DIMENSIONS OF DIFFUSION:
DELIVERING PRIMARY HEALTH CARE AND NUTRITIONAL INFORMATION
IN WESTERN SAMOA

By

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Doctor of Philosophy
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DECLARATION

Except where otherwise indicated
this thesis is my own work.

Pamela Thomas
December 1986
This thesis examines the delivery of primary health care and nutritional information through a system of community-based women's groups, established in the small Pacific Island state of Western Samoa in 1923, to improve infant and maternal health. The study provides a geographical perspective of innovation diffusion and information flow in a small developing nation undergoing rapid but uneven social, political and economic change. It considers the long-term interaction between location, social, political and economic structures, and individual human activities, and their cumulative impact on the delivery of primary health care and nutritional information. In particular it considers the ways in which gender and the characteristics of the information to be disseminated influence the diffusion of both primary health care and nutritional information. The study is of particular relevance to the current primary health care policy of the World Health Organisation.
ACKNOWLEDGEMENTS

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CHAPTER 1

INTRODUCTION

The promotion and protection of the health of the people is essential to sustained economic and social development and contributes to a better quality of life ... (World Health Organisation Declaration of Alma Ata 1978:2).

This is an empirical study concerned with the delivery of health-related information through village women’s groups established to improve the health of the people. The study concentrates on the maintenance of these health groups over time and space and on the ways in which health information flows through them. As adequate nutrition is fundamental to improved health it focuses on the delivery of nutritional information. The study has particular relevance to the World Health Organisation’s current primary health care policy; to recent development theories; to theories of information flow and innovation diffusion and to theories of social change.

The World Health Organisation reaffirmed in its Alma Ata Declaration in 1978, the basic human right to good health and nutrition. In keeping with recent development strategies which focus on basic human needs and the “another development” school the declaration outlines a policy of primary health care based on equality of access through community participation, community decision-making and self-reliance. It emphasizes the need for health education and the promotion of “proper

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nutrition and recommends that women and women’s groups should play an important role in these areas (WHO 1978:16-24).

Neither the Alma Ata policy nor recent development theories provide adequate guidelines on how the policy should be implemented or how health information moves to and through the community, let alone through women’s groups. The long-term impact of such intervention is unknown as most information on the community approach to Third World development is derived from projects implemented since the early 1960s and therefore provides little longitudinal data on which to base models, particularly as most of the studies are of projects that have failed. The strategy of achieving equality in the provision of social services through community participation has been largely unsuccessful in the developed world and has usually benefitted the middle classes without having any impact on low income families (Le Grand 1982:272). There is therefore an urgent need for studies of Third World community-based primary health care projects that can provide an analysis of both the long-term social and health-related impacts of such projects and precisely how information is delivered through them to the community.

This thesis presents a case-study of a women’s village-based primary health care system which has now been in operation for over 60 years and has at some stage incorporated all the criteria laid down by the Alma Ata Declaration.

The Western Samoan women’s health committees, komiti tumana.


4See Cole, Exman, Taylor and Berman 1980:76.


(literally cleanliness committees), were established by the New Zealand administration\(^7\) in 1923 in an attempt to improve nutrition, sanitation and hygiene. The committees were based firmly on the ideology of equality of access and community participation. These committees became so successfully integrated into Samoan village life that they are now regarded by Samoans as a traditional organisation. Three generations of Samoan women have been involved in self-motivated and innovative community health care. Village women built, maintained and staffed village health centres and provided first aid and nursing care for those who were ill. In many villages women’s initiatives resulted in improved sanitation, hygiene, housing and water supply. Each committee was visited each month by a formally trained Samoan nurse who monitored infant and maternal health and gave information on nutrition, hygiene and sanitation to individual women. It was customary for all women to attend these meetings. Every month the committee inspected village households to ensure they met the standard set for sanitation.

The committees are regarded by WHO, FAO and UNICEF personnel in the Pacific and by the Samoan and New Zealand governments as an example of successful intervention - the aim of all development planning. However in 1980, when I first undertook research in Samoa, the committees were stratified, authoritarian organisations that conformed closely to the dominant male political structure. Attendance was declining, villages were only superficially clean, the standards set for sanitation and hygiene were slipping (Schoeffel 1984:1-2) and the nutritional status of both adults and children had deteriorated (Western Samoa Department of Health 1980:7-8).\(^8\) An increasing number of adults suffered from obesity and its related

\(^7\)In 1920 Western Samoa became a League of Nations Mandated Territory under New Zealand administration.

\(^8\)See Jansen 1969; King 1975; Jansen 1977; Quested 1978; Brazil 1979 and Weerasinghe 1980 for nutritional studies of children under five years of age. A large-scale study of Samoan obesity has been conducted by Baker 1981. Also see Zimet 1981.
Figure 1-1: Western Samoan Transport Networks and Selected Villages, 1983
problems and an increasing number of children were under-nourished (Department of Economic Development 1980:169). A small survey I conducted in 1981 confirmed that "many women are ignorant about the nutritional needs of their children” (Jansen 1977:306) and that "lack of knowledge of the relationship between food and health and ... the importance of good nutrition are common” (Department of Health 1980:10).

The overall situation was unexpected in a small, literate society\(^9\) in which almost every village has a health committee which all women are expected to attend and which has been visited each month for over 60 years by a trained nurse whose major role has been to monitor infant and maternal health and provide relevant information on nutrition, hygiene and sanitation. The situation raises questions about the long-term effectiveness of community-based women’s groups as channels for primary health care and health-related information, as well as questions about the processes that influence attendance and the delivery of information through these groups.\(^{10}\)

**Aims and Objectives**

The major aims of this thesis are:

1. To establish the nature and pattern of the delivery of nutritional information through the Western Samoan women’s committees over time and space.

2. To explain these patterns and the processes which led to them, including the processes which underlay the establishment of the committees and their persistence over time.

3. To provide longitudinal data on the delivery of health information through women’s groups.

If the processes which were responsible for the establishment.

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\(^9\) Samoa has 98 per cent literacy and an equal proportion of boys and girls attend secondary school (Department of Statistics 1983:37). The positive relationship between education and improved health has been well documented in Malaysia, India and Africa.

\(^{10}\) Schoeffel (1984) provides an excellent overview of the decline in committee attendance. She attributes this to modernization, professionalization of the health service and lack of political support. Hammer (1982) points to modernization and to the ritualisation of health activities as major factors in changing attendance patterns.
persistence and change of the committees and the delivery of nutritional information through them can be explained. The integration of a model of information flow with one of social change may be possible. This will contribute to a better understanding of the delivery of primary health care and developmental information through community groups in Third World countries undergoing rapid transformation. The small scale of Samoan society and its unusual homogeneity allow an approach which is both broader and deeper than usual and provide a situation where, if locational differentiation is found, such differentiation is likely to be more marked in larger, heterogeneous nations and to have more serious implications for social and economic development.

The Theoretical Framework

I approach the study from a geographic perspective and attempt to bring together within a framework of social change, theories of time-space geography, structuration, innovation diffusion and information flow.

Theories of Innovation Diffusion and Information Flow

This study falls within the sphere of innovation diffusion and information flow, both long-standing concerns of geographers (Hagerstrand 1952, 1965, 1974; Brown 1968, 1981; Blaikie 1976, 1978). However the existing diffusion literature from geography and other disciplines is theoretically disparate. Some theories support "top-down" approaches to development, others the "core-periphery" models and others the "item-communication-adoption" paradigm (Blaikie 1978:79). Following Rogers (1969) a considerable amount of literature has concentrated on the characteristics of those adopting innovations or those who most successfully pass information to others, with little concern for structural or infrastructural constraints. There remains the assumption that innovations

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11 Some of the earliest literature is that of Ryan and Gross (1942, 1950) based on the diffusion of hybrid corn seed in mid-west America. The agricultural bias in diffusion studies has persisted.
are "good" and that once people are given sufficient information it is only a matter of time before they will act upon it. Little consideration has been given to the flow of information to and through community groups, particularly in the Third World. Beal (1969) addressed this briefly but it was not taken up again in depth until Rogers and Kincaid (1981) analysed the flow of family planning information through women's clubs in Korea.

Although innovation diffusion and information flow are ultimately concerned with planned social and structural change, rapid, uneven change is seldom allowed for in information flow models and theorists have not addressed the question of interaction between information or innovation, day-to-day human activities, and the changing social structures within which activities take place. Nor have they considered the impact of historical factors or the influence of social context in influencing human interaction. From the now considerable literature on diffusion and information flow (extensively reviewed by Brown 1968 and 1981, Blaikie 1977, Blaikie 1978, Rogers 1983, Gore 1984), the following findings are of particular relevance to this study.

Little of the diffusion literature considers diffusion through women's networks. The exceptions are Blaikie (1976), who points to the differences in family planning information flow to men and women; Colle (1976), who discusses health information for Indian village women; Colle and Colle (1977), who analyse Indian women's information networks, and Rogers and Kincaid (1981), who study the flow of family planning information to groups of women. None of these studies is longitudinal. Most Third World diffusion studies have been concerned with agricultural innovations, and as agriculture in the Third World has almost without exception, and often erroneously, been considered by development planners and researchers to be men's work, women's information networks have been largely ignored, as has the possibility that women's uses of space and time, and information

12) I have addressed this briefly in Thomas 1983.
networks, differ from those of men. Diffusion researchers have seldom been concerned with the inter-relationship between human activity and structure or infrastructure, and their impact on diffusion, or with the unintended consequences of either the innovation or the systems established to channel the innovation. Rather than having a positive effect on individual welfare, the diffusion of developmental information and innovations have "tended to increase regional inequalities, widen the disparities between social and economic classes and increase elitist entrenchment" (Brown 1981:10).

Recent reappraisals of innovation diffusion now seek to explain these inequalities through a locational, structural approach (Johnston 1983; Walmsley and Lewis 1984; Gore 1984). A number of writers point to the influence that structure has on diffusion, rather than the influence that diffusion has on structure (Frank 1969; Blaut 1977; Blaikie 1978; Gould 1980; Brown 1981). This thesis develops the perspective of diffusion as a dynamic interacting relationship between the innovation or information and the social, political and economic structures.

It is now apparent that for all the diffusion publications, 3,085 up to 1983, (Rogers 1983:xv), diffusion theories when applied to the realities of Third World societies are of little practical value in bringing about the improvements in people's lives that are called for in most development plans. Innovation, when it does occur, tends not to follow the form predicted by diffusion models (Blaut 1977:345). More emphasis must be given to the suggestion of Stohr and Taylor (1981:454) that each strategy for innovation and development is unique to the society in which it evolves.

13 Mazey and Lee (1983:19-23) provide examples of how women's use of space influences diffusion of women's rights in America. Lord, Monk and Rengert (1982:2) explain that women's use of space has been ignored because when geographers study landscape (and diffusion of innovations) 'they focus on the outdoors'. The Women and Geography Study Group of the IRG (1984:107) also point to the lack of consideration development theorists have given women in the development process.

14 Pred (1978) has attempted this within a time-geography framework.

15 For examples from the Pacific see Crouch and Chamala 1982; Thomas 1983.
Information flow and innovation diffusion cannot be seen in isolation from the temporally and locationally specific social, economic and political context within which individuals live and interact (Brown 1981:239). Nor can they be seen in isolation from the complexities of how individuals acquire knowledge and what makes information meaningful to them (Gore 1984:195).16

Finally, both the specific characteristics of the information or innovation being diffused and administrative infrastructures influence diffusion. Blaikie (1976) has shown that the characteristics of family planning information in India influenced its communication channels at both administrative and local levels and that different information moved along different channels within the same community. Allen (1976), Blaikie (1976), Leonard (1977) and McKillop (1981) have all shown how physical and administrative infrastructures influence information flow and the diffusion of innovations.

Diffusion theory is unlikely to progress further unless it can integrate the dynamic interaction between human activities and social structure with specific innovations within time and space. My approach to information flow therefore is based on the premise that innovation diffusion and information flow are dynamic processes influenced by the characteristics of the information or innovation itself as well as by human activity, human interaction and the social structures within which human activity takes place. In turn innovation diffusion and information flow, and the channels established for the purpose of disseminating this information or innovation, which may themselves be an innovation, bring about changes in human activity, in people's use of time, in the way they interact and in social structure. Serious consideration must be given to McLuhan's (1964:24) paradigm that the medium is the message and that "the message of any

16 Also see Gould 1975 for an explanation of the importance of individual's mental maps and frameworks of knowledge in influencing innovation diffusion.
medium ... is the change of scale or pace or pattern that it introduced into human affairs ... the content or uses of such media are as diverse as they are ineffectual in shaping the form of human association". A framework for reflexive and dynamic interaction is found in time-space geography. Pred (1978), and Gaspar and Gould (1981) provide the necessary connection between innovation diffusion and time-space geography.

Time-space Geography

Time-space geography is based on the premise that people's day to day activities differ over time and space and between societies with different political, economic and social organisation. Some activities must be undertaken for survival and some are optional, and these differ with society (Thrift and Pred 1981). This alters human interaction patterns, as well as the ways in which change is articulated. I argue that it also alters the ways in which information flows and the ways in which innovations are adopted and adapted. Pred (1978:367) suggests that a reflexive interaction operates between innovations, individual activity and society, and lists a set of dynamics which he maintains are involved in the spread and impact of innovations. While Pred and the time-space geographers appear to be stating the obvious, these dynamics of daily life have been largely ignored by diffusion theorists although they are crucial elements influencing information flow. Pred states that everything that affects an individual affects society and vice versa: anything that affects a person's daily activities affects life as a whole, and vice versa: and daily activities lead to an accumulation of experiences that shape intentions and influence movements and human communication. He shows how the introduction of new technologies and new institutions, like the women's committees, alter daily activities and experience. Gaspar and Gould (1981) show how social structure and physical infrastructure influence personal interaction which in turn influences the dissemination of agricultural information.
Therefore even in a small, homogeneous society such as Western Samoa, locational differences in the use of time and space, such as those that come with the move from subsistence agriculture to greater reliance on wage labour, or those that follow the establishment of a new social group like the women’s committees, or new activities like secondary schooling, should alter the way people interact with one another and influence the way in which information flows, even when information moves through channels established specifically for its equal dissemination.

Theories of Structure and Action

The time-space theme has been expanded by Thrift (1983) who, following Giddens (1979 and 1981), proposes a new paradigm for social change. It allows for locational and temporal specificity of structure, social action and human interaction; and reflexive links between individual activity and structure. This provides a useful framework for approaching the delivery of information through community groups as it provides a synthesis of theories of social action and social change within a geographic framework and is sufficiently fluid to allow the integration of aspects of information flow and innovation diffusion. Thrift brings together in what he terms the "structuration school", the models of several writers with similar perspectives on social action and lays the foundation for a nonfunctionalist theory of social action that retains strong elements of determinism, but allows for individual innovative activity.17 In Thrift’s paradigm, individuals are seen as active participants in society as opposed to "cultural dopes" or "mere bearers of a mode of production" (Giddens 1979:71).

Human interaction owes its form to structures, which allot individuals

17 The structure-action debate has been central to sociological thought for many years with a strong division drawn between those who maintain that social structure determines action and those who take a more phenomenological view and maintain that action is largely voluntary. See Merton 1936, Parsons 1949 and 1951, Parsons and Smelser 1956, Pareto 1966, Blau and Merton 1981, Boudon 1968. Cohen (1968:95-128) provides an excellent review of the structure-action debate.
their relative positions in the interaction. This allows for stratification, the use of power and authority, and for individuals to fulfill expected and culturally determined roles. Layder (1981) maintains that over time interaction structures evolve, which provide the accepted framework for human interaction. They are crucially concerned with power, an important factor in an analysis of the Samoan situation. However, structures are not seen as all-determining but as simultaneously constraining and enabling action and interaction (Giddens 1979:69). There is room for independent voluntary action but the degree of voluntarism that individual structuration theorists allow varies.


... social structure cannot exist independently of motivated (but not necessarily reasoned) activity, but neither is it simply the product of such activity...social structures...are both constituted by human practices, and yet at the same time they are the very medium of this constitution (Thrift 1983:29).

Although considered a structural functionalist, Mair’s 1971 work anticipates the structuration approach and adds a useful perspective. She maintains that within any structure there is always some choice of action. She calls this room for manoeuvre. It is the use of room for manoeuvre, often as a result of conflict, that helps bring about social change. Men, she states, have greater room for manoeuvre than women and young people more than old (Mair 1971:129-130) and innovative action is usually motivated by the desire for personal esteem. Friedmann (1979) suggests that innovative activity occurs only when it leads to social approval and financial success and that the power inherent in innovation must be legalised and institutionalised.¹⁸

These writers call for a theory that can directly link human activities

¹⁸Higgins (1986) and Aydialot (1984) also discuss these aspects of innovation diffusion from an economic perspective.
or practice, with social structure, and acknowledge that time-space intersections are essentially involved in all social existence (Giddens 1979:54). The structurationists propose various mediating structures through which action penetrates structure (Figure 1-2). All see human interaction being influenced at two levels - the objective and the subjective. Bourdieu, and Berger and Luckmann, consider interaction to be influenced largely by cognition, world view or systems of knowledge that are specific to time and place, but Giddens and Layder together with the much earlier human group theorists Lewin (1945) and Homans (1950) see social institutions or regular social activities providing sets of mediating structures that are influenced by more generalised structures, which are the values, rules and resources which guide the system.

Figure 1-2: Mediating Structures between Structure and Action suggested by Some Structurationists
(Source: Adapted from Thrift, 1983)

I have found Layder's (1981:97-98) division of structures into objective, substantive and interaction useful (Figure 1:2) as they provide a simple framework for analysing information flow within a community group. Objective structures are those which exist at a high level of generality, influencing action in a rather diffuse, though systematic way. They include

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19 Archer (1982:457-8) maintains that Giddens's approach to structuration is non-propositional in that it fails to specify when there will be more voluntarism and when more determinism.
language, class, the economy, polity and the sets of values of a specific geographic region. Substantive structures are contextual in that they are the institutions or concrete sites of interaction, within which action and interaction are influenced in a more direct way. Layder gives work, clubs, social groups and religious groups as examples of substantive structures and it is in this category that I place the women’s committees of Western Samoa. And most important, Layder concentrates on interaction structures which influence the ways in which interaction between people occurs. The processes of change in interaction structures are of crucial importance to understanding the delivery of nutritional information through community groups.

The interaction structure refers to a localized body of regulations which provide a framework for structuring human interaction within organisations, institutions or sites of regular communication. In the context of the Samoan women’s committees it refers to the regular and accepted conventions which determine the ways in which action and interaction takes place between the participants at a committee meeting. The interaction structure is predicated upon those interacting being aware of, and conforming to, these conventions, or at the very least, the existence of some agreement about the right way to behave in a given social situation. As a product of time, location, beliefs and action, an interaction structure is “more complex than the sum of its ‘parts’ (that is, individuals)” (Layder 1981:105) and cannot be reduced to practices alone, although these are what generated it. Bourdieu (1977:81) stresses that in any human interaction

... relations are never, except in appearance, individual-to-individual relationships ... the truth of the interaction is never entirely contained in the interaction.

As a product of past and present processes an interaction structure is

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20 Goffman (1959) provides explicit examples of the ways in which social context and the individual’s interpretation of it influence the role the individual assumes and the way in which interaction takes place.
situation-specific. Thrift (1983:37) argues that the interaction structure usually influences activities in ways that reproduce the interaction structure and hamper transformation of the social structure. The situation-specificity of interaction structures in embodied within Gidden’s concept of locales.

Giddens (1979) maintains that all action and interaction take place within clearly defined areas that are not necessarily locational but comprise a cluster of life-spaces within which individuals divide their time and interact. He calls these life-spaces locales. Each locale is made up of a number of different but connected settings for interaction and resembles some definitions of community (Weber in Neuwirth 1969; Wirth 1957; Plant 1974). Within these locales some sets of practices or institutions (which Giddens calls institutional locales) are dominant. Thrift (1983:40) interprets Giddens’s locales as providing

... the opportunity for action and the constraints upon action, that is, the base for what is known about the world and the material with which to do (or not to do) something about it. In any region the life paths of particular individuals can interact, simply because they are collateral ... in time and space. Whether they will interact, however, depends on the particular pattern of production...and that, in turn, results in (and stems from) a particular pattern of locales that punctuate the landscape. Each life-path is, effectively an allocation of time between these different locales. In any particular organisation of production, certain of these locales will be dominant: that is time must be allocated to them. They are economic (and state) imperatives ... These dominant locales provide the most direct link between the interaction structure of a region and objective social structure, because they are the main sites of class production and reproduction.

I have interpreted Bourdieu’s concept of habitus as the cognitive or epistemological reflection of Giddens’s locale and in this study I use the term locale to refer to the village in which individuals live and, when specified, to the extended family. Thrift outlines five effects of locales on people’s lives.21 Locales structure people’s lives by providing: the major nodes through which their lives must flow; the major arenas for interaction

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between individuals, and the major contexts within which knowledge and experience about the world is gathered and common awareness engendered. They are also the major sites of socialisation "within which collective modes of behaviour are negotiated and renegotiated and rules learned but also created" (Ricouer 1981 in Thrift 1983:40). They provide the day-to-day routines for most people, and since locales and the institutions within them are usually class differentiated they will structure people's lives in ways that are class specific. People will be expected to conform to behavioural norms, depending on their status.

All structurationists allow for habitual or reflexive action as well as reasoned action. As Bourdieu has shown, reasoned activity can quickly become routine or habitual. Action, whether reasoned or habitual, has unintended consequences which form the context for subsequent interaction and action. Bhaskar (1979:44) maintains that in their conscious activity people

... for the most part unconsciously reproduce (and occasionally transform) the structures governing their substantive activities of production. Thus people do not marry to reproduce the nuclear family or work to sustain the capitalist economy. Yet it is nevertheless the unintended consequence ... Moreover, when social forms change, the explanation will not normally lie in the desires of agents to change them that way.

Structuration and Theories of Community

The concept of community is central to the Alma Ata Conference approach to primary health care, as well as to any explanation of information flow through community groups. The locale, made up of a number of different but connected settings for interaction, can be closely equated with some definitions of community, as whatever else it may be, a community is a sphere of human interaction. Although Thrift includes a

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22 Also see Plant (1974:35).

23 The unintended consequences of purposive action are thoroughly discussed by Merton (1936).
discussion of community in his framework for social action he sees community as long-term cooperation and familiarity with situations and events, conforming to definitions of Gemeinschaft (Toennies 1887). Community is seen by Plant (1974) and Berreman (1978) to exist in small-scale, traditional societies where closely linked interaction networks both depend on familiarity and help reproduce it.

Being able to predict the behaviour of those with whom one must deal is one of the social advantages of community membership. This ability comes not only from long observation of particular persons but from the systematicity of communal relationships (Calhoun 1980:126-127 in Thrift 1983:47).

The concept of community has often been imbued with notions of democracy, consensus and stability and has been the subject of considerable sociological discussion related to the scale and division of labour. I have found the most useful definition of community to be Weber's, outlined in Neuwirth (1969:143-169). Although people who comprise a community have feelings of mutual solidarity, Weber maintained that social organisations or communities result from the need to control competition for scarce resources. To do this individuals or groups restrict membership, operating what Weber termed "community closure" to monopolize economic, political or social interests. Weber considered that successful monopolization of economic and/or political advantages would be accompanied by claims for corresponding social esteem. More importantly, and at odds with many perspectives on community, Weber did not envisage community members being engaged only in harmonious social interaction. He allowed for power struggles, conflict and

... the utilization of all sorts of coercion, and for the forceful subjugation of the weaker by the stronger ... communities are not necessarily socially or economically homogeneous, but may develop their own internal stratification system (Weber, translated by Neuwirth 1969:150).

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24 Toennies's division between Gemeinschaft and Gesellschaft; Redfield's (1947) division between folk and urban societies; and Durkheim's (1953) mechanical and organic solidarity.

25 I have been unable to find any trace of the original Weber work.
Of specific importance to the Samoan situation is Weber's statement that action and interaction that complied with social norms need not rest on voluntary consent, but could be enforced. Plant (1974:55) states that in communities with little division of labour, authority is often unitary and pervasive, "governing the whole way of life", while in larger communities, where interaction is not so intense and where the mode of production is more varied, authority is more dispersed. This concept is closely linked to the discussion of scale. I do not believe that information flow in Western Samoa, or in any other small, village-based society undergoing rapid change can be understood without some reference to the qualitative and quantitative differences in human interaction between small, local communities, where people know one another well and more open urban communities where interaction is more dispersed. Wirth (1957:54) supports this perspective. When individuals interact frequently in known relationships, where the life-path and the history of individuals are known, interaction is qualitatively different from interaction between individuals who meet seldom and are not well known to one another. Rogers and Kincaid (1981) and Blaikie (1976) show that the greater the homogeneity of individuals and the greater the degree of community the better information flows within the community. These same factors however make it more difficult for new information to enter that community (Rogers and Kincaid 1981:216).

Integrating Theories of Information Flow and Structuration

I have found no structurationist studies which incorporate the impact of deliberate, external intervention on structure and action. The innovation diffusion and information flow models do not allow for the reflexive interaction of structure, action and information through time and space. To adequately explain nutritional information flow through the

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26 Trouillot 1982 however provides a useful historical study of the Santa Domingue coffee industry over 200 years, using a systems approach to human action.
Western Samoan women's committees I have amalgamated these two schools of thought.

Thrift's paradigm for social action in time and space provides the basic framework from which I approach the delivery of nutritional information through the Samoan women's committees. Into this framework I introduce two elements from models of information flow - the characteristics of the information and the formal channel established for delivering the information or innovation. Finally, although factors external to the locale are of considerable importance in influencing activities within it, I deal with them briefly and concentrate on their localised impact.

Based on an amalgamation of these theories I put forward the following hypotheses:

1. The delivery of information through community groups is determined by a dynamic and reflexive process of interaction between the information, the system established for its dissemination and locationally specific political, economic and social structures.

2. Political, economic and social structures differ over time and space, therefore the delivery of information will be uneven and vary with location, within location and with time.

3. Planned intervention and human action have unintended consequences which continually influence subsequent structures and the delivery of information.

Research Design and Methods

There is no established procedure for empirical research based on the structuration approach to social action, let alone an approach that integrates information flow with structuration. As Archer (1982:457) has pointed out, structuration is "ever a process and never a product". It is therefore difficult to base an empirical study on an approach which allows no end product and no discontinuity. In any society however, specific and recognised events mark differences in the tempo of change. There are also marked discontinuities. To make analysis and explanation possible I have identified and investigated four different communities and four specific time-
frames. I have divided the thesis into two major parts: the first presents a broad view through time, the second, a micro-level investigation over space. Part one deals with historical processes and an analysis of the interaction between objective, substantive and interaction structures, human action and nutritional information over time. Part two is concerned with the outcome, in 1983, of these historical processes. It provides a spatial and structural analysis of the delivery of nutritional information in four communities.

Research Methods and Data Sources for Part One

For simplicity the historical section (1900-1982) is divided into four chronologically ordered parts, determined by historical events and recognisably different phases in the development of the committees.

The first establishes the pre-conditions for the introduction of the committees; the second their establishment and initial structure; the third, committee expansion during a time of social change and the fourth, committee transformation and locational differentiation during a time of rapid and uneven social change following Samoa’s political independence in 1962. In each time-phase I consider the on-going processes of change in the formal and substantive structures, and in women’s day-to-day activities, and how these influenced attendance, action and interaction in the women’s committees. My analysis of the first two time-phases is based on written records all of which were prepared by Europeans. I have drawn largely upon official archival material dealing with Samoan administration, health, social welfare and mission work, as well as a considerable body of anthropological literature. Although cross-referencing data provided some substantiation of events, this part of the thesis is coloured by my own interpretation of these records and by the values of the writers. For the period from 1940 on, personal interviews with older Samoans and the growing body of reports and records written by Samoans, provided a more

27 The names of those interviewed are in Appendix 1-1.
balanced perspective. Documentary material used for this part of the thesis includes records from the New Zealand National Archives, Wellington; the Western Samoa Legislative Assembly Library and the Nelson Library, Apia; Western Samoa Department of Health records (there are serious gaps in the Department of Health’s detailed records prior to 1970 as most of these were destroyed by fire); and records in the Fiji Archives, Suva. I have also drawn on Schoeffel’s work (1979, 1980, 1984) on Western Samoan women and the women’s committees.

Research Methods and Data Sources for Part Two

Throughout the second part of the thesis a variety of research methods were used, details of which are shown in the appendices of the chapters to which they pertain. Part two is concerned with the spatial determinants of information flow: the type and degree of structural and committee differentiation between villages in 1983, and the differences in the ways in which information flows through them. The Western Samoan Department of Statistics recognises four different types of villages: urban villages within about 14 kilometers of central Apia, peri-urban villages on the coast northwest of Apia, rural villages located in the “rest of Upolu”, and all villages in Savai’i (see Figure 1-1). From my own experience in Western Samoa I do not agree with this classification as rural Upolu and Savai’i villages seem qualitatively and quantitatively similar, and in Apia, small villages on customary land are quite dissimilar from settlements of the same size in new freehold suburbs. (For simplicity I refer to all settlements as villages.) I asked four Samoans independently to classify the villages listed in the 1981 census, using whatever criteria they thought best. All used the degree of adherence to the Samoan traditional way of life, ja’a Samoa, as their major classificatory tool. The details of this classification which I have adopted and the correlations between qualitative and quantitative village data are explained in Appendix 5-1. The four
major categories of villages are traditional, semi-traditional, modern and non-traditional villages. Each exhibits different social and political structures, however the economic structures of the modern and non-traditional villages, (both of which were urban), are the same. These village categories provide a macro-pattern within which an over-view can be gained of formal, substantive and interaction structures and then related to committee structure, committee distribution and committee attendance patterns. Data on committee structure, distribution and attendance were gained through a survey of the district nursing service monthly and annual reports, informal interviews with 25 nurses and three district nursing supervisors, a written questionnaire to nurses, an analysis of 1,200 infant record cards, and total of 56 visits to committees in 26 locations (see Appendix 6-1).

From each of the four types of villages I selected one sample village for micro-level investigation and to provide concrete examples of how structure, action, information, time and space interact to determine the flow of nutritional information through community groups. Poutasi is a small rural traditional village on the opposite side of Upolu from Apia; Faleasiu is a large peri-urban, semi-traditional village on the coast northwest of Apia; Vaiala is a modern village around which Apia grew and Tulaele is a non-traditional village in a new freehold suburb on the outskirts of Apia (Figure 1-1). A description of these villages and life in them forms part of Chapter 5. These villages were chosen because they were representative of their type, I knew them well and knew families with whom I could stay. This made it possible to collect detailed personal information and to gain insights which would otherwise have been impossible and without which a study of this type could not have been undertaken. In each village I conducted a household survey to determine women’s dominant daily activities, household size, the number of householders in wage labour, women’s interaction patterns and their relative
status within both the household and the village hierarchy. The survey included all 34 households in Poutasi, 30 in Vaiala, 25 in the suburb of Tulaele and 25 households in Tauao'o, a sub-village of Faleasiu. I administered formal interviews, using a written questionnaire with open-ended questions to determine committee attendance and non-attendance and reasons underlying it as well as to gain some impression of how much nutritional information women received. Details of these questionnaires are shown in Appendix 9-1. A total of 199 formal interviews were conducted with women between the ages of 20 and 59.

The hypotheses require detailed investigation of the nutritional information channelled through the women’s committees and how this information influenced its movement at both administrative and local levels. This was gained from interviews with the Department of Health nursing, teaching, nutritional and administrative staff; from the nutritional curriculum, and participant observation. Nurses’ opinions about nutrition and nutritional information came from written questionnaires distributed through the Department of Health (see Appendix 6-1) and informal interviews. Information about changes in the channels for nutritional information was derived from Department of Health monthly reports and informal interviews.

Finally, an analysis of the specific way in which nutritional information is delivered in different villages was made from tape recordings of committee meetings. These were transcribed and translated with assistance from Christina Tapu, a trained nurse and pastor’s wife who is fluent in Samoan and English.

Throughout my fieldwork I found that informal conversations and comments, chance remarks and observation, were often of greater value than formal questionnaires or statistical data in explaining the realities of human action and the impact of structure on information flow. It was frequently in the relaxed conversation following the completion of a formal
interview that opinions reflecting the "real", rather than the "ideal", situation were expressed. My experience confirmed that of Maddocks in Papua New Guinea. I found "anecdotes and intimate observation ... as revealing as the more mathematical data from surveys" (Maddocks 1978:37) and throughout the thesis this informal information has influenced my analysis of survey data.

I lived in Western Samoa from 1975 to 1979, and undertook village research in 1980 and 1981. For this study I carried out 11 months fieldwork between December 1982 and October 1983, dividing time between Poutasi, Faleasiu and the two Apia villages. Five weeks (November/December 1983) were spent on research in the New Zealand National Archives, Wellington and one week (May 1983) in the Fiji Archives, Suva.

Chapter Outline

The second chapter of this study establishes the historical preconditions for the introduction and maintenance of the women's committees: Chapter 3 their introduction, original structure and the information that flowed through them; Chapter 4 investigates the years from 1940 to Independence in 1962 and committee adaptation to structural changes. Chapter 5 deals with a time of rapid social transformation (1961-1983) and the spatial differentiation of social, political and economic structures. It is also concerned with administrative change during this time and its impact on the women's committees. Chapter 6 establishes the evolution of different types of committees and their distribution and attendance, while Chapter 7 outlines the interaction between structure and individual action in determining committee access and attendance and explains the locational differences in attendance. The nutritional information disseminated in 1983 and the official channels for its dissemination are discussed in Chapter 8. Chapter 9 brings together the determinants of space, time, information, structure and action in the actual events of committee meetings in two villages.
Different aspects of the three hypotheses are dealt with throughout the thesis.
CHAPTER 2

PRECONDITIONS FOR ESTABLISHING THE WOMEN'S COMMITTEES

Three sets of pre-conditions influenced the establishment and structure of the women’s committees in Western Samoa: the social organisation of Samoan society; the effect of the introduction of European diseases; and European perceptions of Samoan health problems.

In 1923, the year the women’s committees were established, Western Samoa had been a League of Nations Mandated Territory under New Zealand administration for three years. The country had seen nearly a century of mission contact and German, British and American settlers had been established on plantations for over 60 years. Western Samoa was not formally colonised during the nineteenth century, but a series of British, German and American consuls worked in collaboration with a group of high ranking Samoan chiefs. In 1900, following what Tennant (1927:21) calls “undignified squabbling amongst foreign powers” and fighting for power amongst Samoan factions, Samoa was declared a German Protectorate and a number of reforms to improve village agricultural production were initiated. In 1914, at the outbreak of the First World War, New Zealand military forces occupied Samoa and instituted a military administration which lasted until 1920 when the League of Nations placed the islands officially under New Zealand administration. By 1923, the sacred and

1Turner 1861 and Stair 1897 provide accounts of early mission life. See Gilson 1970 for details of Samoan life between contact and 1900 and Davidson 1967 for a political history to independence in 1962. Fox and Cumberland 1962 provide a useful history of land use and agriculture.

2Ordinances were passed in 1900 compelling every Samoan land-holder to plant 50 coconut palms annually (See Fox and Cumberland 1962:142).
secular influences of the missions. The effects of two colonial regimes, and the introduction of a cash economy had brought about a number of changes, not least political centralisation. Roads in some parts of both major islands improved communication links and a network of village representatives (pulemu'u), appointed by the administration, linked each village with central government. However, as the Samoans were only involved marginally in the cash economy changes in day-to-day village life were minimal. They had retained control of most of their land which provided the major base for their social, political and economic structures and Chinese and Melanesian indentured labour had been brought in to work on the commercial plantations. In 1923 most of the population of 37,000 (Pirie 1963:71) lived in coastal villages of between 200 and 300 people (Keesing 1934:41), made up of a number of extended families, or aiga, who engaged in subsistence or semi-subsistence agriculture. Only the villages around which Apia had grown, were not totally reliant on agriculture. As locales for action and interaction Samoan villages were small, compact and relatively homogeneous. The social, economic and political structures were based upon a relationship between a system of hierarchically-ranked chiefly titles and control of land. Reciprocity and redistribution were important elements in the social, political and economic lives of the people and control of land and titles was inherent in the maintenance of rank and status.

3 See Schoeffel 1979 for an account of their influence on women.

4 In 1889 uncontrolled sale of land to Europeans led to the Berlin Conference on Samoan Affairs prohibiting further alienation of Samoan land and today 80 percent of Samoan land remains under customary tenure. The Berlin Conference also recommended a Commission be set up to investigate land claims. When it began work in 1893 claims totalled more than twice the total area of the country (See Davidson 1967 and Thomas 1985).

5 See Meleisea 1980.
The Samoan Village Structure and Locales for Interaction

The specific way in which Samoan society was structured, and the interaction structures within which human activity and interaction took place, were crucial to the acceptance and maintenance of the women’s health committees. Samoa was an hierarchically-ranked and authoritarian society and its political system dominated day-to-day activities and interaction. The two main foci of power, influence and authority were the aiga and the nu’u, or village, and it was within these two different types of locales that most people interacted. The aiga provided individuals with their identity and their position within the village polity. Each aiga was led by a matai, or chief, (almost always male), elected by the family. He held a specific title which was linked to clearly defined areas of land which, by virtue of his title, he controlled. The title was ranked within the village and district hierarchy of titles and legitimised by family genealogies and mythology.

A chief may be recognised as being of paramount rank because it is commonly recognised that the initial holder was a direct descendant of the Tagaloa family of Gods (Holmes 1974:18).

Each title carried with it the right to exercise authority, or pule, over the aiga, to use land and to legitimately “assert priority to scarce resources and to make and enforce decisions” (Freeman 1983:123). The matai was responsible for organising the family labour force in the production of food and goods as well as the distribution of all produce. Untitled men, women and children in the family provided the labour force and had little status. While all family members with genealogical links to the title holder had rights to live on family lands, these rights depended on rendering tautua, or service to the matai (Marsack 1954:3-4). If his wishes were not obeyed he had legitimate authority to punish or banish, but such decisions were usually made in consultation with other family members. As Samoa had a non-unilineal inheritance system (Tiffany 1975:267) access to land could be claimed through male or female lines and men and women had a choice of
residing in any aiga with which they had family links. The mobility this allowed was later to have considerable impact on Samoan village life and on the structure of the women’s committees. Residential flexibility not only ensured life-time security for all, but also provided checks and balances against the autocratic behaviour of matai, as without a labour force he was unable to produce the food and goods required to maintain personal esteem and the good name of his title.

Unlike many hierarchical societies, Western Samoa had no rule of primogeniture and matai were elected to the position by the extended family. As a man seldom became titled until he was middle-aged, no constant class lines emerged (Keesing 1934:30). However once he gained a title a man immediately changed his day-to-day activities and interacted in different groups and in different ways (Mead 1928:36-37). This also altered the status, day-to-day activities and interaction patterns of his wife.

As marriage was exogamous and residence often patrilocal, the aiga consisted of geographically dispersed members who maintained active links through regular visits and reciprocity (Gilson 1970:29), so that Samoa was criss-crossed by “a maze of marriage and other relationships that blurred the clear cut identity even of traditionally hostile districts and kin groups” (Keesing 1934:53-54). Exogamous marriage and patrilocal residence meant that villages comprised a number of in-marrying women, whose status differed from that of women born in the village and who would hold different positions in the women’s committees.

The village provided the major locale within which individuals interacted and its particular polity bound the rules for interaction. Samoan villages were virtually autonomous communities responsible for making and enforcing their own rules and conventions. They had a high degree of cohesion and communal responsibility based on traditional family links and

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6Keesing (1934:55) and Holmes (1974:20) provide explanations of how titleholders were selected.
long affiliation with specific areas of village land and the families that controlled them. Rank provided the guiding principle for all interaction and Samoan villages were highly stratified, each with its own clearly defined ranking system. The influence of rank was not diffuse or indirect as Layder's (1961:31) description of objective structures suggests, but was reflected directly through interaction structures in village institutions and the family.

Each village was controlled by a council, or *fono*, made up of all the village *matai*, who could collectively exert authority over the entire village. Within the *fono* a *matai*’s power and influence were in direct relationship to his rank. The title, not the individual, determined both power and prestige, and the specific nature of a man’s interaction with others (Keesing 1934:30). As all prestige, power and authority were concentrated in the titles, their attainment was a constant source of competition and conflict, not only between individuals but between different family factions. The struggle for prestige permeated society producing an inherent instability. It is likely that this instability and the lack of an hereditary class led to strict community closure within both the *fono* and the village, and to the mass of etiquette and ceremony that surrounded every formal occasion and all interaction.

Within the village all adults belonged to one or other of the village organisations according to sex and this division produced what was known as the "village of the ladies" and the "village of the gentlemen". The village of the gentlemen comprised the *fono*, made up of the titled men and the *aumaga*, which was the group of untitled men who served the *fono* and engaged in community village work under the directions of the *fono*. The "village of the ladies" was made up of the *aualuma*, or unmarried women or girls born in the village, and the *faletua ma tusai*, the in-marrying wives of the *matai* and the *fainsi laiti* (literally little

*Schoeffel’s (1980:2) division is expanded by Shore (1981:201-202).*
women) who were the wives of the untitled men, usually in-marrying. These groupings cut across ties of kinship and affiliation creating a high degree of cohesion and integration but maintaining divisions of sex and status. Each group was internally stratified, taking the village *fono* as its reference point for interaction. Only the group of *fafine latti* held no formally organised meetings.

The "Village of the Gentlemen"

The *fono* was the major organisation for political and social activity and for the production and reproduction of the political economy. It was to provide the basic structure and interaction patterns for the women's committees. Freeman (1983:128) saw the structure and conventions of the *fono* as being the primary expression of the ethos of Samoan society, constituting the focal point of Samoan culture as well as providing an expression of the particular characteristics of each village. Action and interaction within the *fono* were, as Layder (1981:105) suggests of such structures, "overdetermined". "Although individuals come and go, each type of *fono* is a continuum, there is cultural transmission of experience in the *fono* and no break in continuity" (Keesing and Keesing 1956:48). Within the *fono* the rank order of members of each local polity was reproduced and

... repeated in a series of interrelated social groups involving all the adult members of the village ... All of these groups are under the direct authority of the *fono* which they are obliged to support and serve (Freeman 1983:129).

As the executive body, the *fono* had authority, legitimated by tradition, to administer, legislate, arbitrate and enforce its decisions in all areas of village life, from moral to agricultural within both private and public spheres. Non-compliance with its dictates were met with fines, corporal punishment, ostracism or banishment. Such punishment not only involved the individual offender, but the entire family. In pre-contact times
the *fono* had the power and authority to impose the death sentence (Gilson 1970:21). It had also (and still has) the power to exact from each household such contributions in labour and goods as it deemed necessary for village occasions and projects. (Legitimate exaction of the labour of untitled men for village purposes was later embodied in the Constitution (Part II 8 (d))). Fulfilment of obligations and obedience to *fono* regulations were not merely compliance under coercion, but a matter of family esteem and honour. The values of *matai* dignity and family honour were of extreme importance and a major responsibility of the title-holder was the maintenance and protection of the dignity and status of the title. Failure to fulfill obligations brought shame, loss of dignity and a slight on the honour of the family, and by extension, the title (Tiffany 1975:271).

The *fono* met frequently and within it rank was continually manifest in where each man sat; in the speaking order which was determined by the seating order; the serving order of the *kava* and food and the specific portions of food distributed. The seating order was complicated by the division of *matai* titles into *ali'i*, or high chiefs’ titles and *tulafale*, or orators’ titles and by the division between the front and the back of the house which prescribed those who could take active part in the meeting and those who could not (Freeman 1983:126-127; Duranti 1981:58). “The orators who sit in the front are the active ones ... the chiefs sitting in the back... show their respect and submission to the higher chiefs” (Duranti 1981:54-55). The *matai* with the highest ranking titles had greatest authority and power of decision and although ideally decisions required consensus of opinion - a time consuming procedure - the wishes of the

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8 See Davidson 1967:19 and Duranti 1981:61-68 for details of the seating order; Holmes 1974:36-38 for details of the serving order for the *kava* ceremony and Te Rangi Hiroa 1930:140-164 for a full account of preparing and serving food and *kava*.

9 The binary opposition between concepts of the front and the back and their relationship to rank and status permeated Samoan epistemology. The phrase “living out the back” was frequently used to refer to someone who lived in the rural areas and was considered to be ignorant and uneducated.
leading matai were usually deferred to. "When a matai of high title expressed an opinion, those of lesser standing could not with propriety dissent" (Davidson 1967:19), nor would lesser chiefs express an opinion in front of those of higher rank (Keesing and Keesing 1956:135). Not only did rank determine who interacted with whom and how, but it determined the subject matter discussed. There was "a wall of inhibition...against expressing opinion outside the correct elite communication channels on issues of elite concern" (Keesing and Keesing 1956:3).

The structures and conventions surrounding interaction within the fono ensured that

... authority-bound subjects [were] correctly talked about publicly by the appropriate elite individuals only ... such matters ... [were] treated formally, spoken of in appropriate places and situations to restricted audiences surrounded by ceremonious behaviour and couched in honorific forms of language (Keesing and Keesing 1956:6).

Strong community closure operated within the fono. Only the chiefs sat in the council meetings and only the chiefs deliberated. However the group of untitled men (aumaga), who played a service role preparing kava and food for the fono, could listen to proceedings from the "back of the house", the role their wives were to play in the women’s committees. The only member of the fono whose status was not directly commensurate with the rank of his title was the pulenu‘u, or village mayor. This position, initiated during the German regime, was continued by the New Zealand administration. The pulenu‘u provided the first breach in village political autonomy by maintaining a direct link between the village and the colonial administration. His role included advising the village of government policies, recording births and deaths and ensuring, or attempting to ensure, that government policies for agriculture and later, sanitation, were carried out (Report of the Royal Commission 1927:478). The village matai, aware of the threat the pulenu‘u posed to village autonomy and authority, stipulated that the fono rather than the Civil Service appoint him. If the
pulenu‘u did not defer to their wishes another was chosen. In this way the matal retained control of the village.

Village autonomy was supported not only by the objective and substantive structures that pertained to rank and authority, but by the control the *fono* maintained over all village organisations. By specifying relative rank it determined how individuals should interact with one another both inside and outside these organisations, continually reproducing each particular village polity, economic activities and interaction structures.

The "Village of the Ladies"

The role, status and corporate groupings of village women have been thoroughly examined by Schoeffel (1979, 1980) who draws an important distinction between *fa‘fine*, or married women, who are usually in-marrying, and *tama‘ita‘i*, a polite term denoting "ladies", the women or girls who were either unmarried, or were not living with their husbands and residing in their natal villages.10 "Women" were considered by Samoans to be those who were sexually active, while "ladies" those who were not in any recognised sexual liaison.

**Table 2-1:** Division between Village "Ladies" and "Women"

<table>
<thead>
<tr>
<th>Ladies</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>Tama‘ita‘i</em></td>
<td><em>Fa‘fine</em></td>
</tr>
<tr>
<td>Born in Village</td>
<td>Born outside Village</td>
</tr>
<tr>
<td>Not sexually active</td>
<td>Sexually active</td>
</tr>
<tr>
<td>Ceremonial roles</td>
<td>Household roles</td>
</tr>
<tr>
<td>Public activity</td>
<td>Private activity</td>
</tr>
<tr>
<td>High status</td>
<td>Lower status</td>
</tr>
</tbody>
</table>

(Source: Adapted from Schoeffel 1980)

Schoeffel (1977:5) suggests that in-marrying women had no public role

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10Schoeffel’s distinction between women and ladies has been elaborated by Shore 1981:204-205.
while “ladies” had an important and highly visible public and ceremonial role. They were the members of the localised descent groups who were not sexually active. Girls joined it at puberty and remained within it until they were married. Widows and divorcees who returned to their natal village, as was the custom, rejoined the aualuma which was usually led by an older woman, or sao tama’ita’i.

Ideally the traditional role of the aualuma was to provide a court and ceremonial setting for the taupou, or village virgin, who was usually the oldest unmarried daughter of the leading matai, and to provide entertainment for visitors. In practical terms it was a valuable organisation for the reproduction of cultural values, practical skills and traditional knowledge. Young girls were taught to weave mats for household use, to weave ceremonial fine mats, to sing, dance and to conform to the strict demands of etiquette. As in all other village organisations, interaction within the aualuma was strictly defined by rank. In formal meetings the daughters of the high ranking ali‘i sat in dignified silence while the daughters of talking chiefs (tulafale) spoke, and the daughters of the untitled men (taulele’a) sat at the back of the house and prepared and served the food.

The Church Groups

Although the churches ideally provided the opportunity for interaction within which “all were one in the eyes of the Lord” the entire congregation came together as an integrated group only during church services. Even there the seating order was divided on principles of rank, age and sex. The affiliated church groups, including the village deacons and layreaders, the youth group and the women’s guild were firmly based on the principle of traditional rank: thus the church served to reinforce the matai system (Gilson 1970:97). Although based on the principle of rank the church

women's guild brought together in a work-oriented group, all village women regardless of age, status or descent and created a corporate women's group beyond the level of the household:

... providing Samoan women with a new source of influence and power by promoting the right of women in the wifely status category to participate in village affairs beyond the domestic level (Schoeffel 1977:11).

Keesing (1934:410) maintained that the church provided a "means of self-expression and competition in singing, giving, church-going and the like" as well as an additional channel through which rank could be manifested by the provision of liberal donations, and large food contributions to the pastor and his family. Contributions to baptisms and funerals combined modern and traditional customs, at the same time upholding relative rank and status. It was widely considered that the church adapted to Samoan culture to a greater extent than Samoan culture was altered by the church. Keesing reports a conversation with an elderly missionary who complained:

... instead of accepting Christianity and allowing it to remould their lives to its form, the Samoans have taken the religious practices taught to them and fitted them inside Samoan custom making them part of native culture ... Christianity instead of bursting the bonds of the old life, has been eaten up by it (Keesing 1934:410).

The way in which the church was adapted to conform to the values and structure of Samoan social, political and economic life was closely followed by the women's health committees.

It was within these village formal and substantive structures that the women's health committees were placed and it was these structures and the values that upheld them that helped to determine their future role in the community and the ways in which nutritional information would be delivered.

The Habitus and Daily Practices

Bourdieu's concept of *habitus*, or the cultural and epistemological milieu within which individuals live, is of importance in explaining Samoan
reactions to the women's committees. Samoan society in 1923 was highly authoritarian. A chief was entitled to the respectful obedience of all those over whom he had authority and this obedience was expected regardless of age (Freeman 1983:130). By honouring and obeying those of elite status, people felt they were honouring themselves (Keesing and Keesing 1956:46). Shame and the maintenance of individual and collective esteem were very powerful factors controlling actions and the concept of shame and its consequences were learned when young.12 Although based on authoritarian principles with clear role divisions between the titled and untitled, Samoan villages were cohesive units, with extensive and intensive mutual knowledge and experience. People lived most of their lives within one another's presence. In a village setting where the houses were close together, unwalled and without internal partitions there was almost no individual privacy and as Berreman's (1978:68) model for interaction in small communities posits, most people "interacted in primary relationships as total persons with known statuses, known personalities, known biographies".

There was little individual responsibility and people both felt they belonged, and were seen by others to belong, first to an aiga, or extended family, second to a village, and third to the various village organisations which were appropriate to their sex, age and status. At each of these three levels community closure was operated to exclude those who did not conform to the various criteria for membership.

Samoan villages therefore conform to Weber's (1968) community and Giddens's (1979) locales at two different levels. The village itself provided a community to which all villagers felt they belonged and within which they were physically situated; and the aiga provided the non-localised community within which individuals had their historical roots. Within the village community were the various organisations which provided the small,

12 Freeman 1983:154 discusses attitudes towards shame and Schoeffel 1979 provides examples of early childhood training.
interrelated institutions within which individuals interacted and went about their daily activities.

Food Practices and Infant Feeding

Samoan food practices and their values surrounding food, as well as their perceptions of health and ill health, were to influence the establishment and effectiveness of the committees. Like many Pacific island societies Samoa had strong customs associated with the redistribution and consumption of food and these played an important part in social organization (Te Rangi Hiroa 1930:140). All socially significant occasions in Samoa involved redistribution of large quantities of food and both its consumption and redistribution were surrounded by ceremonial procedures. The type and amount of food presented by each family was made publicly known and was an important way of maintaining the prestige and honour of both the family and the village. Pride and a strong element of competition ensured that lavish quantities of high quality food were always provided at public occasions. It was important always to be seen to have plenty of food, as an inability to contribute the amount expected was a slight on the honour of the aiga and the esteem of its individual members.

Pork was the highest status food and was integral to any ceremonial occasion. A whole pig, partly cooked\textsuperscript{13} in the umu, (stone oven), decorated with red hibiscus flowers and carried on a litter of fresh banana leaves and coconut fronds provided the centrepiece of any ceremonial occasion. The food served at such an occasion might include whole fish wrapped in coconut fronds and steamed in the umu, whole steamed chicken, raw fish steeped in coconut cream, a variety of shellfish, crab, crayfish, octopus, pigeon and flying fox, whole baked breadfruit and taro with palusami (coconut cream wrapped in young taro leaves and steamed inside a small packet of breadfruit leaves).

\textsuperscript{13}If pork was too well cooked it was impossible to divide according to the way demanded by etiquette. See Te Rangi Hiroa 1930:120-127 for the ceremonial division of food.
The major staples in everyday meals were taro, breadfruit (in season) and green bananas, served with either palusami or a mixture of coconut cream and saltwater. Seafood provided the bulk of the protein. The only green vegetable traditionally eaten seems to have been young taro leaves. Although Stair (1897) wrote that the Samoans ate a great profusion of vegetables, their diet seems to have had a very high carbohydrate content.

Infants were breastfed but were frequently weaned very early. Turner (1861:125) observed that children were often totally weaned by four months, which he claimed was a "fruitful source of mortality among children". He commented on very high infant mortality, suggesting it was not less than two-thirds (Turner 1861:219). The problem of early weaning and poor infant feeding was widely commented on by early missionaries and settlers. It was common practice to deny newborn infants breastmilk until eight to ten days after birth, feeding them instead on masticated coconut kernel squeezed through a piece of barkcloth (Stair 1897:177). Weaned infants were fed taro and banana and the soft flesh of the green coconut masticated by a relative and rolled into small balls and popped into the child's mouth.

Although it was widely maintained that Samoa was a land of affluent subsistence, that famine was virtually unknown and that the system of reciprocity, redistribution and easy mobility ensured that everyone always had enough to eat, there seems to have been a concern with food beyond the maintenance of status and prestige. Warfare, rife both before and after contact, and in particular the disruption caused by many epidemics which followed contact may have been responsible. I found between 1976 and 1983

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14 The mother's milk was considered poisonous until it could be thrown on hot stones and not curdle (Turner 1861:125). Kraemer (1902:89) quoting Turner suggested this may have been a form of infanticide or a means by which the old women who tested the milk could exact payment from the family to pronounce it fit to drink.

15 This practice continues. I have seen older women sitting with their grandchildren, chewing food, rolling it into small balls and sticking them on their thighs for the small children sitting in their laps.
that food remained a major pre-occupation in people's lives.\textsuperscript{16}

It is not surprising in a society where the provision of food was so important that obesity was equated with high status.

**Samoan Perceptions of Health and Ill Health**

There seems little doubt that in pre-contact times the health of the Samoan people was good. Early accounts of Samoa "are unanimous in stressing their superior physical development and their generally robust, healthy appearance" (Pirie 1963:24). La Perouse (1787 in Pirie 1963:16) described the Samoans as "the tallest and best made that we have yet met with.... their stature is less astonishing than the colossal proportions of the different parts of their bodies". He stated that they were of such physique that the Frenchmen felt puny beside them. Wilkes (1839:123-127) remarked that they were "sturdy beggars" but like later visitors commented on the incidence of filariasis, bronchial disorders, yaws and skin diseases. Although there was high infant mortality those who survived childhood were reported to be extremely healthy. Keesing (1934:373-376) maintained they had a physical heritage from lusty Polynesian voyagers, a comfortable climate and environment and although their life was strenuous it left ample time for rest, and play. Shelter and clothing suited the climate and food and water were plentiful.

Pre-contact Samoans seem to have had no awareness of health as a concept, nor a vocabulary for it, although today a differentiation between *malosi*, (strong), and *va'e'au*, (weak), is used to express feeling well or unwell. Matters of physical well-being were bound up in the interpretation of life and in its religious conceptions (Keesing 1934:375). Ill health, (*ma'i*), was thought to be a product of the supernatural and the spirit.

\textsuperscript{16}In 1983 food was a major theme in school children's essays and poems and a constant topic of conversation.
world was very much a part of everyday life. The malice of the spirits, (aitu), or the invocation of a family god by a sister or a paternal aunt could cause illness as could possession by an angry spirit or the breaking of a tapu. A person could also be possessed by aitu as the result of social dislocation within the aiga (Kinloch 1980:16), or as a result of some disobedience. In addition to family spirits whose wrath could be incurred, there were national spirits, acknowledged by all Samoans, who could cause illness.

Some illness was attributed to natural causes - to eating rotten fish, or long exposure in the sun, rain or water - but if such illness did not respond to treatment it was considered to be the result of aitu. Kinloch (1980:14-15) categorises two types of illnesses, as ma'iga, or "broken sickness" alluding to some incursion into the "wholeness" of the body, and ma'i aitu, or spirit illness. Ma'iga contains the concept of chronic ill health or physical weakness while ma'i aitu contains the idea of an illness which is ultimately curable.

Each type of illness was treated by a specialist. The fofo, who specialised in massage and herbal treatments, treated ma'iga, and the taulasea dealt with spirit possession. Each village had three or four fofo each specialising in specific types of problems. They were usually older women whose skills were passed from mother to daughter. If the treatment of one fofo was unsuccessful, another with different skills was called in and the illness diagnosed by which cure was effective. In the 1920s the Samoan healers also carried out various types of surgery, most commonly for ulcers.

18 See Mead 1969:98-100 for ethnography concerning sickness, death and burial.
19 Perhaps the best known were, and still are Talasea, a female spirit who it is said is very beautiful and who tends to attack those with brown hair (Goodman 1971:469), Nifoloa, a demon thought to live in Savai'i, and Sa uma'iafi who takes the form of an old woman and is known particularly around the village of Salae'imoa.
20 Also see Moyle 1974:156.
and eye problems. The methods and results of such surgery were viewed with considerable concern by European medical personnel.21

Traditional medicine dealt with recognised illnesses by known experts in known and accepted ways and reflected the stocks of medical knowledge in Samoa at that time. Within the traditional system there was always the acceptance of failure, and treatments were borne stoically as it was not acceptable to complain of pain, discomfort or lack of success. It is against these perceptions of illness, and Samoan specific stocks of knowledge concerning sickness, its causes and cures, that the introduction of both European infectious diseases and the women’s committees must be seen.

Samoan perceptions of the sudden influx of deadly and unknown diseases and of the ineffectiveness of traditional healers to deal with these epidemics seem to have gone unrecorded, except for brief European comments of social disruption and demoralisation.22

The Impact of Epidemics and European Perceptions of Samoan Health

Throughout the Pacific the experience was much the same as in Samoa.

Epidemic upon epidemic ... have been followed by severe famine ... plantations, which of necessity, had been much neglected during measles, were left to ruin during the excitement of war, consequently scarcity of food became very great (Bleazard 1894:3).

Two years later the situation had not improved. Bleazard in his 1896 Annual Report to the Methodist Mission again wrote of health problems:

... when the drought and famine had somewhat abated there followed an epidemic of diarrhoea and dysentery, resulting in the death of a great number of children (Bleazard 1896:1).

At the turn of the century colonists believed that Pacific island races

21 In a memorandum (10th August 1920) to the Chief Health Officer, Department of Health, Wellington, Kendall, an ophthalmic surgeon who spent three months in Samoa gave a graphic account of these operations and their unfortunate results, many of which resulted in blindness.

22 See Goodall 1954.
were doomed to extinction. In Samoa recurring epidemics of measles in 1893, 1911 and 1915 killed new generations of children. Whooping cough, influenza, and dysentery affected the whole population.

**Table 2-2: Events Affecting the Western Samoan Population: 1890-1920**

<table>
<thead>
<tr>
<th>Event</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>1891 Influenza</td>
<td>(Collier 1893)</td>
</tr>
<tr>
<td>1893 Measles</td>
<td>(Carne 1893)</td>
</tr>
<tr>
<td>1893-4 Civil War</td>
<td>(Gilson 1970)</td>
</tr>
<tr>
<td>1896 Drought and Famine</td>
<td>(Bleazard 1896)</td>
</tr>
<tr>
<td>1899 Civil War</td>
<td>(Gilson 1970)</td>
</tr>
<tr>
<td>1907 Dysentery and Whooping Cough</td>
<td>(McArthur 1967)</td>
</tr>
<tr>
<td>1911 Volcanic Eruption on Savai'i</td>
<td></td>
</tr>
<tr>
<td>1911 Measles and Dysentry</td>
<td>(McArthur 1967)</td>
</tr>
<tr>
<td>1915 Measles</td>
<td>(McArthur 1967)</td>
</tr>
<tr>
<td>1918 Influenza Pandemic</td>
<td>(AHIR A-4 1924)</td>
</tr>
</tbody>
</table>

Not only were populations thought to be declining, but the general standard of health was considered by Europeans to be deteriorating.

Epidemics are much more frequent ... the Samoans are not as robust as they were formerly, and thousands of them are physically incapable of throwing off even comparatively slight attacks of sickness (Collier 1895:1).

Little had been done by the German regime to improve Samoan health or to counter the spread of disease and it is likely that the general decline in health exacerbated the effects of the 1918 influenza pandemic.

In November 1918 the S.S *Talune* arrived in Apia and passengers with influenza were permitted to land. In a highly mobile society the disease spread quickly and in six weeks over one-quarter of the population had died. Mortality was selective, affecting men more than women; those with a tendency to obesity were particularly prone (Pirie 1963:78). Thirty percent of all adult men died and 25 per cent of adult women, but within

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23 See Collier 1895; Cless, Stewart and Thomson 1896; Troed 1912; Lambert 1929; Saldom 1975; Measles alone had killed 70,000 Fijians in 1775 when "whole communities were struck at one time...there was no one left to gather food or carry water" (Corney, Stewart and Thomson 1896:36). In Tonga, one-twentieth of the population died in 1893 and the "remainder was so demoralised that it was threatened with famine" (Thomson in McArthur 1967:76).

24 Trail (1920:1) in a report *Medical Conditions in Western Samoa* stated "It did not seem...the policy of the German government to interest itself in the natives' health...the native ward was not habitable when taken over". Keesing (1934:379) however wrote that the Germans had laid plans for comprehensive health activities.
the male population. 45 per cent of the Samoan matai and nearly 50 per cent of the Samoan pastors died.\(^{25}\) Whole villages were wiped out, houses fell into disrepair, plantations became overgrown, and the death of nearly half the sacred and secular leaders threw villages into confusion.

For Samoa it was this epidemic, not the Great War which marked the watershed between two eras. The survivors were bereft not only of relatives, friends and leaders: they were bereft of confidence, and in many instances, of a faith equal to such a strain (Goodall 1954:362).

The social, political and psychological disruption caused by the loss of over one quarter of its population and half its leaders provided a political and psychological situation conducive to the establishment of village health committees. Traditional healing methods were obviously ineffectual. The church had provided no immunity, indeed more church leaders than any other group had died. With the leadership structure in disarray strong authoritative opposition to setting up the committees was unlikely. There may indeed have been a felt need and a feeling of relief at promises of support and assistance to help overcome health problems.

From the administration's point of view, population decline and the cloud of the influenza epidemic under which New Zealand began its administration ensured that its initial focus was on improving health (AJHR A-4 1923:7). An additional powerful incentive was being seen to fulfill responsibilities laid down by the League of Nations Mandates Committee which demanded an annual report on the social wellbeing of the Samoans.\(^{26}\)

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\(^{25}\) Goodall 1954:36 reports that "of 220 pastors in active service 103 died. Twenty-nine out of 30 members of the Au Toteaina (Council of Elders) ... were amongst the casualties": Pirie 1963:78 states that 65 per cent of all Roman Catholic catechists died.

\(^{26}\) The New Zealand government was frequently reminded of its moral responsibilities toward the Samoan people. A letter from the New Zealand High Commissioner in London to the New Zealand Prime Minister (25th January 1922:ref A1301) reminds that "it is possible that the question of the treatment of diseases which are prevalent amongst the natives will be raised some day ... by the Mandates Committees of the League of Nations".
Medical Research and the European Perspective

In the 1920s many international experts were called in to identify the major health problems and to suggest priorities.²⁷ Yaws, hookworm, filariasis and eye disease were all prevalent but high infant mortality and lack of hygiene were reported to be the major causes of low population growth and ill health. The reports of these health experts confirmed the earlier opinion of Trood (1912:103) that infant mortality resulted not only from introduced disease but from "neglect of children" and in particular "carelessness and ignorance on the part of the Samoan mother as to the correct feeding of babies" (Christie 1926:21). Although a Samoan medical practitioner was later to show that Samoan food could provide a fully balanced weaning diet (Fa'atiga 1940:255-262) Samoan infant care, feeding and particularly weaning practices were considered inferior to those of the more developed world. It is doubtful however whether Pacific Island practices were any worse than those in European cities or in some New Zealand communities at the time. Lambie (1956:8-17) writing of her early nursing training in New Zealand in 1912, stated that "gastroenteritis was very common...partly due to bad feeding practices and partly to the frightful feeding bottles of that era". In regard to hygiene she reported that during school health inspections "some of the poorer types were sewn into their clothes for the winter". The situation in parts of Europe was worse.²⁸ The European perception resulted in an emphasis on introduced infant feeding practices and on their superiority. This emphasis continues to the present day.

Ignorance of the rudiments of sanitation and hygiene were widely

²⁷ They included Trail 1920, Makgill 1922 and Ritchie 1922, all of the New Zealand Department of Health; Lambert 1922, of the Rockefeller Foundation; O'Connor 1920, of the London School of Tropical Medicine and Kendall 1920, a British ophthalmological surgeon.

²⁸ In his classic British study of the rural village Akenfeld, Blythe (1969) writes that in the 1920s no houses had piped water and the village had one "stinking pond" from which water was drawn (p.14). In many households "nobody could get enough to eat no matter how they tried" (p.35). Also see Orwell 1937:104.
considered to be a further cause of health problems. The Acting Chief Medical Officer (Trail 1920:4) reported that "probably 75 percent of the disease in Samoa is attributable to the absence of any sanitary system". Although it was recognised that the Samoans were extremely clean in their personal habits they were considered "practically ignorant of the laws of ordinary hygiene" (Kendall 1920:2-3). Ritchie (1920:4) reported that sanitary conditions were disgraceful. The solution, it was widely agreed, was "the inculcation of common sense, hygiene and education" (Kendall 1920:3) and "pamphlets in native language, simple lectures in mission and state schools" (Makgill 1922:2) in association with the Christian injunction that "cleanliness is next to Godliness" (Kendall 1920:3).

The New Zealand Experience

The New Zealand Department of Health already had considerable experience with high infant mortality and lack of sanitation among its Maori population and had been particularly innovative in social welfare. At the turn of the century the Government had set up a Department of Public Health in Wellington to establish preventive medicine at the community level. Under its auspices a Maori, Dr Maui Pomare, started the Maori Nursing Service with trained Maori nurses going out to Maori communities to teach the rudiments of health, hygiene and child care. In 1907 an association "based on the idea of mutual self help and education for the care of mothers and infants" was formed by Dr (later Sir) Truby King. The Plunket Society, as it came to be known, was based on local neighbourhood groups visited by a specially trained corps of nurses who regularly monitored infant health and educated women on maternal and infant care, infant feeding, hygiene and the nutritional principles laid down

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29 See Salmond 1975:7-8
by Dr King. The New Zealand social welfare and public health experience provided the ideology and the model for the new Samoan village health service.

The Samoan women's committees combined elements of both the New Zealand community health services and followed their development closely, although there were fundamental differences. The New Zealand and Samoan systems were based on the ideology, if not the practice, of individual equality and equality of access to community services. However the Samoan social structure was both highly stratified and authoritarian, and access to any resources that were considered valuable was restricted to the elite.

That the system of village health committees was established when it was and in the way it was, was the result of historical coincidence. The successful establishment of the committees required not only specific historical events but people concerned with preventive rather than curative medicine. The idea of women's health committees required acceptance by both the New Zealand administration and the Samoan people. It needed people both interested in, and experienced in, maternal and child health care who were sympathetic toward Pacific Islanders. More importantly, it needed medical personnel who could deal with the health problems of women without embarrassing them. This required women. Ideally, the establishment of the Samoan women's committees needed a woman doctor with high status, trained in, and concerned with, preventive medicine, who also had some experience with, and sympathy for, Samoan women.

At a time in New Zealand when less than one doctor in 200 was a

30Dr King was an idealist who maintained that the physical, mental and moral conditions of the whole community could be improved and the populations of hospitals, asylums and prisons reduced if women were adequately prepared for maternity, infants properly fed and children given a rational education. He was a strong advocate of breast feeding, regular feeding and natural foods. See Salmond 1975.
woman the chance of finding a woman doctor in Apia was remote. The chance of finding one who fulfilled the ideal qualifications for setting up the women's committees seemed impossible. Two women doctors, both concerned with preventive medicine and maternal child health care, were in Samoa at the time - an astonishing coincidence. The story of the Samoan women's committees is one of time, place and people. The pre-conditions for their establishment, together with this extraordinary intersection of time, place and people, influenced not only the introduction of the committees but the action and interaction that followed.

31 In 1896 Emily Seideberg McKinnon became the first woman in New Zealand to graduate as a medical doctor.
CHAPTER 3

THE INTRODUCTION OF THE WOMEN’S COMMITTEES

Special efforts will be made to reduce infant mortality by systematic child welfare work ... and as much responsibility as possible should be thrown upon the Samoan to hold his interest and gain his cooperation (Keyes, AJHR A-4 1927:6).

In 1922, the Administrator in Western Samoa, following the recommendations of international medical personnel, requested that the New Zealand government appoint a Chief Medical Officer who was a "public health man". As public health and preventive medicine were relatively new spheres of medical knowledge and interest, such men were few and far between and as the First World War had left the entire British Empire short of doctors and nurses it was difficult to find any staff for the new health service. In 1923, Dr T. Russell Ritchie, who had visited Samoa in 1920 to advise on strategies for the new service, was appointed Chief Medical Officer. He was personally committed to preventive medicine and the community self-help approach experienced while working with the Department of Health in Wellington, and believed that a similar system would be successful in Samoa. He specifically recommended that the rural health service be designed to enlist the assistance and cooperation of the

1 A.B. Tate to C.D. Gray November 30, 1922.

2 Numerous memoranda from the Administrator and the Chief Medical Officer in Samoa requested more medical staff, in particular "men of good quality". See Memorandum from the Administrator, Western Samoa to the Minister of External Affairs, Wellington, February 2, 1921:1; Report to the Department of External Affairs on the Samoan Medical Service, 1922 and Memorandum on Medical Conditions in Western Samoa from O’Connor to the Minister of External Affairs, January 5, 1922:9. Living conditions and pay were both considered to be poor and many staff left before fulfilling their contracts.
Samoan people and that Dr Truby King visit Samoa for several months to "study conditions affecting infants and to advise us as to the most suitable methods to adopt, having regard to local conditions and foodstuffs" (AJHR 1922:6).

When Ritchie took up his post in Apia at the beginning of 1923, Dr Regina Roberts (nee Flood Keyes) was engaged in voluntary health work among women and children in Vaiala, an urban village near her home in Apia (Schoeffel 1980:26-27). She was an American medical practitioner, who had served with the army during the First World War, and the wife of the American vice-consul to Western Samoa. Because of her husband's diplomatic position she was unable to take paid employment and devoted time to teaching Samoan women the principles of health, hygiene and child care. Keyes (1927:15) reported that women were anxious to learn and that whenever she held an informal clinic she had 100 per cent attendance. Keyes is reported to have had a strong, decisive personality, a factor which is likely to have been influential in her dealings with Samoan women, who were accustomed to authoritarian older women and to women who had status in their own right. Her title of doctor would have accorded her status, as would her husband's diplomatic role.

Late in 1923, Dr Mabel Christie arrived in Samoa and was appointed to the newly established post of Child Welfare Officer. Together Ritchie, Keyes and Christie devised a community health experiment based on the two New Zealand community health models and Keyes's experience with Samoan village women. The system was based on groups of village women who were to be responsible for overseeing and policing health matters within the village, and a team of doctors and nurses who would give regular medical checks, regular lectures on health matters, and practical teaching in first aid, infant care, infant nutrition, household hygiene and

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3 Full recommendations are outlined in his "Report on Medical Conditions in Western Samoa", 1920 (mimeo).
village sanitation. The experimental project incorporated 24 villages, four plantations and two mission stations between Apia and Falefa (Figure 3-1) which were visited fortnightly by Dr Keyes and her assistants.\(^4\)

**Figure 3-1:** Location of Experimental Women’s Health Committees, Western Samoa, 1923

*Fa’a Samoa* and Setting up the Committees

To conform to Samoan etiquette the establishment of the health groups was discussed with the village *fono* before it was mentioned to the women and by stressing the need for self-help and Samoan assistance, Samoan pride and dignity were maintained. There was little opposition. The influenza epidemic had resulted in much younger village leadership and it is likely that the many new matai were less conservative and more receptive to new ideas than in the past. It was realised that traditional treatments were ineffective against the new diseases and a felt need for help was apparent in the popularity of Keyes’s Apia clinics and in recurring reports of appeals from village women to help prevent the death

\(^4\)The full visiting schedule is in Appendix 3-1. Also see Keyes 1925,2.
of their children. An additional motivating factor in the acceptance of the committees was the high status of the Europeans involved and the importance which Samoans placed on prestige and competition.

Initial visits to villages were undertaken by the Chief Medical Officer, Keyes and frequently, the Administrator. The backing and highly visible support of the highest ranking European in the country gave the new undertaking not only status but legitimacy (Keyes 1927:21). Such visits were surrounded by a great amount of ceremony involving the whole district in a tala pa’ita, or ceremonial presentation of food. Everyone in the district knew of the visits and the reasons for them. In a highly competitive, status conscious society, each village wanted to be involved in an undertaking that was so obviously prestigious. News of the committees and the Administrator’s involvement spread quickly and by the end of the year similar committees were demanded by villagers in other parts of the country. While Keyes continued with the experimental area, Christie, accompanied by a Samoan nurse and an orator to take care of the ceremonial aspects of the excursion, walked, canoed and rode on horseback around much of the rest of Samoa where she

... visited every village in five large districts, inspected babies and children ... set up committees. 85 villages were visited in the year ... in all there were about 1,360 Samoan women of the women’s committees actively engaged in assisting in the work of child welfare (Christie, AJHR A-4 1926:20).

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5Downs (1944:41) in her memoirs after many years in Samoa wrote that “so many children died before they were a year old we were constantly asked by mothers to tell them what to do to save the babies”. Also see Keyes 1927 and Christie 1926.

6Lambert (1924:5) provided a full description of the Administrator’s health visits or (malaga). Also see Te Rangi Hiroa (1930:145-146) for a description of a tala pa’ita.

7The Administrator’s refusal to delay a malaga to allow Ritchie to attend to a woman in childbirth appears to contradict the importance he placed on supporting health activities. The incident is reported in the AJHR 1927. Also see Field 1984:65.
The structure of the committees

The women's health committee structure was based on that of a formal European committee, with an executive composed of a president, secretary and treasurer. There was considerable flexibility however, which officially allowed for Samoan input in both the choice of committee members and in committee procedures. Both were carried out in accordance with Samoan values associated with rank, status and the etiquette of their time. Almost without exception the committees were "composed of the leading women of the village ... often the wife of the village pastor has been elected president" (Keyes AJHR A-4 1927:16). Christie also remarked that the usual pattern was for the committees to comprise

... the more enlightened class. The wives of government Native officials and the wives of Native pastors of all denominations are the first to be taken into the committee. Others are added according to the size of the village (Christie. AJHR A-4 1926:20).

This small group of women was given authority by the Department of Health to organise and oversee village health activities. It might be expected that the highest ranking women of the village would have held the executive positions, but this was not the case. Initially the executive roles were held by women who had no traditional affiliation with the village. The wives of a few government officials may have been of the village but the pastors' wives were not. Later the Department of Health appointed the executive or made strong suggestions as to its composition invariably choosing the pastors' wives as the committee presidents. These women were outside village political factions and many had had a good education, including health training, at Papauta Girls School in Apia. Whether the choice of outsiders was a true indication of perceptions of status at that time is uncertain, but it is very likely to have been a

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8Samoan pastors are disallowed from serving in their own or their wife's natal villages.
matter of etiquette and village women’s deference to outsiders, particularly
to the church. It may also have been thought that these women, who
probably spoke some English and had greater experience in dealing with
Europeans, would be more beneficial to the village.\(^9\)

An administrative chain of command was established linking
Government, through the Department of Health and women’s committee to
village women. A subsidiary linkage was provided by the *palenu’u*, who
was expected initially to attend the women’s committee meetings. A
government administrative chart drawn up at the time gives an indication
of the importance attached to the committees and the new and powerful
roles they provided for women, exclusive of the male domain and male
authority (Figure 3-2).

\[
\text{Administrator} \\
\quad \text{Secretary of Native Affairs} \\
\quad \quad \text{District Fiapule (32)} \\
\quad \quad \quad (\text{Members of Parliament}) \\
\quad \quad \quad \text{District Councils (32), composed of the Fiapule, who is President,} \\
\quad \quad \quad \text{and representatives from each village in the district} \\
\quad \quad \quad \text{Villages (170)} \\
\quad \quad \quad \quad \text{Village Women’s Committee.} \\
\quad \quad \quad \text{Responsible for child welfare} \\
\quad \quad \quad \text{and village work} \\
\quad \quad \quad \quad \text{Village Committee of Chiefs} \\
\quad \quad \quad \text{and Orators (Fono).} \\
\quad \quad \quad \text{Responsible for village laws} \\
\quad \quad \quad \text{covering sanitation, schools,} \\
\quad \quad \quad \text{cultivation of land, roads, etc.}
\]

\text{Figure 3-2: Western Samoan Administrative Chain of Command, 1923}
(Source: AJHR A-4 1923:3, New Zealand National Archives)

\(^9\)In 1983 most older women questioned about this considered it would have been a matter of
defereence to the church.
Procedures and Interaction within the Committees

The initial procedures laid down by Ritchie, Christie and Keyes allowed for a variety of activities during the committee meetings and were based on a set of regulations which were clearly authoritarian, demanding the active participation of all women attending and giving the committee authority to order all village women to attend the clinics and to observe health-related regulations. The early clinics were held in the meeting house of the leading matai or pastor (thus lending the event status and legitimacy) with a table and chair for the medical officers placed at the front, the most prestigious part of the house. The clinics integrated the ceremonies that Samoan etiquette called for, with formal health procedures, and the meetings opened and closed with speeches, prayers and the presentation of food. Although lengthy speeches were discouraged as the medical staff had a busy schedule, they were not totally dispensed with. The official opening was followed by a short health talk on infant feeding, care of children or sanitation (Keyes 1927:14) and special instructions were given if any disease was particularly prevalent at the time. The medical officer then called upon the president to report on the work done and committee members to come forward in front of the meeting to report individually on work they had delegated to others and on conditions in the village. All cases of illness were reported to the medical officer together with action taken (Keyes 1927:15). Babies were then weighed and measured, their weights recorded and advice given the mothers. The work of the pulenu'u and the committees was reviewed, and anyone too ill to attend the clinic was visited at home. The committee executive was given lessons in first aid and the use of simple medicines. The meeting ended with the formal presentation of food. These procedures became firmly established. The inclusion of both Samoan and European procedures suggests that Keyes, Christie and Ritchie were aware of the importance of incorporating Samoan cultural values within the committee structure. This flexibility was an important factor in the maintenance of the committees.
The value of competition and the strong Samoan need for esteem was not lost on the health personnel and was frequently deliberately engendered within the committees.

The child's weight is publicly announced, and if there is any gain the mother is praised. If any loss ... an investigation is made at once ... the mother, if at fault, is admonished ... An effort is made to create a spirit of emulation in the village and between villages. Attention is called to villages especially diligent in sanitation and kindred matters. The Natives are praised or criticized according to their work (Keyes. AJHR A-4 1927:17).

Competition was used not only within the committees, but also between villages. Ritchie in his regular village visits and in his articles for the Samoan newspapers\(^{10}\) attempted to encourage national pride as well as inter-village competition in health matters.

Many villages have built very firm latrines ... but there are some ... where the work has not been done at all ... these villages must get to work immediately or they will show themselves to be backward villages in which people will be considered lazy and too ignorant to look after their own health. Remember that what you are doing is being watched in other countries, and I am sure every Samoan would like other countries to think that the Samoans are a progressive people (Ritchie, O le Faatonu, August 1925:4).

The authoritative nature of the committees was undoubted. The medical officers laid down clear regulations and the president and her executive, with assistance from the pulenu'u if necessary, were expected to enforce them. In an authoritarian society this was accepted. The authority of the committee executive formalised by Government through the link with the Department of Health, was regularly reinforced by the visit of the medical officer. All women with children under two years of age were ordered to attend the visit of the medical officer and those failing to attend could be reported to the pulenu'u who had the power to fine them.

(Appendix 3-2 contains the complete women's committee rules laid down in 1924). It was ruled that each committee...

...must meet once a week, and different women appointed to do certain tasks. A curfew at night must be rung for all children

\(^{10}\)Published in both English and Samoan
under twelve years. Other members of the committee are responsible for the children staying indoors through the hot hours of the day, while others have to superintend the daily bathing of the children in the fresh-water bathing pool... once a week the members of the committee make a thorough inspection of the village, fales, cookhouses etc. (Christie. AJHR A-4 1926:20).

Other rules required committee members to help all expectant mothers, ensure that suitable food was available for young children, see that children were breastfed regularly and that no work on the part of the mother interfered with regular feeding. If the mother had insufficient food, the medical officers held the committee responsible for finding some. A further rule demanded that the government newspaper O le Savali “should be read every month, not only to the committee but to all the women in the village”. This newspaper was printed in Samoan and contained health-related articles directed at the women’s committees. Topics included “Care of the breastfed baby in its first twelve months”, “Common diseases of the Samoans and their treatment”, “Feeding and hygiene of the Samoan mother during pregnancy”, “Cleanliness of the villages”, “The medicines used by the women’s committees and their application” and “Rules of the women’s committees”.

The committee was instructed to report to the pulenu’u any “severe thrashing of children” because medical personnel considered that some parents “thrash their children much too severely with very little cause” (O le Faatonu August 1925:2-3). The regulations were not free of moral injunctions.

In the interests of the women themselves and of their babies the committee should use its influence to discourage fa’a Samoa marriages (marriages or liaisons made outside the Church) (O le Faatonu August 1925:3).

The president was responsible for seeing that these rules were kept, for giving first aid or medicine to the sick and for contacting the medical officer when anyone was seriously ill. Other areas of community service suggested by the medical officers included “the supply of fresh drinking-
water, the provision of bathing facilities, the construction of flyproof latrines ... the provision of playing areas for children ... the keeping of pigs out of the village" (Christie AJHR A-4 1926:20). These early suggestions became important committee activities which led to greatly expanded community roles for women and provided the female elite with the opportunity to expand their authority beyond their own households and church groups. The committees, the rules and regulations laid down by the medical personnel and the legitimate authority they allowed women to enforce these regulations provided opportunities for power and prestige that Samoan women immediately recognised and seized with enthusiasm. For all village women the committee meetings provided new spheres of action and a new context for interaction. While the elite maintained choice in their involvement in the new health activities, the competitive nature of Samoan society provided covert coercion for them to take part. The wives of untitled men had no choice but attend the meetings and found themselves in yet another situation where their actions were dominated by those in authority. However, committees were prestigious and the meetings exciting and all women were anxious to become members (Keyes AJHR A-4 1927:21).

The Health Information

Given the perceptions of Samoan health held by Europeans at the time and the attitude of expatriates, health information was handled in an unusually delicate way and with an awareness that...

... the suggestion that their sorrows come because of dirty villages will be resented, they do not wish to hear that their own carelessness and insanitary habits breed flies which carry disease ... or that the ceremonial that surrounds the meals exposes food to flies (Downs 1944:40).

The information given was positive and practical, much of it highly visible, and much of it curative rather than preventive. The aim was "to have children's ailments treated on their first appearance, when very little treatment is necessary" (Christie 1926:21). The practical nature of this
information was of considerable importance in both maintaining interest in the committee and in patterning the type of interaction that took place between medical personnel and village women. Each committee was given a medical kit which contained a wide selection of basic first aid items including antiseptics, bandages, aspirin, castor oil, hydrogen peroxide, oil of eucalyptus, iodine, argyrol and cod-liver oil (for marasmic children) (Keyes AJHR A-4 1927:16) and the executive were shown how to take temperatures, pulse and respiratory rates, proper sterilisation procedures for any first aid, correct dosages for castor oil and other medicaments distributed, as well as care for mildly sick patients and how to give enemas.11 The control of first aid kits and practical demonstrations provided the executive with exclusive rights to new and powerful knowledge and to psychologically powerful material goods, the use of which, surrounded by specialised behaviour, was readily ritualised. The executive maintained firm control of both knowledge and equipment.

The committee meetings became the occasion for the treatment of yaws, eye-diseases and other infections. The rapid effect of new drugs12 was considered by medical personnel to not only enhance the appeal of the committees and Western medicine but indirectly to provide legitimacy for other health information.13 Villagers flocked to the clinics for treatment and information. From the start nutritional education took second place to the curative aspects of committee work, but as “improper” feeding was considered to be the leading cause of infant mortality, information on what Europeans considered “proper” feeding was given some emphasis. Downs provides an example of expatriate nutritional perceptions and knowledge of

11 Samoan doctor Iuelu Kuresa (1937) provides an account of teaching practical medical skills to women’s committee members. There was considerable emphasis at this time placed on bowel functions and the use of enemas. See Downs, Turbott and Kuresa 1937.

12 Lambert (1928:19) described the “magical” influence of new arsenical compounds in the treatment of yaws.

13 See Ritchie 1924:3.
The babies are plump and beautiful at 6 months but by 8 they get thinner and thinner. “You are starving the baby” I declared sternly. “Oh, no”, the family insisted “we love him too much to deny him food”. “Then what do you give him to eat?” I ask innocently. Then we see the cause of the trouble. The baby is allowed to eat anything from the food mat of the grown ups, taro and indigestible bananas, fat pork and esi (pawpaw). “You must give him milk” I tell them (Downs 1944:41).

In common with other medical personnel Keyes, Downs and Christie lamented the lack of cow’s milk and patent baby-foods and found the practice of “boiled green bananas, baked taro and ripe bananas masticated by the mother, (mama), then fed to the baby” (Keyes AJHR A-4 1927:20) distasteful. For weaning they recommended cow’s milk supplements, mashed pawpaw, the flesh of the green coconut, boiled arrowroot and coconut-cream, rice-water and boiled rice and when the child was older, cow’s milk, eggs, fish, scraped taro and yams. Infants were to be fed with a spoon and from their own bowl, but as a retired Samoan nurse and dietician complained, “how could the mothers do this, there was no cow’s milk, they had no spoons or forks or bowls. But with mama the child had properly digested food...it was properly chewed” (Pers. Comm., Anui Lagi 29.4.83, Fasitoouta Village).

Lack of cow’s milk however was overcome by the introduction of milk powder. Glazo had recently been formulated in New Zealand and it was recognised as an important breakthrough in improving infant nutrition and reducing infant mortality.15 The work of the newly established women’s committees and the nutritional problems of Samoan infants were reported internationally and in 1925 the New Zealand Red Cross, “interested and sympathetic to the Samoan cause” wrote to the Minister for External

14Downs’s book was written after 30 years in Samoa.

15Results of research into Glazo were published in the New Zealand Nurses’ Association Journal, “Glazo is a reliable milk preparation of nutrient value equal to fresh milk, with fewer bacteria and guaranteed sweetness” (Kai Taki 1922:177). It was emphasized that it could not replace mother’s milk but was a “very valuable product”.


Affairs asking how they could best help prevent infant malnutrition. The Administrator of Samoa replied:

There is one very important way in which the New Zealand Red Cross can help the Samoans and be a means of saving lives, viz. by supplying a certain amount of dried milk (Glaxo) for the Samoan children for use in connection with the child welfare scheme (Memorandum:Administrator to the Minister for External Affairs March 11, 1926, File IT 8/23).

In 1926, one-and-a-half tons of Glaxo were duly shipped by the New Zealand Red Cross and used "under the control of Native nurses and Native women's committees for invalid and sick babies" (AJHR A-4 1927:4) and milk in one form or another has been a continued import and a form of intermittent food aid ever since. The nutritional advice given to Samoan village mothers at this time was in line with the most up-to-date New Zealand infant feeding methods which included bottle supplements, regular feeding and the preparation of infant formula and was based on the Dr Truby King method. Powdered milk and bottles were enthusiastically received and have remained the cause rather than the cure of many infant feeding problems. Although careful instructions were said to be given on mixing the formula and sterilising bottles, few village fales had adequate facilities for keeping bottles clean or adequate cash to provide a regular supply or mixtures of sufficient strength.

In accordance with Dr Truby King's feeding schedule, village women were also told that once infants were two months old they should be fed four times in twenty-four hours and that infants must be totally weaned by nine months of age. These recommendations, later published in a training manual for Samoan nurses and women's committees, and in the government Samoan language newspaper O le Savai'i, still formed the basic infant care and nutrition text for nurses in the late 1960s. The tone of the book was unmistakably authoritarian.

From birth onwards, baby must be fed only at regular times, and must certainly not be given the breast every time he is cross or cries or wants it. A good rule is four-hourly feeding, using both
breasts...and NO NIGHT FEEDING (Downs. Turbott and Kuresa 1937:14).

The dissemination of health information in the committees was supported by the most modern visual aids of the time. Coloured pamphlets and posters were printed in Samoan and in 1926, with financial assistance from the Rockefeller Foundation. Ritchie acquired two magic lanterns, a film projector, (Figure 3-3), six sets of slides and supporting lecture charts in Samoan on hookworm, filariasis, the danger of flies and nutrition.16 These were widely shown in the committees throughout the country and were "seen by the great majority of the Natives" (Wellington Post. 22.5.25.)

Figure 3-3: Film projector and generator used to show health films in the women's committees, 1926-1929
(Source: New Zealand National Archives, File IT 94/1 Vol.1).

It is unknown how effective the magic lantern shows were in increasing Samoan understanding of the relationship between mosquitoes and filariasis, or food and health, but they were extremely popular and must have added to the excitement and prestige of the committees.

16 See memorandum Ritchie to Secretary for External Affairs, Wellington 26.4.25.
Staffing the Rural Health Service

As more Samoan medical staff were trained to "spread the Gospel of Health" the Samoan rural health service expanded, overcoming the problems of communication in areas of Savai'i. By 1926 there were 14 dispensaries, two district hospitals and a clear administrative structure based on Ritchie's original scheme for six health divisions (Figure 3-4).

Figure 3-4: Western Samoan Health Divisions and Health Facilities, 1923

By 1926, nearly all villages had women's committees and 49 Samoan nurses were either in the districts or in training (Samoa Times, December 1926:10). Apia hospital was well equipped to "train Native girls as nurses" and its bacteriological laboratory was "the largest and best in the South Pacific islands" (Western Samoan Medical Department 1927:3). As most of the young women chosen for nursing training were from Papauta Girls

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17 The first Samoan nurses graduated in February 1921 and by July of the same year two more were working in the rural districts to "spread the Gospel of health" (Samoa Times, July 1921:4).
School\(^{18}\) which was attended by the daughters of high-ranking chiefs, the early Samoan nurses had considerable status in their own right. This added to the importance with which the rural health service and the women's committees were perceived, and indirectly gave credence to the health information they gave.

In 1927 the health budget was 25,912 pounds, 19.1 percent of the whole revenue of Western Samoa, or about thirteen shillings per head (Keesing 1934:383-4). Access to health care and information improved as more staff were trained.

The opening of dispensaries in the out-districts depends on our supply of native nurses. Each year sees further advance, and during the past year we were able to open six...and in addition to station a native nurse trained in child welfare work, at Fagamalo, Savai'i (Ritchie AJHR A-4 1927:4).

Structure, Action and Information

Three years after their introduction, almost all villages in Western Samoa had a health committee (AJHR A-4 1927:4). They were recognised by government as an extremely important extension of the health service and regarded by outsiders not only as an integrated group but the major grouping of village women. Members considered that they belonged to an organisation that conferred prestige both inside and outside the local polity and their pride in belonging to the committee was manifest in the uniform they adopted and wore to all meetings and occasions on which the committee attended as a group (Figures 3-5 and 3-6). By 1926 the women's committee members had begun fund-raising to provide additional medicines and health equipment and they made official visits to committees in other villages.

Committee activities and meeting procedures became standardised.

\(^{18}\)Papauta School was established in 1892 by the London Missionary Society to educate the daughters of high ranking chiefs and pastors. It had a baby clinic and girls were given practical experience in infant care. The training closely resembled that of the Plunket Nurses in New Zealand and the girls were later referred to as Karitane nurses, the name given their counterparts in New Zealand. (See Turbott to Secretary to the Administration, January 23, 1936).
Figure 3-5: Women’s Committee Members, Western Samoa, 1926
(Source: AJHR A-4 1926, New Zealand National Archives)

Figure 3-6: Children wait for the Women’s Committee meeting to begin, Western Samoa, 1926
(Source: AJHR A-4 1926, New Zealand National Archives)
First aid clinics were held every day, inspections of household sanitation every Saturday and maternal child health clinics every month. The introduction of the women's health committees not only altered the daily activities of its members but provided the executive with authority which for the first time extended into the domestic affairs of other women. The executive had government authority to enforce new activities, many of which were based on idealized, middle-class European gender roles.\(^{19}\)

Ironically, although neither of the two women initiating these activities fitted conventional, middle-class roles and both worked in an almost exclusively male profession, the roles they attempted to introduce, and in some instances to enforce, were profoundly urban and middle-class and made little allowance for the rural context of Samoan women's lives. Women, with the sanction of the committee, were to be responsible for feeding the family and ensuring that children were fed properly, although it was customary for young men to collect food, cook and serve. Children were to be fed regularly, although most older children foraged for themselves. Samoan households ate only two meals a day, at which the serving sequence was strictly ordered by rank. Demand feeding of infants was strongly discouraged. Pregnant and lactating women were expected to stop "stooping and weeding in the hot sun and carrying heavy loads of firewood" (Christie AJHR A-4 1926:21). The committee was to restrain pregnant women from standing waist deep in the lagoon fishing as these activities were considered dangerous. Young Samoan women accustomed to activity during pregnancy were expected to follow their middle-class, urban, European sisters and just sit.

Although it is likely that the executive only enforced regulations and acted upon information that made sense to them, politely ignoring the rest,

\(^{19}\) A wide body of literature has shown the influence of middle-class, urban, European values of colonists and missionaries upon Third World societies. See Rogers (1980) for a general account; Galley for an account of Tonga; Schieffelin (1980) for the influence of missionaries on Samoan women's status and Lechte (1978) for the impact on Fijian women.
the authoritative structure of the committees offered the opportunity for regulations to be manipulated in such a way that their enforcement enhanced the self-esteem of the executive. It is also likely that compliance with regulations bore less relationship to a perceived need for improved health than to coercion or the need to be seen to be modern.

The work of the committees was widely reported, boosting their prestige both inside and outside the village. The Apia-Falefa experiment was reported to have reduced infant mortality and increased the live birth rate\(^{20}\) (Keyes AJHR A-4 1927:15-21) and it seems that infant health and sanitation visibly improved all over the country.

The Samoan women's committees have taken a most intelligent interest and pride in this branch of their work, and are really doing wonderful work amongst the children. A marked improvement can be seen in the cleanliness of the skin and general well-being of the children (Christie, AJHR A-4 1926:20).

Lambert (1928:15) called the work of the committees "the most brilliant illustration of the possibilities of preventive medicine amongst native peoples" and the Governor-General of New Zealand praised "the excellent work of the child welfare committees in the villages" (*Samoa Times*, December 24, 1926:2). Although it was in the interests of those involved to give optimistic and positive reports, my discussions with elderly Samoans suggest that health among village communities improved significantly.

It was also recognised that the committees not only brought about improved health but "women have been given a greater share in village affairs and with added responsibility they have shown greater interest in health matters" (Keyes AJHR A-4 1927:21). The improvement in health however was shortlived. With the rise of an independence movement, the *Mau*, women's committee health work stopped.

\(^{20}\)It is unclear what Keyes meant by live birth rate.
From Health to Politics

Towards the end of 1926 agitation among the mixed-race population (afakasi), against the New Zealand administration over their lack of political and economic opportunities, gained widespread support and later spread to villages.\(^1\) An afakasi group, known as the Citizens’ Committee, launched a critical attack on the Department of Health, asserting that the people were discontented with the medical tax introduced earlier and claiming departmental inefficiency and over-staffing.\(^2\) In 1929 a clash between Mau demonstrators and the New Zealand constabulary resulted in the death of Tamasese, one of the leading title-holders in the country. A period of non-cooperation with government followed and the “native” supporters of the Mau included opposition to health and medical activities in their anti-government programme. During 1929

... the Mau banned all registration of births and deaths ... unfortunately they have also caused all women’s committees under the child-welfare scheme to cease to function, and, worse still, owing to their actions nearly all sanitary control in the various villages has been lost ... it is impossible to reach the natives without their friendly cooperation ... little has been accomplished this year (Department of Health Annual Report 1928:2-4).

As women’s committee health activities were stopped, women living within reasonable distance of Apia turned their attention to the Mau, providing well organised support for the movement.\(^3\) They raised money

\(^1\)Keesing (1934:177-178) maintains the Mau had its roots in the past and could be compared to other Polynesian prophet movements. Thomas (1985) points to the demands for legal access to land, employment and political power for afakasi as an important aspect of the Mau. Also see Field 1984.

\(^2\)The introduction of an annual tax of one pound per adult male brought about a rapid increase in those seeking medical aid (Keesing 1934:381). In 1921 and 1922 there were complaints from afakasi that medical students were sent from New Zealand to practise on Samoans (Memorandum: Administrator to Minister for External Affairs, Wellington February 2, 1921) and in 1927 a Royal Commission was called in to look into allegations of incompetence and “tyranny”.

\(^3\)It is unknown how many committees attempted to continue with health work without the regular visit of the medical officers, but when visits began again in 1932 three committees were still functioning.
for the Mau, organised protest meetings\textsuperscript{24} and when male Mau members were forbidden to rally in Apia following the 1929 incident, donned their committee uniforms decorated with Mau colours and took to the streets to demonstrate. Keesing saw this as

... a most portentous influence in the new Samoa. In admitting the Samoan women to spheres of political activity in which before they could not customarily participate openly, also in developing wider interests and a sense of unity and power among their sex, it is proving an important factor in the modern cultural revolution (Keesing 1934:186).

The women's Mau, as it was known, provided an exhilarating adventure, but it was short-lived.\textsuperscript{25} The collapse of the rural health service it brought about however had a long-term effect on health (Pirie 1963:81).

Plantations were neglected, children withdrawn from the schools, health conditions uncared for, village cleanliness and neatness allowed to lapse even, in some communities, below the standards of the old days (Keesing 1934:184).

In 1928 Ritchie resigned due to ill health and Christie and Keyes left Samoa. Many expatriate health personnel had also left and the Acting Chief Medical Officer (1928:2-4) complained that through illness and marriage the department had lost five trained native nurses. The primary health care system that had taken so much personal effort to establish seemed to have collapsed and could be written off as a failure.

Although Pirie (1963:81) feels that discontinuance of health work was the result of "backsliding" rather than malicious disobedience, Lambert, who was there at the time, maintained that latrines were torn down by the indignant Samoans and "fields and village stank with a foulness which defied the administration while it killed the Samoans" (Lambert 1941:226). The Acting Chief Medical Officer also saw the decline in health work as a deliberate move (Department of Health 1929).

\textsuperscript{24} Schoeffel (1980:29) reports an effective strategy adopted by Samoan women for expressing disapproval of the administration. At a protest meeting in Apia where women were harried by a contingent of police, at a given signal they turned their backs, threw up their skirts and bared their bottoms - a forceful Samoan expression of disgust.

\textsuperscript{25} A march of 613 women to the tomb of Tamasese in December 1930 was its final appearance (AJHR A-4 1931:4).
The organisational structure of the committees, however, had been well established and when the excitement was over and after time for reflection, there was a local initiative to re-establish them.

At least it has given the more thoughtful Samoans time to realise the value of the work that was being done. Today one often hears even the Mau chiefs regret the fact that the health of the people is going back and that yaws is reappearing among the children. Indeed, some Mau villages have instituted health committees of their own (Keesing 1934:385).

Re-establishing the Committees

The re-establishment of the committees once again depended on the work of dedicated individuals who were unusual for their place and time. In 1930, eight Samoan graduates of the medical school in Suva returned home with Dr Iuelu Kuresa, a previous graduate who had been doing a refresher course in public health. He was a brilliant student and had won honours in medicine, surgery and public health (AJHR A-4 1931:7). With his sister Momoi, the first Samoan nurse to train in New Zealand,26 Kuresa was the moving force behind the successful re-establishment of the women's health committees. He is remembered as a charismatic man, highly regarded by both the Samoan people and his European medical colleagues27. His ability to combine scientific knowledge with a deep understanding of Samoan culture, values and medical beliefs28 together with the enthusiastic support of the new Chief Medical Officer, Dr Turbott29 led to the successful re-establishment of the women's committees. Turbott and Kuresa set out to re-establish the women's committees and restore confidence in the rural health service.

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26 Momoi Kuresa was for many years the Superintendent of Nursing. She spent much time in the field, was much loved by the nurses and although now in her 80s she is still keenly interested in promoting health work.

27 See North 1936:6 and Lambert 1941.

28 This ability is clearly documented in an article published in the Native Medical Practitioners (1936:44-9) which discusses European medical surgery from the perspective of a Samoan family. Also see Kuresa (1930:31-3).

29 Dr Turbott was later well known in New Zealand as the "Radio Doctor".
In nine months Upolu was circled once completely ... Savai‘i was twice completely circled on foot ... the sick were seen, the chiefs and orators spoken with until co-operation was assured, the women’s committees stimulated ... and generally an atmosphere of trust and helpfulness established between the CMO and the villagers ... I personally formed the first (sic) village committee at Lauili, and taught the women to recognise and treat simple ailments (Turbott to Secretary to the Administration, January 23, 1936).

Turbott, an indefatigable worker, re-organised the rural health structure, changed the duties of the Native Medical Practitioners (NMPs) to a preventive rather than curative role and ordered them out into the field “to visit people in their own homes” and to lecture and give practical lessons to the women’s committees rather than sitting in the dispensaries waiting for the sick to come to them. He was impressed by their work.

I spend half my time in the field... going on tours around the districts, seeing that the NMPs were on the job... field work includes schools, village curative medicine, minor surgery, preventive teaching in personal hygiene and sanitation. Now the NMPs do this work every day and under interested supervision do wonderfully well ... I found this village work absorbingly interesting (Turbott to Irwin, January 20, 1936).

Kuresa died in March 1939 while visiting women’s committees. His death was reported as the result of extreme overwork and exhaustion, but some Samoans, it was reported, believed it to be divine retribution for recommending that building latrines was more important than building churches (Schoeffel 1980:33). It was largely due to Kuresa’s work that Turbott was able to report that “during the year Samoan women’s committees were formed in 111 villages and others are in the process of formation” (AJHR A-4 1936:22).

Not content with re-establishing the committees, Turbott set about reforming health education both in the nursing school and in primary schools. He maintained that the nurses’ training was unsuitable (Turbott to Secretary for the Administration, September 17, 1935) and took over teaching them himself, stressing practical work and health demonstrations and organising weekly English lessons for them. He changed the duties of
the nurses in the rural areas and ensured they were moved every three months "so they will not get into lazy ways away from supervisors" and generally maintained close authoritative control over the rurally based staff.

The combined work of Turbott and Kuresa gave the health service new impetus. The experience of the Mau, as Keesing suggested, not only brought about greater Samoan appreciation of the health work the women's committees had been doing, but had welded the committees into strong activist groups and given women a new perception of themselves and their influence both inside and outside their villages. Following the Mau, nursing training was extended from two to three years, more emphasis was placed on maternal and child welfare training and the rural health service and the self-help health approach were strengthened. Samoan women returned to their health-related roles with enthusiasm. The Acting Matron, Miss North, reported visiting large and well-formed committees in both Savai‘i and Upolu with over 100 women at each, all "eager and anxious to learn ... [they] assured us of their help and support of the nurses" (North 1936:6).

The year 1938 marked the consolidation of the improved health service ... in relationship to the establishment of the women's committees, the baby welfare work is regarded as being one of the most important branches of medical work ... a welcome indication of the effect of intensified instruction are frequent requests through the women's committees for cooperation of the administration in erecting conveniences etc ... during the year the NMPs visited 16,000 fales and 1,820 villages, giving admirable service to their own people. All women's committees render excellent service and by close cooperation with the medical authorities materially assist in the promulgation of sanitary education (AJHR A-4 1938:24-25).

Conclusion

The introduction and the acceptance of the women's committees were specific to time, place and people and their precise form was influenced by historical events as well as by internal and external structures and values, supporting the hypothesis that historical factors are important in
attempting to explain information flow and the diffusion of innovations. It is unlikely that such events could be have been predicted or could be replicated. The acceptance of the committees was influenced by the existence of a previous corporate grouping of women as Schoeffel (1980:36) suggests. More important was the access they provided women to new forms of authority, esteem and prestige.

By 1940 committees had been established in 192 villages. Members organised monthly clinics which were attended by all village women and were visited by a Samoan nurse trained in maternal and child care, who from time to time was accompanied by the district NMP. Many villages had "set aside a fa'ate for the reception and care of the mildly sick and members of the committee deputed to attend them" (AJHR A-4 1939:27).

With the authority of the Department of Health, the committee president could legitimately order the fulfilment of health-related activities and clinic attendance, giving rise to a fundamental irony - equal access to primary health care and nutritional information was achieved through unequal access to authority.

Although committee activities were relatively flexible and clinic meetings incorporated Samoan ceremonies, four years after their re-establishment the committee organisational structure and the health-related activities and information delivered through them remained predominantly European and it is unlikely that the committees would have persisted to the present without adapting more closely to Samoan political and social values and without being integrated into the village structure. The years between 1940 and independence, in 1962, were years of expansion and transformation and provide an example of the reflexive interaction between innovation and social, political and economic structures.
CHAPTER 4

COMMITTEE EXPANSION AND TRANSFORMATION

I would like to pay particular tribute to the women’s committees in the villages, which cooperating with SMPs Samoan Medical Practitioners and nurses provide a very strong backbone of the work of promoting health and welfare of the young in the territory. Without these committees and without our nurses we should be able to make but a poor showing (Lonie, Director of Health, 1951:6).

In the years between 1940 and 1962 the women’s committees played such a large role in primary health care they came to be known as the "backbone of the health service". This phase in their development provides an example of the inter-relationship between structure and human activity and of the dual impact of the committees on women’s lives and village structure, and women’s activities and village structure on the committees. This process was reflexive and on-going, and produced continual minor transformations of committee structure in response to local and national change. During this period there were four specific changes in committee structure which were crucial to their continuity and the ways in which information flowed through them.

In the years between 1940 and 1950 the committees embarked on extensive and expensive new health-related activities: membership was expanded from an elite minority to include all village women; and committee organisational and interaction structures were adapted to conform more closely to the ranked hierarchy of the male fono. Finally, in the following years the committees in their new form became accepted as a traditional Samoan institution to which it was customary for all women to belong.
It is unlikely that these changes would have occurred in the way they did without changes in the national political economy and the resulting move from European to Samoan political control, or without the continued encouragement and support of the Samoan matron, Momoi Kuresa, who devoted her working life to improving maternal and infant health.

In 1947, agitation for political independence which had continued since the Mau, culminated in the passing of the Samoa Amendment Act 1947 and political processes were set in motion which would lead to independence. The Act effectively shifted economic and political control from expatriate to Samoan hands (Fox and Cumberland 1962:176) and gave Samoans ultimate responsibility for Department of Health policy. This was accompanied by economic expansion and the 1940s were marked by an increased involvement in the cash economy, greater participation in urban wage labour and a move from village subsistence agriculture to greater reliance on cash cropping. The influence of World War II and the influx of 12,000 American servicemen, together with high international prices for copra and cocoa, resulted in a buoyant economy and greater government spending on health, education and infrastructure. Many of the new committee activities would not have been possible without economic expansion and the rapid move towards a more monetized village economy. Nor would they have been possible without the new spirit of self-confidence that came with political self-determination.

Many efforts had been made to get the Samoan people really interested in European medicine and health measures ... these

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1. The Act called for a new legislature which was to include eleven Samoan members who could be either elected or nominated by the districts, and gave them increased political responsibility. The Administrator was replaced by a less powerful High Commissioner and a Council of State was formed to include the High Commissioner and a Samoan advisor. Davidson (1967:163-187) provides an excellent account of events leading up to these constitutional changes.

2. Changes in employment and the economic situation during this period are fully discussed by Fox and Cumberland (1962:113-125); Pirie (1963:111-139); Davidson (1967:157); and Fairbairn (1958:153).

efforts began to bear fruit and by 1949 many districts had “come alive” in the medical sense. They were now actively demanding a health service developed on an advanced scale, but at the same time they insisted upon district participation (Memorandum: Powles to Department of Health and Others, April 6, 1951:4).

The replacement of European medical personnel by trained Samoans was given fresh impetus and following 1947 the initiative for solving health problems was largely the responsibility of the Samoan people. The New Zealand Government and its officials could “offer advice and persuasion ... [but] no solution [was] possible without the consent of the Samoans” (Powles 1951:4). To assist village participation in health, the government introduced a scheme of shared funding for health development projects, in which the district and the Samoan government each paid half the cost of the buildings and the New Zealand government paid the extra cost of equipment. In addition the New Zealand cabinet allocated 10,000 pounds from the profits of the New Zealand Reparation Estates as its contribution towards hospital equipment (Powles 1951:4). This boost to the rural health service provided the women’s committees with the opportunity to expand their health-related responsibilities.

Expanded Committee Activities

In the 1940s the women’s committees encouraged by Momoi Kuresa built their own committee houses, which they organised as village hospitals, dispensaries and maternity wards. These “hospital fale”, as they were called, were staffed by the committee executive and were well equipped.

They had gloves, pans, bedpans, urinals, there was a cupboard for this equipment. I used to inspect them for a cupboard, bed for delivery, bed for the clinic, chairs, instruments, kidney dishes, bowls ... the women’s committees provided all this. The money came from them (Pers. Comm., District Nursing Supervisor Leotele, 7.6.83).

The committee houses were without exception large and well built and

\[4\text{New Zealand Reparation Estates comprised many of the German plantations which were confiscated at the outbreak of World War I, or went bankrupt during the War. These estates, which came to be known collectively as the Reparation Estates were handed over to the people of New Zealand as their sole war reparations. At independence they were handed back to the people of Western Samoa.}\]
sited in prestigious locations providing constant reminders of their importance. They also reflected increased village prosperity. Both the buildings and the equipment were financed by the women who raised funds from weaving bees, dramas (which enterprising committees toured around the district), dances and the sale of agricultural produce. Some urban villages organised entertainment and dances for tourists, raising over 100 pounds (Hirsh 1958:295). The committee houses were a major achievement for very small groups of village women who had limited access to, and experience in dealing with, cash. By 1950 almost every village had a committee

... with its *fale* for the treatment of the mildly ill and for the convalescence of patients ... if a patient becomes ill in a village, he is usually seen by some representative of the women’s committee (Lopdell to the High Commissioner. April 21, 1949).

The construction of committee houses however was not motivated entirely by altruism or a felt need for a women’s house. As in the provision of other amenities, inter-village competition played an important role.

Both district and villages had begun to develop a similar rivalry in respect of hospitals, schools and water supplies. For these purposes they were willing to levy themselves heavily (Davidson 1967:263).

Competition in some women’s committees extended to the employment of their own district nurse and older nurses reminisce about the construction of increasingly elaborate and better equipped committee houses, which were thought to have reached the epitome of elegance in Faleasii in the early 1940s with a walled house, complete with European-style kitchen, a water-sealed latrine, showers, and separate rooms for both the district nurse and maternity cases. Although competition was considered by some health

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5 The village of Matauta, near the commercial centre of Apia, raised sufficient funds in this way to install septic tanks and water-sealed latrines throughout the village.

6 The original house on the water’s edge has since been replaced by a large and attractively decorated building on the same site.
authorities as "not always healthy" (Ooman 1957:1). The existence of a well-built committee house provided an excellent health facility, a source of village and personal pride and a visible manifestation of female solidarity and organisational ability.

To maintain the committee health service and to carry out treatments ordered by the doctors, committee members were given expanded training in basic nursing, primary health care and maternity work. "At least two older women in each village have been taught how to deliver babies in the aseptic manner" (Report on Child Welfare and Nutrition Education 1957:1) and most women had their babies "... at the Women’s Committee fale or in their own homes, under the care of the District Nurse or some member of the committee trained by her" (Dill-Russell 1960:16). Women organised a roster system to ensure a sustained first aid and nursing service.

There was however a limit to the amount of work the committees could undertake without allowing non-members greater participation in meetings and decision-making. The need for a larger, more cohesive and willing workforce led to the first major change in committee structure.

Structure, Action and Adaptation of Committee Structure

By the late 1940s the small elite committee had given way to one which allowed member status to all women. As the committee was a prestigious organisation most women were anxious to be involved and the satisfaction of officially belonging ensured a reliable workforce. Expanded membership allowed the fulfilment of more ambitious goals: and in response to the government scheme of shared funding for development projects the women’s committees became involved in improving district medical services. While men undertook to provide land and labour for schools and roads, the women’s committees assumed responsibility for raising funds for district hospitals and dispensaries, for maintaining accommodation for medical staff and providing their meals, and for policing and maintaining hospital
grounds. The executive from each village committee formed a district committee to oversee these activities and met monthly with the DMO, to discuss the work to be done, to roster duties (AJHR 1950:41), and to determine the contribution of each village committee in cash, goods and labour.

In districts with an enthusiastic DMO and well-organised women's committees, women raised funds to provide sheets, beds, benches, mats and safes for the hospital over which they maintained a proprietorial interest, considering the hospital and its facilities "theirs". As the wife of one of the DMOs explained:

The women did a lot of work on the hospital. The main ward and one of the houses had no windows, so they got money and put in louvres. First in the wards and then in the nurses' home and doctor's house. Then they got more money and they bought a generator for electricity for the hospital ... then my husband thought it was better to have another meeting and ask the women's committees to collect pillows, pillowcases, sheets, towels, sleeping mats, floor mats and mattresses. So they did all that and they did it well (Pers. Comm., Department of Agriculture Women's Officer Lotte Naseri, 19.4.83).

The district committees collected funds to construct a committee house at the entrance to the hospital grounds, from which they monitored people entering and leaving and ensured "decent" behaviour within the grounds. These responsibilities are still undertaken by rural women's committees.

The second major change in committee structure was a direct consequence of the first and of new attitudes towards European authority and the re-organisation of the Department of Health. The increase in committee size led to greater committee responsibilities and the accumulation of greater economic resources which were controlled by the small executive under the leadership of the president. In most villages the executive were the wives of pastors or government officials, selected by the Department of Health. These women were neither affines nor cognates of the village. With the increased power and importance of the committees this caused disquiet amongst village leaders. Samoan power is associated
with traditional authority, and decision-making is ideally a matter of consensus for which there are clearly defined structures both within the extended family and in the *fono*. This diffuses direct power and mediates against its accumulation in one person. The committees had no built-in structure for consensus or for diffusing power and now had considerably more members than the *fono* (Schoeffel 1980:84-90) which was limited to between 12 and 15 *matai*. Unlike the *fono* in which members ostensibly shared decision-making the women’s committees were controlled by three or four women. To overcome the conflict this concentration of power engendered, the committee executive was expanded to include the wives of the highest ranking men of the village, but the position of president remained a problem. Women now considered it inappropriate to be represented at district-level meetings by a president who did not belong to the village so during the late 1940s the wives of leading village chiefs replaced the pastor’s wives as presidents of almost all committees. This would not have occurred prior to the passing of the Samoan Amendment Act when the New Zealand administration exerted control over the Department of Health and committee leadership.

In the past the president was not the wife of the high chief ... the president was selected by the district nurse or the DMO. But then the high chief’s wives wanted to be president. They wanted power and to be sitting high. So they told the nurse. What could she do? The *palagi* [Europeans] had gone and that was the *fa’a Samoa* (Pers. Comm., District Nursing Supervisor Leotele, 7.6.83).

Most women today state that the change was a matter of conformity to *fa’a Samoa* which allows those of highest rank and status to provide leadership for village organisations (Schoeffel 1979:456). In reality the move did not conform to *fa’a Samoa* and was in opposition to the

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7 Although consensus in village decision-making, arbitration and legislation was the ideal, in practice the highest ranking chiefs dominated the decision-making process.

8 Changes in the authority structure may have been made at the instigation of the *fono*, but there is no evidence to support this.
traditional structure of the "village of the ladies", where the sisters of high chiefs (tama'ita'i) held higher rank and status than chief's wives who were in-marrying women (Schoeffel 1980:36).  

When I went to Poutasi in 1945 the president was Tinae, but this was changed to the wife of the leading ali'i, high chief, because what she says is recognised and taken by the others. You have to work through the wife of the ali'i to get anything done (Pers. Comm., Committee Past-President Soloia Meleisea, 16.4.83).

Several elderly Samoans interpreted these events as a bid by aspiring male members of parliament to gain support from the powerful women's committees. This support was most easily gained by ensuring that their wives were committee presidents. The pastor's wife was not only relieved of her position on the executive but in many villages was excluded completely from committee meetings. Wives of Samoan government officials were also excluded if they were neither affines nor cognates of the village. These regulations still exist in many committees today.

Changes in the power structure required deposing the pastors' wives without causing offence. This was negotiated in a very Samoan way and provides a good example of the relationship between structure and human action. The rationale for excluding pastors' wives from leadership was that it went against Samoan sensibilities for these women to be concerned with matters of the body, which when discussed in a public setting placed them in an embarrassing situation, particularly since the committee's health work had become so extensive. It was of course shameful for Samoan women to cause such embarrassment. The pastor's wife, it was decided, would serve a better and more valuable service looking after spiritual matters pertaining to village women, while the wife of the high chief as a "woman" of the village, should look after the more mundane health-related aspects. This decision was endorsed by most village women who unofficially and with some amusement now relate that without the restraining influence of the

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Both Keesing (1934:476) and Stanner (1953:305-323) discuss changes in what was considered fa'a Samoa at this time.
pastor's wife they could talk about a wider range of topics and enjoy jokes, gossip and story-telling - activities they could not engage in when committee meetings were led by the pastor's wife.

The use of their own committee houses for meetings rather than the pastor's house or the *fono tele* of the leading chief also gave women greater freedom.

There is this peculiarity about the Samoans, they are so sensitive about using the *fale* of the chiefs for the wrong reasons ... this was the place for the men to deliberate about serious things ... not for women to talk about health and having babies. So they built their own ... and they put up large bouquets of flowers to tell everyone - this is the women's committee - then they felt free in their own house to sit and gossip and laugh and scream. They still put up the flowers - you can see them every day at that house down the road (Pers. Comm., Retired Dietician Anui Lagi, 29.5.83).

With the wife of the leading chief as president and the other executive positions filled by the wives of the highest ranking men in the village, the committee executive retained authority to make and enforce decisions, but the locus of committee authority had changed. In the past it had derived from government through the Department of Health. It was now based on the village male authority structure.

**Committee Adaptation to Samoan Social Structure**

This adaptation of women's committee structure brought about changes in the relative status of women, in the organisation of committee activities, and in the ways in which both committee meetings and the monthly clinics were conducted. A new committee interaction structure evolved, based on what was considered correct behaviour, given new power relations between women, and the introduction of new committee activities. By the mid 1950s this structure had become accepted as traditional and remains unchanged in rural villages today. Although Samoan rules of etiquette still governed the way the activities were conducted, the seating

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10 This statement provides an interesting Samoan perception of the relative importance of men's and women's work and of health matters.
order in committee meetings now followed that of the *fono* and determined
who spoke and when, who participated and how. Visitors, including the
district nurse, sat at the front of the house in the position of honoured
guest, the executive to one side in the places their husbands occupied in
the *fono*. The other wives of titled men sat in a group beside them and
the *tama’ita’i* on the opposite side of the house, indicating their different
status. The wives of the untitled men sat at the back in the position of
least importance.

The decline in European control and a reduction in regular European
supervision led to an increase in the time spent on Samoan ceremonies.
The official part of the meetings were now

... conducted with the same dignity and formality as meetings of
the *fono* ... the meetings begin with prayers and each speaker uses
polite and chiefly language. Strict priority of rank and status is
observed with regard to who speaks first, who replies ... speeches
tend to be as lengthy as those in the *fono*, and the women have
the same appreciation of the oratorical style (Schoeffel 1980:65).

The monthly clinics, (which in accordance with Samoan practise I will
continue to call committee meetings), began with prayers followed by
lengthy speeches to welcome the nurse. There was a break for morning tea
before infants were checked and their progress entered on their record
cards. Advice was given where it was needed and any minor injuries
treated. The nurse then gave a health talk or a health demonstration.
These included first aid, bottle feeding, how to make feeding bowls for
infants from coconut shells, how to keep the house clean and food away
from flies and how to prepare food for weanlings. Any pregnant women
were checked and anyone ill at home was visited by the nurse. The
executive were given advice on the treatment of any patients, the
committee first aid equipment was inspected and households checked for
sanitation. A ceremonially presented meal followed and the meeting
concluded with further speeches and prayers.

11 Meetings other than those directly involved in health will be specified.
The specific way in which each activity was carried out was determined by rank and provided a regular reminder to those present of the exact status of all village women, reinforcing the ranking order of the *fono*. Compared to the meetings of the 1920s, these were more formal, with an increased emphasis on ceremony at the expense of health matters.

The regulations introduced in 1923 that had carried moral injunctions, or were alien to Samoan culture had been dropped (see pages 56 and 57) and the DMOs and district nurses were no longer in a position to demand that the committees fulfilled health-related activities determined in Apia and sanctioned by the government. Regulations and committee activities were now decided upon and enforced by the committee executive backed by the legitimate authority of their husbands if necessary. In addition, the committees had taken over the major ceremonial functions of the *auluma* and were now responsible for entertaining visitors and making women's contributions to village events (Davidson 1967:283).

By independence the way in which meetings were conducted, and the structure of both committee membership and leadership, had become consolidated. The assimilation of an institution which displayed all the criteria of a modern bureaucratic organisation points to considerable flexibility in the Samoan system and upholds Schoeffel's (1984:211-212) observation that while Samoans consider they have tenaciously opposed European cultural influences, colonial paternalism rather than Samoan traditionalism was the conservative force. The committees, like the Christian church, were an amalgamation of European and Samoan structures. Both were based on the use of legitimate authority. Both constituted an executive and a clearly structured administrative hierarchy, with established procedures, set goals and rules, and a defined system of accountability, and continued through generations.\textsuperscript{12} Regardless of their European foundation the committees were considered a traditional Samoan

\textsuperscript{12}These criteria are those of Blau and Schoenherr (1971:5).
institution to which all women felt they belonged. The wives of the leading
ing village chiefs automatically formed the executive and the wife of the highest
ranking chief almost always held the position of president.

The Impact of the Committees on Village Structure

By becoming fully integrated into the village system of authority,
village women and the committees lost some of their previous autonomy.

When I first became committee president ... that was in 1949 I
think ... when my husband became the high chief of the village. I
asked my husband everything I should do. I followed his
instructions and orders. Everyone obeyed me (Pers. Comm.,
Committee Past-President Suliolo Tamasese, 8.9.83).

The balance of female power and status shifted further away from the
tama'ita'i, or "ladies" of the village, to the faletua ma tausi, the in-
marrying wives of the chiefs and orators. As Schoeffel (1979:424-471) has
shown, this trend began with the missionaries who, by according higher
status to the secular role of wife than to the sacred role of sister,
downgraded women's independent rank and status as "ladies" of the village.

The changes in the committee authority structure did not pass unnoticed
by Samoans. Looking back over fifty-five years as a district nurse, La'ü of
Fasito'o maintained:

The committees were easily formed because there were already
organisations. You introduce new things through these
organisations. But soon it changes. It's all hierarchy. Always
the hierarchy arranges things in Samoa. It always comes back to
the basic system. This leads and guides the villagers. It is a
good point to keep the tradition intact in the women's committees
- you couldn't get things done without it (Pers. Comm., Retired
District Nurse La'ü, 30.4.83).

Although the committees brought all village women together in one
group cutting across traditional age and status divisions, they were far
from egalitarian and the new structure allowed more clear cut and finely
rank-differentiated divisions of labour than in the past. All women took

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14 Shore (1981:202-203) explains the ways in which women's roles were more differentiated by
group membership than men's.
some part in committee working bees, cutting copra, mat weaving, and in the fund-raising plays and dances, but the more prestigious work which involved organisation, authority and control, was the prerogative of the wives of high ranking men. They organised the clinics, provided treatment in the village “hospital fale”, policed the village freshwater pool and the district hospital.

We enjoyed guarding the hospital and keeping things in order ... we always looked forward to it. We all stayed together in the same fale ... we would be there all day talking while the other women had to work. It was like a week off camping. We played cards (Pers. Comm., Committee Past-President Soloia Meleisea, 6.4.83).

In many respects this was a sensible division of labour as the wives of titled men were often too old to engage in strenuous work but it placed a considerable strain on the young wives of untitled men who, Pirie (1963:136) reports, were expected to work harder than in the past. They were not only delegated the heavy committee duties but were also expected to continue helping with family agricultural work and to mind small children. With the older women, the traditional babyminders, also busy with the committee “it [was] not uncommon to find a baby left screaming at home all day with a brother or sister 4 - 8 years old” (Holmes 1954:233) although an important activity of the committee executive was supposed to be encouraging and overseeing good infant care and regular feeding. But as the young wives of untitled men held lowest status in Samoan villages, with the exception of children (Schoeffel 1979:241) they did as they were told.

In those days, when I was a district nurse in Savai‘i, if the president said do this and this, they obeyed. If she told the taulele’a (wives of untitled men) don’t do this and this, they didn’t do it. There were no questions, nobody said a thing. They obeyed (Pers. Comm., District Nurse Olive, 27.4.83).

At this time new activities were introduced in the clinics which added

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15Pirie also suggests they bore more children.
to women’s work and provided further opportunities for competition. To encourage women to “help build up their household and the health of the family” Momoi Kuresa introduced monthly inspections of household goods, known as the astasiga. Each month the president or the nurse suggested a new household item (sheets, food safes, mosquito nets, sleeping mats, roof thatches), which each woman should make or buy and bring to the following committee meeting for inspection. The way in which these goods were inspected was an adaptation of the traditional display of fine mats. Each item was paraded through the house, the name of the woman it belonged to called out, and comments made about the quality and/or cost of the item. In 1950 infant record cards, modelled on those used by the New Zealand Plunket Society, were introduced (AJHR 1951: 46) and the weight of each infant was graphed. District nurses today believe that in the ensuing efforts among women to outdo one another in the quality of goods displayed and the size of their infants, the health-related meaning of these activities was soon forgotten.

The Nutritional Information

It is impossible to know how much nutritional information was delivered in the committees during these years or what the constraints were to its flow, but Holmes (1954:234) states that in the women’s committees “medical education has emphasized hygiene to the detriment of infant’s nutrition”.¹⁶ She also suggests problems with the dissemination of nutritional information. “In a society largely patriarchal in outlook, new ideas, especially when they come from a woman, may cause ridicule” (Holmes 1954:238).

Although infant nutrition had formed an important informational component of committee meetings for nearly thirty years no scientific nutritional research was conducted in Western Samoa until the 1950s.

¹⁶Appendix 4-1 lists the nutritional information that was officially supposed to be disseminated.
when under the auspices of the South Pacific Health Services and the South Pacific Advisory Nutrition Service, (part of the South Pacific Commission) several studies were undertaken. Bell (1950), Malcolm (1954), Holmes (1954) and Ooman (1956) all agreed that "nutrition appears to be influenced more by dietary customs than by the availability of food" (Holmes 1954:223), but with the exception of Holmes, European inability to consider cultural preferences other than their own remained as strong in the 1950s as thirty years earlier.

The virtues of cow’s milk were given greater emphasis than in the past and health officials remained convinced that milk was the solution to all Pacific Island infants’ nutritional ills.

If cow-milk is available, either fresh or tinned, these nutritional difficulties can be overcome easily. The beautiful undisturbed development of white children in Europe, North America, Australia and New Zealand can prove this point (Ooman 1956:7).

Bell (1950:6), in a study of infant and maternal nutrition and haemoglobin values, also considered lack of cow’s milk an important factor in infant health problems and recommended a school milk scheme. She also recommended that the Department of Health encourage village mothers to breast feed their babies for as long as possible rather than advising them to stop by nine months. She proposed a new weaning diet which included the introduction of pawpaw juice at one month of age, the introduction of fish and meat at eight months, and breastfeeding on demand until 15 months where possible, if not, cow’s milk or powdered milk were recommended (Report on Child Welfare and Nutrition Education.

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17 With the exception of a Samoan doctor, who made a study of Samoan weaning foods. See Fa’atiga 1942.

18 The SPC Quarterly Bulletin, (April 1956:7) outlines the contemporary nutritional research into food preservation, evaluation of nutritional status, production and distribution of foodstuffs and the chemical analysis of food.

19 Bell (1950:6) pointed out that with increased population there would be a reduction in exports and greatly increased strain on food resources. She recommended that apart from milk, "policies should be directed toward maintaining the indigenous diet as far as possible".
Holmes, while noting that lack of cow's milk resulted in weaning diets deficient in protein, was prepared to accept the importance of Samoan customs and that

... it is possible to prepare an excellent weaning diet from Samoan village foods ... if sufficient trouble is taken and full use is made of the available foods by preparing them suitably ... Since nutritional status was much influenced by locality and custom, it is suggested that the nutrition of the infant might be improved if more consideration were given to village customs in Public Health and Child Welfare programmes for Samoa (Holmes 1954:239).

It was some time however before the results of these studies brought about changes in the nutritional information disseminated to village women and in 1960 women were still told to give bottled supplements, boiled water, four feeds in 24 hours rather than demand feeding, no mashed food until six months and to be completely weaned from the breast by nine months. Masticated food was still "strongly discouraged" even though Holmes (1954:234) had pointed out that "many mothers fail to soften the food in any other way, and often the baby gets only a hard lump of taro or banana".

Some of the nutritional information clearly reached both men and women. Holmes claims that village women could recite the nutritional information given by the district nurse and Monaghan (1955a:211) reports that during her years as matron in Western Samoa "numbers of fathers from out-lying villages ... came to ask for advice and a recipe for milk mixtures for their babies".

Media Support for Nutritional Information

Between 1940 and 1960, nutritional information disseminated through the committees continued to be supported by posters, slides, films and newspaper (Figure 4-1). A mobile clinic regularly toured the women's committees and showed poster displays and films on sanitation, hygiene and

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20 The full recommendations are contained in Appendix 4-1.
infant nutrition. By 1948 the newly established radio station was being used to support health education.

There has been a series of two health lectures weekly in Samoan and one in English over the new broadcast system and a "Women’s Committee Hour" is planned in addition (AJHR A-4 1948:34).

![Sister Monaghan uses a South Pacific Commission nutrition poster during a talk to a women’s committee. 1955](Source: SPC Quarterly Bulletin 1955:22)

Articles in the government newspaper O le Savali continued and the South Pacific Commission assisted with visual aids. Efforts were made to provide material in Samoan language and the South Pacific Commission was increasingly aware of the need to provide material relevant to individual Pacific societies. The New Zealand Department of Health apparently was not.

Posters and other illustrative matter ... that have been sent from the New Zealand Department of Health look singularly incongruous.

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21 The SPC Quarterly Bulletin 1955:19-21 lists all visual aids available. They include a filmstrip, display posters, flannelgraph on the use of soap in a New Caledonian setting; a filmstrip on filariasis in a Samoan setting; and a filmstrip on milk for babies, a flannelgraph on bottle feeding in a Micronesian setting and a poster showing the correct diet for pregnant and lactating women within a general Pacific setting.
in the Island setting. One is tempted to relate how a poster depicting a fish looking at a tooth-brush drew the question "What sort of a bait is that?" (Bell 1950:6).

The Effectiveness of the Committee Clinics in Improving Health

There is no doubt about the effectiveness of the committees during this period in changing women's roles, their daily activities and use of time, but did they help improve health? At this distance in time it is impossible to know what role the women's committees played in the appreciable decline in infant mortality and the increase in life expectancy. Infant mortality declined from 73 per 1000 live births in 1942 to 42 per 1000 in 1951 (McCarthy 1954:22) and life expectancy rose to 62.3 years for men and 65.5 years for women (McArthur 1956:175-6). Both rates were better than for New Zealand Maoris (Pirie 1963:94). It seems likely that this improvement can in part be attributed to widespread participation in the women's committees. But the scientific reports, private letters, memoranda and hospital census data dealing with Samoan health and hygiene during the 1950s provide conflicting evidence. Almost all were written by Europeans, many of whom were visiting or working in Samoa for the first time, and who therefore had an inadequate basis for comparison. It is likely that poor conditions were exaggerated for the sake of a good story, for obtaining more staff, or increased economic assistance.

The women's committees were always highly commended but there were few reports of sustained improvements in health or of satisfactory nutritional knowledge resulting from their work.

The women's committees are a ready-made [sic] foundation for putting progressive ideas into action ... In fact the possibilities are so good that the development of mother and child health, along European lines, appears to be within reach ... but knowledge about the right foodstuffs and procedures is not yet satisfactory (Memorandum, Ooman to Executive Officer for Health, SPC, October 22, 1955:1-2).

A report of the Medical Research Council of New Zealand, based on research between 1948 and 1953 states that "after weaning the children
appear thin and small, with a small proportion showing signs of obvious under-nourishment" (McCarthy 1954:35) while the Department of Health (1957:1-2) records that "it is during the weaning period, from 9-18 months that we find most ... cases of malnutrition. The number of cases for the year ending 31st. December 1957 was 1,164." This was attributed to lack of education.

Until recent years great difficulty has been found in trying to make the mothers understand that the younger children need special attention especially in regard to feeding. This still applies to the majority of older mothers, but the young mothers who had had the benefit of some education realize that we are trying to help them help their families and are usually willing to try whatever the district nurse or SMP suggests (Western Samoa Department of Health, 1957:1-2).

In areas where there were strong "women's committees ... the number of malnutritions [sic] notified have dropped by about three-quarters in the last two years" (loc. cit.).

Bell (1950) and later Elliott (1959:1) commented on the continued use of the traditional healers and Elliott, an ophthalmologist, reported the highest incidence of eye disease he had ever experienced. Although in the committee clinics considerable emphasis had been placed on village sanitation and hygiene, sanitation was reported to be poor.

Although a great deal is done by the women's committees to clean up villages and organise proper disposal of refuse, this is clearly insufficient as the fly menace is extremely serious ... a great deal more time and effort should be given to health education ... Radio broadcasts should be increased and enlivened by plays etc. It is only when the public knows what is required and why and is prepared to co-operate that conditions will improve (Dill-Russell 1960:14-15).

Department of Health Administrative Problems

By the end of the 1960s, 13 years after Samoans effectively took control of the health service, serious administrative problems threatened the survival of both the rural health service and the women's committees and it is unlikely that the committees would have survived had they not become so well integrated into Samoan village structure. The problems
were first heralded in 1949. Extensive Samoan demands for improved curative services in the rural districts led the Director of Health, Dr Lopdell to propose a revised health service plan which included additional district hospitals and rural staff.\(^2\) The plan was regarded by the Departments of Island Territories and Health in Wellington to have "too much emphasis on the curative side and ... requirements beyond the realm of practical politics" (Memorandum, Ritchie to Secretary, Department of Island Territories, October 19, 1949). The South Pacific Health Board, asked to report on the situation, offered a number of suggestions, most of them in opposition to Lopdell. The Board's report was angrily opposed by both the Samoan administration and Department of Health personnel\(^2\) who maintained that the New Zealand Health Department and the South Pacific Health Board had

... misconceived ideas and incomplete information on the present set up and lack of understanding on part of the Health Department in N.Z. on local conditions and of political and social change here in the last three years ... and a willingness to offer destructive criticism without checking on the spot ... peremptory and dogmatic advice of a misleading nature is offered on the flimsiest [sic] background knowledge (Telegram No.502, Malo, Apia to Department of Island Territories, Wellington, October 20, 1950).

The main themes of the Board's report were medical centralisation and professionalisation of the service. On the one hand the Board recommended that increased effort be put into preventive measures at village level, on the other that the women's committees be relieved of their primary health care functions.

\(^2\) See the Report on Policy and Development of the Medical Department, June 15, 1949 and Organisational Structure of the Health Department, October 11, 1949 in the New Zealand National Archives, File IT 8/12 No.5.

\(^2\) The correspondence arising from this battle is voluminous but the major arguments are contained in Lopdell to Powles (undated) 1949; Lonie, Chief Medical Officer, Apia to Secretary to the Administration, April 21, 1949; Memorandum Ritchie, Director-General, Department of Health, Wellington to the Secretary, Department of Island Territories, October 19, 1949; Telegrams, Powles, Malo, Apia to Department of Island Territories, Wellington, October 20 and 21, 1949; Patrick, Secretary of Department of Island Territories to Minister of Island Territories, January 26, 1950; Cruikshank, Inspector General, South Pacific Health Services to Powles, High Commissioner, Samoa, April 16, 1951; Powles, High Commissioner, Samoa to Secretary, Department of Island Territories, April 6, 1951. (New Zealand National Archives, File IT 8/12).
In response to these recommendations Powles, the New Zealand High Commissioner, countered:

To suggest that village women’s committees should not undertake treatment, as the Board does, is like suggesting that a New Zealand mother should not herself give her baby castor oil (Memorandum, Powles to Department of Health and Others, April 6, 1951).

In Powles’s view the Board had obviously overlooked political changes, that the Samoan people were now in control of health, and the fact that primary health care and preventive medicine were ultimately concerned with involving village people in taking responsibility for their own health needs. The die for the future service however had been cast.

With inconsistent staffing and periodic shortages of nurses and doctors...

... the district health service suffered severely, as the department could do little more than maintain essential curative services ... it is no longer possible to continue to visit schools ... Also the loss of the Health Sister, the maternal and child welfare work carried out by the District Nurses has suffered badly through lack of organisation and adequate supervision (Annual Report of the Health Department, AJHR 1959:10-14).

These problems had little initial impact on the women’s committees which as autonomous institutions continued to hold regular meetings, to maintain the district hospitals and oversee village sanitation. But by independence the SMPs in district hospitals had been forbidden to engage in surgery, and the women’s committees had been relieved of their curative, first aid and nursing work, which were considered by outsiders as “unprofessional”. It marked the beginning of the end of the women’s

24 Although between 1945 and 1958 the number of Samoan doctors had increased from 22 to 43 (AJHR 1945-1958) and 19 fully trained district nurses were in the rural areas, the rural health service was hampered by inconsistent staffing and periodic shortages of nurses and doctors. Rural postings were unpopular and the Department of Health was no longer prepared to enforce rural postings. See Elliott to Secretary of Island Territories, August 4, 1959. NZNA File IT8/12 No.6.

25 This was a blow to their prestige and they countered with threatening the first strike in Samoan history. A lengthy correspondence with the Samoan Medical Practitioners Association, the New Zealand Prime Minister and United Nations is contained in New Zealand National Archives File:IT8/12.
committees as groups in which primary health care was based on community participation. Women not only lost their prestigious practical health work but felt a keen sense of failure. More important, this decision moved the responsibility for primary health care out of the hands of village people and into those of paid government workers. The women's committees looked for other channels through which they could achieve esteem. Their new activities had no or only indirect association with health. Agricultural projects, equipping schools, supporting the church and greater emphasis on contributing to village festivities afforded the prestigious goals the Department of Health no longer provided. Although the committees retained their reputation as the "backbone of the rural health service" health was only one facet of their work and their health activities were indirect.

Conclusions

In the years between 1940 and independence the women's committees expanded their membership and activities and underwent structural and procedural transformation. In this time they developed into Samoan institutions that were closely integrated into the village social, political and economic structures. This transformation supports the theses of Giddens, Layder and Thrift in that it resulted from a process of continual dynamic interaction between innovations initiated in the committees, including changes in women's roles and relationships and their use of space and time, between Samoan village structure and cultural values, and national political and economic policies. The situation supports the hypothesis that the introduction of innovations has unintended consequences which continually influence the subsequent structure of the women's committees and the village.

Although there had been rapid population growth during this period and escalating urbanisation, Samoan society remained small-scale and the

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villages continued to form cohesive units that jealously guarded their autonomy. People "remained deeply conscious of their associations with the village and district, with their positions in the lineage structure" (Davidson 1967:428). They interacted in known relationships within small, hierarchically-organised communities. Village cohesion and sense of community enhanced conformity to accepted patterns of behaviour and provided an important determinant in committee development. The committees in turn helped maintain village cohesion, confirming Calhoun's (1980:126) argument that "community both depends on familiarity and helps produce it". Community closure, as Weber's theory of community proposes, was continually operated in the committees to maintain control over scarce resources.

The women's committees also show that even within a highly structured, small-scale, hierarchical society there was room for innovative activity. Village women set and attained a number of ambitious goals, reflecting considerable organisational ability, the capacity to see new opportunities and to take advantage of them, and a determination to innovate using fa'a Samoa as a camouflage for these actions if necessary. However, as women's new activities, new authority and interaction patterns became consolidated, what had been innovative action became habitual, or what Parsons (1937) would term "behaviour", influencing the patterns of action that followed. In the process, health initiatives lost their health-related meaning and were used to achieve goals that had no health association. During this period it seems that the medium itself, the system of women's committees, not the message it was established to disseminate, had the greatest impact on Samoan society. The development of the women's committees both helps explain and lends credence to McLuhan's claim:

> For the message of any medium or technology is the change of scale or pace or pattern that it introduces into human affairs ... it is the medium that shapes and controls the scale and form of
human associations and actions. The content or uses of such media are as diverse as they are ineffectual in shaping the form of human associations (McLuhan 1964:245).

McLuhan however, fails to take account of the fact that the processes of innovation and change are reflexive and the medium itself is subject to continual transformation.

In this phase of their development the committees showed little obvious sign of spatial differentiation and time was the variable of major significance. Over the following 20 years it was to be space.
CHAPTER 5

SOCIAL CHANGE, VILLAGE DIFFERENTIATION AND COMMITTEE DECLINE

The committees and the nurses used to be known as the backbone of the health service - now we are just the tail end (Pers. Comm., District Nurse Olive, 20.7.83).

Between 1962 and 1983 the number of women's committees increased from around 200 to 553 but the proportion of women attending, and support for committee activities declined, jeopardising the delivery of primary health care and nutritional information. The degree of decline was spatially uneven and closely associated with reduced support of the Department of Health for rural health services. In these 21 years Samoan society underwent rapid transformation. The population almost doubled, extensive internal and international migration altered village demography, and new sources of economic and political power brought changes in the use of authority and in attitudes towards the *fono* and the women's committees. The inter-relationship between village formal, substantive and interaction structures, which in the past had ensured community cooperation and support for community-based organisations, began to disintegrate and structurally different villages emerged.

**Demographic Change**

Differential rates of population growth and internal and international migration have influenced both the social and political structure of Samoan villages and committee attendance. Like most Pacific Island nations, over the last 50 years Western Samoa has experienced rapid population growth. Between 1936 and 1976 the 3 per cent average annual increase was one of the highest in the world, placing strain on the rural health service and
committee organisation. Population growth began to decline in the early 1970s with extensive out-migration, and declined further in the 1980s with a drop in fertility which was more marked in the urban areas (Department of Statistics 1982(3)). Today, Western Samoa has a population of around 157,000 of whom 33,000 (21 per cent) live in Apia and the rest in coastal villages *averaging* 500 people.

Extensive internal migration has been an historical characteristic of Western Samoa. Movement is age specific and a high proportion of those migrating both into Apia and overseas has been in the 15 to 39 year age-bracket. Although internal migration patterns are confused by virilocal marriage and by the high proportion of women who return to their natal villages for extended periods, as well as by young people who move to live with relatives in other villages, the dominant flow since 1920 has been from Savai'i and rural Upolu to the northwest coast of Upolu. Today an emerging pattern is movement out of the central Apia villages to new freehold suburbs on the outskirts of town. The major motives for internal migration in the past were education and employment but it is now recognised that migration has important social connotations (Connell 1983:38) and is seen by young people as part of 'being modern'. Harrison (1978:95) associates it with 'a rite of passage...an almost essential aspect of a transition in social life'. Apia, as the political centre for an intensely political society, has also attracted the ambitious and high-ranking village matai and their wives. Since the early 1970s the growing concentration of economic and political power in Apia has left many rural villages without strong leadership in either the *fono* or women's committee (Thomas 1984a:140).

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2 Given this continual mobility including that of young children who are adopted out of the village, the counter-movements discussed by Walsh (1982:88) are unreliable.

3 Pitt (1977:7) has shown that in 1964 half the primary school children in the villages he studied went to Apia or overseas for secondary schooling. Also see Shankman 1976.
Emigration to New Zealand, American Samoa, Hawaii and mainland United States has been of major significance in the recent and rapid social transformation of Samoa. Emigrants are drawn from all over Samoa but over half have come from villages in Apia and the northwest coast of Upolu (Connell 1983:30-31). The motive for emigration is now overwhelmingly economic. Samoan migrants working in New Zealand earn as much as ten times more than in Western Samoa (Salale 1980:3) and five to seven times more in American Samoa. It is considered by Samoan families that “migration is a far more lucrative investment than anything available in the village” (Shankman 1976:71) and the decision to emigrate is usually made by the migrant’s aiga or matai who expect to receive regular remittances. Few young people are interested in remaining in the village and supporting the aumaiga or the women’s committee.

Remittances from emigrants have grown steadily since 1970 and in 1984 alone amounted to T41 million (T1=$A.60) (Department of Economic Development 1984:32), with unofficial inflows estimated at more than twice this figure. They now comprise the fastest growing component in the country’s economy. The trend has been for women to remit more money, more regularly than men, and my research confirms Shankman’s finding (1976:60-61) that “a large amount of money is transferred between women”, usually from daughter to mother, giving older village women greater economic leverage than in the past. Almost all households receive remittances but the frequency and amounts vary considerably. A high proportion of remittances is spent on imported food (Tiffany 1979:151), school fees, church, and support for family, village or women’s committee.

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4 Major emigration began during World War II when most migrants were aged between 15 and 24 (McArthur 1967:129). In the ten years between 1957 and 1966 just over 10,000 people, or 8 per cent of the total population emigrated (Lorenzo 1969:3), and emigration reached a peak in the early 1970s when the official number of net migrants for the five years to 1975 was 12,232 (Department of Statistics 1979:50).

5 Also see Ward and Proctor 1980:398.

While Samoans have increased their consumption of imported goods, agricultural production continues to decline. This paradoxical trend of consuming more while producing less is, in large part, the result of migration and remittances (Shankman 1976:xi).

The population today is concentrated in villages along the northwest coast of Upolu, leaving Savai'i, the larger island with little more than one-quarter the total population (Figures 5-1 and 5-2).

**Table 5-1:** Population Distribution by Region, Western Samoa, 1961-1981

(Percentage of Total Population)

<table>
<thead>
<tr>
<th>Area</th>
<th>1961</th>
<th>1971</th>
<th>1981</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apia Urban</td>
<td>18.9</td>
<td>20.5</td>
<td>22.0</td>
</tr>
<tr>
<td>Northwest Upolu</td>
<td>24.2</td>
<td>24.3</td>
<td>25.8</td>
</tr>
<tr>
<td>Rest of Upolu</td>
<td>28.7</td>
<td>27.4</td>
<td>25.4</td>
</tr>
<tr>
<td>Savai'i</td>
<td>27.8</td>
<td>27.7</td>
<td>27.0</td>
</tr>
</tbody>
</table>

(Source: Adapted from Department of Statistics 1979 and 1983)

With excellent transport facilities between Apia, the international airport at Faleolo and the inter-island ferry terminal at Mulifanua (Figure 1-1) this region has experienced in-migration since the 1960s. Many villages now have populations of over 1,000 and settlement is almost continuous along the 44 kilometers of coastline between Apia and Faleolo. These villages contain a proportion of rural relatives who have moved to take advantage of better educational and employment opportunities (Pitt 1970:172). Villages on the southeast coast of Savai'i and around Asau have also grown in the last ten years. Saleiologa, the ferry terminal, has become the major administrative centre for Savai'i where government offices, a market, banks, library, Land and Titles Court, Magistrates Court

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7 Tinned fish, frozen turkey tails, chicken backs, mutton flaps, rice, flour and sugar are now staple foods in both urban and rural villages. Urban villages are almost totally dependent upon store-bought food, most of it imported (Thomas 1981a:32-35).

8 See Appendix 5-2 for map showing population increase 1971-1981.
and small businesses offer employment opportunities. In Asau employment opportunities are offered by a timber mill and a forestry project. Settlement throughout the country has also been influenced by new roads and many villages have moved from their original lagoon-side sites or have established new sub-villages near the road.

Settlement inland remains sparse and the overall population density low. Only in central Apia, where houses are crowded onto small areas of customary land surrounded by commercial buildings, is population density high (Table 5-2). By 1970 overcrowding in these areas had led to health and social problems (Soon 1971).

Age distribution is uneven with a higher proportion of those aged 15 to 29 years and a lower proportion of those under five years of age living in Apia (Figure 5-3). With out-migration and declining fertility, household size is reported to have dropped from 12 in 1961 to 5.1 in 1981 (Department of Statistics 1983:43) but given that many households still comprise an extended family, this seems low. Using the same definition for household as the Department of Statistics¹⁰ my household data from rural, peri-urban and urban villages shows an average household size of 10 with a variation between urban and rural villages and between different types of urban villages. Vaiala, a village in central Apia, has an average household size of 14; Tulaele, a settlement in a new freehold suburb, 6; Faleasiu, village on the north-west coast of Upolu, 12; and Poutasi, a rural village on the southeast coast of Upolu. 10.

The Impact of Demographic Change

Extensive migration has resulted in most villages in rural Upolu and Savai‘i remaining much the same size as before Independence while the population more than doubled in villages along the northwest coast of Upolu and the southeast coast of Savai‘i. Rural villages are characterised by a high proportion of older people and young children while urban and

¹⁰A household is defined as those who regularly eat together.
Figure 5-1: Population Distribution, Upolu, 1981

Figure 5-2: Population Distribution, Savai'i, 1981
Table 5-2: Population Density per Km² by Region, Western Samoa, 1961-1981

<table>
<thead>
<tr>
<th>Region</th>
<th>1961</th>
<th>1971</th>
<th>1981</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apia</td>
<td>2148</td>
<td>2996</td>
<td>3317</td>
</tr>
<tr>
<td>Northwest Upolu</td>
<td>744</td>
<td>951</td>
<td>1991</td>
</tr>
<tr>
<td>Rest of Upolu</td>
<td>224</td>
<td>275</td>
<td>270</td>
</tr>
<tr>
<td>Savai'i</td>
<td>168</td>
<td>215</td>
<td>228</td>
</tr>
</tbody>
</table>

(Source: Adapted from Department of Statistics, 1979-1983)

Figure 5-3: Population Distribution between Urban and Rural Areas, by Age and Sex, Western Samoa, 1981

Peri-urban villages have high proportions of people in the 15 to 35 year age group. Rural villages are short of able-bodied young men and women to help with agricultural and household work, a situation exacerbated by many young people remaining in school for two to three years longer than prior...
to 1975 when district high schools were established in all rural areas providing secondary education for 70 per cent of young people (Department of Economic Development 1980:162).

The move of women's committees into agricultural projects and the higher proportion of infants in traditional villages, some of them infants of urban family members, places a greater work load than in the past on young married rural women who now have little time to devote to committee work. Although excellent transport facilities allow more mobility than 20 years ago, out-migration has left rural villages with small and relatively cohesive populations. People still work and interact in known relationships within the village social and physical environment. Relative rank and each individual's family and community responsibilities remain clear cut and known to all and in most villages there is still social pressure to conform to the accepted patterns of behaviour, including attending the committee. The maintenance of individual and family esteem are still powerful factors influencing behaviour (Freeman 1983:154).

In peri-urban and most urban villages, households have expanded rapidly. The influx of relatives from rural villages could not be assimilated without altering existing social relationships. The new arrivals do not feel the same obligation to the village community as long-term residents, and as most of the immigrants spend their time in school or at work outside the physical and social environment of the village, new interaction patterns have emerged based on larger household units. Wage labour, the emergence of the workplace or school as an important locale for interaction and greater economic and social independence of the household from the village community. Support for community institutions including the committee has declined. In the very large villages along the northwest coast of Upolu rapid expansion has led to the division of villages into sub-villages. These villages have a high proportion of well educated young people who are prepared to question traditional authority and to flout traditional patterns of behaviour, including support for the women's committee.
In villages in central Apia, where shortage of land has precluded physical expansion and overcrowding is common, the pattern is for several households of one family to be clustered together on very small portions of family land. Although the family remains loosely integrated within the village structure it has become socially and economically independent and on a day-to-day basis operates as an autonomous unit with little or no pressure to support community organisations or the traditional ranking system.

Economic and Political Change

Since independence the village economy has developed from one reliant largely on semi-subsistence agriculture to one with multiple sources of income, most of which now derive from outside the village and beyond the direct control of the matai. The impact of remittances and the increased numbers in wage labour have changed the daily activities and interaction patterns of villagers and weakened the authority of the matai, who no longer have complete control over the family or village economies. Remittances have also given older women greater economic independence than in the past and these funds, rather than women’s communal work, are now used to support the committee. This has helped weaken the committees as community organisations.

Since 1975, the agricultural labour force, agricultural production and exports have declined changing the foundation upon which matai establish their political and social positions. In 1977 government attempted to improve village agricultural productivity with the establishment of the Village Development Programme which provided heavy subsidies for

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11 Some villages have established secondary settlements on family land inland from Apia.

12 During this time imports have quadrupled, leading to a trade deficit of $49.3 million in 1983, an increase of 800 per cent in ten years (Department of Economic Development 1984:4).

village-based development projects. Special recognition was given to the role of the women's committees who were encouraged to embark on a series of agricultural and development-related projects. Many committees established poultry farms and piggeries drawing on younger members to provide labour while the executive managed the finances. Although few of the projects were successful and few continued for more than three years (Moran 1983:3-4; Alailima 1981) they added to the regular work young married women were expected to undertake - a commitment for which they received no reward. At a time when an increasing number of young women had secondary education and held ambitions for paid employment, this was resented.

Following independence the Samoan political system underwent fundamental changes which had long term implications for village power relations and committee structure. Many of the consequences were unforeseen. The new constitution allowed only matai to stand for election and vote and by introducing a secret ballot gave the same weight to the votes of high and low-ranking matai. This was in opposition to traditional practice where the decisions of high-ranking matai carried greater weight than those of less important men. In addition a secret ballot ran counter to the tradition of decision-making by public discussion and consensus in the fono (Harrison 1978:128). In the early 1970s aspiring members of parliament who wished to out-vote rivals created new titles or divided existing ones between two or more members of their aiga so that between 1973 and 1980 the number of registered matai increased three times faster than the population (Klei 1982:2). Today nearly all older men have a

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14 Two of 47 seats are reserved for those legally classified as "independents". These seats are voted for by individuals registered as of European extraction and includes those of mixed-race.

15 Also see Davidson 1967:150.

16 Klei shows that in 1961, 4,594 matai were on the electoral roll with a ratio of one matai to 21 persons. By 1982 over 15,000 titles were registered. Some matai hold more than one title but may vote only once.
title and the ratio of those who can give orders to those who are expected to carry them out has changed. The criteria governing election to a title have also changed. In the past it was unusual for young men to have a title and the criteria for election were knowledge of the *fa'a Samoa* and proven ability to look after the family. In those days most *matai* lived in the village with which their title and land were traditionally associated. New economic and educational opportunities have provided new ways of gaining status and prestige and an increasing number of important titles are bestowed on young, educated and financially independent men, many of whom live in town.

The Impact of Political and Economic Change

The impact of political and economic change has led to an overall weakening of the traditional systems of authority and conflict resolution. This augmented the decline in community activities. Changes are most obvious in the urban and peri-urban areas where greatest reliance is placed on wage labour and in 1983 were particularly noticeable along the northwest coast of Upolu from where a significant number of villagers commute into Apia to work each day. Although commuting has been common since the mid-1960s and was considered "advantageous in that it involved little disruption with village life, either social or economic" (Connell 1983:25) this is no longer the case. In these areas, community cooperation in house-building, fishing and agriculture has almost disappeared, and support for community organisations other than the church is weak. Families now pay cash for services and food rather than relying on family and community assistance, obligation and redistribution. Fines and ostracism, the traditional means of social control, are no longer effective and can seldom be enforced. Remittances have also "weakened the strength of both the *aiga* and the *matai* as social power declines in the face of

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17 Harrison (1978:156-159) has shown that bestowing titles on the young, well-educated or wealthy was often a means of overcoming "status dissonance" - or a situation in which rank and status were not commensurate.
economic power” (Connell 1983:45). Economic power is now considered by Samoans to be more important than in the past.

In those days when I was young we served the high chief as king. His word was law. Today there are many changes. For example even though you are an important chief but poor, your words don’t become law now. But the high chiefs who are rich, they maintain their authority (Pers. Comm., Journalist Lelei, 22.6.83).

Others consider that the increase in the number of titles for voting purposes “did more to destroy the prestige and authority of the matai than all other changes” (Pers. Comm., Former Registrar, Land and Titles Court Tuiletufuga, 11.6.83.). The degree to which matai authority has declined however varies with location and although there are exceptions, change has been greater in urban villages than in rural communities where the matai retain some control over family and village affairs.

Loss of matai authority prompted a strong reaction both locally and nationally. Faced with agitation for universal suffrage, government attempted to strengthen the authority of the matai and the women’s committee leaders by introducing legislation in 1983 which would give both groups formal authority over community participation in village development. The fono attempted to impose greater control over village activities than in the past; in the early 1980s several court cases involved matai who had infringed criminal law in attempts to enforce authority. Threatened by the increased number of women whose husbands had titles, the presidents of some women’s committees attempted to exert greater authority than in the past.

There was a big change after independence. Too many presidents thought themselves too high. They didn’t want to listen to the nurse. Today they want to make all the orders. Today they want

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19 In one village the fono burned down the house of a bus driver who refused to attend church. They also threatened physical harm to any villager who rode on his bus. When an elderly matai broke the ban, he was tied up like a pig on a pole and left lying in the sun all day. See Observer January 8, 1981:1. In other villages curfews were imposed at 9 p.m.; young men were beaten if their hair was longer than the fono prescribed; and all villagers were expected to conform to new levels of modesty in dress.
to run things their way. They don't care about health. They just want to be high and give orders. They forget that the committee is for helping all women. They just want to help themselves (Pers. Comm., District Nursing Supervisor Leotele, 2.5.83).

Young people state that the behaviour of village leaders reinforces their beliefs that *fa'a Samoa* and the traditional system of authority have little to do with modern life. They feel that to be successful they must break away from the "old ways". This includes no longer supporting the *aumaga* or the women's committee.

**Changes in the Rural Health Service**

Three decisions made by the Department of Health in the mid-1970s influenced women's committee structure and indirectly that of the villages. These were the centralisation of the health service and the employment of male sanitary inspectors; the division of large committees into two or more groups; and the distribution of food aid from the FAO/World Food Programme\(^{20}\), through the women's committees.

The recurrent health budget and bilateral and multinational aid are concentrated on equipping and staffing the National Hospital in Apia (Department of Health 1982:33-37)\(^{21}\) although the rural health service, the Nutrition Centre and the Health Education Unit (established with multinational funds in the early 1980s to improve primary health care and preventive medicine) are hampered by lack of equipment and staff and inadequate transport (Department of Health 1981:41-42). Trained staff have been withdrawn from rural areas leaving a situation in which "about 80 per cent of the total countries [sic] population [is] being catered for by 20 per cent of the health medical personnel" (Department of Health 1982:27). The employment of paid sanitary inspectors to do the work the

\(^{20}\)The FAO/World Food Programme Scheme No. 741, 1976-1983.

\(^{21}\)The Department of Health receives aid from the governments of New Zealand, Japan, the United States and the United Kingdom; multinational aid through UNICEF, UNFPA, and WHO; the South Pacific Commission and a number of voluntary organisations.
women's committees had done free of charge for many years led to resentment among village women (Schoeffel 1980:87) and loss of prestige.

Although the budget for hospital maintenance remains underspent rural hospitals and health centres are increasingly poorly maintained and both hospital staff and district nurses are often without transport or the most basic drugs (Department of Health 1982:35-36). Repeated unfulfilled requests for vehicle and hospital maintenance and for drugs has led to a deterioration in the morale of rural staff and their relationship with the women's committees.

So far only worthless promises. I'm beginning to think that as long as we do the work, no one seems interested in our welfare (Monthly Report, Poutasi Hospital, March 1975).

Drugs are short, especially the essential ones. It seems we are running out of everything, forever (Monthly Report, Tuasivi Hospital, February 1982).

The reduction in services and the transfer of women's practical health work to professional staff, combined with the movement of health personnel out of the rural districts\(^{22}\) has left many rural people with no option but to seek medical attention in town or to turn to traditional healers. District nurses now recommend that women go to town to get the drugs, dressings or attention that were once supplied through the women's committees. The direct result is a decline in district-level co-operation between women's committees, a decline in co-operation between the district nurses and the women's committees, a further move away from committee involvement in health-related activities and a decline in attendance.

Although the Fifth Five-year Development Plan 1984 states that "continued emphasis will be given to the primary health care approach in close collaboration with village authorities and the women's committees" (Department of Economic Development 1984:108), and although government

\(^{22}\)In 1978 government decided to allow private medical practice and this led to an exodus of doctors from rural hospitals. In 1983 there were 27 doctors at the Apia National Hospital and 11 full time doctors and two part-time in the rest of the country. On Savai'i four of the six rural health service doctors were expatriates, three of them volunteers. In rural Upolu two of seven doctors were retired men pressed back into part-time service.
uses the work of the women's committees to support claims for international aid, village women are not consulted about health or development-related matters (Schoeffel 1980:116) and no written policy for strengthening primary health care is available. The status of the rural health service, and indirectly that of the district nurses and the women's committees, continues to decline.

The introduction of the FAO/WFP food aid programme in 1977 led to a further deterioration in the relationship between the women's committees and the Department of Health. Milk powder was distributed by the district nurse through the women's committees to mothers who were pregnant or lactating or had children under four years of age. As most of the recipients were young and untitled, the distribution of milk powder was in opposition to traditional distribution patterns which ensured that resources were distributed to the titled and the elderly. This led to considerable conflict between the district nurses and the committee executive, most of whom were ineligible for food aid. In some committees the situation deteriorated so rapidly that the nurses handed over the responsibility for distribution to the president. Although in urban villages food aid was available direct from the hospital, women in Apia established new committees in order to have it delivered to their neighbourhood (Pers. Comm., FAO/WFP Associate Eli Puliata, 16.7.82). When food aid was discontinued in 1982, rural committee members believed that the Department of Health personnel in Apia retained the milk powder for their own use. This belief is still widespread and relations between the Department of Health and some committees remains strained.

Of the three Department of Health changes in policy, the decision to divide the committees had the greatest immediate impact on committee and village structure. By the early 1970s committees in a number of villages had become so large that meetings took all day so the Department of Health asked the committee presidents to hold them over two, or in some
cases three days. As no clear guidelines were provided regarding size, women saw this as a legitimate excuse to set up new independent committees, with membership based on family and political affiliations, rather than optimum working size. The move also gave many women the opportunity to stop attending, by claiming they visited one of the other committees.

At a time when the women's committees and the district nursing service most needed support and guidance, Momoi Kuresa, their champion for 40 years, retired.

Impact of Department of Health Policies and Change on the Women's Committees

Withdrawal of medical personnel and rural health services has resulted in a change of villagers' attitudes toward the Department of Health. They no longer call the district hospital "our hospital" or consider that assisting the Department of Health is helping themselves. In districts where the women's committees still clean the hospital buildings and grounds and provide medical staff with meals, these services are provided more grudgingly than in the past. In villages closer to Apia, where district hospitals are poorly staffed and virtually empty, the women's committees have stopped all their activities outside the monthly meeting with the district nurse. Both the introduction of food aid and Department of Health policy to divide committees were catalysts for open conflict between village women. Conflict has also arisen over committee involvement in long-term economic projects such as those initiated by the Rural Development Programme, where profits were expected to be shared among members rather than invested in community services. The increased amount of cash handled by the executive and the establishment of investment accounts and committee lending clubs has led to growing conflict over the way in which finances are handled. Few executive members have training in dealing with cash and many women consider they
are being cheated. These events occurred at a time when the changing status of matai, the increased influence of the young, educated and employed and the emergence of distinct political parties had resulted in increased tension and a decrease in the effectiveness of the mechanisms for conflict resolution. They also occurred at a time when the executive's authority to demand attendance or assistance with committee projects was declining. The increase in the number of matai meant that a much larger proportion of women felt they should be on the executive or included in decision-making.

Many women's husbands have a title now. Now all women want a say in the committees and especially they want a say about the money. They now think they are as good as anyone else. They won't put up with the old ways (Pers. Comm., Journalist Rosie Afamasaga, 4.6.83).

Community closure to protect access to social, political and economic power could no longer be maintained by a small elite. The wives of young, well educated and employed matai who were usually better educated than most of the executive felt they should have a voice in committee affairs. This added to committee conflict. Young women consider the old women "uneducated and old fashioned". The older women consider the young "unmannered". It is little wonder that the Department of Health decision to divide the committees led to their rapid fragmentation into numerous independent, and frequently antagonistic, groups. The impact of this chain of events on village structure was both reflexive and cumulative.

With the exception of divisions based on church denomination, the division of the committees into two or more groups was the first formal division to occur within village institutions. Once started it was a move neither the Department of Health, the committee executive, nor the fono could halt.

If women didn't like the established committee, or hated them or had conflict, rather than solving the dispute they just broke away and made another. They took the lazy way (Pers. Comm., Retired DMO Iakapo Esera, 20.7.83).

As the committees became more numerous, they became smaller and
overall attendance declined. Loss of committee members, (a legitimate excuse for openly expressing and maintaining conflict) and the existence of two or more antagonistic groups of women within the one village, altered women’s interaction patterns, weakened the power of the committees and weakened village cohesion, which in turn led to greater fragmentation of the committees. It is the opinion of some Samoans\(^{23}\) that it was conflict between women that led to divisions within the *fono*. Schoeffel (1984) and Hammer (1982) have argued that the Department of Health action was the most important factor in committee fragmentation but the Samoan women I interviewed say this would have occurred anyway.

The women’s committee broke away from bigger to smaller units. Initially it was the Department of Health, but it was also the power structure. People here are breaking away to gain better access to what’s available (Pers. Comm., Women’s Advisory Committee Secretary Noumea Simi, 4.10.83).

The division of the women’s committees occurred largely in villages that had experienced greatest population growth and most rapid change.

**The Emergence of New Settlements**

Although there has been widespread and differential change in Samoan villages, families living in rural and peri-urban villages retain links, although in some cases tenuous, with the families and lands associated with the village in which they live. The *fono*, the women’s committee and the church remain part of the village structure although support for them has declined, and the relative rank of the village matai is still known and recognised. This is not the case in the suburbs which emerged on the outskirts of Apia in the early 1970s. Prior to 1970 little freehold land had been available for purchase, and until remittances and wage employment provided more ready access to cash, land was too expensive for most Samoan families to buy as they could not use customary land as equity for

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\(^{23}\) Amongst those who hold this opinion are Dr lakapo Esera, Tuiletufuga Enele, Fetu Tuatagaloa.
loans. The simultaneous availability of cash and land\textsuperscript{24} provided Samoans with the opportunity to live a more individualistic lifestyle, similar to that led by the part-European community, a lifestyle to which most Samoans I interviewed aspired. Living in town is associated with personal freedom

... without the omnipresent intimate social ties ... Apia is an attractive escape from the obligations of the village and domestic life (Shore 1977:234).

These new suburbs provide no traditional structure on which social relationships or community institutions can be based. Although people say they like to be free of family and village obligations they maintain that they do not like living in close proximity to people they do not know.

We don’t like to talk to all those other women. We don’t know them. They don’t come from our village. They don’t come from our family. How do we know who they are? (Pers. Comm., Moevanu, Tulaele Village, 20.7.83).

The Four Villages

By 1983 the temporal processes described in this and earlier chapters were spatially manifest in four structurally different types of villages. These were classified by Samoans\textsuperscript{25} who named them traditional, semi-traditional, modern and non-traditional villages (Figures 5-4 to 5-6). Each type of village has specific social and locational characteristics. Traditional villages are located in the rural areas of Upolu and Savai‘i. They have experienced least change and the village remains a single social unit and the most important community in people’s lives. They are based on customary land and have an average population of around 300. Most semi-traditional villages are located along the northwest coast of Upolu and have an average population of just over 800. These villages have experienced rapid demographic, economic and political change. Increased tension

\textsuperscript{24} Major subdivisions included those at Vaivase, Vaivase Uta, Falealii, Tulaele, Tiavi and Siusega.

\textsuperscript{25} The method of village classification and the data that support it are described in Appendix 5-1.
and a reduction in conflict resolution has led to the division of villages into sub-villages many of which now function as autonomous units each with its own *fono* and women’s committee.²⁶ Although village fission has been an historic response to population growth, the rapid division of villages in the mid-1970s and early 1980s was unprecedented in Western Samoa.

Modern villages are located in urban areas on a combination of customary and freehold land. All families recognise traditional links with both the land and the village polity, but because of their urban location the people of these villages have had greatest access to education and employment and are considered by Samoans to be “modern”. The *fono* has little influence and the extended household has become the dominant community to which individuals belong. The average population of modern villages is 685. The fundamental differences between modern and non-traditional villages, both of which are urban, is population and the association with the land and village families. Non-traditional villages are located on freehold land where families have no historical association with either the area or other families. The nuclear family forms the largest social unit. The average population is 319.

In 1983 there were 202 traditional villages, 60 semi-traditional, 21 modern and 45 non-traditional villages, the latter including plantation, school and government settlements. These four types of villages are exemplified by Poutasi, Faleasiu, Vaiala and Tuleale (Table 5-3). Each provides a different setting for the women’s committees and the delivery of nutritional information as the following case-studies show.

²⁶The number of cases heard in the Lands and Titles Court (the court has exclusive jurisdiction in disputes over customary lands and titles) quadrupled between 1970 and 1980.
Figure 5-4: Location of Four Types of Villages, Upolu, Western Samoa, 1983

- Traditional villages
- Semi-Traditional villages
- Non-Traditional villages
Figure 5-5: Location of Four Types of Villages, Savai'i, Western Samoa, 1983.
Figure 5-6: Location of Four Types of Villages, Apia, Western Samoa, 1983
Table 5-3: The Social and Spatial Characteristics of four Samoan Villages

<table>
<thead>
<tr>
<th>Village Type</th>
<th>Polotasi</th>
<th>Faleasui</th>
<th>Tualele</th>
<th>Vaiola</th>
</tr>
</thead>
<tbody>
<tr>
<td>Distance in kms from central Apia</td>
<td>58</td>
<td>26</td>
<td>7</td>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Population</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Total</td>
<td>481</td>
<td>2763</td>
<td>340*</td>
<td>468</td>
</tr>
<tr>
<td>0-4 years</td>
<td>63</td>
<td>414</td>
<td>34</td>
<td>80</td>
</tr>
<tr>
<td>15-19 years</td>
<td>38</td>
<td>362</td>
<td>59</td>
<td>197</td>
</tr>
<tr>
<td>20-59 years</td>
<td>153</td>
<td>986</td>
<td>108</td>
<td>258</td>
</tr>
<tr>
<td>Women 20-59 years</td>
<td>71</td>
<td>482</td>
<td>51</td>
<td>119**</td>
</tr>
</tbody>
</table>

| Population change since 1971 | -5% | +30% | -33%*** | -5% |

| Number of households | 34 | 231 | 41 | 49 |
| Average household size | 10 | 12 | 6 | 14 |

<table>
<thead>
<tr>
<th>Village Characteristics</th>
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<tbody>
<tr>
<td>Official sub-villages</td>
</tr>
<tr>
<td>Major social unit</td>
</tr>
<tr>
<td>Land Tenure</td>
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<tr>
<td>Land Use</td>
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<tr>
<td>Land Available for agriculture</td>
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<tr>
<td>Major Economic Activity</td>
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<tr>
<td>Major Women's Activities</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>% Households with 1 or more residents in paid employment</td>
</tr>
<tr>
<td>% Households with 1 or more women in paid employment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Village Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Formal Organisations</td>
</tr>
<tr>
<td>Fale lalaga</td>
</tr>
<tr>
<td>Aumulama</td>
</tr>
<tr>
<td>Church</td>
</tr>
<tr>
<td>Fono</td>
</tr>
<tr>
<td>Aumaga</td>
</tr>
<tr>
<td>Number of Churches</td>
</tr>
<tr>
<td>Number of Committees</td>
</tr>
<tr>
<td>Average number of Village Organisations women belong to</td>
</tr>
</tbody>
</table>

* These are my figures for the settlement around the major crossroad
** The sex ratio is 100:112
***This must be a typographical or statistical error
(Source: Department of Statistics 1981, 1983; Household surveys)
Case Study 5:1 Poutasi, a traditional village

Poutasi is considered by Samoan people to be a village in which "the fa'a Samoa is held strong". It is a one-hour, T1.50 (SA1) truck ride across the island from Apia and is well integrated into the cash economy. The households are clustered among coconut palms and breadfruit trees between the lagoon and a large freshwater pool. Most houses are within 500 meters of the central malae which acts as an important focus for village life. The families living on the main road, some 750 meters from the centre of the village, remain part of the village community but the families of five government officers (health, education, police and agriculture) who live closer than this to the village centre, are not and are excluded from village activities. Over half the houses are traditional, open-sided fale. The land belonging to village families stretches inland to the mountain tops in a multi-textured patchwork of coconut, bananas, taro patches, pandanus groves and secondary forest.

Twenty aiga hold rights to these lands.

The population of 401 has declined marginally since 1971. The major employment is semi-subsistence agriculture and all households sell copra and taro to the leading aiga or in the Apia market. One family also engages in commercial fishing and one runs a daily passenger service into Apia. All but one of the 34 households receive remittances from families overseas. Ten households have a resident family member in full-time paid employment. Five of those employed are women: four school teachers and one nurse. Two women in one household make handicrafts for sale and most older women spend at least two days a week weaving mats. Young untitled women help on the land and with committee work which while I was there involved cutting and preparing pandanus for mat making and manufacturing small charcoal burning stoves. They also help with the household, cooking and minding children. Young men work on the land, help with cooking, carry out occasional village work for the fono and spend most afternoons and early evenings playing netball, cricket or billiards. Of the 38 young people between 15 and 19 years old, 11 girls and 10 boys were in high school, but were expected to help with agricultural jobs before or after school.

Unlike many other rural villages, few matai titles in Poutasi have been split and all but four families have their leading matai resident in the village. The ranking structure is clearly defined and the leading aiga retains considerable authority and wide-ranging political and economic control. His authority in 1983 was enhanced by his position as Member of Parliament for Falealili district. The fono meets formally each week and maintains control over village activities, organises the community work of the young men, sets and polices village regulations and controls the amount, type and use of contributions to community events and the church. But fono control, according to villagers, is declining and former prohibitions on drinking beer, playing pop music and wearing jeans, are now ignored.

Everyone in Poutasi knows everyone else and most belong to the appropriate age, sex and status organisations although attendance is no longer enforced. The groups to which women belong are the women's committee, the fale lalaga or weaving group of the wives of the matai, the aualuma, which still meets occasionally to prepare for

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an important visit or wedding; and the church guild, choir and
youth group. There are two church denominations, the Christian
Congregational Church of Western Samoa (CCCWS) and the Roman
Catholic Church, each with its own groups, but they engage in many
combined activities. Two families are Seventh-Day Adventists.

Households are large. The one in which I stayed is one of the
largest in the village. It is led by an elderly widowed matai and
includes his untitled brother and his wife, and 12 of their 14
children, one of whom is married and remains in the household with
her husband and small son. The elder son lives and works in Apia
as a carpenter and one daughter works in American Samoa and
sends occasional remittances. The married daughter teaches at the
district high school and is the only resident member of the household
in paid employment. Five children are at school, one is under five.
three work on the family land and two as unpaid helpers in the
household of the leading ali'i. There are no expectations that those
who have left school will do anything other than remain in the
village or marry out. However the family expects the two daughters
at high school to become school teachers.

The household shares in village activities and contributes food,
goods, money and labour to village and church projects. It has close
associations with other village families and regularly assists or relies
on neighbours for food, labour or goods.

Case Study 5:2 Faleasiu, a semi-traditional village

Faleasiu is a very large village that stretches over one kilometer
along the road between Apia and Faleolo. Buses pass every ten
minutes placing the village within easy commuting distance of
employment centres. The village lands are fertile, relatively flat and
easily worked but continual in-migration has left families short of
land and unable to expand agriculture as village lands are adjoined
by freehold plantations. In the ten years between 1971 and 1981 the
population grew by nearly 33 per cent, even though almost every
family had members who emigrated during this time.

Faleasiu has four virtually autonomous sub-villages - Moamoa,
Tauao'o, Sapulu and Lealāli'i - each with its own maota, fono and
women's committees. The sub-villages do not have a central malae
to act as a focus for village activities. The village as a whole acts
as an integrated community only for an important event such as the
death of a high ranking chief or the wedding of a high chief's
daughter and the Faleasiu fono seldom meets more than once or
twice a year. Although most residents in Faleasiu know who the
major village families are, new arrivals do not know the relative
rank of the important matai or which families have traditional
associations and obligations. Residents have little contact with
people outside their sub-village, which comprises families who have
traditional political affiliations. The fono in each sub-village meets
every week, but meetings are short as many of the matai commute
into Apia each day. The fono has little control and no longer
commands the labour of young men. Although people adhere to
traditional patterns of behaviour for formal occasions, this behaviour
is not part of their daily lives.

The sub-village of Tauao'o has 31 households and an approximate
population of 340. There are 32 resident matai but only 14 titles
originate from Faleasiu. All households engage in semi-subsistence
agriculture but it is not considered an important activity. All receive remittances and all but three have at least one resident member in wage labour or in small business. Thirteen women work for wages, eight in Apia, two at the airport, one as a self-employed taxi proprietor and three as part-time labourers at the Tanumalala banana project. All but two employed women are under 35 years of age. The women who do not have paid employment are extremely mobile and visit Apia at least once a week where they go shopping and to the movies. Very few of the older women make mats and nobody does any committee work.

The village has electricity and all families in Tauao’o have a European-style house, but for the sake of comfort, they also have a Samoan fale “out the back”.

The household I visited regularly is led by a very elderly matai and his wife, and comprises their married daughter, four of her five teenage children and occasionally, her husband. The oldest child lives in New Zealand and although she is unemployed the aim of the family is for all the children to live in New Zealand. While waiting for visas they reluctantly help on the family land. The youngest child is still at high school. All food, with the exception of taro and bananas and an occasional chicken, is purchased in Apia. The family lives in two small European-style houses with electricity and television and the traditional maota of their matai. The houses are extremely close to neighbours but there is almost no contact between the families. There is no cooperation in village activities, very little cohesion and little regular communication between villagers. The existence of five churches in Faleasiiu increases community fragmentation.

Case Study 5:3 Vaiala, a modern village

Vaiala is one kilometer from the centre of the Apia commercial area. It is physically divided into Vaiala Tai, the original village near the sea, and Vaiala Uta, a new settlement 1500 meters inland. Like many modern villages Vaiala has experienced both in-migration and extensive out-migration and between 1971 and 1981 the population declined by 120 to 703. Vaiala Tai has a population of 468. Physical constraints to village expansion (swamp and lagoon on one side and freehold land on the other) have helped Vaiala Tai retain more of the qualities of traditional villages than most other modern villages. It retains a large central maota and a single church. Both are important integrating factors. Of the 75 men over 30 years of age, 70 are reported to hold titles, but 40 titles originate from outside the village. A number of high-ranking Vaiala titleholders have emigrated and these titles have been split to retain a titleholder in Samoa. Titles carry little or no authority outside the family. The village retains a single fono and two women’s committees. The fono meets irregularly and outside office hours and in comparison to fono meetings in traditional villages, are short and poorly attended and concerned with national politics rather than village affairs. There is little evidence of traditional authority and matai openly express difficulties imposing regulations within their own households, let alone the village. However the village of Vaiala still cooperates occasionally as a community to provide hospitality or traditional contributions of mats and food at important ceremonial events.
All households in Vaiala Tai rely on wage labour or business interests and all but three receive remittances. The households that do not receive remittances are led by successful professional or business men who help support rural family members. Nineteen households (56 per cent) have at least one woman in paid employment and with the exception of two, all young women have secondary education. All wanted to emigrate.

Although houses are very close together and families live in close proximity to one another there is little day-to-day cooperation outside the church and the group of older, in-marrying women who comprise the members of both the women’s committee and the church women’s guild. Only three households do not comprise an extended family. The household where I stayed was part of an extended household group which comprises eight adults and 13 children. They live in three sleeping houses clustered around the large house of the oldest matai. The family comprises the old matai, his wife and sister: the three married children of the matai, their spouses and their ten children. In addition the family cares for the infant of a daughter working in New Zealand and two teenage students, children of relatives in Savai‘i. Five family members are in fulltime employment. One is a school teacher, two are carpenters, one an office worker and one a secretary. Two get occasional work on the wharves nearby. Eleven children are at school. Five children and two grandchildren of the senior couple have emigrated. All the children and young men and women spend a large part of their spare time playing cricket, football or netball with other villagers on the mālace which provides an important focus for village life.

Although in Vaiala the extended family provides a virtually autonomous social and economic unit, there remain elements of village structure.

Case Study 5:4 Tulaele, a non-traditional village

In 1972, part of a freehold coconut plantation, seven kilometers from the centre of Apia and two and a half kilometers inland from the main coast road, was divided into quarter acre (.101 ha.) house lots. Land was purchased by families from all over Samoa, but predominantly by those already living in urban villages. The first houses were built in 1973 clustered near a cross-roads. This settlement has a primary school, a general store and two churches. The population of the 41 households in the vicinity of the cross roads is 310. Twenty-five households comprise nuclear families, all reliant on wages or private business. Ten families do not own the houses they live in but are “house sitting” for relatives overseas. All households but one have at least one resident in wage labour or business and 13 (32 per cent) have at least one woman in paid employment. In all, 17 women have paid employment, three at the nearby brewery, one at the local primary school and the rest in central Apia. The settlement comprises Samoans, part-Europeans and Chinese families and includes a dentist, doctor, electrician, office workers, carpenters, drivers, school teachers, a bus proprietor, a professional musician, labourers, and shop keepers.

The suburb has no fono and no formal structure upon which to base one, but has four women’s committees. There is no building or community playing area where people can congregate and the local store provides the major meeting place and news exchange. Fifty-five
per cent of households have no formal affiliation to a *matai* and claim to be independent of the *fa‘a Samoa*.

The family I visited regularly is typical of the nuclear households in the suburb. The husband is an office worker and his wife stays at home to look after their five small children, two of whom are at school. The house is owned by the wife’s mother, who lives in Savai‘i but visits frequently. The young wife has no assistance with the children and little family support. The bus into Apia only runs every two hours and it is difficult to go to town with three small children and no pram. Major food shopping is done by her husband and only bread and biscuits are purchased locally. The young wife has little contact with her neighbours and is physically and socially isolated. Approximately every three months she and the children return for a few weeks to her natal village on the opposite side of the island. Although she lives in a modern suburb in a new, European house, away from the demands of village and nearby family, a situation to which many young rural women aspire, she finds life lonely and difficult. She has more contact with her rural relatives 65 kilometers away than with her next door neighbours.

There is no feeling of community or solidarity amongst those living in Tulaele. There is no structure for social integration or support outside the women’s committees, which meet only for the monthly clinic.

Conclusions

As the case studies show, in Samoa the outcome of political, economic, demographic and administrative change in the 21 years following independence has been surprisingly uneven for a small culturally and linguistically homogeneous nation in which transport links are excellent and remittances blur urban-rural inequalities in access to cash. The combined impact of these changes has largely destroyed the mechanisms for control of scarce resources and conflict resolution. Those of high rank can no longer maintain privileged access to political or economic power. Although there have been attempts to maintain the traditional system of rank and authority by electing young and economically successful men as titleholders, this in itself alters the formal and substantive structures, just as it alters status relationships between women and what are considered acceptable women’s roles.

The four types of villages show that in different locations there are appreciable differences in women’s activities, their expectations, and the size of the social unit in which they interact regularly confirming Giddens’
proposition that all action and interaction take place within clearly
differentiated locales, each with different settings for interaction. Over
these 21 years the inter-relationship between the village setting and its
institutions is highlighted in the way that the women’s committees have
taken part in the process of change, both initiating change and reacting to
it. The relationship between the village formal, substantive and interaction
structures, and the opportunities they offer for the delivery of primary
health care and nutritional information are considered in the following
chapter.
CHAPTER 6
COMMITTEE DISTRIBUTION, ACCESS AND ATTENDANCE

Today, there are committees everywhere, but not many women attend. Only the old ladies. I don’t know why we bother. Out the back its all right. There the matai still have some power (Pers. Comm., District Nurse Ana, 6.8.83).

Sixty years after their introduction the women’s committees remain the major channel for delivering primary health care and nutritional information to village women. Although outwardly all committees appear much the same, in the years since independence four distinct types of committees have emerged, each exhibiting specific patterns of distribution, access and attendance and different ways in which interaction and activities within them are conducted.¹ This chapter analyses the characteristics of each of these committee types and explores the relationships between committee attendance, committee type and location.

The Four Types of Committees

All committees have a number of common characteristics. All are registered with the Department of Health, have at least two executive members and hold a monthly meeting with the district nurse. The pattern of activities remains the same as in the past. The nurse weighs and checks infants, records their progress, gives advice and nutritional information, and monitors pregnant women. An asiasi is held and food shared with the nurse. However committees differ in the ways in which these activities are carried out as well as in the number of women and children attending the clinic, in the rank, age and status of their members.

¹See Appendix 6-1 for details of the methodology.
and the degree of access members have to health care and nutritional information. These differences are associated with the type of villages in which the committees are located and the type and size of the social group, or community, from which their members are drawn. Of the 553 committees, 357 draw members from an entire village or sub-village, 91 from the members of a single extended family, 53 from women living within a neighbourhood of a new suburb and 52 from the congregation of a single church. I have called these village, church, neighbourhood and family committees.

Membership of village committees cuts across church, family and other social divisions and members are all cognates or affines of the village families with close political and/or family affiliations. Women know one another well and meet frequently outside the committee. These committees still have a very formal organisational structure with the executive controlled by the wives of the high ranking matai and all activities organised to conform to relative rank. For example, the meal and asusaga are formally presented and the seating in the house arranged in strict accordance to rank. Women usually wear a committee uniform with the executive readily differentiated from other members by lace-trimmed collars and cuffs or blouses of different colours. Although attendance has declined since the mid-1970s committee membership is regarded as the norm and in some committees coercion is still used to ensure participation. Village committees are found in all types of villages but are characteristic of traditional villages and those semi-traditional villages where change has been least extensive.

Membership of church committees is restricted to the congregation of a single church. The executive comprises the pastor’s wife and/or the wives of the church deacons, who are usually also wives of high-ranking matai. These committees maintain the formal structure and seating pattern of the village committees but as membership is restricted and
church committees are found in villages that support other types of committees, the groups are small. Most committee activities are related to fund-raising for the church rather than health, and women meet regularly to work on both church and committee affairs. Church committees are characteristic of villages that have experienced rapid in-migration and all but two groups have been established since independence.

The membership of neighbourhood committees is based on residential proximity and cuts across church and family affiliations, if there are any. Members seldom have family or political links and none have traditional links with the land in the area. Most neighbourhood committees are found in newly settled suburbs. Although there is no traditional basis for a hierarchically-ranked social structure the committees retain elements of village committee organisation with the executive made up of the wives of pastors or matai. Seating is not ranked, but the executive and wives of matai sit on the opposite side of the house from the other women. Committee procedures are carried out with less formality than in church and village clinics. These committees have few members, most of whom are older women who have little contact with one another outside the committee. Very few women with young children attend and when they do, they attend irregularly. The committees often provide the only social group to which women belong outside the household. Neighbourhood committees have been established since the mid-1970s, with the exception of those on freehold plantations.

As membership of family committees is restricted to the women of one extended household these committees are small. Although the committees retain an executive made up of the senior women of the family, activities and the seating order are informal. There are no committee activities outside the clinic. All family committees have been established since 1978 and are located in urban areas where villages no longer function as cohesive units.
The Committee/Village Association

The four types of women's committees exhibit distinctive spatial and social characteristics (Figures 6-1, 6-2 and 6-3). Although there is some overlap in the association between village and committee types there is a spatial continuum from large, well attended, formally structured committees in traditional villages to small, informal, irregularly attended groups in modern and non-traditional villages. In Apia however, the relationship between village and committee type is sometimes confused as some large, modern villages support the original village committee, often established in the 1920s, as well as recently established family and church committees. In this situation land tenure provides a consistent indicator of committee type. Villages located entirely on customay land support village committees, while larger villages which are often situated on both customary land and small areas of freehold land (often Crown land), support family or church committees. Neighbourhood committees are all on freehold land.2

The statistically significant pattern is one of village committees located in traditional villages, church and village committees in semi-traditional villages, family committees in non-traditional and modern villages and neighbourhood committees in non-traditional villages (Table 6-1).

Committee Distribution and Physical Access

Until 1970 it was unusual for a village to have more than one committee, but with increased social fragmentation peri-urban and urban villages now have three or four, while some large villages like Laulii and Aega support eight or more. Between 1971 and 1981 the number of committees grew from "approximately 300 ... to about 500" (Department of Health 1981:18) with a further 10 per cent increase to 553 by 1983. Most new committees are based on church, family or neighbourhood membership.

2The relationship between land tenure and the location of Apia committees is shown in Appendix 6-2.
Table 6-1: Contingency Table showing the Association between Village and Committee Types

<table>
<thead>
<tr>
<th>Village Type</th>
<th>Committee Type</th>
<th>Village</th>
<th>Family</th>
<th>Church</th>
<th>N'hood</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-traditional villages (45)</td>
<td></td>
<td>1</td>
<td>45</td>
<td>8</td>
<td>30</td>
</tr>
<tr>
<td>Modern villages (21)</td>
<td></td>
<td>25</td>
<td>24</td>
<td>18</td>
<td>5</td>
</tr>
<tr>
<td>Semi-traditional villages (60)</td>
<td></td>
<td>93</td>
<td>22</td>
<td>25</td>
<td>18</td>
</tr>
<tr>
<td>Traditional villages (202)</td>
<td></td>
<td>238</td>
<td>0</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>357</td>
<td>91</td>
<td>52</td>
<td>53</td>
</tr>
</tbody>
</table>

$\chi^2 = 329 \ p > .001^*$

*Although the blank cells reduce the reliability of the test, the association between village and committee type is overwhelmingly supported.*

and are located in the vicinity of Apia or the proto-urban areas of Salelologa and Asau (Figures 6-1, 6-2 and 6-3).\(^3\) Predictably, the greatest concentrations of committees are in areas of highest population, but neither village size nor population density are consistent indicators of distribution as in Apia, and along the northwest coast of Upolu, the ratio of committees to population is higher than elsewhere in the country (Table 6-2). In villages with large populations, committees are more numerous and closer together than elsewhere. Many urban women live within 500 meters of six or seven committees, while most rural women live within 500 meters of one. For example, six committees are located within 300 meters of the National Hospital's Family Welfare Centre, which is especially equipped to deal with maternal and child health care (Figure 6-3). This allows excellent physical access to primary health care, but is an extravagant use of scarce health resources as a very low proportion of women attend these committees.

\(^3\)Also see Appendix 6-3.
Figure 6-2: Distribution of Women's Committees, by Committee Type, Savai'i, 1983
Figure 6-1: Distribution of Women's Committees, by Committee Type, Upolu, 1983
Figure 6.3 Distribution of Women's Committees, by Type, Apia, 1983
Table 6-2: Ratio of Women aged 20-59 years to Committees, by Village Type

<table>
<thead>
<tr>
<th>Village Type</th>
<th>Number of Committees</th>
<th>Number of Women 20-59 years</th>
<th>Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional</td>
<td>240</td>
<td>14,467</td>
<td>1:60</td>
</tr>
<tr>
<td>Semi-Traditional</td>
<td>159</td>
<td>7,713</td>
<td>1:49</td>
</tr>
<tr>
<td>Modern</td>
<td>68</td>
<td>2,717</td>
<td>1:40</td>
</tr>
<tr>
<td>Non-Traditional</td>
<td>87</td>
<td>2,746</td>
<td>1:31</td>
</tr>
</tbody>
</table>

(Source: Department of Statistics 1982 and District Nurses' Annual Returns, 1982)

Table 6-3: Estimated Proportion of Women attending Committees, by Village Type

<table>
<thead>
<tr>
<th>Village Type</th>
<th>Number of Women 20-59</th>
<th>Number Attending</th>
<th>Percentage Attending</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional</td>
<td>14,667</td>
<td>10,212</td>
<td>70</td>
</tr>
<tr>
<td>Semi-Traditional</td>
<td>7,713</td>
<td>2,631</td>
<td>48</td>
</tr>
<tr>
<td>Modern</td>
<td>2,717</td>
<td>796</td>
<td>29</td>
</tr>
<tr>
<td>Non-Traditional</td>
<td>2,746</td>
<td>631</td>
<td>23</td>
</tr>
</tbody>
</table>

(Source: District Nurses' Annual Returns, 1982)

Committee Attendance

Committee attendance varies markedly with village type and women's social relationships with major differences found in the proportion of village women attending, the regularity of attendance, the number of women attending at any one time, their age and rank, and the number who accompany their own children. Department of Health reports show that an average of 51 per cent of all women aged between 20 and 59 years attend the committees, very much lower than in the early 1970s when 100 per cent attendance was said to be common in rural villages. The highest proportion of women attending is found in traditional villages and the lowest in non-traditional villages (Table 6-3). Overall, where there has

---

4 Also see Schoeffel 1980 and 1984 and Hammer 1982.
been most rapid change, there is a high ratio of committees to women but very low attendance. This pattern is confirmed by lower attendance ratios in the villages in Salelologa and Asau (see Appendix 6-4).

My visits to committees show that attendance is consistently one-third less than that reported by district nurses, however the spatial patterns of attendance observed are the same as those reported (see Appendix 6-4). Village committees, regardless of location, have more members than other types, with the exception of church groups located in modern villages. This is particularly true in villages where church committees members belong to the Seventh-Day Adventist or Mormon Church. Each of these churches emphasizes health and nutrition and foster close co-operation between their members. Of the 52 church committees, 40 are based on membership of one or other of these two denominations. The largest committees are those located in traditional villages where up to 80 women still attend at any one time. The size of committees is influenced not only by the size of the social group from which membership is drawn, but as the church groups indicate, by the cohesion of that group. Where social relationships between women are weak attendance is both poor and irregular (Table 6-4). Family committees however do not fit this pattern and are discussed in detail in the following chapter.

The regularity with which women and infants attend committees differs with both committee and village type.\(^5\) Church committees regardless of the village in which they are located are the most regularly attended, followed closely by village committees. Women attending church committees, make an average of 8 visits a year, those attending village committees 7.2, family committees 5.1 and neighbourhood committees 5.0. Attendance of village committees in traditional villages is more regular than in the same type of committees in modern villages. Again the average for church attendance is boosted by the unusually regular attendance of

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\(^5\)See Appendix 6-1 for the methodology for collecting attendance data.
Table 6-4: Mean Number of Women attending Committee Meetings, by Village and Committee Type

<table>
<thead>
<tr>
<th>Village Type</th>
<th>Committee Type</th>
<th>Village</th>
<th>Family</th>
<th>Church</th>
<th>N'hood</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-traditional</td>
<td></td>
<td>14</td>
<td>6</td>
<td>14</td>
<td>8</td>
</tr>
<tr>
<td>Modern</td>
<td></td>
<td>15</td>
<td>8</td>
<td>17</td>
<td>7</td>
</tr>
<tr>
<td>Semi-traditional</td>
<td></td>
<td>21</td>
<td>6</td>
<td>13</td>
<td>5</td>
</tr>
<tr>
<td>Traditional</td>
<td></td>
<td>42</td>
<td>-</td>
<td>17</td>
<td>-</td>
</tr>
</tbody>
</table>

(Source: District Nurses' Annual Returns 1980-1983)

members of the Seventh-Day Adventist and Mormon committees. In committees with membership from denominations that do not exhibit the same concern for physical health and social cohesion church committee attendance differs little from that in village committees in the same location. Attendance in all family and neighbourhood committees is irregular.

In the 26 committees visited, the age and status of the 701 women observed attending and the number of women accompanied by children other than their own differed markedly with village type. Women who are past childbearing age, most of whom are wives of matai, comprise approximately 30 per cent of clinic attenders in traditional villages, 40 per cent of women attending semi-traditional villages, and just over 50 per cent of those attending family and neighbourhood committees (Table 6:5).

Non-attendance Patterns

Just as the characteristics of women who attend the committees varies with village type, so do the characteristics of non-attenders, a high proportion of whom are young untitled women with small children. The

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6 As I could not ascertain the exact age of all women attending, with the assistance of the district nurses I divided them into women who had young children and were approximately 30 years of age and under and those who were older.
Table 6-5: Age and Rank of Attenders and Woman-child Relationships in 26 Committees, by Committee Type

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>N=</td>
<td>410</td>
<td>282</td>
<td>68</td>
<td>21</td>
</tr>
<tr>
<td>Young taulele'a own children</td>
<td>64</td>
<td>50</td>
<td>40</td>
<td>43</td>
</tr>
<tr>
<td>Young matai with own children</td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>Young tama'ita'i with own children</td>
<td>4</td>
<td>6</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Older matai with grandchildren</td>
<td>13</td>
<td>15</td>
<td>31</td>
<td>33</td>
</tr>
<tr>
<td>Older matai with other relatives</td>
<td>5</td>
<td>5</td>
<td>13</td>
<td>7</td>
</tr>
<tr>
<td>Young taulele'a with other relatives</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Young taulele'a with non-relatives</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Older matai not accompanying children</td>
<td>10</td>
<td>17</td>
<td>5</td>
<td>10</td>
</tr>
</tbody>
</table>

(per cent)

* As all the older tama'ita'i were also matai I have incorporated them in this category.

(Source: Committee visits (see Appendix 5-1))

situation in the four villages in which I conducted surveys confirmed my observation that in the urban areas a very high proportion of non-attenders are young mothers (Table 6-6). The women whom the committees are intended to assist are those least likely to attend, seriously reducing the possibilities for delivering primary health care and nutritional information and hampering the overall effectiveness of the women's committees as channels for improving infant and maternal health.

Infant Attendance Patterns

Among the children who are brought to the committees the national trend is for them to stop attending once they are toddling, or when their mother has a new infant (Jansen 1977:296). The exact age at which mothers stop bringing them and the regularity with which they attend however, varies with location. Although I found that attendance was
Table 6-6: Age and Rank of Committee Non-attenders in four Villages, by Village Type

<table>
<thead>
<tr>
<th>Village Type</th>
<th>Trad.</th>
<th>Semi-trad.</th>
<th>Modern</th>
<th>Non-Trad.</th>
</tr>
</thead>
<tbody>
<tr>
<td>N=</td>
<td>20</td>
<td>40</td>
<td>40</td>
<td>32</td>
</tr>
<tr>
<td>Young taulele'a with small children</td>
<td>45</td>
<td>67</td>
<td>73</td>
<td>78</td>
</tr>
<tr>
<td>Older taulele'a with older children</td>
<td>11</td>
<td>7</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Young tama'itali with small children</td>
<td>11</td>
<td>7</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Older matai with grown children</td>
<td>33</td>
<td>26</td>
<td>17</td>
<td>17</td>
</tr>
</tbody>
</table>

(Per cent)

+ These children may be adults or at school
+ In the villages surveyed I interviewed only one tama'itali who was not married to a matai. I have therefore classified them as matai.

(Source: Household surveys in Poutasi, Fa'asaisi, Vaiala Tai and Tualaele)

decreasing the Department of Health Annual Report for 1982 notes "... a marked improvement in the performance of district nursing activities ... and an improvement in the coverage of the child health clinics" with an increase in the number of children seen by the nurse (1982:17-18). The figures presented by the Department of Health to support this statement (Table 6-7) show a similar spatial pattern to those of women's attendance, with low attendance in Health District 17, which incorporates all of Apia, and in Health District 11, which includes Salelologa.

In Apia, 56 per cent of children up to four years of age were reported to have been seen at least twice by the nurse during 1982, while in districts 2 and 3, (northwest Upolu), this rises to 71 per cent. The average number of attenders for health districts 4 - 16, which with the exception of Salelologa, incorporates the rural areas of Upolu and Savai'i, is reported to be 92 per cent. The actual situation however is not so encouraging as the figures are based not on regular attendance, but on the number of children with a health record card and who the nurse has seen

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7 See Appendix 6-4 for a map of Health Districts and tables of women's attendance by Health District.
Table 6-7: Children aged 0-4 years seen twice or more by the District Nurse, by Health District

<table>
<thead>
<tr>
<th>Health District</th>
<th>Infants 0-11 months</th>
<th>Children 1-4 years</th>
<th>Total Children 0-4</th>
<th>% with records</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Total 0-11 months</td>
<td>Total 1-4 years</td>
<td>Total 0-4</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>1364</td>
<td>5298</td>
<td>6662</td>
<td>56**</td>
</tr>
<tr>
<td>2</td>
<td>320</td>
<td>1897</td>
<td>2217</td>
<td>85</td>
</tr>
<tr>
<td>3</td>
<td>307</td>
<td>1650</td>
<td>1357</td>
<td>90</td>
</tr>
<tr>
<td>4</td>
<td>197</td>
<td>693</td>
<td>890</td>
<td>93</td>
</tr>
<tr>
<td>5</td>
<td>210</td>
<td>947</td>
<td>1157</td>
<td>76</td>
</tr>
<tr>
<td>6</td>
<td>212</td>
<td>573</td>
<td>785</td>
<td>95</td>
</tr>
<tr>
<td>7</td>
<td>154</td>
<td>555</td>
<td>709</td>
<td>97</td>
</tr>
<tr>
<td>8</td>
<td>110</td>
<td>382</td>
<td>412</td>
<td>100</td>
</tr>
<tr>
<td>9</td>
<td>155</td>
<td>508</td>
<td>663</td>
<td>95</td>
</tr>
<tr>
<td>10</td>
<td>48</td>
<td>158</td>
<td>206</td>
<td>97</td>
</tr>
<tr>
<td>11</td>
<td>415</td>
<td>914</td>
<td>1329</td>
<td>70</td>
</tr>
<tr>
<td>12</td>
<td>70</td>
<td>320</td>
<td>390</td>
<td>98</td>
</tr>
<tr>
<td>13</td>
<td>146</td>
<td>650</td>
<td>796</td>
<td>95</td>
</tr>
<tr>
<td>14</td>
<td>193</td>
<td>970</td>
<td>1163</td>
<td>99</td>
</tr>
<tr>
<td>15</td>
<td>287</td>
<td>899</td>
<td>1106</td>
<td>73</td>
</tr>
<tr>
<td>16</td>
<td>284</td>
<td>439</td>
<td>643</td>
<td>94</td>
</tr>
</tbody>
</table>

* These figures conform to neither the 1976 nor 1981 census.
** Lowest rates of immunization.
(Source: Department of Health Evaluation Report, 1982)

...twice or more during the year. A high percentage of children in 1981 and 1982 were fully immunized during a special immunization drive which involved the provision of a health card and two visits by the nurse. The figures therefore indicate excellent immunization coverage, but not necessarily improved clinic attendance.

The problems of irregular infant attendance are widely recognised by the district nurses.

Many mothers only bring the child for 12 months - until it has had its innoculations. They never come again. Or when the baby is a bit big, many women are too lazy to come. They would rather sit at home when the baby is getting to one year...or maybe they have two. It's hard to come then, so they don't bother. But usually they stop at about 12 months (Pers. Comm., District Nurse Pulou, 6.6.83).

Pulou's statement is confirmed by data from the infant record cards. Forty-one per cent of children aged up to four years living in modern and non-traditional villages have cards which show entries only for immunization. In semi-traditional villages, 28 per cent attend the clinic for
immunization only, but in traditional villages where attendance is higher this drops to 18 per cent. If, as the Department of Health figures suggest, 56.3 per cent of children in Apia have cards, but nearly one-half of them attend the committee only for immunization, the number of children visiting the committees regularly is very low. When children who visit only for immunization are excluded, infants who are taken to the committees before they are 12 months of age, made on average six visits in their first 12 months. This drops to 3.6 in the second year; 2.1 in the third and to 1.5 in the fourth. There is however considerable variation between individuals, with five per cent attending eight times a year or more for the first two years, and four times a year for the following two. Forty percent attend less than twice a year after two years of age. Of 1,200 records seen, only six had made 20 or more visits out of a possible 48.

The attendance pattern of infants, as might be expected, depends upon that of women. Infants are taken to village and church committees more often and until they are older than to family and neighbourhood committees (Table 6-8). It is uncommon to see women anywhere in Samoa at a committee meeting with more than two children although many have three children under five years of age. The health record cards point to a serious problem. During the period recognised as that of highest nutritional risk (12 to 24 months) many children no longer attend the committees or do so infrequently. Therefore many mothers do not receive nutritional advice specific to this at-risk group. This is also a period when children are at risk from many other minor health problems, including burns, abrasions and infections which the nurse is equipped to deal with. The situation is most serious in Apia where few attend and a high

8The ages of the 83 children admitted to the Apia National Hospital between 1982 and 1983 suffering from malnutrition, ranged from 9 to 19 months with a mean of 14 months.
proportion of infants are bottle fed (Quested 1978)\textsuperscript{9} and are therefore particularly prone to nutritional problems (Department of Health 1980:7-11). Although young urban mothers have access to the Family Welfare Centre at the National Hospital, few use it (Family Welfare Centre Annual Report 1982).

**Table 6-8:** Average Annual Visits to Committees per Infant, by Age and Committee Type

<table>
<thead>
<tr>
<th>Committee Type</th>
<th>Age in Months</th>
<th>0 - 12</th>
<th>13 - 24</th>
<th>15 - 36</th>
<th>37 - 48</th>
</tr>
</thead>
<tbody>
<tr>
<td>Village</td>
<td>6.1</td>
<td>3.6</td>
<td>2.1</td>
<td>2.1</td>
<td></td>
</tr>
<tr>
<td>Church</td>
<td>7.0</td>
<td>3.9</td>
<td>3.2</td>
<td>2.0</td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>4.6</td>
<td>4.4</td>
<td>4.1</td>
<td>3.0</td>
<td></td>
</tr>
<tr>
<td>Neighbourhood</td>
<td>4.7</td>
<td>3.4</td>
<td>2.0</td>
<td>.8</td>
<td></td>
</tr>
</tbody>
</table>

(Source: Department of Health infant health record cards, 1976-1983)

**Four Villages and their Committees**

The association between village and committee types and the differing patterns of access and attendance are exemplified in the villages of Poutasi, Faleasii, Vaiala and Tulaele (Table 6-9). Case studies 6-1 to 6-4 point to the different possibilities for the delivery of primary health care and nutritional information each of these villages offers.

\textsuperscript{9}Nardi (1982) shows that the incidence of bottle feeding in rural village is also increasing as the result of young women working in both paid employment and in agriculture.
### Table 6-9: Four Samoan Villages and the Characteristics of their Women’s Committees

<table>
<thead>
<tr>
<th>Village Type</th>
<th>Traditional</th>
<th>Semi-Trad</th>
<th>Non-Trad</th>
<th>Modern</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Village</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Poutasi</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fa'asiiu</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tufaalea</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vai'ala</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Committee Characteristics

<table>
<thead>
<tr>
<th>Number of Committees</th>
<th>1</th>
<th>5</th>
<th>4</th>
<th>2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Committee Types</td>
<td>Village (1)</td>
<td>Village (4)</td>
<td>N’hood (1)</td>
<td>Village (1)</td>
</tr>
<tr>
<td></td>
<td>Church (1)</td>
<td>Family (2)</td>
<td>Family (2)</td>
<td>Village (1)*</td>
</tr>
</tbody>
</table>

#### Committee Clinic Attendance

<table>
<thead>
<tr>
<th>% village women attending clinics</th>
<th>51</th>
<th>41</th>
<th>23</th>
<th>29</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of women attending</td>
<td>31</td>
<td>22</td>
<td>9</td>
<td>15</td>
</tr>
<tr>
<td>% Attenders who are older women</td>
<td>33</td>
<td>40</td>
<td>55</td>
<td>46</td>
</tr>
<tr>
<td>% Children 0-4 attending</td>
<td>58</td>
<td>44</td>
<td>26</td>
<td>28</td>
</tr>
</tbody>
</table>

#### Committee Clinic Structure

<table>
<thead>
<tr>
<th>Seating Order</th>
<th>Formal</th>
<th>Formal</th>
<th>Informal</th>
<th>Semi-formal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinic Activities</td>
<td>Prayers</td>
<td>Welcome</td>
<td>Asiasiga</td>
<td>Welcome</td>
</tr>
<tr>
<td></td>
<td>Welcome</td>
<td>Asiasiga</td>
<td>Meal</td>
<td>Asiasiga</td>
</tr>
<tr>
<td></td>
<td>Morning Tea</td>
<td>Asiasiga</td>
<td>Meal</td>
<td>Meal</td>
</tr>
<tr>
<td></td>
<td>Asiasiga</td>
<td>Farewell</td>
<td></td>
<td>Farewell</td>
</tr>
<tr>
<td>Structure of Clinic Activities</td>
<td>Formal</td>
<td>Formal</td>
<td>Semi-formal</td>
<td>Semi-formal</td>
</tr>
</tbody>
</table>

#### Fund raising Activities

<table>
<thead>
<tr>
<th>Activities</th>
<th>Weaving</th>
<th>Weaving</th>
<th>Loan Club</th>
<th>Weaving</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pandonus plantation</td>
<td>Loan Club</td>
<td>Bingo</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stove-making</td>
<td>Loan Club</td>
<td>Bingo</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Service Activities

<table>
<thead>
<tr>
<th>Activities</th>
<th>Guard hospital</th>
<th>Guard hospital</th>
<th>None</th>
<th>Village sanitation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Village sanitation</td>
<td>Entertainment</td>
<td>visitors</td>
<td>Support church</td>
</tr>
<tr>
<td></td>
<td>Entertain visitors</td>
<td>Support church</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

* This committee is listed in Department of Health records as being in Tufaalea. It is not located in my fieldwork sample.

** Based on the average attendance of 4 visits

*** The figures for Fa'asiiu are based on the sub-village of Tuuo'o.
Case Study 6-1 The Poutasi Committee

The Poutasi committee was started in the late 1930s and a small hospital built on the edge of the freshwater pool. In the 1960s the committee raised funds to help equip the new district hospital and to improve village sanitation, and over the years has embarked on a number of initiatives, including water-sealed latrines and an electric generator, to improve the standard of living in the village. Together with other committees in the district Poutasi women were responsible for maintaining the hospital grounds, inspecting village sanitation and household hygiene. The committee was known to have a strong and enthusiastic president and under her leadership established banana and pandanus plantations and engaged in a variety of fund-raising activities. In the mid-1970s political factionalism led women of the Roman Catholic Church to attempt to establish an independent committee, but leadership was strong enough to avert this.

Today, women maintain that those belonging to the Catholic Church are jealous of the power of the committee president and are still interested in starting their own committee. In the past the Poutasi committee had a reputation for outdoing other villages in the amount of funds it could raise, in the lavish way it entertained village visitors and the number of amenities it provided for the village (Schoeffel 1980:72) but as in many other village committees it now has few goals and little sense of direction, and funds raised go towards feasts for visitors or to provide food and goods for the pastor, rather than on improvements in village services or amenities. Committee attendance has declined considerably in the last five or six years.

Although committee attendance is regarded by all women as correct behaviour and women state that all women attend the clinic and are fined if they do not, only 51 per cent of women attend and fines are seldom imposed. On average 25 women and 33 children attend the clinic. They comprise four executive, five matai, four tan'ai'ai and 12 taulele'a. Members are drawn from all church denominations and from all but seven households in the village. The women have two committee uniforms, one for clinics and one for special ceremonies. Although they say it is compulsory to wear the uniform to the clinic only eight or nine women do so.

Today the committee engages in few community service activities. It maintains the pandanus grove established 20 years ago and helps guard the entrance to the district hospital, but there is little interest in either of these activities and district level cooperation has declined. The most recent committee activity is the manufacture of small charcoal burners which the president sells to women in Poutasi and neighbouring villages, and regular bingo nights, which are sometime run in association with the CCCWS church. There is some uncertainty about what happens to the proceeds, but women feel it is not their business to enquire.

Poutasi is unusual in that it no longer has its own committee house and the current president holds all executive positions. As in most other traditional committees she is the wife of the highest ranking chief in the village and is assisted by the wives of five other high ranking men. This group meets each week to weave mats and

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10 The background to this attempt and the way in which it was resolved is discussed by Schoeffel (1980:71-74).
discuss committee affairs as well as for the ceremonial meal at the pastor’s house each Sunday where village activities are informally decided. The Sunday meeting is usually restricted to members of the CCCWS Church.

The seating order in the clinic is determined by the male ranking structure and activities are formally structured.

Case Study 6-2 The Tauao’o Committee

The original Faleasiliu committee was established in 1927 and has remained well known for its beautiful and well appointed committee house. In the mid-1970s three new committees were established in Faleasiliu, one of them in the sub-village, Tauao’o. In 1980, following a dispute between women of families which supported different political factions, a further committee was formed in Tauao’o, providing women with three committees within 200 meters of their houses. The Tauao’o committees are poorly attended and together attract only 21 members, 11 of whom are older women. Each committee draws members from the households with which the president has close family affiliations. Attendance is regarded as the norm, but other activities are now considered more important than committee attendance. Apart from mat weaving undertaken by the older women and occasional fund raising for a committee contribution for an important social event, there is little committee work outside the clinics, although there is discussion amongst members of the older committee about starting a chicken project. Both groups have a savings club with a bank account in Apia and make regular cash contributions, some of which are shared out before Christmas, and some used to make committee contributions to village or church functions. The older committee assists with guarding the district hospital but the other group refuses, maintaining that the hospital is a waste of time and they have to go to Apia for any medical assistance. In both, the clinic meetings are formally organised and the seating order based on the relative rank of the families which make up the two different groups.

Women have little contact with those who belong to the opposing faction, a division which is strengthened by their membership of different Churches.

Case Study 6-3 The Vaiala Tai Committee

The Vaiala Tai committee is the oldest in the country and was informally established by Dr Regina Flood Keyes in 1921. It is no longer well attended and eight of the fifteen regular clinic attenders are older women, five of them wives of matai. All but one take their grandchildren to the committee. The traditional division between in-marrying women, who are usually older wives of matai born and brought up in rural villages and the tama’ita’i who are young, and urban born and educated, provides a continuing source of conflict which directly influences committee attendance and activities. This conflict, which often stems from problems between mother and daughter, or mother and daughter-in-law, is suppressed in traditional and semi-traditional villages. It is recognised that the committee and the clinic in Vaiala have become two functionally and socially different groups. The committee comprises an active group of eight or nine older in-marrying women, who meet weekly to make handicrafts and raise funds for the church by holding dances and
selling vaifalo (tapioca porridge with coconut cream) in urban offices. They also raise funds to provide committee contributions for village events like weddings, or bestowing an important title as well as help organise the monthly committee meeting.

Most young women refuse to take part in fund-raising but a few occasionally attend the committee meetings. They maintain that the older women are ignorant and know nothing apart from fa‘a Samoa. The older women find the young ones uncooperative and unhelpful. The president of the committee is a young, well educated working mother and wife of a member of parliament who holds an important Vaiala title. As she works she has little direct involvement in activities other than the clinic. The older women responsible for organising the clinic ensure that it is conducted in a formal manner with seating and the serving order based on male rank. Although aware of the opinions of the young women, they refuse to change this.

Case Study 6-4 The Tulaele Committee

In Tulaele there are three committees within 250 meters of the major cross-roads. Two are neighbourhood groups and the other a family committee. In all only 17 women attend regularly, ten of whom are older women who bring their grandchildren or the children of relatives. The first committee was established in 1977, three years after the suburb was settled. Three older women decided a committee was needed as there were several families nearby with children and two of the women had grandchildren living with them. Two women were pastor’s wives and one the wife of a matai. The president, Alimau, visited the women in her immediate neighbourhood and asked them to attend. Initially membership comprised six women and 20 children who were later joined by women and children from Vaiusu Uta. The Vaiusu women did not belong to the committee but came only for the clinic and later began their own group. In 1980 an independent family committee was established by a large Chinese family and in 1983 following a change of president and rivalry and controversy over control of the committee bank account, some members of the original committee established a further group, but by the end of 1983 the district nurse had still not visited it.

The neighbourhood committee has nine regular members, six of whom are older women with their grandchildren. The president is a Church deacon whose husband is a dentist and holds two titles. The other two executive members are the wives of pastors. All committee members live within 200 meters of the president’s house, where the clinic is held. There are no activities other than the monthly clinic which is organised in a semi-formal way with the seating order divided into titled and untitled women. The pastor’s wife is considered to be titled. The committee has a savings account to raise funds for a Christmas party and a gift for the district nurse. None of the members have any other organisation or social group in common and meet only at the local corner store or on the bus to town.
Conclusions

The association between village type, the type of committee each village supports and the possibilities each offers for delivering primary health care and nutritional information supports the hypothesis that formal, substantive and interaction structures differ with locale. As the previous chapter shows, in each type of village examined, the size of the village, its structures, women’s day-to-day activities, and the breadth and intensity of women’s social relationships differ. These locational differences are highlighted by the age of committee attenders and the relationship between infants and those who take them to the committees. Committee distribution, attendance and activities reflect these differences but at the same time play a part in creating and reinforcing them. For example, as the proportion of older members increases, the opinion of young women that “the committees are for old ladies” and have no role in young women’s or their children’s lives, is strengthened. If, as I suggest, committee type and attendance patterns represent an historical and spatial continuum, from well-attended, formally-structured, rural committees which provide most women with young children direct access to nutritional information, to poorly attended, informal, urban clinics, where over half the women attending are past child bearing age, the future outlook for delivering primary health care and nutritional information through the women’s committees is not encouraging.

The adaptation of committees to change, their distribution and the patterns of attendance support the hypothesis that there is a reflexive inter-relationship between human interaction, daily activities and the political, social and economic, or formal structures, and social institutions, or substantive structures, and that these are specific to time and place. However, as the Tulaele committee shows, neither the committee organisational structure nor committee interaction structures have adapted to change at the same rate as changes have occurred in women’s lives.
The committee organisational structure exhibits considerable endurance of behaviour associated with rank and status, even in locations where there is no ranking structure and where behaviour associated with rank has little to do with women's daily lives. This supports Bourdieu and Layder in that changes in structure lag behind changes in everyday activities. Women attending the clinics conform to patterns of behaviour based on ideals which are rooted in the past rather than those associated with everyday life. Even in a time of rapid change, the committee interaction structures change relatively slowly, as those who do not, or cannot, conform to the accepted patterns of behaviour, no longer attend the committees. The uneven changes in committee structure, activities and attendance over 60 years point to the need for a temporal component in the models for both information flow and development, and to the need for these models to incorporate rapid and uneven social change. This chapter however, provides only an overview of the relationship between locale, the committees and attendance patterns. It does not explain the factors which determine attendance.
CHAPTER 7

COMMITTEE ATTENDANCE: CHOICE AND CONSTRAINTS

Attend the women's committee? I wouldn't be seen dead in one (Young Woman, Vaiala Village, 8.7.83).

Here we obey the president. To the committee I must go. Even when I'm tired and don't want to. Here we hold the tradition (Young Woman, Poutasi Village, 9.9.83).

Samoan women's committee attendance behaviour has little to do with physical access.¹ and it would be simplistic to suggest that all those who do not attend do so through choice or that all those who attend do so because they are coerced, just as it would be simplistic to suggest that the lower attendance of young women is because they are constrained by paid employment or consider committees old-fashioned. The questions of choice and constraint governing committee attendance are considered here in relationship to village type and women's age and status. By considering individual women's perceptions of their attendance patterns in relationship to the formal, substantive and interaction structures of the village in which they live, it is hoped not only to provide an explanation of committee attendance but also some understanding of the processes which underlie information flow and social change.

All structurationists allow for some degree of individual choice of action and suggest that structure simultaneously enables and constrains it, but they provide no indication of the kind of locale within which greatest choice of action is most likely to be available.² As formal, substantive and

¹Le Grand (1982) provides an excellent study of social and spatial constraints to access to health and other social services in Britain.

²See Archer 1982.
interaction structures vary with location, it can be expected that the constraints to choice of action will also vary. Mair observes that the scope for independent and innovative action in small-scale, traditional societies is less than in more open systems and that it is usually either the young and better educated, or those who do not have high status and therefore have less to lose from non-conformist behaviour, who have more opportunity for choice, or room for manoeuvre. Women, she maintains, have less room for manoeuvre than men and an important motivating force in its use is "to find new ways to gain esteem". Mair states that new relationships and interaction patterns are incompatible with pre-existing ones...

not because they entail new kinds of action, but because they necessitate the neglect of established obligations. Hence it is of considerable significance whether the new relationships into which people enter take them away from the village environment (Mair 1971:130).

My examination of the choices and constraints that influence women's attendance decisions is based on interviews with village women and district nurses, and on observation and casual conversations. The results of this research point to the importance of looking beyond answers given to a formal questionnaire and the need to incorporate within analysis, observation, casual conversations and the particularities of specific social settings.

An Overview of Attendance and Non-Attendance

Interviews show that women who attend the committees fall into three main categories - those who feel they must obey village regulations or the committee president; those who consider it correct behaviour and that by attending the committee they are both maintaining their personal prestige and supporting the village and the family; and those who expect to derive some health benefits. Observation and informal conversations identified two further groups. For one, the social pressure to attend is so

3The details of the methodology are outlined in Appendix 7-1.
strong that they have devised strategies to overcome the economic difficulties associated with attendance. For the other, attendance is closely related to their ability to exhibit wealth and to maintain control of social, economic and political resources. The reasons women give for attendance vary with village type and with age and status (Table 7-1).

The non-attenders interviewed also fall into three groups - those who do not feel obliged to attend and choose not to; those who would like to attend but are constrained from doing so by their position in village society or from inability to meet the contributions required; and those who do not attend because they work. Observation and informal conversations identified a further group who feel obliged to attend but have found socially acceptable strategies to enable non-attendance. Seven major reasons are given for not attending, the most important of which are conflict and the expense of contributions (Table 7-2).

The factors influencing attendance behaviour are complex and vary with time, location, age and status. Factors that enhance choice in traditional villages constrain it elsewhere, just as the factors which constrain choice for young women enhance it for those who are older. The type and amount of choice women have over attendance is closely associated with the ways in which they are integrated into the community and their perceptions of the purpose of the committee.

My research points to three widespread problems which seriously undermine the effectiveness of the women’s committees as channels for primary health care and nutritional information, and prompts questions about the overall utility of the system. These are the non-attendance of children who are either ill, from poor families, or illegitimate, and most in need of assistance; the limited realisation by village women of the committees health functions; and conflicting perceptions of the reasons for non-attendance held by village women, district nurses and Department of Health policy-makers.
Table 7-1: Reasons given by Women for attending Committees, by Rank and Village Type

<table>
<thead>
<tr>
<th>Village Type</th>
<th>Traditional</th>
<th>Semi-Trad</th>
<th>Modern</th>
<th>Non-Trad</th>
</tr>
</thead>
<tbody>
<tr>
<td>Matai Tau*</td>
<td>21</td>
<td>35</td>
<td>14</td>
<td>14</td>
</tr>
</tbody>
</table>

(per cent)

Overt Coercion
- To obey the president: 16% (Traditional), 41% (Semi-Trad), 10% (Modern), 23% (Non-Trad)
- To obey the high chief: 8% (Traditional), 10% (Semi-Trad), 3% (Modern), 9% (Non-Trad)

Covert Coercion
- Women always attend: 20% (Traditional), 28% (Semi-Trad), 22% (Modern), 20% (Non-Trad)
- To support the village: 30% (Traditional), 10% (Semi-Trad), 10% (Modern), 6% (Non-Trad)
- To support the family: 5% (Traditional), 5% (Semi-Trad), 16% (Modern), 14% (Non-Trad)
- To support the young women: 10% (Traditional), 0% (Semi-Trad), 8% (Modern), 0% (Non-Trad)

Health
- To help the children: 6% (Traditional), 2% (Semi-Trad), 10% (Modern), 12% (Non-Trad)
- To get help from the Hospital: 0% (Traditional), 0% (Semi-Trad), 2% (Modern), 20% (Non-Trad)
- To improve people's health: 2% (Traditional), 2% (Semi-Trad), 7% (Modern), 5% (Non-Trad)

Don't Know
- 3% (Traditional), 2% (Semi-Trad), 4% (Modern), 5% (Non-Trad)

*Tau = Taulele’a
The group of tama’ita’i is too small to be statistically significant. I have included older women in this group with matai, as they are frequently the wives of matai, and young women with the taulele’a.

As age and status are usually commensurate I have not categorised them independently.

(Source: Village interviews, 1983)
Table 7-2: The Major Reasons given by Non-attenders for not attending Committees, by Rank and Village Type

<table>
<thead>
<tr>
<th>Women's Replies</th>
<th>Traditional Matai Tau</th>
<th>Semi-Trad. Matai Tau</th>
<th>Modern Matai Tau</th>
<th>Non-Trad. Matai Tau</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>N=</strong></td>
<td>10</td>
<td>10</td>
<td>15</td>
<td>25</td>
</tr>
<tr>
<td><strong>Disinterest</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>There is no point in it</td>
<td>8</td>
<td>3</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td><strong>Conflict</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Political disagreement</td>
<td>24</td>
<td>5</td>
<td>54</td>
<td>6</td>
</tr>
<tr>
<td>President is &quot;too high&quot;</td>
<td>16</td>
<td>5</td>
<td>12</td>
<td>16</td>
</tr>
<tr>
<td>Banished from the village**</td>
<td>14</td>
<td>7</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Isolation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Don't talk to other women</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Not asked to join</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Don't know other women</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Other Health Options</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prefer the <em>fofo</em></td>
<td>20</td>
<td>6</td>
<td>6</td>
<td>12</td>
</tr>
<tr>
<td>Prefer the hospital</td>
<td>0</td>
<td>0</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Prefer <em>Emanuelu</em>**</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td><strong>Expense</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Contributions too high</td>
<td>14</td>
<td>39</td>
<td>10</td>
<td>16</td>
</tr>
<tr>
<td><strong>Work/Employment</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>In paid employment</td>
<td>4</td>
<td>10</td>
<td>2</td>
<td>20</td>
</tr>
<tr>
<td>Too much housework</td>
<td>0</td>
<td>18</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td><strong>Dislike of Tradition/Committee</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Too much <em>fa’a Samoa</em></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Too old fashioned</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Just clubs for old women</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td><strong>Other Reasons</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The nurses know nothing</td>
<td>0</td>
<td>7</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Husband doesn't like it</td>
<td>0</td>
<td>8</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Prefer TV or movies</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

* In rural villages this refers to both families ostracised for contravening village regulations and to government employees in government housing.

** *Emanuelu* is a faith healing movement started in 1981. It is discussed at the end of the chapter.

(Source: Village interviews, 1983)
Choice and Constraint in Traditional Villages

In traditional villages attendance is still associated with correct behaviour and is seen by women to uphold the prestige of the family, the committee and the village. The committee is perceived as an integral part of the village community and the local system of authority. Non-attendance is considered to deliberately flout the authority of the executive and indirectly that of the *fono*, which in turn can bring shame upon the family to which the woman belongs. The clear-cut nature of women's roles and expectations, the importance of age and status divisions, and the lack of variation in the use of space and time of women in each age group are apparent in their attendance patterns and the reasons given for them.

Attendance in Traditional Villages

Social pressure is the major reason young women¹ give for attendance (86 per cent) and just over half say they attend because they must obey those in authority. They feel that they personally gain esteem from conforming to the correct standard of behaviour. Only 3 per cent of the young women who attend, say they do so for health-related reasons. Eight per cent of older women state they attend to help improve the health of the village or family but most (65 per cent) because it is considered correct behaviour. Although older women do not feel the same overt coercion as younger members, the need to conform to accepted roles is very important, most particularly for the wives of high-ranking *matas*.

Two important factors which influence attendance but are not mentioned by women are the committee’s continued attraction as a social event and the opportunity it offers women to personally exhibit wealth in a society where there are no other socially acceptable opportunities to do so in public. (Contributions to public and family functions are made by the

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¹Young women are classified as who are around 30 years of age or younger and have young children.
matai on behalf of his family.) Older women, who today have access to
cash and to imported goods, have increased the quality of the goods
required for the asiasiga. At the same time the food contributions have
been changed to include a high proportion of store-bought items. To
maintain personal and family esteem women must provide contributions
that meet acceptable standards of size, type and quality. The ceremonial
nature of the village committees means that each woman’s contribution is
publicly announced and displayed (Figure 7-1). If the goods are considered
inferior she runs the risk of public ridicule so women who cannot afford
adequate contributions are caught in a dilemma. If they attend they are
shamed for providing poor quality contributions, but if they stay away they
are considered to lack concern for village regulations and may be ostracised,
which for some is more shameful than being publicly laughed at. Most of
the women in this situation are the young wives of untitled men, some of
whom live in poor households or in households where there are no older
women to help with cash or contributions. This is a situation the district
nurses say they can do nothing about.

They like to make a big meal, but this is a problem for the
poorer ones. I tell them don’t buy expensive food like pisupo
(tinned corned beef) and give it to the nurse. Give us vegetables
that you grow. But you know it is hard to get them to stop the
custom - the fa’a Samoa - they think that its rude not to. And
of course vegetables aren’t the food you give a guest, so they go
and buy these imported things. That’s custom for you (Pers.
Comm., District Nurse Salu, 16.6.83).

The asiasiga has developed into a ceremony in which older women
compete for personal or family prestige but claim this enhances the prestige
of the committee and village. They do not consider the impact of this on
young women who have neither the time to weave mats nor the cash to
buy expensive goods. Poorer women overcome this problem by borrowing

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5 It is interesting to note the nurse’s perception of what constitutes custom. This points to
the rapidity with which customs change.
money for food from friends or the committee loan fund⁶ (Figure 7-2) and borrowing goods for the asiasiga from relatives in other villages.⁷ None of the women I spoke to considered it contradictory that economic difficulties were shameful for non-attenders and those who made poor contributions, but not if those who attended continually borrowed to do so.

**Figure 7-1:** Women display a high-quality bed mat at an asiasiga at Saina Committee, May 1983

Borrowing has become standard practice and everyone, including the nurse, accepts it.

I know they borrow for the asiasiga and for the food. I know they, they just keep them [sheets and towels] in those big boxes and never use them for the family. They use them to show off. Especially the older ones. They are so full of pride. So I say to them "these are to be used for the good of the family, to keep you healthy - not to be kept in that box and used only when you die". But they take no notice. They just laugh (Pers. Comm., District Nurse Olive, 16.6.83).

Repayment of the debts incurred for committee contributions is a

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⁶Most committees have a loan fund, which charges up to 20 per cent interest per week. See Schoeffel 1980:82-83.

⁷I saw the same pair of towels exhibited in clinics in three different villages and later found that the women displaying them were sisters.
The Committee Executive collect contributions for their loan fund, Toapa'i Committee, August 1983. Growing problem and is leading to resentment among men many of whom believe the committees no longer provide the village with a useful service, but are expensive, time-consuming social functions where women gossip and cause trouble. Ten of the twelve men I questioned thought women should attend only when all household and family commitments had been met. Two thought the committees gave women too much independence. The Department of Health has recognised the dilemma of contributions for some years but maintains that if the astasiga was stopped or the type of goods restricted the older women would no longer attend and that without their support the committees would collapse (Department of Health 1972:21).

The committees also provide a social occasion where women tell the latest jokes, swap gossip and information with one another and the nurse, catch up with events in nearby villages, discuss the latest scandal in the television programme8 “Days of Our Lives”, share a large meal and have a good laugh at the palagi (European) visitor trying to dance the Samoan siva (Samoan dance) (Figure 7-3).

8Western Samoa receives the television signal from American Samoa.
Non-Attendance in Traditional Villages

Non-attendance is relatively low in traditional villages and of the 30 per cent who do not attend, just under one-half are young mothers, usually those with least access to cash. Half of these women are habitual non-attenders from families whose women have not attended for ten years or more. Thirty-four per cent of young non-attenders state that they cannot afford the cost of either the contributions or money expected for the savings club. From observation and informal conversations I believe that this is true of around 80 per cent of young non-attenders. Many of these women have attended at some time in the past and would continue if they could afford it. Twenty per cent of older women also admit that contributions cost more than their family can afford. Young women in this position say they feel ashamed and isolated or that "the other women don’t like us", while the older women maintain that it makes no difference to them. Few women claim their husbands do not allow them to attend.
Habitual non-attenders are without exception from families which other villagers consider as "outsiders", even though they have blood links with village aiga. These families are recognised as providing little support for village organisations or community services and as making no effort to conform to acceptable patterns of behaviour. Women in these households have very restricted social links. On average habitual non-attenders belong to only one village organisation (usually the church), while other women belong to four. The households of non-attenders are usually poor, are short of young men and as they seldom have a resident matai are politically powerless. They have a higher proportion than other families of what villagers consider illegitimate children\(^9\) (see Case Study No 1 in Appendix 7-2). For most women it is not considered deeply shameful to have an illegitimate child, but to bring the child to the clinic is considered indiscreet and indiscretion is shameful. Nurses report that very few illegitimate children are brought to the clinics. In the 56 clinics visits I made I knew of only two. The number of illegitimate children is increasing\(^10\) and in Poutasi village 7 of a total of 63 children under 5 years of age are considered illegitimate.

Conflict is also an important constraint to attendance in traditional villages and has greatest influence on women in positions of authority. Fifty per cent of older non-attenders claim they do not attend because of political or personal conflict. Arguments over committee leadership and accounting procedures are the most common reasons given for personal conflict, but conflict between opposing village political factions is also an important reason and one that has been exacerbated since 1982 by the

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\(^9\) Children born of "Samoan marriages", or stable non-formalised relationships are not considered illegitimate.

\(^{10}\) It is difficult to find data to substantiate the opinion of rural and urban elders and Department of Health maternity staff that the number of illegitimate children is increasing rapidly. Jansen (1977:295) reports 6.1 per cent of mothers in a sample of 128 from Apia and Savai'i as unmarried with a higher proportion in Apia than Savai'i. Attempts in 1982 by the Department of Health statistics officer to collect data on the number of infants born to single mothers in the National Hospital were discontinued.
emergence of two national political parties.\textsuperscript{11} Pride does not allow women of one political faction to support a committee led by the women of the other. In traditional villages where the most remote family connection is known to all, women are obliged to support their \\textit{oga} whether the conflict directly affects them or not. Eight per cent of women do not attend because their families are temporarily banished from the village for some unresolved disagreement with the \textit{fono} or the misdemeanor of a family member.

Non-attendance is not only a matter of ostracism or shame. It places poorer families in a vicious circle as in many villages non-attenders and their families are not permitted access to the district hospital or health centre. If they do have access they are charged outpatient and inpatient fees ten times higher than those expected from committee members. The usual Department of Health consultation fee is 10 sene (SA.0.6) and hospitalisation T1 (SA.60) a day. In districts where the women's committees control hospital registration and collection of fees, non-members must pay T1 for consultation and between T5 and T10 a day for hospitalisation.\textsuperscript{12} It is considered by villagers that those who do not provide support for the committees should not have the advantage of cheaper rates. This practice is condoned by the Department of Health. Therefore those who can least afford committee contributions are expected to pay higher medical costs. I have seen this result in sick children remaining untreated and seriously ill adults and children being taken on long journeys on the back of an open truck to the National Hospital in Apia or to the Tuasivi hospital in Savai'i.

The 16 per cent of young women in traditional villages who claim that they do not attend because they work points to the changing pattern

\textsuperscript{11} See Ioane 1983 for a discussion on the impact of these parties.

\textsuperscript{12} The lower fee which is the standard Department of Health fee goes to the Department of Health and the balance to the district women's committee to help provide equipment for the hospital.
of women’s activities in traditional villages. In response to the growing number of women in paid employment and increased pressure on young women to work on the land or in the household, the committee executive has renegotiated the rules governing attendance and correct women’s behaviour. Paid employment and house or agricultural work are now acceptable reasons for non-attendance on condition that these women provide regular contributions. In this way support for the executive and village hierarchy is clearly demonstrated and women “participate” without attending. Neither village women nor the nurse consider this practice to be absenteeism. (which may account for the discrepancy between official attendance figures and my observations).13 As a result it is now acceptable for young mothers to work in the house or on the land while the older women of the household take the children to the clinic. Young women have little choice but do what they are told by the older women of the household.

These days the young mother is too busy running around doing things to keep the grandmother’s image high. The daughter-in-law does the work. She’s the one who gets her face burned doing the cooking while the grandmother sits in the committee (Pers. Comm., Chief Nutritionist Brenda Sio. 20.6.83).

A family life crisis has always provided a legitimate excuse for occasional non-attendance, but the number of crises people are expected to attend has increased with better communications,14 and what is considered a legitimate crisis has expanded. Economic activities like cutting copra for church contributions or school fees, marketing taro in Apia, and helping on the plantation are all reasons for non-attendance that were not acceptable ten years ago when there was less demand for cash, and more young men and women to assist with work. The excuses which women use for non-

13 The difference between contributing and physically attending was discussed fully with both nurses and village women to ensure there was no misunderstanding. Both groups maintained that a contribution was commensurate with physical attendance.

attendance are often not genuine but if a contribution is provided, their validity is not checked as this would be beneath the dignity of the executive.

In traditional villages 20 per cent of older women maintain they do not attend because they prefer to use the fofo (traditional healer). On further investigation, most of these women proved be the wives of low ranking matai and not on the committee executive. They saw no point in providing contributions for which they received no material or social benefit and chose to stay away.

In traditional villages few women have choice over attendance and the influence of social pressure is omnipresent. Older women, most particularly those of high rank, feel strong pressure to attend and jealously guard the access to prestige and authority which the committees afford. Women with wealth are subject to the pressure of competition and deliberately use the committee as a venue for displaying and maintaining relative advantage. High-ranking women have sufficient room for manoeuvre to negotiate and renegotiate the rules governing attendance, and exercise community closure against those who do not or cannot conform to the criteria they establish. Young women have very little choice of action and are subject to overt and covert coercion to either attend or to stay at home. The need to provide adequate contributions enables the attendance of most older women but severely constrains many younger ones. The women with greatest choice over their attendance decisions are the small group of older women who as the wives of low ranking matai feel they have little to gain from attendance and nothing to lose from non-attendance. They have sufficient status to preclude either coercion or ostracism. The other small groups of women with some degree of choice are the young tama'ita'i and the young women in paid employment. Their independent status allows greater choice of action than is available to other women. Overall, in traditional villages, committee attendance is still perceived as a prestigious activity and the
situation observed by Keesing and Keesing in the early 1950s still pertains. "By honouring and obeying those of elite status, people felt they were honouring themselves" (Keesing and Keesing 1956:46). However, the degree of choice available to women in traditional villages has changed. In the past the committees provided high-ranking women with the opportunity to initiate bold, new, innovative projects. Today they offer little more than the opportunity to engage in small adjustments to behavioural patterns.

Choice and Constraint in Semi-traditional Villages

In semi-traditional villages the amount of choice women have over committee attendance and the reasons they give for attendance are closely related to the high incidence of conflict, to reduced support for community institutions, and the increased control women have over their use of space and time. Forty-eight per cent of village women attend, nearly half of whom are older women. Attendance is still associated with correct behaviour but there are fewer pressures to conform than in traditional villages and very few women feel the same obligation to obey those in positions of authority. Support for all village organisations is spasmodic and ostracism as a means of enforcing committee support is largely ineffectual.

Attendance in Semi-Traditional Villages

With three or more committees in each village and membership based on sub-village or traditional family affiliations, a high proportion of attenders have close family links with the president of the committee they attend and it is a matter of pride to exhibit family solidarity. Seventy per cent of those who attend do so because of social pressure. Young women either feel obliged to obey those in authority or attend because they consider it is correct behaviour and supports the village or family. Few older women feel they must obey those in authority but nearly half are influenced by the need to support the family or the village. Many of
the older women attending are wives of matai who do not take children to the meeting. Although they maintain they attend to support the village and family, they enjoy displaying wealth. The very high quality of the goods provided for the asiasiga and the expensive contributions for the meal point to the number of households with members overseas or in local paid employment and women's access to cash. There has been little attempt in semi-traditional villages to adjust the criteria governing acceptable attendance or non-attendance and although the children of some working mothers are taken to the clinics by their grandmothers or other relatives, women feel no need to provide contributions in lieu of attending.

Non-Attendance in Semi-Traditional Villages

Conflict is overwhelmingly the most important factor influencing non-attendance of older women and tensions between members of different political parties or opposing family factions dominated all discussions of non-attendance. Over half the older non-attenders maintain that it is impossible for them to support a committee run by "the opposition" and also admit to finding it difficult to cooperate with women from their own aiga. Increased family disputes over land and titles which have resulted from both a breakdown in conflict resolution and the increased number of titles (see Case Study 2 in Appendix 7-2)\(^{15}\) and growing conflict between families over the behaviour of young people add to the tensions in semi-traditional villages. Few young women consider political or family conflict a reason for non-attendance and the reasons they give point to their wider choice of daily activities. Young women in traditional villages give nine different reasons for non-attendance, those in semi-traditional villages offer fourteen. As Table 7-2 shows the reasons women give differ markedly

\(^{15}\) The breakdown in conflict resolution is apparent in the increased number of disputes over land and titles brought to the Land and Titles Court, Apia between 1980 and 1983. See Epati 1981.
between village types. A high proportion of women prefer other health options, a preference which is often connected with inability to pay the committee contributions. It is considerably less expensive to occasionally take a child to the National Hospital in Apia when it is ill, than to regularly provide committee contributions. The cost of an average monthly committee contribution is T7 (S$A5.30), a considerable outlay in a society where the average weekly take-home pay is T35. A visit to the hospital in Apia costs T1.20 for the return bus fare and 10 sene for the hospital fee. Few women perceive any health-related benefit in committee attendance.

In semi-traditional villages young women have more choice over their attendance behaviour than those in traditional villages and more choice than older women. They have a wide range of acceptable roles and many no longer feel the need to conform to the behavioural patterns of the older women in their families. Neither attendance nor non-attendance has any direct impact on their self esteem or on that of their families. Those who feel there is no point in attending or that the cost of contributions outweighs the social or medical benefits, stay away. For older women attendance is still perceived as correct behaviour and is an important means of gaining and maintaining personal and family esteem. Conflict and family factionalism both enable and constrain attendance behaviour.

Choice and Constraint in Modern Villages

The reasons women in modern villages give to explain their attendance behaviour indicate community fragmentation and the extent of changes in attitudes toward fa'a Samoa. They also reflect changes in women's lifestyles, expectations, and activities open to them. Most important, they indicate different perceptions of the role of the committees.

Attendance in Modern Villages

Unlike rural villages, in modern villages there is little differentiation between the reasons older and young women give for attendance. Only 29
per cent of women in modern villages attend the committees. Many attend irregularly. Just over 50 per cent of those attending are older women whose husbands are *matalu*. Although living in town they feel some pressure to conform to the same patterns of behaviour as women in traditional villages. In urban villages some women who do not attend as *taulele'a* begin once their husbands gain an important title\(^1\) highlighting their belief that committee attendance is closely related to correct behaviour and traditional authority roles.

Well, now I am a *faletua*. I have to think about the *fa'a Samoa* and the proper thing to do. Now I must join the committee. I must support my husband and the family. Now I must support the committee. That's the *fa'a Samoa* (Pers. Comm., Christina, Lotopa Village, 20.6.83).

Sixty per cent of those who attend, do so because they consider that the committee provides some form of health benefit, contrasting strongly with the situation in rural villages where only 3 per cent of attenders say they attend because of the health-related benefits. In part this is a reflection of the reduced importance of social and political factors, but it also reflects the high proportion of Seventh-Day Adventist and Mormon committees in modern villages and their strong health bias. Women are encouraged by these churches to attend the committees and the health reasons for doing so are clearly spelled out.

Non-Attendance in Modern Villages

Employment, lack of interest, conflict, a variety of other health options, expense, dislike of *fa'a Samoa*, dislike of the president's authority, the nurse's ignorance, and isolation are among the reasons given for non-attendance. What is surprising is that nearly 20 per cent of young non-attenders maintain that they would like to attend but cannot because they are not asked to join and have little contact with other women. The

\(^{1}\)Mead (1928:36) explains the way male roles change when they acquire a title. While this change is not so dramatic today, women also face changes in roles and expectations when their husbands are elected to a title.
exclusive nature of church and family clinics makes it particularly difficult for new arrivals to town to join a committee or to start one. They do not have social access to a committee unless they can overcome prejudice and distrust of strangers, or have sufficient status and confidence to start a new committee. For young, untitled women this is impossible. The health problems of young, new arrivals and their children are compounded by their lack of confidence to visit the hospital. In household visits I found several young women with seriously ill children who felt there was nowhere to turn for help. They could not overcome the psychological barriers associated with visiting the hospital, and private doctors’ fees were more than they could afford. They did not know a local sofo and were too embarrassed to ask local women for assistance or permission to visit the committee (see Case Study 3 in Appendix 7-2). This situation seldom affects older, titled women for whom their husband’s title confers status and confidence.

On the other hand a high proportion of young women (30 per cent) associate clinic attendance with fa’a Samoa and behaviour they consider old-fashioned. The committees have no role in their lives. With a range of other health options, they say they prefer to go to the hospital, to the Family Welfare Centre, or Emanuela, a faith-healing group established in 1981. These are options not readily available to rural women.

In modern villages only a few older women see committee attendance as a prestigious or socially important activity. Most of those who attend do so for health reasons. There is not the same pressure as in traditional or semi-traditional villages to provide expensive contributions and women do not feel the same need to exhibit wealth. Few women complain of the cost of contributions, but those who do, agree with women in semi-traditional villages that it is very much cheaper to visit the hospital when necessary. The 8 per cent of non-attenders who complain of the nurse’s ignorance represent the growing number of young women with four or five years of secondary schooling and their realisation that some older nurses

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17 This figure varied with age. Of all taulele’a 19 per cent associated committee attendance with “old fashioned” behaviour. Thirty percent of those between 19 and 40 years of age considered it “old fashioned” behaviour.
are not well educated. None of the young working women interviewed felt any obligation to provide committee contributions in lieu of attendance and considered it unimportant whether their children were taken to the committee or not.

Although few women in modern villages feel pressure to attend, non-attendance is not always a matter of choice. Some are constrained by lack of social access and other urban-born and educated women are subject to pressure to not attend, as their friends associate committee attendance with behaviour that is old-fashioned or from "out the back". Many are vehement in their disapproval of the committees and maintain they are "a rip off", "clubs for old ladies", and that they "wouldn't be seen dead in one". For these women esteem is gained by non-attendance.

Choice and Constraint in Non-Traditional Villages

The fragmented nature of non-traditional village social structure, the lack of clear-cut age and status roles, the diversity of ways in which women use their time and space and the committee's lack of importance as venues for gaining prestige or authority, are apparent in the reasons women give for their attendance patterns. In these new suburbs only 10 per cent of young mothers attend and membership comprises predominantly older matai and the wives of pastors.

Attendance in Non-Traditional Villages

The major reason women of both age groups give for attendance is to improve the health of their children or to get help from the hospital. In a social setting which has few links with traditional village structure, very few women feel any pressure to attend although 12 per cent of older women state they feel obliged to attend so they can help the younger women and their children, unaware that their efforts often prompt the opposite response. Older women have exercised considerable room for manoeuvre in that they have deliberately established new committees so
that primary health care, drugs, vaccinations and food aid are delivered
direct to their homes or to the immediate neighbourhood. This, they
claim, is much easier than trying to get to the hospital with two or three
small children, no pram or stroller and an irregular bus service. Although
it still costs more to visit the committee than the hospital older women
consider it worthwhile. With no ranking structure to provide a framework
for competition between women, there is little pressure to provide a lavish
meal or expensive goods for the asiasiga. There are however attempts by
older wives of high-ranking men to introduce some form of hierarchical
structure based on status and wealth and there are attempts in some
neighbourhood committees to introduce ranked seating order and to increase
the quality of the goods for the asiasiga (see Case Study 4 in Appendix
7-2). As in modern villages a high proportion of women attending for
health-related reasons are members of the Mormon or Seventh-Day
Adventist Churches for whom strong, healthy children and support of the
church are both means to gain esteem.

Non-Attendance in Non-Traditional Villages

In a social setting where a high proportion of women live in nuclear
households, few women have access to a committee unless they start their
own, or belong to church that is concerned with health or live in very
close geographical proximity to an older woman who has started a
committee and has invited neighbours to join. In Tulaele all women
belonging to the neighbourhood committee live within 200 meters of the
house of the president. Young mothers in nuclear households, most
particularly recent arrivals to town, are often isolated and have limited
options over committee attendance. They feel that committee membership
is "only for special women" and that it would be bad mannered to invite
themselves. Their social isolation is obvious in the slow way local
information moves. Ten young mothers, all of whom had lived in Tulaele
for two years or more, were surprised when I told them that there were three committees in their neighbourhood. Young women living in nuclear households who have three or four small children find it physically difficult to attend even when the meeting is held nearby. Roads are poor and there is nobody to help look after children at home, or help get them to the committee (see Case Study 4 in Appendix 7-2). Informal interviews show that most young women have no expectation of ever attending a committee and that the committees are perceived as having nothing to do with their lives or the health of their children.

In non-traditional villages most women have considerable choice over attendance, but some are left with very little room for manoeuvre. They are caught at the frontier of change where time and space are not in accord. Physically located in an area of extensive and rapid change, their values and perceptions belong to the past. They maintain traditional roles and values in a setting where there is no structural framework to support these roles. Their resulting isolation leads to lack of access to formal and informal health care.

The Rural to Urban Pattern of Choice

The amount of choice women have over their attendance decisions is closely associated with the type of village in which they live and the number of options they have for both using time and space and for gaining personal or family prestige. Women in traditional villages have least choice, those in non-traditional villages most choice. Women in traditional villages, where women's activities are limited and their roles and status clearly defined, have few ways for gaining esteem other than conforming to the accepted patterns of behaviour. Women in semi-traditional villages have a wider choice of acceptable roles than those in traditional villages but these options are usually open only to the young and well-educated. Older women's actions are subject to both direct and indirect pressure. Factors such as conformity to accepted patterns of behaviour and the need
for prestige, both enhance and constrain attendance. In modern and non-traditional villages, the combination of the variety of roles open to women, the lack of clear role definition and lack of effective mechanisms to ensure role conformity, have given women more choice over their attendance behaviour than is open to women in traditional villages. In these locales, committee attendance is not associated with prestige and for young women they frequently have the opposite connotation. In the urban areas a new role for young women is emerging. It incorporates active rejection of behaviour associated with the traditional way of life, and now provides an important structural constraint to attendance.

There are however constraints to attendance in all types of villages which influence all age groups.

**Ill Health, Illegitimacy and Poverty as Constraints to Attendance**

Ill health, illegitimacy and poverty are constraints to attendance which commonly go hand in hand. They point to the loss of the committees' primary health care function and the committee executives' lack of consideration for the welfare of village families. In the past, a sick child would have been seen by the nurse at the committee or at home. Today sick children are frequently not seen at all.

When a child gets sick or underweight the mother is ashamed and hides it away. It happens often now. They don't bring it to the committee. They feel bad in front of the others. They feel the others say they have no brains. They talk and gossip and say she has no food and laugh at her. So it finally collapses, then they have to bring it to the hospital. A small problem becomes a large problem (Pers. Comm., DMO Leota, Fusi Hospital, 5.7.83).

Few nurses now visit children at home and in many committees, if the mother has not provided a contribution, the president will not advise the nurse that the child is ill, or she will threaten the nurse with non-cooperation or a bad report to the matron if she visits the children of non-attenders. This places nurses in a dilemma, as a high proportion of the sick and malnourished children are illegitimate or from poorer households.
A survey of the malnourished children from all over Upolu who had been admitted into the Apia National Hospital between October 1982 and October 1983, showed that of the 70 cases on which adequate data had been collected 41 were from families that did not belong to the women’s committees and 19 children were either considered illegitimate or had been abandoned or informally adopted, often both. Informal adoption is common in Samoa and although it runs counter to Samoan perceptions of their culture, children who have been left for relatives to rear are sometimes resented and poorly cared for. Adopted infants are at greatest nutritional risk as they are bottle fed and are frequently completely weaned overnight. The nurses are aware of the existence of these children but never see them in the committees. The usual pattern in all households is for healthy children to be taken to the committee and for sick ones to be left at home.

In all villages there is a group of habitual non-attenders who according to other women are incapable of organising themselves or their children sufficiently to attend. Children from these households seldom attend school, or at best, attended spasmodically. They are usually easily identified as the thin, dirty and lethargic children. Although it is unfashionable to discuss inequality that cannot be explained by class or economic divisions, Samoan women recognise that these women are unable to cope with the demands of society. When I asked villagers why these women did not attend the common response was “Oka, oka, they’re weak in the head, but strong in the belly”, a reference to their fecundity. Most had a number of children, none of whom were ever seen by the district nurse, and as few attended school they were never seen during school health inspections. In the four villages surveyed, an average of 6 per cent of women were considered to belong to this group with a slightly higher proportion (7.8 per cent) in rural villages. All had children.

17 Also see Jansen 1977:303.
Perceptions of Attendance by the Department of Health and the Nurses

Economic constraints to attendance were first reported by the Department of Health in 1972 and repeated ten years later in a WHO report which cites the explanations of village women.

Women were not allowed by their husbands to join because of political or other feuds with the husbands of members; because husbands thought there was too much socializing and gossiping going on; that women felt they could not adequately live up to the financial commitments involved (Hammer 1982:2).

The report adds "some people just didn't care about village work" and that this occurred most frequently in Apia where people were close to the hospital. Although the 1982 Department of Health discussion paper on women's committee attendance (see Appendix 7-3 for the full paper) noted "women leave women's committees because they cannot afford it (time and money)" the assumption is still that all women have access and that those who do not attend do so from choice. This is reinforced by the Director of Health's address to the thirty-sixth World Health Assembly in 1983 in which he stressed that all women "voluntarily form a group and, under their president, conduct all social and health activities at the village level" (Lavea 1983:315) and in the document Health for All Samoans by the Year 2000 which declares:

The village women's committees of Samoa are ... composed of all women in the villages, organized primarily to assist in health programmes ... young and old. all these women participate in the public health activities for the betterment of the society (Department of Health / WHO 1983:3).

This perception of access is also that of the district nurses who still assume that attendance is optional. Formal interviews show that 27 of 31 nurses believe the major reason for non-attendance to be laziness. This perspective recurred in informal discussions and conversation about clinic attendance, nutrition and sanitation, and is common among health workers

18 Nurses' answers to a formal questionnaire and their informal comments on attendance are given in Appendix 7-4.
throughout the Pacific. Nurses believe that women use village conflict and male disapproval as excuses to stop participating. The assumption that women choose to not attend influences the Department’s primary health care policy and its solutions to non-attendance.

A policy for the National Hospital and Tuasivi Hospital must be decided in respect of accepting people from the district in routine medical care. Quite a number of people can avoid being involved in the women’s committees and in supporting the district hospital or health centre, by simply going to the National Hospital ... This should be discouraged by not accepting them for attention unless in the case of a transfer or an emergency, or where there is no doctor working in the district ... It must be made clear to these families that the Health Department will soon discontinue giving them this very privileged service, therefore they must join a women’s committee. In the Apia area, if families will not or cannot join a women’s committee that family may receive attention at the National Hospital or Family Welfare Centre. These people also have a choice to see a private doctor (Department of Health, 1982: 1-2).

The Option of Non-Formal Health Care

The combined impact of withdrawal of government support for the rural health service, the decline in committee prestige, lack of clear committee goals and directives, constraints to attendance, and the high cost of medical attention for non-attenders has led to a marked increase in the use of non-formal health care. Nurses report a growing preference for the fofo and faith healing. In 1981 the emergence of an indigenous faith healing group, Emanuelu, provided a health option that by the end of 1983 was beginning to undermine committee attendance. The fofo have always provided an important health option. This option is particularly attractive at a time of social, economic and political uncertainty. The fofo remain unaffected by political factionalism, are available immediately, are known and trusted. They come to the house of the patient, do not expect

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19Reid (1984:298) reports that Maternal and Child Health nurses in Papua New Guinea attribute absenteeism to "sloth, obstinancy and stupidity". Also see "Report on the FPSP Nutrition Education Workshop, Suva" (Renda and Tisa 1983) which outlines the responses of health workers from eight Pacific Island countries.

20There are inconsistencies between the attitudes of Department of Health administrators and Departmental reports.
to be paid in cash, and their treatment involves no expensive drugs. All but six families in the villages studied had at some time in the preceding three months used the fofo. When I asked women to whom they would first take a sick child, 88 per cent replied the fofo. This is true of Poutasi which has a district hospital 300 meters from the central malae and of households within 300 meters of the National Hospital in Apia.

Emanuelu provides a different solution. It promulgates the belief that faith in Jesus is all that is required for health. It actively discourages the use of medicaments or inoculations and mothers are encouraged to forbid their children being inoculated. Enterprising nurses have found ways around this by demanding that reluctant women sign a paper saying they refuse to have their children inoculated. Women usually relent. Healing is conducted in a public ceremony which involves laying on of hands, incantations, biblical texts, hymn singing and exorcising evil spirits with water. The public meetings provide a new but familiar form of hierarchically organised ceremony that combines activities from the women's committees, the Church and the fono, but allows everyone to participate in the healing process. There are no demands for contributions. In a society in which church-going is an important and prestigious activity and an increasing number of households have access to televised American faith healing programmes beamed from American Samoa, Emanuelu has high status and legitimacy, with the added attraction of being American and therefore modern. The movement also gains legitimacy from the fact that its leader, So'oalo, has formal medical training. She is a New Zealand-trained nursing sister who spent 15 years in the United States of America. In three years the movement has spread from one small group in Apia to many villages in Western and American Samoa.

Conclusions

Samoan women's committee attendance behaviour shows that the relationship between action and structure is more complex than the
structurationists suggest. Even in a small nation that is comparatively culturally homogeneous there are considerable variations in the types and amount of independent action possible and these vary with village type, and with the age and status of women. In the close, cohesive communities of traditional villages, where roles and rules are unequivocal, there is little room for manoeuvre. In the more open, fragmented urban villages where the accepted patterns of behaviour are not clear-cut and a variety of activities are open to women, there is greater opportunity to engage in independent and innovative activity. Most activity however is shaped by the formal, substantive and interaction structures, and innovative action is undertaken because women wish to conform to existing structures, not change them.

In the past when the committees had clear goals and directives, they provided women with the opportunity to legitimately engage in bold, innovative activities through which they gained prestige. Today, they provide women with the opportunity to do little more than make small re-adjustments to rules and regulations. The unintended consequences of these adjustments nevertheless bring about changes. As Giddens (1979:7) maintains, all action has consequences which change structures and influence subsequent action and interaction. The committee executive, reacting to changes in the economic and political structures, alter the attendance pattern of the committee every time it adjusts the criteria governing legitimate non-attendance. Individual women change both the attendance structure of the committee and the village interaction patterns every time they engage in new ways to acceptably avoid attendance or raise the quality of the goods required for the aitasiga, or order young women to work at home while they attend the clinic. The unintended consequences of these actions are a continual transformation of both the organisational and attendance structures of the committees and of the action and interaction patterns of village women. This in turn alters the possibilities
for subsequent action, as what were once innovative activities become institutionalised, or habitual, and other innovations take their place. As rules are negotiated and renegotiated the possibilities for delivering nutritional information through the women's committees are continually transformed. The type of transformation depends on location.

The situation confirms the propositions of Giddens and Archer that structure both constrains and enables choice of action. For example, within the one village the same factor can both enable and constrain attendance. In traditional villages competition for power, authority and esteem enhances attendance of older high-ranking women but seriously constrains that of young women. The values associated with high rank and family solidarity both encourage and constrain attendance but vary with location and the degree of family and community conflict. Women's perceptions of the committees also vary with location influencing attendance. This variation confirms Bourdieu's concept of an epistemological milieu which varies with life experience and the use of space and time.

Mair's hypothesis that women use their room for manoeuvre to gain or maintain esteem is confirmed by the Samoan experience but in Samoa action is also motivated by the need to gain or manifest family, or in some instances village, prestige. Where the criteria governing rank and status have changed and the committees no longer provide an important means of gaining esteem or maintaining control over scarce resources, and where women have found new ways to gain esteem, attendance has declined rapidly. Mair's suggestion that young people with lower status have the greatest room for manoeuvre does not hold true in Samoa. Those with greatest room for manoeuvre are those who have found new ways to gain esteem, not those with lower status. However her observation that the well-educated have greater options is supported. In Samoa young, well-educated women have greater status, more options and greater independence than those with little education, nevertheless they are subject to
considerable social pressure to find paid employment. Few well-educated women attend the committees. In all locations those with least room for manoeuvre are young women of low status. In rural villages they are subject to pressure to either attend or stay away. In urban villages the discontinuity between traditional structures and urban life-styles leaves these women alienated and with little access to a committee.

Declining attendance has wider implications for women than simply the loss of primary health care and nutritional information. In a society in which only matai vote, and women, with the exception of the few with matai titles, have no formal political voice, the committees have provided them with considerable informal political and economic power. With the disintegration of the committees women lose a channel for formal and informal information and their only opportunity for political and economic aggregation of interest outside the family group. Until young women find other corporate channels through which they can voice their opinions, they will have decreasing influence on village or national policy. The health implications are obvious. The young, poor and isolated, those who most need health care, are those who are increasingly excluded from it.
CHAPTER 8

THE CHARACTERISTICS OF NUTRITIONAL INFORMATION

Primary health care is ignored. Nutrition is ignored. Nobody cares because that's women's work. They only care about curative medicine. They can only see those fancy machines and all that technology. It's as though they're blinded by it. But that's men's work, so it's important (Pers. Comm., Dr Asaua, 13.6.83).

For 60 years the Western Samoan Department of Health has considered that the delivery of nutritional information was an important element of women's committee activities. Over this time, as the previous chapters have shown, the possibilities for delivering both primary health care and nutritional information through the committees have been restricted by changes in committee activities and attendance patterns. The delivery of nutritional information however is restricted not only by the decline in attendance and the reduced time spent on health-related activities, but by the specific characteristics of the information and the way they interact with cultural values and social, political and administrative structures. Following Blaikie (1976), this chapter investigates the relationship between the characteristics of nutritional information, international nutrition assistance, national nutrition policy and Samoan society and the ways in which the information influences the channels established for its delivery.

The Nutritional Information Systems

All nutritional information disseminated by the Department of Health is channelled through three interconnected networks: the District Nursing Service, the Nutrition Centre and the Health Education Unit. The major

1Also see Blaikie 1972 and Blaikie 1975.
target for all three is women grouped together in women’s committees (Figure 8-1).

![Diagram](image)

**Figure 8-1:** The Formal Nutritional Information Systems, Western Samoa, 1983

The Health Education Unit began visiting women's committees in 1983 to give health talks and demonstrations and to show films. The unit is also responsible for training nurses in community education and for coordinating public health education. It is led by a Samoan staff nurse assisted by a Filipina volunteer trained in community health, and a Samoan graphic artist. None have formal nutritional training. Other staff are seconded from relevant hospital sections when necessary. For the unit's rural visits members from several women's committees congregate in one village (Figure 8-2). The presentation made by a team of five or six covers a series of topics including a short segment on nutrition.\(^2\)

The Nutrition Centre, located at the National Hospital in Apia, has a staff of five including a New Zealand-trained Samoan dietician, a New Zealand volunteer home economist, two American volunteer nutritionists and a Samoan assistant. The staff are responsible for teaching nutrition to nurses, providing the media with nutritional information, teaching nutrition courses at Papauta Girls School and giving nutrition demonstrations to urban women attending the Family Welfare Centre (Figure 8-3). In 1982 a

\(^2\) The Health Education Unit also visits groups of school teachers and theological colleges. In the first quarter of 1983 the team visited 25 villages attended by women’s committee members, school teachers and puérès from 56 villages. By the end of 1983 they were still adjusting their village presentations to make them more acceptable and more useful.
Figure 8-2: Six Committees in Aleipata District attend a Health Education Unit Presentation

Nutrition Centre staff member accompanied the district nurses to women’s committee clinics to give nutritional talks and demonstrations on the preparation of new foods to committee members. Staff shortages curtailed these activities in 1983 and nutrition education was reduced further when the Samoan dietician who heads the Centre was given the added responsibility of overseeing the hospital kitchen.

The major channel for delivering nutritional information remains the District Nursing Service, operating through the monthly women’s committee (Figure 8-4). In 1983 the service comprised four district nursing supervisors and 47 district nurses, 36 of whom were based in villages outside Apia. The Service is made up of experienced, mature nurses, 86 per cent of whom are over the age of 40, and 90 per cent of whom have over ten years district nursing experience.
Figure 8-3: A Nutrition Centre Demonstration, Apia, June 1983

The Nutritional Information

The nutritional information which health educators and district nurses are expected to deliver to village women covers infant feeding, general family nutrition, and obesity-related information. All nutritional information is based on the concept of a balanced diet and the division of food into three categories: carbohydrates, protein, and vitamins and minerals. Nutrition is taught as a science, and training begins with the nutrients found in food, followed by the relationship between nutrients and health, the ways in which the body processes food, and the different properties and functions of vitamins, minerals, protein, carbohydrate and fat.

Infant nutrition training includes the properties of breastmilk, balanced

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3The outline for the nurses' nutritional training course is shown in Appendix 8-1 and details of the nutritional curriculum in Appendix 8-2.
infants’ diets and different infant weaning foods. Nurses are told how to select and prepare infant weaning food, the age at which solids should be introduced, how to introduce solids, the preparation and handling of infant formulae and bottles. The properties of cow’s milk and its importance in children’s diets is also emphasised. The reasons for including fresh fruit and vegetables in the diet and the importance of regular meals are stressed. General nutritional information is structured around the division of food into three groups - those providing energy, health and body building. Nurses are taught which foods belong in each of these groups and the kinds of foods which together provide a balanced meal. Planned meals are emphasised. Obesity-related information has been included in the curriculum since 1980 as it was not until then that its need was
Nutritional courses now outline the causes of obesity, the diseases related to it and how to recognise them, and provide diets which recommend a reduction of carbohydrates, in particular local staples, a reduction in fatty and highly sweetened food and an increased intake of green, leafy vegetables.

This information has a number of in-built problems which make it difficult to disseminate. In all societies food and eating are surrounded by strong cultural values and practices; in many societies people have difficulty associating nutritional information and its scientific orientation with the reality of eating; nutrition is widely considered to be the responsibility of women and in some societies suffers the low status accorded women’s activities; and nutritional education shares with preventive medicine the difficulty of adequate cost-benefit analysis or quantification. Health educators are seldom given training in how to teach nutrition. It seldom has high priority in national health budgets which are increasingly devoted to centralised, curative services. In developing nations, the externality of nutritional information is a major problem and in Samoa, the importance of food in manifesting and maintaining rank and status provides an additional problem.

The Impact of Eurocentric Nutritional Information

The Eurocentric nature of the nutritional information delivered in Samoa and the Eurocentric assumption that nutrition is women’s work both remain unchanged 25 years after independence and 20 years after the first fully-trained Samoan dieticians began work. Nutritional information is delivered by women to women. Expatriates continue to influence the type.

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4 The nutritional survey of Weerasinghe (1980) showed a rapid increase in obesity-related disease in Western Samoa. The studies of Zimmet (1980), and Baker and Hanna (1981), showed that with urbanisation, teenage and adult Samoans become the fattest people in the world.

5 Jelliffe and Jelliffe (1975) and Shaw (1979) have attempted to quantify the economic advantages of breastfeeding, and Berg (1973) to quantify the economics of good nutrition in broad developmental terms.
of nutritional research undertaken, the nutritional training available, the
nursing school nutritional curriculum, the content and design of nutritional
teaching aids and to a large extent, funding for nutritional improvement.
There appears to be less realisation today than in the past that nutritional
information and visual aids need to integrate Samoan values and language.

All Samoan nutritionists, dieticians and home economists have been
trained overseas. Six Samoan women have completed New Zealand degree
courses in dietetics or home science and 22 have completed the South
Pacific Commission’s course in community development at the Community
Education Training Centre (CETC) in Fiji. The 10 month course includes
a unit on home economics which has a nutrition component. There is
growing concern about the utility or transferability of this type of training\(^6\)
as it is now recognised that this reinforces European female stereotypes and
encourages the use of imported foods and cooking methods\(^7\) (Schoeffel
1982). As it seldom relates nutrition to Pacific island foodstuffs and eating
patterns some consider that the training is more harmful than useful (Pers.
Comm., FPSP Regional Nutritionist, Gloria Renda 1.11.82). It is also
suggested that the scientific bias of nutritional training provides a barrier
to nutritional improvement (Pers. Comm., WHO Nutritionist Jean
McCaughley 2.10.84).\(^8\)

The type of nutritional information and the ways in which it is
formally channelled are in part influenced by the perceptions of what aid
donors consider a “successful” development project. World Health
Organisation, UNICEF, the Foundation for the Peoples of the South
Pacific, UNFPA, FAO/WFP and the South Pacific Commission provide
funds for nutritional improvement in Samoa. To date aid has been given

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\(^6\) See Slatter 1983 for an evaluation of the CETC course.

\(^7\) The course includes teaching how to make bread, bake and ice cakes, make pastry, and cook rice-based dishes.

\(^8\) Berg (1985) and Manoff (1985:15-16) suggest this is an international problem.
for the construction of the Family Welfare Centre and Nutrition Centre, the establishment of the Health Education Unit and for vehicles. The South Pacific Commission provides nutrition visual aids and training materials. Few funds are available for nationally relevant nutritional training or for developing nutritional curricula or visual aids relevant to Samoa.

International aid has provided Western Samoa with a sophisticated new hospital that houses expensive life-support and monitoring systems for adults suffering from the effects of chronic overnutrition and for children suffering from undernutrition but to date has not assisted with the investigation of how nutritional problems might be prevented.

Sixty years after the introduction of nutritional information to village women, the scientific approach to the subject still makes it difficult to teach in a society with no language and no conceptual framework for scientific classification. All nutrition texts and training are still in English and nurses’ poor grasp of the language, a problem recognised by Turbott in 1936 (Chapter 3), remains a major reason for the disappointing exam results of nursing graduates (Pers. Comm., Nancy McDonald, Director, School of Nursing, 19.8.83). Inadequate English also hampers the effectiveness of the refresher courses established in 1982 to upgrade district nurses’ nutritional knowledge and nursing skills. The problem is compounded by the fact that those responsible for nutritional training are usually short-contract, expatriate volunteers who seldom speak Samoan and have little knowledge of the culture or food practices.

Translating nutritional concepts into Samoan is difficult as there is inadequate linguistic differentiation between food that is considered nutritionally good for health and food that is not. *Mea'ai lelei* (literally good things to eat), the words used by nutritionists to denote nutritionally good food, are translated by village people as “high status food”, “preferred

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9The FPSP held a nutritional media workshop in Suva in 1982 for health workers in the Pacific and considered ways in which the media could be utilised.
food” or “a lot of food” regardless of nutritional value. All food, with the exception of rotten food, is considered good. “Bad food” is still interpreted as “rotten food”, not food that lacks nutrients. The slogan “taumafatatau” or “let’s eat right”, used for the 1983 World Food Day promotion, was thought by visiting nutritionists to convey the concept of eating food that was good for health. It was interpreted by many nurses, village people and school children as a recommendation to eat a lot. To add to the linguistic problems there is confusion over the translation of “green vegetables” (fu'aluaunauna) as “green” is often interpreted as unripe. The problems of meaning are exacerbated by the number of commonly used proverbs that pertain to food. Sayings like E ola le ai mea lelei e ola fo'i le le ai mea lelei (you’ll live if you eat good food and you’ll live if you just eat), reinforce the practice of including little or no protein in a meal. This proverb is most frequently used as an excuse or apology when the main meal consists only of boiled taro, bananas or breadfruit with a little coconut cream.

The nutritional categorisation of food into three major groups leads to linguistic and conceptual confusion as the Western grouping of foods by nutritive value differs from the ways in which Samoans categorise food, which is by status and ways in which it is served. Fresh fruit and green vegetables, classified as food by expatriates, are not considered food by Samoans. Uncooked food is not considered food nor is it considered to have any part in a Samoan meal (raw fish in coconut cream is an exception), therefore recommendations that Samoans include green vegetables or fresh fruit, like pawpaw, in their meals is in direct opposition

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10 The categorisation of food into groups is now recognised internationally as a hindrance to nutritional teaching as emphasis is placed on the grouping rather than on the food. Manoff (1985:15-16) provides an excellent summary of these problems.

11 This is common in the rest of the Pacific. See Barrau 1958: Quain 1948. Also see Levi-Strauss (1966) for a discussion on the binary opposition between cooked and raw food and its relationship to linguo-cultural oppositions. See Levi-Strauss (1966:99-108) for a discussion on the relationship between food beliefs, food prohibitions and social structure; and Leach (1964) for discussion on the relationship between food classification and language.
to cultural practice and considered both wrong and ridiculous. Fruit and green vegetables are considered fit only for animals and children. There is the widespread problem of transferring the meaning of terms like nutrition, carbohydrates, amino acids and protein into a language that has neither the lexicon nor the conceptual frameworks for them. These problems urgently require research if nutritional education is to be meaningful and effective.

The Eurocentricity of Visual Aids

The nutritional posters, slides and printed materials available, including those produced in Samoa, still use European visual and verbal conventions and with two notable exceptions, include imported food. All are based on the concept of a balanced diet and the division of food into food for health, bodybuilding and energy (Figure 8-5). In an attempt to evaluate the information conveyed by the four most commonly-used posters I asked 30 village women and 21 district nurses\(^{12}\) to identify the foods depicted and explain the meaning the posters conveyed to them. The posters tested were the SPC three food group poster (Figure 8-5); the SPC/Fiji National Food and Nutrition Committee Island food poster; the SPC food tree posters; and the SPC maternal/infant nutrition poster (all in Appendix 8-4). With little variation, apart from translation of text, all are used throughout the Pacific. The three food group poster and the maternal/infant nutrition poster have remained the basic nutritional teaching aids for over 30 years and have changed little (see Figure 4-1 on page 95). I found that rather than clarifying nutritional concepts, some of these posters are poorly understood and add to district nurses’ and village women’s confusion. In 1955 there appears to have been a greater awareness than today of the need to provide each Pacific Island nation with visual aids appropriate to its culture (see Chapter 4).

\(^{12}\)The small size of the sample restricts the significance of this evaluation. Time precluded a larger survey. It is therefore intended only as an indication of the situation.
Figure 8-5: The South Pacific Commission Three Food Group Poster used in 1983

With the exception of the Islands food poster and a poster produced by the Nutrition Centre all posters include food items that are not recognised, are not available, or the nurses are told to discourage. The three food group poster shows a selection of island foods together with white bread, cereal, tinned food, cheese, a glass of milk and meat cut into small, neat cutlets. Nobody recognised the bowl of cereal (bottom righthand corner); 61 per cent of the village women interviewed did not recognise the cheese or butter; 51 per cent did not recognise milk. 41 per cent wondered what the picture of the meat represented. Cheese and butter form no part of Samoan diets and are not available in rural villages. In Apia they are too expensive for most Samoans to buy. Milk, when people can afford it, is bought in cans and served mixed with tea direct from the teapot. It is never drunk by the glass. Cutlets are seldom recognised in a society where meat is cooked and served as an entire carcase, or is purchased in tins, barrels or large chunks. My findings confirmed Schoeffel’s (1982) observation that village women do not recognise the taro and yam depicted
in the SPC posters and thought they were some new European food that the nurses were promoting. Women believed the posters were encouraging the use of imported food. One-third of those interviewed did not recognise the drawing of taro, their most commonly-used staple food. Generally, younger women had less difficulty than older ones recognising milk, butter and cheese as these items appear in primary school readers. The nurses recognised all the foods shown but in common with village women few had a clear understanding of why the food on the poster is categorised in the way it is. Nobody clearly understood that a nutritionally balanced meal included one food from each of the three groups shown on the poster, or that the instruction on the poster to take one food from each group did not mean one piece of every type of food displayed. Women did not understand why butter and coconut were in the same category or why they were in the same category as bread. It was assumed that all tinned food would be in the same group. Other nutritional posters available in Samoa depict carrots, cauliflower, apples, pears and grapes, none of which grow in Samoa, or oranges that are bright orange in colour when Samoan-grown oranges are greenish/yellow (see Appendix 8-4).

When asked what story the posters told, 45 per cent of village women replied that they did not know. Those who proffered an explanation thought that the posters said to "eat palagi (European) food": "palagi food is best", "eat a lot of food", "eat every kind of food shown every day", "we must buy proper baby bottles and pots". All nurses provided explanations of the posters but 55 per cent thought that the posters recommended that each of the foods in the poster should be eaten every day. The Samoan people have a well-developed sense of the ridiculous and the SPC food tree series creates both confusion and hilarity and highlights the problem of using European symbolism for concepts like food abundance, food shortage, life and health. Trees of life, cornucopia and vegetable-men do not make sense in a society where pictures are interpreted literally (Figure 8-6).
Figure 8-6: A South Pacific Commission Food Tree Poster

"Whoever saw a pineapple growing up a tree?"; "What are all those things doing up a tree?"; "Where do you have a cow as small as a chicken?" were the amused or scornful rejoinders. A similar study of Fijian village women’s perceptions showed the same results. Nutritional posters were considered nothing more than "wall paper" (Thomas 1981).

My analysis of 79 posters drawn by Samoan school children for a nutrition poster competition in 1982 clearly shows the influence of external nutritional material and the lack of association between the posters, nutrition and eating. Many children included food that was imported and extremely expensive, or food they had never seen. Carrots appeared in 41
posters, apples in 10 and cakes, onions, pears, cheese or grapes in four. One child included the picture of a rabbit with the statement "rabbit is the highest in protein and a boost in fat and calories". There are no rabbits in Samoa, neither is rabbit meat available.

The one exception in an otherwise misunderstood collection of visual aids is the SPC/Fiji National Food and Nutrition Committee Island food poster. It alone conveys a positive nutritional message, although the slogan "naturally the best" is an English verbal convention that does not translate. Every woman to whom I showed the poster felt proud of it and was aware that it promoted the use of locally grown foods that were considered by "outsiders" to be good. Everyone wanted a copy. Their comments included: "This one shows all the best kinds of food, see it is all our food", "See how good our Samoan food is?", "These are the best foods for Samoan people". The poster incorporates several important features. It is simple, it is in full colour and attractive, all the foods are immediately recognisable, there is only a very short written message and the items it depicts are the right size in relationship to each other. The only other poster that was relevant to Samoan food practices and depicted a readily recognised Samoan meal using Samoan traditional foods had been produced by the Nutrition Centre in 1982 (Figure 8-7). Only a single copy had been made.

The nutritional visual aids distributed in the Pacific appear to need complete re-appraisal. In 1983, not one of the numerous posters, calendars or flip charts that promoted nutrition in Fiji, Tonga or Western Samoa had been field tested before distribution or evaluated after it. It is unknown how much more effective the flow of nutritional information would be in Western Samoa if appropriate visual aids were available. This area needs further research but it seems likely that more culturally relevant material would reduce the current confusion.

13 This is a common problem throughout the Third World. See Development Communication Report, No.20.
Figure 8-7: Poster produced by the Nutrition Centre, Apia showing a balanced meal of Samoan food

Nutritional Information and the Administration

At national level two major characteristics of the information influence its delivery. As nutrition is associated with domestic activities it is inaccurately classified as women’s work and there is widespread aversion to accepting that there are nutrition-related problems in Samoa.

All those involved in the practical dissemination of nutritional information are women and all those involved in nutrition administration and training are young women. Those responsible for administrative decisions and nutritional policy are high-ranking, usually older, men. As there are inadequate administrative communication channels between the two (Department of Health 1981:41) and young Samoan women have little administrative or political influence, nutrition has low government and departmental priority. Women’s lack of influence is exemplified by lack of transport for district nurses and nutrition activities. Although there is no shortage of vehicles within the Department of Health the work of the Nutrition Centre and the district nurses is continually hampered by the
unavailability of transport (Department of Health 1981:41-2). District nurses wait for three and four hours while vehicles are used by doctors to do their family shopping or the male driver spends three hours "getting petrol".

Although the gravity of the nutritional situation has been outlined in the last two Five-year Development Plans, as well as in nutritional surveys undertaken within the Department of Health and in the Report of the First National Nutrition Workshop held in 1980, nutritional problems are given little consideration by government. I found that government officers and the Department of Health administrators were poorly informed about nutrition and were disinclined to accept that there were nutritional problems. In a society where the ability to provide large quantities of food is closely associated with prestige, the suggestion that there are nutritional problems appears to be taken as a personal or national affront, confirming Downes (1944) comment (Chapter 4) that Samoans do not want to hear about their own problems most particularly when they are concerned with food or hygiene. The recommendations put forward at the National Nutrition Workshop that government establish a national food and nutrition committee to formulate nutritional policy and to coordinated nutrition education and research have been shelved. The recommendations still have not been tabled in parliament.

The combined impact of women's lack of influence and the administration's lack of consideration for nutritional problems has resulted in inadequate nutritional and primary health care training for nurses, inadequate funds for staffing the Nutrition Centre and continued reliance on expatriate nutritional staff and visual aids. This means that the Eurocentric approach is continued. There is no forum within which nutritional policy decisions can be made, no written departmental guidelines setting out the nutritional curriculum and no infrastructure which would allow district

\[14\] In 1984 UNICEF provided the Nutrition Centre with a vehicle.
nurses to provide input into nutritional decisions or training. The nutritional syllabus for district nursing training remains ad hoc and varies with the staff available to teach it.

Nutritional Information and the District Nurses

The lack of feedback from experienced district nurses into the nutrition syllabus has led to the continuation of inadequate and irrelevant nutritional training. A number of misconceptions about Samoan food practices continue to hamper the delivery of nutritional information. Nutritional information continues to be channelled to women, few of whom outside the urban area have the major responsibility for cooking.15

The person in the household who gets the information about nutrition is not the person who does the cooking. Cooking is hard work and usually left to the young kids - the teenagers. And the idea of planning a meal is unknown. You eat what you've got. Anyway, nobody ever passes on information about nutrition. They don't know what it is. Its just not important (Pers. Comm.: Rosie Afamasaga, Fasito'otai Village, 6.12.82).

Training materials continue to depict only women cooking and preparing food. Nutritional teaching is still based on the assumption that meals are or will be planned and that a balanced diet can be readily provided. District nurses and Samoan nutritionists recognise that strong cultural values preclude an equitable distribution of food within households and that children receive little protein (Annandale, Levi and Sapolu 1981:12). However they do not query their nutritional training which is based on the assumption that children can have, or do have, the same food as the rest of the household. From my own experience some small children, if they are a particular favourite, will receive a reasonable amount of protein, but most do not.16 In rural villages 90 per cent of women interviewed confirmed that children ate after the higher ranking members of

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15 Women are largely responsible for cooking in the urban areas where cooking is done in the European way, on a kerosene or electric stove. In rural households it is still done by teenagers or young men (Fuimaono 1980:36).

16 See Jansen 1977:1
the family but maintained that children had the same food as adults. This
was clarified by a Samoan matai.

Although people say children eat the same food as adults they
really mean that no special food is cooked for children. If chicken
soup is made, the man will eat the legs and breast, the women
may have the wings and back, but children will only get the soup -
the water the chicken was cooked in. So although in one sense
children eat the same dish as the adults, they only get the soup, not the meat (Pers. Comm., Jack Afamasaga, Fasito'otai Village, 6.12.82).

Some nutritional information that nurses are expected to pass on to
village women is in direct opposition to Samoan values associated with
both etiquette and what constitutes a proper meal. Other information
contradicts traditional food practices associated with pregnancy, lactation\textsuperscript{17}
and infancy. This places nurses in a difficult situation as they do not like
being laughed at in public for giving advice that it considered either
ridiculous or bad mannered:

In nutrition they showed us those three sources of food and told
us about the foods for ante-natal mothers and they taught us
about Samoan vegetables like laupolo (pumpkin leaves), laupele
(Hibiscus manihot), tumua fai (banana blossom), and lau manioka
(cassava leaves). I was surprised. They said it was good to eat, but I can't believe it. Samoans don't like to eat those things. When I try to tell them they laugh and say "No, no, they're only for cows and horses, they eat those. You must be going weak in the head". But in town at the hospital, they think it is all right for Samoans to eat this rubbish. I don't think they know about us out here in the villages (Pers. Comm., District Nurse Tasi, 18.9.83).

The recommendation that fruit should be included within meals also
poses problems when the prevailing opinion is:

Fruit like esi (pawpaw), misiluki (ladyfinger bananas), and vi
(Samoan apple) are all right for pigs and children, but not for
people. You won't find men eating this kind of stuff (Pers.
Comm., Jack Afamasaga, Fasito'otai Village, 6.12.82).

In the urban area however vegetables like beans, Chinese cabbage and
pumpkin are now eaten in some households but they would never be served

\textsuperscript{17} For example most pregnant and lactating women will not eat seafood (see Jansen 1977:304-305).
to guests. Nutritional information which stresses eating less is in opposition to the belief that the provision and consumption of large quantities of food is prestigious. Obesity is equated with the ability to provide large quantities of food and therefore with high status. As a result nutritionists have difficulty convincing nurses that obesity is a health problem.

Obesity is a European concept, certainly not a Samoan one. Samoans expect to be fat and are expected to be big. There is no concept that to be fat is bad or unhealthy. You need to be big to look like a reasonable wife or mother. Obesity is simply not seen as a nutritional problem, even by most nurses, who are themselves very large (Pers. Comm., Chief Nutritionist, Brenda Sio, 29.11.82).

Nutrition is not well understood in Samoa and nutritional training continues to ignore Samoan food practices (Jansen 1977:306).

**Nutrition and the District Nurses' Work Load**

Nurses now have less time than in the past to deliver nutritional information. In the early 1960s the dissemination of nutritional information was still an important part of their work. Now it is just one facet of a complex set of responsibilities for which they feel they are not adequately trained and because they are not trained, are not paid for. The job specification for district nurses in 1983 shows that nurses have very little time to deliver any information. They are expected to weigh and measure children, give specific infant, family and obesity-related advice as well as family planning information. They are expected to give general health talks, to check village sanitation and household hygiene, to diagnose and treat simple illnesses and be able to detect infant nutritional problems and provide relevant information. In addition they must keep a variety of written records including an infant health record card, an infant health register, an innoculation register, a family planning register and monthly attendance and progress reports. In rural areas district nurses also monitor the health of ante-natal and lactating women, make regular school visits.
organise and oversee special filariasis, inoculation and family planning campaigns, deliver babies and contraceptive pills, food aid and medicines and encourage women to keep chickens and plant vegetable gardens.

Inadequate salaries are a constant bone of contention and point to low administrative regard for preventive health. A regular complaint from nurses is, "We are paid so little, we work for God". Officially, nurses are instructed not to accept food or gifts from women's committees, but the Department of Health administration justifies its refusal to increase salaries by stating that the nurses are well paid in food and gifts. In 1983 district nurses were paid T3,100 a year ($A2.200).

The hospital administrators appear unaware of the difficulties nurses sometimes face and are dissatisfied with their performance. Their attitude is that the nurses are "fat and lazy" and are neither as dedicated nor as hard working as in the past. Low salaries and lack of departmental recognition of their work together with the marginalisation of the rural health service discussed in Chapter 5, have led to antagonism toward the administration - a situation which influences the way in which nurses work and, indirectly, nutritional information flow.\(^\text{18}\)

**Nurses' Nutritional Information**

Problems associated with nutritional information are reflected in the nurses' nutritional knowledge. This, together with the ways in which they assess nutritional problems and their causes, influence their delivery of nutritional information in the committee clinics. If nurses do not have information they cannot deliver it; if they do not consider it important it is unlikely they will give it precedence; if they consider it ridiculous or bad mannered they are unlikely to pass it on; if it is inappropriate they may

\(^{18}\)In Kenya it was found that this type of antagonism dramatically influenced the efficiency and effectiveness of extension workers and agricultural information flow (Leonard 1977). In Papua New Guinea lack of job satisfaction, lack of drugs and bureaucratic problems were also found to influence the delivery of health information (Reid 1984; Frankel 1982) and were reported 20 years ago (Reid 1964).
adapt it. A questionnaire\(^\text{19}\) (Appendix 6-1) to which 31 district nurse replied shows a widespread realisation amongst nurses that a number of infant and adult health problems stem from poor nutrition, but they consider that the major cause of infants' inadequate diets to be the mother’s laziness or disinterest (Table 8-1).\(^\text{20}\) Very few thought the reason might be lack of knowledge.

**Table 8-1:** Reasons given by District Nurses for Poor Infant Nutrition

<table>
<thead>
<tr>
<th>Reason</th>
<th>% of all Replies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother’s laziness to grow vegetables</td>
<td>26</td>
</tr>
<tr>
<td>Lack of money to buy good food</td>
<td>17</td>
</tr>
<tr>
<td>Mother’s laziness to prepare food well</td>
<td>16</td>
</tr>
<tr>
<td>Illegitimacy</td>
<td>5</td>
</tr>
<tr>
<td>Mother travelling too much</td>
<td>6</td>
</tr>
<tr>
<td>Mother’s laziness to give proper care</td>
<td>6</td>
</tr>
<tr>
<td>Mother’s lack of knowledge</td>
<td>9</td>
</tr>
<tr>
<td>Mothers rely on Samoan herbs</td>
<td>5</td>
</tr>
</tbody>
</table>

(Source: Questionnaire to District Nurses 1983)
Some of the nurses’ full replies are given in Appendix 8-3.

District nurses' information on infant nutrition is good, that on family nutrition and obesity-related problems is not. For all three topics the amount of information they could recall declined with age, suggesting lower educational qualifications required in the past and loss or distortion of knowledge.

Seventy-five per cent of the nurses scored over 60 per cent in their recall of infant nutritional information. In informal conversations all nurses talked confidently about infant feeding, weaning and the problems

\(^{19}\) The nutritional questions were set by the Nutrition Centre staff and marked by them with assistance from a nutritionist in Fiji. Each set of questions was marked out of five. The results of this type of survey are questionable as they reflect only what the respondents can recall at the time and what they can express in writing. The survey was intended only to give some indication of the situation.

\(^{20}\) For some of the nurses’ full replies see Appendix 8-3. The perspective that women are lazy is true of health workers throughout the Pacific. See Renda and Tisa (1983) and Reid (1983).
associated with bottle feeding. There was however confusion about the age to start weaning and the types of weaning food to recommend in the urban areas. Three urban-based nurses stated that they no longer advised mothers to give small children vaisalo or the other weaning foods they are supposed to recommend because it was more convenient to buy bread or rice and they considered that women would think the nurse old-fashioned if they suggested traditional weaning foods.

Knowledge about obesity-related nutrition and general family nutrition is confused and poor, reflecting the age of nurses, their inadequate training and their difficulty with the relationship between nutrition and daily eating habits. Of the 20 nurses who completed the question on a balanced diet, only three had accurate knowledge of the three food groups and what constitutes a balanced diet. All nurses are aware of the connection between food, obesity and obesity-related diseases, but their knowledge of preventive or remedial diets is poor.21

21There is a widespread belief amongst nurses that iced water makes people fat and rice keeps them slim. (The Chinese community in Samoa eats rice and remains thin).
Conclusions

Blaikie's hypothesis that the characteristics of information influence the way in which it moves are confirmed by the Samoan experience. Expatriate perceptions of women's roles determined the initial establishment of the women's committees as channels for delivering primary health care and nutritional information. These perceptions have been institutionalised and continue to influence both nutritional training, the visual aids that support it and the major target group for nutritional information. Within Samoa, the administrative structure of the Department of Health and Samoan perceptions of the information and its importance influence its flow at both national and individual levels. The lack of feedback ensures that problems associated with nutrition and delivering nutritional information are not overcome. As a result the committees become increasingly ineffective as channels for delivering nutritional information.

The direct way in which the characteristics of information influence its movement is apparent in the decisions of district nurses and health administrators. The importance nurses place on Samoan etiquette, their problems with English language, their inability to query information that contradicts Samoan beliefs and eating patterns, all restrict the amount of information they receive and are likely to pass on. Examples of these constraints are presented in case studies in Chapter 9.
CHAPTER 9

DELIVERING NUTRITIONAL INFORMATION IN THE WOMEN’S COMMITTEES

Now what about Lima? Still on Glaxo...or skimmed milk? Give her soup now. And give her pawpaw and rice pudding - just two or three spoons. Don’t feed her tea in that bottle (District Nurse to wife of matai, Tulaele Committee).

Sione has lost a little weight, but I’m sure you are feeding him well. He’s still getting his skimmed milk? (District Nurse to wife of matai, Poutasi Committee).

The social, political and economic factors which have interacted at national and village level to determine the opportunities of the women’s committees to provide primary health care and nutritional information also have an influence in the micro-level setting of the committee meetings. The delivery of nutritional information is influenced by locationally-specific committee interaction structures which have evolved over time to provide a framework for socially acceptable committee behaviour.

Although Samoan women still regard the committee meetings as social occasions where traditional rules of etiquette are observed, where formal language is used by those of elite status, where behaviour is dignified, and where the seating order mirrors that of the fono and provides precise guidelines for who speaks to whom about what, in reality there is considerable flexibility in the ways in which the conventions are interpreted. The degree of flexibility is closely associated with village type and the extent to which the seating order conforms to that of an “ideal” fono. Although it could be assumed that all the women attending the committee meetings have equal access to primary health care and nutritional information, this is not the case. The interaction structure and the extent to which it conforms to ideal patterns influences communication content as
well as the language, and tone of voice employed by the nurse when speaking to different committee participants. I have called the ways in which nurses communicate forms of address. Although nurses vary in their ability and in the amount of effort they put into their work, there is uniformity in the ways in which they vary the forms of address with rank and village type. Six major forms of address were apparent:

1. **Formal**: Very polite conversation, using formal language with little informational content. Usually used when the nurse wishes to placate a woman or feels uneasy about giving information.

2. **Suggestive**: Information given in the form of a polite and tentative suggestion. Usually used when speaking to individual women.

3. **Imperative**: Unexplained, but extended information, given in the form of an order. Usually used when speaking to individual women.

4. **Explanatory**: General or explicit information, the rationale for which the nurse explains, usually using intra-clinic examples. Usually used when addressing the entire committees.

5. **Conversational**: Relaxed, friendly conversation which includes only minimal nutritional information. Usually used when speaking to individual women.

6. **Joking**: Restricted information or advice delivered in the form of a public or personalised jest or amusing aside. Usually used when addressing the entire committee.

Duranti’s (1981:58) linguistic study of the Samoan *fono* provides a useful model for investigating the relationship between village type and the committee interaction structure, as it indicates the flexibility between the seating order in an “ideal” *fono* (Figure 9-1) and the reality of that in committee meetings.

Other micro-level factors which impinge on the interaction structure and influence nutritional information flow are the number of women attending each meeting, the size of the committee house and the amount of time the meeting takes. All vary with village type.
Source: Duranti, 1981: 55-58

Figure 9-1: The Symbolic Division of an Idealised Fono

Village Type and the Committee Interaction Structure

Observation in 26 committees shows a close association between village type, the seating order, forms of address used and the formality with which meetings are conducted (Table 9-1). Although there is some flexibility, in traditional villages the interaction structure is more likely to resemble the ideal than elsewhere. The seating order is divided into five different status groups - the executive, the faletua (wives of chiefs), the tauasi (wives of orators), the tama’ita’i and the taulele’a - with a clear division between the symbolic "front" and "back" of the house, or the active and non-active participants. All women know one another and the nurse well and during the meeting interact in ways that are determined by the seating order which reflects relative rank. In contrast, before the committee meeting formally commences, communication between women is informal and only minimally influenced by the spatial arrangements. The nurse uses a wide variety of forms of address and alters them to coincide precisely with rank. The delivery of nutritional information in these
villages is limited not only by social constraints to communication but also because the houses are large, acoustics are bad, a large number of women and children attend, and the meetings often take four to five hours. It is difficult for young women at the back of the house to hear what the nurse is saying particularly at the end of a long meeting when children are hot and tired and the noise level has risen.

In direct contrast, in non-traditional villages where there is no local ranking structure, where women do not know one another or the nurse well and status relationships are not clear cut, the interaction structure allows much greater communication between women and the nurse, although informal conversation between women is more restricted than in committees where women are well acquainted. Although it is known which women are the wives of matai few feel obliged to follow patterns associated with ideal committees and seating is divided into two groups only - the executive and all other women. Traditional etiquette is upheld only during the meal and the formal welcome to the nurse, and even these activities are very much less formal than elsewhere. The nurses use only three forms of address regularly. The very small number of women attending and the smallness of the house ensure that all women can hear what the nurse is saying when she addresses the group.

The flexibility of interaction within committees in semi-traditional and modern villages varies in direct relationship to location and village structure. In villages which have retained some sense of community, where the ranking structure is known and the elite maintain a degree of authority, the interaction structure constrains information flow. Where there is little sense of community and the matai have little or no authority and where women no longer feel bound to conform to traditional patterns of behaviour, there is very much greater flexibility in committee interaction. All committee meetings are structured to conform in some way to patterns of behaviour that are no longer part of everyday life outside the committee.
Table 9-1: Factors influencing Nutritional Information Flow in Four Types of Villages

<table>
<thead>
<tr>
<th>Village Type</th>
<th>Physical Setting</th>
<th>Interaction Structure</th>
<th>Communication</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Size of House</td>
<td></td>
<td>Forms of address used</td>
</tr>
<tr>
<td></td>
<td>Large</td>
<td></td>
<td>Formal</td>
</tr>
<tr>
<td></td>
<td>Medium</td>
<td></td>
<td>Convers'1</td>
</tr>
<tr>
<td></td>
<td>Small</td>
<td></td>
<td>Imperative</td>
</tr>
<tr>
<td>Traditional</td>
<td>40</td>
<td>Executive</td>
<td>Explanatory</td>
</tr>
<tr>
<td>Semi-Trad.</td>
<td>21</td>
<td>Female</td>
<td>Imperative</td>
</tr>
<tr>
<td>Modern</td>
<td>17</td>
<td>Male</td>
<td>Imperative</td>
</tr>
<tr>
<td>Non-Traditional</td>
<td>8</td>
<td>Taulele</td>
<td>Explanatory</td>
</tr>
</tbody>
</table>

Average number of women attending: 40, 21, 17, 8
Average number of infants attending: 49, 25, 20, 14

Form of address used:
- Formal
- Convers'1
- Imperative
- Explanatory
- Suggestive
- Joking

Congruence between seating order and form of address:
- Very strong
- Strong
- Weak

Interaction between seating groups:
- None
- Little
- Considerable

Degree of Constraint to information flow:
- Very High
- High
- Low
- Very Low

* mata'ata = wives of mata'ata
** As the seating order determines the extent of participation in the meeting, this refers to the extent to which women conform to the patterns of behaviour associated with the seating order.
Even in non-traditional villages the ideal women's committee structure underlies activities and in some of the longer-established committees in these villages there are attempts by wives of matai to introduce more formal seating patterns although there is no traditional social or structural basis for this.

The specific ways in which time, space, structure, action and information interact to influence the delivery of nutritional information is shown in the following two case studies of committee meetings. In each of these committees the nurse and village women were accustomed to my presence and to the proceedings being tape-recorded.

The case studies are presented in the following format. Description of the meetings is presented in bold type-face, indented and single-spaced, while my comment and analysis of activities are presented in normal type-face, double-spaced. Transcripts of dialogues between the district nurses and village women are presented in the following type-faces.

1. Private communication between nurse and mother - normal type.
2. Public communication from nurse to all women - *italics*.
3. The nurse's private comments to me - square brackets.
4. Description and action - (rounded brackets).
5. Form of address used by the nurse - (*italicised in brackets*).

I have given all the women participating in these two meetings pseudonyms.
Case Study 9-1 Delivering Nutritional Information in a Village Committee

Just after daybreak, Lemapu, the committee secretary, bustled through the village blowing a conch shell to remind women of the committee meeting. Tina had forgotten about it. There was no food in the house, no money left from the last cheque from New Zealand and she did not have the towels required for the asiasiga. To make matters worse, the baby’s new suit from Pago Pago was dirty and one of her sisters-in-law had gone to town wearing the skirt of her committee uniform. These problems were handled by the household with accustomed ease. While Tina went to borrow money from her cousin next door, her small brother Tama was sent off to the gardens to get a basket of taro, her sister to wash the baby’s suit, a sister-in-law to borrow new towels from a relative in the neighbouring village. With the borrowed T5 Tina bought a tin of corned beef from the trade store which together with the taro and the large packet of biscuits I had given her mother would provide a satisfactory contribution. While the taro cooked over the open fire Ali‘imau, Tina’s mother dried the baby’s suit in front of it. A bowl of coconut cream to accompany the taro was prepared by her brother-in-law. The baby was bathed by his father in the freshwater pool behind the village, massaged with oil and given a large meal of taro mixed with coconut cream, “to make him weigh heavy and keep the nurse happy”. At 8 a.m. Tina strolled the 300 meters to the committee house calling out greetings and small talk to her neighbours along the way. Her small brother carried the basket of food, her sister the towels and clean clothes for the baby. Her other two children Sau, aged 28 months and Tasi, 4 years had been left at home as Tina considered it too much trouble to take them and Sau had diarrhoea and had probably lost weight.

The committee house had been swept, fresh floor mats put down and large bouquets of hibiscus and frangipani hung from the front rafters. The stragglers were hurriedly getting seated when the nurse arrived at 8.20. Twenty-four women and 28 children were present. They comprised three executive, three faletua, four tusi, four tama‘ita‘i and ten taulele‘a. Although it was stated by village women that all women attended the clinic and non-attenders were fined, only 50 per cent of village women were present. There was no comment about non-attenders and fines were not levied against them.

Of those attending, five had brought no children, fourteen women had their own children, four their grandchildren, one her sister’s children and one young girl accompanied her baby brother. Fourteen women wore the committee uniform, the executive distinguished by their lace-edged collars. As in most traditional villages, the house used for the committee meetings is large and the seating arrangements in strict accordance with those of the male fono (Figure 9-2). Had the nurse been new to the district, the seating order would have provided an immediate indication of the relative rank of every woman present. As it was, she lived in the next village and knew all the women and their family histories.

The secretary, who was the wife of the pulenu’u, formally welcomed the nurse and a tausi followed with prayers. Two young taulele‘a then served the nurse and the executive with Samoan cocoa, bread and jam. Once they had finished, the name of the first child
Figure 9-2: Seating Orders characteristic of Village Committees

was called by the secretary and the mother and her two children moved to sit in front of the nurse.

Dialogue No.1

(Taulele'ale'a with two children, one 14 months old and one nine days).

Nurse: (Conversational) He's healthy? Oh yes, he's putting on weight. Good. Keep feeding him well. Give him plenty of protein. Here's the new baby too. Well let's have a good look at him. How old is he now?

Mother: Nine days.

(As the baby had not been seen at the clinic before, the nurse checked him thoroughly and made a new record card. His length, chest, head and arm measurements were taken, his hearing, vision and hips checked. His birth weight, and family health particulars were then entered on the new card.)

Nurse: (Conversational) Looks just like his grandmother. Now you breastfeed him for as long as you can and you must remember his vaccinations. The BCG. Bring him to the hospital in six weeks and I will do it. I haven't the vaccine or I would do it today.

(Explanatory) I must remind you all about the day for vaccination. Many children never had their immunisation because when the team arrived the mother and child were in Apia. The most important thing is for the child to receive his vaccination at the right age ...
remember when the child misses the dosage at the right time he is liable to suffer from an infectious disease at any time. Those who have regular doses need not worry. If you give birth today your child can receive BCG for tuberculosis tomorrow. Don’t forget our children go from house to house and are carried by one person and another. You never know they may get germs from these people. This is why it is very important for the newborn to have immunisations as soon as possible for protection and this one called BCG is against tuberculosis. You only have it once, unlike the others for whooping cough and others where you have three doses. Tuberculosis is very common now and the baby is likely to get it any time, so that is why you must have the vaccination. And there is also this other vaccination for whooping cough. Most of you reckon its only for whooping cough but its not ... in our programme there are six other communicable diseases being prevented as well. The child is prevented from tetanus toxin as well. This toxin is when the child feels stiffness in his body. There is also a disease which affects the throat. And you mothers recall a medicine given orally to prevent the disease which causes crippling among the little ones. It is rare now. This is why we urge the vaccinations.

Mother: Good
Nurse: (Imperative) Bring him and I will do it. Don’t forget his card. This one with the photo of the father and child on it. Oh, drink plenty for the milk. And if you want family planning, see me about it in six weeks time. That’s about right.

This dialogue is typical of those in traditional villages where the mother is a taule’ale’a, when children are thriving and the nurse knows the woman well. In common with most interactions of this type the nurse gives almost no nutritional advice apart from telling the mother to give the older child plenty of protein and to continue breastfeeding the infant. It is common for nurses to use words like protein without an explanation of what it is, the types of foods that contain it, or why children should be given foods that contain it. The short talk on innoculations also highlights the way in which nurses use language that neither they, nor village women
fully understand. Nurses believe women are impressed by it. It also provides an example of the way in which nurses adapt information to the situation. Most nurses remind women about family planning, but as in this case, neither encourage it nor give further information about it.

Dialogue No.2

(Taule'ale'a with child 13 months. The child has sores on his legs, a very runny nose and had lost a kilogram in weight since he was seen two months previously.)

Nurse: (Imperative) That's bad. he's lost weight. You must feed him more food. What are you feeding him?

Mother: Boiled taro and vegetables and milk.

Nurse: (Imperative) Well feed him taro, vegetables and soup and don't feed him tea with sugar. And how are his feet now? And what about his filariasis tablets - did he take them? He must have good food.

[These sores are caused by poor diet and a dirty house.]

(Suggestive) If you boil taro with vegetables and a bit of fish or tinned fish, sores like these get better. Keep your house mats clean, put them in the sun. Wash the children properly - with soap - and they won't get these sores. Everyone can buy soap these days.

(Imperative) Now you feed him properly. You women are too lazy.

(The nurse gives the mother a bottle of gentian violet and tells her to paint the child's sores while she fills in the record card "Still has sores. Advised better diet").

This dialogue provides an example of the way in which the village ranking system influences the way in which nutritional information is delivered. The change from the imperative form of address when speaking to the taule'ale'a to the suggestive when addressing the committee as a whole, indicates that the committee is in a traditional village. Because the woman is a taule'ale'a and has little status, it is acceptable for the nurse to give her orders, to scold her and publicly suggest that the child has sores because she can't afford to feed it properly or wash it with soap. It would an unthinkable breach of etiquette to speak to a matai in this way.
The nurse tells the woman to feed the child taro, vegetables and soup but leaves the explanation until she addresses the entire group. This dialogue is also indicative of the way nurses adapt nutritional information to suit the reality of village life. The nurse recommends tinned fish, knowing that tinned fish is more commonly used than fresh fish. As it has lower status than fresh fish there is the possibility that children may receive some of the juice, if not the flesh. The nurse recommends vegetables, but not what kinds of vegetables. In keeping with women who sit at the back of the house, the woman neither asks for further information nor for clarification of the advice.

Dialogue No.3

(Tama'ita'i and child 14 months)
Nurse: (Joking) He looks well. Weight is improving. You must have fed him well this morning. [They think I don't know what they do.]
(Mother) Any new teeth?
Nurse: Two.
(Mother) (Conversational) Is he talking yet?
Nurse: Only the best language.
(Mother) (Laughter)
Voice: What's the joke?
Nurse: Oh, the clever boy can now say ai kai (eat shit). He's a proper Samoan.
(Mother) (Laughter)
Voice: That's the first thing they always teach babies here.
Nurse: (Conversational) Are you still breastfeeding?
Mother: No, he was weaned before a year old.
Nurse: (Conversational) Not pregnant again?
Mother: No.
Nurse: (Conversational) He's getting big now. What are you feeding him?
Mother: Vaisalo and vegetables.
Nurse: (Explanatory) Good, he'll do well if you give him plenty of vaisalo and some mashed vegetables and pawpaw soup. And give him some more meat and fish. Just a little bit at first if he doesn't like it. Put in some cabbage or bean.
Nurse: Where's Manoa?
Mother: He's got fever. You know the usual thing.
Nurse: (Explanatory) Oh all right. Give him a good massage. And plenty to drink. They will both do well if you give them some more fish and chicken and plenty of pawpaw. It's good for the skin and stops them getting fevers.
Mother: We don't have much pawpaw. Is there something else?
Nurse: Oranges and guava are good.
Mother: Oh, what about skimmed milk? Is that good?
Nurse: Its OK, but breastmilk is better.
Mother: But they said on the radio that the skimmed milk powder from the hospital was good for all babies.
Nurse: (Explanatory) Yes, I know, but for Samoan babies breastfeeding is best. Those ideas are for town.

The similar status of the nurse and the tama'ita'i allows equal participation in the interaction. The nurse feels free to suggest that the children should be fed more fish and chicken; the tama'ita'i, who sits at the front of the house, feels free to ask questions. In village committees the tama'ita'i are the only women who participate in this way. The nurse did not attempt to explain that a large meal before the clinic does not indicate sustained weight gain or improved health. Neither did she attempt to gain further information about the condition of the sick child who had been left at home. Fevers are a common infant complaint and are usually treated by the fofo. In the past the child would have been brought to the meeting or the nurse would have checked it at home. The nurse filled in the child's health card and added the comment "has fever" but did not mark that he was not present. The nurse assumed, as most Samoan women do, that if a child is weaned from the breast before one year of age the mother is pregnant. Abrupt, early weaning because of pregnancy is a common problem and although nurses who have attended refresher courses are told to encourage mothers to continue breastfeeding when they become pregnant, nurses believe this information is "not good for Samoan women" and seldom pass it on. The queries about skimmed milk powder are common as is the contradiction between what women hear on the radio and what nurses are taught to recommend. As this dialogue shows, nurses combine formal and informal health advice. When they think it appropriate they do not hesitate to recommend the fofo.

1 Both the nurse and tama'ita'i have status independent of their husbands.
Dialogue No.4

(A high ranking tausi with her grandchild 19 months old. The woman remains seated and sends the screaming child to the nurse with a taule'ale'a. She sends another woman with a handful of sweets in an attempt to quieten the child, but he puts them all in his mouth at once and continues to scream. The child is very thin and has black, decayed front teeth. As he refuses to stand on the scales, the young woman stands on with him and the nurse subtracts her weight.)

Nurse: (Formal) He's lost some weight I think.
She feeds that child too much rubbish.

Grandmother: Yes.

Nurse: (Formal) (To grandmother) Is he eating well?

Nurse: Good.
(The nurse wrote on the card, “lost weight, but eating well”.

This entire interaction took less than 30 seconds and is characteristic of the lack of information given in village committees to high-ranking women. The nurse used formal language and although she was aware of the child’s nutritional problem she offered no advice to either the grandmother or the young woman who brought the child to be weighed, nor did she comment on the child being given so many sweets. In a context where exact status relationships are known it would have been ill-mannered for the nurse to be heard publicly telling a high-ranking woman what to do or to give her nutritional information most particularly when the woman remains seated and does not herself take the child to the nurse. High-ranking women who bring children to the committee often remain seated as most consider it undignified to leave their positions (it is also physically difficult as most high-ranking women are very heavy). I frequently saw young children at the committees given sweets, biscuits or soft drink and although nurses pointed out to me that these were bad for children’s teeth I never heard them point this out to other women. This may have been because the children most frequently seen with sweets were accompanied by either faletua or tausi.

Dialogue No.6

(Faletua with grandchild 37 months. The child
is covered in infected sores which he is scratching. The grandmother accompanies the child to the nurse unsuccessfully attempting to stop him scratching. The nurse looks at his long, dirty fingernails.

Nurse: (Formal) The sores are no better. They are much worse. Did you give him the ferrous sulphate?

Grandmother: Yes, but he doesn’t like it. It’s done no good.

Nurse: [No she didn’t. she took him to the fofo.]

(Formal) Did you bring the bottle so I can give you more?

Grandmother: No. He doesn’t like it.

Nurse: (Formal) Well, that’s the way with small children. Here’s some solution to stop the infection. Put it on twice a day. I’ll put some on now.

[She’s another one who feeds the child too much rubbish. She spoils him. She thinks she is being kind since his mother went to New Zealand but I can’t tell her, she would feel bad...ashamed. She is a falelua. In Samoa you can’t tell them things. That’s the fa’a Samoa. She thinks she knows best. These old ones do, but she doesn’t feed him properly - only rubbish.]

Pam: What about the fingernails?

Nurse: [They need to be cut and he needs to be cleaned. She would be angry if I told her.]

The combination of the woman’s high rank and the characteristics of information on nutrition and hygiene made it impossible for the nurse to give advice, particularly as her offer of more medicine had been turned down. The nurse, anxious to placate the woman, used formal language and attempted to salvage the situation by offering lotion in lieu of medicine.

Like many older, high-ranking women, the falelua did not seek the nurse’s advice and refused to accept the remedy provided although she was aware that the child was unwell. This dialogue exemplifies the problem of infants reared by their grandmothers or older relatives. Older women are seldom prepared to accept that both children’s diets and nutritional information have changed since they were young women.

Dialogue No.7

(Taule‘ale‘a with children 2 months and 14 months.)

Nurse: (imperative) Get up and stand on the scales Sau. Hurry, its getting late. Where’s Lua?
Mother: At home. He's getting better.
Nurse: He had a bad fever and cough - like measles.
What's being done to him?
Mother: We are washing him and applying oil.
Nurse: Have you been to see the doctor?
Mother: No.
Nurse: (With exasperation) What?
Mother: She takes him to the jofó. They think it's a Samoan sickness all children get. But it's not.
Nurse: We have never been to see him.
Mother: (Imperative) You should have gone to see him like I told you. There are medicines available. medicines for itchiness and fever. He's restless and uncomfortable and you never bother to take him. Now what about Sau? He's itchy too?
Mother: Yes. He can't sleep at night because of the itch.
Voice: (Joking) Pull down his pants a bit, his balls are squashed. That's why he's itchy.
(Naughter)
Nurse: (Imperative) He looks all right. Feed him well. Not just taro and breadfruit. You have to give them fish and meat. Don't eat it all yourself. And give them both plenty to drink. Wash them properly, with soap, then take them to the doctor. Do as I tell you next time.

The informal joking comments are typical of committees where women know one another well. Although these asides often embarrass those at the receiving end, they add to other women's sense of enjoyment and superiority. Those who make comments are almost always high-ranking women, or those sitting in the front of the house. The nurse's exasperation and her use of the imperative indicate that she was speaking to a taule'ai'a. Although the mother wanted to question the nurse about the children's itch, what medicine the doctor might prescribe and whether they might be admitted to hospital, this would have been considered bad mannered from a taule'ai'a. Although ideally her temporary move from the back of the house to the front to sit near the nurse should have allowed active participation, the woman still felt unable legitimately to ask for information.

By 11 a.m. the noise level at the back of the fale had risen. children were hot and tired, and it was difficult to hear what the nurse was saying above the conversations about the price of tinned
fish and complaints about the quantities of beer village men were drinking. By mid-day all the children had been checked and interest in proceedings was revived with the asiasiga. It was conducted in a formal manner. Each woman's towels were displayed up and down the house by two taulele'a while a tau provided a running commentary on their size, quality, cost and possible use. Instead of the requested towels one woman brought a bright green mosquito net. It appearance was greeted with considerable ribald laughter and explicit comments about what might happen under it.

This was followed by the ceremonial announcement of the food contributions that individual women had made. The name of the woman, that of her family, and the exact contribution were announced together with comment on the quality of the contribution. The nurse then gave a short talk during which seven of the ten taulele'a were preparing the food in the annex at the back of the house where it was impossible to hear what she was saying and throughout the talk the executive were busy talking amongst themselves and sorting out contributions to the loan fund.

Nurse: Now I want to remind you that you must always bring this health card with you. This one with the picture of the father and child on it. This is new and the Department of Health wants to help all mothers by making sure you keep it. When you go to another village, you must take the health card with you. Then the nurse in that other village knows how your child is growing. You see inside it has these lines. They tell you if your child is growing well. If the weight is above the top line it is growing well. If it is below the bottom line it is very bad. You are not feeding it like a proper Samoan. If you don't have this card you cannot get your child into primary school. So don't lose it. Now I want to remind you about papaw for children. You can make papaw soup for small ones and when they are bigger mash it up. Leave the papaw until they are yellow. They are better when they are soft. They have more proteins and vitamins and acids that are good for the health of the family. When you use them green, when you put them in soup, they are not good. That's all I have to tell you. Papaw is good for the strength of your children. It has vitamins and acids which are all good for your children. I want to remind you to be good mothers. Don't leave it for the pigs.

The health talk was delivered in a ritualistic way without enthusiasm. As the noise level was high, few women could hear and even fewer appeared to be interested. The timing of the health talk, the size of the
house, the number of women and children present was typical of committees in traditional villages and highlights the problems the nurses face in attempting health education in this type of setting.

As soon as the nurse had finished speaking the meal was ceremonially served. The food had been apportioned in strict accordance with rank. Although not as lavish as in some village committees, the nurse’s tray included a whole fish, shellfish, taro, rice and corned beef. The executives and other wives of matai had tinned fish, corned beef, taro and rice; the tama’itai had tinned fish, taro and rice and the taulele’a had tinned fish and rice. The meeting formally ended at 1.05 following prayers and a formal speech of thanks to the nurse. When the Department of Health van arrived at 1.30 p.m. the meeting had taken five hours. Ninety minutes had been spent checking children, 65 minutes filling in record cards, 20 minutes on the asiasiga and nearly an hour on ceremonial speeches and eating. Forty-five minutes were spent in informal talk and the rest of the time waiting for transport. Although the meeting had been long, it had been an enjoyable social occasion during which women had had a good laugh, caught up on the local and district news, eaten a pleasant meal together and had their children’s health monitored. Fourteen women (56 percent of those attending) had received cursory nutritional advice relevant to their children, but only three had received any explanation as to why they should use this advice. The taulele’a at the back of the house heard neither the health talk nor any of the other public information as they were either preparing food or unable to hear because the noise level was high and the house large. No nutritional information other than that appropriate to children was given.

Although this committee was not as formally organised as some in traditional villages, the way in which nutritional information was delivered was similar to those I attended in most traditional and semi-traditional villages. The amount of information, the type of information, the way in which it was delivered, and to whom, were influenced by the social context of the meeting and by what was accepted by all participants as appropriate behaviour within that context. The unwritten rules that underlay the way in which women interacted with one another were based on historical, social and spatial factors, the most important of which were the village ranking structure, which determined where women sat, and the characteristics of information. Rank both restricted and enhanced nutritional information flow. The wives of untitled men felt that their status prevented them from asking for information or from querying the
nurse's advice as contravention of committee conventions impinged on their personal and family esteem. Their low status however enabled the nurse to give them explicit but unexplained information about nutrition and hygiene. As a result untitled women who brought sick children to the clinic usually received information relevant to the child's condition. This was not true of the wives of titled men, who received little direct information of any sort and almost no nutritional information, even when the nurse recognised that it was required. Women of high rank felt they would lose esteem if they sought advice or questioned the nurse. As participants who sat at the front of the house, however, they could hear both public and private information.

In traditional villages only the very small group of tama'ita'il, who held rank independent of their husbands, received both explanatory information relevant to their children's situation as well as any information the nurse addressed to the group. They were not constrained by rank from being given information and did not feel that their personal or family esteem was influenced if they asked for information. As in most other traditional villages only 16 per cent of women attending the committees were not constrained in some way from being given or receiving nutritional information.

Although the divisions between the front and the back of the house are not so clearly delineated in committees in semi-traditional villages, rank and status remain the most important constraints to nutritional information flow. The division is less influential in committees in modern villages where the rules governing participation are more flexible than in very formally structured committees.
Case Study 9-2 Delivering Information in a Neighbourhood Committee

Mafa lives just around the corner from the president's house where the monthly committee meetings are held. She lives in a nuclear household with her husband and five young children. Mafa attends the committee irregularly, doing so only when the weather is fine, when she remembers, when the children are well and when she can afford it. Mafa was reminded of the committee meeting at 7.30 a.m. when she went to the store to buy bread. As she had just received T20 from her sister in New Zealand she bought a small bag of rice, two onions, and a tin of meatloaf for her committee contribution. After two of the children had left for school, the small children had to be washed and clean clothes found. While Mafa was washing the baby the three-year old began playing in the ashes of the cooking fire in the fale outside and came in, his face, hands and clothes black. She nearly gave up the committee visit.

Although it was considered good manners to be at the committee to welcome the nurse, Mafa heard the Department of Health van turn the corner long before she had finished preparing the food for her contribution. Twenty minutes later she struggled off carrying the baby under one arm, his clean clothes and the food under the other, and trying to stop the two-year old from jumping in the puddles and the three-year old from running on the road. It wasn't until she arrived at the meeting that she realised she had forgotten the sheets for the asiasiga.

Mafa recognised all the twelve women present but had previously spoken to only six of them although they all lived in the same neighbourhood. She slipped inside and sat down in the first available space. The nurse had already started and formal apologies had been given and accepted. The same nurse had visited the committee for two years and was acquainted with some of the women's family situations but had no other social relationship with the area. With the exception of the three executive who sat together, the seating order of the meeting was not differentiated by rank (Figure 9-3). In all, 12 women and 17 children participated. The women comprised the three executive, three wives of matai, two pastor's wives and four women whom I have called taulele'a, although there is no ranking structure to support this classification. Four women brought their own children, five their grandchildren, one brought her own and her sister's child and another her small sister. Only the president did not bring a child to the meeting.

Dialogue No.1

(Matai with three grandchildren aged 3 months, 15 months and 39 months. The baby finishes her bottle while the other two are weighed. The 15 month-old child is thin, slightly pot-bellied and has sores. The older child looks well.)

Nurse: (Conversational) I don't like these sores, and she is looking thin. See, she has not put on weight since I came last month. (The nurse shows the grandmother the weight-for-age graph.) Is she eating well?
Figure 9-3: Seating Order characteristic of Neighbourhood Committees

Grandmother: Yes, but she’s had a bit of fever. I have been giving her the rice and oil from the hospital. But she doesn’t like to eat much. What else should I do for her?

Nurse: [That’s the free food - from overseas] What about the milk? She should be getting milk.

Grandmother: She doesn’t like it. It smells bad. Is it all right for the Samoan people?

Nurse: (Explanatory) Yes, its all right, but if you like to buy it, try Anchoria, and give more vegetables - some pumpkin and bean with the taro. There’s plenty in the market now.

Grandmother: I’ll tell my daughter to get some.

Nurse: (Explanatory) Now what about Lima? Still on Glaxo? Or skim milk? (Imperative) Give her soup now. Pawpaw, vaisalo, rice pudding - just two or three spoons. Don’t feed her tea in that bottle. These ones are always a problem. The husband ran away and the mother has five children. She works in town and lives with the grandmother. It’s the grandmother who looks after the children, but she’s too old for it. It’s too much work and there’s not enough money. I got special food from the hospital but I don’t know what happens to it. These town babies are always hard for us. The mothers work and don’t breastfeed and the old ladies don’t know about bottle feeding - how to make the mixture properly, how to keep the bottle clean and to boil the water. It’s a problem.

The nurse knew the home situation of this woman and that she was the widow of a matai but in an informally-structured meeting where
women did not know one another well and there was no pressure to conform to traditional forms of behaviour she did not feel constrained from giving advice or from using the imperative. Nor did the older women feel restricted from asking questions. The instruction "Don’t feed her tea in that bottle" would have been considered very poor etiquette in a village where the seating order had been clearly structured, where the nurse lived in the same district and was expected to conform to locally accepted patterns of behaviour, and relative rank was known to all. The nurse was careful not to offend the older woman by suggesting in public that she could not afford the expensive baby milk formula. When referring to buying Anchoria she did not use the term "if you can afford it" which would have implied poverty, but "if you like to buy it", implying choice. The nurse’s asides to me show that she was aware of the relationship between urban social and nutritional problems. The woman’s comment about the milk powder smelling bad indicates widespread complaints about FAO/WFP milk powder to which vitamin A had been added, making it smell fishy. In rural villages it was fed to the pigs.

Dialogue No.2

(Taule'ale'a with a baby six months old.)

Nurse: (Conversational) Still breastfeeding?
Mother: No. I'm pregnant.
Nurse: You don't need to stop the breast. What are you giving him?
Mother: Skim milk.
Nurse: Has he started to eat yet?
Mother: Yes, mashed banana and taro and some pawpaw. Is there any other food I should give him?
Nurse: (Explanatory) Boil his pawpaw and prepare his food properly. And give him sago and vaisalo. Mash the taro well, put in some egg too. Give him just a little bit at first, then he will like it.
Mother: Do I boil the pawpaw and the taro?
Nurse: Yes. Add some milk, if you like.
[Can't stand telling it over and over again.] Sitting up yet?
Mother: Yes. What about this pele2 on the radio. Can

2(Manihot esculenta)
people really eat that stuff? Can we really give it to children?

Nurse: Yes, it is good for the body. Oh, here are some Pregamel tablets - they'll make your husband strong.

(Laughter)

Don't forget to go to ante-natal.

Mother: But what about the pele? How do you make it? Why is it good?

Nurse: You boil it with a little water or put it in soup. Just a little is enough.

Unlike most young women attending village committees, this young woman was an active participant in the proceedings. She did not hesitate to ask questions, or to repeat the same question. The frequency with which this happens is obvious in the nurse's exasperation at having to repeat the information. Although the woman was interested in feeding the baby well and in discussing the information she heard on the radio, the nurse gave no information beyond confirmation that pele was good for the body then promptly changed the subject. The woman's persistence on this point, highlights the difference in the expectations young urban and rural women have of both the nurse and of themselves.

**Dialogue No.3**

(Taule'a'e'a with a plump baby five months old.)

Nurse: (Conversational) Hmmm, nice, getting very fat. What's Lua eating - banana and taro I suppose? Still on your breast?

Mother: Yes.

Nurse: Good. Continue with his breastfeeding. He's very healthy. Let his hair grow. What else is he eating? I cut it off. He had scabies very badly.

Mother: Taro and rice.

Nurse: (Explanatory) Give him some soup too with vegetables. Some bean and some vaisalo, if you can make it, or rice, or porridge. Not too much. Soon he can have chicken soup, tomato and pumpkin.

Mother: How do I cook the vaisalo?

Nurse: Ah, an Apia girl. Now Fa'ava'a is from out the back, she'll tell you.

Fa'ava'a: No. Vaisalo is too much work...rice is better. It's easy to cook. Its better when you are in town.

Nurse: Oh, all right. Are you on family planning?

Mother: Yes, I went there and was told to come back next week.
The dialogue exemplifies urban attitudes towards "traditional" and "modern" foods and the nurse's disinclination to explain how to make vaisalo or to persuade the woman that vaisalo is a good weaning food for infants. Fa'ava'a's refusal to explain how to make vaisalo and her insistence on recommending rice provides another example of the difference rural and urban women's attitudes towards the nurse. The interaction structure of committees in traditional villages would preclude participants from publicly disagreeing with the nurse.

**Dialogue No. 4**

(Pastor's wife with three grandchildren, 3 months, 16 months and 4 years.)

**Nurse:** Another bottle baby, we get many of them in town. And that's where we get malnutrition. *(Conversational)* How is her tummy now? Has the diarrhoea stopped?

**Grandmother:** Yes, I gave her the magnesium. She is well now.

**Nurse:** Oh yes, her weight is up. That's good. *(Explanatory)* Well just carry on with the Glaxo. Soon she can have soup. Now what about Ioane? He's eating well? Here put some lotion on those sores. Did you bring the bottle? I'll give you some more.

*(Explanatory)* I would like to remind you all that when you bottle-feed baby, you must be careful to wash the bottle and teat properly, and I must tell it again and again, you must boil the water. I know it is hard, but here you have a proper kerosene cooker, or some have electricity. It is easy for you. And you must keep the flies away. Or else baby will get sick. Diarrhoea, lost weight and then malnutrition. Please I ask you all to be careful. Tell your daughters to breastfeed. I know it is hard in Apia, but it is best for Samoan babies.

**Voice 1:** Do we have to use boiling water?

**Voice 2:** You need it for the mixture.

**Voice 3:** No you don't. If you use boiling water it goes hard (lumpy), doesn't it? *(to nurse).*

**Nurse:** *(Imperative)* Listen, you don't use boiling water for the mixture. You boil the water and then let it get cool.

**Voice 1:** But it takes so long and the baby is hungry.

**Voice 3:** Well always keep plenty boiled.

**Nurse:** *(Explanatory)* That's the right way.

**Voice 2:** Read the tin. It's written in Samoan.

**Voice 4:** And there are pictures to show you - if you are from out the back.
Nurse: (Imperative) But don’t make the bottle before you need it. It can go bad and make the baby sick.

Voice 3: Look, you boil it, then put it in a clean bottle or a jug. Put it in the safe. Then when you need it you mix it up with the powder. But you have to follow the directions on the tin. You should put in what it says. Not too much powder. Not too little powder. Or the baby will be sick. Go and read the tin.

This discussion on how to prepare baby formula led to a conversation on the advantages and disadvantages of bottle feeding in which all the women present took part. It was a useful learning experience in which the nurse played only a minor role. The situation highlighted the inadequacy of district nurses' training in how to encourage or utilise this type of learning situation. The equal participation of young women and the nurse and the possibility for a young woman to effectively take over the nurse's teaching role indicate the absence of a village ranking structure; women's confidence in their own knowledge and their right to discuss it; a higher level of education than is usual in traditional villages; and a willingness to admit ignorance. It also indicates the difference between urban and rural women's perceptions of themselves. In traditional and semi-traditional villages adherence to the roles associated with the seating order, the number of women and children present at the committee, and the size of the house would have made such an exchange physically and socially impossible. There was an edge to the conversation however and the remark about the woman being "from out the back" suggested that she was ignorant because she was a new arrival to town.

During the meeting four women came with their children, had them weighed and left immediately. Three left food contributions the other left T1 with the president "to help pay for the electricity". At 10.40 when no more women had arrived and all the children had been seen the asistata was held. It was not formally organised and prompted little comment apart from admiration for the Mickey Mouse sheets from Los Angeles. Nobody seemed aware that Mafa had not brought the required sheets. Ten minutes later the meal was served. The women's food contributions had been acknowledged by the president and although everyone knew what each woman had brought the contents of the contribution were not publicly
announced. Although there was pressure to provide a reasonable contribution, women did not feel that their families would lose esteem if they did not.

The meal had taken little preparation and under the supervision of the president was served by two of the younger women. It was typical of those served in urban committees and included boiled rice, chicken soup, tinned fish, noodles, tinned meat loaf and tinned chicken wings. The food was distributed evenly but the nurse was given an additional basket which contained several unopened tins. When the plates had been cleared away and only seven women were present the nurse gave a short health talk.

Nurse: (Holding up the SPC Three Food Group poster) As you can see—all these foods are very good for the body—melon, pumpkin, taro, ripe bananas, mandarin, fish, egg, carrots, cabbage, bean, tomatoes, peanuts. Many varieties of sea foods—these are the right foods for your body and the body of the expectant mother, children and mothers who have just given birth. This poster here reminds us of what we must eat and especially you, young mothers who are blessed with child bearing. Try and feed the children with these foods. Little booklets have been distributed to you about children’s milk mixture in comparison with their age. All these vegetables can be chopped together with a piece of onion and a pinch of salt. For protein you may add fish, meat, tinned fish. Add it together in a pot with water and boil to make soup, then give it to the child. These are also very nutritious for expectant mothers, postnatal mothers and adults. All these foods such as melons, ripe bananas etc. can now be bought from our market fresh every day. Sometimes when we have salt beef we think no more of taro leaf, cabbage and beans. But a good mother will always remember the three food groups—protein, vitamins, carbohydrates such as taro, taamu, banana, rice, bread. Oil foods help us keep warm and give us energy to play and keep fit. Good foods help us fight against diseases. Eat beans, cabbages and tomatoes and fruits. If you eat these three food groups daily, no doubt you will live a strong life. Some would eat only cabbage and forget the other two, but if you don’t eat well you will also give birth to a sick baby. And if you eat well you will no doubt give birth to a strong baby. I urge you all to eat well from these three food groups because it helps prevent you from disease. It makes baby’s skin smoother and enriches the milk for baby. Remember try not to wean the baby too early.
only when baby refuses to suck from the breast.
You know about family planning. Six weeks after delivery, you come to the office and ask for advice on family planning. It is very important to try and space the children. Wait until the other one is old enough.

In the 56 clinic visits I made, I heard five nutrition talks similar to this. Only two were in traditional villages and both were shorter than those given in modern or non-traditional villages. Although all nurses attempted to make the information relevant to women's lives, none was very successful. The talk confirms that nurses have some grasp of the relationship between food and health, but do not understand the concept of the three food groups or how they relate to the food people eat. In all five talks the nurses attempted to cover infant and maternal nutrition without adequately covering either. This talk illustrates the way in which nurses use scientific terms without explaining them or explain them inaccurately. It also highlights the problems associated with translation. When the nurse wanted to convey the word "health" she used the Samoan word for strong (malosi). Although the woman who helped translate the transcription into English was university-educated and knew the context of the talk, she translated malosi as strong, not healthy.

The small number of women who remained to hear the talk (7 out of 12) highlights a dilemma in informally structured committees. Although informality allows a free flow of information between women, and between the attenders and the nurse, it also allows them to come and go as they please.

The meeting ended at 11.45 with a formal speech of thanks from the president to the nurse. Transport arrived at 12.15 p.m. All 12 women attending had received nutritional advice that was relevant to the children they were accompanying. Four women stayed only long enough for their children to be checked and then left, but those who remained also received public information and took part in a discussion, which appeared to be a valuable learning experience. Overall, the amount of nutritional information contained within each dialogue was greater than in village committees and all women received advice regardless of the health of their children. The nurse
spent more time with each mother than in village committees although the dialogues were only marginally longer. Unlike committees in traditional and semi-traditional villages time was spent on discussions on health matters. Although there were only 17 children the meeting took nearly 4 hours. Seventy minutes had been spent checking children, giving information and in discussion, 30 minutes filling in record cards, 10 minutes on the asistaga, 30 minutes eating and one and a half hours talking while waiting for transport.

In committees in non-formal villages the possibilities for delivering nutritional information are severely restricted by very low attendance. However within the meetings the opportunity for delivering both primary health care and nutritional information is very much greater than in traditional or semi-traditional villages. The interaction structure that has developed in these new committees reflects the informal organisational structure of the villages within which they are located, and as the dialogues show, rank was not a constraint to delivering nutritional information. In a situation where women did not know one another well, where the nurse was not part of the local hierarchy, and there was no traditional ranking structure to uphold, there was little pressure to publicly maintain family esteem and very much less pressure to exhibit wealth. There was still social pressure however to provide adequate food contributions and to support the committee in some material way.

Who is given Nutritional Information?

It would be expected that illness or loss of weight would be major criteria determining who within the committees received nutritional information. The dialogues show however, that village type and the formality of the interaction structure have a more significant influence. Records of 343 dialogues indicate that the forms of address used by nurses are closely associated with rank and village type but that while rank is the predominant factor in traditional and semi-traditional villages it has little significance in modern or non-traditional villages (Table 9-2). Analysis of dialogues also show that the overall likelihood of a woman with a sick child receiving extended information is only marginally better than if the
child is well and that this likelihood differs with village type and rank. There is a greater probability of a woman with a sick child receiving relevant information if she is untitled and if she attends a committee in a non-traditional village (Table 9-3).

Table 9-2: Occurrence of Forms of Address, by Village Type and Women’s Rank

<table>
<thead>
<tr>
<th>Form of Address</th>
<th>Traditional/ Semi-Traditional</th>
<th>Modern</th>
<th>Non-Traditional</th>
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</thead>
<tbody>
<tr>
<td>Mōai Tamatai Tau</td>
<td>(55)</td>
<td>(21)</td>
<td>(42)</td>
</tr>
<tr>
<td>Mōai Tau</td>
<td>(55)</td>
<td>(15)</td>
<td></td>
</tr>
<tr>
<td>(Number of Interactions)</td>
<td>(55)</td>
<td>(21)</td>
<td>(42)</td>
</tr>
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<td>33</td>
<td>36</td>
</tr>
<tr>
<td>Suggestive</td>
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<tr>
<td>Explanatory</td>
<td>15</td>
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<td>14</td>
</tr>
<tr>
<td>Imperative</td>
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<td>47</td>
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<tr>
<td>(Per cent)</td>
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Significance of variance between rank within committees

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<th>Modern</th>
<th>Non-Traditional</th>
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<tr>
<td>$\chi^2=89.5$</td>
<td>$\chi^2=10.67$</td>
<td>$\chi^2=1.2$</td>
</tr>
<tr>
<td>$p&lt;0.001$ df=6</td>
<td>$p&gt;0.025$ df=3</td>
<td>$p&lt;0.050$ df=3</td>
</tr>
</tbody>
</table>

Table 9-3: Multi-way Contingency Table showing probability of receiving extended Nutritional Information, by Rank

<table>
<thead>
<tr>
<th>Woman’s Rank</th>
<th>Child’s Health</th>
<th>Village Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Titled</td>
<td>Sick</td>
<td>(15) 0.25</td>
</tr>
<tr>
<td>Well</td>
<td>(38) 0.18</td>
<td>(21) 0.26</td>
</tr>
<tr>
<td>Untitled</td>
<td>Sick</td>
<td>(38) 0.92</td>
</tr>
<tr>
<td>Well</td>
<td>(96) 0.57</td>
<td>(36) 0.10</td>
</tr>
</tbody>
</table>

Number of incidents shown in brackets
Tamatai have been omitted

Women of high rank with children or grandchildren whom the nurse

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3 Analysis was based on multi-way contingency tables, using logit linear models. Assistance was given by Ross Cunningham, Statistics Adviser, the Faculties, ANU.
recognises as needing remedial nutritional advice, receive very little information regardless of the type of village within which they live, as their rank precludes the nurse from giving it and such women from asking for it. This is more marked in traditional villages. Women with little status are more likely to receive pertinent and often extended information when it is seen by the nurse to be needed, but in traditional villages this information is given in the imperative and seldom allows for dialogue or explanation. In large committees untitled women receive little or no public information and seldom hear the health talk, as they are preparing food or sitting too far from the nurse to hear what she is saying. Only in non-traditional villages, where neither titled nor untitled women are constrained by formal interaction structures, is extended information given both to individuals and to the group. The size of the house and reduced concern about maintaining status roles allows for dialogue between the nurse and individual women, and for discussion between the nurse and all women participating in the committee. Although in modern villages participants and the nurse have no interaction outside the committee, women's rank, manifest in the seating order, can still restrict the delivery of information.

In all types of villages the children taken to the committee are usually those whom the mother or grandmother do not consider sick, increasing the likelihood that remedial advice is not sought, and if given, is not considered seriously. This needs further investigation. The exclusion of sick children and the strong probability that women with sick children would not be given relevant information, are perhaps the most obvious manifestations of the committee's loss of health rationale and of the ritualisation of health-related activities.

In all committees emphasis is on clinical procedures rather than education or information. Most of the nurse's interaction time with individual women is spent weighing infants, filling in records, and treating sores. It is obvious that some nurses are uncertain how to use the weight-
for-age graphs and that loss of weight is sometimes not considered a
problem. (The inaccuracy of the scales and difficulty in getting a clear
reading may have something to do with this.) The noise, the shortage and
inappropriate nature of visual aids, the nurse’s lack of nutrition and
communication training, the long duration of the meetings, the lack of
women’s attention and the lack of immediate visible results all militate
against the nurse spending more time on delivering nutritional or other
health-related information. The dialogues show that almost all nutritional
advice concerns infants. I did not once hear a nurse give information or
advice to adults about obesity or obesity-related problems although many
women attending clinics appeared overweight. Only during the health talks
is there mention of family or maternal nutrition and most young, untitled
women do not hear the talk.

Nurses working in traditional and semi-traditional villages have
difficulty maintaining equilibrium between two distinct roles - that of
district nurse and that of well-mannered woman. As no Samoan woman
would unwittingly offend a woman of rank or violate the unwritten
regulations governing polite behaviour, district nurses conform to their role
of Samoan woman first and district nurse second.

Receiving Nutritional Information

Delivering and receiving information are two independent but linked
actions. It would be valuable to this study to know the strength of this
linkage and whether or not those who were given information in the
committees received it, or remembered it, but to adequately assess this
demands a separate study. A general overview gained from administering
199 questionnaires (Appendix 9-1) to women between the ages of 20 and 59
in four different villages confirmed the pattern of unequal delivery of

\[1\] It is recognised that knowledge, attitude and participation (KAP) tests are inadequate as they provide only information that can be recalled and give little indication of attitudes to innovations. They remain the standard way of testing the receipt of information. I used a modified KAP test to check the amount of information Samoan women had received.
nutritional information. The data show that women's recall of nutritional information is poor (Table 9-4) but that the committees remain the major channel for nutritional information (Table 9-5), and that women's rank and village type influence the receipt of nutritional information.

Table 9-4: Women's Scores for Recall of Nutritional Information

<table>
<thead>
<tr>
<th>Recall of Information</th>
<th>Women's Total Score out of 15</th>
<th>Percentage of Women receiving Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>&lt;2</td>
<td>3</td>
</tr>
<tr>
<td>Very Poor</td>
<td>3-4</td>
<td>7</td>
</tr>
<tr>
<td>Poor</td>
<td>5-6</td>
<td>66</td>
</tr>
<tr>
<td>Adequate</td>
<td>7-9</td>
<td>20</td>
</tr>
<tr>
<td>Good</td>
<td>&gt;10</td>
<td>4</td>
</tr>
</tbody>
</table>

Table 9-5: Women's Mean Nutritional Information Scores, by Village Type and Committee Attendance

<table>
<thead>
<tr>
<th>Type of Information</th>
<th>Traditional and Semi-Traditional</th>
<th>Village Type</th>
<th>Modern</th>
<th>Non-Traditional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infant Nutrition</td>
<td>84</td>
<td>18</td>
<td>27</td>
<td>30</td>
</tr>
<tr>
<td>(Scored out of 5)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Nutrition</td>
<td>2.8</td>
<td>1.9</td>
<td>2.5</td>
<td>2.0</td>
</tr>
<tr>
<td>Obesitv Nutrition</td>
<td>2.0</td>
<td>1.2</td>
<td>1.9</td>
<td>1.4</td>
</tr>
</tbody>
</table>

Young, untitled women had the poorest recall of nutritional information, and the *tama'ita'i* the best. All women attending committees in non-traditional villages had better and more equal information than women attending committees in traditional villages where receipt of information was markedly uneven. As might be expected from the pattern of delivery and from the information that nurses themselves could remember, Samoan women had more information on infant nutrition than on family nutrition and extremely poor knowledge of obesity-related

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Some of the women's full replies are shown in Appendix 9-2.
nutrition. Although all women said they thought nutritional information was important only three out of 199 said they talked about it with anyone outside the committee. Therefore there is no contagion or neighbourhood effect in the flow of nutritional information.

Conclusions

As hypothesised, inequalities in the delivery of nutritional information exist not only between and within villages but within committees. The patterns of inequality are closely associated with village type and localized values and structures which are manifest in the the unwritten regulations which govern socially acceptable activity and communication within the committees. As Thrift (1983), Layder (1981) and Bourdieu (1977) point out, the interaction structure is a product of both past and present processes and is more complex than the sum of its parts (that is, individuals). Without analysing the role of the interaction structure over time and space it would be difficult to adequately explain either the inequalities in nutritional information flow in Western Samoan women’s committees or the processes which underlie some of the changes in Samoan women’s lives.

The interaction structure, by embodying local values and accepted ways of doing things, as well as the accumulation over time of actions and their unintended consequences, has legitimised the unequal delivery of nutritional information. This situation is cumulative, continually influencing subsequent action. Only in villages where there is little conformity to traditional values and little sense of community is the interaction structure sufficiently flexible to allow a relatively unconstrained flow of information.

As structuration theorists suggest, interaction structures are situation specific, but it would be simplistic to suggest that they are reproductive of themselves and not transformative of the social structure. The Western Samoan example shows that the interaction structure, while providing a reference point for behaviour that is considered to conform to traditional
culture, has reproduced itself in quite different forms in different locations and has brought about continual minor transformations in the social structure. This is true even in traditional villages where the pressures associated with conformity to accepted conventions themselves bring about social change. The committees have a contradictory influence on women’s lives. They provide institutions for both initiating innovative activities and upholding established values.

The theses of Rogers and Kincaid (1981) and Blaikie (1976) that the greater the homogeneity of society and the greater the degree of community cohesion the better the flow of information, are not borne out in the case of nutritional information in Western Samoa where the characteristics of the information and cultural values ensure an inverse relationship between community cohesion and information flow. A sense of community is a “two-edged sword” in the process of innovation diffusion and information flow. In small, traditional villages where people interact in known relationships there is greater adherence to behaviour associated with the ideal, than in villages where change has been more intense. Although strong authority structures and the importance of maintaining personal and family esteem by conforming to accepted roles enhance committee attendance, they severely constrain the delivery of nutritional information. In non-traditional villages, where there is little sense of community, no village-based authority structure, and where committee attendance has little to do with conforming to accepted roles, committee attendance is very low but information flow within the meeting is relatively unimpeded by the social context of the occasion.

The events which continue to take place in the women’s committees of Western Samoa point to the importance of understanding the processes of structure and action in time and space when attempting to explain the ways in which primary health care and nutritional information are delivered through community groups established for these purposes.
CHAPTER 10

CONCLUSIONS

The aims of this study were to establish and explain the nature and pattern of the delivery of health-related information through the Samoan women's committees over time and space; to explain the processes responsible for the successful establishment of these groups, and later, their persistence and change; and to provide longitudinal data on the delivery of primary health care and nutritional information through women's community groups, with particular reference to World Health Organisation's current primary health care policy.

The study confirms the hypotheses that even in a small and relatively culturally homogeneous nation, where community groups were established to provide all women with equal access to primary health care and health information, the delivery of these services is both poor and uneven and varies with location, within location and with time. Just as in industrial societies, access to primary health care and nutritional information in Samoa has become the prerogative of those who can afford it, or those who are so subjected to social pressure that they borrow the money or goods required for acceptable participation. The data show the specific problems associated with channelling information through community groups and through women's groups in particular, and the need for both governments and international development agencies to consider the constraints that women's status and other demands on their time impose on intervention programmes of this type. Community groups will be effective as a means for improving health only if the constraints to access and information that using community groups entail, can be overcome. The data exemplify the diffusion problems inherent in the nature of nutritional information.
The successful introduction of the women's committees was the result of specific historical events and of a chance intersection of time, place and people that is unlikely to be replicated (Chapter 2). However, the way in which they were introduced provides a model that is relevant to most societies today. Their establishment incorporated careful adherence to Samoan etiquette with recognition of the social structure, reliance on Samoan participation, the visible and continued support of officials of high status, generous economic support, and the use of competition in a highly competitive, status-conscious society (Chapter 3). The maintenance of the committees and their change over time and space were the result of flexibility in both Samoan social structure and committee organisation, the opportunities the new institution offered women for innovative actions, expanded power, status and self-esteem, and their incorporation within what came to be considered as traditional Samoan culture (Chapter 3). This structural integration, which for 40 years ensured the continuity of the committees, is today, at a time of marked social discontinuity, an important factor in their disintegration (Chapter 6).

Over the last 60 years, it has been the committees and the changes they brought to women's lives, rather than the services and information they were established to provide, that have had greatest impact on Samoan society. By providing the opportunity for women to expand their political and economic involvement in village and district affairs the committees brought about changes in women's perceptions of themselves and in their social, economic and political roles, which in turn led to continual changes in social structure. The process was not one-way. The structure of Samoan society and the activities of individual women brought about changes in the organisation of the women's committees and inequalities in access to the services and information they provided (Chapter 7).

In the 20 years following the introduction of the committees, there were marked improvements in health (Chapter 3). Although the
committees still provide an important focus for infant immunisation. Filariasis campaigns and other short-term health programmes, they have been ineffective in achieving lasting improvements in sanitation, hygiene or nutrition. Most villages have latrines and piped water, but the concept of preventive medicine is still not understood and the vital conceptual link between nutrition, hygiene, sanitation and health has not been made. Improvements in health were achieved through the social obligation to obey those in authority or to compete with other communities, not through an understanding of the health rationale which underlie these activities (Chapter 7). The committees have never provided adequate health education to ensure the sustained and informed individual effort that is required for long-term improvements in health. It seems unlikely that health education alone is sufficient to ensure better health as long-term improvements in sanitation, hygiene and nutrition in the industrial world have seldom been achieved without the support of enforceable legislation. In Third World countries where traditional authority structures are breaking down and, as in Samoa, centralised control is limited, greater effort will need to be put into education.

A problem underlying the establishment and maintenance of primary health care projects today is their lack of status. Primary health care systems have no immediately visible impact, no expensive, concrete inputs and are usually dominated by women. Individuals, administrations, governments and aid donors prefer to be associated with curative services which provide visible evidence of their importance and thus enhance individual, collective and national esteem.

Theoretically, the study has shown that the current models of information flow and innovation diffusion are inapplicable in Samoa and are probably inapplicable in other Pacific island societies where information and innovations are disseminated through community groups. The influence of location and rapid and uneven change are greater than the models allow.
for. The theories of information flow and innovation diffusion which posit a strong core-periphery factor with marked distance decay (Hagerstrand 1952, 1974, Brown 1968, 1981) are disproved in Samoa where my research has shown that the flow of nutritional information through community groups increases with distance from the centre. Distance, however, is a less consistent indicator of information flow than the size of the community, its social, political and spatial organisation and the ways in which individuals interact. The study supports the theory (Rogers and Kincaid 1981, Blaikie 1976), that information external to the location moves slowly in community groups where all participants are well known but it does not support their assumption that the converse is true. Although information moves more freely in groups where participants are not closely affiliated because structural restrictions to group communication do not operate, few women participate in the groups through which information is delivered. This situation highlights the two dilemmas inherent in using community groups to diffuse health services or other developmental information. A strong sense of community, which is usually accompanied by a high degree of conformity to accepted social norms and/or the use of overt or covert coercion, ensures participation in community group activities, but may seriously constrain the flow of information within the group, as conformity to social norms associated with group communication can restrict interaction. Second, the integration of an introduced institution into an indigenous social system encourages continuity over time, but may also restrict widespread participation and thereby institutionalise inequalities in access to the services and information for which the institution was created. Weber’s theory that communities are based on the need to control scarce resources and that coercion and authority may be utilised, demands consideration in theories of information flow through community groups.

Diffusion theories have largely failed to consider the influence of gender. Women’s uses of space and time and their communication
networks differ considerably from those of men, just as information
disseminated among men may not be acceptable for discussion among
women. Recognition of this basic differentiation should be an essential
component of any innovation diffusion or information flow model.

As hypothesized, planned intervention and both individual and
collective responses to it have unintended consequences which continually
alter the ways in which members participate in community groups and the
ways in which information moves. Intervention is also strongly influenced
by the emergence of individuals who show personal qualities that are either
unique or unusual for their time and place. These factors have
implications for model building as human activity and its consequences, and
therefore the pattern of information flow, can seldom be predicted.

Information flow through community groups is strongly influenced by
the characteristics of the information, its source, the gender and status of
those responsible for its delivery, and the channels established for its
dissemination. Although expatriate perceptions of Samoan society, external
funding, and Samoan administrative infrastructures have all influenced the
overall delivery of nutritional information, they have been less pervasive
than the interaction of time, space, Samoan social structures and the
activity of individuals in creating locationally differentiated patterns of
information flow.

It is clear from the Samoan example that information flow, innovation
diffusion and social change cannot be seen independently of one another.
The flow of nutritional information in Samoa today cannot be explained
without considering historical factors and 60 years of dynamic and reflexive
interaction between the system established for its dissemination, individual
human activities and locationally and temporally specific social, economic
and political structures.

As the provision of primary health care and the pattern of nutritional
information flow differ markedly with location within a small society,
universal models which go beyond outlining basic components are likely to be of little value when applied to the realities of large, multi-cultural and/or rapidly changing societies. This does not augur well for the long-term success of the World Health Organisation's primary health care policy as the implementation and maintenance of locally relevant programmes will require constant evaluation, feedback and adjustment to change. This will take very much more time, training, personnel and political and economic support than is usually available or considered necessary.

Methodologically, the study has raised questions about the utility of the structuration approach to social change, especially its assumption of structure as process and its failure to incorporate the impact of deliberate intervention. As the Samoan example shows, societies exhibit discernible discontinuities. The identification of mediating structures has proved useful in investigating the relationship between information flow, individual human activities and the broader framework of social and structural change. The identification of the interaction structure as an historical, social construct is of particular importance in understanding diffusion and its relationship with social change.

The Temporal, Spatial and Social Patterns of Nutritional Information Flow

In Samoa the delivery of primary health care and nutritional information is poor, with a marked deterioration in the possibilities for their dissemination over time and in areas where social, economic and political change has been most marked. Three distinct but inter-related patterns of information flow have been defined. These are associated with particular temporal, spatial and social contexts and help explain women's lack of nutritional knowledge and the deteriorating standards of sanitation and hygiene.
Temporal Patterns

Over time, the pattern has been one of declining participation in the women’s committees, most particularly by young women, those with small children, the poor, and the socially isolated, restricting the opportunities for delivering both primary health care and nutritional information. The committees remain the major channel for these services, and information does not diffuse beyond those attending the committee meetings. Over time there has been increasing spatial differentiation in committee distribution, social access, attendance and the ways in which information is delivered. Before 1970 very high and regular committee attendance was common throughout the country. It was associated with a strong sense of community, adherence to accepted social norms, the legitimate use of authority to ensure attendance and compliance with health regulations. Although today the Samoan government maintains that all women have access to primary health care and that all women participate enthusiastically in the committees, district nurses’ estimates show a national average of 51 per cent attendance, while my research shows an overall attendance of only 40 per cent.

Economic and social restrictions to committee attendance are becoming more common. Greater pressure than formerly is now placed on young women to find paid employment or to work in the household or on the land. The change from subsistence to a cash economy with women’s increasingly unequal access to cash has led to changes in the criteria governing social access to health services. Participation in committee activities has always relied on the provision of contributions but the substitution of locally produced goods by those that are store-bought has restricted participation, just as a reduction in the effectiveness of conflict resolution mechanisms and growing community fragmentation have restricted involvement in committee activities. Women and their children now attend less regularly than in the past. Infants are seldom taken to
the committees beyond the age of 18 months, and sick children, who in the past would have been taken to the committees or visited at home, are no longer seen by the district nurse. Nurses are strongly discouraged from visiting non-committee members and women feel that they lose esteem if they take sick children to the committee. Illnesses or minor complaints once treated by the nurses or committee executive are now dealt with by traditional healers, the district hospital, or more frequently, not at all.

Between the mid 1940s, by which time the committees had adopted the organisational characteristics of the male ranking system, and the early 1970s, the national pattern was one of high attendance but restricted and unequal access to information. It is likely that prior to 1945, information not only moved more freely and evenly but was of a more practical nature.

Two significant changes have reduced the utility of the committees as organisations for improving health. Over time the responsibility for village primary health care has been transferred from the community to the state - a responsibility it has been unable to fulfill; and the committees have been transformed from health organisations into social institutions. These changes have been accompanied by a reduction in health-related activities, the ritualisation of major committee health practices and changes in the reasons why women attend. Most women now consider the committee meetings social occasions and attendance a social obligation rather than an opportunity to improve health. As a result, health-related information is seldom sought, discussed or implemented. Health-related committee activities no longer provide women with esteem and as a consequence are not considered important. Only in committees organised by those churches whose doctrines emphasise both bodily and spiritual health do women attend primarily for health-related purposes.

In a society where the official emphasis is now on the Western model of centralised, curative health services, reduced committee attendance, restricted information flow within them and their loss of health rationale have serious implications for the future health status of the people.
Spatial Patterns

Spatially, the national pattern is one of deteriorating information flow in areas which exhibit the most rapid population growth and greatest discontinuity with the social and spatial organisation of the past. There is a close association between location, women's use of time and space, the size and cohesion of the community within which they interact, the degree of choice they have over decisions, and the way in which information moves. In small, rural villages which exhibit cultural continuity and a degree of community solidarity, a high proportion of women attend the committees but most are constrained by the conventions which regulate communication from asking for or being given information. In those urban villages where families have traditional affiliations with the land, and there are remnants of the traditional ranking and authority structures, committee attendance is poor but those attending have relatively free access to information. Lowest participation is found in the new freehold suburbs on the outskirts of the capital, where families have no long-term affiliation with the locality or their neighbours and there is no sense of community solidarity. Women attending committees in new suburbs have better information and more equal access to it than those in rural or peri-urban villages. In rural villages an almost equal number of young and older women attend. Most women bring their own children to committee meetings. In urban villages, a high proportion of attenders are older women who bring their grandchildren. Although a greater proportion of young urban women are in paid employment than in rural villages, most do not attend committee meetings because they associate them with patterns of behaviour they consider old-fashioned, because they fail to see any benefit from doing so, or because they lack social access, not because they work.
The pattern of information flow is also determined by how closely the organisation of the committee meetings follows that of a traditional male *fono* and how well the *fono* manages conflict. Women's age, rank and economic status, and their need to maintain esteem within the community influence both attendance and access to information in the committee meeting. Throughout Samoa, the poor and socially isolated are structurally excluded from access to primary health care and nutritional information. In rural villages, where the mechanisms for conflict resolution and control of economic and political resources remain in the hands of the ranked elite, and where some degree of traditional authority is retained, the flow of information is determined not by the health status of women and children, but by relative rank and the desire of both women and the nurse to conform to the patterns of behaviour considered to be acceptable in a formal, public setting.

The characteristics of nutritional information and its association with food practices make such information difficult to disseminate to those of high rank, most particularly when the nurse lives in the district and is well known. The committee interaction structure precludes high-ranking women from being told what to do or from being given nutritional information, as this implies an inability to provide food. This is a serious allegation in a society where the ability to provide lavish quantities of food is of social and political importance. Few nurses are prepared to contravene laws associated with etiquette when their families belong to the district. Wives of untitled men are given information relevant to their children's health but this is minimal and seldom explained. Their low status and the lack of importance with which they perceive nutritional advice precludes them from seeking further information.

In new suburbs where there is no traditional ranking structure, where the interaction structure is flexible and the nurse is not well known,
communication is both more equal and less restricted than elsewhere. In these locations low participation and the district nurse’s lack of ability to educate, rather than women’s rank and desire to conform to the rules of etiquette, constrain nutritional information flow.

Nutritional Information

A growing literature confirms difficulties in achieving desired dietary changes (Chapter 8). Problems of supply, entrenched food practices, and the social importance of food are given as major factors. Difficulties with the information itself and the ways in which it is taught are seldom considered, least of all within primary health care models. There are widespread problems with the scientific orientation of nutrition training and the concentration on food categorisation rather than on food itself. In Samoa the association between food and status, the externality of the information, and lack of observable links between everyday food practices and health, make dissemination slow and difficult. In addition, the female bias of nutrition teaching and the consequent low priority of the topic, hinder its movement at all levels. Sixty years after nutritional information was first introduced it is still channelled only to women although district nurses and Department of Health administrators are aware that young men in Samoa do the bulk of the cooking and young children often feed infants. Nurses’ nutritional training is inadequate and often irrelevant to Samoan village life. As in the rest of the Pacific training is usually provided by short-contract expatriate volunteers who have little Pacific experience. Nurses receive almost no training in how to communicate their knowledge effectively and the visual aids available portray foods that are not available, not recognised or not recommended. Nutrition-related posters carry complicated and confusing messages. None have been field tested before distribution and none have been evaluated.
Integrating Theories of Diffusion, Time and Space, Structure and Action

The Samoan example shows that diffusion models would be of greater utility in planning community-based programmes of primary health care and nutritional improvement if they incorporated aspects of time-space geography and the approaches to social change contained within the structure/action debate. This would provide a model with a flexible framework applicable to small, village-based societies undergoing rapid and uneven change.

As the time-space geographers claim, diffusion is a dynamic process which alters with time, location, and with the daily activities, experience and established interaction patterns between individuals. The introduction of new technologies or systems for diffusing innovations or information change daily activities and interaction patterns. I have shown that they also change social structure, which in turn influences future patterns of information flow. When these aspects of time-space geography are incorporated within diffusion theory they provide the crucial elements of dynamism and locational differentiation that have to date been missing.

The structuration school proposes reflexive links between individual activity and structure, and suggests that human interaction is largely determined by locationally specific objective and substantive structures, while recognising that there is room for independent action. This allows for the incorporation of individual activity without reducing the model to particularism. When innovations and information are incorporated within the reflexive process between structure and action the essential relationship between innovations, structure, action and change is established. The integration of elements of time-space geography and structuration allows the amalgamation of two major schools of diffusion thought: that which considers the impact of indigenous structures on diffusion of innovations and information and that which considers the impact of innovations and
information on indigenous structures and action. In this way the model is able to deal with the relationship between innovation diffusion, information flow and social change.

From diffusion theory, the characteristics of the information, the status of those involved in disseminating it, and the cohesion of the community should be included. These elements, together with gender and the recognition of the impact of activities that provide people with esteem, provide a flexible framework for a model of information flow through community groups which is appropriate to small societies undergoing rapid change.

This study has analysed some of the constraints and opportunities associated with providing sustained programmes of primary health care and nutritional improvement through community groups. Although the Alma Ata Declaration recognises the need for cultural specificity in establishing primary health care programmes, few development projects allow the resources to enable this, just as little consideration is given to the problem of implementing projects which incorporate two ideologically opposed approaches to development. Improvements in health must rely to some extent on information and assistance from outside the community and therefore on a hierarchy of information which must be assimilated into a community-based system established on the premise of equality, community decision-making and a bottom-up approach to development. It is finding an acceptable balance between the top-down and bottom-up approaches to primary health care that will take time, effort, dedication and the continual adjustment and re-adjustment of the programmes to both changing needs and altered perceptions that result from both the intervention and social change. In the final analysis it is impossible to predict the long-term outcome of health intervention or how information might be perceived or acted upon by the recipients. Perhaps we should all consider the reflections of an elderly Samoan district nurse after nearly 50 years in the field:
When I was a nurse, this was the first time to teach the mothers to feed babies only four times a day. This was the first dried milk powder. It was stressed that babies needed extra supplement. People came and said they should use artificial milk. It was introduced into the hospitals too. We nurses, we were told it was good, we were trained to do it. We thought it was right and we showed the mothers. But something went wrong. Mothers took to the dried milk. They thought it was a better idea than the old way. They took to it completely when it was intended only as a supplement. Or they just put anything into the bottle. Well, it caused malnutrition. Nobody did it deliberately. We thought it was the right thing. We were trying to help. But you have to be careful giving help. By giving help, you might be causing things (Pers. Comm., Retired District Nurse La'u, Fasitoouta Village, 29.4.83).
RECOMMENDATIONS

The study raises a number of issues which should be addressed by the World Health Organisation and other institutions concerned with nutrition and primary health care, if the strategy for improving health through community groups is to be more effective. Recommendations cover three areas: establishing and maintaining programmes, overcoming constraints to the delivery of information, and improving nutritional education at all levels. Some of these recommendations are specific to Samoa.

Establishing and Maintaining Programmes

Primary health care programmes should initially relate to health needs recognised by both the government and the community and provide recognised corporate and personal benefit. Campaigns to create awareness of health problems should therefore precede the establishment of primary health care projects which rely on community participation. To achieve this both the government and the public should be informed of the social and economic rationale for primary health care and preventive medicine. Particular attention should be given to informing governments of the relative benefits of primary health care and preventive medicine as against those of centralised, curative services.

As the Samoan example shows, the establishment of community-based systems of primary health care requires the visible and continued support of those of high status, and in hierarchically-ranked societies, of those perceived to have legitimate authority. To maintain effective projects field staff should have high status or esteem, come from outside the local district, be regularly transferred and be given continued administrative support and direction. In Samoa this requires better trained and better
paid nurses, a more efficient infrastructure and a greater sense of responsibility among health administrators than currently exists. Channels for feedback must be established and utilised and the programme must provide women with a sense of achievement. The effectiveness of the system must be regularly monitored and the delivery of services constantly adjusted to overcome locationally specific constraints that arise from social, economic and political change. There are no shortcuts. This takes time, energy and patience. Unless these provisions, together with allowance for locational differentiation, are built into programmes, a situation like that in Samoa arises.

In the Pacific the churches are underutilised organisations for delivering primary health care services. In those societies where governments and health administrators exhibit little political will for improving or supporting primary health care, the churches may provide an effective and flexible alternative. Churches retain high membership, their leaders have high status and church personnel responsible for social services often exhibit motivation and dedication seldom found in government services. Churches in the Pacific have traditionally been associated with health care but inadequate funding and government intervention have led to a decline in their health services. Funding to establish or expand church involvement in small-scale, locally-relevant primary health care programmes should be encouraged. Where governments are unwilling to relinquish full responsibility for primary health care, the support of the churches should be sought to encourage motivation and participation in primary health care activities and to reinforce the work of the health service. Involvement of the churches would require cooperation between various denominations and between churches and government.

Four options are open to the Samoan Department of Health to improve the delivery of primary health care and nutritional information. The Department of Health could replace the existing system of formal
women's committees with health clinics which do not rely on a community-based organisational structure: it could retain the committees and their executives but restructure committee activities to allow greater equality of access; it could channel primary health care service through the churches; or it could combine these three strategies using committees, clinics or church groups where each seemed most appropriate.

The introduction of clinics, held fortnightly, alternating day and early evening sessions, and offering access to men and women, would help overcome economic and social constraints to both attendance and access to information. Clinics should be held in politically neutral venues, like the local school or church, at times appropriate to the major activities in the area. Those people requiring assistance should be able to consult the health worker privately, and to spend only as much time as is required for the provision of the service. This type of clinic would rely on individual responsibility for health care. Although it would overcome current structural constraints to services, it would be more difficult to organise participation in community health education events like demonstrations, health films or dramas.

If the committee structure is retained, contributions, the osiasiga and social ceremonies should be phased out to allow greater social access and to reduce the time the meetings take. The nurses' workload should be reorganised to reduce paper work and allow more time for health education, practical demonstrations and community participation. Greater emphasis must be placed on education for prevention rather than on providing curative services. The nurse's health talk should be given at the beginning, rather than at the end of meetings and the president should be held responsible for ensuring that all sick children are visited by the nurse. Any long-term improvements will require a renegotiation of the balance of power between the committee presidents and the health workers. The Department of Health must change its policy toward non-committee
members and support nurse’s visits to sick non-committee members and their children without jeopardising cooperation of the committee executive. The district nurses should have access to health workers from outside the district who could regularly give nutrition demonstrations, and practical lessons in hygiene and sanitation.

The churches have a strong organisational structure, excellent premises and personnel who could assist in encouraging access to primary health care. The village pastors and their wives, most of whom have had basic training in primary health care, provide a largely unutilised resource for promoting better health practices. Although some churches may not provide the ideal institution for education on family planning, others have taken positive steps to incorporate this topic in theological training and secondary colleges.

The fourth option would provide a system that is locally relevant and would require only relatively minor changes to the existing system. The establishment of clinics with flexible hours, operating in church or school buildings, would provide an urban alternative to the existing committees and allow unrestricted social access. Greater use of the Family Welfare Centre should be encouraged.

In all four situations the immediate priorities are the revitalisation of the health rationale for clinics and/or committees: the restoration of individual or family responsibility for health; and the recognition of the need for primary health care and preventive medicine. The most efficient and effective way of doing this is through the mass media, the churches and schools. The mass media, like the churches in the Pacific, are underutilised in supporting social and economic development. The media alone cannot bring about change but they can overcome the constraints of both physical and social access to information and create awareness, change attitudes and motivate participation in programmes. The effectiveness of new social marketing techniques in radio and television has been well
Proven, most particularly in establishing motivation for desired nutritional change.\(^1\) Video, film and drama have also provided effective support for nutritional, health and agricultural change. Low-cost programmes using audio cassettes with recorded messages designed for village women have also proved effective in India.\(^2\) In Samoa and much of the Third World radio is an inexpensive medium with a very wide audience that can be used to raise awareness of health problems, inform the population of the health services available and motivate the population to use them. Mixed media campaigns have been successfully organised in a number of developing nations.\(^3\) In Samoa the effectiveness of the infant immunisation programmes can be attributed to a campaign of this sort. The use of the media however must be carefully planned and coordinated and the media component of the project budgeted for in the initial project plan. Messages must be prepared by media professionals rather than by health personnel who have no media training\(^4\) and must be pre-tested and monitored. Before successful messages can be created research must be made into how the target audience perceives its problems, what will motivate it to change activities, and which medium is best suited to certain circumstances.

UNESCO now provides training programmes in media skills for development which could provide a core of Pacific island specialists in this field and both UNICEF and WHO support the establishment of pre-planned communication components in health projects.


\(^{3}\) For examples from Tanzania see Hall 1979 and Mahai 1981:252-260; Swaziland see Hornick and Sankar 1985:7-8; India see Colle 1980, daCunha 1985:185, Indonesia see Griffiths and Nobbe 1985:3-14, Latin America see Benjamin 1985:277-189.

\(^{4}\) For problems associated with unprofessional use of the media in health education see Thomas 1986.
Reducing Restrictions to Delivering Nutritional Information

To overcome the social constraints to delivering information, health workers should come from outside the district, or failing this, regular visits from non-local health workers should be organised. Visiting health workers should concentrate on specific health issues that local workers find difficult to discuss. Constraints to interpersonal communication can also be overcome by the use of relevant, field-tested visual aids. These include both the more traditional posters and flip charts and the use of drama, film, video and audio cassettes. The rapid spread of video in the Pacific that has accompanied the availability of electricity, generators and battery-operated television sets together with the development of inexpensive handheld cameras, provides the opportunity to revolutionise diffusion techniques. It is now technologically and economically feasible to make video films of individual communities, their health practices, how they perceive their problems and ways in which health might be improved. Video acts as a catalyst for discussion, education and change and provides the climate for action. Two health workers trained in video techniques, operating a single camera and visiting communities for two or three days can be extremely effective if they are supported by regular health workers.

Improving Nutritional Education

Nutrition training and visual aids in the South Pacific need complete revision. Training of health workers should include careful consideration of nutrition to ensure that the link between health and local eating patterns has been made. Greater effort must be made to produce texts and educational materials that are relevant to individual societies. All materials should be field tested, revised and re-tested. All health workers must be given training in educational techniques that is appropriate to informing adults and encouraging participation and discussion. Health workers should be given part of their training in the field and given considerable

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5 See Thomas 1985:61-76.
experience in teaching methods before they are posted out. In societies like Samoa where there are constraints to passing on information, health workers should be taught strategies to minimise these restrictions. This requires the development of courses for health workers which are relevant to individual societies, rather than regional courses or those based on expatriate models. Nutrition and health education should be included in both primary and secondary school curricula and taught to both boys and girls.

Long-term improvements in health will require greater personal and corporate dedication, more effort, more time, money and trained personnel than current governments or development agencies consider necessary. However, sustained improvements in health and nutrition are the essential foundation for social and economic development. Primary health care deserves the full and continued support of World Health Organisation, international aid agencies, donor governments, local governments, village communities and individuals.
Appendix 1:1

Interviewees for Historical Perspective

Ali‘imau, Anulagi Aiona, Dr Faleniu Asaua, Sally Betham, Allepata Brown, Dr Takapo Esera, Dr Mika Fepeule‘ai, Moevanu Ki, Sillilatu Ki, Momoie Kuresa, Lo‘u, Solioa Meleisea, Olive Momoisea, Lotte Naseri, Dr Kitiona Naseri, Fa‘amotau Neilsen, Leotele Palipo‘i, Sulilo Tamasese, Dr. Leota Tautasi, Luisa Tanuvasa.

Past-President, Mulivai and Tui‘oeloa Committees
Retired Dietician and District Nurse
Community Services, USP, Suva.
Matron, Nursing Services
District Nurse
Retired District Medical Officer
Acting Director of Public Health
Past-Vice-President, Vaiala Women’s Committee
Retired Pulenu‘u, Vaiala.
Retired Matron, Nursing Services
Retired District Nurse
Past-President, Poutasi Women’s Committee
District Nurse
Home Economist, Department of Agriculture
Retired District Medical Officer
President, Nurses Association
District Nursing Supervisor
Past-President, Vaiala Women’s Committee
District Medical Officer

District Nurses Interviewed December 1982 - September 1983

<table>
<thead>
<tr>
<th>Name</th>
<th>Health District</th>
</tr>
</thead>
<tbody>
<tr>
<td>Olive Momoisea</td>
<td>Apia</td>
</tr>
<tr>
<td>Kinioni</td>
<td>Apia</td>
</tr>
<tr>
<td>Pulou Mataia</td>
<td>Apia</td>
</tr>
<tr>
<td>Gagamoe Aialia</td>
<td>Apia</td>
</tr>
<tr>
<td>Sopo’i Tu‘igaepa</td>
<td>Apia</td>
</tr>
<tr>
<td>Fetu</td>
<td>Apia</td>
</tr>
<tr>
<td>Leva’i Tanoa</td>
<td>Apia</td>
</tr>
<tr>
<td>Evelini</td>
<td>Apia</td>
</tr>
<tr>
<td>So‘e Tu‘a‘ino</td>
<td>Apia</td>
</tr>
<tr>
<td>Puapuuga Tamaseu</td>
<td>Apia</td>
</tr>
<tr>
<td>Salu</td>
<td>Apia</td>
</tr>
<tr>
<td>Sualogi Pati</td>
<td>Apia</td>
</tr>
<tr>
<td>Eseta</td>
<td>Apia</td>
</tr>
<tr>
<td>Fa‘alavelave Masina</td>
<td>Apia</td>
</tr>
<tr>
<td>Fa‘amoana Fano</td>
<td>Apia</td>
</tr>
<tr>
<td>Faomalufa Akeripa</td>
<td>Apia</td>
</tr>
<tr>
<td>Allepata Brown</td>
<td>Apia</td>
</tr>
<tr>
<td>Winnie Seualo</td>
<td>Apia</td>
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<tr>
<td>Masina Leni</td>
<td>Apia</td>
</tr>
<tr>
<td>Taololo Moa</td>
<td>Apia</td>
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<tr>
<td>Toeta Aili</td>
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</tr>
<tr>
<td>Lioi Josefa</td>
<td>Apia</td>
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<td>Sopani Safune</td>
<td>Apia</td>
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<tr>
<td>Atuimano</td>
<td>Apia</td>
</tr>
<tr>
<td>Fa‘ilelei Maninoa</td>
<td>Apia</td>
</tr>
<tr>
<td>Tapai Taupau</td>
<td>Apia</td>
</tr>
<tr>
<td>Sefepa Paiala‘ua</td>
<td>Apia</td>
</tr>
<tr>
<td>Lotofoa Tiatia</td>
<td>Apia</td>
</tr>
<tr>
<td>Lesi Josia</td>
<td>Apia</td>
</tr>
</tbody>
</table>
Appendix 3:1

Apia-Falefa Experimental Health District

The district within which Dr Regina Flood Keyes carried out experiments in maternal and child health care between 1924 and 1926 lies on the north coast of Upolu, extending 33 kilometers east from Apia.

For health purposes the district was divided into two sections: the first consisted of the villages between Apia and Solosolo and the second, those from Solosolo to Falefa. Each village was visited fortnightly. Keyes’s visits were based on two, weekly schedules.

Monday: Vaiala, Matauta, Matauta-uta, Fagafalga
Tuesday: Letoga, Vailele, Vailele Plantation
Wednesday: Louli’i, Luatuanuu, Solosolo
Thursday: Fagali’i
Friday: Moataa, Matafagalele
Saturday: Magiagi

Monday: Papauta Girls’ School
Tuesday: Surprise inspections
Wednesday: Saluafata, Lufilufi, Faleapuna, Salesi, Fusi, Eva, Falefa
Thursday: Inspections
Saturday: Methodist Training College, Piula

The district comprised 24 villages, three European plantations and two mission stations. The plantation located at Vailele, Fagali’i and Vaivase employed Melanesian and Chinese labour. The missions were the Methodist Mission, including its high school and a training college at Piula and a Mormon settlement and school at Sauniatu. The trading stations were at Luatuanuu, Solosolo, Lufilufi, Faleapuna and Falefa. The population of the district in 1926 was 4,182 (Source: AJHR A-4, 1927:15-21).
Appendix 3:2

Rules of the Women’s Committees in 1926

1. Meetings must be held once a week and different women appointed to do certain tasks falling upon the committee.

2. The president presides, and is responsible to the Medical Officer for the manner in which the work is carried out.

3. A bell must be rung morning and night. The morning call is for attention to minor complaints such as colds, coughs, sores, small cuts and to the cleanliness of the children. The night bell at 8 is the curfew for all children under twelve years.

4. All houses, kitchens and latrines must be inspected every week. Persons in charge of dirty places are reported by the committee to the Pulenuu, the Native official in charge of the village.

5. All cases of illness are to be reported to the Pulenuu (Native Official), and if serious they must be brought to the attention of the Medical Officer of the district.

6. Aid must be given to all ill persons or others needing attention.

7. During epidemics the women’s committees distribute medicines from house to house, maintain quarantines and assist the Medical Officer and nurses.

8. The committee shall help all expectant mothers, and those who are suckling their babies.

9. The committee must see that suitable food is available for young children. They should see that children at the breast are fed regularly, and that no work on the part of the mother interferes with such regular feeding. If a mother has not sufficient natural food for the baby, the committee must try and get suitable food for such baby.

10. In the interests of the women themselves and their babies, the committee should use its influence to discourage marriages contracted according to old Samoan custom.

11. The medical articles in the Savali should be read every month, not only to the committee but to all the women in the village.

12. The committee shall report to the Pulenuu all cases of severe thrashing of children. There are in Samoa some parents who thrash their children much too severely with very little cause. Such parents do not deserve to have children and should be severely punished for their cruelty.

(Source: AJHR A-4, 1925:2-3; 1926:20; 1927:16)
Regulations regarding sanitation and hygiene were as follows:

1. All mats must be put outside every sunny day.

2. Mosquito nets must also be put out in the sun and washed every week.

3. Every fale must have flyproof a safe in which food and dishes are kept.

4. All dishes must be washed with hot water after meals and put in the safe.

5. No bad food must be kept in the fale but burned.

6. No persons must spit on the floor of the fale as this bad habit causes disease. Any one with a cough must spit into a cocoaanut [sic] shell with a little kerosene in it. This can be burned.

7. All sheets, pillow cases and clothes must be washed once a week.

8. No pigs, dogs or fowls must be allowed in the fale. They make dirt and cause disease.

9. All rubbish, rotting leaves and other decayed vegetable or animal matter about the fale must be swept up, collected and burnt every day. No tins or cocoaanut shells must be left lying about as these collect water in which mosquitoes breed. Mosquitoes bite people and cause disease.

(Source: Ritchie, O le Faatonu Vol.12. No.8. 1925:3)
Appendix 4:1

Weaning Information Recommended in 1957

1. Start esi (pawpaw) juice at 1 month of age.

2. Vegetable clear soups at 3-4 months using one yellow vegetable, one green vegetable and taro or yams. Then gradually add finely mashed or pounded vegetables until at 6 months they are having thick pureed vegetables.

3. Introduction of eggs - cooked, to the diet as well as mashed ripe bananas etc.

4. Introduction of fish or meat soups at 8 months.

5. Breast feed until 15 months of age where possible and if this is not possible cows milk or powdered milk either full cream or skim depending on the families finances.

6. Weaning to take at least a week and preferably a month as slow weaning is better for both mother and child.

7. The inclusion of one protein food in their daily diet.

8. The supervision of feeding the younger children by one of the senior members of the women's committees whilst the mothers are absent from the village working on the plantations.

(Source: Department of Health 1957:2-3. File:IT1.8/23, New Zealand National Archives)
Appendix 5:1

The Classification of Villages

The four Samoans responsible for the classification of villages were a senior officer in the Department of Agriculture, a retired senior member of the Land and Titles Court, the director of the Rural Development Unit in the Prime Minister's Department, and a senior member of the Rural Development Bank. All had a good knowledge of the country and travelled around both islands regularly. Each was asked independently to classify by whichever means they thought most appropriate, the villages listed in the 1981 Village Directory. (Department of Statistics 1981). All agreed that villages fell into four major categories. The major criterion for differentiation was the degree to which the village conformed to traditional ranking and authority systems. This was chosen independently by each of those making the classification. Traditional villages were nearly always those that retained strong elements of the traditional village structure and strong matai authority. There was some disagreement over the classification of some villages in the urban and peri-urban areas but this was minor and in discussion was resolved.

The final qualitative classification was then tested against the quantitative data available. These included population, population change, distance from Apia, major economic base, land tenure, land availability. Analysis of variance tests showed that all variables had a significant effect and there was a close correlation between the qualitative and all quantitative factors.
**Table 11-1:** Characteristics of Traditional, Semi-Traditional, Modern and Non-Traditional Villages

<table>
<thead>
<tr>
<th>Variable</th>
<th>Trad.</th>
<th>Semi-Trad.</th>
<th>Modern</th>
<th>Non-Trad.</th>
<th>F Score</th>
<th>p &gt; .05</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean Population</td>
<td>421</td>
<td>810</td>
<td>685</td>
<td>319</td>
<td>13.629</td>
<td>+</td>
</tr>
<tr>
<td>Distance in kms from Apia</td>
<td>96</td>
<td>38</td>
<td>3</td>
<td>23</td>
<td>38.507</td>
<td>+</td>
</tr>
<tr>
<td>Mean number of Committees per village</td>
<td>1.22</td>
<td>2.44</td>
<td>3.0</td>
<td>1.8</td>
<td>25.802</td>
<td>+</td>
</tr>
<tr>
<td>Mean number of women attending per village</td>
<td>50.6</td>
<td>41.9</td>
<td>37.9</td>
<td>14.0</td>
<td>18.791</td>
<td>+</td>
</tr>
</tbody>
</table>

* Non-traditional villages include plantation settlements and government stations. When urban non-traditional villages are categorised independently the mean number of women's committees per village is 4 and the mean number of women attending per village 16.1.

+ Significance level of log of distance 167.511

**Table 11-2:** Contingency Table showing Significance of Land Tenure, by Village Type

<table>
<thead>
<tr>
<th>Village Type</th>
<th>Mixed</th>
<th>Customary</th>
<th>Freehold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditional</td>
<td>10</td>
<td>191</td>
<td>1</td>
</tr>
<tr>
<td>Semi-Traditional</td>
<td>17</td>
<td>29</td>
<td>14</td>
</tr>
<tr>
<td>Modern</td>
<td>10</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>Non-Traditional</td>
<td>9</td>
<td>1</td>
<td>35</td>
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<tr>
<td></td>
<td>46</td>
<td>227</td>
<td>55</td>
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</table>

χ² = 204 \ p > .001
Table 11-3: Contingency Table showing Significance of Population Change, by Village Type

<table>
<thead>
<tr>
<th>Village Type</th>
<th>Population Change</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>&gt;-5%</td>
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<tr>
<td>Traditional</td>
<td>42</td>
</tr>
<tr>
<td>Semi-Traditional</td>
<td>7</td>
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<tr>
<td>Modern</td>
<td>4</td>
</tr>
<tr>
<td>Non-Traditional</td>
<td>10</td>
</tr>
</tbody>
</table>

|                | 63    | 154   | 49     | 22      | 40    | 328  |

p = >.001
Figure 11-1: Population Change, Western Samoa 1971-1981, by Electoral District
(Source: Department of Statistics, 1983)
Appendix 6:1

Research Methods for Chapter 6

To ascertain the distribution and characteristics of the different types of committees I used the Department of Health district nurses' annual returns for 1981 and 1982, the district nursing supervisors' reports, a questionnaire sent to district nurses (see below (a)), personal interviews with district nurses and district nursing supervisors and a total of 56 visits to 26 different committees, listed below (b). To gain information on the regularity of women's and infants' attendance, attendance data was collected from health record cards of infants born in 1977, 1978, and 1979, providing full four-year coverage. Data from 1,200 health record cards from 38 committees in 28 villages were analysed. The committees are listed below (c).

a. Questionnaire to Nurses on Committee Attendance and Nutritional Information Disseminated

This questionnaire was distributed to all district nurses through the Department of Health. Twenty-one of the 35 questionnaires sent to district nurses outside Apia were returned. All 11 questionnaires given to district nurses based in Apia were completed. The questionnaire was written in both English and Samoan and was translated by the staff of the University of the South Pacific Extension Service, Apia. The majority of replies were in Samoan. The attendance figures were checked with the district nursing supervisors. The questionnaire was intended to provide information on three distinct topics:

1. Committee attendance and non-attendance.

2. District nurses' perception of the major health problems in their districts and the factors that they consider could have contributed to them.

3. Nurses' knowledge of nutrition; the kind of nutritional information they disseminate; the causes of malnutrition; the ways nurses feel poor nutrition could be overcome and the incidence of malnutrition they perceived.
The questions on nutritional information were based on the nutritional component of nurses training and were compiled by the Nutrition Education Centre whose staff helped score the returned questionnaires.

**Questionnaire on Women’s Committee Attendance, Health and Nutrition in Western Samoa**

<table>
<thead>
<tr>
<th>Name</th>
<th>Village of Birth</th>
<th>Village of Residence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Years of service as a District Nurse

1. Name of Committee

2. Number of women usually attending this monthly committee clinic.

3. Number of women you usually visit at home in this village.

4. Number of women with small children in this village who do not attend your clinic.

5. Is the Women’s Committee in this village well organised? Yes or No.

6. Do the Faletua of the Women’s Committee attend this clinic? Yes or No.

7. Has there been any decline in interest in the Women’s Committees in the villages you work in? Yes or No.

8. If yes, what do you think has caused this?

9. What do you find are the three most important health problems facing children in your district?

10. Do you think people are aware of these problems? Yes or No.

11. Do you think that the women in your district understand the need for good nutrition? Yes or No.

12. In some villages people do not eat the right kinds of good for good health. What do you think is the reason?

13. During 1982 how many times did you talk to clinics about the following topics?

* The right food for weaning babies
* The right food for school children
* The right food for the family.
* The right food for pregnant or lactating mothers
* The right food to avoid obesity.
1. Please list briefly what you tell women about a balanced diet.

2. Please list briefly what you tell women about diabetes and hypertension.

3. Please list briefly what you tell women about weaning babies.

4. Do you think that women in your district are (a) very interested in nutrition (b) interested in nutrition (c) not interested in nutrition?

5. What are the major problems you have in teaching women about the right kinds of food for their families?

6. Would you like more training in teaching nutrition? Yes or No

7. What do you think are the most important nutritional problems facing people in your district?

8. How do you think these problems could be overcome?

9. In the last 10 years there has been an increase in children suffering from malnutrition and an increase in underweight babies. What do you think is the reason for this?

10. During 1982 how many underweight babies did you see in your district?

11. How do you think this problem can be overcome?

b. The Committees visited during 1983

<table>
<thead>
<tr>
<th>Committee Name</th>
<th>Committee Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poutasi</td>
<td>Village</td>
</tr>
<tr>
<td>Lepa</td>
<td>Village</td>
</tr>
<tr>
<td>Lotofaga No.1</td>
<td>Village</td>
</tr>
<tr>
<td>Fusi (Savai'i)</td>
<td>Village</td>
</tr>
<tr>
<td>Fusi (Upolu)</td>
<td>Village</td>
</tr>
<tr>
<td>Sa'asa'oi</td>
<td>Village</td>
</tr>
<tr>
<td>Saina</td>
<td>Village</td>
</tr>
<tr>
<td>Vailele No.1</td>
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<tr>
<td>Toapa'ipai</td>
<td>Village</td>
</tr>
<tr>
<td>Utuolili'i</td>
<td>Village</td>
</tr>
<tr>
<td>Faleasitu Moamoa</td>
<td>Village</td>
</tr>
<tr>
<td>Tuamaimata</td>
<td>Village</td>
</tr>
<tr>
<td>Va'isigano No.1</td>
<td>Village</td>
</tr>
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<td>Apia Vini Fou</td>
<td>Village</td>
</tr>
<tr>
<td>Vo'ala Uta</td>
<td>Village</td>
</tr>
<tr>
<td>Louli'ii LMS</td>
<td>Church</td>
</tr>
<tr>
<td>Louli'ii SDA</td>
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<tr>
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<td>Family</td>
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<tr>
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<td>Family</td>
</tr>
<tr>
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<tr>
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<td>Aele Fou</td>
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c. The Committees from which data was collected from infant record cards

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</tr>
<tr>
<td>Vaia No 2</td>
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<td>Vaia No 3</td>
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<tr>
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<td>Vaigano No 3</td>
</tr>
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<td>Matatu Tai</td>
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<td>Leone No. 3</td>
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<td>Pesega No. 1</td>
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<td>Vailele No. 1</td>
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Figure 11-2: Distribution of Women's Committees in Apia, 1983, by Land Tenure
Figure 11-3: Distribution of Village Committees, Western Samoa, 1983
Figure 11-4: Distribution of Church Committees. Western Samoa, 1983
Figure 11-5: Distribution of Family Committees, Western Samoa, 1983
Figure 11-6: Distribution of Neighbourhood Committees, Western Samoa, 1983
Figure 11-7: Western Samoan Health Facilities and Population, by Health District, 1983
Table 11-4: Ratio of Committees to Population, by Health District, 1981

<table>
<thead>
<tr>
<th>Health District</th>
<th>Total Comm.</th>
<th>Total Pop.</th>
<th>Ratio of Comm. to Pop.</th>
<th>Total Women Comm. 20-59</th>
<th>Total Women to Pop.</th>
<th>Total Chi ldren Comm. 0-4</th>
<th>Total Chi ldren to Population</th>
<th>Ratio of Comm. Women to Chi ldren</th>
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Total 552 156,349 1:283 27,844 1:59 22,866 1:41

(Source: *Department of Statistics, 1981  
** Personal Communication, Director of Statistics 1983)

Table 11-5: Women's and Children's Committee Attendance, by Health District, 1982

<table>
<thead>
<tr>
<th>Health District</th>
<th>Women 20-59 Attending</th>
<th>Women % Attending</th>
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<th>Children % Attending</th>
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Total 27,843 14,319 54.82 23,005 13,833 64.0

*Attendance figure given is higher than 0-4 population in 1981 census)
<table>
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<th>Committee Name</th>
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<th>Nurses' Returns</th>
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<td>Fusi (Upolu)</td>
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<td>Aele Fou</td>
<td>Neighbourhood</td>
<td>21</td>
<td>32</td>
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</tr>
</tbody>
</table>

* The nurse had asked only mothers with children under 24 months to attend this clinic.
** A family funeral restricted attendance.
*** Low attendance was remarked upon by both nurse and committee president. The reason was unknown.
(In villages where more than one visit was made the attendance average was used.)
Appendix 7:1

Methodology for Chapter 7

To ascertain the motivation for attendance and non-attendance and how much choice women had over their actions, formal and informal interviews were held with women in Poutasi, Matautu, Faleasini, Afega, Vaiala Tai, Lotopa and Tulaele. A total of 133 attenders and 66 non-attenders were interviewed. The questions regarding attendance, non-attendance and the major reasons for it formed part of the formal household survey. The questions were straightforward.

1. Do you attend the women's committee monthly meetings with the nurse?
2. If yes, what is the main reason for attending?
3. If no, what is the main reason for not attending?
4. If no, would you like to attend the committee?
5. Do you think attending the committee meetings with the nurse are (a) very important, (b) important (c) not very important (d) not important?

Observations and many casual conversations with village women and nurses over 11 months provided additional insights which could not have been gained through formal interviews. A formal questionnaire to district nurses (Appendix 6:1) included questions on what district nurses considered were the major reasons for non-attendance. The questionnaire was answered by 31 of the 47 district nurses. Regular informal conversations were held with 18.

Analysis of the reasons given was based on village type, age and rank.
Appendix 7:2

Case Study No 1: Economic Constraint in a Traditional Village

Eti belongs to one of the poorer families of the village. She lives in the same household as her untitled parents with her three sisters, the husband of one sister, and their ten children. Their small house on the outskirts of the village is poorly maintained and overcrowded. Eti's father is a distant cousin of the family titleholder but as he seldom fulfills agricultural obligations to the matai and is only a distant relative he has only tenuous rights to land. One of Eti's sisters is unmarried, one has a husband who is considered by other villagers to be "lazy" and weak (the term used was vaivai which is usually used to describe women), and the third had a de facto husband who had run off with another woman while she was pregnant with their third child. He contributes nothing towards the upkeep of the family. The only cash income for the entire family is from an older sister who works in Apia as a cleaner. The household has insufficient money to send anyone overseas and remittances received by the matai are never shared, although he is sometimes obliged by the fono to contribute goods on behalf of Eti's family. The members of the household do little agricultural work and all that is planted is eaten. It is widely recognised in the village that the family regularly "borrows" taro and coconuts from other families' plantations. In this predominantly young and female household it is impossible to provide the contribution expected by the church, the committee, and the village, and over the last ten years the family has slowly become further marginalised as the difficulties of providing contributions has increased. One sister attended the committee three or four times after the birth of her first child, but felt embarrassed because of her poor contribution and because she did not have pretty clothes for the baby and because "other women laughed and talked behind my back". Eti and her sisters say they would like to attend the committee, but feel constrained not only by lack of money but by the attitude of other women towards them and their household. The only time their children have been seen by the district nurse was when they were immunized "because the nurse came and said that we would get into bad trouble if we didn't take them to the hospital for it." The younger children show signs of under-nutrition. They are thin, pot-bellied and covered in scabies.

Case Study No 2: Political Constraints to Attendance in a Semi-Traditional Village

Neia's husband has a high ranking title in a village where there are four titles of approximately equal rank. Leadership has been continually disputed over the last twelve years and a great part of the fono meetings are spent attempting to settle disputes between the families of these men. Since 1981 land has been the major issue of contention. The government granted the village 100 acres of Crown land to help overcome a serious shortage of agricultural land, but left the division of it to the village leaders, who could not agree on how it should be apportioned. The dispute took on political overtones prior to changes of government leadership in 1982 and the emergence of two national political parties. Each village faction supported a different political leader and those who supported the man whose government was
responsible for granting the land maintained they had the right to apportion it as they saw fit. The dispute led to open violence. For forty years the village had supported a large and well organised women's committee with an executive made up of the wives of the highest ranking men. When the dispute over land initially arose, women ignored it and went ahead with plans to raise funds for the committee to visit New Zealand but following the politicisation of the dispute, the treasurer, who belonged to a different faction from the president, let it be known that she was concerned about the money for the New Zealand visit and did not know what the president was doing with it. No direct accusation was ever made and it was not discussed openly in public where the president could have clarified the situation. It was recognised by women as an excuse for open conflict. Neia and the women of her family refused to attend a committee led by "that other woman who steals our money and our land". The two groups of women now refuse to speak to one another and their co-operative ventures that benefitted the entire village have collapsed. In the past the women had a roster for policing the fresh water pool and the main road while children cross it to and from school and worked together to put in proper concrete and river-stone bases for their outdoor showers. Nobody works together to carry out these activities now and Neia says that she "wouldn't dream of working with those other women". She is talking of beginning her own committee "only for our people".

Case Study No 3: Social Isolation in a Modern Village

Sina and her husband Ioane moved into Apia from a rural village in Savai'i in February 1983 with their four children aged seven, six and four years and 11 months. They had been instructed to come by Sina's maternal uncle who wanted Sina and her husband to look after his wife's house while he and his family were away in Hawai'i. The length of his absence was unknown. Before leaving he gave them T$100 ($A75) and suggested that Ioane get work on the wharves nearby. Ioane manages to get occasional work, but ships are infrequent and there is a large pool of labourers. Work is available one or two days a week and pays T$10 a day.

Six months after moving to Apia, Sina knew nobody. Her uncle's wife's family had not approached her. She had not been asked to join the women's committee, nor was she advised when the nurse visited. When I spoke to other village women about Sina they had either never heard of her or stated in a derogatory way that she was "from out the back". When I visited the household in July the smallest child was extremely thin, had a large bruised lump on his shoulder and an arm that appeared broken or out of joint. Sina told me that six days previously he had fallen down the steps of the fale. From the location of the abrasions it looked to me as though the child had been hit. He had had no medical treatment and had not been taken to the hospital because Sina "didn't like to take him" because she was unsure how to go about it and who to see. She was also afraid that people would not help her because she was from "out the back" and that the child would be hospitalised which would necessitate her staying at the hospital with him, leaving nobody to look after the other three children who were not attending school. When I asked if she had taken the child to the fofo (traditional healer), she said she didn't know of one nearby. As the monthly committee meeting was to be held two days later I suggested that she take the child to see the district nurse.
When I called four days later, the child was in a worse condition, in obvious pain, not eating and had a bad cough and difficulty breathing. Sina had not gone to the committee because she felt that other women hated her and did not want her to join them. She did not have the money to buy the contribution that she thought would be expected. In Savai'i she had always taken taro and shellfish, but in Apia, all the goods had to be purchased. The only solution she saw open was returning to Savai'i with the child to see her own village fofo or the district nurse, but as the child's condition had become so bad she was embarrassed to do this. She said the nurse would be angry with her and it would be bad for the family. Returning to Savai'i was impossible anyway as Ioane had had no work for a week and there was insufficient money for food, let alone the bus and boat fares.

I encouraged her to take the child to the hospital and when I called three days later she had done so, but had visited casualty, had been seen by an Indian doctor who spoke no Samoan and who prescribed cough medicine. The child's shoulder was much worse and inflamed. A Samoan friend of mine took Sina and the child to the Family Welfare Clinic that day. The child was admitted with a broken arm, dislocated shoulder and pneumonia. He was in hospital for three weeks.

When I left Samoa in December, Sina remained isolated and without acquaintances. None of the children was at school. Nobody from the church, just a few doors away, had visited her and she did not feel sufficiently confident to join the congregation.

Case Study No 4: Constraints in a Non-Traditional Village

Ana lives in a "European" house with her husband and five children. The land and house belong to her mother but were paid for by contributions from Ana and her brothers and sisters. Other members of the family from all over Samoa stay here when in Apia, but much of the time it operates as a nuclear household. Although Ana's husband has a regular office worker's salary it is difficult to maintain the family on this, particularly as they have insufficient land for growing food. When other relatives visit, they bring taro and fish, but expect Ana to provide meat and other expensive store-bought food. They consider that Ana and her husband lead "easy lives" with "easy money" and ignore the high cost of urban living and the financial difficulties Ana faces attempting to maintain her household and five small children. She feels obliged to accommodate relatives and to feed them well and has to borrow money to do so.

Ana has lived just around the corner from the president of the committee for six years but was not asked if she would like to attend the committee until 1981. She attended irregularly for 18 months but stopped when she became pregnant again. This coincided with the election of a new committee president, who expected better food contributions and wanted women to provide better quality goods for the aiatasiga. The smallest acceptable food contribution was two tins of fish which cost T3. In addition to providing food, women were expected to contribute at least T2 each month to the Christmas fund. An additional contribution of 50 sene a visit was imposed by the new president to pay for electricity. Ana's reaction was:

This 50 sene business, its a rip-off. The new president
demands things from the people. I won’t go any more. Anyway it’s just weighing kids and painting spots and if you ask for medicine she just says “go to the hospital and get it”, so you may as well go to the hospital in the first place. And you have to bring food for the nurse’s visit… a tin of fish, pisupo (tinned corned beef) or chicken. It would be embarrassing to take nothing. You wouldn’t be banned, but people would laugh behind your back. And these days they’re all old women. They’ve got nothing better to do. Young women are too busy for that kind of rubbish.

Ana felt with a new infant on the way the committee was more than she could afford as her husband gave her housekeeping money only spasmodically and visits from relatives used up anything she had saved. Ana also felt that the difficulties in getting the children to the meeting made it not worth the effort. There was nobody at home to help or to care for the four and five year olds while she took the other three to the committee. Trying to carry food, goods for the asisiga and the smallest children and at the same time attempt to shepherd the other along a muddy road and get them to the committee clean was hard work. Ana maintained that another reason for stopping attending was that the staff at the hospital were better trained than the district nurses and if necessary she could have the children seen by a doctor. However, she admitted that she attended the hospital only when the children were very sick, as it was difficult to get them all there for regular checks and in a neighbourhood where people didn’t want to know one another, she could not ask them for help. All the children had been innoculated at the hospital because she had heard on the radio that it was very important.
Appendix 7:3

Discussion Paper on the Problem of Families Not Belonging to the Women's Committees

A. Factors Contributing to the Problem

1. Many health workers are "high-minded" and do not see their roles as one of servitude to the people (matai syndrome).

2. Women leave women's committee because they cannot afford it, (time and money) - too many obligations to women's committee, to hospital and for frequent visitors.

3. Political and family feuds usually between village matais often affect women's committees and force them to split up.

4. Dislike or suspicion of a President or Secretary also causes women to break away.

5. Some women who break away form splinter women's committees, others choose not to belong to any at all.

6. The SMP (skimmed milk powder) project has contributed to the problem.

7. Some women do not perceive any advantage at all in belonging to a women's committee since health care services are given equally to all people whether women's committee members or not.

8. Some members of the public both as individuals and in collective groups, tend to view the problem, as belonging exclusively to the Health Department and not as a problem that is their concern. Whatever assistance they give towards solving the problem is seen as something they are doing to help us. The Health Department and the service it gives to people is somehow perceived as a service that we give in order to benefit ourselves (the workers/givers) rather than as a service given to benefit them (the receiver/consumer). This attitude is fundamental to the problem and one the department will need to change before it will succeed in achieving greater community participation for self-reliance in health.

B. Possible Solutions

1. Launch some sort of campaign/meeting, health talks etc. to educate the public about the purpose and objective of the Health Department, that is, to help people to help themselves - to keep good health, to quickly regain good health etc.

2. The health worker must also fully understand their true role as one of service, through the primary health care approach. These concepts must be emphasized during under-and post-graduate training and be constantly reinforced thereafter.
3. The influence of the district nurse is considerable. She needs to try and limit time (during committee meetings) for traditional rituals, eating etc. and to educate women to place more value on simple, locally produced, less expensive food and goods - and reduce the quantity! Some district nurses have managed to achieve this!

4. The district nurse should also become less involved with the actual meeting or committee matters but rather concentrate on the conduct of her clinic and follow-up of children and women. The Pulenuu, Alii and Faipule of the village and districts should be made aware of the importance of the health aspects of women’s committee activities.

5. Women’s health committees should consist of no less than 15 families except under special circumstances e.g. inland settlements. Pulenuu etc. should exercise some control or mediatory influence to prevent the formation of small committees, and to bring together splinter committees. The Department will need to adopt a firm policy in this regard and inform all responsible bodies and the public with meetings with Pulenuu, Committee Presidents, Alii and Faipule.

6. A policy for the National Hospital and Tuasivi Hospital must be decided in respect of accepting people from the district for routine medical care. Quite a number of people can avoid being involved in women’s committees and in supporting the district hospital or health centre, by simply going to the National Hospital in Upolu or going to Tuasivi Hospital in Savai'i. This should be discouraged by not accepting them for attention unless in the case of transfer or an emergency, or where there is no doctor working in the district.

7. District Nurses should continue to homevisit non women’s committee families while the public is being informed about policy changes but it must be made clear to these families that the Health Department will soon discontinue giving them this very privileged service, therefore they must join a women’s committee.

8. In the Apia urban area, if families will not or cannot join a women’s committee that family may receive attention at the National Hospital or Family Welfare Centre. These people also have a choice to see a private doctor! Home visiting in Apia should not be necessary, except under special circumstance.

(Source: Department of Health, Apia (mimeo))
Appendix 7.4

District Nurses’ Comments on Committee Non-Attendance

“When the baby is a bit big they stop coming. Many women are too lazy to come. They would rather sit at home when the baby is getting to one year...maybe they have two. It’s a bit hard to come, so they don’t bother. Usually they stop at about 12 months. They are stupid and lazy. They don’t use their heads. When I call to see them on home visits, they say they come to Family Welfare Clinic...but they don’t. It’s a big lie. Some say their husband won’t let them. That’s big lie too.”

“Many mothers only bring the child for 12 months - until it has had its innoculations. They never come again...many don’t come because they are ashamed. They have to bring things and don’t like to any more, or they don’t have the money for it. This is a big reason why they don’t come. But some are lazy. They don’t bother about their children.”

“There are many small groups in town...but women still don’t come. They make lots of excuses. They say they are going to the clinic at the hospital. We can check to see if they have the clinic vaccination cards. If they don’t we call and see them again. They use lots of excuses. Many are just lazy. But we can’t force them.”

District Nurse’s Comments on the Difficulties of Young Nurses

“Some of the young nurses like me, we are not high enough for them if we are young and don’t have husbands who are matai. Then women don’t come. They get lazy to come. It’s all right for older nurses like Olive, whose husbands have titles or work in the Treasury. I can ask them to do things and they don’t do it. I can’t fine them. Only the president can and in town she can’t even do that. I can’t force them to do anything. I can only say do this ... like put a door on the toilet. For me they are lazy to do it. And it is difficult to talk to the older ladies. They will listen to Olive but it is difficult if you are not high up. They think that if you are young, you don’t know anything and that they know more than you. And they don’t like to be told anything by anyone who is younger than them. It is difficult. But they don’t know about bottle feeding, or the foods we eat these days. They came from the villages and it was different then. But they think they know all about it. You have to have a lot of patience and keep trying to tell them without getting angry. I sometimes feel angry when I see children being given bad food. They think they know and they don’t. And many mothers work and don’t care about their children. They just leave them and won’t come to the committees. They don’t want them. Many are too young and some are too lazy.”
Table 11-7: Reasons given by District Nurses for Declining Women’s Committee Attendance

<table>
<thead>
<tr>
<th>Nurse’s Replies</th>
<th>Percentage of Replies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Women’s Lack of Interest</td>
<td></td>
</tr>
<tr>
<td>Mothers are too lazy</td>
<td>20</td>
</tr>
<tr>
<td>Women aren’t interested</td>
<td>9</td>
</tr>
<tr>
<td>Conflict</td>
<td></td>
</tr>
<tr>
<td>Disagreement between women and president</td>
<td>14</td>
</tr>
<tr>
<td>Disagreement between women in the committee</td>
<td>6</td>
</tr>
<tr>
<td>Conflict between village families</td>
<td>3</td>
</tr>
<tr>
<td>Women don’t like being told what to do by</td>
<td>1</td>
</tr>
<tr>
<td>the President</td>
<td></td>
</tr>
<tr>
<td>Women think the President is “too high”</td>
<td>4</td>
</tr>
<tr>
<td>Lack of Cooperation</td>
<td></td>
</tr>
<tr>
<td>Women will not cooperate with one another</td>
<td>5</td>
</tr>
<tr>
<td>Lack of Authority</td>
<td></td>
</tr>
<tr>
<td>Nobody makes them attend now</td>
<td>5</td>
</tr>
<tr>
<td>They all want to be president</td>
<td>2</td>
</tr>
<tr>
<td>There is no village control now</td>
<td>4</td>
</tr>
<tr>
<td>Other Health Options</td>
<td></td>
</tr>
<tr>
<td>They can go to the hospital</td>
<td>3</td>
</tr>
<tr>
<td>Prefer to go to the traditional healer</td>
<td>3</td>
</tr>
<tr>
<td>Faith in God, not in the nurse</td>
<td>3</td>
</tr>
<tr>
<td>Expense</td>
<td></td>
</tr>
<tr>
<td>Contributions are too expensive for some</td>
<td>8</td>
</tr>
<tr>
<td>Other Constraints</td>
<td></td>
</tr>
<tr>
<td>Some husbands object (too much gossip)</td>
<td>5</td>
</tr>
<tr>
<td>Some have too much work</td>
<td>5</td>
</tr>
</tbody>
</table>

*The nurse’s full comment was: “Some mothers have no faith in the nurse. They believe God heals sick people. That’s why they don’t attend the committee.”*
Appendix 8:1

The Nutritional Curriculum for Nursing Training, 1982-3

Preclinical Class (year 1)

Nine lectures on nutrition over two months with weekly evaluations.

1. Course outline and introduction to nutrition
2. Food and its function in the body (2 lectures)
3. The three food groups (2 lectures)
4. A balanced diet/malnutrition
5. Nutrition and dietary disease
6. Food services in the hospital wards (2 lectures)
7. Hospital diets

1A Class (year 2)

Twelve lectures, covering four months.

1. Diet for burns
2. Diet for gastritis and gastric surgery
3. Anaemia and its relationship to diet
4. Obesity and cardiac conditions
5. Diabetes mellitus
6. Factors affecting the nutrition status of the community (2 lectures)
7. Teaching nutrition in the community (5 lectures)

2B Class (year 3)

18 lectures over 4 months

1. Food needs of pregnant and lactating mothers
2. Food needs of the 0 - 1 year old (2 lectures)
3. Food needs of preschool children
4. Food needs of school children
5. Food budgetting (2)
6. Factors affecting the nutritional status of children in the community (2 lectures).

Teaching nutrition in the community (7 lectures) to commence late 1983. Community education lectures will include:

1. Recognising infant malnutrition
2. Malnutrition: teaching parents
3. Learning traditional custom (how to behave properly in the committee and how to talk to the matai).
4. How to find out about family problems
5. How to find out what the family eats
6. How to be sure about correct etiquette
7. How to give demonstrations
8. How to show women how to budget
9. How to keep people's attention
10. How to use games to help teach people
Appendix 8:2

Infant Nutritional Information Taught at the Nursing School

The composition of breastmilk together with the reasons why infants need supplementary fruit and vegetable juice (lemon, papaya, tomato and coconut) at three to four months. The role of vitamins and minerals in infant diets was taught together with the ways in which fruit and vegetables should be cooked to retain nutritional value. The introduction of mashed fruit at four months as well as such traditional Samoan weaning foods as vaisalo (arrowroot with coconut cream) and sua esi (papaya soup). The introduction of polesi (porridge), saito (sago), sua alaisa ma le susu (rice cooked with milk). The introduction of solids slowly and in small amounts, with one new food at a time. By the time a child is 12 months old, it should be eating the same selection of food as the family, which should include protein as well as green, white and coloured vegetables. It is stressed that infants' food must be well mashed and that children should eat with the parents. Each nurse is provided with, and shown how to use, a flip chart (produced by Glaxo and SPC) which outlines in Samoan language the recommended food-for-age by month. The nurses are also taught how to interpret the weight and height graphs in relation to recommended weight-for-age on the new infant record cards; to recognise symptoms of under-nutrition and other feeding problems and to provide practical, remedial advice.
Appendix 8:3

Nurses’ Replies to Questions on Adult and Infant Health and Nutrition

District Nurses’ assessment of 3 most common health problems of infants

- Scabies and skin infections (28)
- Diarrhoea and Gastroenteritis (24)
- Underweight/lack of food (20)
- Coughs and chest problems (14)
- Fevers (12)

District Nurses’ assessment of 3 most common health problems of adults

- Diabetes (18)
- High Blood Pressure (18)
- Heart Problems (8)
- Diarrhoea/stomach upsets (8)
- Chest complaints (6)
- Scabies and boils (6)

Some reasons given by District Nurses for poor infant and adult Nutrition

1. “Too much reliance on starchy food.”
2. “They rely too much on store-bought food.”
3. “Too much sugar and not enough exercise. People are lazy to work.”
4. “Some spend too much money on beer and cigarettes.”
5. “Some want to live like the palagi but they don’t know how.”
6. “They are too lazy to grow vegetable gardens for food, but they are aware of what has been taught by the district nurse and the programmes broadcast by 2AP (the radio station).”
7. “They refuse to prepare Samoan food because their village thinks them very low.”
8. “Too much money and food goes on church contributions.”
9. “Some do not understand the importance of the right food for their health, but some do, but refuse to buy it and some know the importance but do not have the money to buy it.”
10. “They need to understand more fully, because good food is not expensive.”
Figure 11-8: The SPC/Fiji National Food and Nutrition Committee Islands Food Poster
Figure 11-9: A Selection of SPC Nutrition Posters
Fafaga pea i mea’ai e pei ona masani ai ile 3-5 masana’ae fa’aatele le aoafa’iga. Fafaga muamua le mea’ai ona fa’asusu lea. Auaua’i mea’ai faapenei:

**TAEAO**
- Fa’i pula ua palu fa’araga
- Su’a ala’a fa’asusu po’o se ‘ulu palu pula de susu (1/2 iputi)
- Suasusu ole tina’o po’o le susu fagu.

**Vai’a Aiga ole Taeso**
- Su’a se fia’ala’au ‘aina suamalie po’o se esi pula ua palu lelei.
  (1/2 iputi)
- Fa’asusu de susa ole tina’o po’o se fagau susu.

**AOAULI**
- Su’a se fia’ala’au ‘aina suamalie po’o se esi pula ua palu lelei.
  (1/2 iputi)
- Suasusu ole tina’o.

**Vai’a Aiga ole Aoauli**
- Su’a se fia’apauna po’o le susa ole nui.
  (1/2 - 1 iputi)

**AFIAFI**
- Su’a se fia’ala’a su’a ‘aina, mase mea’ai masoa e iai talo, ‘ulu, fa’i ala’a ma se susu.

A leau se i’a manu fasi, i’a po’o se fuamoa, fa’aloa le susu pauta, e palu i mea’ai masoa ma fafa’aga ai lea pepe.

La manatua ole pepe olo’a vave lana tuputupu a’e, ma e mana’omia tele fofa mea’ai Fa’atupu Tino ma mea’ai e mea’ai le Soifua Maloloina. O se pepe ola maloloaina lelei e mana’omia e ia mea’ai mai vasega e 3 o mea’ai i aso talatasi. Fa fa’aatele faaua’i le aoafa’iga o mea’ai le pepe e’i a’i.

**Figure 11-10:** The 1956 SPC Maternal/Infant Nutrition Poster used here in an Infant Feeding Calendar produced in 1982
Figure 11-11: The WHO World Food Day Poster, 1982
Appendix 9.1

Methodology and Questionnaire for Determining Women's Nutritional Knowledge

There were basic problems in attempting to find how much nutritional knowledge women could recall as time-lapse between receipt of information and being interviewed varied, as did women's ability to express what knowledge they had. The information scores are based therefore on what women could impart to me. All committee attenders interviewed had attended a meeting in the preceding six months but may not have received information on the same nutritional topics. It is likely that a few women who claimed not to attend committees had attended them some time in the past.

Although it is accepted that knowledge, attitude and practice (KAP) tests are not a satisfactory means of testing information dissemination\footnote{They do not allow for the flow of information over time and data is usually collected from only one point [see Rogers 1976:208-209].} no more adequate method has been put forward. I have therefore used a modified version of a formal KAP test together with informal interviews. While this was still inadequate, it provides some indication of the information women receive and how they perceive it. The way results are patterned afford it validity. One hundred and ninety-nine women, (66 non-committee members and 133 committee members) from six communities were interviewed, including two total populations. All women between the ages of 20 and 59 who were present in Poutasi and Vaiala villages during the weeks in which interviews were conducted were interviewed. All women of the same age group living within 200 yards of the major crossroads in the centre of the suburb of Tualele were interviewed. The sample was made up of a random sample of women from the villages of Salasa'ali, Fasito'otai and Lotopa.

The questionnaire was constructed in the following way:
I personally administered the questionnaire and recorded all replies. The questionnaire was administered in Samoan or English depending upon the respondent's preference. I was assisted by two Samoan interpreters, both of whom I had worked with during previous periods of research. One is a secondary school teacher, the other had secondary education in New Zealand.

Women were first asked a series of questions on general nutritional knowledge and practice, designed to give them a chance to recall information. More detailed information was then sought on the three major nutrition topics - family nutrition (balanced diet and the three food groups), obesity-related information and infant nutrition. Answers to each of these three sectors was considered together with informal comments women made, and scored from zero to five, with a total score of zero to fifteen. The marking was based on the Nursing School nutritional curriculum and information disseminated by the Nutrition Centre. Many questions were open-ended and while this made scoring and analysis more difficult and open to my own value judgement, I do not believe it possible to gain this kind of information with close-ended questions. Throughout the interviews informal discussion was invited. I have included here only the final portion of the questionnaire.

Section E

1. Have you ever been told anything about the kinds of food that are good for the family's health? Yes/No

2. If yes, what did you hear?

3. Where did you hear this information? (If two replies were given, the most important was asked for).
4. Did you discuss this information with anyone else? Yes/No
5. If yes, with whom?
6. Do you think this information was (a) very important, (b) not very important, (c) not important?
7. Did you try to use this information? Yes/No
8. If no, why?
9. If yes, are you still using it? Yes/No
10. Have you ever heard any information about a balanced diet? Yes/No
11. If yes, what did you hear?
12. What else can you remember? B (If women had not mentioned the three food groups in the preceding answers, they were asked if they had heard about it and if so, what they had heard.)
13. Who told you about this?
14. Did you talk about this information with anyone else? Yes/No
15. If yes, who did you talk about it with?
16. Did you think this information was (a) very important, (b) not very important, (c) not important.
17. Did you try to use this information? Yes/No
18. If no, why not?
19. If yes, are you still using it? Yes/No
20. If no, why not?
21. If you wanted to make one balanced meal for the family, what kinds of food would you use?
22. If it would be easier, you could use these pictures. Choose the pictures of the different kinds of food you think together would make a balanced meal.

Section F

Can we now talk for a little time about the food for babies and children?

1. Did you breastfeed your babies? Yes/No
2. If no, why?
3. For how long did you breastfeed your: first child, second child,...etc.

4. At what ages did you introduce solid foods, or foods other than milk?

5. What were the first kinds of solid food you gave?

6. Who told you about the kinds of food to feed your babies?

7. Whose information was most important to you?

8. What other information have you heard about feeding babies less than twelve months old?

9. Who told you this?

10. (If the source of information was NOT the district nurse the following question was then asked)

11. What does the district nurse tell you to feed babies less than twelve months old?

12. Do you think this information is (a) very important (b) not very important (c) not important?

13. Did you talk about this information with anyone else?

14. If yes, who with?

15. Do you use the information the nurse gives you? Yes/No

16. If no, why not?

17. What have you heard about feeding children over twelve months old?

18. Who did you hear this from?

19. Whose information do you think was most important?

20. Do you think this information is (a) very important (b) not very important (c) not important?

21. Do you use the information? Yes/No

22. If no, why not?

23. Some people in Samoa say that many people are overweight, or very fat. Do you think they are right or wrong?

24. Do you think it is good to very fat. Yes/No

25. Have you heard of any sicknesses people get because they are very fat. Yes/No
26. If yes, what kinds of sicknesses?

27. Why do you think some people become very fat?

28. Have you heard any information about the kinds of food you can eat so you so not become overweight? Yes/No

29. If yes, what have your heard?

30. Where did you hear this information?

31. Have you talked about this information with anyone else? Yes/No

32. If yes, who with?

33. Did you think this information was (a) very important (b) not very important (c) not important?

34. Do you use this information? Yes/No

35. If no, why not?

36. If yes, are you still using it? Yes/No

37. If no, why not?

38. Finally, here are the three last questions. Do you think the women in Samoa have enough information or education about food that is good for the health of their families? Yes/No

39. Who do you think are the best people to give information about your health and the kinds of food that are good for the health of the whole family?

40. Is there anything you would like to say about the women's committee clinics and the way you get information about food for the family from the nurse or other visitors?

41. How do you think the committee clinics could be improved?
Appendix 9.2

A Selection of Women’s Replies to Questions on Family Nutrition

Replies from Taulele’a

We should eat protein, vitamins and carbohydrate and drink lots of water - that’s about all I have heard.

We must use green vegetables and drink cow’s milk and have three meals a day.

You must balance your food and have coconut, pawpaw, mango and taro.

You must take care of food like meat, especially pork. Some animals are sick. And we must plant more vegetables for the family’s food.

We should eat three kinds of food a day - like fish or meat, cabbage, milk, pawpaw and bananas.

The nurse said to eat breadfruit, fish and vegetables, because they make a balanced diet and are good for the family.

They tell us (the nurse) how to balance your diet. You must change the kinds of food you eat each day.

Replies from Tama’ita’i

They say use vegetables in soup (stew) with mutton flaps. If you use the right kind of food then each meal should include vegetables, meat, starchy food, some fatty food and some fruit.

The nurse says we must eat the right food and choose one kind from each of the three groups. Protein, vitamins and carbohydrate. We need fish, eggs, meat or sea-food eaten with fruits and also with taro, yam or banana. A food from each of these kinds should be eaten by the family each day.

Well I know about how to balance the family’s food. To give some protein, some vegetables and a vegetable of each colour for each meal. The family needs a mixture of foods ... some of this information is important for me, but for some it is not. It’s a matter of education...and lack of finance. For some people it is ignorance. They don’t know and have very limited knowledge about how and what to cook.

Replies from Matai

We should eat foods which are good. For example fruits, green vegetables, meat, fish, taro and breadfruit. And I know about the three groups of food. About protein, meat, fish and egg. About
vitamins - that's fruit - mango, pumpkin and green vegetables. And then there's breadfruit, taro, bread and bananas.

We should have protein - fish, eggs and meat. And vitamins - vegetables, fruit, mango, pawpaw and then carbohydrates which are taamu, breadfruit and bread. One of each of these with bread and tea is a balanced meal.

I've been told by the district nurse about three kinds of food. Proteins like meats, fish and eggs. Vitamins are in vegetables and green fruit and then there's carbohydrates in taro, yam, breadfruit, bananas and bread... we should eat them all.

To stay healthy we must eat the right kinds of food...any food from the three food groups each day. And we need plenty of exercise and not over-eat.
Appendix 9.3

A Selection of Examples of a Balanced Diet given by Women

1. Taro, bread, breadfruit, coconut cream
2. Tinned fish with onion, fa'afifu, taro, mutton flaps, rice.
3. Umu taro, palusami, fish (This is a traditional Samoan meal).
4. Bread, jam, biscuits, tinned fish, taro, rice.
5. Chicken, tomato, beans, taro, bread, rice.
6. Tinned corned beef, taro, breadfruit, green bananas, coconut cream.
7. Seafood, fresh fish, taro, breadfruit, chicken.
8. Chicken backs, fa'afifu, taro, bananas, vaisalo.
10. Fish, seafood, pork, chicken, palusami, taro, green bananas, breadfruit, soup, noodles, bread, jam, cake.
### Women's Nutritional Information Scores

**Table 11-8: Incidence of Nutritional Information Total Scores by Committee Type and Women's Rank**

<table>
<thead>
<tr>
<th>Total Score</th>
<th>Matai Tam*</th>
<th>Tau*</th>
<th>Matai Tau</th>
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</thead>
<tbody>
<tr>
<td>N=</td>
<td>28 12 44</td>
<td>13 14</td>
<td>10 12</td>
<td></td>
</tr>
<tr>
<td>&lt;4</td>
<td>0 0 0 2</td>
<td>0 7 0 17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4-5</td>
<td>29 10 27</td>
<td>15 7 10 25</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5-7</td>
<td>57 8 55</td>
<td>8 22 70 41</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8-9</td>
<td>14 57 16</td>
<td>69 50 20 17</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&gt;9</td>
<td>0 25 0</td>
<td>8 14 0 0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Tau = Taulele'a  *Tam = Tama'ita'i

Significance of variance between clinics $\chi^2 = 33.08, p > 0.001$  
$df = 8$

Significance of variance between total score of attenders and non-attenders $\chi^2 = 19.15, p > 0.005$  
$df = 4$
## Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>AJHR</td>
<td>Appendices to the Journals of the House of Representatives</td>
</tr>
<tr>
<td>CETC</td>
<td>Community Education Training Centre</td>
</tr>
<tr>
<td>FAO</td>
<td>United Nations Food and Agricultural Organisation</td>
</tr>
<tr>
<td>FPSP</td>
<td>Foundation for the Peoples of the South Pacific</td>
</tr>
<tr>
<td>SPC</td>
<td>South Pacific Commission</td>
</tr>
<tr>
<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organisation</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Fund for Population Activities</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Childrens Fund</td>
</tr>
<tr>
<td>WFP</td>
<td>World Food Programme</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
</tr>
</tbody>
</table>

## Glossary

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>afekasi</td>
<td>person of mixed blood</td>
</tr>
<tr>
<td>ai</td>
<td>to eat</td>
</tr>
<tr>
<td>aiga</td>
<td>family</td>
</tr>
<tr>
<td>aitu</td>
<td>spirit or ghost</td>
</tr>
<tr>
<td>ai'i</td>
<td>titular chief</td>
</tr>
<tr>
<td>asiaasiaqa</td>
<td>display of household goods in the women's committee</td>
</tr>
<tr>
<td>aualuma</td>
<td>group of women who are resident in their natal village</td>
</tr>
<tr>
<td>aumaga</td>
<td>untitled men of the village</td>
</tr>
<tr>
<td>elemi</td>
<td>tinned fish</td>
</tr>
<tr>
<td>esi</td>
<td>pawpaw (<em>Carica papaya</em>)</td>
</tr>
<tr>
<td>fa'alupega</td>
<td>traditional phrases in formal language that give the name, rank and genealogy of families</td>
</tr>
<tr>
<td>fa'a Samoa</td>
<td>customs and traditions of the Samoan people</td>
</tr>
<tr>
<td>fafine</td>
<td>woman</td>
</tr>
<tr>
<td>fafine laiti</td>
<td>wife of an untitled man</td>
</tr>
<tr>
<td>faguna</td>
<td>bottled soft drink</td>
</tr>
<tr>
<td>fa'i</td>
<td>banana (<em>Musa spp.</em>)</td>
</tr>
<tr>
<td>fa'fe'a'u</td>
<td>pastor</td>
</tr>
<tr>
<td>falaoa</td>
<td>bread</td>
</tr>
<tr>
<td>fale</td>
<td>house</td>
</tr>
<tr>
<td>fale talaga</td>
<td>women's weaving group</td>
</tr>
<tr>
<td>fale tele</td>
<td>guest house used for meetings</td>
</tr>
</tbody>
</table>
faletua
faletua ma tausi
fofo
fonatia
fono
fu'alua
fu'alua aina
fuamoa
ia
ite toga

ifo
kapisi
kava
komiti
lau
laulau
lau manioka

laupole
laupolo
lautalo
maa
ma'i
ma'i gau
ma'i aitu
mama
maile
malaga
malosi
mamalu
mata
matai

mau
maukeni
mea ai
mea'ai lelei
mea alofa
misiluki
momoe
moa
niu
nu'u
palagi
palusami
pe'epe'e
pelesittini
pi

wife of a titular chief
wives of chiefs and orators
traditional healer
doctor
a formal meeting of chiefs
vegetables
green vegetables
egg
fish
fine mat used for ceremonial purposes
formal apology
ceremonial drink made from the root of Piper methysticum
committee, originally komiti
tumama or women’s health committee leaf
food trays made of woven leaves
leaves from the cassava plant (Manihot esculenta)
green vegetable (Hibiscus manihot)
leaves from the pumpkin plant
taro leaves
shame
sickness of the body (broken sickness)
sickness caused by spirits
masticated food fed to infants
open space in the centre of the village
ceremonial journey
strong or to feel strong
honour or dignity
green
chief, usually the titled leader of the family. Also used to refer to the wife of a chief
Samoan independence organisation
pumpkin
food
good food
gift
ladyfinger banana
mutton flaps
chicken
coconut
village
European
coconut cream cooked in taro leaves
coconut cream
women’s committee president
bean or pea
pīsupo  tinned corned beef
ptonu’u  sub-village
polesi  porridge
pule  control or authority
pulenu’u  village government official
slaito  sago
sao tama’ita’i  leading tama’ita’i
sua i’a  fish soup
sua fa’i  banana soup
sua est  pawpaw soup
supo  soup
susu  breastmilk
susu apa  tinned milk
susu pa‘ata  powdered milk
ta‘amu  root crop (Alocasia maccorrhiza, and Xanthosoma sagittifolium)
tai  on the coast side
talo tara  major staple food (Colocasia esculenta)
talo pa‘ia  ceremonial presentation of food
at district level
tama  son
tama’ita’i  women living in their natal village

taule’ale’a (pl. taulele’a)  an untitled man, also used to refer to the wife of an untitled man

taumafa tatau  let’s eat right (slogan for World Food Day 1982)
taupou  village ceremonial virgin
tausi  wife of an orator
tautua  to provide service or goods
ti  leaves of the Cordyline terminalis used for healing
tulafale  chief holding an orator’s title
tumu fai  banana blossom
ufi  yam (Dioscorea esculenta)
ula  necklace
ulu  breadfruit (Artocarpus altilis)
tua  inland or at the back
umu  cooking oven made of hot stones covered with leaves
vaʻisalo  porridge made of the flesh of young coconut
vaivai  weak
vi  Samoan apple (Spondias dulcis)


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