Revitalization of Samoa's Village Women's Committee for Public Health Promotion

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Part One: Village Government and the role and status of women and women's associations.

1.1 Background

Part one of this report will explain how village women's committees fit in to the contemporary system of village-based local government in Samoa. Village women's committees named *Komiti Tumama (*hygiene committees) were part of Samoa's public health system for nearly 50 years (1930s-1980s) but have largely lost this role over the past 25 years. It draws on data from a recent survey (2013-2015) of governance in all villages in Samoa, conducted by a research team from the National University of Samoa (Meleisea et. al. 2015).

1.2 Population and services

The population of Samoan living in Samoa is now approximately 200,000 and there are as many, if not more, Samoans living overseas, mainly in New Zealand, Australia and the USA. The influence of the Samoan diaspora on Samoa is very significant and remittances comprise a substantial proportion of Samoa's GDP.

Samoa comprises two main islands and five very small ones, of which two are inhabited. The islands are not distant from one another and a regular ferry service links the two main islands with good road networks on each island. Samoa does not have development problems associated with remote and isolated island communities, as is the case with most other Pacific Island states. Most villages have access to electricity, piped water supplies and village and district schools, and district health centres.

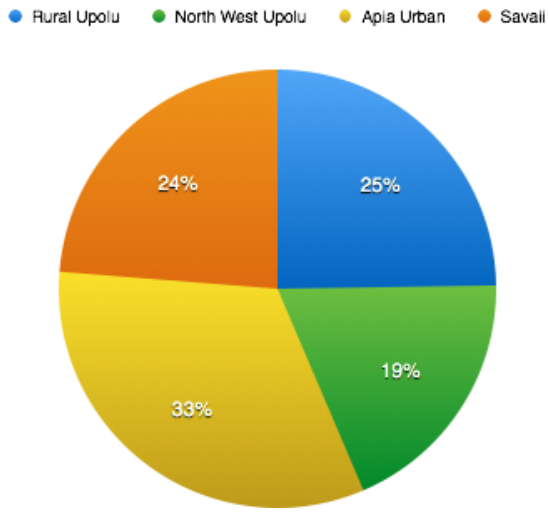
Figure 1: Map of Samoa

There are over 275 local government areas of which 192 are traditional villages, 48 are sub-villages of traditional villages, and 35 are non-traditional villages. Non-traditional villages include new settlements, large residential compounds and suburban areas.

Although most Samoans (80%) live in rural areas, overall the rural population of Samoa has not grown much, with the exception of the densely populated and increasingly urbanized villages of North-West Upolu. Historically the population of Samoa has grown from 32,612 in 1903 to 187, 820 in 2011. The population of villages and districts in some rural areas has declined or remained static in the last decade or so. People have either moved to peri-urban villages, the town of Apia or migrated overseas.

Figure 2 illustrates the distribution of the population. The 2011 census of population and housing shows that 69% of households live on customary land, 25% live on freehold land (mainly in the town) and the remainder lives on government or church-owned land (Samoa Bureau of Statistics (SBS), 2011:87). The most densely populated region of the country is North West Upolu, followed by the Rural Upolu and Savai'i Island. The Apia urban area is located on Upolu. A very small township on Savaii, within the boundaries of the village of Salelologa, is not yet designated 'urban' but provides many of the island's core services and facilities (SBS, 2011).

Figure 1: Distribution of population in Samoa, 2011



Although it is often said that Samoa has considerable underutilised land for agriculture, including subsistence agriculture, most urban households have only ¼ acre house sites, while in northwest Upolu, increasing population density means that many households have very limited access to customary land for cultivation. Those without access to land are dependent on cash to buy food,

1.3 Local Government Institutions

The Constitution of Samoa recognizes traditional local government under Article 100. Local government services are village-based; the national government treats all settlements (traditional villages, suburbs, major government and church compounds) as though they were villages in terms of the provision of government services, even those that do not have traditional governance structure.

The *Internal Affairs Act 1995* provides for the Internal Affairs Division of the Ministry of Women, Community and Social Development (MWCSD) to oversee the wellbeing of villages, village authority, and to provide for 'other matters relating to the culture and traditions of Samoa'. The representatives of *fono* (village councils) report to the Internal Affairs Division. Apia town has no municipal council. The Planning and Urban Management Agency [PUMA], under the Act of 2004 (amended 2005), administers the urban area. Within the town boundaries of Apia there are traditional villages, a central business district and suburbs comprise freehold sections of land.

1.4 Traditional villages

A traditional village (*nu'u*) is a polity governing a group of extended families within a territory, which typically extends from the top of the central ridge of mountains

to the coast. In modern Samoa village populations range in size from a few hundred people to several thousand people. Villages with large populations are often divided in to sub-villages Local government in traditional village is based on *fono* (village council of chiefs) are based under a traditional system of authority. Each *fono* is made up of *matai* (chiefs, heads of families and lineages*)* of various ranks in the village hierarchy, who represent the families of the village. All traditional villages have an honorific salutation (*fa'alupega*) that specifies the rank and history of the *matai* titles of the village. They are important because they define the village territory and leadership historically, dating back to the 19th century or earlier. They have assigned seating places in the village meeting house (which is usually the property of the highest ranking *matai)* and these seating places are ranked according to traditional criteria.

Matai make decisions for the village in the *fono*, based on consensus and following discussions in which all *matai,* irrespective of their rank; have the right to express opinions. Each *fono* elects a village representative [1](*Sui o Nu'u*). In traditional villages local government also includes village women's committees (*komiti*) and associations of untitled men (*aumaga*).

Fono have considerable power and authority in setting priorities for the provision of health and education services, water supply, agricultural development, business operations, land use, customary observances and maintenance of law and order. Thus, they exercise considerable influence over land, fisheries and other important resources.

Traditional villages comprise one or two (sometimes more) Christian churches of various denominations. Church pastors (or catechists in the Roman Catholic church) are expected to remain aloof from village politics, however the *matai* who comprise the *fono* are usually also leaders of the laity in their churches. The major churches with village congregations are Congregational, Roman Catholic, Methodist and Mormon. Church congregations are informal agents in village government as the main contact point between village families, and are major agents of social control. Whereas the *fono* usually meet only once a month, church congregations usually meet several times each week for services, choir practice, fundraising and meetings of church leaders.

Populous villages are divided into sub-villages (*pitonu'u*). Other reasons for divisions are proximity (for example, if part of the village is located on the coast and part located inland) or because of political disagreements within the village. Depending on

[1] Now officially termed *Sui o le Nu'u*, these village representatives used to be termed *pulenu'u*.

the local situation, some sub-villages have their own separate *fono*, *aumaga* and *komiti.* For example the two Pilot villages for PEN-Fa'aSamoa[2] were both divided into sub-villages; Faleasiu, in densely populated North West Upolu has a population of 3,745 (2011 census) divided into four sub-villages while the comparatively small village of Lalomalava on Savaii with a population 387, had three sub-villages.

1.5 The Village *Fono* Act

Enabling legislation for traditional village government is *Village Fono Act 1990.* The Act permits the exercise of power and authority by the *fono* of traditional villages in accordance with 'custom and usage of their villages'. The structure of village government is based on the customs, usage and history of each village as interpreted by its legislative body, the *fono*. These councils appoint sub-committees for local services such as schools and water supply as they see fit.

The *Village Fono Act 1990* empowers the *fono* to make rules for the maintenance of hygiene in the village; to make rules governing the development and use of village land for the economic betterment of the village; to direct any person or persons to do any work (as defined under the Act) required for the village, and to impose punishments in accordance with the custom and usage of its village for village misconduct (as defined under the Act). However, the legislative powers of the *fono* are limited because national criminal and civil laws bind everyone in Samoa. Disputes over matters of customary law are normally taken to the Samoa Land and Titles Court.

Village powers of punishment include the imposition of fines in money or food, or imposition of orders for an offender to undertake work on village land. In practice, fines and penalties are levied against the *matai* of the family of an offender, who is held responsible for the conduct of his *'aiga* (extended family) in the village. The fine is then paid from collective family resources. It is also common practice to exclude from participation in village governance a *matai* who does not abide by village rules. In extreme cases, *fono* may order an offender to leave the village, but if taken to court the civil courts will usually over-rule such orders on the grounds of individual or human rights under the constitution.

In 2011, consultations on the Amendment of the Village *Fono* Act of 1990 were carried out by the working/advisory committee of the Justice and Law Sector to seek the views of the villagers and community members throughout the country about ways to

[2] A village-based program for early detection and management of non-communicable diseases.

stop the alarming increase in the involvement of young people in criminal activities. In particular, the participant's views were sought about the importance of customary and Christian principles in making decisions. One issue raised by communities was freedom of religion. With many new Christian sects becoming established in Samoa, some villages are concerned about religious division in their communities.

The issue of women's exclusion from village government was not raised in these consultations. However, concerns have been raised about the extent of authority provided to *fono* under the Act. The report of the review of the *Village Fono Act 1990* (Samoa Law Reform Commission, 2012) recommended that *fono* register their members and document their decisions within a formal process for the registration of village by-laws. It is envisaged that the registrar for the by-laws would have the authority to accept or reject the by-laws, based on compliance with best practice guidelines provided. Only the sections of the by-laws that are compliant with the constitution would have the full power of the law.

In 2014-15 village by-laws were being prepared under the Good Governance Project of the Internal Affairs Division of the MWCSD. Villages may voluntarily request the assistance of the MWCSD to harmonize their draft by-laws in keeping with the principles of good governance (they should be participatory, consensus oriented, accountable and transparent, responsive and effective and efficient). It is expected that village by-laws will be reviewed two years from the date of registration (none had been registered as of June 2015). As of April 2015, the Internal Affairs Division had worked with 20 villages towards writing their village by-laws. Support included a talk by a lawyer on the Samoan legal framework and constitutional rights. They worked with four village groups: the *matai*, divided into chief and orator groups; the women (village women's committees); and the youth (untitled men and young women). The four groups must approve the finalized by-laws, with signatures.

During these consultations, practices by villages were discussed, for example the practice of reporting offences to the *fono* before the police, and villages were advised that such practices are contrary to the law. In some villages where there was a ban against women holding *matai* titles, the villages agreed to remove the ban. *Fono* preparing by-laws have also discussed procedural matters, and have been advised that villagers who are being fined or otherwise punished should be allowed to present their side of the story to the council. However, some villages consider such a provision to be contrary to custom.

A draft Bill is currently under consideration by the parliament to amend the *Village Fono Act 1990* in accordance with the results of these consultations. The proposed provisions will strengthen the definitions of village authority in relation to defining *fono* policy and procedures to be followed in making *fono* decisions. Among the defined powers of the *fono* that are proposed in the Bill are the authority to protect Samoan customs and traditions and to safeguard village traditions, norms and protocols.

1.6 Village leadership

The 2011 Census of Population and Housing recorded that 16,787 persons in Samoa were *matai*. A recent survey (Meleisea et.al. 2014) recorded 13,423 *matai* living in villages. *Matai* titles are names, which commemorate an ancestor or an historical genealogical event and most are historically associated with one particular village. *Matai* titles belong to lineages comprising all those who are ancestrally connected to the title. Titles are conferred by a consensus decision among the male and female elders of the lineage. A *matai* represents his or her family's dignity and honor, and is responsible for calling family meetings, arbitrating disputes in the family, and leading discussions about the organization of funerals, weddings, events in the church to which the family belongs and other family projects and concerns. *Matai* often serve as deacons in the church of the village to which their title belongs.

There are two orders of *matai*: *ali'i* and *tulafale*. The distinction between the two orders is not as important in modern Samoa as it was in the past. *Tulafale* have a traditional role as orators, and each village appoints one of its senior *tulafale* as the village spokesman (*tu'ua*). He serves as the spokesman for the village on formal occasions. (This traditional role is distinct from the modern role of village representative previously described in 1.4 above.) Holders of high-ranking *ali'i* titles are considered to have the traditional right to express a final decision on a matter before a *fono*, after all its members have had a chance to speak.

The ritual bestowal of *matai* titles usually requires acknowledgement of the village to which they belong before the title can be legally registered. The normal procedure is for the title bestowal ceremony to be held in the village to which the title belongs. It is now common for *matai* titles to be split among two and often dozens more holders. In effect, nearly all males over 40 are *matai*. Only a few of Samoa's highest ranking titles remain undivided. Nowadays many *matai* live outside the village to which their titles belong, some live overseas and others live in town or in other villages.

Samoa is a kin-based society and its kinship system is flexible, allowing an

individual to trace ancestry through both maternal and paternal connections. The primary affiliation by an individual – which section of his or her family he or she has the strongest attachment to – is usually determined by residence. Thus, if a person lives with his or her father's family, he or she mainly contributes to that family and serves its *matai*, while if a person lives with his or her mother's family; it is that family that he or she will contribute to.

1.7 Status of women in villages

In the organisation of traditional villages a married woman takes her status from her husband, irrespective of the traditional rank of her own family or her educational achievements. If he is a *matai*, she takes her place among the women of the village based the rank of the title held by her husband. If he is an untitled man, she shares his equivalent low status in the ranking system. In village life there is a defined role for a married woman, particularly if she is the wife of a *matai*. She serves his family and if his title is one of local importance, she becomes a leader in the village women's committee and often in the women's fellowship group in the church, as well.

Traditionally, marriage within the village was frowned on, or forbidden. Young women married "out" to men from other villages. Marriage was an important means of establishing a nation-wide network of family alliances and connections above the village level. This was the basis of the sacred covenant (f*eagaiga*) and sacred space (*va tapuia*) between brother and sister. Women give service to their husband's family as outsiders but receive service in their own family. A sister who marries away from her own village, creates an alliance for her brother and family, and in return a brother is obliged to look after his sister and her children should the need arise. Nowadays marriage within villages is very common, and these traditional values have been weakened.

As will be explained in the following section, the leaders among women are the wives of the highest-ranking *matai*, usually *ali'i*, The term for the wife of an *ali'i* or a clergyman, (and a polite usage for any married woman), is *faletua* (house at the back). The term connotes domesticity; the house at the back is where food is prepared, where work is done and where family life is conducted, in contrast to the house at the front, which is reserved for meetings and formal occasions.

Married women are expected to join their husband's church if they had belonged to a different church before they were married. Wives are expected to be subservient in their husband's family, to render service to his parents and siblings, including his adult sisters living there. In effect this means going to the back of the house and preparing food and doing other chores. But when a man chooses to live with his wife's family, his status is also somewhat subordinate; he is also expected to serve his wife's relatives.

There is no role for the husband of a matai and the imbalance in status between a woman matai with an untitled husband is anomalous and therefore socially problematic.

When both husband and wife are *matai* there can be conflicts of interest in relation to the allocation of resources. One of the main responsibilities of a *matai* is to represent his or her family at funerals and other ceremonies to acknowledge extended family connections. The *matai* must organise the extended family to pool money and fine mats to be presented at these ceremonies, and later redistribute the gifts received in exchange. When both husband and wife have these obligations to different extended families it can put them under a lot of economic and social pressure.

Many well-educated women who are eligible to become matai decline to do so. This is because it is widely believed that a brother, even when he is less well educated, has a superior claim to hold the family matai title. For these reasons, women *matai* are more likely to be widows, unmarried, or married to husbands outside the cultural system and these reasons explain why most of the 17 women who have been elected to parliament over the past 50 years were (or are) unmarried, widowed, or married to non-Samoans.

Very few women have leadership roles in the churches of Samoa. The Catholic and Mormon churches do not ordain women, the Catholic Church does not allow women to be deacons and the Church Latter Day Saints (Mormon) do not allow women to be elders. The two major Protestant churches in Samoa are very conservative in comparison to their mother churches in other parts of the world (for example, the Congregational Church in the United States began to ordain women in the 19th century, and the United Methodist church has ordained women since the 1950s). Samoa's Methodist and Congregational churches have resisted the ordination of women because it goes against the 'traditional' order, which they assisted to create in Samoa over a century ago. However both of these denominations allow women to be deacons, although few women take this role.

The village pastor or catechist and his wife are expected to exemplify the Christian model of conjugality as Samoans joined Congregational, Methodist and Roman Catholic churches. The effectiveness and influence of this model endures to the present day and was adopted by the Catholic Church; as the celibate Catholic clergy lived apart from the village, the church trained catechists and their wives to occupy positions in their parishes similar to that of their Protestant confreres.

1.8 Women in local government

Only *matai* may sit in the village local government council and make decisions. According to official statistics, only 9% of *matai* are women (SBS, 2012). The previously

cited survey of traditional villages found that of village-based 13,423 *matai*, only 735 (5.5%) were women, that many villages discourage women *matai* from sitting in the fono, further, nineteen village do not recognize a *matai* title if it is held by a woman.

There is no consensus among Samoans about women's right to hold *matai* titles; some regard it as a traditional right, others believe that bestowing titles on women is acceptable modern custom, while others hold that according to Samoa custom *matai* titles should be held only by men. Before Samoa became independent in 1962, almost all Samoans lived in traditional villages and very few women held *matai* titles. But as educational opportunities were opened up to Samoans in the 1960s, women began to hold titles in increasing numbers.

Few Samoans had access to higher education until the late 1950s, when selective government secondary schools were first established. Before that, intermediate-level schooling was mainly only available to the children of mixed-race families in Apia.

Since the 1970s, Samoan families have invested equally the education of boys and girls

Before the new selective national colleges established their senior secondary levels, the top-performing students were sent to senior secondary schools in New Zealand, and later to teachers' colleges, schools of nursing and universities. Girls were well represented among those gaining admission to secondary colleges in Samoa and New Zealand and since that time there has been little gender disparity in educational participation or attainments at any level.

Families evidently considered investment in girl's education to be as useful as investing in the education of boys, and in this respect Samoan custom worked in favor of girls. Farming and fishing is considered men's work and most routine household chores such as collecting food from the family plantation, feeding livestock, making a ground oven (*umu*)and cutting grass are done by boys and young men, while girls and young women are expected to keep out of the sun to protect their complexions and do indoor tasks. Sending girls to school did not significantly affect the household labor supply and most primary schools were close to villages, so there were few obstacles to educating girls.

Educational opportunity has enabled women to succeed in increasing numbers

in the modern sectors of the economy: in the public service, in business and in the professions. By the 1970s, increasing numbers of women were being given *matai* titles and among the first of them were women who had obtained degrees or diplomas overseas. Women are most likely to be given a *matai* title in recognition of high educational or career attainments or because they had rendered particular service to the family with generous financial support. Bestowing a title upon women honors her, but it does not necessarily carry the expectation that she will become a leader in her ancestral village.

Most traditional villages still have one village-wide women's committee; of the 240 traditional villages and sub-villages only seven villages had no active women's committee.

In effect, many women *matai* hold their titles on an honorary basis; they may or may not have authority in the extended family, but typically have limited opportunity to exercise authority in the village. There are some exceptions of course, such as Fiame Naomi Mata'afa. Fiame is a leader in her village and has represented her district in parliament for the past 20 years. She is the sole holder of one of Samoa's highest-ranking titles and is a direct descendant of past holders of Samoa's paramount titles. Her father was Samoa's first prime minister (1962-1967) and her mother, La'ulu Fetauimalemau, was one of Samoa's first women parliamentarians.

The previously cited village survey found that most traditional villages still have one village-wide women's committee; of the 240 traditional villages and sub-villages surveyed, 167 had one village-wide *komiti* and 66 villages had more than one *komiti*, with each *komiti* representing a different religious denomination or, in the case of very big villages, a different sub-village (*pitonu'u*). Only seven of the traditional villages had no active women's committee. However even where women's committees that are active in the community they do not have any formal authority in village matters. Women may be leaders among women but they have little direct voice in village government.

1.9 Associations of untitled men, boys and youth in village governance

In addition to *fono* of *matai*, traditional villages have *aumaga* (associations of untitled men) who serve the *fono*. Usually, the son of the highest-ranking matai is its *sao aumaga* (leader). When the fono meets, the *aumaga* gathers as well, to serve the *'ava* (ceremonial beverage) and to help prepare and serve the food. The members of the *aumaga* are not necessarily 'youths' because the group includes all men and teenage

boys who are not *matai*, and can therefore encompass a wide range of ages.

Village churches also have youth groups (*autalavou*), which include all the unmarried and untitled men and women and teenage boys and girls of the village who belonging to the same church community.

Fono and churches play a major role in organizing and engaging youth, particularly young men. A typical arrangement is for the youth groups to work periodically for families in the village that need extra labour. Such work is compensated with payments in cash and food, and usually involves tasks such as weeding or spraying plantations and cutting grass. On the recreational side, the youth play rugby. Girls are included as 'youth' in the church groups but are somewhat peripheral to the core masculine labor and sporting activities of village youth. *Fono* and church congregations are motivated to find ways to occupy male youth because there is more concern about their behavior and the need to control their behavior in relation to their use of drugs (cannabis) and alcohol and getting into fights. Concerns about young women are mainly about pregnancy outside marriage. When this occurs the *fono* may fine the woman's family.

The situation of youth is an important development issue. The median age in Samoa is 20.7 and the number of people aged between 15 and 29 is 47,414, accounting for a quarter of the total population.

The situation of youth is an important development issue. The median age in Samoa is 20.7 and the number of people aged between 15 and 29 is 47,414, accounting for a quarter of the total population. As most young people in Samoa have at least 10 years of schooling, there is an expectation in both rural and urban areas that school leavers will obtain paid work, but only 32% of people of working age are classified as 'economically active', and available data suggests that semi- subsistence farming continues to engage a large proportion of the population (International Labour Organization, 2015). The 2012 Labour Force Survey reported the youth (15-29) unemployment rate at 16.8% – double the unemployment rate in the total population. Approximately 20% of females in the 15-29 age group are unemployed compared with 14% of young men.

1.9 Rural health services

Samoa's health services are mainly provided by the public sector through taxation and donor assistance. Samoa has a total of 10 hospitals: there are two major hospitals Tupua Tamasese Meaole (TTM) National Hospital in the town of Apia and Malietoa Tanumafili II (MTII) Referral Hospital in Tuasivi, Savaii; five small district Hospitals on Upolu and three on Savaii as well as several smaller district Health Centers. There are also a number of private medical practitioners who rely for diagnostic services on the facilities of the national hospital.

Services in rural areas tend to be limited by a shortage of health professionals, especially medical doctors. WHO (2015) reports that in 2013 there were four doctors and 16 nurses for every 10,000 of the population. Because health services are not equitably distributed, well-off families in rural areas with cars are likely to seek services from the main hospitals rather than from the district hospitals and health centers, which are mainly staffed by nurses. The urban area has larger numbers of qualified health professionals. The National Health Service (NHS) is rotates physicians employed in the main hospital in Apia to work at least one day a week from each of the six district hospitals. The government is planning measures for renewed emphasis on community and primary health services. The Faculty of Medicine at the National University of Samoa is currently designing post graduate diploma courses in primary care to upgrade qualifications and encourage doctors to provide services in rural areas.

WHO observations (2015) suggest that medical equipment for NCD may not properly managed and some health facilities lack functioning basic equipment for the management of NCDs such as scales and blood pressure measures Although drugs are centrally purchased and government subsidized, some essential medicines for treating non-communicable diseases (NCDs) such as blood pressure lowering medicines, hypoglycemic and lipid-lowering medicines are not always available through rural health services. Regulations require that certain medications can only be dispensed by pharmacists or trained pharmacy technicians.

Part Two: Village women's committees and community health

2.1. Historical origins

Samoa has had traditional village women's organizations for many hundreds of years

In pre-Christian times the term "the village of the ladies" (*'o le nu'u o tama'ita'i*) indicated the sphere of female authority under high ranking chiefly women to organize village ceremonies and hospitality in the village, and the production of the most valued goods, such as fine mats (*'ietoga or 'iesai*) tapa cloth (*siapo*) and other categories of textile wealth, and perfumed cosmetic oil. An indication of the autonomy of the 'village of the ladies' was provided by the pioneer missionary John Williams who recorded in 1832 that the ladies of Amoa in Savaii autonomously decided to become Christians and organized for a church to be built, even though the men of Amoa had decided to remain unconverted (Schoeffel 1981).

Until the 1920s the 'village of the ladies' and its association of daughters of the village *(aualuma o tama'ita'i*) was only open to women belonging to the *matai* lineages of the village, and not to women from other villages who came to live in the village as the wives of village men, not even the wives of the high ranking *matai*. Another women's organization was the weaving group (*falelalaga* -- which still exists in some villages) that included both daughters of the village and in-marrying women,

Modern women's associations (komiti tumama) were first introduced in Samoa in the 1920s to promote improved public health

In, in villages of traditional importance in old Samoa (due to the rank of their highest *matai*), highborn young women were appointed as 'village princesses' (*taupou*). They were chosen because their genealogy traced descent from the ancient gods. They were ritually installed with titles from the name of an important ancestress and their virginity was carefully guarded. Eventually they were given in marriage to a high chief of another village. One of the roles of the organization of 'daughters of the village' was to look after her and live with her in their own special house.

Under the New Zealand administration (1921-1962), a new form of village

women's association was introduced. Initially the focus was on peri-urban villages of Apia, spearheaded by a Dr. Roberts, (a physician and the wife of the US Consul) and Mrs Rosabel Nelson, the part Samoan wife of a leading local businessman. The New Zealand administration At that time mainly infectious diseases were endemic, including hookworm, filariasis, yaws and leprosy. With the aim of promoting hygienic means to eliminate these diseases, leadership authority was given to the wives of village *matai* (rather than to the sisters' 'village of the ladies') The new associations were called *Komiti Tumama* (women's health and hygiene committees)[3]. Thomas (2015) cites a medical expert of the period who described Samoan Women's Committees in1929, as "a brilliant illustration of the possibilities of preventive medicine" (Lambert 1928:3)

Thomas (2014) attributes the establishing of many effective *Komiti Tumama* in the 1920s to the colonial incentive to improve public health after the disastrous 1918 influenza epidemic. This killed one in every five Samoans, mainly the elders and leaders of Samoa, and young children. She writes that:

> *… 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.*

Another contributing factor was the social conditions favoring leadership among women during the Mau rebellion of the late 1920s and early 1930s. Connections with the colonial health services were broken during this period, in districts that refused cooperation with the New Zealand Colonial Administration. The Mau flourished in most districts of Samoa with its motto "Samoa for the Samoans" demanding that Samoans be given a leading role in decision-making at national and district levels. In 1928 the New Zealand Administration proscribed the Mau and brought in armed forces to subdue it. Men associated with the Mau went into the mountains to hide, and their place was taken by national, district and village women's Mau groups, who carried on the protests, marching through Apia town in Mau uniforms, and engaged in many other groups activities including organizing inter-village and inter-district cricket matches among women and youths to raise money for the cause.

[3] Some years ago an NGO was established called 'Komiti Tumama', with membership in a number of villages. This group should not be confused with the nationwide system established under the New Zealand administration in the 1930s

When the political situation was calmed by new colonial policy, in the 1930s a number of Samoan doctors (graduates from the Fiji School of Medicine) set out to revive and increase the numbers of *Komiti Tumama*. Among them was Dr Ielu Kuresa. His younger sister Momoe Kuresa had trained as a nurse. They were among the leaders in the early work of establishing *komiti tumama* throughout Samoa, under the direction of the Department of Public Health. Dr Kuresa's strategy had been to get *komiti* re-established in the most important villages (those associated with paramount *matai* titles), and with these prominent examples, other villages followed suit. The focus was on the reduction of infectious diseases and improving water, sanitation and hygiene. The initiative was accompanied by a village sanitation campaign; every village was required to construct communal latrines[4]. These were constructed on jetties over the sea (previously, in most villages, the place for defecation was below the tideline on the beach). Many villages were assisted to establish improved water collection points and bathing pools using coastal springs. The job of the *komiti* was to ensure they were used and kept clean. Some villages were also provided with simple gravity-feed water supply systems.

The focus of the work of the village komiti was to reduce infectious disease through improved water, environmental sanitation and household hygiene

In the early period of establishment the New Zealand administration encouraged leadership of the committee to be given to the wife of the village pastor, in those days likely to have been the most educated woman in the community. However by the 1940s, *komiti* became part of the governance structure of traditional villages, with the wives of the highest-ranking *matai* taking the leadership roles in the *komiti*.

2.2 The role of women's committees in community health 1930-1980

The *Komiti Tumama* were organized according to the Samoan customs of the time, into three sections. Following the principle by which a married woman takes her status from her husband, the wives of chiefs and orators comprised the executive section, and in most *komiti* the wife of the highest-ranking *ali'i* was president and the wife of the highest-ranking *tulafale* was the secretary. The daughters of the village had their own section of the *komiti*, but in most villages they had no formal role. The 'service' section of the *komiti* comprised the wives of the untitled men of the village. Over the

[4] In the 1970s the Peace Corps ran a successful campaign to begin replacing the communal sea latrines with household water seal toilets.

years many women's committees raised funds – some received donor support – to build their own committee houses. However in some villages the komiti continued to use the traditional meeting house (*faletele*) of the highest-ranking matai of the village.

Komiti organized monthly clinic in villages attended by public health nurses, and village inspections to ensure that standards of hygiene and environmental sanitation were maintained

An important task of the *komiti* was to conducted regular inspections, often with the district nurse, to make sure that there were no breeding places for mosquitoes and other disease vectors in the village, and to ensure that every household had hygienic standards of living. They supervised the village bathing pool and drinking water sources (some villages still have *komiti* houses beside the village bathing pool). They organized monthly clinics for mothers of babies and young children, led by visiting public health nurses, and in many villages they also provided first aid services for minor illnesses and injuries. Most *komiti* had a medicine box containing a first aid kit and materials for the hygienic delivery of babies by the village midwife (*fa'atosaga*).

Komiti also had authority in local governance matters related to community health, which was delegated to them by the fono. For example, the *komiti* could fine women who disobeyed village rules or failed to bring their children for monthly health checks or to immunization clinics. Many *komiti* also managed community water and sanitation projects related to public health improvement. In the 1960s they implemented Samoa's first mass drug administration for filariasis.

The monthly village maternal and child Health (MCH) clinics were attended by the district nurse; she was often from a high status family and resident in the district. Clinics were held in a traditional village meeting houses. The morning was taken up with weighing babies, giving immunization shots and health checks, updating the MCH cards issued to every mother. The *komiti* were based on fa'aSamoa, so certain cultural practices tended to somewhat undermine their effectiveness. When the health talk was given by the nurse, the younger women were rarely present, having gone off to prepare and serve the lunch. Family planning education was also hampered by cultural norms. According to protocol (*va tapuia*) sexual matters must not be discussed in front of people related through a brother and sister (for example a man's wife and his sister) In late 1970s family planning information in village clinics was usually provided on an

occasional one-to-one basis in a curtained corner of the meeting house, for privacy.[5] The final part of the clinic was a health talk before lunch, followed by a *fiafia* (singing and dancing) in the afternoon. Some villages raised funds and built special houses for the *komiti* to meet in; these can still be identified in villages today by the floral arrangement that are daily hung in front of the house. But others preferred to use the meeting house (*faletalimalo*) of the highest ranking chiefs, for reasons of local prestige.

A study by Thomas (1980) that is critical of the idea that fa'aSamoa could be blended with effective public health processes. She wrote:

> *Committee adherence to traditional hierarchy and power together with the involvement of committees in non-health related "development" activities led to unequal access to primary health care and health information and a situation where committees comprised largely older higher status women and/or those who could afford the increasingly expensive contributions the executive demanded. Young women with children, often the wives of untitled, lower status men, could not afford the goods or money required. When young women did attend, they were often, as their status demanded, at "the back of the house" preparing the meal for the visiting nurse thereby not receiving health-related information appropriate to their child or themselves.*

In 1962 when Samoa became Independent, a Central Women's Committee was established but subsequently the *masiofo* (wives of Samoa's paramount chiefs (*tama a 'aiga*) replaced it with a National Council of Women. With funds raised by village *komiti,* and a great deal of voluntary labor by *komiti* members a Mother's Centre was built in Apia. The original idea was to provide a place in the center of town where women visiting the town from villages could come with their children to rest and obtain refreshment and health advice. However this initiative never realized it's potential and there is still no national organization that links women's committees in all of Samoa's villages.

In 1975 following the UN International Year for Women the government established a Women's Advisory Committee (WAC)under the Department of the Prime Minister, with eight appointed members, including representatives of the public health nursing section of the department of health, and the home economics unit in the Ministry of Agriculture. The role of the committee was to advise on women's roles in rural development. In 1982 the WAC membership was reduced to three and became an minor adjunct of the national committee of village mayors (Komiti o Pulenu'u). Its role

[5] A family planning clinic was established in Apia in the 1970s but many village women were embarrassed to seek its services.

and importance declined and eventually it was disbanded. Concerns and project proposal from *komiti* had to be channeled to government and donors through the village mayor. Another attempt to start a national organization representing all the village komiti was established as an NGO (*Komiti Tumama Atina'e*) in the late 1990s and was able to secure funding for *komiti* projects in some villages, but did not attract nation-wide support.

2.3 Women's committees and social and economic change

From the 1980s health services in Samoa became more modern. Road networks, telecommunications and piped water supplies were improved and expanded, rural health centers were improved, district hospitals were established as well as two national based health services were provided, and health inspection services were established. Accordingly, the role of the *komiti* in community health promotion declined. Thomas's study, previously cited, also comments that:

> *… further factors are the increasing number of young women who work or are overseas, rapid urbanisation and the accompanying social and economic changes and the low status given by government to primary health care and health education."*

The *komiti* were de-linked from the public health nursing services in the Ministry of Health because nurses no longer went out to villages (except in the case of special programs); instead people in villages sought advice and treatment from the nearest health center or district hospital, or if they had the means to do so, went to the outpatient clinics at the main hospitals on Upolu and Savaii.

The institutional arrangements linking the *komiti* to the central government have changed several times. In the 1980s they were linked to the Prime Minister's Department and the Ministry of Agriculture for 'women in development' projects which emphasized income generation rather than public health, but responsibility was later transferred to the Women's Division of the Ministry of Women Social and Community Development (MWSCD) which was established in 1991.

The Women Division has some health-related programs with *komiti*– for example the Pacific regional 'Healthy Islands' and 'Healthy Lifestyle' programs are implemented through the Secretariat of the Pacific Community (SPC) to women's divisions or Bureaus in 24 countries and territories of the Pacific region. The programs provide regional training programs and materials, but at the national level, as in the case of Samoa, the resources provided are insufficient to enable the Women's Division to work regularly and intensively with village *komiti*.

Many of the key health promotion practices became ritualized. For example the household inspection (*asiasiga*), in additional to inspecting household compounds to ensure that disease vectors were removed, had also tried to ensure that every household had sufficient items of property for hygienic practices and standards of living. Each monthly inspection targeted a particular item, for example each members of the committee was expected to show that inspection group that she had the target item; which might be sleeping mats, sheets, towels, mosquito nets, insect-proof food safes, plates, spoons, cups and washing bowls. These inspections had the effect of encouraging every family in the village to make an effort to acquire the items to be inspected.

Ritualization of key public health procedures has been a long standing problem

By the 1970s the inspection had become a ritual; committee members displayed new household property in a spirit of status competition (Schoeffel 1985). Some committee members borrowed new items to show, if they had not been able to buy something. As Thomas pointed out (as noted in 2.3 above) the ritualization of this aspect of the practice deterred the participation by young women and those from poor households. Household inspections were hard on families with no money to buy new household items to display. However by the 1970s Samoans had begun to migrate to New Zealand in large numbers, and send money home to their relatives. This enabled families with low traditional rank to assert higher status by building comparatively well-furnished modern houses.

Another trend was to break up *komiti* into smaller groups in large villages. This was because the traditional nucleated village settlements pattern with houses located close together around a central plaza (*malae*) was changing. As money flowed in from relatives overseas, people were able to build new houses with concrete floors and iron roofs in large compounds away from the village center, beside roads. Because of distance factors, the public health nursing service found it more convenient to organize several clinics with different family or church-based komiti. Although this made for increased efficiency

The status and authority of komiti has been diminished over time as health services were modernized.

from the nurses perspective, it tended to undermine the cohesion and authority of komiti as a village-wide organization.

By the late 1980s the health inspectorate (mainly employing young men) took over responsibility for the condition of water supply and village sanitation, so in many villages the *komiti* no longer considered this work their responsibility for which they, unlike the health inspectors, were not paid.

Village *fono* require all households to maintain the side of their property facing the road; to keep the grass cut and to plant decorative hedges and gardens. Those who do not may be fined. Some villages plant and maintain floral borders on village roadsides where there are no houses, adding to the beauty of the village. However less attention is paid to the back of houses, out of sight, where refuse can collect water providing breeding places for the Aedes mosquito that carries filariasis, dengue fever and chikengunya and zika virus, and discarded coconut shells can attract rats. Chickens and dogs wander largely unchecked in and out of cooking houses at the back of main dwelling houses -- also potential sources of disease. A recent small survey of eight village *komiti* which was investigating knowledge, attitudes and practice on feeding babies and children under-five year found that many women cited poor hygiene in households as the cause of malnutrition in young children. Due to poor hygiene the children got sick and did not eat, they thought. They advocated a return to the household hygiene inspections to improve conditions.

Despite the neat appearance of Samoan villages, at back of houses, out of sight, refuse can collect water providing breeding places for the Aedes mosquito that can transmit filariasis, dengue fever and chikengunya and zika virus

Most villages still have *komiti* but the village survey previously cited found that not all villages do. Of 240 traditional villages and sub-villages surveyed, 182 (76%) had a village-wide *komiti*. The most common description of their role was 'cleaning and beautifying the village'. It should be noted that "cleaning' in this context means organizing grass cutting and sweeping up litter. Even in villages with a village-wide komiti, organized activities among women tend now to be more church-focused than in the past. Most village-based women belong to a women's fellowship group with many weekly activities including cleaning and decorating the church and fund-raising.

2.4 Village women's representatives

In 2004 the government appointed village women's representatives (*Sui o Tama'ita'i o Nu'u*) for the first time. They were appointed on the basis of nominations by their *komiti*. They receive only half as much payment from the government as the village representative. Most of them are older women with secondary education who are married to a *matai* of the village, and many are also daughters of their village. According to traditional criteria, women born into a village have higher status, as 'daughter of the village', than women from elsewhere who have married into the village (Meleisea et. al. 2015).

The women's representative has several official duties, including the recording of births and deaths in the village. Her main role is to provide liaison between the *komiti* and the government; she is a contact point for all government agencies wishing to communicate with village-based women. She may call also meetings of the *komiti*, in consultation with its executive members. She reports to the Women's Division in the Ministry of Women, Community and Social Development and organizes its village-level programs for women.

If a *komiti* wishes to raise a matter with the fono, the usual procedure is for the president of the *komiti* to take it to the village representative, who then raises it on her behalf when the *fono* meets. This means that the *komiti* and its leaders usually has no direct voice in the *fono* at the time when matters they have raised are discussed.

2.6 Cultural attitudes to health and the 'hierarchy of resort'.

It is widely believed that many ailments are foreign and require treatment at the hospital or health centre, but that some ailments are suffered only by Samoans and that these ailments can only be treated with Samoan traditional medicine.

Any health promotion measure in Samoa must take account of traditional beliefs. 'Hierarchy of resort' is a relevant concept used in medical anthropology to analyze choices people make when they need treatment, especially in situations where two health systems coexist, such as traditional medicine and modern science-based medicine, as is the case in Samoa. The most recent and detailed study of Samoan traditional medicine (Macpherson & Macpherson 2003) traces the evolution of Samoan medicine from pre-Christian beliefs that attributed almost all illness to the agency of spirits, to practices similar to those described throughout Polynesia (Whistler 1992). There is no evidence that Samoans used ingested herbal remedies in the pre-Christian era, although massage

was an important aspect of therapy, along with ritual (shamanistic) means of communicating with spirits. However, as Samoans came into contact with missionaries and people of many other cultures after the 1830s, there was considerable borrowing, including new modes of divination and diagnosis and the use of herbal infusions and various salves, along with older ritual practices.

The idea developed that many ailments are introduced (*ma'i palagi*) and therefore require treatment at the hospital or health centre, but that there are also certain suffered only by Samoans (*ma'i Samoa*) and that these ailments can only be treated with Samoan traditional medicine.

Put very simply, the hierarchy of resort in Samoa works like this: a person feeling unwell may attend a hospital or health clinic for treatment, which may not make that person feel better. It is likely that he or she will then decide that the problem must be a Samoan illness, and so consults a *fofo* (traditional healer). The sequence may be the other way around; after treatment by a *fofo* a person may feel no better, so seek treatment from a hospital clinic or a private practitioner. In this way of thinking the symptom is the focus of resort, and it is difficult to understand symptoms part of a disease syndrome. For example recurrent fevers may be traditionally diagnosed as the Samoan illness *mumu,* and not recognized as symptoms of filariasis, which may not become physically manifest for many years.

Most Samoans have faith in traditional medicine, which is probably why it is apparently effective despite the lack of much scientific evidence of its efficacy. The individual attention provided by traditional therapy is attractive to patients; so different from sitting in queues outside clinics for perfunctory diagnosis or treatments and provision of medications that are not well understood. Practitioners usually prescribe a course of treatments requiring several sessions of therapy. Samoan therapies are also susceptible to fads, which come and go, such as belief in the curative properties of holy water, or certain introduced fruits.

The efficacy of their interventions may be reinforced by traditional Samoan treatments for conditions that are not recognized as self-limiting. For example congenital dermal melanocytosis (Mongolian spot) in newborn babies is traditionally diagnosed as the Samoan malady *ila* requiring the attention of a *fofo*. In most cases the mark will naturally disappear in a few months, this natural process is understood as a confirmation of the efficacy of the *fofo*'s treatment.

Another aspect of Samoan attitudes to health is a tenancy to spiritual fatalism encouraged by the widely belief that prayer can overcome any illness, if it is God's will. While this may be spiritually very positive, it may have the less positive effect of reducing incentives to prevent illness or to seek treatment for illnesses that respond to treatment if diagnosed in their early stages.

2.7 Food, culture and nutrition education

Women's committees throughout Samoa have been given advice on nutrition since the 1970s, through various programs. The leading agency for nutrition education since the 1960s has been the Secretariat of the Pacific Community (formerly the South Pacific Commission). Initially nutrition education was linked to programs of home economics for the staff of government, NGO and church groups providing programs for rural women.

Later the nutrition programs focused on health promotions encouraging the consumption of 'Pacific Island food" local staples such as taro, and fruit and seafood. Illustrative posters were mass produced and training programs for community workers were provided. In the 1990s UNICEF sponsored a Pacific-wide home gardening project to teach people to grow and eat vegetables such as tomato, cabbage and others, and there were many similar projects sponsored by various aid donors. In Samoa, for a time, there was a nutrition center at the main hospital in Apia with a demonstration garden and classes to how to cook vegetables.

Mass education and messages on healthy eating has been promoted by various programs in Samoa for the past 40 years

For several decades there has been concern about the well-documented high prevalence of diabetes and cardiovascular disease and some cancers associated with the apparently growing prevalence of obesity in Samoa, particularly among adults over 25. As Dr Vermuellen, a physician who worked in Samoa for many years, pointed out in a seminar at the National University of Samoa in August 2014, this is a modern phenomenon. In the past large meals of rich, varied foods (*to'onai*) were served only on Sundays or at feasts, and few Samoans were obese. Nowadays, he pointed out, many people eat a *to'onai* type of meal every day.

There are many well-known and well-documented factors in dietary change.

Fiti-Sinclair (2004) conducted a study commissioned by FAO of Samoan attitudes to fruit and vegetables in their diet. She found:

> *Although many Samoans eat some fruit and vegetables today [which they did not consume traditionally], the present-day diet of the average Samoan is still far below what is recommended by WHO … The STEP survey implemented by the Ministry of Health in 2002 showed that most Samoans eat fruit less than three days per week, and 35.6% of the population eat virtually no fruit at all (2004:3).*

She points out that the starchy staples (taro, banana, breadfruit) were counted as 'vegetables' consumed by 35% who did eat vegetables and that the vegetable consumption would be much lower if these staples has been excluded.

Fiti-Sinclair draws attention to the importance of understanding traditional Samoan attitudes to food. The traditional concept of a proper meal is *mea a'ano*, the staple food (breadfruit, taro, or plantains/bananas) and *mea lelei*, a supplementary dish of seafood or soup- and nowadays tinned fish, imported chicken, or imported meat. Fruit (most fruits are introduced cultivars) was consumed as an occasional snack. There were no leafy vegetables in the traditional diet with the exception of taro leaves, which were baked with coconut cream and consumed in small amounts as a relish.

Sinclair writes:

> *Although the classification of food (taught in schools and by health and nutrition workers and in posters and brochures) into energy, body-building and protective foods is well known by those interviewed, the Samoan classification of foods is still into mea ai lelei and mea ai aano, and the fact that vegetables were not part of this classification of foods means that when preparing a meal, vegetables are not considered part of a meal and therefore not included. The way most Samoans eat vegetables now is as part of a soup or chow mein or apa eleni or fasi mamoe fried with beans, pumpkin or cabbage. Samoans would eat the vegetables in these dishes as part of the mea ai lelei, but beans, eggplants or other vegetables cooked on their own, or a green leafy salad is often left untouched by many Samoans.*
>
> *A Samoan meal of mea ai aano with accompanying mea ai lelei is completed with a cup of tea or koko Samoa, often drunk at the end of the meal. Sweet foods such as desserts or fruits are not part of a Samoan meal, although cakes and pies are beginning to be accepted as part of a public feast or when hosting important visitors. Fruits are eaten as a snack or given to young children, the sick and old people, whose bodies need strengthening. Fruits are not for 'strong' people.*

Hardin and Kwauk (2015) note that most Samoans know that fruit and vegetables are 'healthy', whether they consume them or not:

> *Samoan food actors focus on local production as a way to increase access to cash and to provide Samoans with financial prosperity. At the heart of this argument is how local food actors take on the role of social entrepreneurs or, more aptly, altruistic capitalists, to reorient dominant public health approaches to the financial empowerment of Samoan people. By bringing to light the desirability of the commoditization of "local foods," local food actors aim to develop agri-business while leveraging market logics to provide opportunities for healthier consumption and, thus, healthier Samoans.* (2015:520)

Despite messages about health and development a further factor is the economics of food. Nutrition issues in Samoa, as in many other parts of the world have structural basis, the result of modernization, globalization, and new modes of living. Samoa is not self-sufficient in food. As Sinclair points out in her previous cited study, fruit and vegetables are expensive, even those that are locally grown. Fresh fish is very expensive. Many households today consume a staple diet of imported rice; bread made from imported flour, and imported noodles, washed down with imported tea or locally produced cocoa (*kokosamoa*) heavily sweetened with imported sugar. Children are given soda or syrupy cordial to drink and salty snacks like imported Bongos or potato crisps from an early age (in families that have money to buy them).

Binge drinking of imported alcohol is a common practice when socializing, particularly among men, and many people smoke cigarettes made with imported tobacco. Frequently consumed meats are all imported and include mutton flaps (sheep belly/ribs), belly beef, and sausages; all very high in fat and relatively cheap compared to leaner cuts of meat (see Gerwerz and Errington, 2010). Currently imported frozen chicken legs and thighs from America is the cheapest meat, at around WST 1.50 -2.00 per kilo, and tinned herrings, which retail for around WST 2-4.00. Locally raised poultry, beef, pork is reserved for funeral feasts.

As Fiti-Sinclair explains, there are cultural obstacles the affect the ability of Samoans to follow WHO recommendations on the consumption of fruit and vegetables:

> *There is a mindset amongst Samoans that makes them buy food on a daily basis. This mindset is deep-seated but it can hinder the success of a (WHO recommended) 5+ a day programme. Traditionally, food was obtained daily from the gardens because it is good to eat fresh food, but also because the starchy staples and coconuts are heavy and must be carried on people's shoulders from the inland plantations, and these take priority over any vegetables. Today, even if there are refrigerators to store more than a day's supply of food, enough money to buy it, transport to carry enough from the garden or market, on the whole, Samoans still buy or harvest foods for just one or two days.*

Associated with this is the idea that what food is there, must be eaten that day, because "e sau lava taeao ma ona 'ai" (tomorrow will come with its own food). So budgeting the food to have enough for the next day is not a common notion, and people tend to cook what is there even if it is much more than is needed. This makes it pointless to try and save by buying food in bulk. It also leads to people eating more than is needed by their bodies. Because the food was there, and because there were no refrigerators in the past, any food that that was prepared was eaten. There was also the chance that the next meal was going to be late, so it was best to eat up any food that was there so they wouldn't be too hungry before the next meal. So although families have refrigerators today and food can be stored safely there, many refrigerators I have seen are empty of food, with just bottles of water for drinking.

Collective living and sharing is at the heart of Samoan culture and the sharing of food is one of the most visible expressions of Samoan values. Food is shared not only formally on social occasions such as a wedding, funeral, bestowal of titles or opening of a new house, but it is also shared on day-to-day basis amongst neighbors. Sharing equally amongst neighbors means people feel free to borrow, as they will reciprocate when they have something they can spare to share. However, this works well when there is equality in the giving and receiving, but it doesn't work so well when one is always borrowing with nothing to give to others.

Equal sharing used to work in the past in villages when there was little difference in the families' resources. However, today, the value of sharing makes it difficult for those who can afford to buy food in bulk, because some neighbours can come and ask for some and one is obliged to give as it is bad form not to share. This happens more in villages, but some urban dwellers still have this habit. This all contributes to the practice of obtaining food daily, so one can say with a clear conscience that she doesn't have something when a neighbor comes to borrow. So instead of buying enough vegetables for a few days when going to the market, the thinking is still just for the food for the day, and if the market is not easily accessible, the chances are nobody will go to the market daily and therefore no vegetables are eaten daily (2004: 5-6).

2.8 Training and communication Issues in the dissemination of public health information

Thomas and others, including the writer, have observed that cultural norms can affect communication including community-based health education. For example in the 1980s I observed that health messages about birth-spacing were not being relayed according to policy. A few nurses incorrectly advised mothers to get their child bearing over with in their younger years then have a tubal ligation. It was evident that the public health nurses needed more training so that they could

fully understand why the health message was important for infant health and well as maternal health, and how to convey it accurately.

The Samoan cultural norms that may affect communication are as follows:

- Speakers use polite forms of speech to present information to a group gathering (such as a *komiti* meeting).
- Younger people are not encouraged to question more senior people: Samoa protocol required them to listen respectfully. If they don't understand something, they are likely to be inhibited from asking for clarification.
- A speaker who is considered to have expertise may not be questioned, even by senior people at a meeting, even if they disagree with what has been said.
- In workshops, the representative of discussion groups may only offer the group's opinion insofar as it is acceptable to senior people present.

Part Three: Revitalization of the role women's committees in public health promotion.

2.1 WHO PEN-fa'aSamoa program

WHO has designed an innovative approach to tackling prevalent non-communicable diseases at community level. It is a package of low technology, cost effective and evidence-based interventions (PEN). It has been trialed in Samoa. The WHO PEN-fa'aSamoa program has three 'pillars'

1. Early detection
    - Community engagement
    - Identification of focal persons in the community
    - Training of an outreach team and the village focal persons.
    - Register and screen the population
    - Refer people with a high risk of NCD to the local health facility.
2. Treatment and management
    - Confirm NCD risk factor
    - Initiate NCD treatment and management program
    - Review at regular intervals
3. Community awareness
    - Implement NCD awareness project
    - Provide feedback on village achievements.

The program has been initiated in two villages; one a large village, Faleasiu, located in the somewhat urbanized northwest Upolu region, the other a small village, Lalomalava, located in rural Savaii.

The program has three particular strengths in the Samoan context:

- It is organized within the governance structure of traditional villages (described in Part One above). It is implemented through the *komiti* (women's committee) with the approval of the *fono* (village council of *matai*) and the support of the *aumaga* (association of youths/untitled men) and so *overcomes* the tendency to set up new community based organizations, which may divide communities and undermine the positive aspects of traditional governance.
- It enables people to objectively learn their risk of an NCD and empowers them to understand that NCDs are 'silent' diseases in their early stages. It *overcomes* the cultural understanding that illness is only present when a person feels ill.
- It helps people to accept that NCDs are precursors of severe illnesses can be overcome with a program of treatment prescribed by the local health center. It helps to *overcome* the association of NCD symptoms with "Samoan illnesses" requiring traditional treatments by *fofo*.

Preliminary evaluation of the program in the two villages indicates that there has been a generally positive response to PEN-faaSamoa and that both want to continue the program. However there have also been differences in the response of *komiti* and their leaders in sub-villages. Some have worked effectively and harmoniously while others have been less responsive and have expected payment to continue the work.

3.2 Revitalizing women's health committees in Samoa: conclusions and recommendations

This report has traced the rise and decline of modern village women's associations in Samoa over the past 95 years. They were originally formed shortly after the demoralizing impact of a devastating introduced epidemic, at a time when many infectious diseases were endemic. Many of these diseases were overcome to a large extent by initiatives implemented through the *komiti,* such as the establishment of village sanitation rules and inspections, growth monitoring of infants, vaccination, and mass drug administration.

When the author of this report conducted her first study of women's committees in 1976-78 (Schoeffel, 1979), they were observed to have considerable authority and prestige in their community, which is not so evident nowadays. The structural effects of organizational change and modernization have been outlined in Part Two above. However there is scope to revitalize the roles of *komiti* around their original role of health promotion, although efforts to do this should take account of social factors that have undermined the *komiti* over time

The *komiti* are continue to be organized according to the rank hierarchy of the village, mirroring the composition of the *fono*, and the roles and status of the *matai*. The wives or (rarely) the sister of the highest-ranking matai are expected to become the leaders of the komiti. The wives and sisters of the highest ranked *matai* are usually as well educated as their husbands and high title succession in Samoa takes account of such matters as education.

However, high traditional rank is not automatically correlated with high economic status; two modern factors, education and wealth, have somewhat undermined the authority of high traditional rank; lower ranking women may have as much or more education and income, and if they don't want to take direction from the *komiti* leaders, they may not attend *komiti* meetings regularly. Over the years some observers have argued that *komiti* should be more democratic, electing the best-educated and most motivated women to become leaders of *komiti*. While I can see the

merits of this suggestion, I do not endorse it. Customary norms about traditional precedence usually prevail in the organization of *komiti* and these norms are likely to have two positive effects; the first to affirm traditional values and the second is to reducing interfamily competition for leadership roles and reduce the effects of family factionalism, and in this way promoting coherence in the community. .

Of greater concern are women in poor and dysfunctional households. They may not attend regularly or respond to *komiti* leadership because they cannot afford to make contributions to fundraising, or may be ashamed for other reasons, such as not having good clothes, or new household items to show at the *asiasiga* (as described in 2.3 above). Or they may reject traditional authority that aims to impose discipline on their behavior.

If there are divisions in the village between families over court-cases or other disputes, village wide cooperation to revitalize the komiti may be difficult to achieve. Moreover, in this situation, some village families, even if they cooperate to support activities in their church, may feel no obligation to engage in village-wide activities unless they are offered payment.

Another issue is that in many villages some women, including some of those who are potential leaders, go to work, or run small businesses and are unavailable to be involved in their village *komiti*. Women have a much lower share than men of overall formal employment in Samoa; the disparity is greatest in agriculture, fishing, trades and elementary occupations. However the proportion of women in professional occupations is slightly higher than men (50.6%), while the proportion in technical occupations (45.2%) is only slightly lower. Women hold 36.3% of managerial jobs (Samoa Bureau of Statistics, 2011: 80) and comprise 47.8% of the total number of working business proprietors (Ministry of Commerce Industry and Labour, 2010).

Even more problematic are situations where men refuse to allow their wives to join the women's committee and participate in its activities. This can be overcome however, if the *fono* rules that husbands must not restrict their wives from joining the *komiti*. MWSCD might consider advocating that village by-laws should include this provision under the amended Village Fono Act. The traditional norm was for all women to join it, unless they were excused for work or school attendance.

There is also the factor of inconvenient distance. Most villages in Samoa were nucleated settlements with houses close together when *komiti* were first established.

Nowadays households are dispersed along main road and planation access roads. Women who have home responsibilities for elderly people or infants may not be able to undertake long walks from their homes to attend meetings.

In considering the options for revitalisation of Village Women's Committee, It is useful to consider the original success factors behind the mobilization of women in villages to improve public health.

- In living memory there had been massive loss of life in the influenza epidemic. Communities through Samoa were motivated to embrace a system that offered them better health at the cost of lots of effort, but very little money.

- Leadership was provided by district nurses. Most if not all of them lived in the district they served, had been trained initially as hospital nurses, were middle-aged in a society that respects age and experience, and many were wives of high ranking matai. Furthermore, all were trained under community health-oriented colonial public health system that was very progressive for its time.

- Villages with traditionally high status were targeted as 'flagships' for the establishment of committees, encouraging other villages to follow suit.

In considering how *komiti* could be revitalised under the conditions of today, consideration needs to be given to incentives. What incentives would encourage women's *komiti* to offer voluntary services to their villages? Most people, men and women who live in Samoa's villages are proud of the identity of their villages and there is a spirit of competition between villages. When someone from a village is publically disgraced, the people of that village are ashamed, and when a village person is a high achiever (especially in sports) the whole village feels proud.

A. Village selection

All villages in Samoa experience social divisions over matters such as family conflicts, land boundaries, land use, religious affiliation, title succession, and other issues so it would be wise to select villages where there is less conflict. With this in mind, the next round of PEN-FaaSamoa should consult with the Internal Affairs divisions and the women's divisions to develop village selection criteria. These criteria could consider village governance the amount of unity and good leadership demonstrated by *komiti* in recent years, and the effectiveness of Sui Tama'ita'i. If the village is large or divided into several sub-villages the more effective of the sub-villages could be chosen for the project instead of all of them. The goal should be to extend the PEN-FaaSamoa model in an environment where success will be maximised, and establishing a process where more villages can apply for selection into the program.

B. Integrate the PEN program with Vector control/sanitation education and action.

The public health issues in Samoa are not only NCDs but also prevalence of viral infections transmitted by Aedes mosquitoes, and diarrheal and other infectious

diseases. When introducing the PEN faa-Samoa to the village council programme link it to the known health issues in the community with educational messages about mosquito control, hand washing, and water and sanitation. Gain support from the village council by explaining how revitalisation of the *komiti* could help to make the whole village healthier.

C. Discourage fragmentation where possible.

In some villages the church women's fellowships are better organised that the *komiti*, but these may not reach all the families in a village. I don not recommend working with church women's fellowships for this reason. It will be better in the long run to try to revitalise an existing, village or sub-village *komiti* that is inclusive of women form all the families and all the churches in that community.

D. Training

Selected *komiti* should be provided with training designed for PEN faaSamoa and village sanitation improvement, and the training should include common public health issues in Samoa, how to make a checklist of village health issues and how to set objectives and how to identify indicators of success; also follow-up training with ideas for village health projects, and project and financial management.

E. Remuneration.

Apart from the equipment and training provided, the expanded project should budgeted an initial grant for each participating *komiti* (for example WST 1000). Let the *komiti* collectively decide when it meets, after training and project introductions are completed, how the money will be used for village health improvement. The programme should not pay any single person, if any payment are to be made to individuals let the *komiti* decide who and how much. Make it clear that the money is a grant to help the *komiti* revitalise their health promotion work.

Encourage the *komiti* selected to participate to develop checklists of public health issues in the community, after training has been provided, and to plan projects for public health improvement, and provide them with information about funding sources such as the CSSP perhaps a special fund for village health projects to be administered by the CSSP. An annual healthy village prize could be considered for the village that achieves the best outcomes against the indicators they have developed to measure progress.

F. Independent Monitoring and Evaluation

After training a monitoring and evaluation programme should be established to track progress with each komiti every six months. MoH may wish to consider contracting the Centre for Samoan Studies to assist the Ministry and Department of health to design a training program and follow-up monitoring and evaluation program.

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