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Partnerships for health: Decimating tuberculosis in the Cook Islands, 1920–1975

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ABSTRACT

How did the Cook Islands manage to achieve a significant reduction in tuberculosis from a high rate in the early 20th century to low rates by 1975? With the mid-century invention of effective drug therapy there was a widespread belief around the Western world that TB could be eradicated. The Cook Islands was one place which almost reached this goal. Based on primary and secondary historical and anthropological research, we argue that the geo-political emplacement of the Cook Islands and development of multi-scale partnerships were crucial to success. Our research indicates the value of understanding and engaging with local community networks and culturally appropriate partnerships in dealing with health issues.

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1. Introduction

What lessons for health promotion can be learned from a small island state in the Pacific? We address this question specifically in relation to tuberculosis (TB), asking how the Cook Islands managed to achieve a significant reduction in this disease from a relatively high rate in the early 20th century, especially in light of continuing high rates in some neighbouring Pacific nations (World Health Organization (WHO), 2010).²

Since the development of anti-TB drugs in the 1950s the eradication of TB has been an elusive hope (Bryder et al., 2010). The Cook Islands was one place where this hope was almost realised with 0–2 notifications each year for several recent decades (WHO, 2010).³ We argue that the specific geo-political location of the Cook Islands and the consequent development of partnerships that included and intermixed personal, local, regional and international scales were central to the successful reduction of TB.

This is primarily an historical study of measures taken to combat TB in the Cook Islands although it also draws on ethnographic approaches employed in anthropology. Viewing TB through both historical and anthropological lenses has produced a study which investigates the impact of cultural beliefs, human relationships and their impact on TB interventions in the Cook Islands.

Following its annexation by New Zealand from Great Britain in 1901, the Cook Islands medical service was a branch of New Zealand's colonial administration with all medical officers appointed in Wellington but responsible to the local Resident Commissioner, until independence in 1965. After independence, in Free Association with New Zealand, the relationship between the two countries and the medical services remained close. Our focus is on the period from 1920s until 1975, which is when TB rates conclusively declined. Our research into the lessons of history indicates the particular value for health authorities of understanding and mobilising local community relationships and networks and developing culturally appropriate partnerships when dealing with health issues.

2. Partnership and scale

'Partnership' may refer to a range of organisational practices and power relations. Types of partnership are culturally and situationally specific. They are dynamic and encompass mutually agreed objectives, a sense of mutual responsibility, engage shared understandings, and make use of the different but complementary resources of each partner (Brinkerhoff, 2002; VicHealth, 2011).

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E-mail addresses: debifp@waikato.ac.nz (D. Futter-Puati), l.bryder@auckland.ac.nz (L. Bryder), j.park@auckland.ac.nz (J. Park), j.littleton@auckland.ac.nz (J. Littleton), p.herda@auckland.ac.nz (P. Herda).¹ Current address: Department of Sport and Leisure Studies, The University of Waikato, Private Bag 3105, Hamilton 3240, New Zealand.² While Tonga and Samoa have similarly low rates, Tuvalu and Kiribati's rates are 20 and 30 times higher (WHO, 2010).³ In a population with high historical rates of TB, the conversion from latent infection to active TB in the elderly is a continuing challenge.

Scholars have identified different qualities of partnerships. Current definitions that include open decision-making, mutual accountability and transparency (Buse and Harmer, 2007) – ideal characteristics in a neo-liberal polity – are not necessarily applicable to partnerships in colonial times or in contemporary small island states (Goldsmith, 2005), where kinship and descent are major organising principles, and values of respect, obedience and care are dominant. Partnership is not often a word used to describe relationships between colonised and coloniser. However, it was just such a partnership which led to the dramatic reduction in TB rates in the Cook Islands. The effectiveness of colonial partnerships in the Cook Islands depended on the quality of the personal relationships involved, whether they were between western-trained and local healers, Cook Islands health professionals and their counterparts in New Zealand, or a locally-trained health assistant and her kin group. As Campbell et al. (2012) have convincingly argued, particular spaces may be both global and local, and global–local networks may be characterised by disconnection and connection. The concept of ‘scale’ is best understood not as hierarchy or ladders but in terms of Latourian processes, which construct networks via the power-saturated engagement of diverse groupings. The Cook Islands during the period of interest provides many examples of scalar partnerships which contributed to desirable health outcomes there.

3. The Cook Islands

The Cook Islands fall into two groups, northern and southern, spread over 2.2 million km² of the South Pacific Ocean. All of the islands lie in tropical latitudes, between 9° and 23° south of the equator, with Rarotonga being the largest island and the site of the capital, Avarua. The huge distances between the northern and southern islands create many difficulties in transport and communication, with implications for running a successful health service. Despite multiple methods of communication now linking these Polynesian islands, inter-island transport remains an issue, yet indigenous Cook Islanders are intensely mobile and have been for centuries. The population grew steadily from around 8,500 in 1915 to 12,000 in the 1930s (Lambert, 1934). It peaked in the 1971 census at 21,323, just before air travel became widely available.⁴ Fig. 1 shows the population estimates over the period in question.

Historically, TB had a significant presence in the Cook Islands: the general hospital is still today called ‘the san’ (sanatorium) by some older people, and the road to the hospital called Sanatorium Road. Although it is not known exactly when TB was first encountered by Cook Islanders, scholars agree that it was most likely introduced by European visitors to the islands in the late 18th or early 19th century (Miles, 1997).⁵ Historian Raeburn Lange noted that in 1835, only 14 years after their arrival, missionaries recorded the deaths of four people from ‘consumption’, as TB was known at the time. By the end of the 19th century TB was a major cause of morbidity and death in the Cooks (Lange, 1982). Patients with chronic pulmonary TB, with cough, fever, loss of energy and weight, and bleeding from the lungs, became common among Cook Islanders with the country losing many people to what was known locally as *maki maro*, a disease that withered or dried up its victims.

⁴ The current population of Rarotonga is approximately 13,000 with a total of approximately 19,000 in the whole group. However, only about 13,000 are resident (Stats.gov.ck\currereleases\popnestvital\popestq.pdf 2012).

⁵ See also South Pacific Commission Research Council, First meeting, Research programme, Report of the Health Committee, R.C.1/Com.H/1/Rev.1, Appendix IV, 3 May 1949, CI 6/1/1.

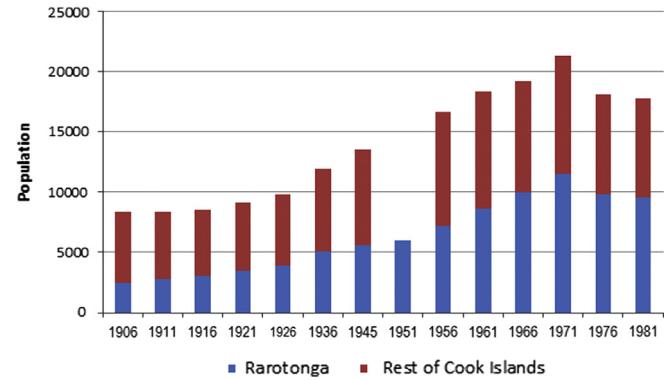


Fig. 1. Population numbers for the Cook Islands showing Rarotonga and the total population with the exception of 1951 when only Rarotonga is available. (Derived from: Economic and Social Commission for Asia and the Pacific (ESCAP), South Pacific Commission (SPC), 1983.)

Table 1

Tuberculosis mortality on Rarotonga from 1926 to 1981. (Extrapolated from Annual Reports, Ministry of Health records, and Cook Island Censuses from the Cook Islands Archives.)

Year	Population estimates		TB deaths Rarotonga	Total deaths Rarotonga	% of Deaths (%)	Death rate per 1000 Rarotonga
	Rarotonga	Total				
1926	3936	9801	36	90	39.5	9.5
1936	5054	11,943				3.6
1945	5573	13,574				
1947			38			6.8
1951	6048	–	36			
1952	6019	–	27	90	30.0	4.5
1956	7212	16,680	20	97	20.6	2.8
1961	8676	18,378	9	43	20.9	1.0
1966	9971	19,247				< 1.0
1971	11,478	21,323				< 1.0
1976	9802	18,128	0			0.0
1981	9530	17,754	0			0.0

The scale of the TB problem in the Cook Islands would not be reliably measured until scientific procedures were developed towards the middle of the 20th century. There are gaps in the data due to an inability to find records for some years or trying to extrapolate from a variety of sources. However, early foreign observers noted that the disease was widespread (Gilson, 1980, p. 20). By 1926 (see Table 1) TB accounted for 39.5% of Rarotongan deaths (Lange, 1982). Some observers thought it was declining by the 1930s, but in 1936 it was reported that the ‘scourge of the island [Rarotonga]’ (TB) was still a major contributor to mortality, responsible for a death rate of 3.6 per thousand (Lange, 1982, p. 313). It is difficult to get comparable rates from elsewhere in the Pacific, although Tarawa (Gilbert Islands) had an estimated TB death rate of 1.7 per thousand in 1930, and 2.6 per thousand in 1949.⁶ The Cook Islands rate is comparable to the 1936 estimated New Zealand Maori TB death rate of 4 per thousand (Finn, 2007).⁷

Before the advent of chemotherapy, immunisation and improved techniques for detecting early TB in the 1950s, the standard treatment for TB in most countries was in institutions which provided patients with rest, food and exercise. The emphasis in prevention was based on

⁶ Death records and 1949 population from compiled annual reports from the Medical Department, Gilbert and Ellice Islands Colony 1916–1975, from the Western Pacific Archives, University of Auckland library. Population for 1930 from Gilbert and Ellice Islands Census returns.

⁷ Reliable estimates of TB mortality, the only method of estimating prevalence, are not available until the 1920s.

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