



The Tuvalu Community in Auckland
A focus on health and migration

Sagaa Malua

“Transnational Pacific Health through the Lens of Tuberculosis”

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Glossary of Tuvaluan Words

<i>fakalotuma</i>	grated green banana baked with coconut cream
<i>fatele</i>	group dancing and drumming
<i>fekei</i>	grated tapioca in coconut cream
<i>kaaiga</i>	family, including extended family and close friends
<i>poke</i>	pudding made from starchy vegetable, flavoured with fruit, sugar , butter coconut cream
<i>pulaka</i>	giant swamp taro, <i>Cyrtosperma merkusii</i>
<i>soa</i>	friend
<i>suasua</i>	grated taro baked in coconut cream
<i>toeaina</i>	elderly man; elected leader of an island community that congregates on another island or land other than the actual island.
<i>tufuga</i>	local healer

Acronyms

AUT	Auckland University of Technology
CYFS	Child Youth and Family Services
EKT	<i>Ekalesia Kelisiano Tuvalu</i> (The Congregational Christian Church of Tuvalu)
GP	general practitioner
GDP	Gross Domestic Product
LMS	London Missionary Society
PAC	Pacific Access Category
PNH	Public Health Nurse
RSE	Recognised Seasonal Employer
TB	tuberculosis
WDHB	Waitematā District Health Board
WINZ	Work and Income New Zealand



Frontispiece: Moealofa Alefaio, Laine Steven, Elena Kefa, Litala Chandra & Mileta Esela entertaining, Tuvalu promotion at CYFS, Westgate, 2013

Introduction

This report on the Tuvalu community in Auckland, New Zealand, is prepared for the “Transnational Pacific Health through the Lens of Tuberculosis” Project, funded by the Health Research Council of New Zealand. The project focuses on Tuvaluans and Cook Islanders, both in New Zealand and in the islands, and uses a syndemic approach to Pacific health. Of particular concern are the synergies between tuberculosis (TB) and diabetes (Littleton and Park 2009). The concerns over the high rates of these conditions in Pacific communities makes transnationalism an important focus, particularly as inter-island mobility becomes easier, assisted by cheaper and faster transport and digital technology (Lee 2009).

As detailed in this report, my research furthers the transnational aims of the project through investigation of the history of migration of Tuvaluans to New Zealand, Tuvaluan community organisation in Auckland, and the connections that exist between Tuvaluans in Auckland and the homeland. The project recognises transnationalism as the “ongoing interconnection or flow of people, ideas, objects and capital across the borders of nation-states, in contexts in which the state shapes but does not contain such linkages and movements” (Schiller 2007:449). As seen in Ian Prior’s work with the Tokelau Islands Migrant Study group (Wessen 1992), what happens “here” and “there” are important in understanding health and social change.

A Project scholarship enabled me to complete a Post-Graduate Diploma in Anthropology in 2011. This assisted me with the present report, since it enabled a detailed study of New Zealand immigration policies and their effects on Tuvaluan migration to the country. I interviewed ten Tuvaluan adults and four staff members at West Fono, the Pacific healthcare provider in West Auckland, which provided information on some of the health issues Tuvaluans are encountering and the health assistance provided through the West Fono Health Trust. In 2012 and 2013 I continued my community research as a researcher for the Transnational Pacific Health Project. This deepened my community knowledge. This report was also aided by my experience as a Tuvaluan living in West Auckland, where seventy-five percent of the Tuvalu population in New Zealand lives (Statistics New Zealand 2006). Finally, this report was aided by my involvement with the Tuvalu Community Trust as a treasurer for six years from 2005 and subsequently as a secretary. I will discuss the Trust in further detail later, but note here that all Tuvaluans in Auckland automatically become members of the Trust.

In this report I focus on immigration, discussing immigration schemes that are accessed by Tuvaluan migrants, the settling and organisation of the Tuvalu community in Auckland (including the island cultural practices being observed), the Church and its role, and education and health. Drawing particularly on my ethnographic fieldwork with members of the Tuvaluan community, I document the difficulties and support networks met by Tuvaluans as they settle in Auckland, and examine the linkages between their immigration and healthcare experiences. Some of the questions I ask relate to Tuvaluans' experiences with authorities, such as immigration officers and healthcare professionals, as they try to settle permanently in New Zealand. I also examine how key institutions—namely churches, Tuvalu community organisations, island communities, and families—are involved in the health and well-being of Tuvaluans in Auckland.

I was quite apprehensive about doing research in my own community because of the tendency to overlook everyday occurrences as trivia. Dyck (2000:44) notes that when conducting research in the home field it is a “challenge to distinguish between personal and professional

interests” when researching people you have connections with. Davies (2008) cites Powdermaker’s point (1966:19) that ethnographers must take on the “role of stepping in and out of society” in an effort to fully acknowledge and utilise their subjective experiences and reflections in their research. My research has political implications, since my findings may be used by the Auckland Tuvaluan community to address some of its issues, and may provide insights into the community for government and other agencies. Therefore, in addition to the usual considerations of respect, anonymity, confidentiality, and care for individuals and families, I am also aware of the broader ethical considerations.

I begin this report by discussing Tuvaluan immigration to New Zealand, focussing on Tuvaluans' reasons for moving and on the settlement schemes put in place to allow Tuvaluans to enter New Zealand. I then discuss the organisation of the Tuvaluan community in Auckland, outlining the role of key community organisations such as churches, island groups, the Tuvalu Community Trust and the Tuvalu Society Incorporated. I then describe the various health promotion initiatives carried out by these organisations, before discussing in depth the role of the West Fono Health Trust, which was the main site of my ethnographic research. Finally, I draw on ethnographic data to examine Tuvaluans' experiences of immigration and healthcare in New Zealand, before summarising my findings and suggesting directions for future research and policy.

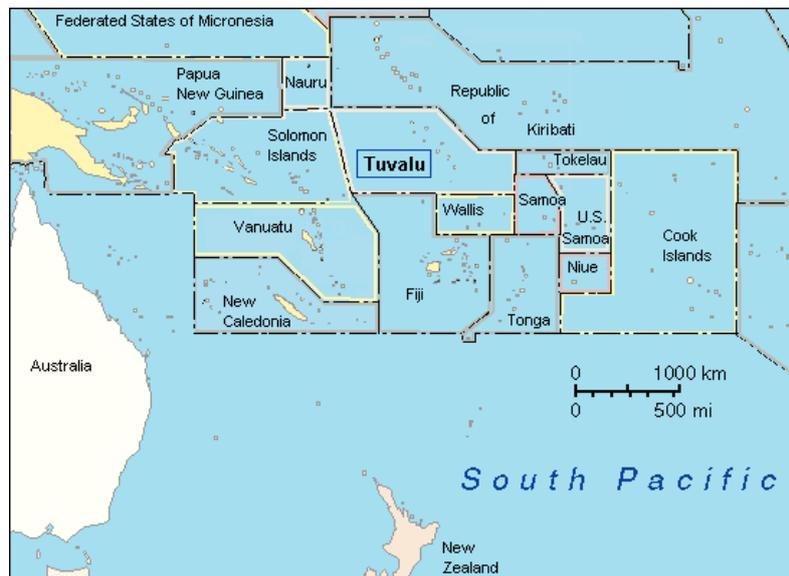


Figure 1: Map of the Pacific showing Tuvalu

Source: <http://www.tuvaluislands.com/maps/maps.html>

1.0 Tuvalu

Tuvalu is a very small country, consisting of nine coral islands and atolls (Figure 2) with a total land area of 26 square kilometres. Its highest point is only 4.5 metres above sea level (Lewis 1989). It is a country with very scarce land-based natural resources but rich marine resources. Currently, it is heavily dependent on aid and remittances from Tuvaluans working abroad (Simati 2009). The total population is 11,000, with about half of this population residing in the capital, Funafuti (WHO 2007; Figure 3 and Figure 4).

Funafuti has one of the highest population densities in the world, with 1610 people per square kilometre. In 2007, 31% of households in Funafuti had nine or more members, compared with 6% in the outer islands (Central Statistics Division 2007). This is a result of migration from the outer islands, which is encouraged by the bright lights of the urban capital and the economic opportunities it offers (Government of Tuvalu 2002; Rhead 2010: 42). Migrants from the outer island communities usually have no rights to land in Funafuti, and thus no rights to access local resources. Migrants from the outer islands must therefore depend on kinship connections with relatives already resident there.

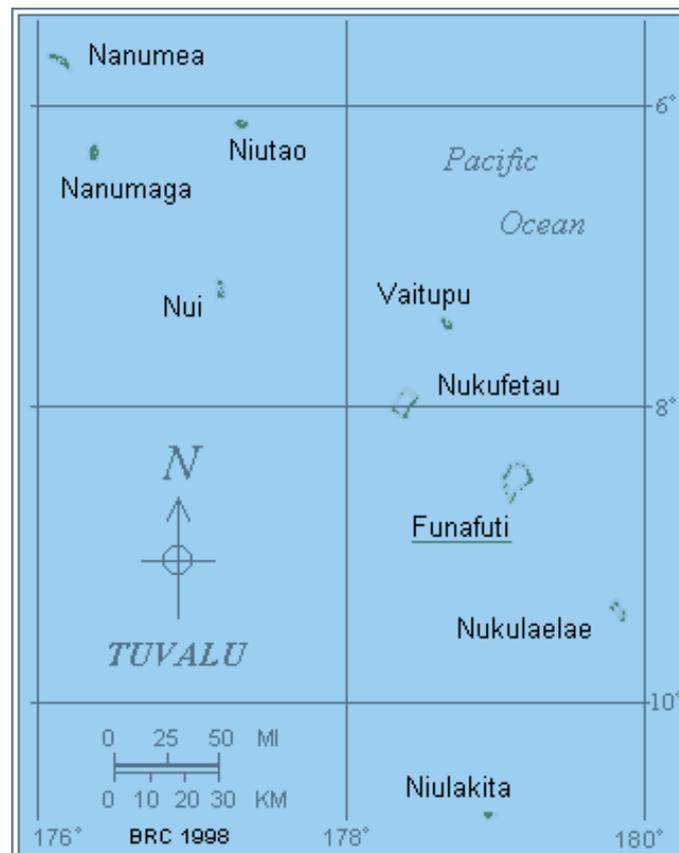


Figure 2: Map of the land masses of Tuvalu

Source: <http://www.tuvaluislands.com/maps/maps.html>



Figure 3: Funafuti mainland, Tuvalu, 2012



Figure 4: Funafuti Island, home to half of the entire Tuvalu population

The overcrowding on Funafuti is further exacerbated by the end of the phosphate mining in the neighbouring island nation of Nauru, which has resulted in many Tuvaluan migrant workers returning home (Shen and Binns 2012). The mining opportunities for Tuvaluans began on Banaba/Ocean Is. and in Nauru in the early 20th century (Macdonald 1982: 117) and ended in the early 1990s (Bedford, Bedford and Ho 2010). The large population on Funafuti results in high unemployment, actual and possible water shortages, and health issues. Furthermore, the high population pushes people with no land to live on the edges of the island where there are many health hazards, such as waste dump sites and “borrow pits”—large pits from which material was extracted to make the airport runway and which are now filled with water and rubbish (Shen and Binns 2012; Figure 5).

Even aside from such problems faced by people on Funafuti, the health of Tuvaluans is problematic. Non-communicable diseases such as diabetes, obesity, and cardiovascular disease are common. Tuvalu’s demographic and health survey of 2007 showed that, of the 851 women aged 15 and over interviewed nationwide, nearly 90% were classified as being overweight or obese. Similarly, of the 558 men aged 15 and over, 77% were classified as overweight or obese (Central Statistics Division 2007). Health is not assisted by rural migration to the capital. Chronic diseases are likely to be caused by people heavily relying on imported foods, such as highly-processed carbohydrates (e.g. white rice) and foods that are high in sugar and fat (Rhead 2010). I observed an abundance of these kinds of imported foods on my shopping trips in Tuvalu in January 2013.



Figure 5: A view from a house over a “borrow pit” in Funafuti

Exercises such as walking and running help a great deal in keeping chronic diseases at bay. However, with the easy access to motorbikes, taxis and cars on Funafuti, people are less likely to walk. Many businesses had motorbikes for hire at the rate of ten dollars a day and taxis charge around three to four dollars for travel within the settlement area. During a shortage of fuel on the island at my last visit, many people queued for hours to buy a two litre fuel ration at a much dearer price. There was a marked decrease in the number of automobiles on the road at any given time, and roads became much safer for pedestrians as more people started to walk rather than depending on motorised transportation.

The most frequent users of motorbikes on the roads tend to be young people. Motorbikes were used for recreational purposes at night, mostly by young people, who would ride many times around the island before retiring for the night. Besides the obvious risks of travelling on motorbikes and in a group, this also creates a health risk that young people may become too reliant on motorised transportation and reduce their physical activities. When I insisted on walking to the Lodge, a five minute walk for me from my residence in Funafuti, an uncle of mine commented on how he wished his teenage sons would also walk to the nearby shop—at about a third of the distance of the Lodge— instead of using a motorbike every time.

Climate also has an important impact on the health and wellbeing of Tuvaluans, and has an influence on peoples' decisions about where to live. Chambers and Chambers (2001) have noted that the islands are especially vulnerable to extreme weather conditions such as storms and droughts, and that these extreme weather events are occurring with increasing frequency as a result of scientifically-attested anthropogenic climate change (Barnett, Pierce and Schnur 2001; Boncour and Burson 2009; Shen and Binns 2012). In addition, sea-level rise is expected to have a major impact on Tuvalu's land area and population in the next 50 to 100 years and, as a result, Tuvalu has become the poster child for climate change discussions (Paton and Fairbairn-Dunlop 2010). Barnett and Chamberlain (2010) have pointed out that the social processes of marginalisation and poverty will become increasingly prominent as extreme weather patterns occur with greater frequency. The effects of climate change may compound the health problems of those who are already struggling, such as landless outer islanders on Funafuti who are unable to find employment. This in turn may make international migration from Tuvalu increasingly attractive. Boncour and Burson (2009) have noted that it is important to consider the impacts of these environmental pressures on international migration. In particular, they note that it will be important for governments to recognise climate change refugees from nations such as Tuvalu. However, support for climate-induced migrants may be difficult in the future, since it is still a new phenomenon and there are no clear international legal obligations around it (Barnett and Campbell 2010).

As a country, Tuvalu plays its part in advocating international climate change awareness and action. Its diplomats are using high-level negotiations and forums as platforms in the fight to reduce climate change. Since the admission of Tuvalu to the United Nations in 2000, the United Nations General Assembly has been one great platform for this campaign. Amongst the appeals and the push for the Kyoto Protocol to be ratified by all industrialised countries, the love Tuvaluans feel for their country comes across very clearly. There is no other place like home and it is "certainly not the wish of the people of Tuvalu to be taken in as environmental refugees", according to former Governor General Dr Tomasi Puapua (Puapua 2002). Though threatening, the ocean is also part of home, and

has provided the Tuvaluan people with a rich food resource and a history of communication through voyaging (see Hau'ofa 1993).

Nevertheless, the Tuvalu Government continues to negotiate migration avenues for its citizens in the event that they wish (or need) to move. Bedford and Bedford (2010) have noted that it is likely that many Tuvaluans and I-Kiribati will be forced to relocate in the next fifty years due to climate change. At the 2009 United Nations climate change conference in Copenhagen, Fiji expressed its willingness to take in Tuvaluans and I-Kiribati as environmental migrants because of its historical links with the two nations. One island in Fiji, Rabi, is where some I-Kiribati from Banaba (or Ocean Island) live, and the Fijian island of Kioa is where some people from the island of Vaitupu in Tuvalu have lived since the 1940s. However, Bedford and Bedford (2010) note that it is crucial to develop strategies that will cater for the voluntary relocation of Tuvaluan families to other countries.

In summary, there are a wide range of pressures on Tuvaluan people living in their home islands. These pressures—which include overcrowding, poor health, a lack of economic opportunities, and climate change—make the Tuvalu government, families, and individuals look beyond Tuvalu for employment opportunities and possible migration destinations.

2.0 Migration to New Zealand

Historically, Tuvaluan migration has tended to be both temporary and circular, since Tuvaluans living abroad (such as students studying overseas, seamen working on overseas vessels, workers in other parts of the Gilbert and Ellice island colony, and those formerly employed in the phosphate mines of Banaba and Nauru) are always expected to return to the islands after their terms of study or work (Simati 2009; Boland and Dollery 2007). Tuvaluans have restricted opportunities to migrate more permanently because of the policies of neighbouring polities.

The most significant kind of international migration that Tuvaluans have participated in is seen by host countries as a way of bringing in cheap labour from non-industrialised countries to fill gaps in their home-grown labour supply. Tuvalu, with its high unemployment rate and overcrowding on Funafuti, is drawn towards such employment opportunities for its unskilled or semi-skilled labourers. New Zealand created such opportunities for Tuvaluans through several schemes that were put in place at different times. I now describe the opportunities that are, and have been, available at certain times for Tuvaluans to enter New Zealand, beginning with the various immigration schemes offered, followed by the immigration rules in place for administering applications for residence in New Zealand.



Figure 6: Leaving the country for overseas

2.1 South Pacific Work Permit Scheme

The first opportunity for migration of Tuvaluans to New Zealand was the South Pacific Work Permit Scheme, which provided working visas for temporary workers from Western Samoa, Tonga and Fiji from 1976 and which was extended to Tuvalu and Kiribati in 1986. Visas were not rigorously controlled under this scheme. The offer to Tuvaluans was made after the 1985 Pacific Forum when twenty workers were given temporary New Zealand work visas. The Tuvalu Work Permit Scheme increased the annual quota to eighty in the late 1980s, with the employment period extended from the initial twelve months to three years (Bedford, Bedford and Ho 2010). The workers were employed in the orchards and market gardens around West Auckland. These annual intakes, and the encouragement to primarily recruit the relatives of those already in New Zealand, were a catalyst for the steady increase of the Tuvaluan population in West Auckland, New Zealand. This scheme was terminated in 2002 due to the large number overstaying their permits and also because of the introduction of the Pacific Access Category that year (Bedford, Bedford and Ho 2010).

2.2 The Pacific Access Category (PAC) Scheme

In July 2002 the Pacific Access Category (PAC) was introduced to allow for the granting of residence visas to citizens from Tonga, Fiji, Kiribati and Tuvalu who made applications under the Residual PAC Places Category through the Department of Labour. The inclusion of Tuvalu in this Pacific labour migrant quota scheme is sometimes said to be the result of ministerial talks between Tuvalu, Australia and New Zealand in light of the effects of climate change (Shen and Binns 2012). It is classified under the International/Humanitarian stream by Immigration New Zealand.

The maximum annual number of successful applicants for both Tuvalu and Kiribati is set at 75 for each nation. The quota for each nation is drawn from a barrel consisting of the names of all the applicants who meet certain conditions set by the scheme. The scheme is becoming increasingly popular so the chances of success have reduced over time (Shen and Binns 2012: 72). The principal applicant is required under these conditions to be a citizen of the participating country aged between 18 and 45 years, and must have excellent health, good English, and no criminal record. Before the application can be confirmed, a job offer with a salary at or above the designated level of income must be approved. Efforts have been made by the Immigration Service to ease the criteria for applicants. For example, the minimum income level for the principal applicant who must have a job offer was lowered from \$31,566 to \$24,793; the principal applicant's partner could also get a job offer and, in so doing, help the partner meet the minimum income requirement; a six month period was allowed to lodge an application for residence after the ballot; and previous illegal immigrants could apply if they had willingly left the country in the past on their own accord.

However, it is still difficult to fill the available positions because of the level of skills needed and the job offer requirements for the principal applicant. Department of Labour statistics show that while 75 or sometimes more are drawn from the ballot, anything between one quarter and one half of that number do not meet the registration requirements (Department of Labour 2011). Those without family connections in New Zealand may be disadvantaged, as it is difficult to find a job offer from Tuvalu. Fares between New Zealand and Tuvalu are expensive, costing \$NZ 1700 (about half per capita Gross Domestic Product (GDP) in Tuvalu) for a return trip, making a preliminary trip to find employment beyond the means of most people. As examples of the difficulties, one family waited for

more than three years for approved job offers for the principal applicant and his wife while, in another case, processing of the family's applications took so long that the job offer expired.

2.3 Recognised Seasonal Employer (RSE) Scheme

The Recognised Seasonal Employer (RSE) scheme provides up to nine months' employment in New Zealand for selected Tuvalu citizens (Bedford, Callister and Didham 2010). Tuvaluans became part of the scheme in 2007/8. The objective of the RSE scheme is to enable citizens of participating countries from the Pacific to fill the excess demand for labour in the New Zealand horticulture and viticulture sectors. This creates a form of inter-dependency between large industrialised countries and non-industrialised countries, where minimum or near minimum wage labour is provided to industrialised countries and remittances from these workers feed the non-industrialised countries' economies (Levitt and Jaworsky 2007). Tuvalu welcomes this scheme because it targets unskilled workers and helps ease the high unemployment problem in the country. In the four seasons between 2007/8 and 2010/11, 276 Tuvaluans were recruited under the RSE scheme, an average of around 70 a year (Department of Labour 2011).

Although families and the Tuvalu economy rely on remittances from RSE workers, the workers' needs for better conditions such as better pay and accommodation are often overlooked. Since the RSE scheme is based on a contract that is between the employers and the workers, the employers determine where to get their workers from and how many they require. This often depends on the workers' performance in a previous season. Consequently, island nations and families have high expectations of workers' performances, which can put great pressure on workers who may struggle with work conditions and the different environment they encounter away from home. It remains to be seen whether this arrangement benefits the labourers themselves.

Labourers are encouraged to save the most money possible to take home to their families, but this depends on the amount of money they can earn during their period of employment. This in turn depends on how workers are paid and how much work they can get in the months that they are in New Zealand. Payment may be calculated by an hourly rate, and this provides a relatively secure income as long as sufficient hours and weeks of work are available, which is not always the case. However, payment may be calculated by output, and for workers who are new to the job, and therefore slower, this may mean that pay is low, especially in the initial weeks while they are acquiring the necessary skills. Workers may have no opportunity to acquire the skills they need to perform their jobs prior to arriving in New Zealand. For example, it is not possible for workers to practice pruning grapes or apples in Tuvalu, since no grapes or apples are grown in the islands.

It will take more long-term evaluation of how the RSE scheme affects Tuvaluans before it can be established to what extent the scheme benefits workers and their families. For some workers, long hours of backbreaking work result in very little money to take home. There is considerable room for improvement from both the Tuvaluan and the New Zealand sides if the scheme is to have optimal benefit for all concerned (Bedford, Bedford and Ho 2010).

In addition to the schemes for Pacific people, New Zealand has three main immigration streams in place for processing applications (NZIS 2008a). Each stream targets a different population and there are different criteria required for entry via these three streams. The streams are:

1. Skilled migrant and business stream;
2. Family sponsored stream; and
3. International and humanitarian stream.



Figure 7: The Nivaga II is about to depart for Fiji in January 2012 to take passengers, especially students studying in Fiji. Also on board are the RSE workers on their way to work in the NZ farms

2.4 Skilled Migrant and Business Stream

This stream admits the least number of Tuvaluan migrants into New Zealand. It is a points-based system designed to ensure that people migrating to New Zealand have the skills, qualifications, and work experience that New Zealand needs (NZIS 2008a). Points are awarded based on the applicant's health, character, and English-language proficiency. In addition, the applicant needs to have 100 or more points based on their skills, work experience, qualification, and age. Approved Tuvaluan migrants amount to only 6.7% (skilled) and 0.1% (business) of the total migrants accepted under this stream, and Pacific people amounted to only 4.2% of the intake in the period between 2002 and 2006 (Bedford 2007).

2.5 Family-Sponsored Immigration Stream

The family reunification category, which makes up around 30 percent of New Zealand's total residency permits, allows in a significant number of Tuvaluan migrants (Shen and Binns 2012). Criteria for acceptance under this stream include reunion with a partner, parent, or child (NZIS 2008b). In the period 2002–2006, 89 Tuvalu migrants were able to come to New Zealand under this category (Bedford 2007). This policy changed in May 2012 to prioritise parents and only allow in those with enough funds available to support their stay. Parents may apply for eligibility under two tiers. The first tier is unlikely to be relevant to many Tuvaluans, as the sponsor's minimum income must be \$65,000 and the parent has to have a lifetime guaranteed income of \$27,000 per year. However, the second tier, which does not have such high financial barriers, had a wait-time of seven years in 2012, and requires that the parents in question do not have children living in their home country, a requirement which is problematic for most prospective Tuvaluan migrants (Immigration New Zealand 2012). This change will significantly decrease the number of parents coming to live with their children in New Zealand. The sibling and adult child category is now closed.

2.6 Section 35A of the Immigration Act 1987, Section 61 of the 2009 Act, and the International/Humanitarian Stream

The Immigration Act 1987 and its 1991 Amendment made a provision under Section 35A for the Minister of Immigration and, later, designated immigration officers, to grant permits of any type "in special cases". Requestors must be in New Zealand, must require a permit to be in New Zealand and to be without such a permit (i.e., 'overstayers'), and must not be subject to a removal or deportation order (Immigration New Zealand 2008; 2011; 2013). Consideration for residency or other permits under this provision is based on various factors, including New Zealand's international obligations. Determinations are made on a case by case basis. The justifications provided by the applicants might include how they came to be without a permit, the length of time they have been in this status, their immigration history, and their specific situation, such as qualifications and employment, and any humanitarian considerations. If the case is seen to have merit it is further investigated, and the requestor may be granted some kind of residency permit. Requests may not be considered and may be declined with no justification (Singh n.d. equitylaw.co.nz). In the Immigration Act 2009 the "Grant of a visa in special case" is section 61. Although the wording is simplified, the provision that a requestor must be unlawfully in New Zealand and must not have a deportation order in force, plus the absolute discretion of the decision-maker (section 11), remain.

New Zealand reserves 10% of its total residence places for international /humanitarian purposes every year as part of its duty to the international community (Shen and Binns 2012: 70). This stream includes the Pacific Access Category as well as quota refugees, asylum seekers and some other categories (Settlement Support 2006). Also included in this stream are those granted residency under Ministerial Discretion and Section 35A (Shen and Binns 2012: 71). Of the 698 Tuvalu migrants admitted in the period 2002–2006, 80.4% were considered under this Humanitarian/International stream (Bedford 2007). Shen and Binns (2012) note that many of the Tuvaluans who gained permanent residency under the one-off "amnesty" Transitional Policy 2000 (298 people), or via Ministerial Discretion (91 people), or under Section 35A (1 person) may have already been living in New Zealand (lawfully or unlawfully) at the time of their applications. This note may also apply to

those 89 Tuvaluans who gained legal residency in New Zealand between 2002-2006 through the Family Reunification category. The Transitional Policy 2000 allowed an especially large number of Tuvaluans to gain New Zealand residency, and is discussed below.

2.6.1 Transitional Policy 2000

The Transitional Policy 2000 offered a one-off opportunity for undocumented immigrants to apply for a two-year work permit while legalising their stay. This helped 298 Tuvaluans who had overstayed their entry visas to New Zealand. Tuvalu at the time had been one of the top five countries in terms of undocumented immigrants per capita (Dalziel 2003; Immigration New Zealand 2004). The amnesty provided an opportunity for many Tuvaluans to legalise their status in New Zealand and, according to New Zealand Census records (Chart 1), the number of officially documented Tuvalu residents grew considerably after this amnesty period. The percentage of the Tuvaluan population born in New Zealand at the time was 28 percent (NZ 2001 Census).

During the amnesty period there were mixed reactions from the Tuvaluan community in response to this immigration policy. Deportations and dawn raids had created fear and distrust of government authorities amongst some Tuvaluans living in New Zealand. A meeting between members of the Tuvalu community and Immigration Department officers in 2000—arranged by the Tuvalu Community Trust in order to help undocumented immigrants gain residency—was poorly attended because many people feared being seized by officials. This distrust of officials is one reason why there are still many undocumented Tuvaluans residing in New Zealand. Those who remained at the meeting with immigration officials in 2000 had their cases reviewed and were given advice on what steps to take to help their residency status. People who did not use this amnesty had to regulate their status by a request for Ministerial Discretion or Section 35A.

2.6.2. Refugee Category

Although New Zealand takes in 750 quota refugees a year and a variable number of asylum seekers as part of its humanitarian obligation to the international community, Tuvaluans are not eligible for this category. People vulnerable to climate change are not recognised as refugees under the United Nations Convention on Refugees (1951) (Shen and Binns 2012), and this was clearly reiterated in a press release from the Ministry of Foreign Affairs and Trade in 2008. This statement dismissed any hopes held by Tuvaluans for using this category. On November 26 2013, a Kiribati man's claim to the New Zealand high court for refugee status because of climate change was also rejected, after that man had made two unsuccessful appeals to Immigration authorities (*New Zealand Herald*, 27 November 2013). Unless there is international recognition of climate change refugees, such claims are bound to fail.

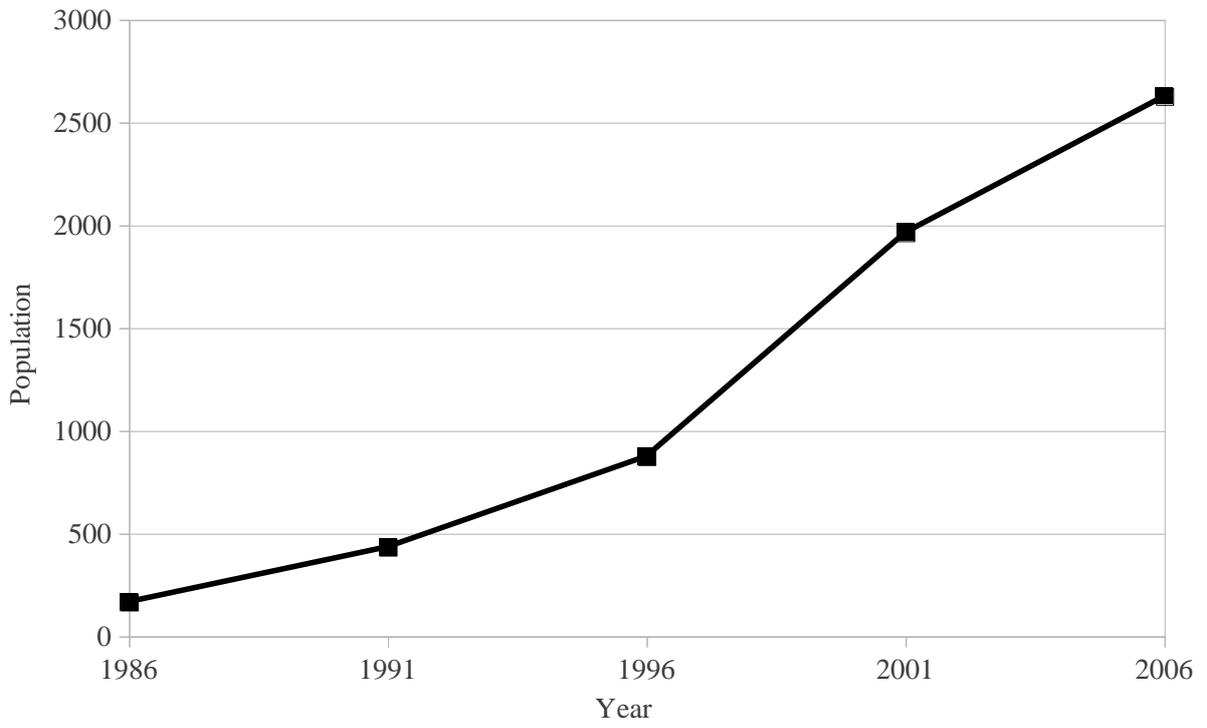


Chart 1: Tuvalu population in New Zealand by census year. Source: Statistics New Zealand 2006

3.0. The Tuvaluan Community in New Zealand

I now describe a number of important features of the Tuvaluan community in New Zealand, including the roles of gender and kinship in the community structure and some important institutions such as community organisations, island community groups, and churches. Outlining these features of the Tuvaluan community will facilitate my subsequent discussion of community healthcare and health promotion, which is a primary focus of this report.

3.1 Background Information on Tuvaluans in Auckland: Kinship, Gender, Work, and Demographics

Auckland is where nearly 80 percent of the Tuvaluan population in New Zealand lives. Most Tuvaluans live in West Auckland, especially around Ranui and Massey (approximately 1521 according to the 2006 NZ Census), where Tuvaluan workers accepted under the South Pacific Work Permit Scheme first settled. Just as kinship is the foundation of transnational Samoa (Macpherson and Macpherson 2009), Tuvaluan transnationalism is also particularly tied into the recruitment of family members to the same areas as those already residing abroad. This has helped to build the concentrated population of Tuvaluans in West Auckland. Sharing a home with others upon arrival in New Zealand is not unusual, as it is a common practice in the homeland, especially on Funafuti with its limited land and housing. It is traditional for Tuvaluans to welcome family and friends to stay with them if they are in search of somewhere to live. Although it is becoming difficult for families living in Funafuti to do this because of the overcrowding problem, it is frequently practised nevertheless. The same occurs in Auckland, where relatives and friends coming from Tuvalu are often offered shared accommodation by their families and friends until they are able to get jobs and rent a home for their family. The Tuvaluan definition of family, or *kaaiga*, is not the nuclear family, but rather includes the extended family and close friends.

The leaders of families and community groups are predominantly elderly males. With the assistance of other adults, these male leaders are responsible for making decisions within the family. Men in the family are expected to be breadwinners, and to go out and work to bring home food to be cooked for the family. In contrast, women's roles are to take care of the family, including the sick and the elderly, and to carry out household chores. These same gender role expectations are present in other settings, such as island and community organisations. Although more Tuvaluan women than men have formal qualifications, a higher proportion of women participate in unpaid work, which typically involves looking after children and sick or disabled family members (Statistics New Zealand 2008). Two-fifths of Tuvaluan women are not in the labour force. The labour force participation rate for all Tuvaluans over 15 years is 64%—just a fraction lower than Pacific people in general. Employment for Tuvaluans is largely as labourers. The median annual income for Tuvaluan men and women in New Zealand for the year ended 31 March 2006 was \$19,000, compared to \$20,500 for the total Pacific population and \$24,400 for the general New Zealand population (Statistics New Zealand 2008). The Tuvaluan population in New Zealand is younger than the overall New Zealand population, with a median age of 20 years, compared to 36 years for the general population. Despite the population being younger, Tuvalu children are relatively absent from the national figures on

children needing foster parents, according to Minister of Social Development, Hon Paula Bennett, in her speech at the Tuvalu Independence celebrations 2012 in Auckland. However, social problems may begin to emerge among the generally young population of Tuvaluans in New Zealand if financial and other stresses increase.

Besides family obligations, many Tuvaluans feel obligated to fulfil their roles as Tuvaluans, as Christians, and as members of their islands in Tuvalu. This results in the establishment of social and community relationships and structures in the West Auckland Tuvaluan population that mirror the arrangements in Tuvalu. Groups from the same island in Tuvalu have formed island organisations, resulting in eight island groups across the Auckland Tuvalu community. The church, which is an important institution to many Tuvaluans, has also developed and expanded to meet the needs of the community. The Tuvaluans' eagerness to embrace Christianity dates back to the arrival of the Christian missionaries of the London Missionary Society (LMS) in the (then) Ellice islands from Samoa in the 1860s (Koch 1978: xv). Within two decades, native religious practices were abolished and the pastor became the head of the native society instead of the paramount chief (White 1965; Macdonald 1982). Other non-governmental organisations have also developed in response to community needs. These various organisations and structures help maintain people's ties and connections to their islands, the church, and to other family members, as well as with other Tuvaluans in Auckland. The next section will elaborate on important organisations established by the Tuvalu community in response to the needs of the Tuvalu people in Auckland.

3.2 The Tuvalu Community Trust and Tuvalu Society Incorporated

The Tuvalu Community Trust and the Tuvalu Society Incorporated are legal entities that play important roles within the Tuvalu community in Auckland. The Tuvalu Society Incorporated looks after the interests of its registered members, and the Trust deals with the interests of the general community of Tuvaluans in Auckland. The Tuvalu Society has an office in Henderson, and some of its services for the community include an emergency house, a school holiday programme, and social services for the community. A second major organisation within the Auckland Tuvaluan community, The Tuvalu Community Trust, was established in 1987 with the aim of assisting Tuvaluans residing in Auckland. In its strategic development framework 2007–2011, the Trust stated that its aim is to increase the effectiveness of the delivery of government development programmes to the Tuvaluan people, with an emphasis on raising the living standards of Tuvaluan people in New Zealand. Its vision is for “every Tuvaluan to live a productive, fruitful and prosperous life, like any other New Zealander” (Tuvalu Auckland Incorporated Constitution 2007:2).

The Tuvalu Community Trust's executive arm consists of the President, Vice President, the Treasurer, and the Secretary. The management committee of the organisation—called the *Komiti*—consists of the executive arm along with representatives from each of the eight island groups. As noted above, Chiefs and leaders in Tuvalu are usually male and, similarly, the leaders of the Auckland-based Tuvaluan island community groups are usually respected men. It was the expectation of members of the community that the role of men is to lead and to make decisions for the group. However, times are beginning to change, and several office holders, including the President, are now women. Changes seen within the community are potentially influenced by the social environment in New Zealand, where exposure to a number of prominent female leaders (such

as Hon Helen Clark, Hon Jenny Shipley, and Dame Silvia Cartwright) has encouraged Tuvaluan elders to become more accepting of women as leaders.

These island group leaders represent their island communities to the Trust's Council of Leaders. The Council of Leaders has no official power, but sits at the top of the Trust's governing structure to mark the leaders' cultural recognition by the Trust. The Trust is currently running a Tuvalu language class for thirty children aged between five and 12 years in an effort to assist the academic performance of Tuvaluan children. This project is largely driven by parents' concerns about their children's failing competency in the Tuvaluan language. For about five years, the Trust has also been running an exercise and nutrition programme for the community: the Enea Ola programme. I will discuss this programme in more depth when I describe the health promotion efforts of organisations operating within the Auckland Tuvaluan community.

The Trust continues to arrange the community's Independence celebrations. It also selects the island group that will represent Tuvalu at the Pasifika Festival, and selects Tuvaluan representatives for advisory groups. The Trust keeps the community informed about its activities via a newsletter. The two organisations—the Tuvalu Community Trust and the Tuvalu Society Incorporated—operate from the office of the Tuvalu Society Incorporated in Henderson, Auckland. The fact that the two organisations are sharing an office is evidence of the good relationship between them. This is supported by the knowledge that many Society members are also active members of the Trust.

The week-long 2012 Independence celebrations provided a good example of the community in action and of the effectiveness of the leadership group. The plans for this occasion were spectacularly supported by the island community groups and their associated youth groups. The fact that some money was distributed by the Auckland Tuvalu community Trust to help island groups prepare for the celebrations was also a positive initiative, according to some of the feedback we obtained from the community. Tuvaluan youths involved in the celebrations reported enjoying the opportunity to perform cultural items in the Tuvaluan language. They also appreciated the monetary assistance given to the volleyball competition for the Tuvalu Independence Cup, and appreciated being able to make money by selling food during the celebrations after receiving seeding money from the Trust.

This was the first time that the Prime Minister of New Zealand, Hon John Key, had been invited to the independence celebrations but, due to other commitments, he was unable to attend and Hon Paula Bennett, a local MP and Minister of Social Development, came in his place (Figure 9). The community felt that it was time to build a relationship with the government and to be more active and connected with the wider community of New Zealand beyond the other Pacific communities. Although the Trust has had good working relations with the Waitakere City Council, and has helped with the environmental cleaning efforts within the community in the West, the Trust decided that it was time to be more visible in its contributions to the wider community. The Minister and the Trust held a follow-up meeting on the 22nd of November, 2012, and are now working together on ways to help the Tuvaluan community to live better and healthier lives in New Zealand.



Figure 8: Spectators, young and old, at the Independence Day, 2012



Figure 9: Minister Paula Bennett, seated with other dignitaries third from the left, as the guest of honour at the Tuvalu Independence Day Commemoration, October 2012

3.3 Island Organisations

Tuvaluan island organisations have been established independently of one another in Auckland as a means of channelling assistance back to home islands. All eight of the Tuvalu islands have set up organisations in their own time, and membership is restricted to people whose families are from that island. These eight island groups are all legal entities and they are treated as affiliated groups of the Tuvalu Community Trust, even though they are not legally bound. Members of island organisations select their own leader, referred to as the *toeaina*, who is assisted in managing the island organisation by elected executive members. When a major event occurs on the home island of a community group, the island group's members in Auckland and elsewhere are expected to contribute. I describe an example of this expectation in the next section on the role of churches in Tuvaluan life.

A significant event on each island's calendar is the island's annual commemoration day. These commemorative days mark memorable events or policies of great significance to the lives of the people from each island. The types of events that are commemorated vary widely. For example, the Funafuti island community commemorates the day that the island was bombed during World War II, whereas other islands choose to celebrate Tuvaluan values more generally, such as valuing education. Vaitupu commemorates the anniversary of its debt repayment on the 25th of November 1883, when it narrowly avoided losing its land to a Samoan-based German trader (Isala and Munro: 1987). The debt was repaid just in time with only Funafuti assisting by giving money to help (Koch 1978:7). This created a bond of friendship between the two islands.

I witnessed the Vaitupu community's 125th celebration of its debt repayment in 2012, and found it to be a good example of how island gatherings function as occasions for members to celebrate and strengthen their ties with one another, with their home island, and with other island groups. During this celebration, visitors representing Funafuti—Vaitupu's island friend or *soa*—visited and shared food with the Vaitupuan. Dancing "*fatele*" served as a form of entertainment, and also served to bond the community together. One elder present at the celebrations mentioned that he found the celebrations very therapeutic. In general, island gatherings enable community members to meet, deliberate, celebrate, and share with one another. As in other Tuvaluan community contexts, men are considered the leaders in island group settings. Elders are also held in high regard and are expected to pass on knowledge and advice to younger community members at gatherings.

3.4 Churches

Christianity is a major influence in the lives of Tuvaluans, whether they are living in the islands or elsewhere (Goldsmith and Munro 1992, Goldsmith 1989). According to the 2002 Tuvalu Census, 91% of Tuvaluans living in the islands identify as belonging to the Congregational Christian Church, Ekalesia Kelisiano Tuvalu (EKT), another six to seven percent belong to various other Christian churches, including, Seventh Day Adventist, Brethren, Jehovah Witness, and Catholic, with 2% belong to the Bahai Faith (Secretariat of the Pacific Community 2005: 23). Thus almost the whole population declares a religious affiliation. Similarly, 96% percent (2,316) of Tuvaluans in New Zealand report a religious affiliation, and all but three percent of these to Christianity (2,244) with sixty percent of Christians (1,353) belonging to the Presbyterian, Congregational and Reformed

denominations. As in Tuvalu, churches hold a powerful position in the Tuvaluan community in New Zealand. For example, churches are consulted and are heavily involved in all major events in the Tuvaluan community, such as the Tuvalu Independence Day celebrations, in which church ministers all take part in a single large service for all community members.

In Tuvalu, the EKT is highly regarded by the people, and is the *de facto* established church. The pastor is the head of the congregation on each island and has the support of his family, various groups made up of deacons, lay preachers and women, and all the members of the church (Chambers and Chambers 2001). He plays an important role in the island's festivities, ceremonies and in weddings and funerals. The Tuvalu community in Auckland respect their pastors in the same way.

In the following paragraphs I describe the ways in which the church congregations in Auckland have formed. These processes demonstrate the importance of religious communities and of the religious leaders, and at the same time show how increasing community size, island loyalties, place of residence in Auckland, personal and family loyalties, and links to the Tuvalu EKT, all play roles in the changing configuration of the Tuvaluan religious landscape in Auckland.

When the Tuvaluan population in Auckland was quite small in the mid-1980s, the church in the central Auckland suburb of Grey Lynn— a congregation chaperoned by Reverend Liu Tepou and comprised of Tokelauans and some Tuvaluans—was sufficient to look after the Tuvaluans' pastoral care. Reverend Tepou was married to a Tokelauan woman, and his family was among the first Tuvaluan families to settle in New Zealand—well before the major influx of Tuvalu migrants in the later 1980s.

One of my research participants, Tau, came with her family from Nauru in 1986, and spoke of a feeling of cooperation and friendship amongst the Tuvaluans in Auckland in the mid-1980s. She noted that the members of the (then small) Tuvaluan community looked forward to their Sunday fellowship together at the Grey Lynn church. She described how, later, another Tuvaluan church congregation was started in Henderson (after consultation with Reverend Tepou) by the Tuvaluan pastor Reverend Laumua Kofe. This church in Henderson, named the Auckland Tuvalu Christian Church, provided pastoral care for many Tuvaluans residing in the Western suburb of Massey who found travelling to Grey Lynn difficult. Tau noted that there was a great deal of cooperation between the churches, and recalled that the two congregations used to have friendly competitions during the Tuvalu Independence celebrations and on other festive occasions. There was a strong sense of community spirit amongst all the Tuvalu families in Auckland at the time due to the small population.

As the number of Tuvaluans increased in Auckland, other churches were established, some of which were affiliated with the EKT. The first Auckland church affiliated with the EKT began in 2002, as some Tuvaluan worshippers from the Grey Lynn church moved away to begin their own congregation, which conducted services solely in Tuvaluan. This church was chaperoned by a senior Tuvalu church minister, Reverend Suamalie Naisalii Iosefa. The members of this new church were mostly from the Nanumea, Nui and Nukulaelae community groups. This congregation managed to secure a land mortgage, which was later handed over to the EKT Church in Tuvalu to manage.



Figure 10: Map of Auckland suburbs. Note the positions of the West Auckland suburbs of Grey Lynn, Henderson, and Massey, where Tuvaluan church congregations were established, and Pukekohe in South Auckland.

A few years later, a branch of this EKT church opened in Pukekohe for those Tuvaluans who live or work in South Auckland, where—as in West Auckland—there are many market gardens employing Tuvaluan labourers. Reverend Pita Tanile'e came from Tuvalu with his family under the PAC scheme to look after the congregation in Pukekohe. A further development saw the creation of island-based church establishments in 2011, on the assumption that island-based church communities would garner stronger commitments to the church from their members. As a result, two new church congregations were formed: the Fagaua Church, which is made up of some Nukulaelea families, and the Lotolelei Church, which is made up of a handful of Nanumean families. Since many Nanumean families in Auckland are not part of the Lotolelei Church (many of

them remained with the first EKT church in Grey Lynn), it is not widely recognised as a Nanumean church in Auckland. Two church Ministers from Tuvalu came to Auckland under the PAC in 2011 to look after the newly established congregations Lotolelei and Fagaua. About two-thirds of the Nanumea families decided to branch out and form their own church—Fatoaga o Keliso, or the Garden of Christ—which is not affiliated with the Tuvaluan EKT and is also not recognised as a Nanumean church, since not all members of the Nanumean community belong to this congregation. Meanwhile, Niutao people in Auckland quietly formed their own church congregation led by Pastor Maheu Papau, a long-time resident of New Zealand who is married to a New Zealand Pakeha. These newly established churches hire halls around West Auckland to hold their services on Sundays.

The Tuvalu Christian Church in Henderson, on the other hand, has successfully paid off the mortgage on its hall and is now establishing a new branch in Wellington. The few Tuvalu families residing in Whangarei are grouped together, and a deacon residing there looks after the congregation. Finally, an ordained church minister who came to New Zealand after his studies in Samoa was assigned to another congregation at Hastings, which mainly serves the RSE workers based there. Running this church is a challenging mission as not all RSE workers reside in one place.

In Auckland it is not as problematic for a church to break away from the EKT as it is in Tuvalu. This is because many Tuvaluan churches already operate without affiliation with the EKT and, in addition, the large distance between suburbs and the social and cultural importance of island community groups serve to reduce the importance of EKT ties. Opinions are divided as to whether churches should be affiliated with the Tuvalu EKT. Affiliated churches are expected to attend the national church meetings in Tuvalu conducted every two years. They are also expected to send an annual donation to assist in the Tuvalu EKT operations. Such remittances are an important transnational tie for some Tuvaluans in New Zealand, especially the older generation, who still feel obligated to send contributions to the church in Tuvalu. Many of these older members of the Tuvaluan community in Auckland are those who worked in the phosphate mines of Nauru and Banaba/Ocean Island while these mines were still productive. While these families were working on Nauru and Ocean Island, church contributions were considered very important. Thus, although many Tuvaluans of this older generation—who primarily came to New Zealand through the family reunion category—are not obligated to give back to the Tuvaluan church, their home island, or their country as they did when working in Ocean Island or Nauru, they still feel strong ties to Tuvalu. This same sense of obligation to the islands underlies the establishment of island organisations in Auckland, which reinforce ties to the islands by fostering a sense of transnational community belonging. It remains to be seen whether future generations of Tuvaluans born in New Zealand will continue to feel such strong ties to the islands, and to the church.

Some tensions have also emerged as congregations have divided from one another and from the EKT. One such instance of tension has emerged around the creation of the Malietasi Church. When there was only the Grey Lynn church and the two Tuvaluan congregations in West Auckland, many Vaitupuan attending these different congregations decided to form a church specifically for the Vaitupu people. However, this decision sparked disagreement within the Vaitupu community, as many opposed this move and refused to leave the churches they were attending at the time. Many families belonged to the Tuvalu Christian Church in Henderson and, as this church had paid off the mortgage on their hall, many felt that their efforts and contributions would be a waste if they were to start again. A dispute over the use of the name Vaitupu to refer to the new church ensued, which

resulted in the Vaitupu island community splitting up between different church congregations and the new church being called the Malietasi (not the Vaitupu) Church.

After three years of separation and many attempts by visiting Vaitupuan politicians and church officials to mend the rift, Vaitupuan church-goers in Auckland finally decided to reunite after an intervention from a well-liked church minister who had spent some years on Vaitupu. The reunification into one Vaitupu island community was welcome news to those of us involved in the Tuvalu Trust management, as each of these split groups wanted to be recognised by the Trust as the official Vaitupu church group. Although there are still some minor tensions between members of these two (now merged) Vaitupu groups, the group is gradually becoming more cohesive. Malietasi is now one of the churches affiliated to the Tuvalu EKT.

Already, important differences can be seen between the Tuvaluan congregations in New Zealand and the church in Tuvalu. While pastors in the islands dedicate all their time to the island's pastoral needs, church ministers in New Zealand tend to have day jobs. Furthermore, in New Zealand fewer congregations own land, and thus the generally accepted state of affairs is that pastors are responsible for the rent of church buildings, using the small weekly contributions from members of the congregation. In contrast, buildings used by the EKT churches in Tuvalu are paid for using annual donations.

4.0 Community Health Promotion

Now that I have outlined some of the significant community organisations in the Auckland Tuvaluan community, I will discuss these organisations' efforts to engage in health promotion. I firstly describe efforts made by the churches and the Tuvalu Community Trust to promote healthy living, focussing in particular on the Trust's "Enea Ola" programme. I then discuss the purpose, structure, and impact of the West Fono Health Trust, which was the primary site of my ethnographic research within the Tuvaluan community.

4.1 The Role of Churches

Dr Colin Tukuitonga, an early advocate of health promotion among Pacific peoples in New Zealand, noted that in the late 1980s churches were surprisingly poor at promoting Pacific health. Tukuitonga noted that, although churches expressed verbal support for establishing the West Fono Health Trust in meetings that he held with them, they were relatively slow to become active in promoting and addressing health concerns (Tukuitonga 2010). However, more recently, Pacific churches have begun to pay attention to the health issues and needs of their communities. For example, some churches have teamed up with the West Fono Health Trust and the Auckland Regional Public Health Service to hold sessions for congregation members on health issues such as bowel cancer and TB awareness. Furthermore, some churches have enacted more practical measures to influence the health behaviours of their congregations.

Many churches enforce a no-smoking rule on their premises, although this is partially a product of many churches using school buildings for their services, which are required to be smoke-free under New Zealand law. In addition, some churches now deliberately serve only water at their social gatherings, which marks a change from the usual practice of members bringing fizzy drinks to gatherings. Some churches have also begun to encourage members to bring only a "light tray" of food, rather than a "heavy tray", to church gatherings. A "heavy tray" of food (see Figure 11) refers to a contribution which includes meat (such as chicken, pork, salted beef, sausages, ham, and fish), carbohydrates (such as rice, taro, potatoes, and tapioca), or traditional dishes—such as *fekei* (grated tapioca in coconut cream), *suasua* (grated taro in coconut cream), *fakalotuma* (grated green banana in coconut cream), and *poke* (a sweet pudding made from starchy vegetables)—which tend to be made from a combination of a starchy root crop such as taro in addition to coconut cream, butter and sugar. In contrast, a "light tray" of food might include salads, sandwiches, nibbles, kebabs, and fruit—many of which are comparatively healthy. For example, in the church that I attend, light trays of food are encouraged at most social gatherings, and I recall that on several occasions elders have expressed pleasant surprise that the food provided is "filling, but light to the tummy". Given the enormous importance of churches in the lives of Tuvaluans (see section 3.4), when churches are involved in healthy changes (such as those mentioned above), they can make a major difference to the health of congregation members.



Figure 11: An example of a gathering in Tuvalu with mostly “heavy tray” food contributions

However, churches have been relatively slow to become involved in community health promotion, and there is a need for churches (both in New Zealand and Tuvalu) to become more pro-actively involved with health workers and providers in order to encourage healthy living among members of their congregations. Furthermore, given the respect accorded to the church by members of the Auckland Tuvaluan community, it may be wise for organisations promoting health initiatives (such as the Tuvalu Community Trust, which I discuss below) to work more closely with churches. However, conflicts may arise in cases of cooperation between churches and other organisations as to who has ownership of a health promotion initiative, since churches, the Trust, and island community groups all function as separate entities within the Auckland Tuvaluan community.

4.2 Health Promotion by the Tuvalu Community Trust and WDHB

One project that the Tuvalu Community Trust currently runs in the Auckland Tuvaluan community is an exercise and nutrition initiative under the Enea Ola project, which is funded and managed by the Waitemata District Health Board (WDHB). The Enea Ola project is a Pacific health initiative based in West Auckland, which facilitates exercise and nutrition classes within some of the Pacific island communities and churches to encourage members to live a healthy lifestyle. The Tuvalu Community Trust established a contract with the WDHB in October 2006 to run a smoke-free, nutrition, and physical activity programme, although the programme has only been running within the Tuvaluan community since 2008. Seven other Pacific ethnic groups entered the same contract with the WDHB, and this collection of WDHB-affiliated groups forms the core of Enea Ola.

Broadly, the goals of the Enea Ola programme are to improve the health and wellbeing of Pacific peoples and reduce the burden of disease through encouraging better nutrition, regular

physical activity, and being smoke-free. For the Tuvaluan community, two objectives of the initiative are:

1. To improve health promotion, health education and lifestyle change support programmes for members of the Tuvaluan community; and
2. To provide a lifestyle change support mechanism for Tuvaluan individuals (and their families) identified as at risk of cardiovascular disease and other chronic conditions such as diabetes.

Enua Ola pulled together a number of exercise programmes that already existed within West Auckland Pacific communities run by the WDHB, and extended these initiatives to include more communities and churches as well as the North Shore region. Within the Tuvaluan community, Enua Ola currently facilitates one-hour swimming classes on Saturday mornings, as well as radio presentations given by a Tuvalu Community Health Worker from West Fono on Fridays. In addition, one way in which the WDHB supports health promotion is to contribute \$5,000 each year to send selected participants to training courses in nutrition and fitness at the Heart Foundation and Sports Waitakere. I had the opportunity to undertake the nine-day nutrition course at the Heart Foundation, and I found it to be one of the most useful courses I had ever done in my life. As a mother responsible for feeding my family, the knowledge of how to cook healthy meals for the people I love is just wonderful. Following this course, I was able to work alongside West Fono health worker Ms Laine Stevens in running health workshops with community members. For these workshops, we followed the nutrition programme designed by the dietician and nutritionist from the WDHB and West Fono, whom we consulted before running workshops in order to ensure that we fully understood the material. The nutrition classes that we ran targeted women's gatherings, such as the church women's fellowships. The women who participated in our workshops had a chance to taste the salads and healthy snacks that we made, and were able to take home copies of the recipes that we used.

Food, however, is always a tricky subject to discuss within the Tuvaluan community, especially with women. In Tuvalu, staple foods include taro, coconut, *pulaka* (*Cyrtosperma merkusii*, giant swamp taro), rice, and fish. Many Tuvaluans who have been brought up in the islands, especially on Funafuti, have had a great deal of difficulty in including fresh vegetables in their diet. Vegetables can be difficult to obtain unless families have their own gardens around their homes or on their lands. However, family gardens are difficult to maintain because of the poor soil quality on coral atolls. Furthermore, land is scarce on Funafuti, and individuals are forbidden from collecting soil or compost from lands not belonging to them. This experience is important to understand when addressing the food habits of Tuvaluans in New Zealand. For this reason I will describe an initiative on Funafuti which could be adapted to provide a model for Auckland, where growing conditions are more favourable.

Fatoaga O Taugasoa Fiafia garden in Funafuti: A case study of a health promotion project

Given that it is difficult for residents of Funafuti to grow their own vegetables, the *Fatoaga O Taugasoa Fiafia* garden (Figure 12)—funded by the Governments of Tuvalu and Taiwan—has been established to help promote healthy eating. The project employs Tuvaluans and Taiwanese to grow fruits and vegetables and sell their harvest to the public every Friday. It also supports people to start their own gardens at home by providing seedlings and support. In January 2012 when I was in Tuvalu, a visiting officer from Taiwan held cooking classes at the Fale Kaupule for people to attend and taste the food (see Figure 13 to Figure 16). Fewer than twenty people turned up, most of whom were mothers. Two of the attendees had been growing their own fruits and vegetables, and were very pleased with both their success and with the support they had received from the garden centre.

Unfortunately the demand for fresh vegetables far exceeds the production at the garden centre. The vegetables—such as cucumbers, spring onions, pumpkins, eggplants, tomatoes and cabbages—are harvested to cater for only 50 shares, so only the first 50 people to arrive at the garden get a share of the harvest. This results in a rush in the morning as people attempt to grab one of the high quality, but not cheap, shares of fresh vegetables (see Figure 17). Because fresh vegetables are scarce on Funafuti, frozen or tinned vegetables are the staple source of vegetables for families.



Figure 12: Fatoaga o Taugasoa Fiafia means the Garden of Happy Friends, January 2012.



Figure 13: A free healthy cooking demonstration by the Fatoaga o Taugasoa Fiafia at the Vaiaku Falekaupule February 2012

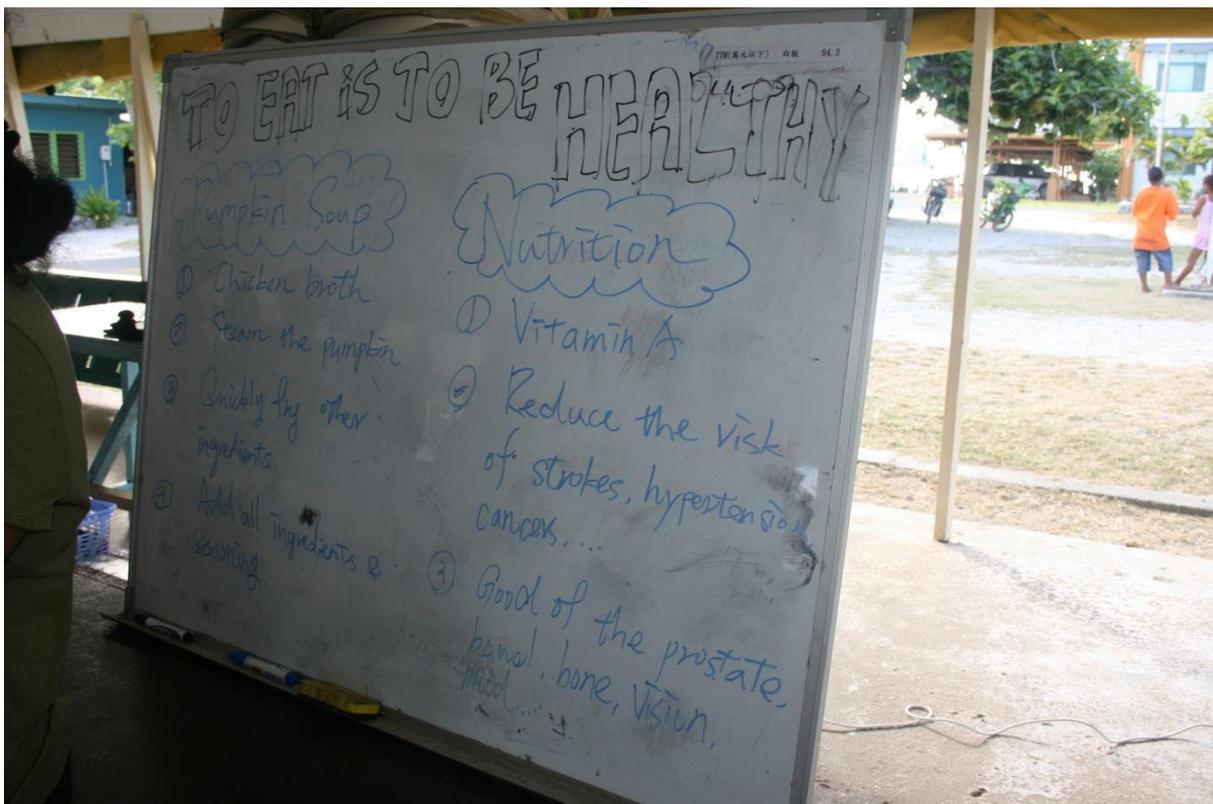


Figure 14: Display of the simple method of making a pumpkin soup and its benefits to our health



Figure 15: Cooking demonstration by Fatoaga O Taugasoa Fiafia, Funafuti in February, 2012



Figure 16: Tasting and note taking time



Figure 17: Market time at the Fatoaga Fiafia with 50 shares of vegetables and fruits sold to the first 50 early bird families every Friday on Funafuti

The diets of Tuvaluans living in Auckland differ from the diets of those in the islands, in some ways for the better. In contrast to Tuvalu, there is an abundance of fruits and vegetables in Auckland. Furthermore, Tuvaluans in Auckland are exposed to other influences on their cooking such as television programmes and magazines. Enea Ola's five-minute radio health programme, conducted by a Tuvaluan health worker from West Fono, is very effective and popular, and I have heard a number of people mention the messages they received on the programme. The health workers—especially doctor Esela Natano—used to go on the radio to talk about the health issues Tuvaluans face in Auckland and to offer advice about how people can look after themselves well. I have also run nutrition knowledge competitions on the radio, rewarding competition winners with \$20 worth of fruit and vegetables.

Perhaps as a result of such initiatives, I have also begun to notice attitude changes among members of the Tuvaluan community towards food. At wedding feasts and community gatherings, I occasionally see people jokingly point to someone else's plate and comment that they are eating too much food or not enough vegetables. This suggests that, even if some people do not follow the dietary advice, Tuvaluans are hearing it, either from the radio programme or elsewhere. However, traditional feasting is still an important part of life for Tuvaluans in Auckland. Community social gatherings occur frequently (such as island commemoration days, funerals, weddings, birthdays, church events, and youth and family functions), and there is a commonly held view among members of the Tuvaluan community that a party is not a party unless there is an abundance of food for eating

and to take home. Traditional foods such as *fekei*, *suasua* and other similar dishes are always the highlights of the feast.

Food is central to every Tuvaluan community occasion. For example, to celebrate the life of a deceased person, the people attending a funeral are asked to accept the family's prepared food as a token of their appreciation. Often children and mothers make use of these opportunities to take home food for the family to use later on. Although this may be a good use of left-over food, often fruits and vegetables are the foods that are left on the table and the pork, fish, and starchy foods are the first to be snatched. Traditional foods are popular, since many such dishes are both well-loved and time-consuming to prepare, and taking food home allows mothers to avoid cooking these dishes for some time afterwards.

As mentioned previously, one of the WDHB's health promotion initiatives is to pay for a number of community members to undertake training, run by Sports Waitakere, to enable them to run fitness courses within their own communities. One Tuvaluan health instructor who qualified from this training course began running a one-hour exercise programme for the members of the Tuvaluan community over the age of fifteen, which ran every Tuesday and Thursday and involved dancing to the beat of Pacific music. The programme was initially greeted with great enthusiasm from members of the community, and the hall where the programme was held was usually packed for every session. However, the programme failed to consistently maintain the interest of community members, and the numbers attending the exercise class soon dwindled. It was a challenge for the Tuvalu Health Committee (which is an informal group of Tuvaluan health workers and clinicians) to maintain attendance numbers. Following the fall in numbers attending the exercise classes, the Tuvaluan health instructor who ran the programme assisted the Health Committee in approaching Tuvaluan youth gatherings to implement a new exercise programme. Rather than require community members to drive to a location for an hour of exercise, they decided instead to hold an hour-long exercise class prior to youth volleyball events, which took place on Friday nights. This approach was highly effective as, frequently, those who came to be spectators of the games joined in the exercise classes. However, the programme received some criticism, as it was sometimes seen as getting in the way and taking valuable time from the arranged competitions. Currently, the exercise programme involves weekly hour-long water walking classes at the West Wave pools on Saturday mornings. The turnout is excellent at times when there are no other activities scheduled. Water walking is especially good exercise for older people, but the timing is a challenge for all in the winter when it is cold and dark in the mornings.

It is a constant challenge for organisers to encourage participation in exercise programmes and other health initiatives run by the WDHB and the Tuvalu Community Trust. It is particularly challenging to encourage women's attendance as, within the Tuvaluan community, women are more likely to be the family members whose time is tied up with staying at home to carry out chores and care for children and the sick. Whatever the reasons behind community members' failure to attend exercise and health initiatives, given the unfavourable health statistics among Pacific peoples in West Auckland and New Zealand, it is important that participation be improved. It is these poor health statistics that have prompted the establishment of Pacific-specific healthcare services, which aim to provide services that recognise the cultural needs of patients. One of these initiatives is the West Fono Health Trust, which is specifically geared to help Pacific communities in West Auckland. I now

provide a detailed account of the West Fono Health Trust, which was the primary site for my own ethnographic research.

5.0 West Fono Health Trust

5.1 History

West Fono Health Trust (Figure 18), formerly known as Pasifika Healthcare, was founded in 1990 to help cater to the health needs of people in West Auckland, especially Pasifika people. West Fono is a space shared and negotiated by health workers, clinicians, patients and many other potential health clients, most of them Pacific Islanders in West Auckland, including undocumented immigrants and families in need. It is now a conspicuous establishment located in the heart of Henderson, a stark contrast to its humble beginning at an abandoned Telecom warehouse on Lincoln Road. It has an enrolled clinic population of 7,000 patients, and a total of 10,500 patients visited the clinic in 2012. As I write about the services West Fono provides, I hope to create an understanding of what attracts clients, especially Pacific people, to drive past two or three health clinics to come to West Fono for healthcare. I hope that this descriptive account helps to create a greater understanding of key factors leading to the success of public health services, especially where Pacific patients are involved.



Figure 18: West Fono Health Trust, Henderson, West Auckland

In October 2010 I had the opportunity to interview one of West Fono's founders, Dr Colin Tukuitonga, which provided insight into the need for such an establishment and its significance to the health of Pasifika people in West Auckland and around the country (Tukuitonga 2010). In addition, I was able to interview the two team leaders from West Fono Community Health Services as well as some community health workers and clients of West Fono. My research also involved analysing information about West Fono's services from an information pack about the clinic and from the West

Fono Health Trust website (West Fono Health Trust 2012). I used photography and the fieldwork method of participant observation among patients and community health workers at work. Photographs are useful documentations of field observations and, through photo-elicitation, that is, using photos as talking points in interviews, photographs help to establish a rapport with people (Fetterman 2009). They are mnemonic devices that function as a “can opener”, enabling rapid engagement with a community (Collier and Collier 1986, Fetterman 1980). In addition, they help to illustrate descriptions within the text. Photography is thus a very useful research tool but it has some limitations (Davies 2008). Some of these are the practical limits of time and space in what can be photographed, but others are cultural or personal reactions from individuals who do not wish to be included in photographs. This was an issue for me as I explain a little further on.

Pacific people’s poor health outcomes in New Zealand only became noticeable in the 1980s. Prior to the 1980s, despite two decades of migration from the Pacific islands, Pacific people were almost invisible in health statistics, since the Pacific population was relatively small and health studies tended to only compare Maori with non-Maori rather than break down statistics into multiple ethnic categories (Dunsford et al. 2011). A report authored by Dr Tukuitonga in 1987 (which was not published until 1990) on the health of Pacific Islanders was the first to have ever collated health data on Pacific peoples in New Zealand, and the results described in the report were worrying (Tukuitonga 1990). Pacific health professionals practising during the 1980s were becoming frustrated by the health system’s slow pace in recognising the particular health needs of Maori and Pacific people. According to Dr Tukuitonga, compared to many other populations within New Zealand, “Pacific people had a totally different view of health and illness and totally different experiences and expectations”, and the health system was struggling to address this issue. For example, a Samoan nurse—Moera Grace—informed me during an interview in 2010 that one factor which influenced Pacific peoples’ expectations of healthcare was the special treatment accorded to non-locals under the health department protocols on their home islands. For example, in hospitals in Samoa, European patients were provided with private rooms, whereas local Samoans were accommodated in larger rooms containing six beds.

The answer to Pacific health workers’ frustration came when, instead of universal funding, population-specific funding and targeted services were implemented, paving the way for minority groups to be able to establish health services to meet their needs (Dunsford et al 2011: 56). West Fono (Pasifika Healthcare at the time) was a pioneering project established under this new funding regime, which spurred the creation of similar health programmes targeted at Pacific people. West Fono was established in collaboration with active members of the community, such as Mary Watts and Epa Auimatagi from the West Auckland District Health Board. This collaboration with community members was a legal requirement put in place to ensure that healthcare projects were developed with community engagement.

The newly established healthcare facility was set up in an abandoned Telecom warehouse on Lincoln Road, Henderson, and it received funding amounting to \$20,000 from the ASB Trust for this. However, this only covered the building materials, so the organisers had to rely on the expertise of a local Samoan builder who turned the place into a functional space for the clinic to run. Pacific health professionals donated their free time to help in the clinic (Tukuitonga 2010).

Changes came in the 1990s when the specific health needs of Pacific people became more widely recognised, and policy and practice began to reflect the growing recognition of the value of

“by Pacific, for Pacific” services (Dunsford et al 2011: 63). Dr Tukuitonga recalled that it was the establishment and growth of West Fono, South Seas Healthcare in South Auckland, and Langimalie in Penrose that made people sit up and take notice. West Fono’s overall approach to health treatment was markedly different to the general services which were available at the time of its establishment. The low fees, the outreach programmes, the nurses who went out into the community, and the nurses and doctors who spoke Pacific languages made West Fono popular; it was “the complete opposite of the conventional primary care model” (Tukuitonga 2010). The high signup numbers, including non-Pacific Islanders such as Maori and Pakeha, speak to the fact that this model appealed to a wide range of people.

Furthermore, although there may be issues with the lumping together of many different nationalities as “Pacific islanders”, the West Fono approach serves many Pacific peoples well. The service uses the skills of health staff from a range of Pacific nations and having a doctor or a nurse who speaks the native language is a strong drawcard. It became clear that this was the case within the Tuvalu community when Dr Esela Natano, a Tuvaluan medical practitioner, began working for West Fono. The enrolment of Tuvaluans at West Fono took a steep climb as a result, and when Dr Natano left to begin a health clinic on the North Shore, many Tuvaluans followed him across the harbour bridge. Now that Dr Natano has left to work in Wellington, and there is no Tuvaluan-specific service elsewhere, the number of Tuvaluans enrolling at West Fono is beginning to increase as seen in Chart 2 below.

The governance model of West Fono was set up with representation from the various island groups. Funding was a struggle as promotion for West Fono was primarily centred on the poor health statistics of Pacific people in New Zealand. In retrospect, the West Fono health professionals realised that it would have worked better if they had advertised for funding on the basis of implications for New Zealand’s economy—namely, if they had linked West Fono to the maintenance of a healthy workforce and a reduction in healthcare spending. The West Fono health professionals now think that they were naïve about how the funding game is played, and have come to realise that projects must ultimately be tied to economics and cost-cutting.

Ms Ligi Pulesea, a Niuean and the current Health Promotion leader at West Fono, reflected on her involvement at the time of West Fono’s establishment and her efforts to improve the health of the Pacific community. She was a community worker who was responsible for engaging in health promotion activities in preschools and Pacific community groups. She later worked alongside pregnant women and young mothers, visiting them at home and linking them with midwives and Plunket (well baby and infant care), with the overall aim of making sure that everything was fine in the families. She also linked them to West Fono if they had no general practitioner (GP), and a large amount of her time was spent “just making sure they had a GP and were well looked after”. This care was of great value to members of the Pacific community, since they were able to get assistance without cultural and linguistic barriers getting in the way.

5.2 Services

West Fono, a member of the ProCare primary health organisation, now operates from a new double-storey building that is within five minutes’ walk to all amenities at the Henderson town centre (Figure 19). Landscapes are indicative of political relations (Strang 2010), and a large building

for this service is an expression of the values, recognition and political commitment to the health needs of the Pacific community in West Auckland. West Fono provides both general practitioner and nurse clinics, as well as health promotion services and social services in West Auckland. The ethnic groups using the services of West Fono include Samoans, Tongans, Niueans, Tokelauans, Cook Islanders, I-Kiribati, Fijians, Tuvaluans, Maori and Pakeha. As illustrated in Chart 2, Samoans are the most frequent users of West Fono services, but there is a relatively large number of Tuvaluan users, with respect to the size of the Tuvaluan population. West Fono charges its enrolled patients \$15 to see a doctor, with no charge for a follow up within five days or a \$5 fee for a follow up after five days. West Fono has managed to keep the charges at a rate that is less than half the amount one pays at many other clinics.

The community services manager, Sally Dalhousie, said in 2012 that West Fono had community-based service contracts with 23 local Pacific churches and groups. During 2012, West Fono's social services were delivered to 150 families at any one time, and its health promotion programme activities occurred within communities on a daily basis. West Fono has also established links with local, regional and national organisations and groups. Sally is proud to point out that West Fono is unsurpassed as the most durable and effective bridge that exists between non-government and statutory organisations and the West Auckland Pacific community. According to a 2012 brochure some of the many health services offered by West Fono include: community health and support services, including breast feeding support and training; family support; breast and cervical cancer screenings; mental health support; HPV education; and an anti-domestic violence programme. Health promotion activities run or assisted by West Fono involve education and exercise programmes such as the Enea Ola (see section 4.2), a cardiovascular fitness programme for men, and gardening projects to assist community members in growing their own fruit and vegetables.

The social and mental healthcare services provided by the team under the leadership of Loga Crichton take a holistic approach to their clients' needs and include family assistance as part of their service. A team of three staff members provide social services and a team of six deal with mental health referrals. Referrals for the West Fono social services come from Child Youth and Family Services (CYFS) Waitakere, CYFS Westgate, Starship (Children's Hospital), North Shore, Auckland and Waitakere hospitals, as well as from schools. The health worker constructs a recovery plan together with the client and, upon approval by the client and the team leader, the plan is executed by the client and the family with the assistance of the health worker. Three-monthly reports to the case manager and daily data entry ensure that clients and the services provided are well followed up.

Both the social services and mental health teams work closely with clients and their families to avoid focussing solely on individual patients—their aim is to ensure that the family receives care as a unit. For example, they ensure that children are immunised and attend school, and that the family receives all of its entitlements from supporting agencies. They liaise with local charity organisations such as the Salvation Army and Vision West for food parcels, and they also help set up families properly with Work and Income New Zealand (WINZ).



Figure 19: West Fono, showing location close to Henderson city centre

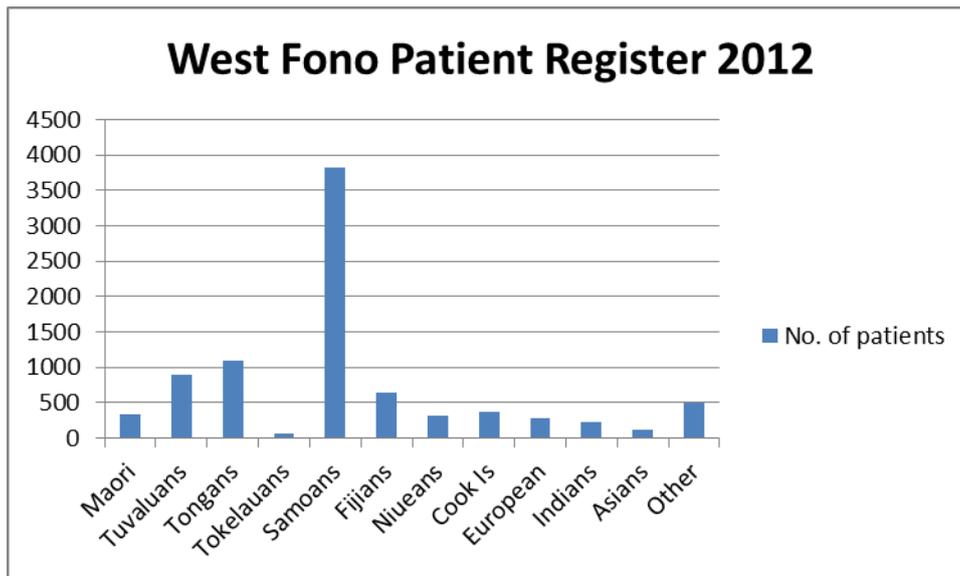


Chart 2: Number of patients at West Fono

The West Fono team often go beyond what would be expected of a conventional primary care organisation. Ligi Pulesea, the health promotion team leader, also emphasised the importance of networking and working as a team in providing social and mental health services. She described how a community health worker may ask around the West Fono workers for spare blankets for a client's family, with no names mentioned. Sometimes the workers may provide clothes or appliances,

such as heater or even fridges, to give to clients in need. Health, welfare, and education are the three main goals that the West Fono staff members work towards with patients and their families. Loga Crichton believed that West Fono's approach is superior to services that focus only on individual patients' needs, since it enables entire families to become familiar with using the New Zealand healthcare system and encourages them to take their healthcare needs seriously.

The Tuvaluan health worker Laine Steven said the programme is geared towards the creation of self-confidence and self-reliance as end products. The service now works towards having clients and families "graduate" from the service after two to three years of assistance as they become more confident using public transport and managing their own healthcare needs. The mental health service was on the verge of being cancelled last year, but fortunately it is now safe under Loga Critchon's management, and even won the bouquet of the month for its wonderful delivery of service. The Tuvaluan West Fono health workers emphasised that there has been an increase in the number of Tuvaluans using the mental health service, which they agreed is a very positive development.

West Fono's health promotion team runs a range of activities, including working with playgroups, preschools and community groups, and cervical and breast screening promotional programmes. They also run campaigns to promote healthy lifestyles, such as the "Healthy As" programme, which is run with the assistance of Auckland University of Technology (AUT). Referrals for this programme come from GPs and the Enea Ola programme. The West Fono health promotion workers also run a gardening programme, which provides seedlings for community gardens and helps communities maintain these gardens.

Two health programmes specifically for women, cervical and breast cancer screenings, are run in culturally-appropriate community settings, such as in churches. Ligi Pulesea suggested that there are a number of barriers stopping Pacific women from using these services, such as fear and shyness, and it may take several times to explain things to some of them. However, once people understand the need for these programmes, they tend to come in. Besides explaining and helping them understand the necessity of cancer screenings, the health promotion team assists women with getting in touch with appropriate health professionals, providing transport if they don't have access to it, and potentially translating if language is an issue. In short, the West Fono workers assist women in overcoming barriers and getting access to important healthcare services. For cervical screening, as for breast cancer screening, West Fono has a regional contract to help specifically with Pacific peoples.

The health promotion team's approach is one of "just making that conversation, making them talk", according to Pulesea. Acknowledging what people do know is always a good idea, since people do not feel that they are being talked down to, lectured, or ordered around. Pulesea says it is best to approach a problem together with the people rather than giving instructions. She usually begins by asking people to talk about what they know, and specifying what she can help them out with. She explained that this face-to-face dialogue-based approach is the most effective way of reaching out to Pacific people. Pulesea emphasised that being patient with people is important, especially in terms of accepting what they can't accomplish. However, catching up with people regularly goes some way towards helping them to keep on track and feel supported.

West Fono is a successful model in its approach to Pacific people's health but does not reach all potential clients. Having health workers speak the native language removes one big hurdle for

clients. The holistic approach ensures other issues the family face can also be dealt with by this health service. However, West Fono is not able to cater to the entire, substantial Pacific community in the large geographical area of West Auckland. This means that a lot of Pacific families are not able to access the services that West Fono is providing, and will continue to struggle if they are not confident to deal with their own health and wellbeing issues and to approach the relevant authorities and government departments.

5.3 Patients' Experiences of West Fono

I now examine the experiences of some of the patients and workers whom I interviewed and spent time with during my research at West Fono. Before examining my participants' experiences I should note that I encountered some difficulties when undertaking ethnographic fieldwork. Firstly, patients sometimes found my use of photography intrusive, given that I was documenting something very personal—their physical and mental health. However, when it was acceptable to my participants, I used photography in order to reveal complexities in situations that I may not have been aware of as I observed them, and to draw attention to and tell stories through the landscapes of West Auckland and West Fono (see Banks and Morphy 1997; Strang 2010). Landscapes were often very significant for West Fono patients, and the documentation of these landscapes is therefore important in fully examining their experiences. For example, the West Fono external signage (Figure 20) was a cue that prompted Tui, a health worker, to voice his feelings about the place. He explained to me that the location, the freehold land, and the Pacific ownership of the space mean peace to him and make him proud every time he comes to work. He recalled that the clinic's previous location was a stark contrast to the central and the conspicuous building that West Fono now inhabits, with its bright green signage running all the way around the building. Keith and Pile (1993:38) wrote that “all spatialities are political” and are a reflection of the powers in play. The delayed realisation that Pacific people in New Zealand might have different health needs was mirrored in the development of the new West Fono physical space, which has a much more commanding presence than the original location in an abandoned warehouse. While the names of some health workers have been kept at their request, pseudonyms are used for all patients and for some workers.

Lima, a West Fono patient, also spoke to me about the meanings that she attached to the West Fono landscape. We met at the West Fono pharmacy where I was undertaking participant observation, and she told me how she had taken her medication home the night before without paying because she had forgotten her purse, and the pharmacist had insisted that she leave with her medication nonetheless. When I met her, Lima was happily returning to the pharmacy in order to pay. Lima's happy return to the West Fono pharmacy building therefore tells a story of the trusting relationship between the West Fono health workers and patients.

Another aspect of West Fono's landscape I noted was my difficulty in identifying where West Fono's physical boundaries should be drawn. Although, physically, West Fono is confined to its building and car park, its services reach out into all areas in West Auckland and beyond. Its fleet of twelve cars is its means of reaching out to the community (Figure 21). West Fono is located in an urban area but I had a tour of the wider West Fono catchment when accompanying a health worker on two family visits. While driving, she pointed to some of her clients' homes, and I noted that they

were clearly located in poor neighbourhoods, judging by the closeness of the houses to one another and the run-down appearance of many of the houses.



Figure 20: West Fono's external signage.



Figure 21: Part of the West Fono fleet

The first family that I visited with Laine Stevens, the Tuvaluan West Fono health worker, had four young children and wanted assistance in securing a house from Housing NZ. The second had two young children and wanted help securing jobs. The recruitment agency that we went to with this second family refused to register them for labouring work on the basis that there was no work available. However, a second agency that we visited was happy to register them. My experiences accompanying a health worker on family visits demonstrated to me what a wide range of services West Fono provides. Just as it is difficult to draw a physical boundary around West Fono, it seems to me that it is also difficult to draw a boundary around the services that the organisation provides. Although many of the services that West Fono provides do not strictly relate to health, it seems difficult to draw a line between those services that influence health and those that influence more general wellbeing, and between services that affect individuals and those that affect entire families.

Siu, a solo Tuvaluan mother of four, acknowledged the great assistance she and her family had received from West Fono, not only in terms of healthcare but also for the organisation's assistance in improving their general wellbeing. Laine Stevens had worked with Siu when she and her family had been having a difficult time. Siu's daughter suffers from epilepsy, which had made it increasingly difficult for Siu to work full-time. West Fono helped to set Siu up with WINZ and, as a result, when I spoke to Siu she was "just managing" with the help of benefits and her budgeting lessons arranged through West Fono. Siu's own eczema was also under control, and the service had managed to find her and her family a one-level house in a new housing complex, which ensured the safety of her teenage daughter with epilepsy.

Another barrier that I faced in undertaking research with West Fono patients and workers was my use of recording devices during interviews. For example, two Tuvaluan patients with whom I recorded interviews were initially very distracted by the digital recording device, which I had placed in the middle of the table. The first interviewee began the interview by speaking as if she were on the radio, thanking everyone for listening. She began to relax as the interview got going, and discussed her experience as part of a family that had received social service support from West Fono. The second Tuvaluan patient I interviewed was a middle-aged man, who rapidly became more comfortable with the device. He was visiting West Fono for his three-monthly medical check-up. During interviews I was drawn into patients' stories, and felt for them at their time of need when West Fono came to assist. Often patients had very vivid memories of their healthcare crises. For example, Siu looked down at her arms as if still searching for those rashes and marks that had covered them a few years back; Tema could describe in detail using English medical terminology the heart valves and faults that had made his heart problematic. Through their stories these patients legitimated the existence of West Fono (Bender 1993), testifying that their recovery was due to services provided.

6.0 The Voices of Tuvaluans in Auckland: Health, Values, and Immigration Experiences

After describing some of the West Fono patients' experiences, I now turn to look more broadly at Tuvaluans' experiences in Auckland. Based on my ethnographic fieldwork, I focus on Tuvaluans' experiences with healthcare and health (in particular, - on some Tuvaluans' experiences with TB), and on how health intersects with matters of immigration and adjusting to the new cultural values and social structures that they encounter upon arrival in New Zealand.

6.1 Health, Healthcare, and Tuberculosis

Based on my interviews with Tuvaluans in Auckland, I can confirm that having health workers who speak the language is an important factor in increasing the number of Tuvaluans prepared to visit a doctor. My interviewees also expressed a preference for health workers of Tuvaluan descent, with whom they typically felt more comfortable. An understanding of traditions and culture is very much appreciated. English is a language barrier for many Tuvaluans wanting to seek medical attention. An interpreting service in New Zealand hospitals began in 1991 (Dunsford et al. 2011:53), and although this assistance is now used by many Tuvaluans, many are not aware of this service and may put off seeing a doctor as a result. Tuvaluan men are particularly good at delaying their visits to a doctor and many only visit when things become serious.

In the late 1990s, Apiseka Eka—the former Tuvalu community health worker at West Fono—found herself spending more time interpreting for visiting Tuvaluan patients than on her own assigned work. This situation helped persuade the newly qualified Tuvaluan doctor working in South Auckland to work for West Fono. A Tuvaluan nurse also came on board to work and run a range of health promotion programmes, which were well received and attended. According to Apiseka Eka, these health promotion programmes involve discussions of important health issues such as TB and meningococcal disease. Ms Eka's role was mainly promoting health sessions to the community by inviting Tuvaluans and West Fono clients and making tea for participants. The two Tuvaluan community health workers currently working at West Fono still help with interpreting when the need arises.

According to Laine Stevens, as Tuvaluans come to New Zealand to settle, there is a great need to educate them about the environment and the lifestyle in New Zealand. Ms Stevens noted that women need to be educated on the importance of immunising children, enrolling children in early childhood education at the earliest time, utilising programmes such as HIPPY (Home Interaction Programme for Parents and Youngsters, run by the Great Potentials Foundation), and the importance of caring for their families—such as ensuring that there is a meal ready, before socialising with friends or playing bingo. Such education could help minimise family disputes and child neglect, which are prevalent in the Tuvaluan community according to Ms Stevens, contrary to Minister Bennett's statement noted above. This difference may be because few of these situations come to the notice of government authorities.

Ms Stevens could recall encountering only one case of TB in her work with the Tuvaluan community in Auckland. It occurred many years back, and she was not able to become very involved

with the family because the family strongly denied being affected by TB. This response is understandable given the stigma associated with the illness by Tuvaluans here and in Tuvalu. One of my interviewees who worked with young children tested positive for TB infection (i.e., latent TB, not active disease) sometime between 2001 and 2005 when workers at her workplace were tested for TB. This was during the time of a major outbreak of TB in the Tuvaluan community, in which 24 children were infected with active disease and five more had latent TB (Voss et al 2006).

Six of us tested positive. I remember some of the six workers did not want to go (to the hospital) but we were all encouraged to go. I think there was one other Pacific Islander but the other four were Maori. I don't know about the others—whether they did their treatments—but I remember being taken to Greenlane Hospital for more tests. I wasn't sure whether I stayed for one night or two for them to do all the type of tests they wanted to do. Then I got my results. They said the bug was still sleeping. I was not admitted, I was only doing my tests. I was always in tears as I was really scared and I had pity on my children. I was thinking of the way the Tuvalu TB cases are segregated from the rest of the patients in the hospital like in Funafuti. In Tuvalu TB is such a bad illness that it is scary because the patient gets isolated from the people. The name TB, gee, especially the one that gets it....so isolated from the rest. You are just left there because you are dying.... (Ane 2012).

Ane's experience with TB has not been a pleasant one, as TB is stigmatised in the Tuvaluan community. It was later found that a woman in a family that Ane had been working with and providing transport for at times was the source of the illness. A group of households tested positive through contact tracing, and the public health nurse (PHN) used Ane to reach these families and deliver medicine and information about TB to them. Although Ane and the PHN tried to make TB less frightening to families by telling Ane's story of testing positive to the disease and taking medicine, many were still afraid. Furthermore, tracking some of these families was difficult because some are highly mobile and move without giving any notice of their whereabouts. It is also possible that people may try to avoid the PHN when she brings them their daily dose of medicine. The medicine, according to Ane, is unpleasant, and there is a great deal of it to take. She told me that she sometimes did not go to work because she felt weak and nauseated from the medicine. These factors—fear, mobility, and the unpleasant nature of the medicine and its side effects—are likely to have contributed to the tendency of many people to ignore the PHN and Ane's encouragement to take the medicine. Thus, they risk having the bug “wake up”—a risk that is always present if patients fail to take their entire course of medicine. TB, Ane noted, is very difficult to get rid of, although she made light of this, joking, “How I want to slap that bug!”

The PHN's efforts to reach families affected by TB sometimes became a hindrance to Ane and her work because for a time she became associated with the dread and stigma of TB and they would try and avoid her if they saw her coming with the PHN. This did not help Ane reach the target number of families with young babies that she needed to help as part of her usual work. Ane noted, however, that the PHN was always encouraging, and told Ane to do her best for the well-being of her fellow Tuvaluans. Sadly, the pair's efforts to heal the sick were not always matched by the patients

themselves because of many Tuvaluans' attitudes towards their health and towards TB. These families' problematic attitudes towards good health are likely to be influenced by several health values and practices that they may have grown up with in Tuvalu.

The stigma associated with TB in the Tuvaluan community in Auckland and in Tuvalu is huge. The segregation of the TB ward from the rest of the hospital wards in Funafuti strengthens the belief that when a person is affected by TB, that person and everything belonging to him or her must be isolated, even after the person is healed. Secondly, in Tuvalu some patients failed to finish their TB treatment plans, because of the many disruptions in health provision, caused by a range of factors, such as medical staff shortages, disrupted shipping schedules to outer islands, and inadequate medicine and medical equipment (Resture 2010: 11).

Another contributing factor is that the value many Tuvaluans place on Western medicine is on par with the respect given to the local healer or massager, called the *tufuga*. Sometimes "western-trained doctors [are] not only or always the first response for Tuvaluans" (Resture 2010: 95); rather, it is common practice to seek a Western doctor's assistance as well as a *tufuga* for ailments. The *tufuga* uses local herbal medicine to create healing potions and gives massages to affected body parts. The recognition of a *tufuga* in the Tuvalu Health Department in 1980 (Resture 2010: 95) is affirmation of the value Tuvaluans place on *tufuga* assistance. This means that many Tuvaluans often have a trusting attitude towards alternative medicine. Where *tufuga* and Western-trained doctors work together, this can have beneficial effects. But in New Zealand, this trusting attitude sometimes carries over to other types of alternative "medicines", and people may not assess their credibility. For example, in Auckland many Tuvaluans drive to Otahuhu to buy bottles of water—which is said to heal ailments of all sorts—from a non-Pacific distributor, despite the associated costs and lack of evidence of efficacy.

6.2 Tuvaluans' Experiences with Immigration

I now describe some Tuvaluans' experiences with immigration to New Zealand, focussing on why people chose to immigrate and how their immigration experiences impacted their health and wellbeing.

Nine Tuvaluans in Auckland told me their stories of their families' migration to New Zealand. For these interviews I targeted married participants in order to get a good sense of what families aspire to obtain from New Zealand. Two of the nine interviewed had moved to New Zealand after having lived for a time in Nauru with their families and seven came directly from Tuvalu.

The information that I gathered from these interviews showed that most migrated to New Zealand because of a desire to create a better life for their family. Two mothers, Siu and Tau, both mentioned education for their children as being a factor in their decisions. Siu described income as a major factor influencing her family's decision to move, since it was very hard to make a living in Tuvalu. Her husband, who was a casual worker at the Island Council's hygiene department, was earning around \$10 a fortnight. "It was tough for my family seeing the children going to school with nothing, no good things." She felt that being able to earn more here in New Zealand would help her provide a better life for her children.

Tau, a member of one of the families who came from Nauru, described a general sense of wanting to have a "good life", particularly for her children. She said,

My family was so poor when I was growing up as a child, life was really tough. It was always hard work every day and poor education. I wanted my children to be able to get good things that I couldn't have when I was growing up, good education and a good life [tears rolling down her cheeks]. It was too difficult to go back to Tuvalu and start life again from the beginning, it was like a beginning from the bottom again to me.

These Tuvalu families from Nauru, however, found life in New Zealand a challenge as "everything needs money compared to life in Nauru where many things were free for us". Budgeting was therefore important and taking advice from those who had been here longer helped Tau and her family to eventually save enough money for a deposit on a house of their own.

Except for the participant who came with her sick daughter for medical treatment, the rest of the participants came to New Zealand with pre-existing family networks in place. They all stayed with family members when they first arrived and moved out months or years later when they were able to support themselves. Although traditions dictate that such hospitality and support be extended to families coming to New Zealand to live, it is a health risk for many families who end up living in crowded conditions with very little financial assistance from dependent family members who are yet to secure a job.

Some of the parents interviewed came to reunite with their children "illustrating the potential for chain migration" (Simati 2009:90). Parents are brought in for various reasons, including to help look after the grandchildren while their parents are working. Conversely, as adult Tuvaluan children are required to take care of their parents in their old age, parents are also brought over in order that they may be well cared for.

Helani, a young mother, similarly described the importance of improving life for her family, particularly her parents, who required good medical treatment and were no longer able to support themselves through manual labour on Tuvalu. She said, "We just want our parents to live longer lives with us, to be well taken care of in terms of medication and fresh fruits and vegetables. Our country lacks so much. Our country is so poor in these areas." These women and their families decided that New Zealand was a good place to migrate to.

A key component of the "better lives" that emigrating families were seeking was a good education for their children. To the families this was a good investment for the future; along with good education, the children would not be growing up in the same poor environment that most parents experienced growing up in Tuvalu. A couple with four children had dedicated their time to supporting their children's education since early childhood and, at the time of my interview with them, were witnessing their children's great academic performances at school. Although the parents' education ended at primary school level, they made sure they did not miss any teacher-parent meetings; at these meetings they picked up tips from teachers on how to help their children at home. I have the privilege to witness their dedication in the support they give to our community's language class which is attended by them and their children every week.

Three families came here after the closing of the Nauru phosphate mines because, as they were in their fifties, they could not see any reason to go back to Tuvalu. They had worked in Nauru for forty years and they would have to restart life all over again if they were to return to Tuvalu. They

would have to cultivate the land, build a house, and do laborious work to begin life there and that would be too much for them at their age. One family thought that because the father was a skilled tradesman they would be useful to New Zealand if they could come and live here. Besides, the forty years spent at the phosphate mines was viewed as working for British, New Zealand, and Australian companies, so they thought they had good support for their cases. Two families were granted residence under the humanitarian category (see section 2.6) and they considered themselves as opening the doors for their other family members in Tuvalu who might want to come and reside in New Zealand. Their adult children are now New Zealand residents as well.

One family came here because the seven-year-old daughter had kidney problems, and she could get medical treatment in New Zealand under the medical scheme run under the bilateral agreement between New Zealand and Tuvalu in 1994. Unfortunately, the medical assistance dried up, and the girl was taken back to Tuvalu. Her condition worsened and she was sent back to New Zealand for medical treatment under private funding. The private funding consisted of a contribution from the Tuvalu government, donations from the Tuvaluan communities in Tuvalu and Auckland, and money from fundraisers in England and Australia. The cost for the kidney transplant was \$162,000 and that was met by the fundraising and the kind work of the medical team at the hospital. The support from the medical team helped the family obtain residence in 1996, and that reduced the bill dramatically. The girl is twenty-six years old now and in good health.

Most of the families I interviewed managed to get residence through the standard immigration processes. One solo mother and her children achieved residence through the PAC (see section 2.2), for which she was very grateful. However, the process to obtain a visa from immigration was a tedious and expensive one for many of the participants. X-rays and other medical reports are expensive to obtain and often expire before the application assessment is made. Two families were struggling to get residence for the parents through the family reunion category (section 2.5) at the time of their interviews. The parents' health problems prevented them getting the health clearance needed for their permanent residency to be approved by the Department of Immigration.

Barriers like health result in people becoming desperate and very susceptible to manipulation and immigration scandals. One family reported spending \$20,000 on lawyers, medical check-ups and in lodging their applications. It was continuing heartache for them as they had made no progress with obtaining residency. During their interview, they said that they now see themselves as earning money only to pay for the processing of immigration applications.

Another family whose application to Immigration was declined due to the parents' health experienced great sorrow at their mother's death due to a heart attack. She and her husband both had heart problems, and she also had high blood pressure and diabetes. Each needed to pay \$46,000 for heart operations. Due to the lack of funding available to them they were unable to afford these operations, and the husband instead used to apply pressure to the wife's back if she experienced pain in her chest. One morning, she woke him up at around 6 am in pain, so he applied the same pressure. He tried and tried, but this time there was no relief, and she turned to him, bid him farewell, and died. The husband summed up his feelings by saying, "Maybe money is more important than people's lives." During his interview he expressed hope that his third child would be granted residence, so that he could then get residence himself. His other two children had attained residence some years ago and it seemed that his only hope was for the last child to gain residence so he could have an opportunity under the family reunification category.

Despite the many difficulties in people's lives in New Zealand, when I asked each of the interviewees if they would like to return to Tuvalu to live, if they were given the opportunity, their answer was a definite "no", although Tuvalu would always be dear to their hearts. The reasons provided were the limited land availability on Funafuti and the lengthy drought that was taking place in Tuvalu during my fieldwork period. The declaration of a state of emergency by the government at the end of September 2011 because of the drought further strengthened the belief that it was time to leave the beloved shores of Tuvalu because of the changes caused by climate change.

The undocumented families in New Zealand feel the health impact of their situation. During interviews I was made aware of their constant fear that the Immigration Service might catch up with them, and of the physical and psychological toll that this took on parents and families. When I questioned parents about their views of the situation, the answers came as a plea. In their opinion, New Zealand is wealthy compared to Tuvalu and they could not believe that it would be such an issue to take in someone with diabetes or heart problems. This view may be simplistic, but it is the desperate response of people who are caught up in a situation where they see no solution.

Life in New Zealand was certainly a struggle for many families after they first arrived. Many people interviewed stayed with family members before finding their own home. Tau told of her family's stay with an uncle following their arrival. During her interview she told me that their five-bedroom home was so overcrowded and poor that the meals were mostly chicken bones or mutton flaps, and she baked almost every day to save money. She told me that sometimes she would go net fishing with her husband, and before casting the net they would say a prayer for a good catch. Another family at the time of their interview were renting a very old house, which leaked so much that, when it rained, rain fell right through the ceiling. The only door lock was a nail.

Across all my interviews with Tuvaluan immigrants to New Zealand, I found that those who were in sufficiently good health to work struggled to find jobs and during this period of unemployment they helped out with the family's care in other ways. In short, although Tuvaluans who moved to New Zealand came in search of "better lives", the lives that they experienced upon arrival were not necessarily healthy or easy.

Conclusions and Future Directions

Tuvaluan migrants bring with them a wealth of cultural influences in terms of family, island and church obligations, and individual relationships and links. In the different environment of New Zealand, some of these obligations weigh very heavily but, at the same time, the social support that these networks provide is very important to the survival and happiness of many new migrants. This relatively new and youthful community in New Zealand has experienced significant challenges and these are reflected in, for example, income and health statistics. However, because the community is so small and partially undocumented, the statistics themselves must be regarded with some caution.

In her Independence Day speech, Ms Scotty (President, Tuvalu Auckland Community Trust) described the situation of undocumented Tuvaluans in New Zealand as a “millstone” for the community. It is an urgent problem, created by policy and regulation that needs to be addressed by change in policy or regulation, or in their interpretation, in order for Tuvaluans in Auckland to contribute optimally to the community and to achieve peace and happiness, which, according to the research of Tufoua Panapa, my colleague in this research Project, are part of what constitutes health and wellbeing in Tuvaluan concepts of health (Panapa, forthcoming 2014). The question of trust is key, and a lot of work needs to be done by the New Zealand government in order for the undocumented members of the Tuvaluan community in New Zealand to develop sufficient trust to come forward to regularise their residency status. One misstep and no amount of policy change will make a difference. Too many members of the Tuvaluan community in New Zealand have memories like Helani’s, whose father was taken from the family in a dawn raid. She described the authorities as treating her family like “prisoners”, and she concluded her story with the bitter memory that her father was “sent back [to Tuvalu] to die”.

Also relating to immigration is the issue of climate change. As Paton and Fairbairn-Dunlop (2010) point out, climate change is not a top motivator in Tuvaluans’ desire to migrate, but they would like to participate in long-term planning around climate change, which may have implications for migration in the future. They do not want planning to be delayed until “when the time comes”, which is New Zealand’s current position. While climate change may not be an important reason for migration, my work with Tuvaluans in Auckland suggests it is an important reason why overseas Tuvaluans do not want to return home permanently.

In undertaking this research I have become aware of some other areas that would benefit from further enquiry and/or action. Education, training and employment is one. How to further engage the Tuvaluan churches to contribute to health and wellbeing is another. Gender issues, such as in household organisation and leadership, are yet another. Maintaining the motivation of participants in various health programmes is a continuing challenge. These are not isolated issues. For example, it is relevant to ask questions such as: What will the effect of the newly permitted female clergy be on women’s opportunities in the community? How could the training of pastors and elders incorporate health promotion awareness?

While there are many questions to be answered, the work already done around food and exercise including cooking and gardening, which has sometimes proceeded through trial and error, has achieved results. Ways forward have been identified. In health services, understood very broadly, West Fono healthcare has proved very acceptable to Tuvaluans, and many lessons can be drawn from

West Fono ways of working. These initiatives and services for individuals, families and groups are all important and take a lot of community energy as well as input from health and wellbeing services. Perhaps just as important to overall health is the on-going work of the Auckland Tuvalu Community Trust aimed at addressing the residency problems for undocumented Tuvaluan migrants and supporting education and employment for all Tuvaluans in New Zealand, and enhancing by example the position of women.

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