Overview report: Transnational Pacific Health through the Lens of Tuberculosis

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In this final report we briefly describe the life of the ‘Transnational Pacific Health’ research project and present an overview of the key features and outcomes of this research project, organised around the project’s aims and objectives.

1.0 The Life of the Project

Preparation for “Transnational Pacific Health” began towards the end of a project focusing on tuberculosis (TB) in several different ethnic groupings in Auckland and historical work on the more recent history of TB in New Zealand. From this work, and that of colleagues in public health and epidemiology we began to realise that TB in Pacific communities was distinctive in some rather alarming ways. In contrast to the mainly isolated cases of TB in other communities, within Pacific communities in Auckland, TB was being actively transmitted. Children and old people were particularly vulnerable, and historical and contemporary transnational linkages were an important part of the picture. During this earlier project we had been exposed to the concept of syndemics. This concept directs attention to negative interactions between diseases within a particular population and between diseases and noxious social conditions. This seemed a powerful framework to confront what we anticipated would be a growing problem for Pacific health: a syndemic relationship between tuberculosis and Type 2 diabetes (Littleton and Park 2009).

Transnationally, not all was doom and gloom. The Cook Islands had very low TB rates and had maintained this pleasing statistic for years after very high rates until the 1970s. How had this happened? In contrast the TB rates in Tuvalu were declining they were still very high. Could we understand and draw lessons from a comparative study where both Tuvaluans and Cook Islanders were vulnerable to TB in New Zealand, but the situations in their home countries presented contrasts, along with commonalities?

Among our colleagues were scholars with personal connections to both Tuvalu and the Cook Islands, and the range of academic skills needed. All but two were from the University of Auckland. The Drs Chambers were from the University of Southern Oregon. In alphabetical order, the members of the research group were: Linda Bryder, Anne Chambers, Keith Chambers, Ward Friesen, Jennifer Hand, Phyllis Herda, Robin Kearns, Judith Littleton, Pat Neuwelt, Julie Park and Yvonne Underhill Sem. After consultation with Tuvalu and the Cook Islands and with members of those communities in Auckland, we designed a project where these scholars could lead and support six graduate students from Tuvalu and the Cook Islands who would carry out much of the research while studying for research degrees. The final team included Tufoua Panapa and Evelyn Marsters as PhD students; Rochelle Newport, Debi Futter-Puati, Setapu Resture, Sagaa Malua as graduate students; and Philippa Blackmore as research manager. Jessica Grant joined the student group for Masters studies from Canada. Deborah Dunsford, a PhD graduate from our earlier project, joined the team to lead the New Zealand-based historical project. Summer students and research assistants who worked on the project included Ally Palmer, Laura McLauchlan and Siobian Patia.

A proposal was submitted to the Health Research Council of New Zealand and funded in 2008. Work began at the end of that year so that by the beginning of 2009 two Masters students in History were ready to start researching the history of health services and TB in their respective island groups. In the months that followed two PhD students joined the team, to carry out ethnographic research on TB and health, while in the third year, two Honours students researched health promotion and health development topics. Meanwhile staff on the project researched the history of
Pacific health in New Zealand from 1950, supplemented the students’ research projects with further investigations and advised and supported the students in myriad ways.

The milestones of the project were all completed by the end of 2012, and the two PhD students plan to complete their theses in 2013 and to travel with some team members to Tuvalu and the Cook Islands for face-to-face discussions of the projects’ outcomes. The various reports, publications and theses are all available for reading or downloading on the project webpage: [http://www.arts.auckland.ac.nz/en/about/schools-in-the-faculty-of-arts/school-of-social-sciences/anthropology/staff-research/social-research-on-tb-and-health.html](http://www.arts.auckland.ac.nz/en/about/schools-in-the-faculty-of-arts/school-of-social-sciences/anthropology/staff-research/social-research-on-tb-and-health.html)

The aims and objectives of the project, as described in the initial proposal are included below and provide the structure for this report.

**Aims**

1. To understand how TB occurs in the context of transnational, gendered life courses and comorbidities, and the implications of this transnational perspective for population health and disease prevention.
2. To identify conditions promoting TB reactivation and transmission in two Pacific populations in New Zealand and countries of origin and the interactions between these locales.
3. To identify historical and contemporary barriers to, and plan for, effective interventions.
4. To produce culturally specific information on the pathways to prevention, diagnosis and adherence to treatment of TB and interacting conditions, that can contribute to services and policy directed at TB control and treatment in New Zealand and the Pacific.
5. In addition the project has a specific objective of developing new Pacific health researchers and research models in a supportive and collaborative environment.

**Objectives**

1. To analyse the implications of transnationalism for the persistence and transmission of TB in New Zealand and the home islands and why that varies (Aim 1);
2. To determine the macro-socioeconomic and life course determinants of TB among the same populations (Aim 2);
3. To identify whether and how the high rates of TB among some Pacific people cluster with other health related conditions by person, place or time (syndemics) and the implications of that for effective interventions and policy aimed at social disparities in health (Aim 1);
4. To identify historical barriers to effective intervention through documenting the history of public health and specifically TB services in the two island nations and the history of Pacific TB in New Zealand since 1950 (Aim 3);
5. To identify the contemporary factors that create barriers or facilitate successful TB prevention, diagnosis, contact tracing and treatment among Pacific peoples (Aim 3);
6. To work alongside the communities participating in this research from inception to completion to design pilot interventions that are effective and culturally appropriate, and to seek funding in support of these interventions (Aim 3 & 4);
7. To support emerging Pacific health researchers in undertaking social science of health research and advancing Pacific research models in a collegial environment (Aim 5).
2.0 Discussion of results

Aim 1: To understand how TB occurs in the context of transnational, gendered life courses and comorbidities, and the implications of this transnational perspective for population health and disease prevention.

Aim 2: To identify conditions promoting TB reactivation and transmission in two Pacific populations in New Zealand and countries of origin and the interactions between these locales.

While a significant public health issue, TB in New Zealand is a relatively minor problem. The national prevalence rate of TB disease in 2012 was 7 per 100 000 per annum (a low incidence country) (ESR 2012). This covers, however, major disparities according to ethnicity, geography, class and history (Das et al. 2006a, 2006b) (see Figure 1). In contrast to the other communities in New Zealand, TB among Pacific peoples has increased especially among the young (Das 2006a) (see Figure 2). Furthermore there is active transmission from adults to children and from local to foreign born people and vice versa creating a significant future burden of ill health (Das 2006a, Howie et al. 2005, Littleton et al. 2008, Sexton et al. 2008, Voss et al. 2006). In 2011, 46 people of Pacific ethnicity (prioritised) were diagnosed with TB disease: 13 were born in New Zealand, 33 were born overseas. This latter figure gives a prevalence rate of 27.2 per 100 000 for Pacific people born outside of New Zealand and a rate of 18 per 100 000 for people of Pacific ethnicity. The term ‘Pacific’, however, hides significant differences between Pacific communities and nations in the burden of disease.

There is significant transmission among Pacific Islanders living in New Zealand. This is suggested by the high proportion of cases (62.4% between 2007-2011) with a non-unique molecular type, as well as the presence of tuberculosis among children (ESR 2012). Mexicans living along the Mexican-USA border have a similar pattern of transmission to Pacific Islanders living in Auckland (Restrepo et al. 2007, Littleton et al. 2008, Wells et al. 1999). Other similarities occur - both populations are transnational with frequent border crossings, both have often marginal economic positions and, at times, equivocal migration status, and significantly Mexicans, like Pacific Islanders, experience disproportionately high rates of TB and diabetes mellitus (DM) (Perez et al 2006, Restrepo et al. 2007).

Epidemiologically TB and DM operate synergistically. Clinical and experimental studies demonstrate that the synergy between TB and DM operates in multiple ways (see Stevenson et al. 2007 for a recent review). Pre-existing diabetes (DM) serves to increase the risk of TB disease through multiple effects on the immune system including increased bacterial loads among DM patients, lowered production of interferon-γ (IFN-γ) in diabetics (Martens et al. 2007), and the depressed activation of alveolar macrophages (Wang et al. 1999). DM and TB also interact to make treatment of both more difficult, prolonged and have higher failure rates. In reverse, active TB disease is associated with difficult glucose control among diabetics, while some TB medication may contribute to hyperglycaemia (Stevenson et al. 2007). It has also been hypothesised that TB predisposes people to DM through amyloidosis of the pancreatic islet cells which impairs insulin
production (Broxmeyer 2005). Finally, there is some evidence of mutual causation via routes such as disorders in Vitamin D metabolism.

![Figure 1: Rate of TB cases between 1990 & 2006](image)
Figure 2: Number of TB Cases for Pacific Peoples
Inadequate Vitamin D is associated with both impaired glucose tolerance (Holick 2007, Flores 2005) and reduced effective cellular immunity allowing reactivation of latent TB (Chan et al. 2000, Martineau 2007, Ustianowski 2005). This interaction has been recognised by the WHO/IUTLD who released a strategy document in 2010 linking the two conditions. Some countries, such as the Marshalls Islands have followed this up by testing patients with TB Disease for impaired glucose tolerance (http://www.worlddiabetesfoundation.org/projects/marshall-islands-wdf12-715).

Diabetes is a significant concurrent stressor in the lives and families of many of our Pacific Island participants. This interaction is particularly evident in Evelyn Marsters’ work. As documented through the clinical literature cited above, diabetes may precipitate tuberculosis reactivation and certainly makes treatment of both conditions difficult. Further, since a significant proportion of diabetes patients end up spending time in dialysis units this provides a new venue for potential TB transmission. Despite our earlier publication on this linkage, and the WHO/IUTLD identification of the issue, there has still been (as far as we are aware) no systematic study of the prevalence of diabetes among TB patients undergoing treatment for active disease in New Zealand. Even without this, the links that our study points to as well as the experience of public health nurses in the region would suggest that patients with TB should be tested for diabetes during their hospitalisation and that GPs be educated about this potential link. In the most recent surveillance report 76 cases (approximately one-quarter of all cases) were recorded to have a concurrent immunosuppressive disease – three of these were HIV cases, the remainder are renal disease, gastroectomy, and diabetes (based on the Episurv forms). None of the cases with immunosuppressive illness were reported to be children (ESR 2012). This figure also indirectly suggests a potentially significant interaction, which corresponds to a recent estimate that approximately 42% of TB cases in the Pacific may be related to diabetes (http://www.worlddiabetesfoundation.org/projects/marshall-islands-wdf12-715).

A syndemic perspective, however, highlights that the synergistic reaction between two conditions does not take place in a vacuum. The synergy is facilitated by social and economic circumstances. Latent TB is always a risk in populations where there have been historical TB epidemics. Our study found that the historical legacy of TB control campaigns, which were successful by the end of the 1960s in the Cook Islands but much later in Tuvalu, means there is potentially a significant proportion of people infected with latent tuberculosis in both the Cook Islands community and amongst Tuvaluans. Assuming TB control by around 1970 in the Cook Islands this would affect people aged 40 years or over in the Cook Islands community and 20 years or over among Tuvaluans (assuming TB control around 1990-2000).

This legacy allows for the possibility of tuberculosis reactivation under circumstances of stress including challenges to the immune system. Diabetes, itself related to stressful living conditions including poor diet, constitutes one of these challenges. In our study we found that many participants lived in multigenerational households, particularly when members of the family are migrating to, or visiting New Zealand temporarily. These crowded conditions facilitate transmission from those with a legacy of TB infection to those with no previous contact with active disease (particularly children). So the syndemic interaction is not just making an individual’s course of disease more difficult but is facilitating the ongoing transmission and hardship to the wider family. A recent ESR report also confirms the close relationship between tuberculosis and deprivation: 58.4% of cases in 2011 were in the four most deprived areas according to the New Zealand Deprivation Index. The highest proportion were in the most deprived areas known as NZDep10 (ESR 2012).
What a syndemic perspective allows is an analysis of disease in interaction with other diseases. One of the barriers to health improvement in populations is the failure to examine linked phenomena. As Bartlett writes in relation to TB and HIV (without reference to the term syndemic):

experts in TB and experts in HIV infection live in different worlds, obtain grants from different sources, write for different journals, and go to different meetings. This great divide applies to clinical care, research, and training; it is lessened by the overlap between the two diseases but not as much as it should be (Bartlett 2007:S125).

In relation to TB and DM in New Zealand this division occurs bureaucratically at the national and local level, while relationships between health and immigration status offer a further difficulty.

**Aim 3: To identify historical and contemporary barriers to, and plan for, effective interventions.**

- To determine the macro-socioeconomic and life course determinants of TB among the same populations
- To identify historical barriers to effective intervention through documenting the history of public health and specifically TB services in the two island nations and the history of Pacific TB in New Zealand since 1950; and
- To identify the contemporary factors that create barriers or facilitate successful TB prevention, diagnosis, contact tracing and treatment among Pacific peoples

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**Figure 3: Invitation to the Launch of Better Lives**
In our research design, these aims and objectives were addressed through all component studies but the historical barriers were a particular focus in the two history Masters theses and subsequent publications, and in the *Better Lives* study set in New Zealand (Dunsford et al 2011). A brief overview can be found in Park and Littleton (2013), and more detailed accounts of Tuvalu in Park, Littleton, Chambers and Chambers (2011), and the Cook Islands in Futter-Puati, Bryder, Park, Littleton and Herda (2013).

As a result of our research we propose that the current TB rates in these Pacific nations (relatively high in Tuvalu, very low in the Cook Islands) cannot be understood without detailed knowledge of the colonialisms in which they participated. Tuvalu (then the Ellice Islands and part of the Gilbert and Ellice Islands Protectorate, and under the control of the Western Pacific High Commission [WPHC]) was at the end of a very tenuous line of empire, centred in London. Although the WPHC headquarters were in Suva, Fiji, reports during the colonial era demonstrate that the Ellice Islands were too far away, and granted too few resources, for effective health care of the sort that would help combat the rampant TB. The situation was exacerbated because Ellice Islanders, along with the Gilbertese, were involved in contract labour for the British Phosphate Company. Conditions on the phosphate islands were often harsh and conducive to the development and spread of TB. By the 1970s when the Ellice Islands became independent, and two decades after effective anti-TB drugs were available, TB was still a most important health problem (Resture 2010). It took newly independent Tuvalu 20 more years before TB rates showed the improvement which continues today. Hence the current TB situation for Tuvaluans everywhere is part of what is the tail end of a century-long TB epidemic, introduced with colonial contact and maintained through colonial practices as well as current socio-economic and geo-political conditions.

In the Cook Islands TB rates are currently so low as to be almost indiscernible: perhaps one case every two or three years. Yet in Auckland, there are several cases each year with Cook Islands people. Again an historical approach is important here (Futter-Puati 2010). The Cook Islands became independent in free association with New Zealand in the 1960s. By this time there had been very serious attempts, especially by Cook Islands doctors, to reduce TB rates and these were successful. By the 1970s TB was no longer a serious health problem for the Cook Islands.

In this good news story, most biomedically trained Cook Island doctors recognised and respected the cultural knowledge of local people and local expert healers in relation to health risks and healing. They worked with them rather than against them. Partnerships with regional and international agencies, as well as the New Zealand Department of Health also facilitated health services. At the same time, the historical records suggest that what might be interpreted as a very authoritarian regime of surveillance, isolation and treatment aimed at reducing the burden of TB, was very largely accepted by the people as the care that was necessary to rid them of this dread disease.

Indeed our recent research on the island of Atiu in the Southern Cook Islands suggests this interpretation of care is still very current (Park and Littleton 2012). Whether it be the quarterly inspections of all houses and yards to check that living conditions are health giving and there are no breeding grounds for mosquitoes, or the full turn out of everyone eligible (and quite a few who were over the target age) for HPV vaccinations, the accepting, and indeed welcoming, of this kind of intensive attention for the good of the community is striking. Detailed historical and ethnographic research provides a community-based perspective which aids when trying to tease out the principles and relationships that made the Cook Islands’ efforts to reduce and prevent TB so successful. In a recent paper (Futter-Puati et al. under review) we have canvassed the variability of acceptable and
effective practices of partnership, not all of which conform to current textbook understandings, as we argue that partnerships have been the key to successful TB control in the Cook Islands and will remain the basis for effective health services and care into the future.

In parallel with this work in Tuvalu and the Cook Islands, several principal investigators (PI) and a research associate (Debbie Dunsford, a PhD graduate from our earlier New Zealand-focused project) carried out a larger New Zealand-based historical study, using the story of TB among Pacific people as a window into Pacific health in New Zealand from 1950-2000 (Dunsford et al. 2011). In that report we chart the rise of interest in Pacific health and health research, describe the slowly dawning recognition that Pacific people are here to stay and that Pacific-led health care and health research is an effective complement to other approaches. We examine the relationships between Maori and Pacific health and the changes in how this relationship was understood over the period. We witness the repeated surprise over five decades that Pacific people suffer with “third world diseases” in New Zealand, such as rheumatic fever and subsequent heart disease. We also note that despite the warnings from the Tokelau migration project, made over 30 years ago, we are still being warned that the New Zealand health services are about to be overwhelmed by diabetes and informed that a population health-based approach, rather than an individual ‘lifestyle’-only approach, is necessary.

A population health approach certainly includes an emphasis on individuals, families and communities engaging in healthy eating and exercise, but does not stop there. Syndemic theory provides a helpful theoretical framework for effective health promotion and illness prevention which necessarily includes political, economic, social and cultural analysis. In asking about the barriers and constraints to effective TB control we are forced to explore diabetes and its syndemic relations with TB, as well as TB’s syndemic relations with helminths (worm infestation), tobacco smoking, immigration policy (relevant to Tuvaluans), household crowding, inadequate heating and ventilation (in New Zealand), inadequate food, or poor access to services. The last part sometimes relates to service factors such as language or physical distance or other communication problems; opening times requiring patients to take time off work; or patient factors such as mobility or immobility or immigration status.

As our research developed we came to understand that in some circumstances diabetes was as stigmatised a disease as TB. People with diabetes could feel watched and criticised at social gatherings, for example, and might avoid these hubs of community life to avoid this surveillance. This is one of the negative side effects of an individualised approach to diabetes control. Responsibility and blame go hand in hand and social stress and isolation incurred through the latter has the potential to exacerbate poor health.

In terms of food and drinks, making healthy choices easy and affordable is a political as well as an industry, NGO, community and family issue. Rochelle Newport’s Masters thesis (supported by an HRC Pacific Masters Scholarship) has focused on the newly introduced Cook Islands fiscal policy in relation to sugared carbonated drinks.

Both PhD theses by Evelyn Marsters and Tufoua Panapa are firmly focused on a multi-level analysis of health and health services. In the Cook Islands case, Evelyn has worked between the Cook Islands and New Zealand and her thesis documents how individuals graft one health system on to another as well as how this transnational relationship in health is managed at an institutional level. Through policy analysis as well as the ethnography of everyday life, she shows the intimate interconnections between health and mobility, diabetes and TB, ill health and disadvantage, and the multi-layered relationships that need to be understood for effective health promotion.
In Tuvalu, Tufoua has focused on the multi-level relationships connecting education, health and development. He has explored Tuvaluan dimensions of “health” in depth, and on this basis, as well as his ethnographic research into everyday life in school and community, he is able to prepare proposals for enhancing relationships between health and education in Tuvalu, as well as for more effective health education and health promotion.

Sagaa Malua has been analysing the connections between health and migration, and health and the New Zealand immigration policy for Tuvaluans in Auckland, as well as examining several aspects of food imports to Tuvalu which relate to health. Following a dialogue between Hon Paula Bennett and the Tuvalu Community Association, of which Sagaa is Secretary, she used some of her work and that of the rest of the research group to help prepare a brief. This assisted the Association to deal with several community issues, including the issue of immigration status.

Figure 4: Tuvalu Village at the Pasifika Festival, Auckland
Figure 5: Sagaa, Tufoua and Evelyn, presenters at the HRC Pacific Health Research Fono

Figure 6: Presenting Masters theses by Setapu Resture and Debi Futter-Puati to the Fiji School of Medicine Library
Aim 4: To produce culturally specific information on the pathways to prevention, diagnosis and adherence to treatment of TB and interacting conditions, that can contribute to services and policy directed at TB control and treatment in New Zealand and the Pacific.

In this overview report, we can comment only briefly on this crucial aim. Our project results indicate that certain reorientations will be necessary to achieve TB control.

A cultural shift is required towards recognition that Cook Islanders, Tuvaluans and New Zealanders in general live in a transnational space. A duty of care extends into this space, beyond national borders. Consequently, patients, doctors, nurses and other health care professionals working in this space need to assume shared responsibility to convey, receive and act upon necessary information from one health service/health professional to another when patients are travelling. (Negative example: elderly person with suspected TB travelled from Auckland to Cook Islands before he could be tested, CI Health service informed, no return communication, and when the man returned to New Zealand a year later, he had active TB and co-resident children were infected as a result, with one having TBD).

Just as necessary is a cultural shift to transcend the barriers between infectious and non-communicable diseases; especially TB and diabetes. Practical outcomes include the testing of TBI and TBD patients for diabetes, and certain diabetes patients for TB; educating and resourcing public health nurses and community health workers who work in TB on diabetes detection and prevention, tobacco cessation and other health promotion efforts; and joint workshops and conferences for diabetes and TB health professionals. The Marshall Islands operational research programme provides a way forward (see http://www.worlddiabetesfoundation.org/projects/marshall-islands-wdf12-715).

Careful consideration of current health education and health promotion practices; and a comparison of these with indigenous understandings of health and education and associated practices, along with closer alignment between these would produce more culturally appropriate and therefore effective health education and health promotion.

Promoting shifts away from ‘siloing’ is needed for effective, inclusive health policy. Examples of siloing include current funding (e.g. WHO) and other practices which segment health promotion activities, political, educational and institutional arrangements which separate health and education, as well as separating specialties within health (see point 2). Work is required at the level of elites to recognise that this is a major barrier to effective services and policies to improve people’s health.

The poverty link is undeniable, therefore poverty elimination is part of TB (and diabetes) control.

A move away from individual blame to sharing the responsibility for health: This includes government with a ‘health in all policies’ approach (ministries of health, finance, education, foreign affairs, agriculture etc), food and beverage industry and associated media, local government (walk and bike-ability, management of retail), NGOs, schools, communities, families, and individuals.
Aim 5: In addition, the project has a specific objective of developing new Pacific health researchers and research models in a supportive and collaborative environment.

We wanted to support graduate students—three each from the Cook Islands and Tuvalu respectively — to work in their own communities, draw on and use local knowledges in their theory building, and to work towards and achieve a higher degree. The six Pacific students were supervised, supported by and worked alongside staff members from three faculties of the University of Auckland and from the University of Southern Oregon who were all Principal Investigators (PIs) on the project. Key to the mentoring and support of our students was a weekly reading/writing group at which a core group of PIs and the students read relevant articles and one another’s writing of one another in a safe and collegially critical environment.

Setapu Resture (Tuvalu) and Debi Futter-Puati (Cook Islands/ New Zealand) joined the project in March 2009 to pursue historical research. They wanted to understand the historical forces which has led to such starkly different patterns of contemporary TB in Tuvalu and the Cook Islands: Tuvalu has the highest rates in Polynesia; the Cook Islands, among the lowest. Guided by their supervisors, Professor Lynda Bryder (History), a scholar of the history of TB; Dr Phyllis Herda (Anthropology), a Pacific historian and anthropologist; and other PIs they uncovered different colonialisms between the British Western Pacific High Commission in the former Ellice Islands, and New Zealand’s colonial rule in the Cook Islands. These differences include resources devoted to health services and those necessities of life — housing, water etc — which make health possible, distance from the colonial centre, contract labour and migration, and especially significant, the attitude of western trained health professionals to indigenous healers. Their theses may be accessed via our website.

Figure 7: Anne and Setapu work in Funafuti archives 23 July 09
Figure 8: Julie Park, Debi Futter-Puati, Yvonne Underhill-Sem, Evelyn Marsters being interviewed for Cook Islands media at Ministry of Health, OH Rarotonga, 2010

Figure 9: Dr Nelesone and Judith Littleton, Hospital, Atiu, 2011
A risk to our project was the relatively small populations of both nations and even smaller numbers qualified to undertake higher degrees in social sciences. Yet the lengthy search for a Cook Islands and a Tuvaluan scholar, each ready to begin a PhD, was successful and two superb ethnographic studies have been completed (Project Reports No. 2 and 3). Tufoua Panapa has concentrated on the triangular relationship between health, education and development in Tuvalu, while Evelyn Marsters’ work is a syndemic approach to transnational Cook Islands health, encompassing New Zealand and the Cook Islands. Both students have been supervised by Dr Yvonne Underhill-Sem (Development Studies) and Professor Julie Park (Anthropology). Associate Professor Judith Littleton (Anthropology) co-supervised Tufoua, with Professors Anne and Keith Chambers (Tuvalu scholars from the University of Southern Oregon) as Advisors. Dr Ward Friesen (Geography/School of Environment) co-supervised Evelyn. Both PhD students have concentrated on the TB-Diabetes connection to give their work focus. Neither has taken the concept of health for granted and important new knowledge about Tuvaluan and Cook Islands ideas and practices around what in English we call “health” is at the core of their work.

Our project is committed to the application of new knowledge to health promotion and health development. Sagaa Malua (Tuvalu/New Zealand) and Rochelle Newport (Cook Islands/New Zealand) both completed Honours dissertations on these topics in 2011, Sagaa was supervised by Assoc Prof Littleton and Prof Park; and Rochelle by Dr Jennifer Hand, a PI on the project, and Dr Tasileta Teevale (both from the School of Population Health). Rochelle concluded in her dissertation that health promotion activities in the Cook Islands have the potential to use transnational social spaces as a site for community capacity building (available on website). Her subsequent Masters of Public Health thesis, also supervised by Dr Hand, explored the potential of fiscal measures to limit access to unhealthy products, such as sugar sweetened carbonated beverages. Sagaa has extended her Honours work to produce a substantial report about the Tuvalu community in Auckland (Project Report No. 4), with special reference to health and health care, and particular attention to the highly problematic immigration policy—health nexus. This work has already been used by the Tuvalu community in a brief they prepared for their local MP and Minister of Social Welfare.
3.0 Looking Ahead

The theoretical orientations of transnationalism and syndemics have served the project well without confining PIs or students to a pre-determined theoretical approach. Now that the individual studies are completed our efforts over the next two years will be directed to producing integrated accounts of the project’s ways of working and our results. These show how Pacific peoples live transnational lives, how they/we act and think about health, how and why diseases and social conditions interact, and delineate the lessons for policy and practice in our three nations. These results also have wider significance beyond these particular groups of islands. Our work is of course not done in a vacuum and our research group works closely with health workers, ministries, community leaders and community members in all locations. We are most grateful for their continuing cooperation and to The University of Auckland and the HRC of New Zealand for their support which was essential to the project.

Bibliography of Theses, Dissertations, Reports, Published Work and work in press from the project can be found on the website.

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