Complicating Childhood: Gender, Ethnicity, and "Disadvantage" within the New Zealand Children's Health Camps Movement

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Abstract. By the mid-20th century New Zealand's children's health camps movement had gained the status of a national icon, highlighting children's health and well-being in a campaign unrivalled, before the 1960s, by any equivalent peace-time cause. The movement's long existence within a relatively small nation state with an increasingly vocal indigenous population makes it an ideal base from which to study challenges to the undifferentiated category of "the child." The success of the movement was based upon a highly unitary conception of childhood and an uncomplicated view of child health. The paper shows how at certain moments in the movement's development a blanket categorization of childhood was challenged, first by gender and later, and more substantially, by the ethnicities of health camp recruits. "Disadvantage" was a constant subtext, but its link with socio-economic status was downplayed in official discourses. Gender was highlighted in the 1920s and 1930s when girls' health needs were informed by (White) racial anxieties. Thereafter the physical and mental health needs of boys underwrote health camp recruitment and programs, even if this was not formally acknowledged. From the late 1980s, however, gender was subordinated to ethnicity. A growing focus on the Treaty of Waitangi issues and relationships of Maori to social services saw Maori children become visible in New Zealand's health camps as never before. With an acknowledgment of difference came competition for funds and an undermining of the national consensus about child health.

Résumé. Avant le milieu du vingtième siècle le mouvement en faveur des camps pour les enfants de santé fragile avait gagné le prestige de symbole national, mettant au premier plan la santé et le bien-être des engants dans une campagne qui n'a pas connu avant les années 60 la concurrence d'une autre

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cause equivalent de temps de paix. La longue durée de ce mouvement dans une relativement petite nation à une population indigène qui se fait de plus en plus entendre en fait une base idéale d'où on peut étudier la contestation de la catégorie indifférenciée de «l'enfant». La réussite du mouvement s'est fondée sur une notion fort unitaire de l'enfance et sur une vue sans complications de la santé infantile. On démontre ici comment à certains moments du développement du mouvement une catégorisation générale de l'enfance a été contestée, d'abord à l'égard du genre et ensuite, d'une façon plus importante, à l'égard de l'ethnicité des enfants reçus dans les camps. «Le désavantage» était un thème sous-jacent constant, mais son lien avec la situation socio-économique a été minimisé dans les sources officielles. Le genre a été mis au premier plan pendant les années 20 et 30 quand les besoins de santé des jeunes filles étaient fondés sur les préoccupations raciales (de caractère blanc). Par la suite les besoins de santé physique et psychique des garçons ont déterminé le recrutement et les programmes des camps for les enfants de santé fragile, même si l'on ne l'a pas formellement reconnu. Depuis la fin des années 80, cependant, le genre a été d'une importance secondaire par rapport à l'ethnicité. Un accent plus persistant sur les questions entourant le traité de Waitangi et sur les relations des Maoris aux services sociaux a fait augmenter d'une façon sans précédent le nombre des enfants Maoris vus dans les camps. La différence ayant été reconnue, sont apparus à la fois une concurrence pour les crédits et un ébranlement de l'accord national sur la santé des enfants.

Over the first part of the 20th century, health camps, residential open-air schools, and tuberculosis "preventoria" were presented in many western societies as models of healthy lifestyles for children, incorporating into their programs wholesome and plentiful food, exposure to sunshine and fresh air, and regular rest and sleep. As sites which captured populations of children for varying periods of time and exposed them to ideal regimes, they also provided a stage on which wider social concerns were acted out. In New Zealand a children's health camp movement has been in existence for over 80 years, bringing together state medicine and voluntary endeavour in its evolution and administration. Its longevity and high profile within a relatively small nation state with a strong and increasingly vocal indigenous population make it an ideal base from which to study challenges to the undifferentiated category of "the child." Gender and ethnicity were key components of such challenges in New Zealand and are highlighted in this article, but "disadvantage," variously constructed, was also a consideration. Over the 20th century, socio-economic status, race, and gender were respectively suppressed, ignored, and selectively highlighted in the children's health camps movement.

New Zealand's children's health camps were inspired by the open air schools and charitable holiday camps of Europe and Great Britain, but acquired a distinctive institutional form in the New Zealand setting. They developed from 1919 as short-term summer holiday camps held
in the country, at the seaside, or in some other temporary venue. Supported partly from voluntary donations, they drew on growing government financial and personnel support, and by 1945 had evolved into year-round operations, located in permanent buildings with attached schools. They remain in existence in six venues, funded overwhelmingly from government contracts and children attend, as they always have, on a voluntary basis with parental or caregiver consent. The heyday of the health camp movement was from the 1940s to the 1960s, during which time the camps gained icon status within New Zealand. A major factor in this was the annual health stamp campaign which saw the issue of a special postal stamp with a ‘health’ surcharge dedicated to the camps. This campaign drew upon the resources of youth groups, service clubs, and schools, as well as New Zealand’s Health and Post and Telephone Departments and was a predecessor of the now commonplace annual marketing campaigns employed by most national charities. The stamps, associated films, and other publicity linked the camps with ideal childhood in New Zealand. Their images were of active, happy and, until recent times, white-skinned boys and girls playing sport, frolicking in the sea, and generally enjoying a vigorous outdoor existence. For a period of approximately two months each year children’s health was promoted as a national issue, and a campaign, unrivalled until the 1960s by any equivalent peacetime voluntary cause, highlighted these images in schools, post offices, cinemas, and other public spaces. In mid-century “homogenising narratives of nationhood,” the health camps movement became a fulcrum of concern for childhood. The image of childhood promoted was cozily optimistic and determinedly uncomplicated.

Internationally, a good deal has been written about the transformation and idealization of childhood over the later 19th and early 20th centuries. The boundaries between childhood and adulthood are seen as becoming increasingly firm across social categories, while childhood itself became a distinctive, protected, and sometimes romanticized stage of human development. Over the first half of the 20th century, “the child” was firmly identified as the key to social betterment. As Roger Cooter has pointed out, this process largely de-sexed children, casting them into a “gender-free zone of attributed innocence,” though notions of childhood were early intersected by class in the British context. In New Zealand, too, variations in socio-economic status were sometimes acknowledged, but as the 20th century progressed and the welfare state expanded its outreach, such differences were increasingly downplayed. In this former British colony with a Maori population increasing in numbers and in political assertiveness, race was to become a sharper point of intersection after the 1950s—though earlier silences
about Maori children were significant in themselves. However, there were moments when gender also posed a challenge to unitary concepts of childhood and where the respective needs of boys and girls were explicitly or implicitly asserted over each other.

Figure 1

Health camps were a more active experience for girls than suggested by this health stamp campaign poster, but gendered images of this kind were common in publicity. (Reproduced by permission of New Zealand Post Limited from their 1937 health stamp campaign.)
The first children's health camps were held in New Zealand following the first World War, when there was a strong official consciousness about the rejection rate among army recruits and the need for a healthy generation to replace those fallen in the war. As in other Anglo-settler dominions of the time, "race" effectively meant Whiteness of Anglo-Saxon origin. This needed to be defined against racial "others," and these others varied according to circumstance. In New Zealand, as in Australia, Anglo-Saxon purity was seen to be threatened by Asian peoples to the north, who were supposedly casting covetous eyes on the antipodean outreaches of British empire. Internally, there was some paranoia about Asian migrants, but as the majority of New Zealand immigrants were still British a more insidious threat was identified within "the race." As a 1924-25 Committee of Inquiry into Mental Defectives and Sexual Offenders concluded:

New Zealand is a young country already exhibiting some of the weaknesses of much older nations, but it is now at a stage where, if its people are wise, they may escape the worst evils of the Old World. It has been rightly decided that this should be not only a "White man's country," but as completely British as possible. We ought to make every effort to keep the stock sturdy and strong, as well as racially pure. . . . The Great War revealed that from [the] loins [of the pioneers] have sprung some of the finest men the world has ever seen, not only in physical strength, but in character and spirit. It also revealed that an inferior strain had crept in and that New Zealand was already getting its share of weaknesses. . . . In these beautiful and richly dowered islands we have a noble heritage—to be in keeping and to ensure the full development of their resources and enjoyment of their blessings the inhabitants should be of the highest type obtainable by human effort.

The eugenicist orientation of the Committee is clear in its report, but in New Zealand eugenics always had a strong environmental orientation, with some of its most vocal advocates acknowledging that heredity might be modified by early intervention in a child's rearing. Significantly, half the members of this Committee were officials from the School Hygiene, Education, and Child Welfare sections of the public service and one, school doctor Ada Paterson, was to be a leading light in the health camps movement.

There are a number of international studies which compare the experiences of indigenous peoples in the face of European settlement, some of them focusing on British settler colonies. Inasmuch as they were included in racial discourses, Maori were perceived as closer to Whites than most brown-skinned indigenes, and therefore potential candidates for assimilation with the majority of settler descent. While Maori had lost the best of their lands and had largely been reduced to the position of a rural proletariat by the early 20th century, Maori values remained strong, as did traditional leadership, despite the emergence of new
forms of political expression and new Maori leaders who were conversant with both Maori and Pakeha worlds. To this extent they were in a stronger position than many indigenous peoples after the First World War. Nonetheless, "similarity" and relative proximity to Whites on the racial scales of the time was a double-edged sword. Social policy was predicated on the assumption that Maori assimilation into the majority population would occur quite readily. Although at a local level there were attempts at Maori autonomy and self-determination in health service delivery, official policies were increasingly geared to the integration of Maori services. There was a separate Maori Division of the Department of Health in existence under Maori doctor and former parliamentarian Peter Buck (Te Rangi Hiroa) during the 1920s but it was later disbanded, and from 1930 Maori health was added to the general work of medical officers of health and district nurses. Such "mainstreaming" (as it would now be termed) did little to underline differentials in health status between Maori and Pakeha, though one significant study published in 1935 showed a Maori death rate from tuberculosis 10 times that of Pakeha. It also meant that Maori perceptions of health were subordinated to Western medicine, though many of the district nurses did learn to take account of local custom in delivering services.

Ironically, while the first children's health camps were promoted as a major force in the campaign against tuberculosis, Maori children were not targeted as recruits. Where race fused with gender in the consciousness of early organizers, it reflected the concerns about White superiority, numerical and physical. Other writers have commented on women's role in maintaining the racial boundaries of nationhood, both as biological reproducers of racial and ethnic groups and as transmitters of group and cultural ideologies. In New Zealand, as elsewhere, debates about racial efficiency took their most prescriptive form in relation to the mature, fecund, female body, but this was one time when they also encompassed the health of pre-pubescent Pakeha girls. Boys needed to grow up fit and strong to defend the British Empire—of which New Zealand was a fiercely loyal component—but girls were its future breeders and, even before puberty, they were never free of their adult destiny. Infant welfare authority Frederic Truby King founded the Plunket Society in 1907 and went on to become one of New Zealand's most vocal child health advocates and Director of the Child Welfare Division of the Department of Health in the 1920s. He was just one of those asserting the need for young girls to be kept in the "best possible physical condition" but, as some school doctors were also pointing out at this time, school medical inspections suggested that girls' incidence of "defect" in nearly every category of examination exceeded that of boys. One school doctor, Ada Paterson, pointed out that:
In modern civilization the girl is brought up under less favourable circumstances than the boy... In the poorer homes [the girl] has a considerable amount of indoor work, which curtails the time spent out-of-doors. In the better-class homes she is often a victim of parental ambition and is made to spend profitless hours at practising [music] or producing useless fancy-work. Her clothing does not give her the same opportunities for healthy development as does that of the boy.\textsuperscript{15}

Health camps were seen as exposing housebound girls, in particular, to outdoor exercise and fresh air, and releasing them from the constraints of domestic tasks and responsibilities. And, at a time when the camps were supposed to turn recruits into "health missionaries," who would take new ideals of personal hygiene and good habits back into the family setting, girls were considered the more effective promulgators of such doctrines, both as children and as future mothers.

It is worth noting that while Paterson peripherally acknowledged socio-economic differences in this report, she and other school doctors increasingly underplayed their importance to child health in the New Zealand context. Some of the first, informal health camps of the 1920s and 1930s were certainly run by committees of local worthies who saw themselves as providing holidays for the poor. However, parental consent was needed for a health camp stay and any charitable connotations were soon suppressed as discouraging parents' co-operation. Health camps needed to be seen as desirable places for children to attend, not as shameful or punitive adjuncts to state child welfare policies. Official discourses increasingly presented "needy children" as coming from all sections of the community and, as the prime agents of health camp selection, school doctors and nurses made a point of sending children from a range of social backgrounds.\textsuperscript{16} Paterson was later to insist that "Extremes of poverty and riches found in older lands and incidental to industrialism are absent [in New Zealand], the necessities for healthy growth being available for almost all,"\textsuperscript{17} and even in the depression she publicly attributed poor nutrition to maternal mismanagement.\textsuperscript{18} Disadvantage was represented by Paterson and her successors in the movement as a matter of rearing rather than resources. No child was exempt from inadequate or ill-judged mothering, and here the lifestyle education of girls was critical.\textsuperscript{19}

The first children's health camps of the 1920s seem to have taken in boys and girls in roughly equal numbers, both sexes participating in vigorous outdoor activities inspired by military routine and precedents. (This replicated the usual pattern in New Zealand primary schools of the time, which were overwhelmingly coeducational.) But it is significant that the few single-sex camps were for girls, and were run in the 1930s by the Christchurch-based Sunlight League. Inspired by the British association of the same name, the Sunlight League wrote admiringly
of Nazi attempts to restrict the procreation of the unfit, but generally placed more emphasis upon attempts to modify heredity through exposure to sunlight, good food, education, and fresh air. The local leader of the Sunlight League, a woman named Cora Wilding, went in for small-scale health camps which catered to girls aged 9 to 12. Accused of discriminating against boys, Wilding defended all-girl camps on the basis that girls would in future have the main work of teaching laws of health and physical fitness to succeeding generations. As she pointed out, they had less opportunity than their brothers to enjoy camping and outdoor life in the normal course of events. In the 1970s and 1980s, the sheer physicality of the health camp routine was criticized for failing to meet the needs of children of a more contemplative bent, and girls in particular. In the interwar period it was seen as releasing girls from the gendered constraints of their normal existence.

Nonetheless, the protests directed at all-girl camps anticipated a shift in the discourse about child health over the next decade. Despite advocating all-girl health camps in the 1930s, Cora Wilding participated in a more general shift in emphasis that came with the second World War and with the advent of permanent, year-round health camps. Acknowledging that the first camps had been for girls as “mothers of the future,” she explained in the mid-1940s that changed conditions had made boys’ camps the more important. Boys at an impressionable age missed the influence of fathers on service overseas, she explained, and boys’ camps, run by the right kind of man, would provide excellent training ground in the democratic principles believed necessary in the postwar era. While school doctors some 20 years earlier had highlighted the inferior health of school girls, by 1940 their annual reports were supplying statistical evidence that boys’ nutritional status was the poorer. One newspaper commented in 1944 that the overwhelming predominance of boys on health camp waiting lists confirmed a popular belief that little boys were “harder to rear” than girls. The first World War and racial discourses of the interwar period had seemed to foreground the importance of the female body—including the pre-pubescent female body—as the bearer of future generations, but the second World War coincided with closer attention to the health and well-being of boys. Boys’ future participation in public life made them the more effective vehicles for the optimistic, democratic values of the postwar era. There may also have been another factor operating here: the mid-century has been seen as a period of increasing anxieties about the male role in New Zealand. As society became more urbanized and distanced from the “pioneering” period, as distinctive male enclaves were restricted and controlled, and more and more New Zealand men saw themselves locked into the breadwinner role, definitions of masculinity became
more complicated. Boys were variously future leaders and family men or, more problematically, delinquents or possible homosexuals.\textsuperscript{24}

This development was tied up with broader definitions of health which became firmly established over the mid-century. Admissions to health camp were justified less exclusively on physical grounds and began to take on board behavioural dimensions of well-being\textsuperscript{25} Associated with this was a decline in the reported incidence of physical disorders such as tuberculosis and other infectious diseases and, with antibiotics, alternative ways of treating them. Nation-wide height-weight surveys of primary school children also suggested improved standards of nutrition.\textsuperscript{26} Broader conceptions of health reflected international trends for a wider range of professional "experts" to have access to school-aged children, most particularly through child guidance and psychological clinics. Such clinics were first established in the United States in the late 1900s and in Britain over the 1920s, with New Zealand facilities opening from the late 1930s. A special committee was convened by the national board of the children's health camps movement in 1957 to consider the implications of an apparently changing clientele, and it recommended that better quality staff be sought to handle intakes which included "emotionally disturbed" children. In his evidence to the Committee, New Zealand's Director-General of Health estimated that health camps had a mixed clientele which was approximately 50% physically debilitated and 50% emotionally disturbed.\textsuperscript{27} The conceptualization of the healthy child now included a sturdy mind as well as a sturdy body—the potential health camp recruit was as likely to display a problematic psyche as a physical ailment, and to be identified as coming from a home in some way disordered.

Boys appear to have dominated waiting lists for a health camp placement from the 1940s to the present day.\textsuperscript{28} However, most of the permanent health camps were built with equal numbers of beds for boys and girls (the exception to this is the last to be opened, in 1983, and it has two boys' units; only one for girls). Before the 1980s there was surprisingly little analysis of this. Statistics on admissions were seldom broken down by gender, and complex cases were usually translated into health terms, the vague classification of "debility" providing a useful catch-all for statistical purposes. But case materials from the mid-century suggest a growing preoccupation with the inappropriate home and classroom behaviour of boy recruits to health camp, in particular. In the 1940s and 1950s this frequently encompassed concern about insufficiently masculine behaviours, characterized by "nervousness" and excessive tears, clinging to adults, and generally "sissy" or effeminate behaviour, some of which was blamed upon mothers' own nervous tension and possessive behaviour. It reflected insecurities about the male role mentioned earlier.
Health camps files provide examples: “Martin” was an 11-year-old boy selected by a local public health nurse in 1955 to go to a South Island health camp. Martin was recommended for health camp because he was highly emotional, found school life a severe strain, and was frequently reduced to tears. His father was described only as a dairy farmer, and his mother—by implication the cause of Martin’s problems—as a “tense, energetic woman of spare frame and severe mien—whose life was a continuous frantic cycle from cow-shed to farm-yard to house and children and back again.” The report noted that “her standards for her children appeared always a little beyond their capabilities or rather impressed the boys with a sense of inadequacy.” She provided good nourishing food but “anxious urging destroyed appetites and the possibility of failing to meet the standard at school gave restless nights.” Martin was listless and unco-operative at school and burst into tears on the slightest provocation.

As a result of a health camp stay the public health nurse reported that Martin was much less easily upset than previously, and had realized his abilities, the benefits of helping the teacher, and being an example to younger boys. He was still among the academic plodders in class but was no longer crushed by this state. The opportunity of community life in health camp, and of seeing others less fortunate than himself was said to have given him a “broader and steadier” approach to his problems. But, significantly, the mother had also seen the light and, the report said, was less openly critical of her “nervy children,” instead extolling their prowess at athletics. The case says as much about the pressure on a rural mother to be a virtually full-time farm worker while meeting new standards of motherhood, as it does about the child. Here, as in so many of the cases of the time, the mother was said to have learnt about the management of her own child, who had returned from health camp no longer “nervous and emotional” but a “real boy.”

By the 1960s and 1970s, concern focused more on the excessive masculinity of boy recruits to health camps, manifest in aggression and destructiveness. There was a marked increase in reports of breakages, so-called “hooliganism” and absconding from health camps over the period. Health camp managers complained about unbalanced intakes of children, with too many instances of behaviour problems among them, as both parents and teachers sought a period of relief from difficult children. The gender dimension of the situation was barely touched upon in the health camp’s published reports, though matrons’ notes and registers were often more specific: “The boys were a very difficult group, many breakages of furniture”; “It has been a pleasure to have this group of girls, no problems at all with them. Most of the boys have been a very trying group, with many behaviour problems.” It was not until a min-
isterial inquiry into the health camp movement was initiated in 1983 that gender was officially problematized as an issue with which the movement would have to deal. This, the so-called "Hancock Inquiry" was headed by a former child welfare officer, university lecturer, and private counsellor who was also heavily involved in the Men Against Violence movement and was influenced by feminist analyses of gender inequities. It took place in an environment where issues of discrimination against women were being recognized within official agencies and at a stage when sexual abuse was being identified as a child welfare issue. In terms of an on-going subtext within the movement, it is worth noting that the inquiry also took place against a background of declining real incomes for low income families and that this was highlighted as a matter of concern in the report. However, the suggestion of possible socio-economic differentials in health camp intakes was politically unpopular and continued to be downplayed in broader publicity.  

By the 1980s more complete statistics were being kept on health camp intakes. The report from the 1984 Hancock Inquiry noted a significant difference between the sexes in reasons for health camp referral, with boys being referred for behavioural problems and girls for such family reasons as parental illness and stress or family tension. In other words, girls were being admitted for reasons outside themselves, while boys were more likely to be seen as the cause of their own admission, and to be exposed to specialist programs to deal with their problems. Where camps had a 50:50 admission quota, public health nurses frequently had trouble filling beds for girls and were sending them on less well-substantiated grounds. But the inquiry also suggested that the demand for services for boys was so strong that it may have been masking girls' real needs; that the pattern of upbringing in New Zealand households was such as to make their behaviour at home and in schools less demanding. In this situation, the inquiry suggested, depressed or unhappy girls' needs may have been overlooked. Recommendations from the inquiry suggested the need for differential responses to boys' and girls' health needs and occasional separate camps for boys and girls where demand existed. It is worth noting that where the latter recommendation was implemented, it usually involved health camps held solely for boys in attempt to reduce waiting lists, and that experiences of all-boy camps in the 1990s were considered so difficult for staff that camp managers often declined further such experiments. Health camps, like other agencies, came to share in the flourishing "anger management" industry and girls continued to be regarded as a moderating influence on male behaviour.

The Hancock Inquiry pointed to another dimension which the health camps had often ignored in their publicity as well as practice: the
changing ethnicity of health camp recruits. This, even more than gender, had come to undermine the cozily inclusive categorization of childhood promulgated in health camp publicity. As noted earlier, the movement’s origins were firmly embedded in a particular conception of race which, if it did not specifically exclude Maori, certainly did not embrace Maori childhood. An episode at one of the first children’s health camps, at a North Island beachfront site in 1929, encapsulates their Pakeha orientation. As the girls paddled or washed their hair in a nearby stream, and the boys “played red indians” and mounted raiding parties in the hills, “Good-natured Maoris came from the neighbourhood to conduct a haangi [the term for a Maori oven].” The Maori cocked a meal for the children and “gave folk songs and a war cry,” their leader, Mr. Ngakihui Tamihana, expressing pleasure at being able to help European children. His party donated fruit, vegetables, and eggs to the camp, and endowed it with a Maori name after an ancestor of their people. Interestingly, this exchange undercut some of the usual paternalist assumptions about interactions between Maori and Pakeha—here it is Maori acting as donor to European children perceived in need of help; it is Maori giving permission, in effect, for the use of the area, and stamming their authority by conceding a Maori name for the camp. But the perception by Maori and Pakeha alike is of the camp as a Pakeha enterprise.

Nonetheless, as Maori urbanization accelerated over subsequent decades and Maori came under school medical inspection, even in rural areas, more Maori children were selected by district nurses for a stay in health camp. Their “Maoriness” was seldom acknowledged, only Maori names in case notes indicating that certain children might somehow be different from the main body of recruits. Where the admission of Maori children drew comment at the national Health Camps Board level, it was simply to endorse broader policy goals of integrating Maori into the Pakeha mainstream. As early as 1937 the Board had rejected holding separate camps for Maori children and administrators agreed in subsequent years that it was mutually advantageous for Maori and Pakeha children to be admitted to camps together. The camps’ already strong socialization function took on an assimilationist thrust, and where reports did acknowledge Maori entrants to health camps, it was to commend their adoption of approved habits. Occasionally case reports noted with satisfaction how Maori-speaking children left camp chattering away in English. For public consumption, however, the inclusion of Maori children was deliberately underplayed: as one Medical Officer of Health privately warned the Health Camps Board in 1957, there was a need to tread warily lest a stigma be attached to the camps, either from their charitable associations, from the reflection they were
seen to cast on mothers of children selected, or from a "race consciousness, as in some quarters there is the perception that camps are primarily for undernourished Maoris of the worst type." A national consensus about the importance of child health and welfare depended upon the erasing of difference and simplistic responses to problems when they became apparent.

Figure 2

The Maori greeting and dark skin of the cartoon character in this health camp poster of the early 1990s show how Maori children were targeted in publicity, but the reference to "hard-case Harry" hints at the behavioural dimension to late 20th-century health camp intakes. (Reproduced with permission of Children's Health Camps Board.)
Health camps consequently played their part in perpetuating mid-century ideals of New Zealand as a classless and raceless society where Maori and Pakeha were equal, largely by rendering invisible Maori needs, culture, and differentials in well-being. This went along with a muting of earlier Pakeha claims to Anglo-Saxon identity. By the mid-century,

No one thought of New Zealand identity in "racial" terms as White. New Zealand society and Pākehā culture were valued for their own sake as normal and necessary, without requiring any justification along racial or ethnic grounds.... It would take a more concerted effort to pry open the realisation that New Zealand identity was inextricably linked with European culture, infused with colonialist assumptions, overwhelmingly White in orientation, and larded with self-serving myths. 39

The concept of "Whiteness" was soon to be reasserted, but in a critical mode which overturned earlier, celebratory usage of the term.

In the 1980s the children's health camp movement was just one of a number of long-standing institutions caught up in what has been termed the "sovereignty bombshell." 40 Maori protest, mostly over land issues in the 1970s, took an even sharper turn in the following decade with claims which ranged from an end to Pakeha monoculturalism, to absolute Maori ownership of New Zealand. This was part of a broader, international assertion of indigenous rights challenging White settler governance in the most fundamental ways. Although Maori protests reflected global trends, they also included elements that were embedded in New Zealand's past, most particularly a grounding in New Zealand's "foundation document," the Treaty of Waitangi. 41 The Treaty, signed in 1840 by Maori chiefs and representatives of the British crown, accorded British citizenship and gave other significant guarantees to Maori in exchange for Crown authority. While treaties were signed with indigenous peoples elsewhere, as Ken Coates has pointed out they did not generally involve "negotiated rights, established between two sovereign powers and designed to forge lasting relationships," as did the Treaty of Waitangi—in theory at least. 42 In the years following 1840 the Treaty was often ignored, but in the 1980s it was strongly reasserted as the basis of New Zealand's ethno-politics. One consequence of its authority was the privileging of biculturalism as official policy at a time when Australia and Canada, countries with more diverse immigrant populations, were moving towards multiculturalism. 43 Although challenged from some quarters, biculturalism in New Zealand acknowledged contemporary Maori and Pakeha as descendants of the Treaty signatories. Indigenous rights were defined as Maori rights, though at various times and on various issues, the notion of a Maori collectivity was contested by tribal ethnicity and identification. The situation re-
flected "a clearly identifiable cultural homogeneity, expressed in a com-
monality of language and customary practice" among Maori, com-
pared with First Nations peoples elsewhere. Although losing much of
their land, Maori had not been placed in reservations, had political rep-
resentation, and represented a higher proportion of the total population
than indigenous populations in Australia and Canada for example—all
factors affecting attempts to improve Maori health status.

This summarizes in very simple form developments and debates
which have generated an enormous literature, judicial and political pro-
cesses, and a good deal of institutional and personal angst in recent
years. What did they mean for an established organization dealing with
children's health and well-being; a body which was already accused of
being stuck in the 1950s? The Maori language version of the Treaty,
which, translated, is broader than the English, exchanged for Crown au-
thority a guarantee of te tino rangatiratanga, or chieftainship, and taonga
katoa, loosely translated as "treasures" or "all things precious." Te tino
rangatiratanga came to be equated with Maori autonomy and control
over issues concerning Maori, including social policy concerns, while
the term taonga was taken to include cultural as well as material prop-
eties,
and was extended to children, language, and health. The "owner-
ship" of Maori children was especially contested in the child welfare
field, but their removal from whanau (extended family), even for a tem-
porary stay in a health camp, was also questioned. Following the 1988
report of a Royal Commission on Social Policy, three key principles
were seen as linking the Treaty of Waitangi and government social pol-
icy: the principles of partnership, participation, and protection. All of
this had implications for children's health camps which, like other bod-
ies in receipt of government funding, had to take on board a commit-
ment to Treaty principles over the 1980s and 1990s.

While the Hancock Inquiry into children's health camps had not di-
rectly referred to the Treaty, it had certainly identified a lack of Maori in-
put to the movement; a lack of partnership in terms of consultation over
policy, negligible Maori participation in camp management, and little
that was deliberately targeted towards the protection of either Maori
children's health or their culture. The report had also foregrounded
the changing ethnicity of health camp intakes, showing that whereas
12.5% of the population in the 5-12 year age group was Maori, 33% of
those entering health camps in early 1983 were Maori (and 6%, mostly
those attending the Auckland health camp, were from Pacific Island
backgrounds). Maori and Pacific Island children differed from Euro-
pian children entering health camps on a number of counts. They were
more likely to be living with a family member other than a biological
parent, came from larger families on average, and from homes charac-
terized by referral agencies as having poor hygiene, nutrition, or home management, or as being overcrowded.50 The supporting study on which these conclusions were based noted that health camp recording systems were largely silent on the subject of ethnicity, only one camp specifically including the information on its admission form. When approached to supply information, some districts were reluctant to do so, fearing to be labelled "racist" merely by recording such details. "Unfortunately," it noted, "a frequent corollary of this perspective is the notion that all children, whether Pakeha or Polynesian, should be treated the same. Inevitably, the ethnocentric view of the dominant culture determines the manner in which children will be treated."51

From the mid-1980s, then, the ethnicity of children admitted to health camp, and of Maori children in particular, became an issue. The all-inclusiveness of the category of "child" was officially fractured and the cultural homogeneity of the health camp experience publicly challenged. Maori and, to a lesser extent, Pacific Island children became visible, literally and figuratively: for the first time health stamps showed children of markedly darker hue, and posters and other publicity included children of obvious Polynesian descent. The response at health camp level varied according to the ethnicity of local intakes. At the Gisborne camp, on the East Coast of the North Island, as many as 60% of children were Maori, and attempts to make the camp a comfortable environment for Maori children preceded the Hancock report.52 The camp was adopted by a local marae, representatives from the local Department of Maori Affairs were included in case discussions over the 1980s, and by 1990 a kohanga reo or Maori language pre-school was based at the health camp. Other camps gained funding for a kaumatua or elder, or a Maori field worker to liaise with Maori parents and local marae, and there were attempts to employ Maori staff in positions other than domestic.53

At national Health Camps Board level the response was slow, but it was hastened by a government shift away from deficit funding through the Health Department to more competitive funding models in the early 1990s. As has happened among First Nations peoples in Canada,54 tribally based Maori authorities successfully claimed government funding for their own autonomous ventures. Other organizations wanting a share in government health revenues had to demonstrate a commitment to Treaty principles. Contracts signed between the Children's Health Camps and government health funding authorities in the 1990s required the camps to "apply the principles of partnership, participation and active protection of Maori interest in their management, employment and service delivery policies and practice."55 Reference to the Treaty was made in the service requirements and was expected in the
inevitable mission statements issued from the late 1980s. The Children’s Health Camps Board began to speak of “holistic” conceptions of health, which were seen to be in keeping with a Maori integration of the spiritual and physical, to emphasize the movement’s “long, close and positive” relationship with Maori, and its delivery of programs in a “culturally appropriate manner.”

Within the camps the visibility of Maori children was now an asset to the movement, an avenue to continued funding, and an indicator of the camps’ relevance to contemporary New Zealand. Ethnicity overshadowed gender as an issue of concern, and although a majority of male Maori children was sometimes implied, ethnicity and gender were not correlated. A 1999 evaluation of children’s health camps for the government’s Health Funding Authority gave no gender breakdown of intakes, instead constructing “equity” as a rural-urban access issue or as one relating to Maori health.

The report mentioned only in passing that the principal source of income for 56% of attendees’ households was a social welfare benefit and that only 29% of health camp children lived with two parents.

As an organization existing for more than 80 years, one which is still “a national icon well loved by politicians and supported by local voluntary action groups”—as even its critics reluctantly concede—the children’s health camps movement illustrates many broader themes in New Zealand society writ small. Not least, it shows changing conceptions of health over time, as reasons for referral shifted from risk of tuberculosis and nutritional deficiency to behavioural problems and mental and emotional health. But from the perspective of this article, the movement shows how a blanket categorization of “childhood” was challenged at certain moments in the movement’s development, by gender and later, and more substantially, by an appreciation of the ethnicity of health camp recruits. “Disadvantage” was a constant subtext, but its link with socio-economic status was muddied by reference to inadequate parenting, “overenthusiastic” or anxious mothers, the continued referral of children from relatively comfortable homes, and the suppression of poverty in official health camp discourses. Disadvantage could take various forms, and gender was highlighted first in the 1920s and 1930s, when girls’ health needs were informed by (White) racial anxieties. Thereafter the physical and mental health needs of boys underwrote health camp recruitment procedures and programs, even if this was not always formally acknowledged. It was not until the 1980s that an official inquiry influenced by feminist concerns recommended differential responses to boys’ and girls’ health needs, in the same way that the special health needs of women had been recognized. But gender was quickly subordinated to the growing focus on Treaty of Waitangi issues and relationships of Maori to social services. Official
policies of biculturalism and the need for accountability with regard to treaty principles saw Maori children become visible in New Zealand’s health camps as never before.

In the long run, this more recent fracturing of childhood has created problems for health camps as a national organization receiving over $NZ 7.2 million annually from government. The success of the movement and its high public profile over the mid-20th century were based on a highly unitary conception of childhood and an uncomplicated view of child health. This meshed well with the tranquil discourses of mid-century New Zealand as a homogeneous society where children were supposedly better off than anywhere else in the world—and if they were not, matters could readily be put in order through mass health camp intakes and exposure to a simple routine of sleep, good food, and fresh air. The acknowledgment of children’s varying health needs and ethnic and socio-economic status, and the suggestion that boys’ and girls’ requirements may be different, raised the prospect of specialist programs better provided by competing agencies. More generally, it has led to decreased optimism about children’s health and undermined consensus about appropriate solutions. The complicating of childhood has led to a multiplicity of responses to health needs and ongoing debates about the appropriate targeting of funds on the basis of ethnicity or “need.”61

NOTES

1 I would like to thank the anonymous referees of this article, who made extremely helpful suggestions.


6 For a useful discussion of this in the Canadian context see Mariana Valverde, The Age of Light, Soap and Water: Moral Reform in English Canada 1885-1925 (Toronto: McClelland and Stewart, 1991), chap. 5; Angus McLaren, Our Own Master Race: Eugenics in Canada, 1885-1945 (Toronto: McClelland and Stewart, 1990), chap. 3.

7 Report of Committee of Inquiry into Mental Defectives and Sexual Offenders, Appendices to the Journals, House of Representatives [AHR], 1925, I-31A, p. 28.


The term "Pakeha" is commonly used in New Zealand to refer to non-Maori persons of European descent.


Earlier comparative work by the author of the tuberculosis study, Dr. H. B. Turbett, suggested Maori superiority over European children in physique and dental hygiene, but a higher Maori incidence of conditions linked with indigence, poor diet, and poor housing, most especially infectious skin, eye, and ear disease, along with respiratory disease. "Maori and Pakeha: A Preliminary Study in Comparative Health," AJHR, 1929, H-31, p. 73-74.

Radhika Mohanram, "(In)visible Bodies?," p. 23; see also Nita Yuval-Davis and Floya Anthias, Woman-Nation-State (London: Macmillan, 1989).


This is reinforced by oral evidence and written recollections gathered in the course of my research, where informants who regarded themselves as from comfortable homes reported being sent to health camp for reasons which mystified them and which seemed to have been taken personally by their mothers.


Address by Dr. A. Paterson to School Committees Association, 21 September 1932, H1 35/70 (B.11), National Archives, Wellington [NA].

References to anxious, overenthusiastic, and overindulgent mothers as well as incompetent ones abound in the reports of school doctors from the 1930s, and some children were clearly sent to health camp because they were "spoilt 'only' children." "Overindulgence" was one of the categories for admission to Otaki Health Camp in the early 1940s. See, for example, Annual Report, Otaki Health Camp, 1940, p. 8; Annual Report, Division of School Hygiene, AJHR, 1939, H-31, p. 44; Press Cutting, Otago Daily Times, September 1954, Press Cuttings, Roxburgh Health Camp, Roxburgh; and "Follow-Up of Cases," 18 April 1961, Maunu Health Camp Archives Box, Whangarei.


Draft of letter [1936?], Cora Wilding Papers, 1,7, University of Canterbury Library.


This conclusion is based upon comments in health camp annual reports, intermittent series of registers from the Roxburgh, Pakuranga, and Gisborne camps, unpublished reports undertaken by medical students and other professionals, Health Department memos, and a 1957 Committee on Children's Health Camps which was established especially to consider the question of a changing clientele and how best to respond to this more varied intake. See Committee on Children's Health Camps, 1957, H1 261/3 (26743), NA, Wellington.

For example, a 1954 survey suggested that a 15-year-old boy was, on average, 100 mm taller than his counterpart in 1934. See H1 35/37 (33808), NA, Wellington.

Dr. H. B. Turbott to Committee on Children's Health Camps, 1957, H1 261/3 (26743), NA, Wellington.


Glenglo Follow Up by Nurse Inspector, 1955, H1 261/16 (31850) NA, Wellington.

See, for example, Medical Officer's Report on Otaki Health Camp, 12 April 1965; J. Murphy to Medical Officer of Health, 3 March 1965, H1 263/2 (32851), NA, Wellington.

Quotes from Gisborne Children's Health Camp Register 1941-76, Matron's comments on intake, 18 June 1970; 4 November 1975.

M. Hancock, interviewed by M. Tennant, 5 June 1991.


Auckland Star, 7 January 1929, reprinted 1944. Education Department Files, Waikato Museum.

Although more heavily concentrated in some parts of New Zealand than others, Maori had never been shifted into reservations. In 1951 19% of Maori lived in boroughs and cities; by the 1970s this had increased to 75%. See Ranginui J. Walker, "Maori People since 1950," in Geoffrey W. Rice, ed., The Oxford History of New Zealand (Auckland: Oxford University Press, 1992), p. 500-3.

Secretary, Auckland Central Council to Dominion Advisory Board, Children's Health Camps, 12 November 1937, H1 262 (16969), NA.

See case materials, H1 261/18, NA.

H1 261/22 (50520), J. D. Murray to Director-General of Health, 22 August 1957.


Fleras and Spoonley, Recalling Aotearoa, p. 45.


Fleras and Spoonley, Recalling Aotearoa, p. 232-36.

Fleras and Spoonley, Recalling Aotearoa, p. 31.


Durie, Whaiaora, p. 84.

Children's Health, Tomorrow's Wealth, p. 51.

Children's Health, Tomorrow's Wealth, p. 22.
55 Felicity Dumble, An Evaluation of New Zealand’s Children’s Health Camps against the HFA’s [Health Funding Authority’s] Prioritisation Principles (Hamilton: Health Funding Authority, 1999), p. 11.
56 See, for example, pamphlet entitled Health Camps: “The Modern Perspective” [1999].
58 Dumble, An Evaluation, p. 5.
59 Dumble, An Evaluation, p. 5.
60 The reference to “overenthusiastic” mothers comes from a quote attributed to a health camp matron in press cutting, Otago Daily Times, September 1954, Press Cuttings, Roxburgh Health Camp, Roxburgh.
61 In 2000 new health legislation proposed by New Zealand’s Labour Government included a controversial Treaty of Waitangi clause which was denounced by opponents as guaranteeing indigenous people superior levels of health care on the basis of indigeneity rather than need, and giving Maori a basis for litigation against the government if Maori health indicators continue to lag behind the rest of the population (Ian Templeton, “Balancing Act to Close the Gaps,” Sunday Star-Times, 10 September 2000, p. C2).