

## “This Racial Menace”?: Public Health, Venereal Disease and Maori in New Zealand, 1930–1947

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In 1939, Whakatane, on the remote east coast of the North Island of New Zealand, came to the attention of the New Zealand Department of Health as an area where syphilis was “suspected [to be] widespread”.<sup>1</sup> This isolated part of the country was largely inhabited by Maori communities, and the revelation that venereal disease (VD) was so prevalent caught the Department by surprise, especially as a nationwide public health campaign against venereal disease had been in progress since 1917.<sup>2</sup> In response, a comprehensive venereal disease campaign targeting Maori alone was developed—the earliest example of such a focus by the Department. This reaction highlighted what Dr Thomas Ritchie, Director of the Division of Public Hygiene, described as the “separate” problem of Maori health.<sup>3</sup>

The intersection of issues of venereal disease and race in the twentieth century is increasingly the subject of historical investigation.<sup>4</sup> Some studies of South Africa and

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<sup>1</sup>Archives New Zealand/Te Rua Mahara o te Kāwanatanga, Wellington Office, New Zealand (hereafter ANZW), H1 45/4/28 venereal disease (hereafter VD) among Maoris 1922–1940, letter from Dr Michael Watt (Director-General of Health) to Dr Gordon Dempster (MOH for Auckland), 1 Aug. 1939. This article is a revised and enhanced version of chapter three in Antje Kampf, *Mapping out the venereal wilderness: public health and STD in New Zealand, 1920–1980*, Berlin, Lit-Verlag 2007.

<sup>2</sup>The contemporary term “venereal disease” that is used in this article refers to syphilis and gonorrhoea.

<sup>3</sup>ANZW, H1 131/45 (23441) VD general 1942–1957, Dr Thomas Ritchie memorandum, 9 Apr. 1942.

<sup>4</sup>Studies that look beyond the 1930s are still scarce. See, for example, James H Jones, *Bad blood: the Tuskegee syphilis experiment*, New York, Free Press, 1993; Karen Jochelson, *The colour of*

*disease: syphilis and racism in South Africa, 1880–1950*, New York, Palgrave in association with St Antony’s College Oxford, 2001; Megan Vaughan, *Curing their ills: colonial power and African illness*, Cambridge, Polity Press, 1991, pp. 129–54; Milton Lewis, Scott Bamber and Michael Waugh (eds), *Sex, disease, and society: a comparative history of sexually transmitted diseases and HIV/AIDS in Asia and the Pacific*, Westport, CT, and London, Greenwood Press, 1997; Ann Marie Hickey, ‘The sexual savage: race science and medicalization of black masculinity’, in Dana Rosenfeld and Christopher A Faircloth (eds), *Medicalized masculinities*, Philadelphia, Temple University Press, 2006, pp. 165–82. For a historiographical overview, see Linda Bryder, ‘Sex, race and colonialism: a historiographical review’, *Int. Hist. Rev.*, 1998, 20 (4): 806–22. The issue of racial health and venereal disease was a major component in the early twentieth-century debate. See, for example, Susan Lemar, ‘Control, compulsion and controversy: venereal diseases in Adelaide and Edinburgh 1910–1947’, PhD thesis, University of Adelaide, 2001, pp. 52–77; Roger Davidson, *Dangerous liaisons: a social history of venereal disease in twentieth-century Scotland*, Amsterdam and Atlanta, Rodopi, 2000, pp. 107–8, 142–5; Alison Bashford, *Imperial hygiene: a critical history of colonialism, nationalism and public health*, New York, Palgrave Macmillan, 2004, pp. 166–72; Philippa Levine, *Prostitution, race and politics: policing venereal disease in the British empire*, New York, Routledge, 2003, pp. 125–6, 152–3. In New Zealand, historians have also stressed the importance of eugenicists’ ideas in the early twentieth century. See Helen Smyth,

Papua New Guinea have found that public health campaigns against VD tended to be racist.<sup>5</sup> Roger Davidson, in reviewing the historiography of venereal disease, has suggested that “the impact of racial stereotyping and discrimination upon VD policy making” was part of the New Zealand debate on this issue in the first half of the twentieth century.<sup>6</sup> Yet so far there is a paucity of writing on Maori and venereal disease.<sup>7</sup>

This article evaluates the significance of race in the development of government policies regarding venereal disease, and explores the hitherto little understood impact that associated public health campaigns had on Maori in the 1930s and 1940s. Utilizing surveys of the incidence of syphilis and gonorrhoea in Whakatane as a starting point, this essay examines the relationship between Maori, doctors and the Department in the public health campaigns against VD.

### Maori and Venereal Disease before the 1930s

Official knowledge of the incidence of venereal disease amongst Maori before 1939 was, at best, anecdotal. Dr Te Rangi Hiroa (Sir Peter Buck), Director of the Division of Maori Hygiene formed in 1920 under the Health Act, reported occasional incidences in Maori settlements, but believed that these originated “from a white source”, and that “the problem amongst Maoris is not nearly so serious as amongst Europeans”.<sup>8</sup> Europeans, Buck argued, were the danger for Maori communities, and he called for compulsory

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*Rocking the cradle: contraception, sex and politics in New Zealand*, Wellington, Steele Roberts, 2000, pp. 11–22; Philip J Fleming, ‘Eugenics in New Zealand’, MA thesis, Massey University, 1981, pp. 33–38, 42–59, 60–70. However, neither study has focused on a link between racial health and venereal disease. Sources used in this study have not revealed a widespread or dominant impact of eugenics in the official public health campaigns against venereal disease.

<sup>5</sup>Jochelson, op. cit., note 4 above; Jenny Hughes, ‘A history of sexually transmitted diseases in Papua New Guinea’, in Lewis, Bamber, Waugh (eds), op. cit., note 4 above, pp. 231–48, on p. 243. For racist health policies in Australia in the early twentieth century, see Mary Ann Jebb, ‘The Lock Hospital experiment’, in B Reece and T Stannage (eds), *European-Aboriginal relations in Western Australian history*, Nedland, WA, University of Western Australia, Centre for Western Australian History, 1984, pp. 68–87; Megan Vaughan insists in her chapter on syphilis and Africans in Uganda that the discourse on race was ambiguous. See Vaughan, op. cit., note 4 above, pp. 144–9.

<sup>6</sup>Roger Davidson, ‘Venereal disease, public health and social control: the Scottish experience in a comparative perspective’, *Dynamis*, 1997, 17: 341–68, p. 354. His assessment has been based on a review of claims by Philip J Fleming (“Shadow over New Zealand”: the response to venereal disease in

New Zealand 1910–1945’, PhD thesis, Massey University, 1989) and by Barbara Brookes (‘Aspects of women’s health, 1895–1945’, in Linda Bryder (ed.), *A healthy country: essays on the social history of medicine in New Zealand*, Wellington, B Williams Books, 1991, pp. 149–64).

<sup>7</sup>In New Zealand, the first in-depth study on venereal disease in twentieth-century New Zealand mentions Maori on only two pages. Fleming, op. cit., note 6 above, pp. 86, 178. Venereal disease and Maori are noted in Derek A Dow, *Maori health and government policy, 1840–1940*, Wellington, Victoria University Press, 1999, pp. 124, 181, 208. There is more extensive scholarship on the nineteenth century, see, for example, Jean Marie Kehoe, ‘Medicine, sexuality, and imperialism: British medical discourses surrounding venereal disease in New Zealand and Japan: a socio-historical and comparative study’, PhD thesis, Victoria University of Wellington, 1992, pp. 97–166. On health care policy and Maori, see Dow, op. cit.; Raeburn Lange, *May the people live: a history of Maori health development 1900–1918*, Auckland University Press, 1999. For a critical overview of the status of scholarship, see Linda Bryder and Derek A Dow, ‘Introduction: Maori health history, past, present and future’, in *Health & History*, 2001, 3: 3–11.

<sup>8</sup>*Appendices to the Journal of the House of Representatives* (hereafter *AJHR*), 1922, H-31A: 10.

measures to prevent Europeans from infecting Maori.<sup>9</sup> In the mid-1930s, there were repeated reports by general practitioners of incidences of VD, especially gonorrhoea, in Maori communities such as those in the King Country region in central North Island.<sup>10</sup>

Yet, overall, there is relative silence on Maori and venereal disease in historical records for these decades. Widespread infection of Maori was believed to be a problem of the colonial past: while infection among Europeans was discussed at length at the official 1922 Inquiry into the Prevalence of Venereal Disease, the Committee believed it was “not common now among Maoris, but it made great ravages in the early days of colonization”.<sup>11</sup> If health officials knew little about European patients, given that sociological surveys would not be conducted until the 1960s, even less reported evidence was available for Maori.<sup>12</sup> Maori patients with venereal disease were not the subject of much comment, and did not appear separately in the VD statistics before the 1940s.<sup>13</sup> Such statistics as did exist were limited, as venereal disease was not notifiable in New Zealand unless a patient absented from the treatment regime. The incidences that were reported in the early 1930s were considered too minor to require government action, a decision probably influenced by the general reduction in health programmes as a consequence of the prevailing economic depression.<sup>14</sup>

Under the universal venereal disease clinic and treatment scheme, running since 1917, clinics were opened initially in the four major cities: Auckland, Wellington, Christchurch and Dunedin. The scheme was “colour blind”, and the Department was confident that all patients were able to receive necessary treatment.<sup>15</sup> However, as late as the 1940s, over 70 per cent of Maori still lived in remote and inaccessible areas and may simply have been overlooked.<sup>16</sup> At the same time, other general health needs appeared more pressing. Maori patients were only beginning to use hospitals as health care centres, and before the 1940s still tended to avoid medical treatment for as long as possible.<sup>17</sup> In 1934, for example, Dr John Mark, medical superintendent of Tauranga Hospital, witnessed Maori learning “how to syringe themselves from other Maori”, thereby avoiding the necessity of visiting either a doctor or the hospital, and he noted that venereal disease incidences became apparent only when Maori women had to be hospitalized with acute pelvic complications.<sup>18</sup>

<sup>9</sup> ANZW, H1 45/4/28, Dr Te Rangi Hiroa to Thomas Valentine (Director-General of Health), 25 Aug. 1922.

<sup>10</sup> W I Cawkwell and K N McNamara, ‘A survey of venereal diseases in the Auckland Province’, Preventive Medicine Dissertation, University of Otago, 1935, p. 36. Similar accounts by doctors are discussed in H B Alexander and C G Hunter, ‘An investigation of venereal disease in Hawke’s Bay, Wellington, Christchurch and Dunedin: with special reference to gonorrhoea in the female’, Preventive Medicine Dissertation, University of Otago, 1935, p. 36.

<sup>11</sup> *AJHR*, 1922, H-31A: 4.

<sup>12</sup> *Ibid.*, p. 10.

<sup>13</sup> Only in the 1940s, and from the 1960s onwards, were Maori and European rates listed separately, unofficially and on internal clinic reports only.

<sup>14</sup> ANZW, H1 45/4/28, letter Michael Watt to William Findlay (MOH for Wellington), 18 Mar. 1932. On a general lack of governmental health policies for Maori, particularly until the 1930s, see, for example, Lange, *op. cit.*, note 7 above, pp. 196, 268.

<sup>15</sup> ANZW, H1 45/4/28, letter Joseph Frengley (Deputy Director-General of Health) to Dr Appleby, 18 Aug. 1922.

<sup>16</sup> David C Thorns and Charles P Sedgwick, *Understanding Aotearoa/New Zealand: historical statistics*, Palmerston North, Dunmore Press, 1997, p. 54, table 2.9.

<sup>17</sup> Lange, *op. cit.*, note 7 above, pp. 42–4.

<sup>18</sup> ANZW, H1 45/- VD general 1922–1935, letter Dr John Mark to Michael Watt, 11 Nov. 1934.

### The Incidence of Venereal Disease in Whakatane

In August 1939, however, reports of cases of active syphilis in the Whakatane area confronted the Department with the new and pressing problem of venereal disease amongst the Maori population.<sup>19</sup> The Department was already reviewing its VD policy, and therefore decided to investigate the scale of the problem thoroughly. This prompt response, in contrast to the attitudes and actions of Departmental officials a decade earlier, can be attributed to a number of factors. It is likely that the Department's acknowledgement of a serious Maori tuberculosis problem—after surveys of East Coast Maori communities in 1933—had led it to reflect on the problem of “social diseases”, prompting an investigation into the extent of VD. At the same time, high Maori infant mortality rates also came under scrutiny.<sup>20</sup> By 1938, Maori infant mortality was 153.2 per 1,000 live births, compared with a rate of 36.6 among Europeans.<sup>21</sup> News of an increase in the incidence of syphilis, a major cause of stillbirths and (if untreated) of infant mortality, was particularly disturbing given that syphilis rates were on the decline in the general population. As Dr Michael Watt, Director-General of Health, announced in 1939, the main task was “to eliminate the grave risk of these young Maori women producing congenital syphilitic babies”.<sup>22</sup> With a persistent lack of medical coverage in Whakatane, the extent of the problem was not known, making it difficult to assess if government assistance was needed.<sup>23</sup> A survey therefore appeared necessary.

The Whakatane problem prompted an unusually fast response by the Department. Dr Gordon Dempster, Medical Officer of Health (MOH) for Auckland, was sent to the region, where he obtained 900 blood samples for Wassermann tests from the inhabitants of Ruatoki, Waimana, Matahi and Waiohau villages above the age of five years.<sup>24</sup> The infection rate for syphilis was 15.2 per cent for females and 11.9 per cent for males. The age range revealed that most of those who were infected were in their prime: women aged between eleven and forty, and men between twenty and forty.<sup>25</sup> Thus, the Department found whole communities in ignorance of their infection, and in dire need of comprehensive treatment.<sup>26</sup>

To counter this situation, the Department put in practice a raft of health care initiatives that exceeded anything it had attempted previously in its general venereal disease policy.<sup>27</sup>

<sup>19</sup> On the incidence, see also Fleming, *op. cit.*, note 6 above, p. 86; Brookes, *op. cit.*, note 6 above, p. 163.

<sup>20</sup> Archives New Zealand/Te Rua Mahara o te Kāwanatanga, Auckland Office, New Zealand (hereafter ANZA), Department of Health Auckland District Office (BAAK) A49/66b 25/42 VD general 1939–43, letter Michael Watt to all MOHs circular, ‘Wassermann tests on Maori mothers’, 2 Oct. 1939.

<sup>21</sup> See Michael King, ‘Between two worlds’, in Geoffrey W Rice (ed.), *The Oxford history of New Zealand*, 2nd ed., Oxford University Press, 1992, p. 287. On infant mortality, see Linda Bryder, ‘New Zealand’s infant welfare services and Maori, 1907–1960’, in *Health & History*, 2001, 3: 65–86.

<sup>22</sup> ANZW, H1 45/4/28, Michael Watt memorandum, 2 Oct. 1939.

<sup>23</sup> ANZA, BAAK A358/143a 25/42 III VD general 1943–1957, letter Dr William Reid (Auckland Hospital) to Registrar Native Department, 15 May 1945.

<sup>24</sup> ANZW, H1 45/4/28, letter Dr Kenneth Davis (MOH for Gisborne) to Michael Watt, 29 Aug. 1939.

<sup>25</sup> ANZW, H1 45/4/28, letter Gordon Dempster to Michael Watt, 20 Sept. 1939. However, Maori suffered disproportionately more from infectious diseases that could have impacted on the results of Wassermann tests. See ANZW, H1 45/4/28, letter A D Nelson to Michael Watt, 8 Apr. 1932.

<sup>26</sup> ANZW, H1 45/4/28, letter Gordon Dempster to Michael Watt, 20 Sept. 1939.

<sup>27</sup> *Ibid.*

In order to obtain an overview of the extent of the syphilis epidemic, public hospitals were asked to implement routine Wassermann tests for all Maori admissions, mental hospitals were instructed to investigate the extent of syphilis in Maori in their institutions for the previous five years, and expectant Maori mothers were screened.<sup>28</sup> In addition, Medical Officers of Health, hospitals and district nurses were alerted to look out for any “other places of infection”, with all cases to be treated.<sup>29</sup>

In view of the evident lack of adequate venereal disease treatment and medical coverage in remote areas, particularly in that of the Bay of Plenty, the Department searched for a full-time medical practitioner. This was a difficult task, not only because of the wartime shortage of doctors, but also—as Watt stressed—because of either the prevalent lack of education amongst medical professionals on venereal disease, or knowledge of “Maori temperament and custom”.<sup>30</sup> In November 1939, the Department finally appointed Dr Golan Maaka, a Maori doctor who had previously treated venereal disease cases during his time in China.<sup>31</sup> When he first visited the area, Maaka found that many Maori were without medical help for VD, despite a diversity of health care available from the whanau (extended family), public hospitals, native medical officers (subsidized local medical practitioners), native school teachers, and Tohunga (traditional Maori healers).<sup>32</sup>

Maaka began the rigorous investigation and treatment of patients in the Ruatoki district who had been diagnosed with syphilis.<sup>33</sup> With the agreement of the kaumatua (tribal heads/elders) and the community, he visited several marae on a weekly basis, and obtained case histories from most of the patients, meticulously noting the patient’s name, age, his or her relationship to other patients on the list, case history, treatment given, results from Wassermann tests, and the progress made. He also included a list of follow-up patients, defaulters, those who reacted adversely to novarsenobillon (NAB, an arsenic compound) injections, new patients, those who had enlisted in the Armed Forces, and those who were “more or less under constant treatment & supervision”.<sup>34</sup>

In fact, the feared widespread infection did not materialize. The incidence of general paresis (general paralysis of the insane)—a late stage complication of tertiary syphilis—amongst Maori patients in mental hospitals was negligible, and public hospitals reported fewer cases than had been expected. As the increase in incidence was understood to be recent, Watt, the Director-General of Health, announced officially in 1940 that the numbers were “reassuring”.<sup>35</sup> Yet although the official attitude was outwardly calm, inter-departmental correspondence reveals that the Department was disturbed by local variations in most surveys.<sup>36</sup>

<sup>28</sup> ANZA, BAAK A358/143a, Departmental circular to all hospitals, 4 Oct. 1939. ANZA, BAAK A49/66b, Departmental circular, 4 Dec. 1939. Vital statistics for Maori were not systemized before 1913.

<sup>29</sup> ANZW, H1 45/4/28, letter Thomas Ritchie to MOHs, 2 Oct. 1939. This policy included the screening of Maori soldiers who came from isolated areas in North Auckland. ANZW, AD1 330/9/1VD general vol. 4 1945–1953, letter Fred Bowerbank (Director-General of Medical Services; he was later made a KBE) to Adjutant-General, 4 July 1945.

<sup>30</sup> ANZW, H1 45/4/28, letter Michael Watt to Dr James Foley, 18 Oct. 1939.

<sup>31</sup> Bradford Haami, *Dr Golan Maaka: Māori doctor*, North Shore City, Tandem Press, 1995, p. 108.

<sup>32</sup> ANZW, H1 45/4/28, letter Dr Golan Maaka to Michael Watt, 27 Oct. 1939.

<sup>33</sup> Haami, op. cit., note 31 above, p. 110.

<sup>34</sup> ANZW, H1 45/4/28, Golan Maaka report, 21 Mar. 1941, p. 8.

<sup>35</sup> *AJHR*, 1940, H-31: 4.

<sup>36</sup> ANZW, H1 45/4/28, letter Michael Watt to Arnold Nordmeyer (Minister of Health), 13 Nov. 1941.

As the general venereal disease statistics at that time did not include age groups, the impact of venereal disease on whole families, and adolescents in particular, had not until then been known. The surveys, such as those by Maaka, that showed high figures of venereal disease infection especially among adolescents provided a motivation for continued government action.

By November 1941, the initial area of investigation was extended to other North Island districts, and the appointment of four more full-time “Maori general practitioners” to cover North Auckland, Rotorua, the East Coast and Wanganui was planned.<sup>37</sup> Although tuberculosis was the second major infectious disease to impact on Maori, a situation of which the Department had already been aware for almost a decade, doctors were advised to “primarily . . . deal with the problem of venereal diseases”.<sup>38</sup> This plan had to be discontinued, however, because of the war.<sup>39</sup> While the Director-General of Health advised the continuation of surveys whenever there were reports of possible prevalence of infection, these were discontinued by 1946.<sup>40</sup>

### The Vexed Issue of Hospitals, Doctors and the Provision of Treatment

The nature and scale of Maaka’s work were certainly exceptional for the time, but hospital boards and doctors who provided health care in rural and remote areas were similarly concerned about how best to treat Maori with venereal disease. In view of the intractable problem of distance between remote areas and hospitals, the Wairoa Hospital Board, for example, was eager to establish a proper venereal disease outpatient service, only to be hindered by the slow response of the Department.<sup>41</sup> Some institutions, such as Rawene Hospital, when faced with inadequate government support to augment their supplies, decided instead to use their own supplies to treat acute Maori cases of syphilis, for “to wait for weeks would . . . be criminal to hygiene”.<sup>42</sup>

Some doctors provided additional health care to Maori, although their duty was merely to enquire about venereal disease. Dr Eric Bridgman, for example, when confronted with Maori incomprehension as to “why one disease alone should be selected for treatment”, felt that to “disregard their requests would be ignoring many sick people in need of attention.”<sup>43</sup> Some Maori cases were treated with NAB even though they lacked any clinical signs indicative of venereal disease, a decision backed by Maori Councils, as these patients, “previously listless and in general poor health”, apparently benefited from the treatment.<sup>44</sup> Though it is puzzling why such persons would be thought to require a treatment specifically for venereal disease, this measure did indicate a genuine attempt to improve their health.

<sup>37</sup> ANZW, H1 45/4/28, letter Michael Watt to MOHs, 13 Nov. 1941. On the Department’s scheme, see also Dow, *op. cit.*, note 7 above, pp. 181–3.

<sup>38</sup> ANZW, H1 45/4/28, letter Michael Watt to Arnold Nordmeyer, 13 Nov. 1941. Between 1936 and 1945, tuberculosis related deaths climbed for males from third to second place of mortality, for females to number one. D Ian Pool, *Te iwi Maori: a New Zealand population, past, present and projected*, Auckland University Press, 1991, p. 116, table 6.4.

<sup>39</sup> Dow, *op. cit.*, note 7 above, pp. 194–5.

<sup>40</sup> Michael Watt to MOH for Auckland, 26 Apr. 1946, BAAK A358/143a.

<sup>41</sup> ANZW, H1 20362, letter R A Peez (Wairoa Hospital Board) to Kenneth Davis, 22 Oct. 1942.

<sup>42</sup> ANZW, H1 45/4/28, letter Carlyle Gilbert (MOH for Whangerei) to Michael Watt, 30 Apr. 1942.

<sup>43</sup> ANZW, H1 131/45/4, letter Dr Eric Bridgman to Waikato Hospital, 31 Oct. 1943.

<sup>44</sup> *Ibid.*

Disputes between the Department, hospital boards and doctors over the financing of care for venereal disease arose over Maori cases just as it did over European ones. These disputes had an impact on the quality of treatment. In the Maori context, most cases involved small hospitals, many of which were struggling with resources, and therefore refused to provide treatment facilities.<sup>45</sup> Under the Venereal Diseases Regulations, the government had pledged to cover the costs of diagnostic tests and treatment for cases in the “public interest”, for seamen and for indigent patients from remote areas. But hospital boards were confused as to the limits of these exemptions, and feared that they would have to draw on their own funds when they were unable to collect fees from patients. In addition, the sudden increase in laboratory work resulting from the Maori surveys was not covered by the government.<sup>46</sup> Difficulties with funding also influenced quite a number of private doctors, who became reluctant to treat patients as “the fee charged for the first visit usually brought the visits to a conclusion”.<sup>47</sup>

Both European and Maori patients who lived in isolated rural areas, distant from health services, often received rather haphazard treatment, yet proportionately more Maori were affected by isolation. Some outlying districts were not served by general practitioners, and the Department therefore received letters from small hospital boards that felt overwhelmed by the prospect of future Maori patients with venereal disease, who, given that they would have travelled considerable distances, would also require food and lodging.<sup>48</sup> As beds were scarce, hospital boards feared that demand would outstrip their resources and stretch their ability to provide medical services. In some cases, follow-up treatment ceased due to transportation difficulties for Maori.<sup>49</sup> At times, the motto seemed to be “better a bit of treatment than nothing at all”.<sup>50</sup>

Differing standards of confidentiality and privacy were applied to Maori and European patients with venereal disease. Although legislation required both doctors and the Department to keep patients’ details confidential, Maori patients who lived in remote areas were dealt with as a group. Privacy was clearly not possible when entire Maori families, accompanied to the doctor by district nurses or other Maori patients, all had to share a ride to the same clinic. This situation often arose as a result of the difficulties hospitals faced in providing bed and board, and the inability or unwillingness of private practitioners to visit the communities.

<sup>45</sup> ANZW, H1 45/4/28, letter Michael Watt to Arnold Nordmeyer, 13 Nov. 1941. The impact of disputes on treatment provision has also been identified in the earlier smallpox vaccination campaign, see Alison Day, “Chastising its people with scorpions”: Maori and the 1913 smallpox epidemic’, *New Zealand Journal of History* (hereafter *NZJH*), 1999, 33 (2): 180–99, on pp. 192–3.

<sup>46</sup> ANZW, H1 45/4/28, letter Auckland Hospital Board to Michael Watt, 15 Feb. 1940; Departmental circular letter to Medical Superintendents and Public Hospitals, 4 Dec. 1939.

<sup>47</sup> ANZW, H1 45/4/28, letter Gordon Dempster to Michael Watt, 16 Nov. 1939.

<sup>48</sup> ANZW, H1 131/45/4, letter Kenneth Davis to Michael Watt, 18 Oct. 1943. Historians have

described similar difficulties of treatment provision in remote areas for Aborigines and Africans. See Jebb, *op. cit.*, note 5 above, pp. 72–4; Milton J Lewis, *The people’s health in Australia 1950 to the present*, Westport, CT, and London, Praeger, 2003, pp. 237–9; Jochelson, *op. cit.*, note 4 above, pp. 162–3, 168. By contrast to New Zealand, both treatment schemes were highly racist, as patients were placed in lock hospitals, and often received no treatment at all.

<sup>49</sup> ANZW, H1 45/47 (20361) VD reports 1941–1943, letter Nurse Flora Cameron to Michael Watt, 14 Dec. 1942.

<sup>50</sup> This is described in ANZW, H1 131/45/4, Duncan Cook to Michael Watt, 27 Aug. 1946.

Financial or administrative problems were not the only reasons for the lack of consideration for privacy—differing cultural sensitivities were also significant. A European male patient was seldom advised to bring his female partner for treatment, even less so if the partner was his wife, and such cases were dealt with on an individual basis.<sup>51</sup> Out of cultural sensitivity, Maori were dealt with on a community or family basis. The Maori survey lists, for example, provided details about sexual and marital relationships, and entire families were asked about infection.<sup>52</sup> School incidences also illustrate this pattern. Maori Councils that approached the Department in possible vulvo-vaginitis cases in schools corresponded openly on the issue: they asked teachers to obtain permission from parents to examine children, and requested adult examination as well.<sup>53</sup> By contrast, the Department responded to incidences in European schools by sending district nurses who were “to make discreet inquiries”, suppress names, and “keep a still tongue”.<sup>54</sup>

### Nurses and Venereal Disease Treatment: “One’s Approach is Definitely Handicapped”

With many Maori patients either refusing to attend hospitals, or living too far away readily to make the journey, district nurses constituted the first line of health care.<sup>55</sup> Yet medical training for nurses in relation to venereal disease barely existed: only during the Second World War did nurses become more involved in the treatment and control of VD. As district nurse inspectors, they traced such cases in the main centres; as district nurses, they became embroiled in debates with doctors and the Department about the provision of venereal disease treatment to Maori.

District nurses regularly informed the Medical Officers of Health of suspected cases, organized the transportation of patients to doctors or hospitals—some by using their own cars as “taxis”—provided health education and, as a consequence of growing concerns by MOHs about treatment of remote Maori cases, were allowed to administer bismuth injections.<sup>56</sup> This additional responsibility of district nurses did not extend into hospitals, and opinion as to whether district nurses should administer these drugs was divided amongst general practitioners and the Department. While the medical profession normally guarded with care the authority of doctors to prescribe and administer treatment, some doctors insisted that the administration of bismuth or even arsenic injections by nurses guaranteed continuous treatment. This unofficial custom had to be reviewed when serious side effects from NAB injections for syphilis cases began to be observed.<sup>57</sup> By August

<sup>51</sup>This sensitivity, however, was not applied to all diseases. In tuberculosis cases nurses visited European families.

<sup>52</sup>ANZW, H1 45/48 VD cases—treatment by district nurses 1941–1943, letter Dr Leith Riddell to Michael Watt, 25 Aug. 1942.

<sup>53</sup>ANZW, H1 35/100 (13294) Juvenile Delinquents 1934–1940, letter School Committee to Peter Fraser (Minister of Health), 15 Aug. 1938; letter Peter Fraser to School Committee, 5 Sept. 1938.

<sup>54</sup>ANZW, H1 35/100 (13294), letter MOH for Christchurch to Elizabeth Gunn, 2 Dec. 1938.

<sup>55</sup>The Department had provided health care for remote areas through the district nurses scheme since 1909. A Native Nursing Scheme was introduced by 1911. See also Alexandra McKegg, ‘The Maori Health Nursing Scheme: an experiment in autonomous health care’, *NZJH*, 1992, 26 (2): 145–60.

<sup>56</sup>ANZW, H1 45/4/28, letter Gordon Dempster to Michael Watt, 16 Nov. 1939. ANZW, H1 131/45/4, letter Frederick Dawson (MOH for New Plymouth) to Michael Watt, 10 Apr. 1942.

<sup>57</sup>ANZW, H1 131/45/4, letter Michael Watt to Dr Falconer Brown, 20 May 1941. One of the factors



1941, district nurses were allowed to administer only intramuscular injections of bismuth.<sup>58</sup> Yet a year later, in order to provide continuous treatment, three district nurses were “all carrying on the arsenic injections (intramuscularly)” on Maori in remote areas, with doctors’ knowledge.<sup>59</sup>

District nurses, who were mainly European, had the challenging task of performing health care duties that were often insensitive to, or incompatible with, Maori custom and culture.<sup>60</sup> Some, feeling morally and educationally superior, displayed a rather supercilious attitude towards Maori patients. An article on public health and Maori in the *New Zealand Nursing Journal*, for example, sympathized with the task of district nurses: “when one has to create an atmosphere for health education in a community of Maoris whose moral and mental characteristics are bad, or utterly lacking, and whose indifference to the advantages of progressive education [sic] is widespread, one’s approach is definitely handicapped.”<sup>61</sup> It was thus not surprising that district nurses found themselves challenged by some Maori patients, who would avoid treatment. Maori patients absented themselves prior to examination by nurses, and parents objected to nurses giving injections to their children.<sup>62</sup> In this respect, despite district nurses being valuable front-line personnel in the treatment of venereal disease in Maori, in 1942, Dr Kenneth Davis (MOH for Gisborne) warned the Department that, if district nurses were to give full treatment, it “would not be agreeable to many of the [Maori] patients, particularly the men”.<sup>63</sup>

While the provision of treatment was certainly an opportunity for district nurses to extend their authority, it also ensured that medical care was still available to those VD patients most in need of treatment, but whose options were limited either because they had to travel too far or because they wanted to avoid hospitals.

#### **Maori Defaulters: “Still Anxious to Co-operate”<sup>64</sup>**

The provision of treatment to Maori patients with venereal disease proved to be difficult in another respect: many patients chose to default on their treatment programme. Certainly opting out was not specific to Maori with VD, as this practice was observable among all sufferers, regardless of race. However, the combination of low levels of income and residence in remote areas impacted on the ability of Maori—more than that of Europeans—to seek and continue treatment.<sup>65</sup> The government scheme for indigent VD patients was often ignored or misunderstood by health professionals, while patients may well have been too embarrassed to ask for this kind of assistance, leading to insufficient or

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that apparently affected Maori patients more than Europeans was their diet (shellfish). Letter Falconer Brown to Michael Watt, 22 May 1941.

<sup>58</sup> ANZW, H1 131/45/4, letter Michael Watt to MOHs, 19 Aug. 1941.

<sup>59</sup> ANZW, H1 45/47 (20361) VD reports 1941–1943, letter Nurse Flora Cameron to Michael Watt, 14 Dec. 1942.

<sup>60</sup> See also McKegg, *op. cit.*, note 55 above, pp. 155–6.

<sup>61</sup> Elizabeth Paora, ‘Public health and other problems of a Maori health district and suggestions

for improvement’, *New Zealand Nursing Journal*, 1940, 33 (9): 285.

<sup>62</sup> ANZW, H1 131/45/4, letter Kenneth Davis to Michael Watt, 22 July 1941; ANZW, H1 45/48, letter Wairoa Hospital Board to Michael Watt, 18 Sept. 1942.

<sup>63</sup> ANZW, H1 45/48, letter Kenneth Davis to Michael Watt, 30 Oct. 1942.

<sup>64</sup> ANZW, H1 45/4/28, letter Gordon Dempster to Michael Watt, 16 Nov. 1939.

<sup>65</sup> King has referred to the “rural proletariat”. King, *op. cit.*, note 21 above, p. 290.

terminated treatment.<sup>66</sup> Defaulting also resulted from Maori custom and lifestyle. Maaka noted that treatment courses were “frequently interrupted by various factors peculiar to the communal mode of living—tangi, Ringatu meetings and of course, the nature of their work of milking, haymaking, maize plucking etc.”<sup>67</sup> Additional deterrents were that blood was tapu, making it difficult to procure Wassermann tests, and that many feared risking their health and welfare when visiting hospitals.<sup>68</sup>

Government officials believed that quick action to assure treatment was required to take advantage of a “window of compliance” before the Maori patient defaulted or absconded.<sup>69</sup> This view was possibly linked to a similar concern expressed in relation to the treatment of Maori patients with tuberculosis in the same period.<sup>70</sup> Medical Officers of Health and doctors alike commented on Maori untrustworthiness and resistance to authority, which made VD control difficult. District nurses were not always welcomed by Maori, and the Department “was looked upon as a hindrance and something to avoid”.<sup>71</sup> The Department was, at times, powerless in its attempts to keep Maori patients under sustained treatment.<sup>72</sup> Yet the majority of Maori Councils did cooperate actively, and often lent their unequivocal support, as in the outbreak of venereal disease in Whakatane where whole families agreed to be tested and examined.

The fear of non-cooperation illustrated the Department’s concerns about assimilation and authority. European defaulters were singled out in an informal discourse of blame by occupation (waitress, factory worker, soldier, and seaman); Maori defaulters were more likely to be singled out by race.<sup>73</sup> Disobedient behaviour by one Maori was believed to affect the attitude of all Maori patients coming for treatment. An incident at a football dance at Ranana on the Wanganui River in autumn of 1932 illustrates this point. A young Maori man knowingly infected a young Maori woman at the dance, and she later became pregnant. The man was one of the very few to be convicted under the provisions of Section 8 of the Social Hygiene Act 1917 for knowingly infecting another person with venereal disease, and was committed to prison for twelve months.<sup>74</sup> The offender had evaded treatment several times prior to this incident, and the Department was relieved that he was prevented from doing more harm. Equally important to health officials, however, was the fact that that this sentence might deter other Maori sufferers from evading treatment: “[a]t present the other Natives are co-operating loyally, and are travelling a considerable distance to be treated, but it is feared that if this man’s

<sup>66</sup> Only five doctors invoked the regulation for their patients in a three-month span. Watt to MOHs, 13 Nov. 1941, p. 1, H1 45/4/28.

<sup>67</sup> ANZW, H1 131/45/4, letter Golan Maaka to Michael Watt, 21 Mar. 1941.

<sup>68</sup> ANZW, H1 131/45/4, letter Kenneth Davis to Michael Watt, 22 July 1941.

<sup>69</sup> ANZW, H1 45/4/28, letter Kenneth Davis to Michael Watt, 26 Sept. 1939.

<sup>70</sup> The non-compliance issue with Maori and tuberculosis is detailed in Debbie Dunsford, ‘War on disease, tuberculosis in New Zealand during WW2’, unpublished paper given at the New Zealand

Historical Association Conference, Dunedin, November 2003.

<sup>71</sup> Mr Haami Ratana, MP (Western Maori District), *New Zealand Parliamentary Debates* (hereafter *NZPD*), 1937, 248: 1015.

<sup>72</sup> Cawkwell and McNamara, op. cit., note 10 above, pp. 35–6.

<sup>73</sup> ANZW, H1 45/4/28 (20361), letter Falconer Brown to Michael Watt, 14 Sept. 1945.

<sup>74</sup> ANZW, H1 45/4/28, letter Inspector of Health to Michael Watt, 12 May 1932. The description of the sentencing is noted in ANZW, H1 45/4/28, letter Clerk of Court to Dr Thomas McKibbin, 11 Aug. 1932.

insubordination is tolerated, there will be numerous other cases refusing to be treated, and infecting others.”<sup>75</sup>

The perception that one Maori patient’s disobedience could influence the rest of the community led some Medical Officers of Health and doctors, eager to ensure continuous treatment, to call for powers extending beyond the provisions of existing venereal disease legislation.<sup>76</sup> In 1939, Dr Carlyle Gilberd (MOH for Whangarei) effectively asked for the compulsory notification of all Wassermann-tested Maori patients, irrespective of test results, although this practice was not permitted by legislation.<sup>77</sup> Some MOHs deliberately performed examinations without consent. Dr Harold Turbott (Director, Division of School Hygiene), for example, admitted that, in cases of vulvo-vaginitis in schoolchildren, he had, in defiance of legislative requirements, “always gone without parental consent”.<sup>78</sup> General practitioners inquiring as to whether they would be protected by law if they carried out examinations on minors without parental consent were advised by Davis (MOH for Gisborne) that, “in the case of many Maori cases, it would be almost an impossibility to contact parents to obtain this permission”.<sup>79</sup>

### **Public Health Education, Venereal Disease and Maori**

Racially differentiated medical and Departmental perceptions of compliance and treatment issues were also evident in educational efforts to reduce venereal disease. The Social Hygiene Act 1925 and the Venereal Diseases Regulations 1941 did not distinguish between Maori and Europeans, yet most of the available literature was produced only in English, and was based solely upon European customs. The advice given in the pamphlets and lectures did not attempt to take note of any differences in relation to sexuality and family in Maori society, assuming instead Maori adoption of European customs and culture.<sup>80</sup> In contrast to other health pamphlets translated into Maori since the early twentieth century, the material that has survived in the archives reveals only one translation, that of the Social Hygiene Act in 1922.<sup>81</sup>

<sup>75</sup> ANZW, H1 45/4/28, letter T Pargeter to Michael Watt, 12 May 1932.

<sup>76</sup> This was before the 1940 Health Act Amendment and the 1941 Venereal Diseases Regulation that gave medical officers more power in notification processes of suspected cases.

<sup>77</sup> ANZW, H1 45/4/28, letter Carlyle Gilberd to Michael Watt, 11 Oct. 1939. Such a list of all blood tests taken from all Northland districts was sent in 1945. ANZA, BAAK A358/143a, letter Hubert Smith (MOH for Wellington) to MOH for Auckland 31 July 1945. The MOH for Palmerston North referred to suggestions by local doctors to use penicillin on Maori defaulters to produce a rapid cure. ANZW, H1 131/45 (23441), letter Duncan Cook to Michael Watt, 21 Mar. 1946. Neither the superintendent of Wanganui Hospital nor the Department were prepared to agree to this, most likely because of the shortage and cost of penicillin.

<sup>78</sup> ANZW, H1 35/100 (20704) Juvenile delinquents 1940–1941, letter Harold Turbott to Carlyle Gilberd, 22 July 1940. For a similar concern, see ANZW, H1 35/100 (13294), letter Gordon Dempster to Michael Watt, 16 July 1940. Clause 84 of the Health Amendment Act of 1940 provided full protection in civil and criminal proceedings. Sources do not reveal whether similar practice was applied to European children, yet it seems highly unlikely. This practice mirrored the handling of anti-typhoid inoculation in the 1930s. Dow, *op. cit.*, note 7 above, p. 192.

<sup>79</sup> ANZW, H1 131/45 (23441), letter Kenneth Davis to Michael Watt, 11 June 1943.

<sup>80</sup> See also Katharine Sophia Goodfellow, ‘Health for the Maori? Health and the Maori village schools, 1890–1940’, MA thesis, The University of Auckland, 1991, pp. 4–5.

<sup>81</sup> See ANZW, H1 45/4/28. A suggestion to translate the Departmental pamphlet on venereal

Health education within Maori communities focused predominantly on sanitary issues and European-style personal hygiene.<sup>82</sup> Unhygienic sanitary conditions were considered not only as the origin of a number of ailments, but also as a factor in the spread of venereal disease. While health officials seldom commented on European living standards, they stressed the frequent and lasting problem of hygiene in Maori settlements. The Department, in conjunction with Maori Councils, therefore worked throughout the interwar period to improve housing conditions, sewerage and water systems.<sup>83</sup> The conditions caused by “lack of cleanliness and privacy” were seen as lowering the resistance to outside infection, including venereal disease.<sup>84</sup> However, incidences of VD at Wanganui River changed concerns about Maori lifestyle into a general concern regarding the health and moral hazard presented by “overcrowding, and undesirable mixing of the sexes”.<sup>85</sup>

In contrast to the selective efforts to educate individual adult Europeans by means of evening lectures and pamphlets, whole Maori communities were called upon by the Department to meet and discuss the problem of sexual mores and venereal disease with the local medical officer or district nurse.<sup>86</sup> However, Maori were not passive recipients of this education. There was far from universal compliance, with some Maori Councils refusing to cooperate, claiming that Maori provision of health education was more appropriate.<sup>87</sup>

### Maori and the City: The Dangers of “Unhealthy” Conditions

During the Second World War, Maori increasingly moved to towns to work in major industry and factories, under the Manpower Regulations. The majority of these migrants were young, single men and women aged fifteen to twenty-four, who mainly went to Auckland and the Wellington–Hutt area, as well as Hastings and Gisborne, cities with ports and existing venereal disease problems.<sup>88</sup> The consequences of this demographic shift were a heightened awareness among the public and government officials alike of the presence of Maori in the cities and a perception of a specific “Maori problem”, particularly in Auckland.<sup>89</sup> This situation caused anxiety and concern in the European population,

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disease into Maori was equally abandoned. ANZW, H1 45/4/28, letter Gordon Dempster to Michael Watt, 20 Sept. 1939. This trend was possibly also influenced by fear of discrimination. See ANZW, Army Department (AD1) 330/9/1 Venereal disease (VD)—general vol. 2, 1941–1942.

<sup>82</sup> *AJHR*, 1928, H-31, p. 36.

<sup>83</sup> ANZW, Department of Maori Affairs (MA) 36/3/3 Health and hygiene 1932–1956, Watt memorandum to Native Department, 16 Feb. 1935. The issue of sanitation and the Department is discussed in Dow, *op. cit.*, note 7 above, pp. 188–96. On the issue of cultural differences between Europeans and Maori regarding sanitation, see Brookes, *op. cit.*, note 6 above, pp. 157–8.

<sup>84</sup> Cawkwell and McNamara, *op. cit.*, note 10 above, p. 35.

<sup>85</sup> ANZW, H1 45/4/28, letter William Findlay to Michael Watt, 27 Apr. 1932.

<sup>86</sup> ANZW, H1 45/4/28, letter Gordon Dempster to Michael Watt, 16 Nov. 1939. A similar approach by Educationalists to view Africans as a homogeneous group has been detailed by Jochelson, *op. cit.*, note 4 above, p. 168.

<sup>87</sup> Some councils, for example, refused to talk about unfounded claims of an alleged increase in cases in the Napier area. ANZW, H1 35/100 (13294), letter Taranaki Council to Michael Watt, 17 Aug. 1938. On autonomy and selective use of European medicine and agency, see also McKegg, *op. cit.*, note 55 above, p. 158.

<sup>88</sup> For statistics, see Pool, *op. cit.*, note 38 above, pp. 153–4.

<sup>89</sup> See Nancy M Taylor, *The New Zealand people at war: the home front*, Wellington, Historical

which in turn influenced the official debate about Maori and venereal disease.<sup>90</sup> A proportionately higher incidence of venereal disease, particularly syphilis infection, among Maori attendees at the Auckland Venereal Disease Clinic fuelled these concerns, especially after July 1941 when attendance statistics at the clinic were, for the first time, recorded on the basis of race.<sup>91</sup>

While in official and medical opinion all the inhabitants of remote Maori settlements were potentially infected, generally in the cities it was young female Maori factory workers and waitresses who were singled out as probable sources of infection.<sup>92</sup> Maori women were considered to be of an “easy going nature”; for them: “a good time now is of more importance than the possibility of tertiary syphilis in a few years to come”.<sup>93</sup> This assumption extended to so-called “ship girls”: young, mainly Maori women who “haunt[ed] the docks”.<sup>94</sup> The Prison Department also raised concerns about the increase in young Maori girls committed to borstal or prison, from 310 in 1939 to 523 in 1943, for apparently having solicited servicemen in towns.<sup>95</sup> The stern Senior Magistrate J H Luxford was led to lament that Auckland “is becoming a refuge for Maori women who want to live lives of immorality” and to decry the “shocking state of affairs that Maori womanhood has fallen to”.<sup>96</sup> In 1943 the government was persuaded to consider appointing five female welfare officers to “supervise Maori girl workers in both city and country areas”.<sup>97</sup> Concerns about the levels of infection amongst Maori girls even led both a Maori Welfare Officer and the District Manpower Officer in Auckland to discuss the attendance of Maori female workers at venereal disease clinics, and to try to obtain confidential information concerning these cases.<sup>98</sup>

Concerns about housing conditions were voiced by health officials for all young, urban females irrespective of race, yet, for Maori, sanitation was an additional topic for comment. While for Child Welfare, the Prison Department and welfare groups, the problem seemed

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Publications Branch, Dept. of Internal Affairs, 1986, vol. 2, p. 500. On the general social and cultural impact of Maori moving increasingly to the cities, see King, *op. cit.*, note 21 above, pp. 289; Pool, *op. cit.*, note 38 above, pp. 121–3.

<sup>90</sup> ANZA, BAAK A358/143a, letter Thomas Ritchie to Gordon Dempster, 13 Jan. 1944. Jochelson has documented a similar concern about venereal disease with the movements of Africans into towns, see Jochelson, *op. cit.*, note 4 above, pp. 166–7.

<sup>91</sup> ANZW, H1 131/45/4, letter Thomas Ritchie to Controller of Manpower Wellington, 18 Apr. 1944. The separate statistics are mentioned in J M Foreman, ‘Work done in the Auckland V. D. Clinic’, Preventive Medicine Dissertation, University of Otago, 1945, unpaginated.

<sup>92</sup> Some authors have suggested that wartime New Zealand concerns about female sexual delinquency were “highly racialised”. Bronwyn Dalley, *Family matters: child welfare in twentieth-century New Zealand*, Auckland University Press, 1998, p.119. See also Fleming, *op. cit.*, note 6 above, p. 178. But working-class, urban European females were

equally singled out, for example, by “vice squads” and discriminatory comments. This suggests that perceptions were gendered rather than merely racial. See also Kampf, *op. cit.*, note 1 above, pp. 206–10.

<sup>93</sup> H Black and M Farb, ‘Prevalence and control of venereal disease: with special reference to Wellington city’, Preventive Medical Dissertation, University of Otago, 1943, p. 37.

<sup>94</sup> ANZA, BAAK A358/143a, letter Dr Bill Thompson (MOH for Auckland) to Thomas Ritchie (Director-General of Health), 25 May 1948.

<sup>95</sup> *AJHR*, 1944, H-20: 3. On Maori offences and their racial perception, see Bronwyn Dalley, ‘Moving out of the realm of myth: government child welfare services to Maori, 1925–1972’, *NZJH*, 1998, **32** (2): 189–208, pp. 196–7.

<sup>96</sup> H Luxford, quoted in *NZPD*, 1944, **264**: 254. However, Luxford was generally outspoken about female delinquent sexuality irrespective of race.

<sup>97</sup> *Press*, 6 July 1943. This was not carried out.

<sup>98</sup> ANZW, H1 131/45/4, Controller of Manpower to Michael Watt, 27 Mar. 1944.

to be one of general sexual delinquency amongst Maori girls, the Health Department believed that inadequate housing conditions were the major reason for the increase in venereal disease amongst Maori women.<sup>99</sup> The State Housing schemes of the first Labour government (1935–49) fell short of alleviating the problems of overcrowding and sub-standard conditions, and the 1942 pamphlet *Slums in Auckland* lamented that a large number of slums were occupied by Maori.<sup>100</sup> The Department documented disturbing conditions in 1944 when, for example, health officials found thirteen Maori in one room in Auckland, of whom three were “syphilitics”.<sup>101</sup> Henry Thorne Morton, the Member of Parliament for Waitemata, underlined the occasionally voiced belief that “the overcrowded and unhealthy conditions in which so many Maoris live . . . [produce] physical and moral deterioration” and spread venereal disease.<sup>102</sup>

### Venereal Disease Surveys and the Concern about Race

While the successful treatment of venereal disease remained a major concern for the Department, another challenge was the prevention of the spread of syphilis and gonorrhoea from Maori to European communities. The Department tried to highlight issues of Maori treatment provision by alerting hospital boards, doctors and district nurses to the potential problems involved, thereby intensifying existing concerns about Maori. Although surveys and test results were not representative of the Maori community as a whole, medical officers and practitioners nevertheless utilized them to make broad assumptions about the prevalence of venereal disease amongst Maori. Dr Tremewan (MOH for Auckland) admitted that the results regarding VD in the Te Kao and the Panguru areas were “loaded”.<sup>103</sup> He had “selected settlements where the incidence was considered by the district nurse to exceed the average”, an assessment based on the nurse’s own prejudices, as absentees were considered “particularly suspect”.<sup>104</sup>

Such misguided official guesses regarding the prevalence of venereal disease amongst Maori became something of a fallacious historical truth, leading, in some cases, to lasting popular and official impressions that all Maori were riddled with VD.<sup>105</sup> The Whakatane survey was the only survey to be conducted on a single group during the Second World War—nevertheless, the pamphlet *The shadow over New Zealand: venereal disease*, published in 1942 and endorsed by the Minister of Health, asserted with ostensible authority that the survey pointed to Maori as “probably the worst focus of infection in New Zealand”.<sup>106</sup> Morton, the MP for Waitemata, quoted an unnamed

<sup>99</sup> ANZW, H1 131/45/4, letter Michael Watt to Controller of Manpower, 18 Apr. 1944.

<sup>100</sup> On the failure of the housing schemes to address Maori needs, see Goodfellow, op. cit., note 80 above, pp. 23, 53–4. The slums are described in W B Bland, *Slums of Auckland*, Wellington, Progressive Publishing Society, 1942, p. 5.

<sup>101</sup> ANZW, H1 131/45/4, letter Michael Watt to Controller of Manpower, 18 Apr. 1944.

<sup>102</sup> Henry Thorne Morton (MP for Waitemata), in *NZPD*, 1944, 264: 255.

<sup>103</sup> ANZW, H1 131/45/4, letter Dr Tremewan (MOH for Auckland) to Michael Watt, 18 Apr. 1946.

<sup>104</sup> Ibid.

<sup>105</sup> ANZW, AD1 330/9/8/ VD Maori 1940–1943, letter Fred Bowerbank to J G Coates, 10 Feb. 1943.

<sup>106</sup> *The shadow over New Zealand: venereal disease*, Christchurch, Progressive Publishing Society, 1942, p. 30. They were quick, however, to state that they did not consider it “typical of the Maori population as a whole”.

Medical Officer of Health who, in 1944, declared that Maori communities were “hot-beds of infection”.<sup>107</sup> In 1947, Doris Gordon, the Director of Maternal Welfare, had to refute comments such as those by a medical practitioner from Rawene, who believed that “practically everyone up here has some Gonorrhoea”.<sup>108</sup> She complained to Arnold Nordmeyer, the Minister of Health, that “the defamation of national character of the Maoris involved in this slur (which slur may be very largely based on false surmises) is doing much to widen the gulf between Pakeha and Maori in the Northland.”<sup>109</sup>

Racial prejudices and fears for the sexual health of the European population evidently influenced both the surveys on Maori rates of venereal disease and the ways in which incidences of VD in New Zealand were dealt with. Cases of vulvo-vaginitis in mixed schools resulted in the refusal of European parents “to send their children to school for fear of infection”; which, by contrast, did not occur when similar cases appeared in European-only schools.<sup>110</sup> The same fear caused unsubstantiated claims about Maori nurses at the Hawke’s Bay Hospital, who were suspected of having imported into the children’s ward venereal disease from their communities.<sup>111</sup> Delegates to the ‘Medical Conference on Public Health Problems in N.Z.’ held in Wellington in 1940, who consisted of Department officials, members of the Medical Research Council, the Medical School, the Army Department, the British Medical Association, and two members from the Royal Australasian College of Physicians and Surgeons, adopted the resolution that “[t]he conference views with concern the high incidence of venereal disease amongst Maoris . . . and urges that in view of this racial menace even more vigorous steps be adopted.”<sup>112</sup>

Mass testing for venereal disease was applied exclusively to Maori communities, Maori patients on their first hospital attendance, and pregnant Maori mothers. Yet when a medical student from the University of Otago questioned the Department about using routine tests for syphilis similar to those adopted by America, the Department insisted that, as “mass testing could not be employed in a democratic state”, it could not be implemented in New Zealand.<sup>113</sup> Nevertheless, the positive results from testing, which identified Maori mothers

<sup>107</sup> Morton, op. cit., note 102 above, p. 255.

A European teacher at the Native School near Gisborne exclaimed that “the incidence of venereal disease among them [Maori] is terribly high . . . Everyone who works among them knows of it”. Quoted in Smyth, op. cit., note 4 above, p. 65.

<sup>108</sup> ANZW, H1 131/45/4, letter Doris Gordon (Director of Maternal Welfare) to Arnold Nordmeyer, 6 May 1947.

<sup>109</sup> Ibid.

<sup>110</sup> ANZW, H1 35/100 (13294), letter Gordon Dempster to Michael Watt, 16 July 1940.

<sup>111</sup> ANZW, H1 68/1/15 Hawke’s Bay Hospital—children with vulvo-vaginitis 1936–1938, MOH for Wellington report, 19 Sept. 1936. On the discrimination against Maori nurses, see also McKeeg, op. cit., note 55 above, pp. 149–50, 154.

<sup>112</sup> ‘Extract medical conference on public health problems in N. Z.’, *New Zealand Medical Journal* (hereafter *NZMJ*), 1940, 39 (214): 343. However, it is not clear whether this referred to concern about spread to Europeans or the welfare of the Maori population.

<sup>113</sup> Black and Farb, op. cit., note 93 above, p. 63. By comparison, other nations appear to have been less concerned about private rights. Wassermann tests were already routine in maternity wards in Melbourne in 1910. Scotland adopted prenatal tests in maternity homes increasingly during the 1930s. Davidson, op. cit., note 4 above, pp. 78, 161. In Chicago, mass testing was applied to organizations such as the *Tribune*. Suzanne Poirier, *Chicago’s war on syphilis 1937–1940: the times, the Trib, and the clap doctor*, Urbana and Chicago, University of Illinois Press, 1995, pp. 123–4.

who had contracted venereal disease, led the Department to contemplate having “every expectant mother, European and Maori, subjected to a blood test” which “may become [the] Department’s policy after the [Second World] War”.<sup>114</sup>

Practical considerations worked against the institution of the proposed mass testing programme. The financial and administrative burdens that testing placed on hospitals served to restrict even the Maori testing regime. To apply the tests in all maternity homes would have stretched resources even further, and the widespread screening of hospital admittance and maternity cases had already ceased by 1943. By this time, only one hospital in the Gisborne area was still complying with the departmental decree, while other hospitals ceased the Wassermann tests because of understaffing.<sup>115</sup> More importantly, the extension of this policy to all mothers attending maternity homes was not considered viable, as it was thought improper to subject European mothers to the stigma attached to venereal disease. The testing programme had no solid legal basis, for the tests were not covered by either the Venereal Diseases Regulations 1925 or the Health Act 1920—meaning that, despite Watt’s directive, there existed “no powers to compel all Maoris in the District to be examined for venereal disease”.<sup>116</sup> Nevertheless, most Maori Councils, which been established from 1900 for the purpose of improving Maori “health and welfare and moral well-being”, and which took an active part in requesting health advice for the whole Maori community, welcomed the examinations.<sup>117</sup> The findings of infection in the Te Hapua district in 1945, for example, prompted the Tribal Committee to press for the examination of the whole population, as they were “not satisfied unless everyone in these settlements is examined”.<sup>118</sup> The extension of sensitivity to Europeans alone in the matter of venereal disease, in this respect, both discriminated against Maori, and benefited Maori health by comparison with the health of those Europeans who remained untested, and thus untreated.

The Department’s stance was patently contradictory at times, with race-based concerns for European sexual health appearing to be as important as those for the sexual health of Maori. On hearing about possible infections in the Whakatane area, Watt insisted that investigations “must be dealt with promptly as otherwise there is a risk of the Maoris infecting the local European community”.<sup>119</sup> Yet in the circular to all Medical Officers of Health in May 1941, he stated that it was a matter of taking steps “to combat this disease *amongst* the Maori population”.<sup>120</sup> Thus the Department used a strategy similar to that

<sup>114</sup> ANZW, H1 131/45/4, letter Harold Turbott to Kenneth Davis, 31 Aug. 1943.

<sup>115</sup> ANZW, H1 131/45/4, letter Kenneth Davis to Michael Watt, 23 Aug. 1943.

<sup>116</sup> ANZW, H1 45/4/28, letter Michael Watt to A D Nelson, 6 Apr. 1932. This assessment was still valid in the 1940s despite the new 1941 Venereal Diseases Regulations.

<sup>117</sup> On the importance of Maori councils in implanting the Department’s health campaign, see also Mason Durie, *Whairoa: Maori health development*, Oxford University Press, 1994, pp. 41–4; Lange, op. cit., note 7 above, pp. 140–6, 186–8, 189–205, 225–8.

<sup>118</sup> ANZA, BAAK A358/143a, letter Secretary to Carlyle Gilberd, 28 May 1945.

<sup>119</sup> ANZW, H1 45/4/28, letter Michael Watt to Kenneth Davis, 14 Aug. 1939. On fears of the Department for European population in the early twentieth century, see Geoffrey W Rice, ‘Maori health and Heaton Rhodes as minister of public health, 1912–1915’, *NZJH*, 2001, 35 (2): 204–20, pp. 210–11.

<sup>120</sup> ANZA, BAAK A49/66b, letter Michael Watt to MOHs, 9 May 1941 (emphasis added). This is in contrast to the African setting where the intention of the government was to limit the contact between Africans and whites. See Jochelson, op. cit., note 4 above, p. 168.



pursued in relation to tuberculosis among Maori, which Dr N L Edison characterized as follows: “If the apathetic European conscience cannot be stirred by some desire to prevent and alleviate Maori morbidity, then, perhaps, some appeal to self-interest may be more efficacious.”<sup>121</sup>

### Conclusion

Between 1939 and 1947, health officials rushed to investigate the extent of venereal disease infection amongst hitherto overlooked Maori communities in remote areas of the North Island. The Department of Health’s campaign through the 1940s was “a work in progress”, grappling as it did with the wartime shortages of doctors, financial constraints and the difficulties of providing medical care for Maori in remote areas. Much of the Department’s approach to Maori with venereal disease, however, reflected what Derek Dow, the historian of the New Zealand Department of Health, has referred to as ad hoc in general.<sup>122</sup> Here, this ad hoc approach led to problems with the division of responsibility for Maori health, and Maori sexual health in particular, between the Department, hospitals, district nurses and doctors.

Public health campaigns against the spread of venereal disease had a definite impact on Maori. Surveys of Maori communities in the late 1930s and the 1940s revealed high incidences of infection, and the Department responded by attempting to detect and treat these cases. In fact, screening campaigns benefited Maori patients more than non-Maori, whose infections were left undetected and thus untreated. Yet, overall, socio-economic status and geographical isolation impacted more on the extent of Maori treatment than on that of non-Maori, a situation that proved difficult for the Department to rectify.

A public perception that Maori were riddled with venereal disease was an unfortunate result of attempts by the Department to emphasize the need to direct medical resources to isolated Maori communities. The reasons for the failure to provide Maori with effective venereal disease treatment schemes were diverse, ranging from isolation, socio-economic factors, administrative disputes and racial discrimination.<sup>123</sup> By the end of the Second World War, the Department generally believed that the main problem in Maori communities had been identified and treated, and that Maori would assimilate into the European community. Therefore, as far as the Department was concerned, any further attention following the 1940s campaigns seemed unnecessary. With hindsight, the campaigns of the 1940s illustrated that little was understood about the spread of venereal disease both in remote Maori communities and among urbanized Maori. They also showed that the Department and the medical fraternity had a limited understanding of Maori society and cultural beliefs, and that resources for treating the problem effectively were very inadequate.

It was not, therefore, just racial discrimination alone, but rather a combination of factors that contributed to the unsatisfactory outcomes of the Departmental response to revelations about the incidence of venereal disease amongst Maori in the 1940s. While the treatment of

<sup>121</sup> N L Edison ‘Mortality from tuberculosis in the Maori race’, *NZMJ*, 1943, 42 (229): 110.

<sup>122</sup> See Dow, op. cit., note 7 above, p. 173.

<sup>123</sup> For a similar finding in the debate about Maori infant health care, see Bryder, op. cit., note 21 above, p. 85.

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Maori with VD at that time bears some similarity to such campaigns waged in South Africa in the same period, the complexity of the relationships between the Department, hospitals, district nurses, doctors and Maori reveals that racial discrimination was not the key determinant in the provision of health care, nor in the official campaign against the spread of venereal disease amongst the Maori population.