

'They do what you wish; they like you; you the good nurse!':¹ colonialism and Native Health nursing in New Zealand, 1900–40

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Introduction

In 1911 New Zealand's Department of Public Health launched its Native Health nursing scheme, to serve the health needs of the local indigenous population, the Māori.² At that time the Māori population numbered about 52,000; most lived in extremely isolated small communities and had much poorer health standards than non-Māori. The circular announcing the scheme explained that the appointees would be trained nurses and midwives (nursing and midwifery registration had been introduced to New Zealand in 1902 and 1904 respectively). Their job was to 'advise expecting native mothers, and ... where possible, attend them in their confinements' and to give instructions in 'hygiene, the management of sick children, and the preparation of suitable food'. Appointments were open to Māori and European (Pakeha) nurses, although the announcement stated that 'first preference ... will be given to Maori nurses'. The nurses were also directed to encourage and assist young Māori girls who showed aptitude for nursing. The circular ended with a quotation from the English social reformer, John Ruskin, 'In every moment of our lives we should be trying to find out not in what we differ from other people, but in what we agree with them.'³

This chapter focuses on these nurses, and how they were received by their Māori clients. It is not intended to be a celebratory account of

nurses educating and rescuing ‘natives’, fighting ignorance and superstition. But nor does it advance the argument that these nurses were simply agents of Western medicine and the State, as suggested by some commentators informed by social control and victimisation models of history writing.⁴ Rather, I will show how Native Health nurses were often thrown into emergency situations during outbreaks of infectious disease, totally reliant on the help and co-operation of the local people who far outnumbered them, and how they were required to negotiate and be flexible in their nursing practices. Past historians have addressed the origins of the scheme and some of the obstacles faced, but have not examined in depth the nurses’ experiences.⁵ The following account utilises the rich source of the local nursing journal, *Kai Tiaki* (translated as ‘Guardian’ or ‘Watcher’), launched in 1908. The journal’s editor from 1908 to 1932 was Hester Maclean, who encouraged nurses to send accounts of their experiences, which she published in the journal. They provide a rare glimpse of the everyday lives of nurses at that time. Native Health nurses reflected on their experiences and offered plentiful advice to other intending nurses, providing insights into their cultural interactions with Māori communities.

The scale of the problem

Māori health was indisputably poor around the turn of the twentieth century relative to the local Pakeha (non-Māori) population. New Zealand became a British colony in 1840 and this was followed by an exponential increase in the European population, as well as a fall in the Māori population. Census data show that Māori population had declined from approximately 56,000 in 1857 to 42,000 in 1896.⁶ There were no accurate data on births and deaths, since Māori were not required by law to register births and deaths until the 1912 Births and Deaths Registration Act.⁷ Yet many estimates were made, including one in 1903 which showed that fewer than half of all Māori infants made it to their fourth birthday, at a time when New Zealand in general boasted the lowest infant mortality rate in the world.⁸ Tuberculosis was recognised as a major disease for Māori (the first accurate estimates, produced in the 1930s, found it to be at least ten times higher than for non-Māori).⁹ Both infant mortality and tuberculosis death

rates are indicative of the relative poverty of the Māori population at that time. In 1913 a smallpox epidemic claimed fifty-five Māori but no Pakeha lives.¹⁰ The death rate from influenza in 1918 was ten times higher amongst Māori than non-Māori.¹¹ But the most immediate challenges in the early twentieth century were repeated outbreaks of typhoid in Māori *kainga* (villages). Public health historian F. S. Maclean estimated that in one small Māori community there were 258 known cases of typhoid in 1916 alone.¹² Typhoid was reflective of the poor sanitary conditions of Māori settlements in that era.

Origins of the Native Nursing scheme

The concept of a nursing scheme for Māori was first mooted in the 1890s by a group of young Māori men who had attended a private Māori school – Te Aute College – and who had formed an organisation to address Māori welfare.¹³ The Te Aute Students' Association supported the suggestion in 1897 by one of its members, Hamiora Hei, to set up a system of nursing scholarships for Māori girls. They lobbied James Pope, Inspector of Native Schools, who in turn persuaded the Education Department to provide scholarships for Māori girls to spend one year training in a hospital, after which they would return to work in their communities. This new generation of Māori saw value in Western medicine.

The scheme was trialled in 1898 at Napier Hospital in the Hawke's Bay, a predominantly Māori area, and later at Auckland Hospital. The scholarships were extended in 1902 to three years, and in 1905 to include a full nursing training. By the following year, nine Māori women had completed their training. Hamiora Hei's sister, Akenehi Hei, was one of those early Māori nurses, entering Napier Hospital in 1901.¹⁴ In 1909 the Department of Public Health employed her in Te Kao, Northland, during a typhoid epidemic, and she was subsequently stationed in other Māori areas, in Taranaki and Gisborne.

The Department of Public Health, which had been set up in 1901, began employing Māori nurses for Māori areas in 1907. Historians have assessed the scheme to train Māori nurses and employ them within their own communities as a failure, owing in part to the reluctance of some matrons to train Māori women and because there were simply not enough to meet the demand.¹⁵ Yet this conclusion is probably

overstated; taking a longer view over subsequent decades indicates that many more Māori nurses were trained than had been assumed. In 1923 *Kai Tiaki* reported, 'Quite a number of Maori girls have gone through the Auckland Hospital, the Napier Hospital, and the Waikato Hospital, and have qualified as nurses and done valuable service afterwards for their own people.'¹⁶ In 1929, the Superintendent of Native Nurses, Amelia Bagley, maintained, 'Applications from Maori girls for nurse training are always sympathetically considered, and there are always a number of Maori nurses in training, and we always have a certain number acting as Maori Health Nurses.'¹⁷ A 1954 article suggested there were 'many highly qualified Maori nurses', although it is difficult to quantify them; while their names can be used as a partial indicator of ethnicity, this is not necessarily a reliable index.¹⁸

The first European woman employed by the Health Department to nurse amongst Māori seems to have been a Miss McElligot, who nursed in an isolation camp during a typhoid epidemic in the Waiapu District in 1910.¹⁹ Following the official launch of the Native Health nursing scheme in 1911, Amelia Bagley, a qualified nurse and midwife who had been an assistant inspector in the Department of Hospitals and Charitable Aid since 1908, was appointed to Ahipara in Northland, again during a typhoid epidemic. Bagley described her experience at Ahipara as 'quite out of the usual run of nursing.'²⁰ She set up a temporary hospital at the local *marae* (meeting place) during the epidemic. By the end of 1912 Bagley had established five nursing stations around the country under the Health Department scheme, leading to her appointment as Superintendent of Native Health Nurses in 1913. She soon had twelve nurses working for her, and in 1915 the District Health Officer paid tribute to her efforts: 'the establishment of eight or nine hospital camps during the year at short notice, and in more or less inaccessible places, is no small work.'²¹ By 1920 there were twenty stations, and by 1940 there were fifty, each serving communities of about 1,750 people.²²

Whether the nurses were Māori or Pakeha, to a large extent their experiences were similar. In particular, their accounts show that the first challenge was the physical one of survival in remote areas with few resources, making them totally reliant on the local population. Mostly they were coping with typhoid epidemics under the guidance of Bagley; *Kai Tiaki* pronounced: 'the necessity for the district nurses

to concentrate on this strenuous nursing ... does not permit of our nurses doing so much in other directions, where they could teach that prevention is better than cure.²³

A position of responsibility

In setting out the requirements for nurses to take up Native Health nursing Amelia Bagley made it clear she wanted the best: with the 'very best qualifications, both general and midwifery'.²⁴ When she advertised a position in the Māori district of Te Araroa in 1912 she explained that the posting was 'a most responsible one, the nearest doctor being fifty miles away, at Waipiro. When he is connected by telephone, it will be a great relief to the nurse. Even then, she must act on her own initiative a great deal'.²⁵

Nurses in post underscored that sense of responsibility. Akeheni Hei sent letters to *Kai Tiaki* describing her experiences, starting in 1909 when she was stationed in Te Kao. Patients in Hei's area included 'two rheumatic fever, two tubercular children, eight with symptoms of typhoid', and the nearest doctor was located some twenty-five miles away.²⁶ Qualifying as a nurse and midwife in 1916, Ngapori Naera was 'appointed district nurse to Te Kaha [in the Bay of Plenty], perhaps the most cut off district in the country'.²⁷ *Kai Taiki* described this as a huge responsibility since the nearest doctor was at Opotiki, some sixty miles away.²⁸ In 1923, a tribute to Nurse Blair, who had worked as Native District nurse for two years at Kahakara, gives an impression of the work involved. The district was cut off by a flooded river and bad roads from any medical aid, except by telephone, making the nurse 'entirely responsible' for all cases of accident, illness and maternity in her area.²⁹ Nurse Tait, who had taken up the position at Te Araroa advertised by Bagley in 1912, reflected on this responsibility: 'the position the nurse is placed in, to act as doctor, to diagnose, treat, prescribe and dispense, makes one sharpen every faculty to do the very best possible. ... I like the work and read more medical books now than ever before, in my nursing career'.³⁰

There was little mention in their accounts of interactions with local doctors. Historian Derek Dow has documented some opposition to the presence of Native Health nurses from doctors, who had been

subsidised by the government to work in Māori areas since the 1840s.³¹ Nurses were not deterred, however; as one 'old district nurse' declared in 1917: 'There is no doubt a good nurse is better than the average medical practitioner in the back-blocks.'³² The number of subsidised doctors fluctuated between thirty and fifty in the first two decades of the twentieth century; with almost half stationed in the South Island or near Wellington, i.e. not in the most populous Māori areas, this meant that the nurses had little recourse to them in any case.³³

Jane Minnie Jarrett, who had been a Native Health nurse since arriving in New Zealand from Newcastle upon Tyne in England in 1913, spoke at a refresher course on Native Health nursing in 1928. She too mentioned the 'anxiety of relying solely on oneself', which she said was a great responsibility and required nurses to 'keep up with the times'.³⁴ However, keeping up with the latest medical developments was not the only, or even the most important, requirement for a Native Health nurse.

A hostile environment

Among the prerequisites which Amelia Bagley listed for a Native Health nurse was 'good health'.³⁵ From their accounts it is clear that the position required considerable physical stamina and the ability to withstand disease. In the course of her duties Akeheni Hei was thrown from her horse and drenched with rain so that she was laid up for six weeks in 1910.³⁶ *Kai Tiaki*, which followed Hei's career with great interest, regretted in October 1910 that the next instalment of her interesting account was not yet to hand, and in the following issue announced the sad news of her death on 28 November 1910. Still in her early thirties, she had succumbed to typhoid whilst nursing members of her family. Nurse Tira Parone, who was in her second year of training at Gisborne Hospital, and described as 'a very promising Maori probationer, and a great favourite with her teachers and fellow nurses', also died of typhoid in 1913.³⁷ Another Māori nurse, Maud Mataira, who had trained at Wanganui Hospital in 1911, died in the 1918 influenza epidemic.³⁸

It was not only Māori women who were susceptible, and nor was it necessarily peculiar to New Zealand; anyone working in such epidemics is subject to risk. Florence Gill, nursing typhoid cases in 1911,

contracted the disease, along with her colleague, Nurse Herdman.³⁹ In 1914 Nurse Grigor at Waikato contracted measles, then ‘shortly after closing her camp hospital, nurse had the misfortune to develop typhoid herself, and is now being nursed in Hamilton Hospital’.⁴⁰ In 1916 *Kai Tiaki* referred to Nurse Blackie at Tauranga as ‘not having recovered sufficiently from her very severe attack of enteric [typhoid] last year’.⁴¹ Gladys Johnson, who qualified at Wanganui Hospital in 1922, contracted typhoid fever and diphtheria in the course of her duties.⁴²

Even when they did not contract an infectious disease, the work was physically demanding. When trying to attract a nurse to the Māori district of Te Araroa in 1912, Bagley put a positive spin on the physical environment, explaining the necessity of riding: ‘You reach them by tracks or beaches, and a good canter over a hard wet beach is truly exhilarating, and helps through the worry usually found at the other end’.⁴³ In 1914 *Kai Tiaki* reported on Nurse Dawson’s work in Thames, commenting, ‘The journeys to many of her kaingas have been most trying during the winters particularly those on the Hauraki swamp after leaving the launches.’ Dawson herself explained, ‘The swamp is simply appalling in the way of bad roads and mud, and Waitakaruru is the worst. In one place it took me an hour and three-quarters to do less than two miles, and I got bogged at the end of it. My horse simply could not get out. Just had to sit still and possess my soul in patience till two Maoris [*sic*] came to my assistance’.⁴⁴

Nurse Fergusson was stationed in Northland from 1919. *Kai Tiaki* commented on her building and carpentry skills as ‘an unequalled example of what a woman can accomplish if she so desires, and the need presents itself, in work that she is supposed to be incapable of doing’.⁴⁵ She even made most of the furniture herself, admittedly with some assistance from the local teacher, Mr Vine, and local Māori who raised money to provide materials for her house.

Local assistance

Teachers in the Native Schools had acted as informal health workers since the advent of the Native school system in 1867, including dispensing medicine and health advice.⁴⁶ Teachers were well established in the communities and far more numerous than nurses. When she

was stationed in Te Kao, Akeheni Hei was accommodated and assisted by the local schoolteacher.⁴⁷ Nurse Dawson referred to a schoolmaster who went to Mokamoke with her because he thought the road was not safe for any stranger to go alone – much less a woman: ‘He is a very nice man, and so interested in the Māori children. I found him very helpful indeed.’⁴⁸

Most of the support, however, came from Māori residents. Bagley warned nurses that they could not expect to function under the ‘approved hospital style’, but must work with the assistance of the people concerned.⁴⁹ After setting up a temporary hospital at a Māori meeting house in 1911, she explained, ‘I am making them all bring their own things ... and for help I am engaging a Maori woman at 15s. a week, whose child is just recovering, and who, with the child, is sleeping with me in the house to-night Then I am getting a girl (Maori) of 16 to do the rough work, and stay in the house for messages etc.’ For Bagley ‘rough work’ simply meant unskilled household work. Parents of sick children often helped out, and Bagley commented that ‘These Maoris [*sic*] are not bad nurses – especially the men.’⁵⁰

Nurse Street reported in 1911, ‘I cannot speak highly enough of the kindness and consideration shown by the Maoris [*sic*] to their nurse.’ She pinpointed language as a problem, but added, ‘usually there is a Maori on hand who can speak English well, and interpret for the nurse; also nearly every Maori can speak a good deal of English, and unless one was a very good Maori scholar, there would be a great risk of misunderstanding.’⁵¹ Other nurses did learn to speak Māori. Nurse Cormack wrote in 1913 that ‘I think I like this work more every day, especially now the Maoris [*sic*] know me, and I can speak Maori a little now.’⁵²

Local stories abounded. One nurse described ‘Three weeks in a Pah [a fortified village, now spelt *pa*]’ in 1913, concluding, ‘My best friend was the most untidy woman in the pah. Half-a dozen times a day she would come over to see if she could do anything for me. Every morning she brought a beautiful bunch of flowers and generally a rock melon, or fruit of some kind.’ After this nurse left the *pa* she wrote that it was ‘quite a treat to go back to the pah to see all the Maoris [*sic*]. They seem to regard me as quite an old friend.’⁵³ A ‘Camp in the North’ was described in 1913, where eleven patients were being nursed and where there had been one death. The nurse explained that

she had received help from a Māori man called Sam who ‘attended to the firewood, carried all the water ... went the messages etc. He had enough to do and was invaluable. He always left us a boiler full of hot water for our own baths before he finished for the night.’⁵⁴

While there are a multitude of narratives illustrating successful interaction between the nurses and local communities, not all women managed to integrate so well. In 1914 *Kai Tiaki* told of a Native district nurse in Opunake, Taranaki, who resigned after nine months, ‘failing to receive help and support in her work ... finding that she could make no satisfactory headway with it.’⁵⁵ The editor hastened to add that this was ‘the only retrograde step that has been experienced since the inauguration of the Native District Nursing Scheme.’ The common impression was that the nurse had become ‘quite a necessary institution in her district.’⁵⁶ Nurse Beetham at Okaiawa in 1912 was one such nurse; nursing in a large district kept her busy, with *Kai Tiaki* reporting, ‘the natives are now becoming acquainted with her and where at first they looked upon the pakeha nurse with suspicion, they now send for her and consult her freely.’⁵⁷ One of the reasons for her success was probably that she was assisted by a Māori nurse, Eva Wi Repa.⁵⁸ Rapidly becoming an ‘institution’ in Māori areas, they could not do so without considerable Māori support.

Empathy and humility

Qualities other than good nursing qualifications and good health were also required. Nurses were well aware that they had to earn co-operation. Setting out the necessary requirements in 1912 Amelia Bagley stressed tact, patience, common sense and a sense of humour ‘and above all things a great love of humanity and a deep insight into human nature, both its light and its dark side.’⁵⁹ The nurses were to be ‘possessed with the happy spirit which can see the funny side of things and the faculty of making friends.’⁶⁰ These were not qualities which could be taught in a nursing school, as Nurse Anderson of Rotorua pointed out in 1914: ‘They are so quick to realise one’s attitude towards them, and a slight fancied or real will drive them away, while a little sympathy works wonders which proves again that a nurse’s personality counts for as much as her training.’⁶¹ These comments by Bagley

and Anderson suggest that initially at least Māori were quite wary of these newcomers.

Māori women had the advantage of knowledge of the language and customs but some historians have suggested that unless they returned to their own *iwi* (tribe) they were not given much respect, and that European nurses commanded more respect.⁶² This was not the case with Akenehi Hei, who appeared to be well received wherever she went, as she herself wrote, ‘They seem pleased to see me among them.’⁶³ Māori in fact took advantage of her knowledge of European society; in Taranaki they asked her to attend a native land meeting and to represent to the Minister of Native Affairs the need for a small local Māori hospital.⁶⁴

Yet in bringing her European training into the local community, Hei faced similar challenges to those experienced by her Pakeha colleagues. She reported in 1909 that the death of a Māori girl in her temporary hospital had turned the locals against her for a time.⁶⁵ She was aware of the need not to ride roughshod over local customs and culture; this comprised an understanding of health and wellbeing which included not only physical and mental health but also spiritual health.⁶⁶ She recounted how Māori were widely debating the ‘effects of European civilisation’, noting that ‘Even in the most Europeanised families there lurks a secret attachment for those dear old customs, which are the result of so many centuries of experience, and [significantly] *no doubt contain many things worth keeping*’ [my emphasis]. She advised, ‘Such customs (ancestral), having kept the Maori race in vigorous health for many generations, deserve consideration A greater knowledge of the native mind will inspire a greater and thereby a deeper sympathy for the Maori people.’ Above all she concluded, ‘Great discretion must be used not to offend the patient’s beliefs, and at the same time uphold one’s own mission.’⁶⁷

Hei’s message was not lost on Bagley. She advised nurses: ‘By working with them and getting them to work with her on right lines the nurse is enabled to realise more the Maoris’ point of view, which is not without reason, and also to understand the difficulties which come in the way of their doing things “pakeha fashion”, as we would like.’⁶⁸

It was not just the patients they had to deal with, Bagley warned, but the wider community. She told the nurses, ‘It is seldom the patient, but always the friends who make difficulties, but to totally exclude the

friends would, in most cases, unduly depress, or cause injurious fretting on the patient's part, and arouse strong suspicions of the nurse's intentions towards the patient on the part of the friend.⁶⁹ Her strategy was to engage a selected relative or friend to help nurse the patient. Again, she was cognisant of the need for tact.

In her 1928 lecture Nurse Jarrett stressed the importance of respecting cultural differences, informing her listeners of the tact and patience required, pointing out how months of good work could be lost if, for instance, a patient admitted to hospital for a simple abdominal operation died of anaesthetic pneumonia. She spoke of the need to respect the *tapu* (sacred things) of all sects, explaining that was where newly appointed nurses sometimes failed. She said, 'One must respect their religion, and be able and sincere when asked by the head of the household to hold a *karakia* (say a prayer) for their sick.' She also thought it important to 'be able to see the other chap's point of view, and gently insinuate one's own'. She believed it important to be honest, while 'Above all, one must have a keen sense of humour that is the saving grace.'⁷⁰

Challenges confronting the nurses

With the best intentions in the world, affection for Māori, an open mind and a sense of humour, nurses still faced major challenges. Imbued with modern (Western) ideas about disease causation and prevention, they did attempt to confront what they regarded as hindrances to effective nursing and impose their will on the locals, even to the extent of admitting they could be 'quite bossy' with patients.⁷¹ Challenges included isolation when dealing with infectious diseases, *tangi* (burial practices), maternity practices and the nurses' relationships with *tohunga* (traditional healers). At every step of the way they were required – or chose – to compromise.

The first issue many nurses had to deal with, as noted earlier, was typhoid. Bagley regretted that nurses were not trained adequately to deal with this condition outside a hospital setting. She believed the teaching did not prepare them for temporary camp hospitals which had poor or no drainage systems.⁷² Nurses were instructed that 'early diagnosis and isolation' were essential, and that lack of sanitation was

a major factor.⁷³ Through *Kai Tiaki* they were instructed how to deal with typhoid. One nurse recounted how she dealt with 'excreta and sputum'; the latter she explained was very copious owing to chest complications. She explained her scrupulous cleaning methods and how she kept separate kerosene tins for excreta and for bath water. All utensils were brought to the boil for an hour or so.⁷⁴

Maintaining such a strict hygienic environment was not always possible, however. In 1916 a nurse gave an account of extremely ill children, suffering from typhoid, ranging from five to nineteen years of age, whom she discovered 'in the most wretched surrounds on this Māori farm.' The old *whare* (house) was overcrowded and very exposed, 'Gales from various directions raged, and nursing could not be done under worse conditions than our nurses encountered there, I think, even in the trenches.' This nurse commented, 'To see what Māori typhoids live through, and the conditions they are frequently found in, makes one utterly disbelieve the hackneyed saying that "The Māori has no stamina, and, like other dark races, cannot fight out an illness etc."⁷⁵

Understanding the need for isolation created a constant dilemma for the nurses. An account of typhoid nursing in 1920 advised, 'In nursing a case you must stay with them all the time. As soon as your back is turned all the family are in to rub noses, sit upon the bed, shake hands, have a talk and, if patient is hungry, give him something to eat.'⁷⁶ This closeness did not end when the patient died. The nurse who gave the account of typhoid nursing in 1916 explained how a nine-year-old child, who had been ill with typhoid for about eight weeks, was lying in state when the nurse arrived, awaiting the arrival of her coffin. The nurse reported, 'An extraordinary proceeding on the part of the Maoris ... was that they were sleeping in this place, beside the dead body. They usually remain with an unburied body all night.'⁷⁷ Writing about tuberculosis in Kawhia in the 1930s, missionary nurse Frances Hayman opined, 'Obviously the worst source of infection was the *tangi*, when all present were allowed to sleep in a room where a dead body lay for some days in an open coffin.' She spoke to the Minister of Health about it, who told her 'when it came to passing any law forbidding *tangis*, he shook his head. This was a religious rite of the Maori race and we must not interfere in any way.'⁷⁸ While government policy was broadly assimilationist, this comment presaged

the post-Second World War approach of ‘integration’, which aimed to form one nation but keep Māori culture distinct, and suggests perhaps more flexibility in official approaches in the earlier period than normally assumed.⁷⁹

Despite the fact that *tohunga* had been outlawed under the 1907 Tohunga Suppression Act it is apparent from the nurses’ accounts that *tohunga* still flourished in many Māori communities.⁸⁰ Native Health nurses in general learned to work with *tohunga*. Francis Hayman was well aware that she was only consulted after the treatment by the local *tohunga*, whose name was Mahara, had proved ineffectual.⁸¹ Nurse Myra McCormick stated that she always let Māori use their own treatments. She believed that it was this willingness to compromise and the fact that she learnt to speak Māori which endeared her to Māori.⁸²

When the scheme was set up in 1911 the nurses, who were also required to be registered midwives, were instructed that ‘where possible’ they were to attend Māori women in childbirth.⁸³ In 1912 Nurse Anderson at Rotorua proudly reported that ‘three women had engaged her to attend them in confinement.’⁸⁴ This was not a common experience; others commented that the nurses were only summoned in emergencies. Bagley explained that Māori ‘are at a loss with abnormalities’ but qualified this by adding that they ‘know how to knead the uterus for haemorrhage.’⁸⁵ Similarly, in 1917 Nurse Whitaker told *Kai Tiaki* readers, ‘The Maori confinements are very funny, but there is a wonderful lot of common sense about them. Our doctor thinks the native women are better unattended.’⁸⁶ Leaving Māori to birth in their own ways continued into the following decades. In the 1930s Hayman reported that it was very hard to get an expectant mother to enter a maternity hospital, which was becoming increasingly popular for non-Māori women.⁸⁷ She wrote that ‘Maori women preferred their husbands or their male relatives to midwives.’⁸⁸ Kathleen Shepherd, who worked as a district health nurse in the late 1930s, also explained that they were ‘not supposed to go to maternity cases – mostly Maori looked after their own folk.’⁸⁹

Nurses in isolated districts did come across obstetric emergencies. In 1928 one nurse described a ‘Case of Complete Inversion of the Uterus’ which she had to deal with in a Māori home with very poor lighting, as the doctor was fifty miles away. She administered chloroform to render the woman unconscious and ‘hastened to re-pose the

inverted uterus before the patient had come round', and then injected pituitrin. She proudly reported that the woman recovered and had another baby two years later.⁹⁰

Nurse Whitaker's 1917 description of Māori births as 'very funny' provoked an indignant reply from 'H. M. La F', saying confinement was 'anything but funny', adding that it showed Whitaker had had very little experience amongst the Māori: 'It will be the greatest factor in preserving the Maori race, when their women seek efficient medical assistance, with hygienic and humane treatment.'⁹¹ This commentator had a point, in that the Māori maternal death rate was much higher than the non-Māori. In 1920 Māori maternal mortality was estimated to be 22.86 per 1,000 live births, compared to 6.48 for European births.⁹² A 1938 report of a government inquiry into maternity services dismissed 'any preconceived idea that childbirth is easy and safe and that the Natives can well be left to themselves [as] not supported by the facts', pointing out that the Māori maternity death rate was twice as high as the non-Māori.⁹³ It noted that a large number were still 'confined in the Native fashion with the assistance of their own folk', and that district nurses only assisted 'where some difficulty has arisen'. The committee added that the limited number of nurses, their large districts and their manifold duties made it impossible to adopt any other course of action, in any case. The main problem it found with the 'Native methods' of childbirth was the 'very unhygienic environment in which it was now so frequently practised.'⁹⁴ Environmental factors were also recognised as responsible for the persistent high rates of infant deaths; Dr Helen Deem, Chief Medical Adviser to the infant welfare organisation, the Plunket Society, commented that little would change until the major issues of housing and poverty were addressed.⁹⁵

From the accounts in *Kai Tiaki* in the early twentieth century it is clear that nurses had to devote much of their time to emergency epidemic nursing with few resources in impoverished communities. These nurses improvised and were totally dependent on local help. By the 1930s typhoid epidemics had subsided, at least partly related to the nurses' success with typhoid inoculation in Māori schools from the 1920s. This allowed nurses to devote more attention to health education, and in particular infant care, which had been among the original aims of the scheme. Another issue which concerned nurses in the

1930s was the decline of breastfeeding among Māori mothers.⁹⁶ They continued to be cognisant of the importance of working through local structures and networks. And nowhere was this better illustrated than the *Te Ropu o te Ora* (Women's Health League), founded in Rotorua in 1937 by District Nurse Ruby Cameron. Cameron had been a Native Health nurse in Opotiki from 1919 and a district nurse in Rotorua from 1931. She founded the League with the support of Te Arawa elders. Its focus was the health of Māori women and children, and it worked through *marae*-based women's committees. Cameron was well known amongst the Māori for her 'knack of getting her message across' and her 'gift of inspiring confidence and co-operation.'⁹⁷ These were attributes which many of the early Native Health nurses had shared.

Conclusion

A letter from a Māori *kaumatua*, Houtai Hohepa, from Waima, Hokianga, in 1913, to the Chief Health Officer in Wellington enclosed some cash, 'by way of a present to the Nurses who have been attending to us Maoris [*sic*] hereabout [during the smallpox epidemic]. Although our monetary gift is a small one, we ask you to be assured that our love and gratitude towards them is boundless and we trust that this will specially be remembered in the days to come.'⁹⁸

Official government policy in the first half of the twentieth century was one of assimilation of the Māori; as medical officer Dr Harold Turbott declared in 1938, the goal was to turn Māori into 'hardy, healthy, self-supporting, brown-skinned New Zealanders.'⁹⁹ Adopting Western health practices was the goal of the young Māori men who formed the Te Aute Students' Association and they advocated a nursing scheme as part of that model. The reality was that nurses on the ground were thrust into emergency nursing situations with few resources and in impoverished communities, which accentuated the health problems they had to deal with. Despite the best efforts of those who initiated the Native Nursing scheme and the nurses who serviced it, the roots of Māori ill health lay in structural economic circumstances, including poor housing. Nevertheless, this does not diminish the endeavours of the nurses themselves, and nor should they be seen

as simply agents of the State imposing Western values on colonial subjects. These nurses soon learned that healthcare was not a matter of foisting their own culture on others. Māori historian Aroha Harris has similarly argued in her analysis of the relationships between officers of the Department of Māori Affairs and Māori in the post-Second World War period that interpretations which depict the former as dominant and controlling, imposing themselves on an unsuspecting population from above, are ‘too rigid, implying flat statistic relationships; the reality was much more complex and multifaceted.’¹⁰⁰ Providing healthcare and other forms of social assistance was always a two-way process. While it is difficult to elicit the responses of Māori to the activities of the Native Health nurses, and recognising the pitfalls of relying on accounts written by nurses themselves with their potential biases, there is nonetheless enough evidence in these narratives to gain an indication of the interaction that occurred. It is clear that Amelia Bagley was not alone in eliciting this response from the Māori *kaumatua* when he told her, ‘They do what you wish; they like you; you the good nurse!’¹⁰¹

Notes

- 1 A Māori *kaumatua* (elder) to Amelia Bagley, cited in *Kai Tiaki* (henceforth *KT*), 4:3 (1911), 110.
- 2 Originally called Native Health Nurses, by the 1930s they combined with other Health Department nurses to be renamed District Nurses.
- 3 *KT*, 5:2 (1912), 26.
- 4 For example, M. Holdaway, ‘Where are the Maori nurses who were to become those “Efficient Preachers of the Gospel of Health”?’ *Nursing Praxis in New Zealand*, 8:1 (1993), 25–34; I. Ramsden, ‘Editorial: equalising the partnership’, *KT*, 82:3 (1989), 2.
- 5 D. A. Dow, *Māori Health and Government Policy 1840–1940* (Wellington: Victoria University Press, 1999), pp. 130–6; R. Lange, *May the People Live: A History of Māori Health Development 1900–1920* (Auckland: Auckland University Press, 1999), pp. 166–76; P. J. Wood, ‘Efficient Preachers of the Gospel of Health: the 1898 scheme for educating Maori nurses’, *Nursing Praxis in New Zealand*, 7:1 (1992), 12–20; A. H. McKegg, ‘The Maori health nursing scheme: an experiment in autonomous health care’, *New Zealand Journal of History*, 26:2 (1992), 145–60; A. H. McMegg, ‘“Ministering angels”: the government backblock nursing service and the Maori health nurses, 1909–1939’ (MA thesis, University of Auckland, 1991); A. M. McKillop, ‘Native Health Nursing in New Zealand 1911–1930: a new work and a new profession for women’ (MA thesis, Massey University, 1998).

- 6 D. I. Pool, *Tē Iwi Māori: A New Zealand Population, Past, Present and Projected* (Auckland: Auckland University Press, 1991), p. 237.
- 7 F. S. Maclean, *Challenge for Health: A History of Public Health in New Zealand* (Wellington: Government Printer, 1964), p. 222.
- 8 Health Department Annual Report, *Appendices to the Journals of the House of Representatives* (henceforth *AJHR*) (1903), H-31, p. 71; *AJHR* (1908), H-31, p. 122.
- 9 L. Bryder, 'Tuberculosis and the Maori', in P. Winterton and D. Gurry (eds), *The Impact of the Past upon the Present: Second National Conference of the Australian Society of the History of Medicine, Perth, 1991* (Perth: Australian Society of the History of Medicine, 1992), pp. 191–4.
- 10 A. Day, '“Chastising its People with Scorpions”: Maori and the 1913 smallpox epidemic', *New Zealand Journal of History*, 33:2 (1999), 180–99.
- 11 G. W. Rice, *Black November: The 1918 Influenza Pandemic in New Zealand* (Christchurch: Canterbury University Press, 2nd edn, 2005).
- 12 Maclean, *Challenge for Health*, p. 202.
- 13 On the Young Māori Party, see also R. S. Hill, 'Maori and state policy', in G. Byrnes (ed.), *The New Oxford History of New Zealand* (Oxford: Oxford University Press, 2009), pp. 521–5.
- 14 See P. A. Sargison, 'Hei, Akenehi, 1877/78?–1910', in *The Dictionary of New Zealand Biography*, vol. 3, 1900–1920 (Auckland: Auckland University Press with Bridget Williams Books, 1996), pp. 309–11.
- 15 P. Sargison, *Notable Women in New Zealand/Te Hauora ki Aotearoa: Ona Wahine Rongonui* (Wellington: Longman Paul, 1993), p. 24; see also McKegg, 'The Maori health nursing scheme', 153, Dow, *Māori Health*, p. 135, Lange, *May the People Live*, p. 167.
- 16 *KT*, 16:1 (1923), 37.
- 17 *KT*, 22:4 (1929), 200.
- 18 *KT*, 47:2 (1954), 63–4.
- 19 M. E. Burgess, 'The history of community health nursing in New Zealand', in M. Pyrus (ed.), *The Nurse in the Community: Community Nursing in New Zealand* (Auckland: McGraw-Hill Book Co. NZ, 1983), p. 217.
- 20 *KT*, 4:3 (1911), 109.
- 21 L. Bryder, 'Bagley, Amelia 1870–1956', in *Dictionary of New Zealand Biography*, vol. 3, 1901–1920, pp. 26–7.
- 22 Lange, *May the People Live*, p. 173.
- 23 *KT*, 8:4 (1915), 199.
- 24 *KT*, 5:1 (1912), 24.
- 25 *KT*, 5:3 (1912), 75.
- 26 *KT*, 2:3 (1909), 104.
- 27 *KT*, 9:4 (1916), 220.
- 28 *KT*, 7:4 (1914), 159.
- 29 *KT*, 16:2 (1923), 63.

- 30 *KT*, 6:2 (1913), 73.
- 31 See Dow, *Māori Health*, pp. 25, 72; D. A. Dow, ‘“Specially Suitable Men”: subsidised medical services for Maori, 1840–1940’, *New Zealand Journal of History*, 32:2 (1998), 163–88.
- 32 Dow, *Māori Health*, pp. 132–3; For similar debates about infant nurses in the early twentieth century, see L. Bryder, *A Voice for Mothers: Infant Welfare and the Plunket Society, 1907–2000* (Auckland: Auckland University Press, 2003).
- 33 Lange, *May the People Live*, p. 177.
- 34 *KT*, 17: 3 (1928), 139.
- 35 *KT*, 5:1 (1912), 24.
- 36 *KT*, 3:2 (1910), 92.
- 37 *KT*, 6:1 (1913), 37.
- 38 *KT*, 12:1 (1919), 45.
- 39 *KT*, 4:2 (1911), 74, 88.
- 40 *KT*, 7:4 (1914), 158.
- 41 *KT*, 9:4 (1916), 220.
- 42 Gladys Johnson, New Zealand Nursing Education and Research Foundation (NERF) Oral History Interview, 0014/128, Alexander Turnbull Library, Wellington.
- 43 *KT*, 5:3 (1912), 76.
- 44 *KT*, 7:1 (1914), 47.
- 45 *KT*, 13:2 (1920), 89; *KT*, 14:2 (1921), 99.
- 46 Dow, *Māori Health*, pp. 88–90; See also J. Simon and L. Tuhivai Smith (eds), *A Civilising Mission? Perceptions and Representations of the Native Schools System* (Auckland: Auckland University Press, 2001), p. 221.
- 47 *KT*, 2:3 (1909), 104.
- 48 *KT*, 7:1 (1914), 47.
- 49 *KT*, 7:4 (1914), 159.
- 50 *KT*, 4:3 (1911), 109.
- 51 *KT*, 4:3 (1911), 110.
- 52 *KT*, 6:4 (1913), 155.
- 53 *KT*, 6:2 (1913), 74.
- 54 *KT*, 6:3 (1913), 146.
- 55 *KT*, 7:4 (1914), 158.
- 56 *KT*, 7:4 (1914), 158.
- 57 *KT*, 5:2 (1912), 25.
- 58 *KT*, 5:1 (1912), 25.
- 59 *KT*, 5:1 (1912), 24.
- 60 *KT*, 5:4 (1912), 99.
- 61 *KT*, 7:1 (1914), 47.
- 62 See for instance, Lange, *May the People Live*.
- 63 *KT*, 2:3 (1909), 104.
- 64 *KT*, 3:2 (1910), 92.

- 65 *KT*, 2:4 (1909), 157.
- 66 Mason Durie, *Whaiora: Maori Health Development* (Auckland: Oxford University Press, 1994).
- 67 *KT*, 3:3 (1910), 103.
- 68 *KT*, 7:4 (1914), 159.
- 69 *KT*, 7:4 (1914), 159.
- 70 *KT*, 17:3 (1928), 139.
- 71 *KT*, 7:3 (1914), 120.
- 72 *KT*, 9:3 (1916), 161.
- 73 *KT*, 13:3 (1920), 132.
- 74 *KT*, 13:2 (1920), 70.
- 75 *KT*, 9:4 (1916), 233.
- 76 *KT*, 13:2 (1920), 70.
- 77 *KT*, 9:4 (1916), 233.
- 78 F. Hayman, *King Country Nurse* (Auckland: Blackwood and Janet Paul, 1964), pp. 25–6, 106.
- 79 On ‘integration’ as government policy, see J. H. Hunn, ‘Report on Department of Maori Affairs with Statistical Supplement, 24 August 1960’, *AJHR*, G-10 (1961), 19.
- 80 McKegg, ‘The Maori health nursing scheme’, 158; on Tohunga Suppression Act, see D. A. Dow, ‘Pruned of its dangers: the Tohunga Suppression Act 1907’, *Health and History*, 3:1 (2001), 65–86.
- 81 Hayman, *King Country Nurse*, p. 80.
- 82 McKegg, ‘The Maori health nursing scheme’, 158.
- 83 *KT*, 5:2 (1912), 26–7.
- 84 *KT*, 5:4 (1912), 99.
- 85 *KT*, 5:3 (1912), 76.
- 86 *KT*, 10:2 (1917), 70.
- 87 See also H. M. Harte, ‘Home births to hospital births: interviews with Maori women who had their babies in the 1930s’, *Health and History*, 3:1 (2001), 87–108; A. Harris, ‘“I wouldn’t say I was a midwife”: interviews with Violet Otene Harris’, *Health and History*, 3:1 (2001), 109–23. On trends in childbirth see L. Bryder, ‘“What women want”: childbirth services and women’s activism in New Zealand 1900–1960’, in J. Greenlees and L. Bryder (eds), *Western Maternity and Medicine, 1880–1990* (London: Pickering & Chatto, 2013), pp. 81–98.
- 88 Hayman, *King Country Nurse*, p. 74.
- 89 Kathleen Norah Shepherd, NERF Oral History Interview, 0014/148, Alexander Turnbull Library, Wellington.
- 90 *KT*, 7:2 (1928), 65.
- 91 *KT*, 10:3 (1917), 161.
- 92 Maclean, *Challenge for Health*, p. 216.
- 93 ‘Report of the Committee of Inquiry into Maternity Services in New Zealand’, *AJHR*, H31-A (1938), 96.

- 94 'Report of the Committee of Inquiry into Maternity Services in New Zealand', p. 96.
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- 96 Bryder, 'New Zealand's Infant Welfare Services and Maori', 78.
- 97 A. McKegg, 'Cameron, Robina Thomson', *Dictionary of New Zealand Biography*, vol. 4, 1921–1940. See also Megan Cook, 'Women's health – women's health activism, 1840 to 1940s', *Te Ara: The Encyclopedia of New Zealand*, updated 15 November 2012, www.TeAra.govt.nz/en/photograph/31479/womens-health-league (accessed 14 April 2015).
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- 100 A. Harris, 'Maori and "the Maori Affairs"', in B. Dalley and M. Tennant (eds), *Past Judgement: Social Policy in New Zealand History* (Dunedin: University of Otago Press, 2004), pp. 191–206.
- 101 *KT*, 5:3 (1911), 110.