New Zealand's Infant Welfare Services and Maori, 1907–60

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THE 1959 CONSULTATIVE COMMITTEE ON INFANT AND PRE-school Health Services in New Zealand described the Plunket Society as 'the oldest, the most widespread and the best established' of the organisations providing such services in New Zealand, with 85 per cent of all babies coming 'under its care'.[1] Shortly thereafter a young Maori medical student, Mason Durie, asked the Health Department for information on health services for Maori children. He enquired if it was correct that Plunket Society nurses were not encouraged to visit Maori mothers in predominantly Maori areas and, if so, why and for how long this had been policy. He asked if the policy extended to Maori living in urban areas.[2] Around this time there were 'voices . . . raised that the Plunket Society will not care for Maori babies'.[3] This paper explores the relationship between the Plunket Society and Maori, and what this tells us about race relations in New Zealand in the first half of the twentieth century.

New Zealand's international standing on infant health

Infant health data have often been used as a barometer of the social progress of a nation or a sensitive indicator of the health of a population. In this respect New Zealand acquired international acclaim in the first half of the twentieth

1. *Consultative Committee on Infant and Pre-school Health Services in New Zealand,* Government Printer, Wellington, 1960, p. 6.

2. Mason Durie to H. B. Turbott, Director-General of Health, 17 July 1961, H1 127 32110. Mason Durie went on to be a leader of Maori health policy, and author of *Whaiora: Maori Health Development,* Oxford University Press, Auckland, 1998.

3. Neil Begg to Turbott, 12 March 1962, H1 127 32110.

century. The US Children's Bureau reported after World War I that, 'New Zealand has the lowest infant death rate of any country in the world . . . The New Zealand rate of 50 deaths per thousand births is far lower than that of any other country.' The Bureau was not alone in attributing this favourable state of affairs in New Zealand to what it aptly described as the 'quasi-public' New Zealand Society for the Health of Women and Children, popularly known as the Plunket Society.[4]

Founded in 1907 by Dr (later Sir) Frederic Truby King, the Society gained its name from the patronage of Lady Victoria Plunket, wife of the Governor of New Zealand. While a voluntary organisation, it was supported by the government, which initially provided a third of its funds and later almost half. Plunket was founded and developed at a time when the promotion of health was urged for the sake of the preservation of the British Empire. The slogan of Plunket's 1917 'Save the Babies' Week—'The Race marches forward on the feet of Little Children'—was revealing, as was the frequent claim that babies were 'our best immigrants'.[5] Other child health initiatives premised on these concerns of 'national efficiency' included the School Medical Service, founded in 1912, and health camps, initiated in 1919.[6]

Plunket nurses trained at the Karitane Baby Hospital in Dunedin, set up and run by Truby King. Local voluntary committees were set up throughout the country to employ Plunket nurses, supply clinics and raise funds locally for the services. The nurses provided advice and education for pregnant

4. See R. M. Woodbury, *Infant Mortality and Preventive Work in New Zealand*, US Department of Labor, Children's Bureau, Washington, 1922, p. 53. Woodbury, *Transactions of the Eleventh Annual Meeting of the American Hygiene Society,* 1920, cited in Raymond K. Richards, *Closing the Door to Destitution: The Shaping of the Social Security Acts of the United States and New Zealand,* Pennsylvania State University Press, Pennsylvania, 1994, pp. 38, 53. While the Society only officially changed its name to the Royal New Zealand Plunket Society in 1980, as it was popularly known as the Plunket Society since 1907 that will be the name given to it throughout this article.

5. Poster for 'Save the Babies' week, 28 October–2 November 1917, Plunket Society archives PS) G7/119, Hocken Library (HL).

6. See Margaret Tennant, '"Missionaries of Health": The School Medical Service during the inter-war period', in *A Healthy Country: Essays on the Social History of Medicine in New Zealand*, L. Bryder (ed.), Bridget Williams Books, Wellington, 1991, pp. 128–48; Margaret Tennant, *Children's Health The Nation's Wealth: A History of Children's Health Camps,* Bridget Williams Books and Historical Branch, Dept of Internal Affairs, Wellington, 1994.

women and new mothers. In particular they encouraged women to breast-feed their infants. The scheme in New Zealand differed from those in other countries in that it was not class specific. Unlike some overseas schemes it was not restricted to the poor.[7]

The Plunket Society gained international fame. In 1923 Sir Maui Pomare, Minister of Health (and also the first Maori medical graduate), paid tribute to the work of the Plunket society. 'Its system', he said, 'placed New Zealand first among infant welfare work'. He quoted figures showing how it had decreased infantile mortality, which in 1875 had been 121 per thousand but was down to forty-two by 1922—'the record for the world', he boasted.[8] A decade later, opening a national conference of Plunket representatives, Governor-General[9] Lord Bledisloe referred to this 'life-saving movement', the development of which, at first in New Zealand and subsequently throughout the whole English-speaking world, might, he claimed:

> without exaggeration, be described as phenomenal . . . According to official statistics the present infant mortality from all causes in New Zealand is approximately one-half of that in England and Wales and the US, one-third of that in Germany, one-fourth that in Italy and Spain, one-fifth that in Egypt, one-sixth of that in British India, and one-seventh that in Chile. For this highly favoured position New Zealand and her people of all classes have to thank the Plunket movement and the man of vision who founded it.[10]

Bledisloe drew his statistics from the *New Zealand Official Yearbook*, where it was explained that 'Deaths of Maoris are not included in the statistics quoted in . . . this subsection. Their omission is due to the fact that a considerably lower

7. Lara Marks, *Metropolitan Maternity: Maternal and Infant Welfare Service in Early Twentieth Century London*, Rodopi, Amsterdam, 1996, p. 168.

8. Opening of new Plunket Mothercraft Home, Kent Terrace, Wellington, 23 November 1923: Health Department, H.127 9251, National Archives (NA).

9. The title Governor of New Zealand was changed to that of Governor-General in 1917.

10. Dominion Conference of the Plunket Society, 1 August 1934, Health Department, H.127 9251, NA.

standard of accuracy and completeness of data exists in the case of Maori registration than in the general death records.'[11]

The statement concerning inaccuracy was correct. Maori deaths were not registered before the 1912 *Births and Deaths Registration Act*, and by 1930 only about 60 per cent of Maori deaths were certified by either a doctor or a coroner.[12] Yet many estimates were made, including one by Maui Pomare who declared in 1903 that fewer than half of all Maori infants made it to their fourth birthday.[13] The death rates had declined by the 1920s, but were still four times higher than those for the European population (see graph). Citing Maori statistics would not have given the Governor-General so much to boast about.

Discussing infant mortality for the period 1921–61, the demographer Ian Pool suggested in 1977 that 'medical facilities [in New Zealand] . . . were probably better than in most other countries'. He continued, 'Herein lies the most paradoxical feature of Maori mortality trends in the period 1921–61, for the Maoris *should* have had very low mortality throughout the era'.[14] In a revised edition published in 1991, Pool no longer considered it a paradox. He explained that Maori were isolated from, and thus effectively excluded from, the health care system, which had gradually begun to assume a role in the decline in mortality.[15] The attribution of the decline in infant mortality primarily or even partially to infant welfare work has been questioned by historians such as Philippa Mein Smith.[16] It is clear, however, that New Zealand had a system that was widely believed to be responsible for its low infant death rates, and yet it was a system that was

11. *New Zealand Official Yearbook 1934*, Government Printer, Wellington, 1933, p. 118.

12. F. S. Maclean, *Challenge for Health: A History of Public Health in New Zealand*, Government Printer, Wellington, 1964, p. 222.

13. Health Department Annual Report, *Appendix to the Journals of the House of Representative* (*AJHR*), 1903, H–31, p. 71; *AJHR*, 1908, H–31, p. 122.

14. D. Ian Pool, *The Maori Population of New Zealand 1769–1971*, Auckland University Press, Auckland, 1977, p. 188.

15. Ian Pool, *Te Iwi Maori: A New Zealand Population Past, Present and Projected*, Auckland University Press, Auckland, 1991, p. 118. See also Raeburn Lange, *May the People Live: A History of Maori Health Development 1900–1920*, Auckland University Press, Auckland, 1999, p. 259.

16. See Philippa Mein Smith, *Mothers and King Baby: Infant Survival and Welfare in an Imperial World: Australia 1880–1950,* Macmillan, London, 1997.

unavailable to, or not utilised by, the Maori people who, with their high infant mortality rates, were arguably most in need of health services. Their isolation is not an adequate explanation for that exclusion.

Why Maori did not use Plunket services

As noted above, the Plunket Society was born at a time of mounting public concern about 'national efficiency' and the future of the Anglo–Saxon race, on which Truby King and others made many pronouncements.[17] It would be easy to assume that as a consequence it showed no interest in Maori or positively excluded them for eugenic reasons. However, this was not the case. Truby King himself was an environmentalist rather than a eugenist, firmly in the mould of the new public health practitioners of the early twentieth century who believed in the powers of environment (and education) to overcome the failings of heredity.[18] Rather, the exclusion of Maori from Plunket's purview was in the first instance a result of a territorial dispute between Plunket and the Department of Public Health, which had been set up in 1901.[19] Two years after the founding of the Plunket Society in 1907, the Department initiated its own 'backblock' nursing scheme, providing district nurses for rural areas; in 1911 it introduced a 'Native Health Nursing Scheme'.[20] Infant health was high on the agenda for these district nurses who numbered eighteen by 1918 and fifty by 1940. (By contrast there were forty-six Plunket nurses in 1920 and 138 by

17. See Erik Olssen, 'Truby King and the Plunket Society: an Analysis of a Prescriptive Ideology', *New Zealand Journal of History* (*NZJH*), vol. 15, no. 1, 1981, pp. 3–23; and Derek A. Dow, *Maori Health & Government Policy 1840–1940,* Victoria University Press in association with the Historical Branch, Department of Internal Affairs, Wellington, 1999, p. 200.

18. See Dorothy Porter, *Health, Civilization and the State: A History of Public Health from Ancient to Modern Times,* Routledge, London, 1999, p. 182 on early 20th-century environmentalists.

19. From 1909–20 this became the Department of Public Health, Hospitals and Charitable Institutions. In the latter year it was renamed the Department of Health. See Derek A. Dow, *Safeguarding the Public Health: A History of the New Zealand Department of Health*, Victoria University Press, Wellington, 1995, p. 9.

20. See A. McKegg, 'The Maori Health Nursing Scheme: An Experiment in Autonomous Health Care', *NZJH*, vol. 26, no. 2, 1992, pp. 145–60.

1940.)[21] Small European rural communities increasingly raised funds to employ their own Plunket nurse who took over that aspect of the district nurse's work (though they could only do this with the Health Department's consent), but the same did not occur in Maori communities. Consequently there were two separate groups looking after infant health in New Zealand, one controlled by the Health Department and the other not. The Department was disgruntled at its lack of control over this area of health care and the money directed to it. For example, in 1924 Plunket was allocated £26,831 of the government health budget (Vote: Health) by the Minister of Health; in contrast to this, Maori health attracted £10,689 and school health £19,186.[22] However, the Plunket Society was a powerful organisation of influential European women who successfully resisted attempts by the Department to take over infant health. The Department kept control of infant health among Maori and some isolated European communities. Plunket's Medical Adviser 1938–55, Dr Helen Deem, explained in 1952 that 'The Plunket Society. . . must not visit Maori pahs ['pa' or settlements] or give advice to those living in Maori fashion as work amongst the real Maoris is undertaken by the Department of Health'.[23] The following year Dr Harold Turbott, Deputy Director-General of Health, explained, 'Maori infant welfare has for many years been recognised as the responsibility of this Department although [he added] there has been an increasing tendency for the Plunket Society to edge its way, it is contended unnecessarily, into this field'.[24]

The division of responsibility had evolved through negotiations between Plunket and the first Director-General of Health, Dr Thomas Valintine, who, unlike many, did not attribute much of the credit for the decline in infant death rates to Plunket.[25] Dr Michael Watt, who succeeded Valintine in 1930, was even more convinced that Plunket was

21. *Plunket News*, August 1959, p. 2.
22. *AJHR*, 1925, B–1 Part iv, p. 27.
23. H. Deem to S. Ludbrook, 10 December 1952, Plunket Society 581, HL.
24. Turbott, 29 October 1953, H 127 26040, NA.
25. In a letter to the Plunket Society secretary he explained his belief that Plunket's role had been exaggerated. Valintine to G. Hoddinott, 16 June 1930, Plunket Society, HL.

'wasteful of time, money and effort'.[26] The Plunket Society fiercely disputed this, and guarded its right to conduct a specialised child health service, except when it came to Maori. One delegate to the 1945 Plunket conference moved that the work of the Society be extended to include Maori. Deem's response that it would be wasteful for both public health and Plunket nurses to visit homes, was accepted. The amended motion, 'That the work of the Society be extended to include the Maori people within our city and town boundaries', was carried.[27]

Watt suggested that in certain areas 'combined schemes' should be set up where the same nurse would undertake the duties of a district nurse and a Plunket nurse. The first 'combined scheme' began on an experimental basis in Taihape (in the central North Island) in 1940, and others were set up during the following decade. The Health Department's ultimate goal, as expressed in 1950, was that Plunket would undertake the work in 'cities and populous areas' only.[28] The Society resented this. Women in rural areas and small towns wanted their own Plunket nurse. In the Waikato community of Meremere the mothers in the 1950s called a public meeting and set up a Plunket sub-branch without the knowledge of either the Health Department or the Plunket Society, although their request for a Plunket nurse was subsequently turned down by the Department.[29] It is unknown whether the drive for a Plunket nurse in Meremere came from the European population only. However, in other areas there is evidence of resistance to 'combined schemes' covering both races. In 1949 Plunket's Nursing Adviser received a letter from the white population of Tolaga Bay on the East Cape of the North Island, a predominantly Maori area. This set out 'in no

26. Health Department Annual Report for 1939–40, cited in Watt's unpublished autobiography, pp. 124–5. See also M. H. Watt, 'Infant Mortality in New Zealand', *New Zealand Journal of Health and Hospitals,* vol. 4, no. 4, April 1921, pp. 88–94.

27. Plunket Society Central Council minutes, 14–16 November 1945, Plunket Society, HL.

28. Letter from Minister of Health, J. T. Watts, to Dominion Secretary, 15 May 1950, H127/1/2 20414, NA; Plunket Society Central Council Minutes, 24 May 1950, Plunket Society, HL. This policy was suggested by Turbott in a memorandum dated 28 February 1950, H1 127 26040, NA.

29. Plunket Society submission to the Consultative Committee on Infant and Pre-School Health Services, 1959, p. 46, Plunket Society, HL.

uncertain terms the determination of the district to fight against any service given to them by a District Nurse who is also attending the Maoris . . . The letter is so definite [wrote the Adviser] that I feel it would be quite useless to pursue the matter further.'[30]

What were the grounds of this opposition? The local Plunket Committee asked pointedly if Maori mothers would be attending the rooms at the same time as European mothers. They also expressed their belief that the nurse would be 'snowed under' by Maori, since Europeans were in the minority. The letter alleged that about half the Maori children suffered from tuberculosis or venereal disease, and expressed fears about their contact with European children. It concluded: 'They feel that Head Office [in Dunedin], in fact no one in the South Island understands what the white people have to tolerate, living in a Maori district . . . and confidentially we were told that the whites would not use the services of the District Nurse'.[31] In short, the local European population felt the nurses were contaminated by their association with Maori, and that all Maori were potential sources of infection.

A similar response came from Kaitaia in Northland, another predominantly Maori area where the whole population was served by two district nurses. An investigation of the nurses' work revealed that they were not welcomed in European homes. The nurses suggested that one of the reasons for this was that mothers did not like them calling after they had been visiting Maori homes.[32] In 1950 the European population of Kaitaia asked Health Minister Jack Watts to help them obtain a Plunket nurse for the area. They explained that, 'the women there would neither go to nor call in the district nurse because she was regarded as a "Maori" nurse'. The deputation wanted their own nurse for European work only, and they wanted a Plunket nurse. The women of Kaitaia, however, subsequently appeared to change their minds on a

30. S. Lusk, Plunket Society Nursing Adviser, to M. Lambie, 30 September 1949, Plunket Society AG7/1192, HL.

31. Secretary, Gisborne Plunket Society, to S. Lusk, 28 September 1949, Plunket Society AG7/1192, HL.

32. Secretary, Kaitaia Branch of Plunket Society, to Mrs Phillpotts, Secretary, Kaikohe Branch of Plunket Society, 10 October 1949, Plunket Society AG7/1192, HL.

segregated service. This change followed a baby show held to raise funds for the Plunket nurse, at which the prize-winner was a Maori baby. Racial barriers seem to have been broken down on that occasion, and Maori mothers were encouraged to bring their babies to the Plunket clinic at Kaitaia.[33]

A segregated service was agreed to at Whangarei, the main population centre in Northland, in 1955 by the Health Department and the Plunket Society. It was decided that the district nurse would do all the infant welfare work in one isolated area where there was at that time only one Pakeha baby. With that exception, the district nurse would see Maori babies and the Plunket nurse Pakeha babies.[34]

It had always been agreed that, while Plunket nurses were not to go to Maori *pa*, Maori mothers were permitted to visit Plunket clinics. In Plunket's 1958 film *Born in New Zealand* it was proudly announced that Plunket excluded no-one from its clinics on the basis of race or creed. In 1960, Auckland branch president Mrs Sheila Horton assured readers of the New Zealand Herald that mothers of any race were welcome at Plunket rooms throughout New Zealand.[35] Wellington's branch president, Mrs H. J. H. Gilmer, asserted that 'in the Wellington area most Maori mothers attend Plunket rooms'.[36] If this was the case in Wellington in 1960, it certainly had not been so in Auckland twenty years before. Dr Wilton Henley, a Lady King Scholar and the author of a research project into the health of more than 1000 babies in Auckland in 1939–40, claimed the study to be representative of a cross-section of infants in Auckland at that time. The only selection used, he explained, was determined by the infants' attendance at the Plunket rooms. Yet the study included only one Maori and one Chinese child; the rest were European.[37] At that time

33. Minister of Health to Dominion Secretary Plunket Society, 11 May 1950, Health Department, H1 127/4/5 25988, NA.
34. Plunket Society Executive Minutes, 23 March 1955, HL.
35. *New Zealand Herald*, 23 April 1960.
36. *Dominion*, 19 August 1960.
37. W. E. Henley, 'A Survey of the Clinical and Nutritional Status of 1076 Infants Aged 6 Months from the Urban Area of Auckland, New Zealand, 1939–40', University of Otago, 1944, Plunket Society AG7 1–8–13, HL. Henley graduated in Medicine at Oxford University in 1935, and was registered in New Zealand in 1940.

there were almost 2000 Maori living in the Auckland urban area, and almost 700 Chinese.[38]

The racial antipathy of some of the mothers, referred to above, may have inhibited Maori from attending. Then there was the attitude of the nurses. At least one Plunket Council member, Mrs Stella Petersen, a school teacher, discovered that in her area, Palmerston North, Plunket nurses were refusing to see Maori babies who had been brought to the rooms, stating that they were acting under instructions from Head Office. After receiving statements from some branches that Plunket nurses would not attend Maori mothers, Plunket's Director of Nursing, Miss Sydney Lusk, sent out a questionnaire to all Plunket nurses in the North Island and some in the South Island. The responses suggested that it was the Maori mothers and not the nurses who were the defaulters. Lusk reported, 'In most cases it had been found that Maori mothers had not the idea of continuous supervision of their babies, and that as soon as her baby was well the average Maori mother ceased to attend the rooms'.[39]

The fact that nurses did not visit Maori in their homes also meant that the nurses did not build up the same relationship with the Maori mothers as they did with European mothers. Lusk and Deem both told nurses that they should visit the homes of Maori 'living in European style'. However, in 1945 Lusk repeated the account given by a council member of a nurse making a first call. 'The door was opened by a Maori mother—thereupon nurse is supposed to have said, "Oh, I'm not allowed to call on you" and to have left.'[40]

Some Plunket nurses were probably more sensitive or more receptive to cultural differences than others. At least one teacher in a Native school did not rate the chances of a Plunket nurse staying long in a Maori area.[41] She claimed that any Plunket nurse sent to her particular settlement 'would be

38. *New Zealand Population Census 1936, vol.3: Maori Census*, Government Printer, Wellington, 1940, p. 2; *vol. 9: Race*, 1945, p. 4.

39. Plunket Society Central Council Minutes, 28–30 April 1953, HL.

40. Sydney Lusk to Mary Lambie, 1 December 1945, H1 20414 127/1/2, NA.

41. On the history of Native schools, see J. M. Barrington & T. H. Beaglehole, *Maori Schools in a Changing Society: An Historical Review,* New Zealand Council for Educational Research, Wellington, 1974; Judith Simon, *et al.*, *The Native Schools System 1867–1967: Nga Kura Maori,* Auckland University Press, Auckland, 1998.

reduced to the gibbers in a week'.[42] From 1942 grants from the J. R. McKenzie Trust were used to provide bursaries to train Maori Karitane and Plunket nurses.[43] A decade later Deem reported that they had trained 'several' Maori women.[44] In 1952 it was noted that those who had been assisted by the McKenzie Trust had 'proved very satisfactory', though no further detail was provided.[45]

For whatever reason, it is clear that before 1960 Maori usage of Plunket services was limited even in urban areas. For instance, 202 Maori babies were born in Auckland in 1950. All mothers were sent the Society's routine letter offering the services of the Plunket nurses but only twenty-four responded.[46] This was a 12 per cent response rate compared to around 80 per cent for their European counterparts.

Attempts to combine Health Department and Plunket nursing, and discussions on Maori usage of Plunket clinics and their responses to Plunket's approaches, provide some insight into the complex relations between the two races at the local level. Remits were frequently brought to Plunket's national conferences regarding the poor state of Maori infant health.[47] Yet there appeared to be little local pressure to change the existing division between Plunket and the Health Department. Plunket was very much a monocultural organisation run by European women who raised funds and met socially. Moreover in some areas they preferred to have minimal contact with Maori, though how representative these cases are is hard to say, given that only complaints would reach the official level. Similar segregationist attitudes were noted in the school sector. While the Native school system had been in existence since 1867, schools were not necessarily segregated on racial lines. Nevertheless, in 1940 G. O. L. Dempster, a medical officer of health, commented on a 'definite colour bar in the North, and a tendency among white

42. Hamilton Grieve, *Sketches from Maoriland*, Robert Hale, London, 1939, pp. 55–7, cited in Dow, *Maori Health & Government Policy,* p. 202.

43. Plunket Society Executive Minutes, 3 July 1942, 25 August 1942, HL.

44. Deem to Ludbrook, 10 December 1952, Plunket Society 581, HL.

45. Memo, re J. R. McKenzie Trust, November 1952, MA1 243 12/866.

46. Deem, Plunket Society Executive Minutes, 28 November 1951, HL.

47. See for example, *Plunket Society Conference Proceedings*, Dunedin, 1926, p. 33; 1928, p. 65; 1930, p. 72; 1934, p. 26; 1946, p. 1; 1950, p. 10.

parents to ask for the segregation of Maori children into Native schools'.[48] The reasons given were the poor health and supposed infectiousness of the Maori children.

The Health Department's services for Maori

The Health Department was not modest in its claims relating to Maori health. Its 1925 pamphlet *New Zealand—A Healthy Country: Striking Facts and Records* asserted that the 'State with its Department of Health, has fully realized that it has had the immense responsibility of not only saving one of the finest native races from extinction, but of putting them on the high road that leads to increase, health and prosperity'.[49] The system evolved by the Health Department for Maori mothers was modelled on that of the world-famous Plunket Society, with one important difference, which will be discussed below.

District nurses from the 1920s were expected to take the four-month Plunket nurse training.[50] Handbooks distributed to Maori mothers, written in both Maori and English, gave similar advice to that imparted in the Plunket handbooks. *Infants and Their Foods*, the first Health Department booklet for Maori mothers, was written by Maui Pomare in 1909. It predated Plunket's first advice manual, Truby King's *Feeding and Care of Baby*, by a year.[51] The Maori handbook was revised and updated in 1916 by Amelia Bagley, the Inspector of District Nurses, who had had considerable experience nursing in Maori areas and was fluent in Maori.[52] Four thousand copies were printed. European mothers apparently also used the booklet, explaining that it was easier to understand than Plunket's publications. As a result of this unexpected popularity supplies were exhausted by the mid-1920s, but a

48. Cited by K. Goodfellow, 'Health for the Maori? Health and the Maori Village Schools, 1890–1940', MA research essay, University of Auckland, 1991, p. 42.

49. Department of Health, *New Zealand—A Healthy Country: Striking Facts and Records*, Government Printer, Wellington, 1925, p. 4.

50. H. Deem to S. Ludbrook, 10 December 1952, Plunket Society 581, HL.

51. M. Pomare, *Nga Kohungahunga Me Nga Kai Ma Ratou, Turanga*, Wellington, 1909, 10 pp.

52. A. Bagley to Inspector General of Health, 31 March 1916, Health Department, H1 B.82 127/30, NA. M. Pomare, *Ko Nga Tamariki Me Nga Kai Ma Ratou: Infants and Their Foods: with Additions by District Nurses for Maoris*, Wellington, 1916, 31 pp.

new edition entitled *Maori Maternal and Infant Welfare* did not eventuate until 1934. Director-General of Health Michael Watt confidently predicted in 1935 that: 'The adoption of the advice given in this pamphlet will in time make a material reduction in the very high Maori infantile mortality rate.'[53] Yet another edition appeared in 1939 as *The Maori Mother and Her Child*.

District nurses, like Plunket, were trained to stress the importance of breast-feeding for the sake of infant health. Dr Te Rangihiroa (Peter Buck), Maui Pomare's assistant and colleague, had claimed in 1908 that: 'The introduction of the feeding-bottle into the Maori home has caused as many deaths as the guns of Hongi.'[54] One district nurse in the Waipu district reported in 1915 that most Maori mothers breast-fed their infants, and that the majority did 'exceedingly well'.[55] Those who fed their infants artificially, she explained, were usually mothers suffering from 'consumption' (pulmonary tuberculosis). It was probably pressure—or advice—from the district nurses themselves, which induced Maori mothers suffering from tuberculosis to abstain from breast-feeding their infants.[56]

By the early 1930s district nurses were complaining that fewer Maori mothers were breast-feeding their infants. In 1931 a nurse in Taumarunui explained that the Maori custom of using grandparents, or the 'whanau' (extended family), as primary child-care givers and the modern belief that the baby could 'just as easily be brought up on the bottle' was undermining breast-feeding. She believed this trend was made 'doubly easy' by the availability of tinned milk.[57] A district nurse at Kaitaia referred to 'a great lack of desire to breastfeed the babies these days'.[58] A third nurse in Paeroa asserted that:

53. Health Department Annual Report, *AJHR*, 1935, H–31, p. 7.

54. ibid., 1908, H–31, pp. 129, 133.

55. ibid., 1915, H–31, p. 28.

56. While there was no mention of 'consumption' in the 1916 booklet, *Infants and Their Foods*, it was stressed that only healthy women should breast-feed. The advice was: 'Where necessary some other and healthy woman should be sought (to suckle the child). Failing these we turn to some other milk-source.' ibid., p. 5.

57. Nurse M. R. Smale, Taumarunui, to Medical Officer of Health, Auckland, 28 August 1931, Health Department, H1 B.82 127/30, NA. On family structures in Maori communities, see Joan Metge, *New Growth from Old: the Whanau in the Modern World,* Victoria University Press, Wellington, 1995.

58. A. Jewiss, District Health Nurse, Kaitaia, to Medical Officer of Health for Auckland, 1 September 1931, Health Department, H1 B.82 127/30, NA.

'The importance of breast-feeding, and failing that, adequate artificial feeding, needs particular stressing, for in my experience, it is exceptional to find a Maori mother who is able to breast-feed satisfactorily after three or four months.'[59] In 1937, the district nurse in Tauranga claimed that 'the Native mothers of today are over anxious to take the babe off the breast feeding and give artificial foods soon after birth'.[60]

During the economic depression of the 1930s Plunket reports on the European population recognised the role of poverty in the failure to breast-feed.[61] Rural Maori communities were hit hard by the depression. By 1933 three-quarters of the adult male Maori population was registered as unemployed and it was harder for unemployed Maori to qualify for relief. When they did qualify, payments were at a lower rate.[62] In the comments on breast-feeding among Maori women the connection between breast-feeding and poverty was rarely made. The focus was on women's 'unwillingness' to breast-feed or their personal failings. Giving evidence to the 1938 Committee of Inquiry into Maternity Services in New Zealand, one district nurse argued that a great advantage of promoting hospital births among Maori women would be the opportunity to educate them on the virtues of breast-feeding.[63]

Maori mothers received health education not only from the district nurses and health propaganda, but also through Maori women's institutes, the first of which was set up at Kohupatiki, near Hastings, in May 1929. By 1937 district nurses were supervising about forty branches in North Auckland alone. Dr Sylvester Lambert, the Pacific representative of the influential Rockefeller Foundation, discussed the institutes in a confidential report for the Labour

59. N. Jamieson, District Health Nurse, Paeroa, 29 August 1931, Health Department, H1 B.82 127/30, NA.

60. L. A. Hill, District Health Nurse, Tauranga, 23 July 1937, Health Department, H1 B.82 127/30, NA.

61. See annual reports of Auckland Branch of the Plunket Society, 1930s.

62. Michael King, 'Between Two Worlds', in *The Oxford History of New Zealand*, 2nd edn, G. W. Rice (ed.), Oxford University Press, Auckland, 1992, p. 293.

63. Report of the Committee of Inquiry into Maternity Services, *AJHR*, 1938, H–31A, p. 17. Despite increase in hospital births among Maori, a 1954 Health Department study showed that 82.2 per cent of a European sample breast-fed their infants, while only 39.4 per cent of the Maori sample did. See C. E. Gardiner, 'Maori Infant Mortality', *New Zealand Medical Journal*, vol. 58, 1959, p. 328.

Government on the 'Maori situation'. He predicted that they would inculcate the 'new domestic culture so necessary for better health'.[64] A 1936 survey on Maori health and hygiene concluded that of the various measures taken, women's institutes had exerted the 'strongest influence for good'.[65] In 1937, the Women's Health League was founded by a district nurse in the central North Island town of Rotorua. Its express purpose was the improvement of the health of Maori mothers and children through the teaching of 'housewifery, mothercraft and personal hygiene, [as well as] native crafts'.[66] There is evidence that by the end of the 1930s Maori mothers were well versed in certain aspects of Western style 'mothercraft'. They were described by district nurses as good and enthusiastic knitters and sewers of baby clothes.[67]

Maori girls were also taught 'mothercraft' in the Native schools, this aspect of their education being stepped up in the mid-1930s.[68] In 1934 Mary Lambie, Director of the Division of Nursing in the Department of Health, drew up an infant welfare course for Standard 6 pupils (in their last year at primary school) in Native schools. The teachers' text was Mary King's *Mothercraft*, a Plunket handbook. By 1939 infant welfare was being taught in most Native schools, and programmes included practical demonstrations. 'Plunket cots' were used, and 'sets of Plunket baby clothes' made. The district nurses were usually involved, and they awarded merit certificates to competent students.[69] Lambert claimed that the development of preventive medicine had turned the Native schools into centres for maternal, infant and child welfare. As Dow writes, this edifice rested on shaky foundations.

64. Dow, *Maori Health & Government Policy,* p. 202.

65. Goodfellow, 'Health for the Maori?', p. 48.

66. A. Else (ed.), *Women Together: A History of Women's Organisations in New Zealand: Nga Ropu Wahine o te Motu,* Historical Branch, Department of Internal Affairs and Daphne Brasell Associates Press, Wellington, 1993, p. 26.

67. Memorandum from Director General of Health to Medical Officers of Health, 2 July 1937; H. B. Turbott, District Health Office, Hamilton, to Director General, 22 July 1937; L. A. Hill, District Health Nurse, Tauranga, 23 July 1937, Health Department, H.1 B.82 127/30, NA.

68. *Plunket Society Conference Proceedings 1934*, Dunedin, p. 26. See also Goodfellow, p. 52; almost 50 per cent of Maori children attended Native schools in the 1930s, ibid., p. 38. See also E. Mountain Ellis & H. Mountain Harte, 'The health work of Emere Makere Waiwakha Kaa Mountain. A Maori Health Nurse', in *Standing in the Sunshine: A History of New Zealand Women since they Won the Vote*, S. Coney (ed.), Penguin, Auckland, 1993, pp. 102–3.

69. Goodfellow, 'Health for the Maori?', pp. 52–3.

Teachers were supposed to act as advisers, sometimes with little knowledge or expertise themselves.[70]

As well as providing training in 'mothercraft', district nurses, like Plunket staff, provided antenatal care. In its final report, the 1938 Committee of Inquiry into Maternity Services noted that district nurses tried to see Maori expectant mothers at least a few times before the birth to provide care and advice.[71] The Committee also stated that Maori women appreciated the value of antenatal care and were willing to accept help even when they intended 'to be confined in Native fashion in their homes'.[72]

There appeared to be no reluctance to take advantage of the services on offer. One nurse commented in 1931 that younger Maori women 'will not learn from the older experienced women, and wish to adopt European methods'.[73] The main difference between the service available to Maori and non-Maori New Zealanders was that there were effectively no clinics for Maori women to attend, though apparently some district nurses held clinics in *marae* (meeting houses).[74] Discussing infant welfare services in Britain, Jane Lewis argued that clinics were more successful than home visiting because women could choose to visit clinics; there was no imposition.[75] Debby Gaitskell maintained that infant welfare clinics set up in Johannesburg for African women and their babies were relatively successful.[76] There was no equivalent for New Zealand Maori. Interaction with district nurses generally occurred when the nurses visited homes, and even that was limited. At the service's peak in the late 1930s, each district nurse served a total population of about 2000, and infant welfare was merely one aspect of their work. As Dow writes, there were never enough district nurses to provide adequate

70. Dow, *Maori Health & Government Policy,* p. 200.

71. Report of the Committee of Inquiry into Maternity Services, *AJHR*, 1938, H–31A, p. 96.

72. ibid., p. 96.

73. M. A. Hall, Kawakawa, 25 August 1931, Health Department, H1 B.82 127/30, NA.

74. H. B. Turbott to Sullivan, Department of Maori Affairs, 30 June 1959, H1 127 32110.

75. Jane Lewis, *The Politics of Motherhood: Child and Maternal Welfare in England, 1900–1939,* Croom Helm, London, 1980, p. 106.

76. Debby Gaitskell, '"Getting Close to the Hearts of Mothers": Medical missionaries among African women and children in Johannesburg between the wars', in *Women and Children First: International Maternal and Infant Welfare, 1870–1945,* V. Fildes, L. Marks & H. Marland (eds), Routledge, London, 1992, pp. 178–202.

coverage. This shortage allowed many who could have benefited from their services to fall through the cracks. In December 1932, Wellington's Medical Officer of Health, F. S. Maclean, suggested that district nurses should have a workload of 1000–1500 patients rather than the 2500 or more in his own district, in order to combat the ongoing problem of malnutrition, which most commonly coincided with weaning.[77]

While the contribution of infant welfare clinics to declining infant death rates in the European population has been questioned,[78] they did provide a form of primary health care. Plunket clinics in the 1930s supplied their clientele with advice and health checks, supplemented by free or subsidised breast-milk substitutes and food parcels for the poor and undernourished, and ante-natal clinics for the mothers.[79] This service, free and accessible with a well-established infrastructure, and widely believed at the time to be highly successful, was effectively unavailable to Maori women who, from the 1930s at least, showed some interest in Western-style health education.

Causes of high infant death rates in Maori communities

It is not possible to assess the influence of welfare services, or the lack thereof, on health status. Helen Deem, for one, thought the problems lay much deeper. Before she became Plunket's Medical Adviser in 1938, Deem had worked as a medical officer in a predominantly Maori area. While not seeing it as in any sense a responsibility of the Plunket Society, she admitted in 1946 that: 'The Maoris are living in appalling conditions, and any health worker faces fearful odds in an attempt to improve matters until such time as the Government sets up the machinery to improve the housing of these people.'[80]

77. Dow, *Maori Health & Government Policy,* pp. 198–9.
78. See, for example, P. Mein Smith, 'Infant Welfare Services and Infant Mortality: A Historian's View', *The Australian Economic Review*, vol. 1, 1991, pp. 22–34.
79. Annual reports of the Auckland Branch of Plunket Society, 1930s.
80. Dr Helen Deem to Dr Albert Blanc, Wanaka, 3 July 1946, Plunket Society 581, HL.

Others within Plunket expressed concern. Mrs Stella Petersen of Palmerston North moved in 1945 that 'the Plunket Society is concerned about the infant mortality rate among the Maori people, and urges that an investigation by made into this problem'.[81] She put the motion to the Central Council again in 1946. While Deem voiced her belief about the need for improved housing and sanitation, she agreed that there was an urgent need for a full investigation and that the Plunket Society should offer to co-operate with the Health Department in such an undertaking. Mrs Petersen's motion that 'the Plunket Society approach the Health Department with a view to organising a survey commencing with one Maori district, to try to discover the factors contributing to the high Maori infant mortality and to consider ways and means of meeting the existing unsatisfactory position', was carried, although nothing appears to have come of this.[82]

In the 1920s studies of high infant death rates in Maori communities had identified the main causes of death as pneumonia and other respiratory diseases, followed by diarrhoea and enteritis.[83] These were undoubtedly related to poor living conditions. There were two epidemics of whooping cough in 1927 and 1941, and a measles epidemic in 1938, which claimed many lives. The contributory role of unsanitary conditions to poor health had long been recognised. Maui Pomare remarked upon the impact of poor living conditions in his first report on Maori health, presented to the Chief Health Officer of the Department of Public Health in 1901, although he also blamed maternal ignorance.[84] Sanitary defects were a constant refrain of the local medical reports provided to the Health Department and to the 1938 Committee of Inquiry into Maternity Services. Decent housing, with running water, washing and sanitary conveniences were the 'chief need' of the Maori people in the north, according to the report on North Auckland presented to the Committee.[85] Similarly, in Mangonui, another Northland community, 'housing

81. Plunket Society Central Council Minutes, 14–16 November 1945, HL.
82. ibid., 10–12 April 1946.
83. Lange, *May the People Live,* p. 33.
84. Report of M. Pomare, Health Officer to the Maoris, to the Chief Health Officer, *AJHR*, 1902, H–31, pp. 61–5; *AJHR*, 1904, H–31, pp. 57–8.
85. Report of Committee of Inquiry into Maternity Services, *AJHR*, 1938, H–31A, p. 6.

conditions are shocking, and members of the Committee visited some Maori homes which were merely sheds made of old corrugated iron full of holes, with mud floors, no water or washing facilities, and no sanitary conveniences'.[86]

A constraining factor in improving housing and sanitary conditions was the prevailing attitude that 'a new house will be of no use without a new mentality to go with it'.[87] This view was expressed, for example, by Dr Duncan Cook, Medical Officer of Health for the predominantly Maori area of Whangarei, in 1936. He argued that more important than the 'material defects of food, clothing and houses' was the personal defect 'of *non-awareness* of the insanitary and unhygienic conditions so well apparent to the average pakeha'. He claimed that the 'amount of ill-health and human misery . . . [in Maori communities] would be intolerable to the average pakeha'. This 'non-awareness' by Maori of their 'spiritual and material degradation' explained the higher mortality among the Maori and, in his view, meant that charity would be ineffective as a solution.[88]

Attitudes such as those expressed by Cook may help to explain why the first Labour Government of 1935–49, that great instigator of the welfare state in New Zealand, which claimed equality of the races as one of its goals, failed to confront the Maori housing issue. Labour launched a massive State housing programme in 1937, building 32,000 houses by 1949. Yet, being urban based and reliant on the principle of cost recovery, the scheme had little impact on the Maori housing situation. Racist attitudes by allocation committees also prevented Maori from gaining access to State housing.[89] A scheme specifically for Maori was inherited by Labour from the previous administration, which had passed the Native Housing Act in 1935. Based on a system of loans, this too had limited impact. By 1940, with an estimated 45,000 Maori people in inadequate housing, fewer than 500 houses had been built.[90] That year figures on Maori housing showed

86. ibid., p. 6; see also Pool, *The Maori Population*, p. 171.
87. Health Department Annual Report, *AJHR*, 1936, H–31, p. 6.
88. ibid., 1935, H–31, p. 8.
89. Gael Ferguson, *Building the New Zealand Dream,* Historical Branch, Department of Internal Affairs, Wellington, 1994, p. 168.
90. C. J. Orange, A Kind of Equality: Labour and the Maori People, 1935–49, MA thesis, Auckland, 1977, pp. 84–94.

57 per cent were overcrowded, 45 per cent had unsafe water supplies and 36 per cent were 'unfit for habitation'.[91] By 1949 only about 10 per cent of the Maori population had been rehoused,[92] though this was admittedly stepped up by the Department of Maori Affairs in the 1950s, which had built more than 5000 houses by 1955.[93]

In his study of tuberculosis among black South Africans, Randall Packard argued that 1940s critiques by environmentalists of the conditions of industrial life, and their calls for social and economic reform, failed to have any impact because of a continuing tendency to define Africans as essentially different from whites and to see this difference as in some way responsible for African susceptibility to disease.[94] Views of the innate differences of New Zealand Maori, as expressed by Dr Duncan Cook for example, may have contributed to similar constraints. Generally, it appears that the approach taken to health problems in New Zealand was driven by the idea that Maori were different but not irredeemable. Charity was to be avoided at all costs. In 1940, Dr Harold Turbott, who had previously worked among Maori as Medical Officer of Health for the East Cape and South Auckland district and was then Director of the Health Department's Division of School Hygiene, summed up the aim of the Department to turn Maori into 'hardy, healthy, self-supporting, brown skinned New Zealanders'.[95]

Conclusion

Ian Pool suggested that two factors accounted for the high levels of Maori mortality compared to European in this period: one was that Maori were a socio-economically depressed minority, and the other that they were isolated and

91. ibid., p. 86; and Ferguson, *Building the New Zealand Dream*, p. 119.
92. Ferguson, *Building the New Zealand Dream*, p. 164.
93. *AJHR*, 1956, G–9, p. 5.
94. Randall Packard, *White Plague, Black Labor: Tuberculosis and the Political Economy of Health and Disease in South Africa*, University of Natal Press, Pietermaritzburg, 1989, p. 242.
95. H. B. Turbott, 'Health and Social Welfare', in *The Maori People Today: A General Survey: Issued Under the Auspices of the New Zealand Institute of International Affairs and the New Zealand Council for Health Education*, I. L. G. Sutherland (ed.), Whitcombs & Tombs Ltd, Auckland, 1940, p. 268.

thus effectively excluded from the health-care system. There is much evidence to support the former. Isolation does not, however, account for the exclusion from the latter, at least in the area of infant welfare. The reasons were far more complex, from administrative territorial disputes to local racial prejudices and culturally insensitive services or nurses. Plunket did not set out to exclude Maori positively. Indeed, Harold Turbott complained in 1962 that Plunket was 'soliciting' Maori mothers.[96] However, in the pre-1960 period, Plunket Society members did not defend that territory with the same determination that they defended the right of European communities to have their own Plunket nurses. This is not surprising, given that the women who ran Plunket raised funds for their services and saw themselves as united in a bond of sisterhood and common interests. But they also claimed considerable public money.

Deem's successor as Plunket's Medical Director from 1955,[97] Dr Neil Begg, sought in 1959 to pre-empt criticism of Plunket's 'neglect' of Maori health. He included a section on 'Infant Welfare Services to the Maori Race' in the Plunket Society submission to the Consultative Committee on Infant and Pre-School Health Services. He regretted that the Plunket services were at that time 'denied' to Maori. Foreshadowing much later concerns about self-determination, he averred: 'It would do something to restore dignity to the race to be permitted to participate in the planning and management of its own health service. There is no reason to doubt that the young Maori mother would not be willing to play her part.' Maori, he asserted, should be granted the same right to choose their infant health advisers as other New Zealanders.[98] The committee sought the opinion of the Department of Maori Affairs, which suggested that Maori were happy with the present arrangement.[99] The committee did, however, add that 'at the same time it must be recognised that the specialised help

96. Turbott to Cameron, 2 April 1962, H1 127 32110.

97. The title changed from Medical Adviser to Medical Director at the time of his appointment.

98. Plunket Society submission to Consultative Committee on Infant and Pre-school Health Services, p. 54, HK.

99. *Report of the Consultative Committee on Infant and Pre-School Health Services in New Zealand*, Government Printer, Wellington, 1960, p. 35. See also *Dominion,* 19 August 1959, evidence of W. Herewini.

Plunket nurses can render should be as available to Maori mother and children needing or desirous of it as it is to Europeans'. Among its recommendations was that Maori should have 'the same right of election as to the source from which they seek help as Europeans have'.[100] Begg was in favour of local autonomy in organising infant welfare services—for Maori and Pakeha. However, it is also clear that this was to occur within a firmly established European framework. Plunket's president, Sheila Ryburn, referring to the high Maori infant mortality in 1969, argued:

> If they could be encouraged to go on committees, join Plunket Mothers clubs and to think about preventive medicine, to take part in fund raising, help to build and look after their clinics, and take a personal interest, I am confident that this would be the answer . . . we should be able to extend our service so that ALL New Zealanders can take advantage of it. This is an exciting prospect and would obviously mean a lot of changes, but this is what we should be aiming for.[101]

Changes did come in the 1970s and 1980s as Plunket moved on racial issues along with New Zealand society more generally, although it was not simply a process of assimilating Maori into Plunket traditions.

In a country proud of its social welfare services and its infant welfare services in particular, and also proud of its race relations,[102] the reality was that during the first half of the twentieth century a dual system evolved in infant care which left Maori disadvantaged. The primary health care provided to the European population through the world-famous Plunket Society clinics and its nurses did not accommodate Maori.

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100. *Report of the Consultative Committee on Infant and Pre-School Health Services*, pp. 35, 39.
101. Plunket Society Central Council Minutes, 20–22 October 1969.
102. See, for example, Keith Sinclair, 'Why are Race Relations in New Zealand better than in South Africa, South Australia or South Dakota?', *NZJH*, vol. 5, 1971, pp. 121–7.