientisation? Will multiple people having a critical consciousness lead to a collective conscientisation at Atoifi and result in transformation? Or, are the paradigms of colonisation and Christianisation so dominant that they will remain the status quo, despite the anti-colonial methodology used in PAR which resulted in the bush ward as a physical symbol of social action?

The problems and conflicts throughout Atoifi’s history have been outlined in this thesis. They have been analysed from a variety of perspectives including social, cultural, historical, political, economic, methodological and religious. I do however believe that Atoifi can be justly proud of having saved thousands of Solomon Islanders’ lives and improving the quality of innumerable others over the past four decades. But yet, it is undeniable that the long-term hospital policies examined in this thesis have cost many more lives that could have been saved with access to basic medical treatment. The failure of the hospital to engage the Kwaio community, and particularly to treat all Kwaio people and their culture with basic respect, has prevented thousands of ailing people—men, women, children, infants—from accessing the service of a modern hospital sited on their own land. The cost has been not only in uncounted lives, but also in the many who have lived, and still live, with chronic and debilitating diseases that could be easily cured or mitigated at Atoifi. These people have felt it impossible to go to Atoifi because of the outright rejection and desecration, sometimes intentionally and callously, of local culture and beliefs,
and sometimes for fear of personal degradation by hospital staff. Viewed in this way, the issue is one not of culture, politics or religion alone but of basic human rights, and a denial thereof in the name of ‘uplifting’ or ‘advancing’ those who do not practice or profess Christianity. The obvious contradiction in terms here will distress many Christians who believe Christianity’s most fundamental message is that one should show love and compassion. This contradiction has been personally expressed to me by many Kwaio who follow ancestral religion. Many present Atoifi staff have, however, come to recognise the pertinent issues for the Kwaio community, as have some former staff (if sometimes only in painful hindsight). This recognition is a key reason why there is now action towards transforming the hospital's policies and practices to address the community’s basic human rights. The bush ward project is one small but important step in this process.
Epilogue. This is Not the End, Just the First Few Steps…

On Monday, 5 June 2006 several hundred people gathered on the ridge overlooking the newly completed bush ward to witness its official opening. Invitations had been sent to hospital, church, government and community representatives to participate in the opening ceremony. It had just started when two RAMSI helicopters landed at the nearby airstrip carrying a group of Fijian soldiers. RAMSI police based at Atoifi collected the soldiers and drove them through the crowd, and they set up camp 80 metres from the bush ward. A makeshift podium had been constructed on which numerous people stood to speak. Community leaders, including Maenaa’adi, Laete’esafi and Esau all spoke of the history and need for the bush ward. The Malaita Provincial Director of Health sent a message read by Ben Tito, East Malaita Coordinator for the Malaita Province Health Department. Newly elected Member of Parliament Stanley Sofu, sent a message and provided food for people who had descended from the mountains to attend. Atoifi provided rice for those assembled. Atoifi administration was represented by Nelson Oleka, a Kwaio staff member and member of the Atoifi Support Committee. Both SDA and SSEC pastors from surrounding villages delivered prayers. There were no messages delivered from leaders of Malaita Mission, Trans Pacific Union Mission or South Pacific Division of the SDA Church. The new CEO was not on campus and Atoifi’s chaplain did not take part. The occasion was marked by Christian music performed by local youth groups and traditional Kwaio music by bush people.

The celebrations also marked the opening of the *bisi*. Bethala Amos, Coordinator of Reproductive Health at Atoifi, delivered a speech that outlined the importance of the *bisi* to women’s health. This was followed by Rukua who spoke on behalf of bush women and urged the significance of the *bisi* for her fellow mountain women. During the ceremony a further RAMSI helicopter landed to deliver an Australian Primary Health Care advisor to Malaita Province. She was aware of the bush ward and *bisi* projects and how they had been planned, funded and built and had come to experience the opening ceremony. Afterwards she explained to assembled leaders that the bush ward and *bisi* opening was a significant event. She had worked for government and
non-government agencies around the world and had heard numerous groups espouse the virtues of bottom-up, community based, culturally appropriate health care but this was the first example she was aware of in which a community had gone beyond rhetoric and had realised their dream. This encouraged the Kwaio leadership and allowed them to see their struggle as significant on a global as well as local level. Further evidence of the global significance of the bush ward and bisi arrived on the opening day in the form of an invitation from the organising committee of the IUHPE 19th World Conference on Health Promotion and Education, asking Esau to deliver a keynote address in Vancouver, Canada in June 2007.\footnote{The global significance of Kwaio culture through music, dance and art was also acknowledged in June 2006. David Akin and I had been requested to assist a group of Kwaio performers travel to an international arts festival to showcase Kwaio performance. This idea gained momentum in 2004 and in 2005 an application to perform at ‘The Dreaming’ Indigenous Festival (www.thedreamingfestival.com) in Woodford, Queensland, Australia was successful. Twenty-two Kwaio performers aged 17 to 77 performed there as the ‘Kwaio Sango Dancers’. The group gathered for the bush ward opening, and that night left for Honiara and on to Australia, travelling from 8–20 June. While in Australia the group performed at the Dreaming Festival and the Out of the Box Festival in Brisbane. They also danced in Mackay, where they were hosted by the Australian South Sea Island community, many of who had Malaitan heritage. Links were made with local descendants of Kiseola (the Kissier family) who had been recruited from Kwaio during the labour trade.}

Despite international recognition, local events had put the opening of the bush ward in doubt. A pig had been stolen from a nearby village in the preceding weeks. The owner blamed bush people for the theft and demanded compensation from bush chiefs involved in planning the bush ward. These chiefs were confident the thief was not from their kin groups and refused to pay. In response the pig’s owner threatened to burn down the bush ward if it were opened on 5 June. The threat was not unrealistic given the recent looting and burning of scores of buildings in Chinatown, Honiara after the announcement of Snyder Rini as new Prime Minister. The chiefs pondered the situation and decided to proceed with the opening. They discussed the situation with the aggrieved pig owner, and stated that the ward was a community project that belonged to no one individual, family, kin group or organisation. If the bush ward were burned down it would not be the hospital staff or administration, nor the police that would be affected or resolve the situation, but the broader Kwaio bush community. Those making the threats knew the bush ward was planned, supported, funded and built by the community, for the community, and if it was destroyed they would be responsible to the community. The threats were therefore withdrawn and the
opening proceeded. I was concerned about the threats but was satisfied that the way the situation was resolved indicated the project’s community ownership and sustainability. A further indicator of the community ownership and sustainability of the bush ward was its use prior to the official opening. A longtime friend and member of the Atoifi Support Committee had become severely ill and was admitted to the ward for three weeks during the preceding month. As a senior leader in the Kwaio bush his actions in being the first person to use the bush ward opened the way for others to follow, and signalled to the hospital staff and administration and broader Kwaio community the facility’s utility.

Protocol dictates I write a conclusion to this thesis, but this is not the end. After forty years of exclusion the Kwaio mountain community have their own ward at Atoifi, something they have wished for throughout this period. After my 14 years of involvement with the Kwaio bush people and Atoifi staff, steps have been taken towards culturally appropriate health care. However, although the physical structure exists, ongoing issues remain. Will the ward operate in such a way as to fulfil the needs of the bush community? Will policy and practice at Atoifi prove able to adapt to the new environment of having a constant reminder that there is not a single way to deliver health services? Will the anti-colonial statement that is the bush ward be tolerated by future hospital and/or church administrations? Can the momentum of the bush ward translate into expanded services at Kafurumu and culturally appropriate services in the mountains? Has this process challenged the sectarianism which refuses to enable love in and of the Other?

The research question posed was: ‘Can the Participatory Action Research process result in culturally appropriate health services for Kwaio bush people?’ To answer this question has fundamentally changed me and the way I view the world. However, it has confirmed my need to work with and for people and my need to continually be reflective and centralise the value of love in my public health research and practice. It has also confirmed that trust in people, through love can produce results deemed impossible by many. The PAR process has undoubtedly resulted in the bush ward becoming a reality. Whether this will form the foundation for an expansion of
culturally appropriate health services in Kwaio and beyond can only be answered in the future.

This thesis has been a unique synthesis of PAR methods used as an anti-colonial methodology for personal and social change in a complex and dynamic context in which PAR had never been used before. PAR without question facilitated the creation of the bush ward and stimulated an ongoing debate on culturally appropriate health care in Kwaio. This is not the end, merely the first few steps of a long journey...

*From these pages I hope at least the following will endure: my trust in the people, and my faith in men and women, and in the creation of a world in which it is easier to love* (Freire 1996:22).
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Image Appendix

Image 2: Atoifi Adventist Hospital. Sept. 2002

Image 3: Atoifi Adventist Hospital Campus. Sept. 2002
Image 4: Kafurumu Clinic and Lafea. Feb. 2004 (photo David Akin)

Image 5: Kafurumu Clinic Settlement. June 2005