The Samoan Women's Health Committees: a study of community vulnerability and resilience

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Presented at the NZ Development Network Conference, Otago University, November 27-29, 2014

Introduction

On November 7, 1918 the ship *Talune* arrived in Apia, Samoa. Passengers carrying Spanish Flu went ashore. Six weeks later, over a quarter of the Samoan population was dead[1]. Mortality was selective. Those who were obese were particularly prone. 45 per cent of Samoan chiefs and 50 per cent of Samoan pastors or priests died[2]. Of the 31 members of the *fono* of high chiefs only seven survived. *Whole villages were wiped out, houses fell into disrepair, plantations became over grown and the death of nearly half the sacred and secular leaders threw villagers into confusion* (see Pirie 1963:78) This catastrophic event was the key catalyst to the establishment of the Samoan Village Women's Health Committees – and over time to changes in women's roles, authority and economic activity. They also improved health and helped a rapid reduction in infectious diseases.

Today, with the focus of many development initiatives on promoting community-based programs and partnerships, the history of what are now known as the Samoan Women's Committees has particular resonance. The way in which the committees were established in 1923 provides a model that is as relevant today as it was 90 years ago[3].

This paper considers the key factors that influenced the establishment and resilience of the Samoan Women's Committees, which by 1929 were considered to be "a brilliant illustration of the possibilities of preventive medicine" (Lambert 1928:3). It also considers how over time the committee changed women's status and responsibilities. The paper has four main sections:

1. The context/preconditions for establishing the committees
2. Samoan values and village structure
3. Key factors in establishing the committees
4. Adaptation, change and resilience

The context and pre-conditions for health intervention

[1] See J.H. Davidson 1967 *Samoa Mo Samoa*, Oxford University Press, Melbourne, pages 91-92. On p 94 it is suggested that the Samoan epidemic 'ranks as one of the most disastrous epidemics recorded anywhere in the world during the present century'.

[2] See Pirie 1963 and Latu Latai 2014

[3] For a deeper discussion on the prerequisites for establishing the committees, the administrative philosophy, maintenance and resilience see Pamela Thomas 2001:532-39 ,'Empowering community health: Women in Samoa', in Oxford Handbook of Public Health Practice, Pencheon D, C Guest, D Melzer and J Muir Gray (eds) Oxford University Press, Oxford

Early accounts of Samoa are unanimous in stressing the peoples' "*superior physical development and generally robust, healthy appearance*" (Stair 1889). La Perouse in 1787 describes Samoans *"the tallest and best made we have yet met… their stature is less astonishing than the colossal proportion of the different parts of their bodies"*. The French are reported to have felt puny beside them. But following European contact came a succession of European diseases to which the Samoans had no immunity – measles, whooping cough, flu, typhoid.

By 1894 Bleazard, a Methodist missionary, wrote *"epidemic upon epidemic… have been followed by severe famine… plantations which of necessity had been neglected during measles, were left to ruin".* The following year, Collier recorded that "*Epidemics are much more frequent… the Samoans are not as robust as there were formerly".*

Table 1: Major epidemics 1891-1918, Western Samoa

1891	Influenza
1893	Measles
1896	Diarrhoea and dysentery
19076	Dysentry and whooping cough
1915	Measles
1918	Spanish Flu

(Source: Pirie, 1963 and various Methodist Mission Society Papers)

But it was the Spanish flu that marked a health and social watershed. "*Survivors were bereft not only of relatives, friends and leaders but of confidence and often a faith equal to this challenge*" (Goodall 1954:362). The country was thrown into confusion.

At this time, Samoa was a Mandated Territory of the League of Nations under New Zealand administration. The New Zealand Administration had a particular responsibility for health. In 1920, a Director of Health was appointed. He was a "public health man" – a new area of medicine – one that was concerned more with prevention than cure. He came with firsthand knowledge of the very successful Maori Community Health Services established by Sir Maui Pomare[4] and Sir Truby King's Plunket Society[5]. He was soon joined by a NZ woman doctor Mabel Christie – a very rare species in those days. By coincidence, in Apia there was already a woman doctor – Regina Flood Keyes, a one-time American Army surgeon whose husband was the American Vice-Consul. For two years, she had been doing voluntary work with Samoan women on women's and children's health in a number of villages around and to the south of Apia[6]. Both women had respect for *fa'a Samoa* – literally, the Samoan way of life, and particular respect for Samoan women. Both doctors were essential to the establishment of the women's health committees.

[4] Dr Pomare started a Maori Nursing Service with trained Maori nurses going out to Maori communities to teach and involve communities in the rudiments of health, hygiene and child care.

[5] In 1907, as association based on the idea of mutual self-help and education for the care of mothers and infants" was formed by Sir Truby King – known as the Plunket Society.

[6] 'Child Welfare' (page 4 A.-4A, Appendices to the Journals of the House of Representatives, Alexander Turnbull Library, Wellington) provides an explanation of the work done.

An additional important pre-condition, was a number of educated, high ranking young women who were, or had been, students at the Papauta boarding school for girls. Established in 1892 by the London Missionary Society for the daughters of high ranking chiefs and church pastors – the curriculum included the basics of first aid and hygiene, sanitation, and maternal and child health care (Latai 2015:316). By 1923, three girls from Papauta were the first students to be trained as nurses (op.cit 2015: 299)[7].

So the pre-conditions for the women's health committees were a demoralised vulnerable society in poor health, a director of health who knew about community health, two women doctors, a pool of educated high ranking girls with some knowledge of basic health care, as well as an Administrator who was student of cultural values - he understood the importance of the etiquette surrounding hierarchically ranked societies.

And there was a social structure that was relatively authoritarian – each village had its *fono*, or council of chiefs, made up of the heads of each family each of whom held a chiefly title. The *fono* made the rules and regulations for the village and ensured they were adhered to. There was the village of the men divided by those with chiefly titles and those without. And there was the village of women. As Schoeffel (1977 and 1984)[8] and Latai (2015) have pointed out, traditionally there were two clearly defined groups of women. The in-marrying women and the women of the village, again divided by rank. The in-marrying women comprised the wives of men of the village – their rank and status dependent on that of their husband. There was also a powerful group of women – the *aualuma*, those born in the village. Their rank and status were dependent on their fathers. They held important ceremonial roles in particular the *tama'ita'í* or daughters of high chiefs, either widowed or unmarried. These divisions were largely analogous to the women who were sexually active and those who were not.

Establishing the committees

The way in which the committees were introduced was an important factor in their acceptance. It was done in strict accordance with Samoan etiquette and the ceremonial requirements of a hierarchically ranked society based on genealogies and the system of ranked chiefly titles. The ability to work within this system and to be seen to reinforce traditional rank and authority were essential.

The Director of Health and the New Zealand Administrator, accompanied by a party of high ranking Samoan chiefs and an orator formed a traditional travelling party known as a *malaga.* As tradition demanded they carried lavish traditional gifts of fine mats and food

[7] Latu Latai discusses in detail the role the London Mission Society played in women's education and health. Many Papauta students later trained as what were initially known as *Karitane* nurses (the name for NZ maternal child health care nurses whose curriculum was used in Samoa) See 'From open *Fale* to Mission Houses' *in Domestic Divinities*, ANU Press, (in press).

[8] For an explanation of village women's groupings see Penelope Schoeffel, 1977 'The Origin and development of women's associations in Western Samoa 1830-1977, *Journal of Pacific Studies* 3, 1-21.

when they formally visited key villages in each district to discuss with the *fono* the health of the people and to beg their assistance in helping improve the situation[9].

By stressing the need for Samoan assistance and allowing the *fono* to make the decision, local pride and dignity were maintained and it was agreed that the women should take responsibility for health. The highly visible support of the NZ Administrator - highest ranking European in the country, the chief medical officer, a woman doctor who could later talk to the women, gave the undertaking not only high status but legitimacy. News of this obviously prestigious undertaking spread quickly and there were soon demands for women's health committees from villages all over the country. In response, Dr Mabel Christie, the Child Welfare Officer, set off on foot, horse and canoe for nine months visiting villages to explain and help establish the health committees and train the committee executive` in basic first aid and sanitation.

> *'Every village (85 of them) in five large districts has been personally visited by the Child Welfare officer and her Samoan nurse…and there are now 1,360 Samoan women of the women's committees actively engaged in assisting in the work of child welfare…on average there are around 16 women to a committee" (Christie 1926:20)*

The first committees included "the more enlightened class of women" the educated wives of pastors or high chiefs ...graduates of Papauta Girls School (Christie loc.cit). In 1927, training nurses to support the committees began in earnest. As in the NZ model, these first nurses were known as *Karitane* nurses[10]. At the time, the total budget for Samoa was 25,912 pounds. The importance of health was evident in the budget for health. 20% went to health.

The committees were established along European lines with an executive comprising a president, treasurer, secretary adapted to conform to Samoan rank. The president was usually the wife of the pastor, committee members the wives of the highest ranking chiefs who had authority by way of their husbands' or father's rank . Each committee was provided with a medical kit and made responsible for conducting a first aid clinic each day; for holding weekly meetings with all women; for reporting any severe thrashing of children and ensuring that all women and children attended the monthly clinic when the doctor or nurse visited (Christie loc.cit). The committee had the authority to command the women of the village to attend meetings and bring their babies and small children. Day to day health care and village health initiatives were left to the women's committee to devise and organise. They engaged in a range of community services including maintenance of a supply of drinking water, provision of clean bathing facilities, the use of food safes, construction of flyproof latrines, keeping pigs out of the village.

[9] See Christie 1926 'Child welfare work in Western Samoa' in Appendices to the Journals of the House of Representatives, New Zealand Archives, Wellington.
[10] See Turbott to the Secretary to the Administration, January 23, 1936a.

The NZ administration allowed for President of the Committees to be formally linked to government through a system of *pulenu'u* or government appointed and paid village officers who reported to the administration in Apia. The NZ administration considered the women's committees so important that it was planned for the president of each committee to hold the position of counterpart to the male *pulenu'u* as shown on an organisational chart from 1926. It was not until 2007 that the idea of a women's *pulenu'u* was actually acted upon.

Village women considered they belonged to an organisation that conferred prestige and status both inside and outside the local polity. Their pride was obvious in their own uniforms, the visits to other villages, construction of their own *fale* (meeting house) and in some cases small hospitals which the women furnished and maintained from money they raised. There was a high degree of competition between villages encouraged by the NZ administration.

Within three years infant and child mortality were reported to have dropped and the system was hailed as a remarkable success (Lambert 1929). The women's committee not only brought changes in health but considerable changes to women's daily activities, in their perceptions of women's roles and the ways in which women interacted with one another. The committees allowed women to expand their political and economic involvement in village and district life. For the first time, women participated in a single group that cut across traditional groupings which were divided by age, rank and status. The committee became the largest organised group in the village with considerable political and economic power. The executive had greater access to labour than the church or village *fono*. Ironically, although the NZ models were based on the concept of equality, the success of the Samoan committees were to some extent based on the use of authority.

The committee meetings were exciting events and international support in the form of film and slide shows provided by the Rockefeller Foundation added to the excitement, and according to the *Wellington Post* newspaper in 1925 "were seen by the great majority of natives" though it is unclear just what people learned from them.

But it all came to grinding halt with the advent of an independence movement, the *Mau.* The committee activities were stopped as village men demonstrated in Apia. When male leaders were gaoled, the women, now easily organised through the committees, banded together and organised independence marches in Apia. It is reported that there was between 2,500 and 3,000 of them regularly marching (Field 1984:177-78). On one memorable occasion a large group marched to the administrative headquarters, called for the NZ administrator, turned their backs on him and bared their backsides. A most humiliating insult.

It took four years for the committees to resume their work and to repair the damage of a halt to immunisation, sanitation, child and maternal monitoring.

Adaptation and change

The next 30 years were a time of consolidation, adaptation and change. The population more than doubled, communication was much better, more young women worked and a monetary economy became the norm. The role of president changed from the wives of the pastors to the wives of the high chiefs …. falling back on the traditional system of rank and making it easier for the high chief to keep control of what women's committees were doing and of the development-related assistance they increasingly attracted. As I was told some years ago:

> *In the past the president was not the wife of the high chief… 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? That was fa'a Samoa* (Pers Comm. District Nursing Supervisor Leotele, June 1983).

But several elderly Samoans interpreted these changes as a bid by aspiring male members of parliament to gain support from the powerful women's committees – support most easily granted by ensuring their wives were committee presidents. As others said - everything always comes back to the *faá Samoa* – the Samoan way.

Over the years the Women's Health Committees became responsible for a wide range of health-related and economic activities, many of which they initiated themselves. In addition to their health activities they also began engaging in small business and agricultural projects and became the leading fund raising organisation in the village – sometimes to the detriment of their health related activities. By the 1960s they had become so well integrated into village life that they were considered to be a traditional Samoan organisation to which women had always belonged. It was this integration, the adherence to the traditional ranking system and their adaptation to a broader type of development committee rather than a health committee that, I believe, was responsible for their resilience. And of course, there was the power and status that the committees conferred on women. The committees irrevocably changed the power structure in the village.

For 91 years the pattern of committee health activity and responsibility has been much the same. Each month the committees are visited by a district nurse – children are inspected, weighed and measured, immunised when necessary and pregnant women are checked, wounds dressed.

The current situation – continued resilience

The University of Samoa's current research shows that today there are 240 traditional villages nearly double the number from the 1920s. They are still governed by the village *fono*, most still have one village-wide women's committee. Sixty six have more than one committee and as population has grown there are now committees based on church or family affiliation (Centre for Samoan Studies, National University of Samoa 2014:7) placing

greater strain on the Department of Health to provide monthly visits by a district nurse. With rapid and widespread social and economic change the committees have changed – babies are often brought to the committee by their grandmothers as many young women have jobs in town or have gone to NZ. Poorer village women now find it difficult to fulfil the labour and monetary demands of committee membership.

More young mothers have had a good education and can ask questions of the nurse – unheard of in the past. Transport is good so if there is ill health, family take the child to the hospital in Apia. More important, financial support for health both from overseas donors and from the government itself, has focused increasingly on tertiary care – on high tech hospitals, state of the art and expensive equipment. Support for community health, preventive health, health education is less and less forthcoming as both government and donors want evidence of effectiveness. Donors and directors of health prefer a new hospital or clinics to the more amorphous preventive health. It is very much more difficult to provide evidence of the effectiveness of preventive health care than to provide evidence of a new hospital. Today, the Department of Health has increasing difficulty in providing the necessary services to the committees and it is increasingly common for committees and rural clinics to run out of simple medications and dressings. Transport for the district nurses to visit the committees is sometimes not available. These problems were becoming evident 30 years ago.

The University of Samoa's current research suggests the committees may be losing their village-wide influence in part due to them being formally incorporated into the government administrative system. In 2007 government agreed to recognise and pay allowances to the representatives of the village women's committees (known as the *Sui o Tama'ita'i*), bureaucratising the committees and bringing them under the purview of the administration.[11] Payment for the work that had always been very proudly undertaken as a duty changed the way women thought about the committee. As mentioned earlier, it is ironic that the formal establishment of the women's *pulenu'u* is exactly the structure that 90 years earlier the NZ administration had anticipated but never put into practice.

So, today, the committees have been in operation for 91 years. Their remarkable resilience due in large part to the specific context of their formation, adherence to their traditional values and hierarchical structure, the high status that the committees were afforded, women's pride in what they were achieving, the increased power and status that the committees afforded village women; the very real improvement they made in children's health, and the hard, dedicated work of nearly four generations of Samoan women.

[11] The *Sui o Tamaitai* play a similar role to that of the *Pulenu'u*, the village mayor, recording births and acting as a conduit between the village and government departments and civil society organizations. However they are only paid half the allowance paid to the *Pulenu'u.* One hundred and eighty two villages had *Sui o Tamaitai* (Centre for Samoan Studies, University of Samoa research 2014:7)

A review of the factors that promoted the success and long-term resilience of this community-based organisation shows that they conformed very closely to the factors being discussed today:

They fulfilled a need; allowed the women to make decisions; encouraged new activities that women felt were important; supported and strengthened traditional social and political values and norms; had on-going support and encouragement; and an ability to adapt to change.

Through their 91 years the Samoan Women's Committees were widely recognised as an important extension of health services.

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