Imperial Health:
Centralisation of Medical Institutions in the British South Pacific

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Short Abstract

This thesis aims to explain the centralisation of medical institutions in the South Pacific, with a focus on the British Empire. It traces the origins of international health in the Pacific to colonial policies by examining the discussions, establishments, and operations of centralised medical institutions. With the British and New Zealand territories as core members, thirteen colonial administrations across five imperial powers were involved in the development and operation of the following institutions: the Central Leper Hospital, the Central Medical School, the Central Nursing School, the Western Pacific Health Service, the South Pacific Health Service, the Fiji Military Forces, and the Second New Zealand Expeditionary Forces. By analysing the discourses surrounding the centralisation process and the operation of centralised institutions, this thesis teases out the intercolonial and sub-imperial relations in the South Pacific. In doing so, this thesis reveals that healthcare in the South Pacific was uniquely shaped by cooperation between colonial administrations to find the most efficient medical services for the Pacific Islands. This thesis is a pioneering study to identify an organised agenda to establish a single healthcare system across colonies.

Long Abstract

This thesis is about the centralisation process of five medical institutions and two military medical services in the South Pacific, with a focus on the British Empire. The various attempts at centralisation spanned the interwar, Second World War, and post-war years in the British South Pacific. It is an ideal region to study intercolonial and sub-imperial relations as there were colonies, protectorates, mandates, overseas territories, a condominium, a dependency of a colony, and the territories of dominions—an assemblage almost as diverse as the people the imperial powers sought to administer. The areas of centralisation included quarantine, education, disease-control, military medicine, preventive medicine, curative medicine, and health services. Together, centralised medical institutions inaugurated an imperial healthcare system in the British and New Zealand territories in the South Pacific that lasted until the eve of decolonisation.

Medical centralisation did not always remain strictly in the boundaries of the formal British Empire. The territories under the British and New Zealand control participated in most institutions discussed in this thesis, forming the core members of the centralised system: Fiji, the Solomon Islands, the Gilbert and Ellice Islands, New Hebrides, Tonga, Western Samoa, the Cook Islands, Niue, and Tokelau. In addition, French New Hebrides, Australian-administered Nauru, Australian Papua New Guinea, American Samoa, and the American Trust Territories (such as Guam) made use of the centralised system to a limited extent. The Pacific Islands became a place of intercolonial, interimperial, and intraimperial cooperation because these islands were all at the peripheries of empires. The South Pacific was considered remote and insignificant to most concerned imperial powers that cooperated in medical initiatives.

Compared to its benefits, the cost of medical centralisation was considered acceptable, even if it meant that the institutions were led by the British. It was, in fact, the peripheral status of the Pacific Islands that made the region the centre of imperial cooperation.

To examine the establishment and operation of these centralised medical institutions, this thesis asks the following questions: Why did colonial administrations jointly establish medical institutions? In other words, why did the British Empire cooperate with colonies of other empires in the field of indigenous healthcare when their interactions elsewhere were characterised by competition? How did they operate such widely intercolonial and interimperial programmes? What did imperial authorities gain from it? And what were the consequences of region-wide cooperation in humanitarian initiatives?

In order to answer these questions, the South Pacific is considered as a geographical entity and its peoples as constructs that existed in the imagination of various imperial administrations. The geographical particularity of the South Pacific was critical in promoting intercolonial cooperation. The scattered nature of the Pacific Islands meant that not every island could have their own doctors and hospitals. Access to medical facilities were also inhibited by the physical distance between islands. Indeed, many islands were considered so remote that they were never visited by colonial officials before medical programmes were implemented. Under these circumstances, cost-efficiency could only be achieved when scattered resources were centrally mobilised. It was a viable way for the British Empire to provide basic healthcare for indigenous people. This thesis also considers race as another significant theme in the history of the South Pacific. Centralised medical institutions were utilised as racial laboratories by imperial powers, and this thesis shows how these institutions constantly stereotyped and racialised the indigenous peoples of the Pacific Islands. Intercolonial institutions brought the so-called ‘savage races’ of Polynesians, Melanesians, and Micronesians into one space. Even

Indians, the so-called ‘half-castes’ (mixed-race people), white Europeans, and Chinese were part of these institutions. This thesis studies how medical services had a clearly eugenics-influenced racial policy during the interwar years, went through the emergency of a world war, and developed into the post-war years when the British started to prepare for an end of empire.

The seven institutions (five civilian and two military) discussed in this thesis were all interconnected. Together, these institutions indicate an agenda to create a sub-imperial medical block in the South Pacific. However, existing studies rarely acknowledge the relationship between the institutions discussed in this thesis. Even when it has been recognised, the full extent of the scheme is not appreciated. This thesis contends that these institutions must be examined together to understand the dynamics of healthcare in the Pacific Islands. Institutional names are good indications of the possible connections between them. The Central Leper Hospital’s role in the centralisation process is lost in literature that has only focused on the institution itself, popularly known as Makogai Leper Colony. Without the word ‘Central’ in the name, it is hard to imagine its connections to other centralised institutions. The Western Pacific Health Service is not even acknowledged as an institution but simply known as a Rockefeller-funded programmes. Its connection to the imperial administration of Western Pacific High Commission is consequently overlooked. Moreover, if the wartime experiences and developments are not considered together with the centralisation movement during the interwar years, it is difficult to understand how post-war centralisation through the South Pacific Health Service was achieved.

To examine the history of medical centralisation in the South Pacific, this thesis is structured chronologically in three parts. Part I includes three chapters each dedicated to centralised institutions established during the 1920s. Part II has two chapters concerning medical centralisation within the Allied forces during Second World War. Finally, Part III will

be divided into two chapters, each discussing medical institutions that were established during the war and further developed after the end of hostilities.

In Part I, Chapter 1 begins with the establishment of the Central Leper Hospital as the earliest intercolonial medical institution that was centralised in 1927. It was run by the government of Fiji, jointly funded by participating colonial administrations and staffed by French Catholic nuns. The hospital's patients mostly came from British, New Zealand, and American colonies: Fiji, the Solomon Islands, the Gilbert and Ellice Islands, Tonga, Western Samoa, the Cook Islands, and American Samoa. While it is better known as the Makogai Leper Colony, its administrative name indicates that it was part of the larger centralisation scheme. After outlining the intercolonial establishment of the hospital, this chapter discusses how the Pacific Islands were connected through 'leper cruise' journeys and how leprosy patients were racially segregated on the hospital island.

Chapter 2 is about the Central Medical School, where indigenous medical practitioners were trained to tackle depopulation problems in Oceania. It was established in 1928 as an expansion of the existing Suva Medical School. The school was run by Fiji, staffed by British tutors, financially assisted by the Rockefeller Foundation, and jointly operated by the imperial governments of Britain, Australia, New Zealand, France, and the US. As the school developed over time, students were drawn from Fiji, the Solomon Islands, the Gilbert and Ellice Islands, New Hebrides, Tonga, Western Samoa, the Cook Islands, Tokelau, Nauru, Papua New Guinea, American Samoa, and the US Trust Territory of the Pacific Islands. This chapter discusses the establishment, development, and racialised policies of the school, depicting it as a space for colonial encounters.

Chapter 3 introduces the Western Pacific Health Service, an umbrella institution that supervised other centralised medical institutions. It was established in 1928 in conjunction with

the Central Medical School. This service was heavily funded by the Rockefeller Foundation and directed by the foundation's representative in the Pacific, Sylvester Lambert. As the name 'Western Pacific' suggests, it was established as a department under the Western Pacific High Commission. During its eleven years of existence, it led medical campaigns on hookworm eradication, soil sanitation, and yaws treatment in the British and New Zealand territories: Fiji, the Gilbert and Ellice Islands, the Solomon Islands, New Hebrides, Tonga, Western Samoa and the Cook Islands. This chapter reveals that the Western Pacific Health Service campaigns were, in many countries, the first time that colonial officials visited remote islands where they collected environmental and demographical knowledge. It is a rare case of an American philanthropic institution running a colonial department in the British Empire, with its employees becoming the Deputy Central Medical Authority in the Western Pacific High Commission.

For Part II, Chapter 4 examines the establishment of the Fiji Medical Corps under the Fiji Military Forces. It was established in 1941 as the war in the northern Pacific gradually advanced south. Since the Fiji Military Forces were under New Zealand command, running the Fiji Medical Corps involved negotiations between Fiji and New Zealand in securing the maximum interest of each party. This chapter first looks at the establishment and medical arrangements of the Fiji Medical Corps, including the establishment of 1 Bearer Company, which was staffed by indigenous Pacific Islanders. It then discusses the ambiguous status of Fijian medical personnel and hospitals under New Zealand leadership.

Chapter 5 investigates how the Second New Zealand Expeditionary Force cooperated with the US and other Pacific Islands during the Second World War. In the early years of the Second World War, the Second New Zealand Expeditionary Force had many men stationed in Fiji. This was called the Fiji Section, which also commanded the Fiji Military Forces. As the

war escalated, New Zealand focused its forces on the Solomon Islands, in its Third Division. Supporting facilities, including divisional headquarters and a general hospital, were located in New Caledonia. This chapter analyses the medical organisations of New Zealand forces by focusing on imperial cooperation in Fiji, the Solomons, and New Caledonia. It also notes how New Zealand relied on the US forces for its medical decisions and resources for war in tropical islands.

The final part of the thesis examines how centralised institutions that were created during the Second World War were developed further after the war. Chapter 6 deals with the South Pacific Health Service. It was a centralised medical service between British and New Zealand colonies, including a pool of medical staff. The service was given full authority in all medical matters in the participating territories and existing centralised medical institutions. Fiji, the Solomon Islands, the Gilbert and Ellice Islands, Tonga, New Hebrides, Western Samoa, the Cook Islands, Tokelau, and Niue were part of it. Its imperial character echoes the character of the Western Pacific Health Service. Despite its initial ambitions, the service failed to bring Australian and American participation. However, Australia and the US continued to take advantage of participation in the Central Leper Hospital and the Central Medical School. This chapter analyses the interimperial discussions surrounding the establishment of the South Pacific Health Service. It argues that the British were able to perpetuate their imperial influence in the region through this sub-imperial institution.

Chapter 7 completes the study of medical centralisation through an analysis of the Central Nursing School and the Suva Medical Centre. The Central Nursing School was planned since the 1930s and established in 1941. Although the school was part of the centralisation plan, it was unable to develop as intercolonially as the Central Medical School due to wartime changes. The majority of its students came from Fiji, with occasional students from the Gilbert

and Ellice Islands, Tonga, Rotuma, and the Cook Islands. The other institution, the Suva Medical Centre, could not be established as planned and merely became an enlargement of the Colonial War Memorial Hospital. Both institutions were planned before the Second World War but were heavily influenced by the prospect of the South Pacific Health Service and wartime changes. By explaining the establishment and development of these institutions, this chapter demonstrates how the Second World War disrupted an ambitious scheme to make Fiji the medical capital of the Pacific.

As a whole, medical institutions were centralised as a cost-effective healthcare system under the British leadership. They also served as racial laboratories and were a means to accumulate colonial knowledge. In this respect, the Pacific Islands can be considered a medical frontier of the British Empire, where unusual cooperative initiatives were made. While the British led the centralisation process, this thesis also acknowledges the active role that New Zealand played in the creation of the imperial and sub-imperial healthcare system. British imperial aspirations in the Pacific Islands were expressed through its ambitious medical centralisation scheme, which was designed to bring together not only the British Empire but also territories under other empires. By engaging with the under-researched region of Oceania, this thesis thus fills a considerable gap in the scholarship of imperial history, medical history, and Pacific history.

One of the significant contributions of this thesis is that it bridges the interwar and post-war periods by discussing the British Empire's experience of wartime medical centralisation. Many histories of the twentieth century usually consider the first half and the second half of the century as totally separate periods. General histories often consider the war years between 1939 and 1945 as an interregnum—unique and unconnected to other periods. However, this thesis will show that the war was only a stage in the long-term process of

centralisation. Medicine and healthcare were prominent factors that contributed to the ability of military forces to maintain imperial regimes. In this respect, it is natural that plans for further medical centralisation between the British and New Zealand colonies emerged during the war.

Finally, this thesis identifies an imperial system of healthcare for a group of colonies. Centralised medical institutions are excellent cases to study lateral relations between constituents of the British Empire in the Pacific. Most of the literature considering the context of empire in medical history consists of works or collections of works on colonial medicine, with a focus on a single territory. Studies of 'imperial medicine' have thus far tended to discuss the relationship between the metropole and peripheries, the use of medicine in constructing an imperial identity, or the role of medicine in protecting mobile populations such as the military. Histories of a single medical system imposed on a group of colonies are heretofore unknown. This thesis is, therefore, a pioneering study to identify and explain an organised imperial agenda and effort to bring a group of colonies under one medical system.

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Abbreviations and Acronyms

2NZEF	Second New Zealand Expeditionary Force
ADMS	Assistant Director of Medical Services
ANZ	Archives New Zealand, Wellington
CCS	Casualty Clearing Station
CD	Communicable Disease
CLH	Central Leper Hospital
CMS	Central Medical School
CNS	Central Nursing School
CWM	Colonial War Memorial
DMS	Director of Medical Services
DDMS	Deputy Director of Medical Services
DGMS	Director General of Medical Services
FA	Field Ambulance
FDF	Fiji Defence Forces
FDR	Franklin D. Roosevelt
FMF	Fiji Military Forces
GOC	General Officer Commanding
IMP	Indian Medical Practitioner
LSHTM	London School of Hygiene and Tropical Medicine
LST	Landing Ship Tank
NAA	National Archives of Australia, Canberra
NACP	National Archives and Records Administration in College Park, Maryland
NAF	National Archives of Fiji, Suva
NMP	Native Medical Practitioner
NZEFIP	Second New Zealand Expeditionary Forces in the Pacific
NZMC	New Zealand Medical Corps
MO	Medical Officer
MCU	Malaria Control Unit

RAC	Rockefeller Archive Centre
RF	Rockefeller Foundation
RNZAF	Royal New Zealand Air Force
SMO	Senior Medical Officer
SPC	South Pacific Commission
SPHS	South Pacific Health Services
TNA	The National Archives at Kew, UK
WHO	World Health Organization
WPA	Western Pacific Archives, Auckland
WPHC	Western Pacific High Commission
WPHS	Western Pacific Health Service

Note on Wording

This thesis attempts to follow contemporary trend of spelling regional and ethnic names. For example, instead of Maori and Hawaii, this thesis uses Māori and Hawai‘i. However, in order to differentiate the mandated period of Western Samoa from modern Sāmoa, Western Samoa will not be spelled with a macron. For terms related to, race, ethnicity, and anthropological divisions of the South Pacific, this thesis acknowledges that these are Western construct and does not intend to reproduce imperialist attitudes inherent in the primary sources. All of the racial names have been subject to political debates and carries specific historical connotations. This thesis follows the historical use of racial categories to note the understanding of race and racial categorisation during the colonial period. This thesis does not intend to apply the same term to refer to contemporary peoples. That said, terms such as ‘Polynesians’, ‘Micronesians’, ‘Melanesians’, ‘Europeans’, ‘Fijians’, and ‘Indians’ will be used as it was used by the colonial authorities at the time. Similarly, this thesis will use the historical names of administrative units, for example, New Hebrides instead of Vanuatu.

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Introduction

The World Health Organization's Western Pacific Region website invites visitors to:

> Imagine having to deliver health services to a population dispersed across dozens of atolls and island groups, covering a distance of up to 5,000 kilometers, with slow internet, extremely high operational costs as well as infrequent transport links.[1]

Seventy years ago, a similar question was asked at the Pacific Science Congress:

> Have you ever tried to work out a workable scheme for giving a measure of medical services to the small native population of an isolated Pacific island? In the Pacific Ocean there are scores of islands with populations ranging from 200 upwards, visited by small vessels at irregular intervals, and having an extremely low annual income per capita. The local inhabitants, however, have their illnesses.[2]

Judging by how similarly these questions framed the challenges of providing healthcare in the Pacific, it is clear that problems in healthcare still remained over the past century.

In response to the outlined challenges, the Pacific Health Ministers Meeting adopted the 'Healthy Islands' vision in 1995 to strengthen Pacific health systems. Two decades later, a report on this vision acknowledged that the context for this collective international effort lay in the history of Pacific regionalism, in which the Pacific Islands worked together towards common goals.[3] This thesis examines this history of Pacific regionalism in healthcare: a British imperial version of the 'Healthy Islands' vision in the first half of the twentieth century.

[1] https://www.who.int/westernpacific/activities/strengthening-pacific-health-systems (accessed 29 October 2022).
[2] Pacific Science Congress, *The Proceedings of the Seventh Pacific Science Congress, Vol.VII* (Wellington: R. E. Owen Government Printer, 1953) 44.
[3] World Health Organization, *The First 20 Years of the Journey Towards the Vision of Healthy Islands in the Pacific* (Online: WHO Press, 2015), 20.

By the early twentieth century, indigenous peoples in colonies were often seen as 'reservoirs of disease.'[4] During the interwar period, indigenous healthcare became the top priority of colonial governments in the Pacific Islands following many disastrous waves of epidemics.[5] But despite the urgent need for medical expertise, many doctors were deterred from working in the Pacific Islands by the tropical climate and the geographical isolation of the region. Moreover, colonial officials often did not understand indigenous languages or cultures, making healthcare difficult. The colonial governments in the Pacific had two ways to solve these problems. The first was to recruit indigenous personnel who were familiar with local customs and would not mind working in the Pacific Islands. The second was to combine medical resources from as many colonial administrations as possible to form one effective medical service. The result was the centralisation of medical institutions across the Pacific Islands under British imperial leadership.

Colonial administrations in the South Pacific connected, cooperated, and competed with one another through a scheme that centralised medical institutions. The British and New Zealand territories were at the core of this system, with a limited degree of participation from Australian, French, and American territories. The centralised institutions are remarkable examples of intercolonial, interimperial, and intraimperial relations, and they formed the backbone of the medical infrastructure of Oceania. This thesis considers the process of medical centralisation and how it facilitated imperial relationships across colonies in the South Pacific. In discussing how medical centralisation ultimately benefitted participating empires, particularly the British Empire, it describes the emergence of an imperial — as opposed to simply a colonial — healthcare system.

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[4] Mark Harrison, *Disease and the Modern World: 1500 to the Present Day* (Cambridge, Polity Press, 2004), 138.
[5] Donald Denoon, Stewart Firth, Joycelyn Linnekin, Malama Leleisea, Karen Nero, *The Cambridge History of the Pacific Islanders* (Cambridge: Cambridge University Press, 1997), 278.

This thesis uses the term 'imperial' to denote connections between constituent parts of the British Empire, which inevitably involved some hierarchical relationships between political units. Empires are 'large political units, expansionist or with a memory of power extended over space, polities that maintain distinction and hierarchy as they incorporate new people' as Jane Burbank and Frederick Cooper wrote.[6] Traditional imperial histories certainly regarded empires as mainly territorial. However, since Robinson and Gallagher coined the concept of 'informal empire', spheres of strong influence also came to be considered as 'empires' even in the absence of territorial rule.[7] 'Imperial' is, therefore, an adjective to describe what is related to or of empire and its connotations have expanded along with the historiography of empire. For example, over the past few decades imperial history experienced the 'cultural turn', which induced historians to view cultural activities (or 'soft power') as a form of 'imperialism.'[8] That said, this thesis regards states such as New Zealand, Australia, and the US as empires not simply because they had informal spheres of influence but because they had formal governing authority over external territories that formed administrative units.

[6] Jane Burbank, Frederick Cooper, *Empires in World History: Power and the Politics of Difference* (Princeton, Princeton University Press, 2010), 8.
[7] John Gallagher, Ronald Robinson, 'The Imperialism of Free Trade', *The Economic History Review,* 6/1 (1953), 1–15.
[8] Mark F. Proudman, 'Words for Scholars: The Semantics of "Imperialism"', *The Journal of the Historical Society*, 8/3 (2008), 425–426.

Imperial Conditions in the South Pacific

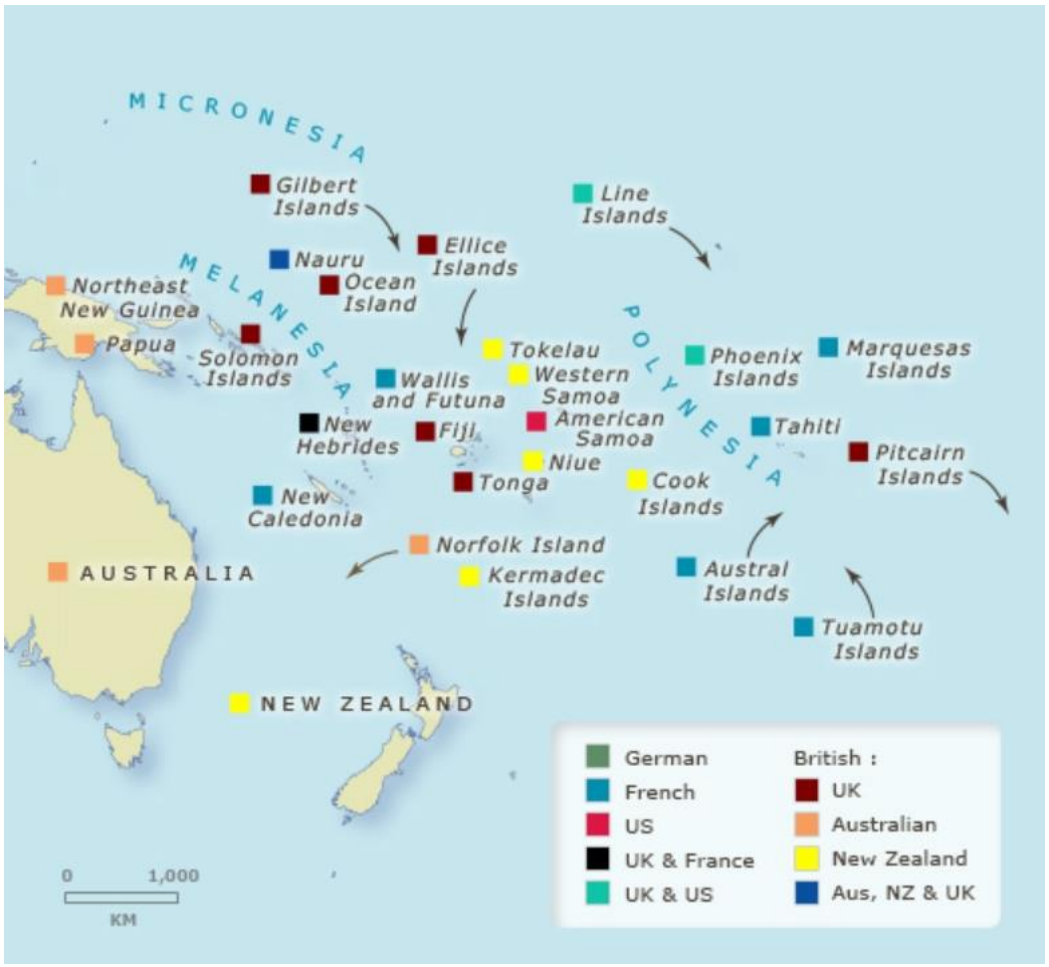


Figure 1. Colonial control of the South Pacific, 1951. [Source: Te Ara Encyclopedia of New Zealand https://teara.govt.nz/en/interactive/24236/colonial-control-in-the-south-pacific]

Fifteen island groups under five imperial powers are examined in this thesis. It is therefore crucial to outline the imperial map of the region as each country's colonial status may be confusing. In the first half of the twentieth century, most of the South Pacific was under imperial control in a startling variety of political forms: dominions, colonies, protectorates, mandates, condominiums, treaty-based protected states, and overseas territories.[9] It is an ideal

[9] The dominions were self-governing, so-called 'white settler-colonies'. Formal colonies refer to the Crown colonies populated by non-white people. Protectorates were states protected by Britain. Mandates were former German and Ottoman colonies, acquired through the League of Nations. Condominiums were colonies jointly governed with another imperial power. Treaty-based protected states were independent states that had their defence and foreign affairs managed by Britain. Other than the dominions, territories forming the colonial

region for studying British imperial relations precisely because the British Empire had various types of colonial governments. In addition to the variety of forms, many had a complicated history of colonial rule. An autonomous chiefdom could become a British protectorate and then a British colony before being transferred to New Zealand. Such diversity reveals complex dynamics between constituent parts of the empires in this region.

For convenience, the terms 'colonies' and 'territories' will be used to refer to islands under the control of an imperial power, regardless of their specific constitutional status. As an attempt to prevent confusion, this thesis will use the term '*British* colonies (or territories)' in a narrower sense, referring to those directly governed by the Colonial Office. This includes protected states such as the Kingdom of Tonga. Those under the remit of the Dominions Office, such as Australia and New Zealand, will be treated as individual imperial powers.[10] Therefore, 'intercolonial' refers to connections between colonies, not necessarily confined to one empire. While this thesis acknowledges the racial categories of Pacific Islanders are a European construct, terms such as Europeans (meaning white people), Polynesians, Melanesians, and Micronesians, will be used to reflect the colonial usage of the terms.

British authorities in the South Pacific were headquartered in Fiji, where the Western Pacific High Commission was based. The High Commissioner for the Western Pacific was also made the Governor of Fiji from 1877 onwards.[11] Under the Western Pacific High Commission were Fiji, a Crown Colony, the Gilbert and Ellice Islands Colony (today's Kiribati and Tuvalu,

empire were governed through the Colonial Office. Finally, overseas territories were parts of the UK that were located far from the British Isles.

[10] For examples of considering these countries as empires, see: Deryck Schreuder, Stuart Ward (eds.), *Australia's Empire* (Oxford: Oxford University Press, 2008); Katie Pickles, Catharine Coleborne (eds.), *New Zealand's Empire* (Manchester: Manchester University Press, 2016); A. G. Hopkins, *American Empire: A Global History* (Princeton: Princeton University Press, 2018).

[11] Deryck Scarr, *Fragments of Empire: A History of the Western Pacific High Commission 1877–1914* (Canberra: Australian National University Press, 1967) xvi.

previously the Gilbert and Ellice Islands Protectorate), the British Solomon Islands Protectorate, and the Anglo-French condominium of New Hebrides (today's Vanuatu), jointly-controlled with France. Tonga was officially not a British colony, but a protected state. Britain also had some overseas territories, the best-known being the widely romanticised Pitcairn Islands, which were settled by mutineers of *HMS Bounty* in 1790.

White settler colonies were already largely autonomous with their own dependencies in the period examined in this thesis, although the legal switch from dominions to Commonwealth happened in 1931 following the Westminster Statute. As Angus Ross has argued, New Zealand had supported, at times even demanded, that the British Empire should gain control of the Pacific Islands since the nineteenth century.[12] By the interwar years, territories administered by the Dominion of New Zealand included Western Samoa, the Cook Islands, Niue, and Tokelau (previously the Union Group). The Commonwealth of Australia controlled both Papua and New Guinea after the First World War. Nauru was a co-mandated territory between Britain, Australia, and New Zealand. In practice, Australia administered the island. These 'empires-in-empire', or 'sub-empires', allowed Australia and New Zealand to rise as imperial powers in the region. Even Fiji, a Crown colony, had a dependency – Rotuma.[13] In summary, the following table details the parts constituting the British Empire in the South Pacific:

[12] Angus Ross, *New Zealand Aspirations in the Pacific in the Nineteenth Century* (Oxford: Clarendon Press, 1964) 288–289.
[13] Harry Luke, *Britain and the South Seas* (London: Whitefriars Press, 1945) 70–71.

Governing State	Territories under Control	Year of Acquisition	Official Status
Britain (Colonial Office)	Fiji (Rotuma)	1874	Crown Colony (with Rotuma Dependency)
	Gilbert and Ellice Islands Colony	1877	Crown Colony (previously a Protectorate until 1916)
	British Solomon Islands Protectorate	1893	British Protectorate
	New Hebrides	1906	Anglo-French Condominium
	Pitcairn	1838	British Colony by Settlement
	Tonga	1900	Constitutional Monarchy under British Protection by the Treaty of Friendship
Australia	Papua	1902	External Territory (previously annexed by Queensland in 1883, made a British Protectorate in 1884, and became British New Guinea in 1888 until it was transferred to Australia)
	New Guinea	1914	League of Nations Mandate (formerly German New Guinea, annexed at the beginning of the First World War)
New Zealand	Cook Islands	1901	Island Territory (previously became a British Protectorate in 1888, and a British territory in 1900, until it was transferred to New Zealand)
	Niue	1901	Island Territory (previously declared a British Protectorate in, transferred to New Zealand with the Cook Islands in 1901, became a separate administration in 1903)
	Tokelau (Union Islands)	1926	Island Territory (previously under the Western Pacific High Commission in 1877, incorporated to the Gilbert and Ellice Islands Colony in 1916, transferred to New Zealand in 1926)

	Western Samoa	1914	League of Nations Mandate (former German colony, seized at the beginning of the First World War)
Britain, Australia, New Zealand (administered by Australia)	Nauru	1914	League of Nations Mandate (former German Protectorate, occupied by Australia in 1914, became a British-Australian-New Zealand joint-mandate through the British Phosphate Commission in 1919)

Table 1. List of colonial administrations in the South Pacific under the British Empire.

The French and Americans were also major players in the region. As noted, France co-controlled New Hebrides with the British. Some island groups, such as the Society Islands or the Marquesas Islands, together formed a colony called the French Establishments in Oceania (today's French Polynesia). New Caledonia was under French control as an overseas territory. Although the United States did not officially claim to be an empire, it was essentially an imperial power, as A. G. Hopkins has argued. Most of the American territories were in the northern Pacific, such as the Trust Territory of the Pacific Islands, but American Samoa was controlled by the US Navy in the South Pacific.[14]

Centralised Medical Institutions in the British South Pacific

This thesis will discuss the centralisation process of five civilian and two military medical institutions in the South Pacific, with a focus on the British Empire. All of these island colonies, except for those under sole French control, participated in region-wide medical centralisation to some extent. The word 'centralisation' has been chosen because it best

[14] For history of American rule in Samoa and Guam, see: A. G. Hopkins, *American Empire: A Global History*, 494–538.

describes the nature of what actually happened, i.e. various colonial medical institutions coming under one focal point of administrative authority. It is not used as a synonym of imperialism but centralisation in this thesis was ‘imperial’ because it primarily happened between constituents of the British Empire. Terms such as ‘unification’ or ‘amalgamation’ were used interchangeably in primary sources during the process. However, this thesis considers ‘centralisation’ most suitable as ‘unification’ may imply an egalitarian structure, which was not the case, and ‘amalgamation’ may suggest a monolithic entity whereas local-specific measures remained in the centralised system.

The first institution to be centralised was the Central Leper Hospital. It was established in 1927 between Fiji and New Zealand territories as an expansion of the previous Makogai Leper Colony in Fiji. In 1928, the Central Medical School was established in Suva with the financial assistance of the Rockefeller Foundation. It was joined by the British and New Zealand territories, including New Hebrides and Tonga. Australian and American territories participated later on. The Western Pacific Health Service was established in the same year under the Western Pacific High Commission. It was funded and directed by the Rockefeller Foundation to conduct disease eradication programmes and supervise the other two centralised medical institutions. This service ceased operation on the eve of the Second World War in 1939.

The Second World War brought a change to imperial relations in the South Pacific. Medical resources were mobilised and pooled between the Allied forces to manage casualties effectively. The Fiji Medical Corps, part of the Fiji Military Forces, was subject to New Zealand command instead of the British. New Zealand forces followed US directions for medical arrangements in the Pacific theatre of the war. This line of command led Fiji and New Zealand to experience a shift in medical leadership in the Pacific Islands. While medical provisions were arranged in a friendly manner between the two countries, New Zealanders

generally resented growing American power.[15] In the meantime, the Central Nursing School was established in 1940 on a moderately intercolonial scale due to wartime constraints.

Once the occupied islands were liberated from Japanese forces, colonial governments of the South Pacific started the process of post-war medical reconstruction. As a result, the South Pacific Health Service was established between the British and New Zealand territories, including Tonga. It was a fully centralised medical service heavily subsidised by the Colonial Office and the New Zealand government. The service pooled medical staff and directly controlled medical matters in participating countries. Other existing centralised institutions were put under the supervision of the South Pacific Health Service. Compared to the Western Pacific Health Service, this post-war institution was able to integrate the medical services between different British colonies in the region to a fuller degree.

The institutions discussed in this thesis were all interconnected. Together they formed parts of a larger agenda to centralise medical services. Only when they are considered collectively can the true scope and imperial aspirations surrounding centralisation be understood. For example, because the Central Leper Hospital is better known as the Makogai Leper Colony, the official and administrative name is much forgotten. This makes it easy to think the hospital was totally separate from other institutions such as the Central Medical School or the Central Nursing School. Also, the Western Pacific Health Service was a department under the Western Pacific High Commission. However, its activities are often simply recognised as Rockefeller Foundation programmes without realising its official name and status. Its supervising role in the centralisation scheme and similarities with the post-war South Pacific Health Service cannot be found in that way. Moreover, the Second World War

[15] James Belich, *Paradise Reforged: A History of the New Zealanders from the 1990s to the year 2000* (Auckland: Allen Lane Penguin Press, 2001), 290–291.

easily gets treated as an anomaly in history. This creates a void in the medical history of the Pacific Islands between 1939 and 1945, preventing one from understanding how the post-war institutions were largely inherited from the interwar years and wartime experience of intercolonial collaborations.

This thesis makes an important contribution to the scholarship by examining all centralised institutions together from the 1920s to the 1950s. In doing so, it connects the interwar years with the post-war period, demonstrating that centralisation in the South Pacific was a long process led by the British Empire, with the aim of enhancing British influence in the region. It is also a pioneering showcase of an imperial healthcare system that covered a number of colonies in different constitutional statuses. The following table lists the medical institutions that will be examined and the year of centralisation.

Institution	Centralised Year
Central Leper Hospital	1927
Central Medical School	1928
Western Pacific Health Service	1928
Fiji Military Forces	1939
Second New Zealand Expeditionary Force	1939
South Pacific Health Service	1946
Central Nursing School	1940

Table 2. List of centralised medical institutions.

Research Questions

The questions which this thesis attempts to answer are as follows: Why did colonial

administrations jointly establish medical institutions? More specifically, why did British colonies cooperate with colonies of other empires in the field of indigenous healthcare when their interactions elsewhere were characterised by competition? How did they operate such widely intercolonial and interimperial programmes? What did imperial authorities gain from it? And what were the consequences of region-wide cooperation in humanitarian initiatives?

In order to answer these questions, the South Pacific is considered as a geographical entity and the islands and their peoples as constructs which existed in the imagination of various imperial administrations. The geographical context was critical in stimulating intercolonial cooperation. The scattered nature of the Pacific Islands meant that not every island could have doctors and hospitals. Some islands were too remote for colonial governments to provide adequate healthcare, and many were never visited by colonial officials before medical programmes were implemented. Cost-efficiency could only be achieved when scattered resources were centrally mobilised. The combined effort allowed colonial administrations to train indigenous medical staff, segregate leprosy patients, conduct disease eradication campaigns, and pool medical staff at an affordable cost. Centralisation was increasingly seen as a viable way to provide basic healthcare for indigenous people and promoted medical unity in the British South Pacific.

This thesis also explores another significant theme in the history of the South Pacific: race. Centralised medical institutions were utilised as racial laboratories by imperial powers, and this thesis shows a constant effort to stereotype and racialise indigenous peoples of the Pacific Islands. Intercolonial institutions brought the so-called 'savage races' of Polynesians, Melanesians, and Micronesians into one space.[16] Even those ethnically Indians, the so-called

[16] For European categorisation of the race, see: Bronwen Douglas, *Science, Voyages, and Encounters in Oceania, 1511–1850* (Basingstoke: Palgrave Macmillan, 2014); Bronwen Douglas, Chris Ballard, *Foreign Bodies: Oceania and the Science of Race, 1750–1940* (Canberra: Australian National University Press, 2008).

'half-castes' (mixed-race), white Europeans, and Chinese were part of these institutions. This thesis studies how medical services changed from a clearly eugenics-influenced racial policy during the interwar years, through the emergency of a world war, and to the post-war years when the British started to prepare for an end of empire.

Historiography

To construct a historiographical framework for medical cooperation between various colonies in the South Pacific one must navigate the streams of medical history, global and imperial history, and Pacific history. This thesis primarily follows the footsteps of previous works on colonial medicine. Connections between colonies and medicine have been at the centre of medical history for decades now. Historians such as Mark Harrison, Megan Vaughan, and Warwick Anderson have written exemplary works which established the field of colonial medicine as an object of analysis.[17] The literature on colonial medicine, however, has a tendency to focus on Africa and Asia. Oceania remains under-researched.

Among those concerning the South Pacific, this thesis consulted exemplary medical histories of Australia and New Zealand. Linda Bryder and Derek Dow have written medical histories of New Zealand, making an especially significant contribution to the history of Māori health.[18] This thesis refers to Bryder and Dow's works as the starting point to analyse New Zealand's approaches to indigenous health, which feature as a significant theme throughout the

[17] For example: Mark Harrison, *Climates and Constitutions: Health, Race, Environment, and British Imperialism in India, 1600–1850* (Oxford: Oxford University Press India, 2002); Megan Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Stanford: Stanford University Press, 1991); Warwick Anderson, *Colonial Pathologies: American Tropical Medicine, Race, and Hygiene in the Philippines* (Durham: Duke University Press, 2006).

[18] Linda Bryder, *A Healthy Country: Essays on the Social History of Medicine in New Zealand* (Wellington: Bridget Williams Books, 1991); Linda Bryder, Derek Dow, 'Introduction: The A, Past, Present, and Future', *Health and History* 3/1 (2001) 3–12; Derek A. Dow, *Safeguarding the Public Health: A History of the New Zealand Department of Health* (Wellington: Victoria University Press, 1995).

thesis. Alison Bashford and Warwick Anderson's works are guiding examples in Australian medical history, being useful in gaining an understanding of Australia's imperial ambitions and racist policies towards indigenous population, which ultimately benefitted white Europeans.[19]

Smaller Pacific Islands have attracted much less attention. Other than Australian Papua and New Guinea, on which Donald Denoon and Warwick Anderson have written excellent books, works on the medical history of the Pacific Islands are scarce.[20] One of the few works relevant to the scope of enquiry in this thesis is Vicki Luker's research. Her works on colonial maternity and leprosy in Fiji serve as starting points for studying the Central Leper Hospital and the Central Nursing School.[21] Jacqueline Leckie's book on the history of insanity in Fiji provides a lens through which to examine the place of medicine and race in colonial governance.[22] This thesis is also in conversation with Annie Stuart's studies on the centralisation of medical institutions, which she refers to as 'unification.' Stuart argues that centralising efforts in the South Pacific were predominantly Rockefeller Foundation projects.[23] While the Rockefeller Foundation was significant in centralising efforts, this thesis demonstrates that the centralisation of medical institutions was more of an imperial project than philanthropy that could be pursued even without external assistance.

However, existing national or colonial frameworks are not entirely compatible with

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[19] Alison Bashford, *Imperial Hygiene: A Critical History of Colonialism, Nationalism and Public Health* (Basingstoke: Palgrave Macmillan, 2004); Warwick Anderson, *The Cultivation of Whiteness: Science, Health, and Racial Destiny in Australia* (Durham: Duke University Press, 2006).

[20] Donald Denoon (with Kathleen Dugan and Leslie Marshall), *Public Health in Papua New Guinea: Medical Possibility and Social Constraint, 1884*–1984 (Cambridge: Cambridge University Press, 1989); Warwick Anderson, *The Collectors of Lost Souls: Turning Kuru Scientists into Whitemen* (Updated Edition) (Baltimore: Johns Hopkins University Press, 2019).

[21] Victoria Lukere, 'Mothers of the Taukei: Fijian Women and "the Decrease of the Race"', PhD Thesis, Australian National University (1997); Vicki Luker, Jane Buckingham, 'Histories of Leprosy: Subjectivities, Community, and the Pacific Worlds', *The Journal of Pacific History,* 52/3 (2017) 265–286.

[22] Jacqueline Leckie, *Colonizing Madness: Asylum and Community in Fiji* (Honolulu: University of Hawai'i Press, 2019).

[23] Annie Stuart, 'Parasites Lost? The Rockefeller Foundation and the Expansion of Health Services in the Colonial South Pacific', PhD Thesis, University of Otago (2002).

writing the history of colonial Pacific Islands. The limited scope of a single nation or colony cannot explain the development of medical services in the South Pacific as a whole. This is because it took an increasingly global trajectory, with medical institutions that were funded or overseen by foreign institutions covering many island groups beyond national boundaries. In order to understand the connectivity between the Pacific Islands and the structural change of medical institutions in the region, a global history approach should be taken.[24] As Mark Jackson pointed out, medical history should pay attention to 'locally lived lives in a globally connected world.'[25]

This thesis goes beyond the colonial frame to consider medical services in the South Pacific on a global and imperial scale. In this respect, the thesis follows the trend set by imperial historians, many of whom have been among the strongest advocates of global history, together forming a subfield in the history of connectedness.[26] As James Belich, John Darwin, and Chris Wickham argued, the study of mobility and interaction between peoples and regions, in other words, the history of connectedness, requires using a 'sub-global' frame, popularly phrased as 'worlds.'[27] This thesis is an attempt to write a history of medical connections in the 'Pacific World', with a focus on the 'British Pacific World', which was, simultaneously, a 'sub-imperial' framework. These 'worlds' may also be called as British 'systems', as John Darwin argued, reaching far beyond the formal territorial empire.[28] The institutions examined in this thesis, in that sense, together formed a British healthcare 'system' covering the 'British Pacific

[24] Mark Harrison, 'A Global Perspective: Reframing the History of Health, Medicine, and Disease', *Bulletin of the History of Medicine*, 89/4 (2015), 639–689.
[25] Mark Jackson, 'One World, One Health? Towards a Global History of Medicine' in Mark Jackson (ed.), *A Global History of Medicine* (Oxford: Oxford University Press, 2018). 1–18.
[26] Simon J Potter, Jonathan Saha, 'Global History, Imperial History, and Connected Histories of Empire', *Journal of Colonialism and Colonial History*, 16/1 (2015).
[27] James Belich, John Darwin, Chris Wickham, 'Introduction' in James Belich, John Darwin, Margret Frenz, Chris Wickham (eds.), *The Prospect of Global History* (Oxford: Oxford University Press, 2016)
[28] John Darwin, *The Empire Project: The Rise and Fall of the British World-System, 1830–1970* (Cambridge: Cambridge University Press, 2009), 1–2.

World'.

In what follows, the most visible connection in the 'British Pacific World' is the sub-imperial relationship between British colonies and New Zealand territories. A. D. Roberts uses the term 'sub-imperialism' to denote the significance a prominent regional power in the history of Uganda, for example.[29] Marshall Johnson and Fred Yen Liang Chiu also use the concept of sub-imperialism but to describe the process whereby some colonised subjects themselves become agents of colonisation, often through the case of local elites working within imperial frameworks.[30] In this way, Tony Ballantyne placed India as a sub-imperial centre in explaining India's central role in knowledge circulation in the Indian Ocean and the Pacific, especially focusing on its ties with New Zealand.[31] Recently, Clinton Fernandes described Australia as a sub-imperial power, in the sense that Australia had its own colonies in the Pacific and has been acting as a 'junior partner' to the British and American hegemonic powers in the twentieth century.[32] New Zealand can also be seen in the same way. By the early twentieth century, New Zealand saw itself as a 'Better Britain', which was a key to the 'recolonisation system' analysed by James Belich. Essentially, this means that from the late nineteenth century, while New Zealand gained political self-governance, socially, New Zealanders considered themselves more 'British' and regarded Britain's interests as New Zealand's interests.[33] New Zealand's imperial identity was not just formed by viewing their white European population as 'British.' Concerning indigenous peoples of the South Pacific, such a close imperial relationship led New Zealand to adopt Victorian racial ideas, as Damon Salesa showed in his book.[34] In another

[29] A. D. Roberts, 'The Sub-Imperialism of the Baganda', *Journal of African History*, 3/3 (1962), 435–450.
[30] Marshall Johnson, Fred Yen Liang Chiu, 'Guest Editors' Introduction', *Positions*, 8/1 (2000), 1–7.
[31] Tony Ballantyne, *Webs of Empire: Locating New Zealand's Colonial Past* (Vancouver: UBC Press, 2010), 7.
[32] Clinton Fernandes, *Sub-Imperial Power: Australia in the International Arena* (Carlton: Melbourne University Press, 2022).
[33] James Belich, *Paradise Reforged*, 76–86.
[34] Damon Salesa, *Racial Crossings: Race, Intermarriage and the Victorian British Empire* (Oxford: Oxford University Press, 2011).

edited volume, Salesa argues that New Zealand was indeed an empire with its Pacific territories of Western Samoa, the Cook Islands, Niue, Tokelau. He framed New Zealand as an 'empire-state', which had its peak years between 1920s and 1960s.[35] Such shared ideas on indigenous racial governance are reflected in the process of medical centralisation. New Zealand, this thesis contends, was an empire and a sub-imperial power in the South Pacific, at least in the medical sphere.

The link between global history and imperial history has become increasingly obvious in medical history. As Sunil Amrith remarked, imperialism is inherent in global health, just obscured by the humanitarian narrative of internationalism.[36] Likewise, Randall Packard argues that what is now called 'global health' has evolved from colonial medicine.[37] Amrith and Packard's arguments may be challenged in various ways. This thesis does not intend to be a critical response to their works, but rather supplement their work in showing how imperial or sub-imperial framework can be useful in analysing the transition from colonial medicine to international/global health.

In medical history, imperial frameworks have been used in a number of ways. One way was to view medicine as innately imperial. This means that Western biomedicine had the power to not only conquer diseases, but to 'medicalise' previously non-medical domains. Medicine, in this perspective, is a cultural institution which can carry Western cultural values to other non-Western cultures. Roy MacLeod views 'medical imperialism' this way, as an act of medicalising other cultures.[38] In this definition, medicine itself is 'imperial' by nature.

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[35] Damon Salesa, 'New Zealand's Pacific' in Giselle Byrnes (ed.), *The New Oxford History of New Zealand* (South Melbourne: Oxford University Press Australia and New Zealand, 2009).

[36] Sunil S. Amrith, *Decolonizing International Health: India and Southeast Asia, 1930–65* (Basingstoke, Palgrave Macmillan, 2006), 8.

[37] Randall M. Packard, *A History of Global Health: Interventions into the Lives of Other Peoples* (Baltimore: Johns Hopkins University Press, 2016)

[38] Roy MacLeod, 'Introduction' in Roy MacLeod, Milton Lewis (eds.) *Disease, Medicine and Empire:*

Another way to use imperial framework is to conceive empire as a whole in the pursuit of Western medicine and medical knowledge. Often, the pursuit of this type of 'imperial medicine' was done from the imperial metropole or sub-metropoles through connected peripheries as means of imperialism and sub-imperialism. The network of Western medical knowledge in this case is imperial because it was used explicitly as a 'tool of empire'.[39] MacLeod defines 'imperial medicine' this way; i.e. that Western medicine was organised and developed in order to aid imperial expansion and control, both economically and militarily.[40] Similarly, for Douglas Haynes and J. D. Alsop, 'imperial medicine' is the medicine of the imperial metropole, that grew particularly through the development of tropical medicine and which used the British Empire as a research field.[41] 'Imperial medicine' to these authors is what is 'British' or medicine of empires.

'Imperial medicine' can also meanan imperial ideology. David Arnold uses the term 'imperial medicine' to denote medical intervention in the colonies. He argues medicine itself was an imperial ideology and authority which left lasting impact in the empire. Through medicine, empires could showcase the 'benevolent and paternalistic intentions' to consolidate imperial hegemony in colonies when military resources were limited.[42] While the politically legitimising functions of medicine was also noted by other authors such as MacLeod, Arnold places more emphasis on medicine's role in establishing hegemony in colonies in his other book.[43] In both books, Arnold pays more attention to the impact of Western medicine and the

Perspectives on Western Medicine and the Experience of European Expansion (London: Routledge, 1988), 1–2.

[39] Daniel R. Headrick, *The Tools of Empire: Technology and European Imperialism in the Nineteenth Cenutry* (Oxford: Oxford University Press, 1981).

[40] Roy MacLeod, 'Introduction' in*Disease, Medicine and Empire*, 6–12.

[41] Douglas M. Haynes, *Imperial Medicine: Patrick Manson and the Conquest of Tropical Disease* (Philadelphia, University of Pennsylvania Press, 2001) 2–11; J. D. Alsop, 'Warfare and the Creation of British Imperial Medicine, 1600–1800', *Clio Medica*, 81 (2007), 23–50.

[42] David Arnold (ed.), *Imperial Medicine and Indigenous Societies* (Manchester: Manchester University Press, 1988), 1–26.

[43] David Arnold, 'Chapter 6 Health and Hegemony', *Colonizing the Body: State Medicine and Epidemic Disease*

indigenous responses. To Arnold, what is 'imperial' is the nature of the relationship between Western medicine and indigenous practices.

On a more transnational scale, imperial systems were significant in sanitary control and international movement, in which empires are considered as a whole. Efficiency and focal points of confrontation are important in this type of approach. Alison Bashford paid attention to state-controlled medical intervention that extended beyond national boundaries. Referring to both physical hygiene and conceptual hygiene (such as racial hygiene), she analysed Australia's position as a settler colony and its imperial network in the construction of 'imperial hygiene'.[44] Also, forced protection of people in foreign lands involved medical services of an imperial nature. Any control of mobility in an empire was often accompanied by medical care imposed on mobile populations, whether they be military or civilians. As Erica Charters has argued, the British Empire portrayed itself as a rightful imperial authority through its ability to provide adequate welfare and medical services to its armed forces.[45]

As such, imperial frameworks have been used in a variety of ways. A historiographical or theoretical consensus in what 'imperial medicine' exactly means do not seem to exist. The term has been used to differentiate each study from those of colonial frameworks. Similarly, colonial frameworks and 'colonial medicine' were used in a number of ways. Shula Marks notes that 'colonial medicine' largely overlaps with the histories of 'tropical medicine' in that it can 'pathologise' other races in medicalised racial discourses. She also remarked how the characteristics of 'colonial medicine' may be similar to modern biomedicine in general. She cites Arnold's book describing the development of modern medicine as a colonising process,

in Nineteenth-Century India (Berkeley: University of California Press, 1993), 240–289.

[44] Bashford, *Imperial Hygiene*.

[45] Erica Charters, *Disease, War, and the Imperial State: The Welfare of the British Armed Forces during the Seven Years' War* (Chicago: University of Chicago Press, 2014), 5–6.

which means professionalised medicine drove out traditional practitioners and claims to be able to eradicate all diseases.[46] This is similar to MacLeod's description of 'imperial medicine' having an 'imperial' power by nature, thus blurring the distinction between 'colonial medicine' and 'imperial medicine.' Like 'imperial medicine', historians have generally used 'colonial medicine' to examine 'medicine in colonies.' There seems to be no consensus on whether there are essential characteristics of 'imperial medicine' or 'colonial medicine.'

Colonial frameworks, in contrast to imperial ones, have been advocated by historians to highlight the multiplicity and plurality of actors, as Pratik Chakrabarti argued. Compared to 'imperial medicine', which many historians critically evaluated as being too monolithic, Chakrabarti considers colonial medicine's focus on a colony can help researchers zoom-in to the frictions and layers surrounding medical institutions to write a history from below.[47] Colonial framework could be especially useful when the subject of investigation is indigenous perspectives on health and medicine or locally-specific medical practices, such as Ryan Johnson and Amna Khalid's efforts to highlight the important role played by indigenous personnel in colonial medicine.[48] Arnold's study of colonial medicine in India also calls for the need to move beyond the diffusionist narrative of metropolitan medicine being projected on India. Instead, he suggests that there was a 'dialogue' between Western medicine and indigenous cultures.[49]

However, an imperial framework can also reveal the complexities of colonial

[46] Shula Marks, 'What is Colonial about Colonial Medicine? And What has Happened to Imperialism and Health?', *Social History of Medicine*, 10/2 (1997), 205–219..
[47] Pratik Chakrabarti, *Medicine and Empire: 1600–1960* (Basingstoke: Palgrave MacMillan, 2014). ix–xxxiv.
[48] Amna Khalid, Ryan Johnson, 'Introduction' in Ryan Johnson, Amna Khalid (eds.), *Public Health in the British Empire: Intermediaries, Subordinates, and the Practice of Public Health, 1850–1960* (New York: Routledge, 2012), 1–21.
[49] David Arnold, *Colonizing the Body: State Medicine and Epidemic Disease in Nineteenth-Century Indian* (Berkeley: University of California Press, 1993), 11–23.

encounters. MacLeod argued in his article that the growing field of global history of science needed scholarship that approaches from various perspectives (both imperial and colonial) to analyse the complexities of colonial relationships. Comparative and horizontal (as opposed to vertical) relationships will offer a fresh insight for historians to move beyond the plainly diffusionist history.[50]

This thesis does not intend to use 'imperial medicine' in the sense used by other authors, because its focus is not on the medicine of the imperial metropole, the dissemination of Western medicine, European bodies in tropical colonies, or the impact of Western medicine on the indigenous societies. Rather, this thesis is mainly concerned with the discourse surrounding medical centralisation on an imperial and sub-imperial scale, aiming to show the complexities of imperial relationships.

As Harrison showed in his study of public health in India, there were contentions and disagreements even between imperial authorities in a given colony and in its relationship with the metropole. The development and workings of public health systems is therefore best understood as 'a dynamic matrix of motives and sectional interests' which sometimes result in alignment between different levels of government and sometimes in friction and conflict.[51] For example, in the case of British India, municipal or provincial administrations were sometimes out of step with the central administration and with the government in London. 'Colonial' and imperial interests were not always aligned but colonial governance of issues concerning disease and medicine was related to broader imperial concerns and also, to some degree, to international ones, particularly when it came to the control of infectious diseases.[52] In order to

[50] Roy MacLeod, 'Introduction', *Osiris*¸15 (2000) 1–13.
[51] Mark Harrison, *Public Health in British India: Anglo-Indian Preventive Medicine, 1859–1914* (Cambridge: Cambridge University Press, 1994). 1–5.
[52] *Ibid.*, 117–138; Mark Harrison, 'The Great Shift: Cholera Theory and Sanitary Policy in British India, 1867–1879', in Biswamoy Pati, Mark Harrison (eds.), *Society, Medicine and Politics in Colonial India* (London:

better understand the complex relations between components of medical institutions in the empire, this thesis follows Harrison's approach to treat empire as one unit of investigation.[53] As Harrison did, multiple layers of interactions should be considered in historical analysis, for example, on a colonial, imperial, sub-imperial, international, intercolonial or interimperial level.[54] In case of this thesis, it is particularly important to analyse at the imperial and sub-imperial level to understand the process of medical centralisation in the British Pacific World.

Geographically, the centralised medical institutions discussed in this thesis concerns fifteen colonies across five empires (including sub-empires) in total, most of which were part of the British Empire. The scope of these institutions reached beyond a colonial level, and were thus imperial or sub-imperial in nature. Centralisation was pursued as a cost-efficient way to have effective health services in the Pacific Islands, saving the resources of many colonial governments. The process of centralisation stemmed from various actors in the region and, involved mobility within empires and promoted a certain degree of flexibility in racial hierarchies. As a final result, an imperial block of healthcare was formed between Britain and New Zealand, in which the British still maintained a leading role. With its focus on the institutional healthcare system, 'imperial health' best describes the essence of these developments.

Global and imperial history intersects with Pacific history in the topic of regionalism. Regionalism is one of the defining characteristics in Pacific history, i.e. international cooperation between the Pacific Islands. This is known as 'the Pacific Way', a term Ratu Sir Kamisese Mara used upon Fiji's independence.[55] The colonial roots of regionalism have been

Routledge, 2018), 37–60.

[53] Mark Harrison, *Medicine in the Age of Commerce and Empire* (Oxford: Oxford University Press, 2010).

[54] Mark Harrison, *Contagion: How Commerce Has Spread Disease* (New Haven: Yale University Press, 2012).

[55] Kamisese Mara, *The Pacific Way: A Memoir* (Honolulu: University of Hawai'i Press, 1997).

discussed by Greg Fry and Sandra Tarte.[56] Since regionalism could not be 'international' before decolonisation, 'intercolonial' or 'interimperial' frameworks would be more appropriate for this thesis. As Tomoko Akami has suggested, it was especially apparent in scientific and health organisations during the interwar period.[57] According to Akami, the Pacific was an 'open space' where 'interimperial cooperation' took place.[58] This thesis is an addition to the scholarship on Pacific regionalism in the field of healthcare.

Intercolonial and interimperial history of medical institutions may challenge popular perceptions on the Pacific Islands. This region is often depicted as empty, remote, and isolated. It is also common to envision small islands in the tropics as idyllic and pristine paradises.[59] This image was romanticised and orientalised in eighteenth and nineteenth century histories of exploration, which perpetuate the exotic descriptions of Pacific Islanders. To counter this stereotypical image, Epeli Hau'ofa proposed viewing the Pacific as 'our sea of islands' instead of 'islands in the sea.' This way, Oceania could be described as inhabited, connected, abundant, and flourishing, contrary to what Europeans liked to imagine.[60] In the past few decades, historians have tried to place Pacific Islanders as the main protagonists in their history.[61] And Sujit Sivasundaram attempts to portray indigenous agencies to counter popular Eurocentric

[56] Greg Fry, *Framing the Islands: Power and Diplomatic Agency in Pacific Regionalism* (Canberra: Australian National University Press, 2019); Sandra Tarte, 'Regionalism and Changing Regional Order in the Pacific Islands.', *Asia & the Pacific Policy Studies*, 1/2 (2014), 312–24.

[57] Tomoko Akami, 'Imperial Polities, Intercolonialism, and the Shaping of Global Governing Norms: Public Health Expert Networks in Asia and the League of Nations Health Organization, 1908–37', *Journal of Global History*, 12/1 (2017), 5–8.

[58] Tomoko Akami, 'The Open Ocean for Interimperial Collaboration' in Yuan Shu, Otto Heim, Kendall Johnson (eds.), *Oceanic Archives, Indigenous Epistemologies, and Transpacific American Studies* (Hong Kong: Hong Kong University Press, 2020), 149–153.

[59] Uma Kothari, Rorden Wilkinson, 'Colonial Imaginaries and Postcolonial Transformations: Exiles, Bases, Beaches', *Third World Quarterly*, 31/8 (2010), 1395–1412.

[60] Epeli Hau'ofa, 'Our Sea of Islands' in Eric Waddell, Vijay Naidu, Epeli Hau'ofa (eds.), *A New Oceania: Rediscovering Our Sea of Islands* (Suva: School of Social and Economic Development, University of the South Pacific, 1993).

[61] Nicholas Thomas, *Islanders: The Pacific in the Age of Empire* (New Haven: Yale University Press, 2010); Denoon (et al.), *The Cambridge History of the Pacific Islanders*.

narratives of the South Pacific.[62] Although this thesis approaches its subject from an institutional angle, paying more attention to the structure than individuals, it sympathises with many Pacific historians who have fought write the histories of the 'sea of islands.' This thesis tries to note the indigenous agency wherever possible. As Johnson and Khalid drew attention to the significance of indigenous medical staff working on the grounds, Pacific Islanders were major actors in the centralised medical system.[63]

Finally, few books are devoted to the study of military medicine in the British colonies during the Second World War, apart from official histories of war. Harrison's volumes on British military medicine during both world wars were one of the first attempts to write an integrated history highlighting the significance of medical units in both world wars.[64] The 'militarisation of medicine', borrowing Harrison's expression, was essential for modern warfare, which may lead to the 'medicalisation of war.'[65] This thesis supplements his works by uncovering the 'militarisation of medicine' during and after the Second World War in the South Pacific. It also follows Charters in regarding the medical care of armed forces as an important analytical tool for understanding the administration of imperial states.[66] Military medical arrangements are one of the key components used in this thesis to explain the effect of the war on the centralisation of medical services in the British Empire.

Much of the literature on military medicine in the South Pacific during the Second World War concerns Australian forces.[67] Some works emphasising the prime importance of

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[62] Sujit Sivasundaram, *Waves Across the South: A New History of Revolution and Empire* (London: William Collins, 2020) 339.

[63] Johnson, Khalid, *Public Health in the British Empire.*

[64] Mark Harrison, *Medicine and Victory: British Military Medicine in the Second World War* (Oxford: Oxford University Press, 2004); Mark Harrison, *The Medical War: British Military Medicine in the First World War* (Oxford: Oxford University Press, 2010).

[65] Mark Harrison, 'The Medicalization of War—The Militarization of Medicine', *Social History of Medicine,* 9/2 (1996) *267–276.*

[66] Charters, *Disease, War, and the Imperial State,* 1–17.

[67] Ian Howie-Wills, *A Medical Emergency: Major-General 'Ginger' Burston and the Army Medical Service in*

malaria on the Pacific front became good references to this thesis in understanding the tropical environmental factor in military medicine.[68] In a larger war context, Anne Perez Hattori's research on the US Navy and Judith Bennett's work on the 'diseased environments' of the South Pacific were useful in gaining a perspective on American medical policies in the war.[69]

Concerning the indigenous medical experiences in the Second World War, Annie Kwai and Asesela Ravuvu's books provide valuable indigenous voices to the scholarship.[70] A significant contribution was made by recent special issue of the journal *Health and History*, guest-edited by Alexandra Widmer and Christine Winter. Widmer and Winter positions the Second World War as 'a watershed for Pasifika medical personnel.'[71] In the special issue, Christine Winter, Victoria Stead, and Safua Akeli Amaama's articles examined indigenous medical staff and healthcare in Oceania during the war.[72] This thesis aims to supplement these works by showing indigenous medical personnel's roles in the Fijian military.

Existing literature showed that the Second World War was directed by empires, taking advantage of colonial resources. In any case, armed forces deployed overseas represent a direct act of expansionist imperialism. During the war, millions of military servicemen from the US

World War II (Newport: Big Sky Publishing, 2012); Jan McLeod, *Shadows on the Track: Australia's Medical War in Papua, 1942–1943* (Newport: Big Sky Publishing, 2019).

[68] Tony Sweeney, *Malaria Frontline: Australian Army Research during World War II* (Carlton: Melbourne University Press, 2003); Ian Howie-Wills, *An Unending War: The Australian Army's Struggle Against Malaria, 1885–2015* (Newport: Big Sky Publishing, 2016).

[69] Anne Perez Hattori, *Colonia Dis-ease: US Navy Health Policies and the Chamorros of Guam, 1898–1941* (Honolulu: University of Hawai'i Press, 2004); Judith A. Bennett, *Natives and Exotics: World War II and Environment in the Southern Pacific* (Honolulu: University of Hawai'i Press, 2009).

[70] Annie Kwai, *Solomon Islanders in World War II: An Indigenous Perspective* (Canberra: Australian National University Press, 2017); Asesela Ravuvu, *Fijians at War* (Suva: South Pacific Social Sciences Association, 1974).

[71] Alexandra Widmer, Christine Winter, 'Health and Medicine during and after the Pacific War: Pacific Islanders, Institutions, Infrastructure, Ingenuities', *Health and History,* 23/2 (2021) 1.

[72] Victoria Stead, 'Indigenous Infrastructures of Care and Survival in Papua New Guinea: Rethinking Pacific Health through Oral Histories of the Second World War', *Health and History* 23/2 (2021), 71–94; Christine Winter, 'Competent Men: Papaun and New Guinean Medical Staff in the Wake of the Pacific War' *Health and History* 23/2 (2021), 95–113; Safua Akeli Amaama, 'Mobilising People, Places, and Practice: Public Health Care in Samoa, 1920s to 1950s', *Health and History* 23/2 (2021), 10–28.

and New Zealand were stationed in the British colonies, including Fiji and the Solomon Islands. This contributed to further centralisation of medical institutions through the Allied forces, which mobilised medical resources in the region. In the case of the South Pacific, at least, military medicine was an important force in both imperial medicine and medical centralisation.

Sources

The analytical framework of this thesis required research on sources located in the United Kingdom (UK), United States of America(US), New Zealand, Fiji and Australia. In the UK, the Colonial Office documents were consulted in the National Archives at Kew. The papers of Trafford Smith, a colonial official in the Western Pacific, were found in the Bodleian Library Archives of the University of Oxford. Reports published by the South Pacific Health Service were obtained from the London School of Hygiene and Tropical Medicine Archives.

In the US, sources were collected from four archives. Documents concerning American Samoa and their Trust Territories in the Pacific were collected from the National Archives and Records Administration in College Park, Maryland. The Rockefeller Archive Centre in Sleepy Hollow, New York, preserved an excellent collection regarding the Rockefeller Foundation activities in the South Pacific. These documents proved essential in explaining the continuous centralisation of medical institutions in the region. The history of the Western Pacific Health Service could not have been constructed without these documents. The Franklin D. Roosevelt Presidential Library in Hyde Park, New York, was also consulted for the papers of Ross T. McIntire, the Surgeon General of the US Navy during the Second World War. Personal files of Sylvester M. Lambert, the Director of the Western Pacific Health Service, was collected from the University of California San Diego Archives.

This thesis also makes great use of documents collected in New Zealand. Western Pacific Archives at the University of Auckland held the Western Pacific High Commission collection. Their reports, memorandums, correspondence, and telegrams were very useful in drawing up the larger picture of the centralisation process. Archives New Zealand in Wellington held papers related to their territories of Western Samoa, the Cook Islands, Tokelau, and Niue. Especially, their documents on the Second New Zealand Expeditionary Force were significant in writing the chapters concerning wartime military medicine. An oral interview was held with Margaret Guthrie in Auckland. Her testimonies helped understand the circumstances surrounding the medical authorities in Fiji during the interwar years.

In addition, the National Archives of Fiji in Suva held an especially useful series of military medical corps records and documents related to the operation of medical institutions. Primary sources relating to Nauru and Papua New Guinea were collected from the National Archives of Australia in Canberra. A full collection of annual reports by the South Pacific Health Service was found in the Pacific Manuscripts Bureau, at the Australian National University, Canberra. Documents collected from the Australian War Memorial, the Sydney branch of the National Archives of Australia, and the Alexander Turnbull Library in Wellington were ultimately not used in this thesis as they were not directly related to the centralised medical institutions.

This thesis also makes use of published sources. Apart from newspaper clippings included in the archive files, this thesis used pamphlets, mostly published by Fiji's Government Press. Articles from *The British Medical Journal*, *American Journal of Tropical Medicine and Hygiene*, *Science*, *Canadian Journal of Public Health* were used in some chapters.

Figures used in this thesis are obtained from Margaret Guthrie's personal collection and websites of the Imperial War Museum London, the Alexander Turnbull Library of the

National Libraries of New Zealand, New Zealand Electronic Text Collection run by the Victoria University of Wellington, and Fijian History run by the University of South Pacific.

Drawing upon the twelve archives listed above, this thesis studies the centralisation of the South Pacific under one imperial healthcare system. By exploring how empires, colonies, and private institutions encountered each other in centralised institutions, this thesis challenges prevailing notions of Oceania as remote, empty, and unimportant to the British Empire. On the contrary, the history of indigenous healthcare shows that Oceania was a highly connected, contested, and global region. Ultimately, it underscores the importance of paying attention to the sub-imperial dimension in the scholarship of the British Empire, medical history, and Pacific history.

Summary of Chapters

This thesis is structured chronologically in three parts. The first investigates the origins of centralised medical institutions during the interwar years. Chapter 1 begins with the establishment of the Central Leper Hospital as the earliest intercolonial medical institution that was centralised in 1927. It was run by the government of Fiji, jointly funded by participating colonial administrations and staffed by French Catholic nuns. The hospital's patients mostly came from British, New Zealand, and American colonies: Fiji, the Solomon Islands, the Gilbert and Ellice Islands, Tonga, Western Samoa, the Cook Islands and American Samoa. While it is better known as the Makogai Leper Colony, its administrative name indicates that it was part of the larger centralisation scheme. After outlining the intercolonial establishment of the hospital, this chapter discusses how the Pacific Islands were connected through 'leper cruise' journeys and how leprosy patients were racially segregated in the hospital island.

Chapter 2 is about the Central Medical School, where indigenous medical practitioners were trained to tackle the severe depopulation problems in Oceania. It was established in 1928 as an expansion of the existing Suva Medical School. The school was run by Fiji, staffed by British tutors, financially assisted by the Rockefeller Foundation, and jointly operated by the imperial governments of Britain, Australia, New Zealand, France and the US. As the school developed over time, students were drawn from Fiji, the Solomon Islands, the Gilbert and Ellice Islands, New Hebrides, Tonga, Western Samoa, the Cook Islands, Tokelau, Nauru, Papua New Guinea, American Samoa, and the US Trust Territory of the Pacific Islands. This chapter discusses the establishment, development, and racialised policies of the school, depicting it as a space for colonial encounters.

Chapter 3 introduces the Western Pacific Health Service, an umbrella institution that supervised other centralised medical institutions. It was established in 1928 in conjunction with the Central Medical School. This service is heavily funded by the Rockefeller Foundation and directed by the foundation's representative in the Pacific, Sylvester Lambert. As the name 'Western Pacific' suggests, it was established as a department under the Western Pacific High Commission. During its eleven years of existence, it led medical campaigns in the British and New Zealand territories: Fiji, the Gilbert and Ellice Islands, the Solomon Islands, New Hebrides, Tonga, Western Samoa and the Cook Islands. This chapter reveals that the Western Pacific Health Service campaigns were, in many countries, the first time colonial officials visited remote islands where they collected environmental and demographical knowledge. It is a rare case of an American philanthropic institution running a colonial department in the British Empire, its staff becoming the Deputy Central Medical Authority in the Western Pacific High Commission.

The second part of the thesis considers medical centralisation during the Second World

War. Chapter 4 examines the establishment of the Fiji Medical Corps under the Fiji Military Forces. It was established in 1941 as the war in the northern Pacific gradually advanced south. Since the Fiji Military Forces were under New Zealand command, running the Fiji Medical Corps involved negotiations between Fiji and New Zealand in securing the maximum interest of each party. This chapter first looks at the establishment and medical arrangements of the Fiji Medical Corps, including the establishment of 1 Bearer Company which was staffed by indigenous Pacific Islanders. Then, it discusses the ambiguous status of Fijian medical personnel and hospitals under the New Zealand leadership.

Chapter 5 investigates how the Second New Zealand Expeditionary Force cooperated with the US and other Pacific Islands during the Second World War. In the early years of the war, the Second New Zealand Expeditionary Force had a large number of men stationed in Fiji. This was called the Fiji Section, which also commanded the Fiji Military Forces. As the war escalated, New Zealand focused its forces in the Solomon Islands, in its Third Division. Supporting facilities, including divisional headquarters and a general hospital, were located in New Caledonia. This chapter analyses the medical arrangements of New Zealand forces focusing on imperial cooperation in Fiji, the Solomons, and New Caledonia. It also notes how New Zealand relied on the US forces for its medical decisions and resources for war in tropical islands.

The final part of the thesis examines how centralised institutions that were created during the Second World War were developed further after the war. Chapter 6 deals with the South Pacific Health Service, which was established in 1946. It was a centralised medical service between British and New Zealand colonies, including a pool of medical staff. The service was also given full authority in all medical matters in the participating territories and existing centralised medical institutions. Fiji, the Solomon Islands, the Gilbert and Ellice

Islands, Tonga, New Hebrides, Western Samoa, the Cook Islands, Tokelau, and Niue were part of it. At the same time, its imperial connotations echo the character of the Western Pacific Health Service. Despite its initial ambitions, the service failed to bring Australian and American participation. However, Australia and the US continued to take advantage of participation in the Central Leper Hospital and the Central Medical School. This chapter unfolds the interimperial discussions surrounding the establishment of the South Pacific Health Service. It argues that the British were able to perpetuate their imperial influence in the region through this sub-imperial institution.

Chapter 7 completes the study of medical centralisation through an analysis of the Central Nursing School and the Suva Medical Centre. The Central Nursing School was planned since the 1930s and established in 1941. Although the school was part of the centralisation plan, it was not widely intercolonial due to wartime constraints. The majority of its students came from Fiji, with occasional students from the Gilbert and Ellice Islands, Tonga, Rotuma, and the Cook Islands. The other institution, the Suva Medical Centre, could not be established as planned and became merely an enlargement of the Colonial War Memorial Hospital. Both institutions were planned before the Second World War but were heavily influenced by the prospect of the South Pacific Health Service and wartime changes. By explaining the establishment and development of these institutions, this chapter demonstrates how the Second World War disrupted an ambitious scheme to make Fiji the medical capital of the Pacific.

As a whole, this thesis argues that medical institutions were centralised as a cost-effective governance method that allowed the British to maintain an influential position in the region. They also served as racial laboratories and were a means to accumulate colonial knowledge. By teasing out the complex dynamics of intercolonial, interimperial, and intraimperial relations in medical institutions, this thesis helps to remedy a profound lack of

research on the region. In addition, it situates indigenous healthcare in Oceania in larger discourses of medical history, imperial history, and Pacific history.

PART I

Chapter 1. The Central Leper Hospital

The first medical institution that was centralised in the South Pacific was the Central Leper Hospital (CLH). It was established in 1927 as an expansion of the existing Makogai Leper Colony in Fiji (variously known as the Makogai Leper Station, the Makogai Leper Asylum, or the Fiji Leprosy Hospital), which was founded in 1911. At its founding, six countries in the British Empire invested in the hospital to treat leprosy patients from at least twelve different ethnic backgrounds.[73] With the hospital setting an example, subsequent centralised institutions also used the word 'central' in their names, e.g., the Central Medical School, the Central Nursing School. However, there are only faint traces of the connection between the CLH and the other centralised institutions in the historiography. This is because the hospital is so widely known by the name of its geographical location, Makogai Island, that its official administrative name is barely noticed. Even official government brochures published after 1927 simply call it 'Makogai.'[74] This chapter will call the institution by its administrative name, the CLH, and use Makogai to refer to the physical place or the hospital before centralisation.

A number of works on the Makogai Leper Colony are referred to in this chapter, the most notable being the special issue 'Leprosy in the Pacific' published in 2017 by the *Journal of Pacific History*. Authors in this special issue have discussed leprosy in Hawai'i, the Cook Islands, Fiji, Western Samoa, and Papua with particular attention to the subjectivity and

[73] From Acting High Commissioner to the British Agent and Consul in Tonga, 14 October 1924, WPHC4/IV 1150/1924, Western Pacific archives. MSS & Archives 2003/1. Special Collections, University of Auckland Libraries and Learning Services (WPA).

[74] Frederick Hall, *The Leper Hospital, Makogai: A Short Description* (Suva: J. J. McHugh, Acting Government Printer, 1920) RC154.9.F5H32, National Archives of Fiji (NAF); *Fiji Leprosy Hospital: Makogai* (Suva: Government of the Colony of Fiji, Government Press, 1954) RC154.9.F5A9, NAF.

community of leprosy patients.[75] Works that kept a focus on the CLH were Jane Buckingham's articles which carried out oral history research of people affected by leprosy.[76] Accounts written by previous staff members, such as Mary Stella and Richard J. Cushing, were useful first-hand records from Makogai.[77] Benjamin Kingsbury's book explains the process of transferring New Zealand patients to the CLH and tells the story of New Zealand patients who went to Fiji.[78]

For an understanding of leprosy in a wider imperial context, works that do not have a narrow focus on the Pacific Islands needed to be consulted. In early twentieth century, the British Empire pursued 'constructive imperialism' under the lead of Joseph Chamberlain, which involved various development projects in the British colonies including healthcare.[79] One of the concerning problems in pursing this policy was leprosy. Alison Bashford has argued leprosy was an 'imperial disease' because it posed an 'imperial danger' of infecting white Europeans in so many of the British colonies. Eradication of leprosy, therefore, became an 'imperial mission' to the British Empire. However, leprosy was not as contagious compared to the attention it received under the imperialist agenda. As Bashford pointed out, its contagiousness was debated throughout the British Empire. The perceived threat was more of a product of fear.[80] According to Zachary Gussow, leprosy gained such a strong social stigma

[75] Luker, Buckingham, 'Histories of Leprosy: Subjectivities, Community and Pacific Worlds', *The Journal of Pacific History*, 52/3 (2017). 265–419.

[76] Jane Buckingham, 'The Pacific Leprosy Foundation Archive and Oral Histories of Leprosy in the South Pacific', *The Journal of Pacific History*, 41/1 (2006) 81–86; Jane Buckingham, 'The Inclusivity of Exclusion: Isolation and Community Among Leprosy-Affected People in the South Pacific', *Health and History,* 13/2 (2011) 65–83.

[77] Mary Stella, *Makogai: Image of Hope: A Brief History of the Care of Leprosy Patients in Fiji* (Christchurch: New Zealand Lepers' Trust Board, 1978); Richard J. Cushing, *In the Service of the Lepers: A Brief Outline of the Work of the Missionary Sisters of the Society of Mary among the Lepers of the Isle of Makogai, Fiji Islands*, (Boston: Society for the Propagation of the Faith, 1940).

[78] Benjamin Kingsbury, *The Dark Island: Leprosy in New Zealand and the Quail Island Colony* (Wellington: Bridget Williams Books, 2019).

[79] Anna Greenwood, 'The Art of Medicine: Diagnosing the Medical History of British Imperialism', *The Lancet,* 400/10354 (2022), 726.

[80] Bashford, *Imperial Hygiene,* 83–93.

in the late nineteenth century following the discovery of bacteria causing the disease. The belief that it was found in tropical colonies among the colonised people spread the fear of contagion among imperialists.[81] Explaining how leprosy was historically stigmatised, Rod Edmond has argued that leprosy was racialised and sexualised as European empires expanded. His book is a good starting point to gain a wider perspective on the disease in the South Pacific during the high imperial era.[82]

Although these works all acknowledge the diversity in the CLH, they do not explain why and how the hospital was centralised between colonial governments. Consequently, the CLH's significance as the beginning of a medical centralisation movement is lost in the scholarship. This chapter examines why a group of South Pacific countries together established the CLH, how the centralisation facilitated travel between islands, and in what ways the hospital practised racial segregation. Focusing on the earlier period of the CLH, this chapter argues that the CLH was a site of connection and segregation at the same time. While Edmond addressed leprosy in empires by discussing a range of colonial cases, this chapter maintains a focus on the CLH to examine the British imperial solution to the leprosy problem. That said, this chapter will use the terms used by the imperial authorities at the time to reflect the historically stigmatising connotations on the disease. For example, 'leprosy' is used instead of 'Hansen's disease' and 'lepers' instead of 'Hansen's disease patient.'

Establishment of the Central Leper Hospital

Centralisation of leper treatment in the South Pacific started at the initiative of Western

[81] Zachary Gussow, *Leprosy, Racism, and Public Health: Social Policy in Chronic Disease Control* (Boulder; London: Westview, 1989), 201–210.
[82] Rod Edmond, *Leprosy and Empire: A Medical and Cultural History* (Cambridge: Cambridge University Press, 2006). 1–23.

Samoa as early as July 1920. On behalf of the New Zealand government, the Governor-General of New Zealand asked Fiji if Samoans at their leper station could be accommodated at Makogai. This was to save the high maintenance cost of the leper station and to provide the patients with better medical attention. Following Fiji's acceptance, Western Samoa sent thirteen lepers to Makogai in August 1922. Another batch of seven patients arrived in May 1924, and more followed in the next years as more patients were diagnosed. To cover the cost of treating Samoan patients, the Western Samoan government paid £1,048 in 1922 for the construction of extra housing and a further £400 in 1925 for extended accommodation. In Safua Akeli's words, this was the 'Makogai solution.'[83]

After taking in Western Samoan patients, Fiji devised a scheme to enlarge Makogai in 1923. The Colonial Secretary of Fiji, T. E. Fell, proposed to make Makogai 'a general one for all the British Colonies of the Western Pacific.' The extended leper hospital would 'confer an immense public benefit throughout the Western Pacific', given the combined efforts of the Western Pacific High Commission (WPHC), Fiji, Tonga, Western Samoa, and the Cook Islands in centralising leprosy treatment. The plan was shaped to ultimately benefit Fiji, the hosting country. While the total cost of running the institution would be shared, the ownership of any investment or constructions made by other administrations in Makogai would belong to Fiji, with Fiji authorities having entire control over the property.[84]

Fell's proposal was forwarded to the Secretary of State for the Colonies by the Governor of Fiji and received strong support from the Colonial Advisory Medical and Sanitary

[83] Western Samoa's leper station was at Nu'utele island at the time. Safua Akeli, 'Cleansing Western Samoa: Leprosy Control during New Zealand Administration, 1914–1922', *The Journal of Pacific History*, 52/3 (2017), 360–373. However, the primary source this paragraph consulted refers to a leper station at Nusufee. It is possible that an island called Nuusafee, not far from Nu'utele, was mistaken. See: Appendix No.1, Memorandum by the Acting Colonial Secretary, WPHC4/IV 329/1935, WPA.

[84] From Acting Colonial Secretary of Fiji to the Acting Secretary of the Western Pacific High Commission, 21 May 1925, WPHC4/IV 1150/1924, WPA.

Committee.[85] Following the approval of the Secretary of State, Fiji embarked on the centralisation scheme in May 1924 by inviting New Zealand and its colonies.[86] The mutual benefit of centralisation was clear. However, there were difficulties in realising the scheme. Two of the main challenges were providing accommodation and finding transport. The first issue was dealt with through Fiji's advisory role in guiding other administrations on the matter of accommodation. Finding suitable transport to collect the lepers from each island on which they resided was more difficult. To determine its feasibility, Fiji approached Tonga and New Zealand with three questions: the approximate number of patients in each country, their willingness to fund the maintenance of patients, and their willingness to bear the cost of transport.[87]

Tonga welcomed this suggestion. In January 1925, the British Agent and Consul reported that 'Tonga would be glad to avail themselves of the immense advantages of such a scheme as is outlined.' To answer Fiji's question, Tonga was willing to bear the cost of treatment and transport for the ten known lepers in the country.[88] Welcoming the response, Fiji offered to temporarily redistribute existing accommodations until a housing dedicated to Tongans was built. Any further lepers found in Tonga could be additionally transferred to Makogai as long as accommodation was available.[89] Permanent accommodation for Tongan patients cost about £591 in the end.[90] In 1927, Tonga sent thirteen patients to Makogai in the

[85] Appendix No.1, Memorandum by the Acting Colonial Secretary, WPHC4/IV 329/1935, WPA.
[86] From Acting Governor to the Governor General of New Zealand, 7 May 1924, ACGA 8280 EX8/8 Part.1 R17962833, Archives New Zealand Te Rua Mahara o te Kāwanatanga, Wellington (ANZ).
[87] Appendix No.1, Memorandum by the Acting Colonial Secretary, WPHC4/IV 329/1935, WPA.
[88] From the British Agent and Consul to the Acting High Commissioner of the Western Pacific, 7 January 1925, WPHC4/IV, 1150/1924, WPA.
[89] From Acting Colonial Secretary of Fiji to the Acting Secretary of the Western Pacific High Commission, 21 May 1925, WPHC4/IV 1150/1924, WPA.
[90] Tonga. Authority for Expenditure in Excess of that provided in the Estimates for the year, 12 November 1926, WPHC4/IV 1150/1924, WPA.

first batch.[91]

New Zealand was also eager to send lepers to Fiji. Since Western Samoa had already sent their lepers to Fiji, New Zealand wanted the Cook Islands and Niue to join Makogai too. Additionally, New Zealand asked Fiji if they could send ten domestic patients who were at their leper station in Quail Island, Lyttleton.[92] In the meantime, Sir Māui Pōmare visited Quail Island in March 1925 to discuss the matter with the lepers. As well as being the first Māori doctor and Māori Health Officer, Pōmare was a prominent Māori politician at the time, serving as the Minister of Health and Minister of the Cook Islands.[93] He personally explained the transfer to the lepers and persuaded them that Makogai would be more comfortable for them. The patients reportedly agreed unanimously to the transfer.[94] According to J. F. Cody, the patients agreed to leave their homeland because they had great trust in Pōmare 'who had been their father for so long.'[95] However, Benjamin Kingsbury showed in his book that the visit to Quail Island and discussion with the patients was done by M. H. Watt, the Acting Director-General of Health, and that a patient named Te Ono Parao protested against moving to Fiji.[96] Cabinet approval did not take long after the patients' consent. New Zealand decided to transfer their lepers to Fiji in April 1925.[97]

The Cook Islands identified 32 patients and Niue reported two following the invitation of Fiji.[98] At the time, the Cook Islands leper station at Moturakau island near Aitutaki was

[91] From Colonial Secretary to the Secretary of the Western Pacific High Commission, 10 November 1927, WPHC4/IV 1150/1924, WPA.
[92] Appendix No.1, Memorandum by the Acting Colonial Secretary, WPHC4/IV 329/1935, WPA.
[93] Māui Wiremu Piti Naera Pōmare, *Dictionary of New Zealand Biography* (Online Source), https://teara.govt.nz/en/biographies/3p30/pomare-maui-wiremu-piti-naera (accessed on 7 August 2022).
[94] From the Director-General of Health to the Secretary of Department of External Affairs, 11 March 1925, ACGA 8280 EX8/8 Part.1 R17962833, ANZ.
[95] J. F. Cody, *Man of Two Worlds: Sir Maui Pomare* (Wellington: A. H. & A. W. Reed, 1953), 149.
[96] Kingsbury, *The Dark Island*, 132.
[97] From J. D. Gray to the Director-General of health, 9 April 1925, ACGA 8280 EX8/8 Part.1 R17962833, ANZ.
[98] Memorandum from the Prime Minister to the Governor-General, 3 October 1925, ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.

insufficient to accommodate all patients.[99] Most patients continued living in their original village or were isolated in small islets near larger islands. According to Raeburn Lange, the Cook Islands hoped to centralise the leprosy cases in one place but never implemented the plan.[100] Instead, following Fiji's invitation, the Cook Islands actively began the search for lepers for transfer to Makogai.[101] Given the large number of Cook Islands patients, Fiji asked New Zealand to build a separate accommodation which cost about £2,110.[102] The first batch of lepers was to be transferred in 1926 once the accommodation was ready.

By the end of 1927, Makogai Leper Colony was established as the CLH between Fiji, Tonga, and New Zealand territories. Of the 439 lepers being treated, the majority were from Fiji, contributing up to three quarters of the patients. At the time, there were fourteen patients classified as Europeans and 'half-castes' and thirteen Chinese patients. The patient population continuously increased as more cases were sent, and more countries joined later. The following table shows a breakdown of patients' nationalities and ethnicities in 1927.[103]

[99] From the Resident Commissioner to the Secretary of the Cook Islands Administration, 3 August 1924, ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.
[100] Raeburn Lange, 'Leprosy in the Cook Islands, 1890–1925', *The Journal of Pacific History* 52/3 (2017), 316–317.
[101] Memorandum from the Resident Commissioner to the Secretary of the Cook Islands Administration, 11 January 1926, ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.
[102] Appendix No.1, Memorandum by the Acting Colonial Secretary, WPHC4/IV 329/1935, WPA.
[103] Enclosure No.4, Annexure, Report of a Committee Appointed to Investigate the Finances of the Institution and to Submit Recommendations for a Revision of the Arrangements that Exist with Other Administrations for the Admission of Lepers, WPHC4/IV 329/1935, WPA.

Country	Race	Unit
Fiji	Natives and Indians	322
	Chinese	8
	Europeans and ‘half-castes’	3
Western Samoa	Natives (Samoans)	15
	Natives (Solomon Islanders)	3
	Chinese	3
	‘Half-castes’	5
American Samoa	‘Half-caste’	1
Tonga	Natives	12
	‘Half-caste’	1
Cook Islands	Natives	57
New Zealand	Maoris	3
	Chinese	2
	Europeans and ‘half-castes’	4
Total		439

Table 3. Racial composition of the CLH, 1927.
[Source: WPHC4/IV 329/1935, WPA]

The Gilbert and Ellice Islands decided to join the CLH in 1932, years after its establishment. The Senior Medical Officer explained that modern treatment of leprosy was based on fresh food, suitable housing, a cheerful environment, and systematic therapy in which able-bodied patients worked in the open air for remuneration. In his opinion, the leper station at Nanikai island in Tarawa was unsuitable for growing fresh crops, too crowded, and lacked frequent visits by medical officers. Transferring patients to Makogai could solve the problem.[104] As Pōmare did in New Zealand, the Resident Commissioner made the decision to

[104] From Acting Senior Medical Officer to the Resident Commissioner of Gilbert and Ellice Islands Colony, 14 August 1932, WPHC9 52/10 Vol.1, WPA.

join the CLH after visiting Nanikai, where he gained 'unanimous consent' to the transfer.[105] In November 1935, 48 patients formed the first group to be sent to the CLH.[106]

These earlier participants of the CLH centralised leprosy treatment for three reasons. Firstly, it was cost-efficient for joining countries to entrust the CLH and Fiji government to run a leper station. This motivation was strongest in the case of Western Samoa. When Western Samoa first brought up the idea in 1920, they found their leper station in the 'most unsatisfactory' condition with excessive cost. Medical authorities complained that the station was managed extravagantly by two Roman Catholic Sisters, upon whom Western Samoa depended for the care of their lepers. By sending the patients to Fiji, Western Samoa did not have to sign any more vouchers submitted by the nuns.[107]

Secondly, centralisation provided better leprosy treatment. As shown in the case of the Gilbert and Ellice Islands, the CLH attracted partners for its high-quality treatment. The Resident Commissioner of the Gilbert and Ellice Islands wrote:

> It is almost impossible to describe in words the contrast between the impression of spacious environment and the atmosphere of good cheer and hopefulness prevailing at Makogai and the sense of crowded confinement, arid desolation, and gloom pervading the islet of Naanikai to which the unfortunate lepers of this Colony are at present compulsorily relegated.[108]

This is the reason patients willingly went to Makogai. The reputation of the CLH at the time

[105] From the Resident Commissioner to the High Commissioner for the Western Pacific, 27 March 1934, WPHC9 52/10 Vol.1, WPA.
[106] From the High Commissioner of the Western Pacific to the Secretary of State for the Colonies, 12 December 1935, WPHC9 52/10 Vol.1, WPA.
[107] From the Administrator to the Minister of External Affairs, 13 November 1920, ACGA 8280 EX8/8 Part.1 R17962833, ANZ.
[108] From the Resident Commissioner to the High Commissioner for the Western Pacific, 27 March 1934, WPHC9 52/10 Vol.1, WPA.

even rivalled the famous American station in Moloka‘i, Hawai‘i.[109]

Finally, transferring all lepers to the CLH was a project to eliminate the perceived threat of leprosy in the participating countries. Rod Edmond has pointed out that New Zealand regarded the removal of patients to Makogai as a solution to ‘the leper problem.’[110] Safua Akeli also describes the transfer of Western Samoan lepers as a process of ‘cleansing.’[111] The reason New Zealand offered Western Samoa a leper transport was to ‘remove lepers immediately’ from the islands.[112] New Zealand was hopeful of ‘removing all of the lepers in the Cook Group’ as well.[113] As Raeburn Lange argued, New Zealand’s ‘imperial motives’ segregated lepers in the Cook Islands which ultimately led to the ‘solution’ of transferring all to Makogai.[114] As for Tonga, the High Commissioner of the Western Pacific referred to the participation in the CLH as ‘the removal of lepers.’[115] The Gilbert and Ellice Islands, too, shared a similar stance when they reported that their lepers were ‘awaiting removal.’[116]

Centralised Operation and Finances

The CLH was an intercolonial project that promoted British imperial prestige in the Pacific. After the first batch of Cook Islanders were transferred to Makogai, Pōmare advised the New Zealand Prime Minister to discuss the improvement of Makogai facilities with the

[109] ‘Conditions in Samoa —Treatment of Lepers’, New Zealand Herald Auckland, 17 August 1922, ACGA 8280 EX8/8 Part.1 R17962833, ANZ.
[110] Rod Edmond, *Leprosy and Empire*, 174.
[111] Akeli, ‘Cleansing Western Samoa’.
[112] From External, Wgton to Admor, Apia, 26 May 1925, ACGA 8280 EX8/8 Part.1 R17962833, ANZ.
[113] Memorandum from the Prime Minister to the Governor-General, 3 October 1925, ACGA 8280 IT110/4/1 Part.1 R17963606 Part.1, ANZ.
[114] Lange, ‘Leprosy in the Cook Islands’, 323.
[115] From the High Commissioner to the British Agent and Consul of Tonga, 29 May 1925, WPHC4/IV 1150/1924, WPA.
[116] From the Resident Commissioner to the High Commissioner for the Western Pacific, 27 March 1934, WPHC9 52/10 Vol.1, WPA.

Colonial Office when he visited London. The quality of treatment in Makogai was only second to Moloka‘i in the Pacific, which was maintained by the American government in Hawai‘i. Pomare saw it as necessary, ‘both in the interests of the patients and for the sake of British prestige, that the Station in Fiji should be kept in an equally up-to-date condition as regards equipment, staffing and treatment.’[117] This imperial motivation justified British and New Zealand financial investment in the CLH.

In order to make the hospital the top leprosy station in the Pacific, Sir Eyre Hutson, the Governor of Fiji, appointed a committee to examine the finances and development of facilities. In addition to five members from Fiji, Pōmare and S. J. Smith from the Department of External Affairs of New Zealand were appointed to represent New Zealand territories. Pōmare’s appointment was particularly appreciated by the committee considering his highly respected status among the Cook Islanders and Māori population.[118]

The committee discussed procedures and funding sources for the hospital’s operation. In 1928, the CLH was registered as Makogai Limited.[119] Since it was ‘a partnership concern’, a business model of a joint-stock company was considered the most equitable way to operate such an intercolonial institution. Each country was credited with the amount they contributed, which was opened in a separate set of books. Working expenses were debited with a 5% per annum interest rate on capital at the end of each year. The interest was then credited proportionately to each country. For the final financial adjustment, the payable interest was deducted from the amount due from each country which was the patient maintenance fees. The cost for patients was to be ascertained after a year, with an actual figure to be charged the

[117] From the Minister for the Cook Islands to the Prime Minister, 10 September 1926, ACGA 8280 EX8/8 Part.1 R17962833, ANZ.
[118] Annexure, From the Committee to the Acting Governor, 26 January 1928, WPHC4/IV 329/1935, WPA.
[119] Stella, *Makogai, Image of Hope*, 75.

following year. Countries that provided extra contributions would receive interest thereon. Fiji made the largest contribution by purchasing the island of Makogai and constructing most of the hospital facilities. Western Samoa, the Cook Islands and Tonga bore the cost of building accommodations for their patients. Although these buildings were ultimately given to Fiji, the amount spent for construction was treated as a financial contribution to the joint stock company. The following table shows the initial financial contribution and units, which represents the size of the patient group, as of 31 December 1927.[120]

Administration	Capital Contribution	Units under Treatment
Fiji	£47,675	340
Western Samoa	£1,448	32.5
Cook Islands	£2,110	57
Tonga	£591	14
New Zealand	Nil.	17
American Samoa	Nil.	2
Total	£51,824	462.5

Table 4. Capital contribution of each participating country. [Source: WPHC4/IV 329/1935, WPA]

Accounts and annual financial statements were rendered to each country by the Medical Department of Fiji, which held the entire control of the institution. Statements for New Zealand patients were directed to the Director of Public Health in Wellington. Those for Cook Islanders were sent to the Minister for the Cook Islands, Wellington, and Western Samoan statements were delivered to the Administrator of Western Samoa in Apia. Tongan accounts were directly sent to the Premier of Tonga, and the Governor of American Samoa at Pago Pago received

[120] Annexure, From the Committee to the Acting Governor, 26 January 1928, WPHC4/IV 329/1935, WPA.

those for American Samoans.[121] The maintenance expenditure continuously rose in the first four years of centralisation following a constant increase in patient numbers and public works. The total expenditure, including medical works and public works, grew from £8,595 in 1924 to £9,788 in 1925, £10,750 in 1926, and £14,306 by 1927, when the institution was established as the CLH.[122] Likewise, the patient maintenance charge, which was £40 per annum per person in 1924, increased to £47.4s.5d. in 1927.[123]

The process of developing the hospital, however, required financial negotiations between participating colonies. The hospital needed a dispensary equipped with a bath and septic tank, an extension of patient accommodation, a hospital for clean labour, an oil mill, refrigerating machines, an improved road for motor transport between Nasau and Dalice, quarters for junior medical officers, one main water reservoir, and a cottage for public works department. To cover the estimated cost of these works, a total of £15,000, the CLH needed a financial source. Eventually, a Makogai Loan Fund was created so payments could be made annually over twenty years.[124]

Although Fiji generally did not wish to make extra contributions to the hospital, it occasionally funded major public works that were not covered by the Loan Fund. In 1936, work on a lighting scheme was approved by the Legislative Council of Fiji at the cost of £3,500. Until then, two small petrol-driven generators supplied the power for the entire hospital, including lighting in the hospital, associated buildings, wireless communication, a ndilo and chaulmoogra oil extraction plant, and two refrigerators. This was costly, insufficient, and unstable. With the new scheme, two diesel engines and generators replaced the existing ones

[121] Summary of Recommendations, 26 January 1928, WPHC4/IV 329/1935, WPA.
[122] Enclosure No.6 Maintenance Expenditure, 1924–1927, WPHC4/IV 329/1935, WPA.
[123] Appendix No. 2. Estimated Cost per Unit on Proposed Basis, WPHC4/IV 329/1935, WPA.
[124] Annexure, From the Committee to the Acting Governor, 26 January 1928, WPHC4/IV 329/1935, WPA.

in the 'clean area', which transmitted current for all electricity needs on the island. Refrigerators were upgraded to larger ones for chilled provisions.[125] Fiji still asked participating administrations to help by bearing cost per capita. This meant an increase in per capita charge by 6/4.5d. calculated as 5% of £3,500, divided by 550 units.[126]

General construction costs were covered by the Makogai Building and Replacement Fund. An annual contribution to the fund was £1,254, calculated at 3% of the value of buildings at Makogai in January 1928. As the leper settlement grew, the funds proved increasingly insufficient to meet the demands. An increase of the annual contribution from £1,254 to £2,000 was proposed in 1939. The increased amount of £746 was apportioned according to the patient numbers sent by each country. The breakdown of each country's extra contribution from 1939 is as follows: Fiji £497, the Cook Islands £93, the Gilbert and Ellice Islands £78, Western Samoa £47, Tonga £16, New Zealand £12, and Niue £3.[127] This reflects that although the CLH was an intercolonial institution, much of the operational costs were borne by Fiji, the centre of the British imperial rule in the South Pacific. Compared to the British colonies, New Zealand and its colonies did not pay too much.

Operational arrangements of the centralised institution were regularly reviewed every five years and when it was deemed necessary.[128] A financial adjustment took place in 1935 when a question of liability to a minimum number of contributions was brought. Fiji pointed out that while everything else was satisfactory, the participating administrations should be liable to contribute to the maintenance of the CLH regardless of the actual number of patients

[125] Financial Minute No. 17 of 1936, WPHC4/IV 329/1935, WPA.
[126] From Acting Director of Medical Services to the Secretary of Western Pacific High Commission, 7 January 1937, WPHC/IV 329/1935, WPA.
[127] From the Acting Colonial Secretary to the Secretary of the Western Pacific High Commission, 20 September 1939, WPHC4/IV 329/1935, WPA.
[128] From the Acting Colonial Secretary to the Secretary of the Western Pacific High Commission, 2 February 1935, WPHC4/IV 329/1935, WPA.

they had. In this regard, Fiji asked participating administrations to guarantee payment for a minimum number of units; that is, for a group of a particular size, even if they had fewer patients at the hospital than anticipated. They proposed 10 units for New Zealand, 12 units for Western Samoa and Niue together, ten units for the Cook Islands, ten units for the Gilbert and Ellice Islands, and eight units for Tonga.[129] This suggestion was accepted by all the joining countries.

Most operational decisions were easily agreed upon except for a few cases of immigrant patients, which later became a matter of dispute. For instance, when Western Samoa first asked Fiji to accept their lepers, they had more non-Samoans than Samoans. Out of eight confirmed and one suspect cases, three were Chinese, one was a Cook Islander, and two were 'half-castes' (one British and one American).[130] In 1925, two Solomon Islanders were sent to Makogai from Western Samoa.[131] Three Cook Islanders were transferred from Niue between 1922 and 1929.[132] The Gilbert and Ellice Islands had a Chinese in their first batch of lepers to Makogai who worked for the British Phosphate Commission.[133]

Many Asian patients did not remain in Makogai until discharge or death. Instead, they were often repatriated to their origin countries. By 1922, 267 Indians who were admitted to Makogai were already taken back to India.[134] As for the Chinese, popularly referred to as the 'Asiatics', those under contract with plantations could be repatriated when their contract terminates. Other cases may or may not be repatriated because leprosy was not included in the

[129] Governor of Fiji to the Governor General of New Zealand, 29 January 1935, WPHC4/IV 329/1935, WPA.
[130] From the Administrator to the Governor of Fiji, 7 April 1921, ACGA 8280 EX8/8 Part.1 R17962833, ANZ
[131] From Admor, Apia to External, Wellington, 6 July 1925, ACGA 8280 EX8/8 Part.1 R17962833, ANZ.
[132] Cook Islands Lepers at Makogai Leper Asylum, ACGA 8280 IT110/4/2 Part.2 R17963608, ANZ.
[133] From the Resident Commissioner to the High Commissioner for the Western Pacific, WPHC9 52/10 Vol.1, WPA.
[134] Makogai Leper Asylum, Division of Public Hygiene, 14 September 1922, ACGA 8280 EX8/8 Part.1 R17962833, ANZ.

legal powers of repatriation.[135] If a Chinese patient could not be repatriated, the country that they were transferred from paid the fees for their treatment.

However, for immigrant Pacific Islanders, involved countries often blamed each other to avoid paying the fees, as in the case of a Cook Islander patient named Patrick (sometimes called Pattrick). Patrick was a native of Pukapuka, Cook Islands, and was in the first batch of Western Samoa in 1922. Claiming that Western Samoa covered his treatment fees for many years before his transfer to Fiji, Western Samoa asked the Cook Islands to pay for his treatment.[136] According to Western Samoa, Patrick was immediately suspected of leprosy upon his arrival in Western Samoa in 1917.[137] Therefore, Samoan authorities had 'no doubt that Patrick contracted leprosy in the Cook Group.'[138]

The Cook Islands objected to this theory. They argued that Patrick must have contracted leprosy in Western Samoa as there were no signs of leprosy in Pukapuka.[139] The Cook Islands further complained that the invoice for Patrick's travel cost (£50) was exorbitant.[140] Western Samoa responded defensively: Patrick was treated at no personal cost for five years before moving to Fiji compared to an American 'half-caste' from Pago Pago who was charged £104 per annum, paid by the American Consul in Western Samoa. Western Samoa also found records of leprosy in Pukapuka dating from 1919.[141] The Cook Islands fought back by

[135] Leprosy in Western Samoa, Answer to Questionnaire of the British Empire Leprosy Relief Association of date January 1924, ACGA 8280 EX8/8 Part.1 R17962833, ANZ.
[136] From Secretary to the Secretary of Department of External Affairs, 8 March 1923, ACGA 8280 EX8/8 Part.1 R17962833 ANZ.
[137] From the Chief Medical Officer to the Secretary to the Administration, 4 July 1923, ACGA 8280 EX8/8 Part.1 R17962833, ANZ.
[138] From the Secretary of Western Samoa to the Secretary for External Affairs, 6 July 1923, ACGA 8280 EX8/8 Part.1 R17962833, ANZ.
[139] Copy of Statement by the Chief Medical Officer, 1 August 1923, ACGA 8280 EX8/8 Part.1 R17962833, ANZ.
[140] From the Resident Commissioner to the Secretary of Cook Islands Administration, 20 August 1923, ACGA 8280 EX8/8 Part.1 R17962833, ANZ.
[141] From the Secretary of Western Samoa to the Secretary for External Affairs, 1 October 1923, ACGA 8280 EX8/8 Part.1 R17962833, ANZ.

claiming that the suspected leprosy cases in Pukapuka turned out to be syphilis patients.[142] In the end, the Cook Islands agreed to pay for Patrick's fees.[143]

It is impossible to pin-point the origin of Patrick's leprosy from the dispute between the two countries. Sources show that the Cook Islands did not find any lepers from Pukapuka when they first sent patients to the CLH in 1926. They did, however, find three cases in 1927.[144] Patrick and other immigrant patients' cases illustrate how the centralisation process involved negotiation over national responsibilities.

The Leper Cruise

The key to successful centralisation of leprosy control was moving all lepers to Makogai. To bring all leprosy-affected islanders in one place, the CLH physically connected the South Pacific via 'the leper cruise.' Transport to move patients, the leper cruise, was the biggest challenge for centralising leprosy treatment.[145] For Fiji, sending patients on a domestic trip was not a problem. It was, however, very difficult for other countries. New Zealand's initial response to Fiji's centralisation proposal was concern that the transport would be 'most difficult to arrange.'[146] The vessel carrying lepers had to be of adequate size, equipped with facilities to segregate lepers, have medical staff on board for the care of patients, be suitable for long-distance travel between islands, and get disinfected thoroughly after the haul. These restrictive

[142] Copy of Statement by the Chief Medical Officer, 1 August 1923, ACGA 8280 EX8/8 Part.1 R17962833, ANZ.
[143] From the Secretary of Western Samoa to the Secretary for External Affairs, 15 September 1924, ACGA 8280 EX8/8 Part.1 R17962833, ANZ.
[144] Lepers Removed to Makogai per S.S. 'Hinemoa', August 1927, ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.
[145] For an example of the use of the term 'leper cruise', see Leper Cruise, From the Managing Director of P.P. Spedding Limited to the Secretary of the Cook Islands Department, 15 April 1926, ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.
[146] From the Governor-General of New Zealand to the Governor of Fiji, 17 June 1924, ACGA 8280 EX8/8 Part.1 R17962833, ANZ.

conditions prevented mercantile marine steamers or HM naval ships from being drafted.[147] Worsening these difficulties, trading vessels refused to take lepers aboard.[148] Most administrations, therefore, had to charter private vessels.

New Zealand reconditioned a government vessel *Hinemoa,* otherwise in service connecting Auckland and Niue, at the cost of £4,500. The total distance of the return trip between Quail Island and Makogai was approximately 3,600 miles, taking 15 days of steaming. The cost for the trip itself, excluding reconditioning fees, amounted to £1,250, in addition to the cost of installing temporary quarters for the lepers.[149] After sending New Zealand patients from Quail Island, the vessel was used to transfer additional patients from Western Samoa and Niue.[150] Western Samoa sent ten of their newly found lepers on *Hinemoa* when New Zealand sent their lepers to Fiji.[151]

Tonga had difficulties finding a vessel too. They asked New Zealand to stop by Tonga when New Zealand lepers were moved by *Hinemoa.* Tonga proposed £350 plus £60 per day whilst in Tongan waters for this purpose.[152] However, this trip could not be made because accommodation for Tongan patients at Makogai could not be completed before *Hinemoa* was due to sail.[153] Tonga later chartered a cutter for the transport of their lepers when the CLH was finally ready to accept them.[154]

Western Samoa, too, 'had the greatest difficulty in arranging transport for these

[147] From J. D. Gray to the Secretary of the Samoan Administration, 12 June 1924, ACGA 8280 IT110/4/1 Part.1 R17963606 Part.1, ANZ.
[148] R. S. Trotter, 25 November 1919, ACGA 8280 EX8/8 Part.1 R17962833, ANZ.
[149] From J. D. Gray to the Director-General of Health, 9 April 1925, ACGA 8280 EX8/8 Part.1 R17962833, ANZ.
[150] Frederick Hall, *The Leper Hospital Makogai: A Short Description* (Suva: S. Bach Government Printer, 1927) NAF. 7.
[151] Lepers for Makogai —to be transported by Hinemoa, 14 July 1925, ACGA 8280 EX8/8 Part.1 R17962833, ANZ.
[152] From External Wellington to Premier Nukualofa, 20 June 1925, ACGA 8280 EX8/8 Part.1 R17962833, ANZ
[153] From the Premier of Tonga to the Minister for the Cook Islands, 20 July 1925, ACGA 8280 EX8/8 Part.1 R17962833, ANZ.
[154] From the British Agent and Consul to the High Commissioner, 3 February 1927, WPHC4/IV 1150/1924, WPA.

unfortunates' when they sent the first batch in 1922. They had to find a vessel that could travel between Western Samoa and Fiji, 650 miles, with adequate facilities for lepers. After discussion, they charted a small 28-ton auxiliary ketch *Maota*.[155] Since the total number of patients could not board at once, *Maota* made two trips carrying 6–7 patients and a medical staff member who cared for the lepers.[156] The problem of finding suitable transport continued in the following years when more cases of leprosy were found in Western Samoa. Whenever there was a large group of patients to transfer, the availability of the CLH was not a problem but 'the question of a steamer for the collection and transport of lepers' posed challenges.[157]

The Cook Islands, most geographically scattered of the participating colonies, is a good case to examine how long-distance collection from islands and drop-off at Makogai was organised. Like other countries, securing a suitable vessel in the Cook Islands was difficult. They reconditioned *Hinemoa*, the vessel that previously carried New Zealand patients.[158] On the first trip, *Hinemoa* departed from Auckland and called at twelve islands of Rarotonga, Mangaia, Ma'uke, Atiu, Aitutaki, Palmerston, Penrhyn, Rakahanga, Manihiki, Pukapuka, Apia (for coal and water) before arriving at Makogai. The full trip took 35 days, sailing 5,562 miles in total, picking up 1–19 patients from each island. [159] The transport cost for using *Hinemoa* was £1,000 per voyage, with an extra £500 for special fittings and attendants.[160]

As the vessel toured around, doctors inspected each island to find any unreported 'fresh

[155] From the Minister of External Affairs to the Minister of Public Health, 24 August 1922, ACGA 8280 EX8/8 Part.1 R17962833, ANZ.
[156] From the Medical Officer of Health to the Administrator of Western Samoa, 14 September 1922, ACGA 8280 EX8/8 Part.1 R17962833, ANZ.
[157] From J. D. Gray to the Secretary of Samoan Administration, 12 June 1924, ACGA 8280 EX8/8 Part.1 R17962833, ANZ.
[158] Memorandum from the Prime Minister to the Governor-General, 3 October 1925, ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.
[159] Amended Itinerary G.S.S. 'Hinemoa' Cook Island Leper Cruise, ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.
[160] From the Minister for the Cook Islands to the Minister of Finance, 18 March 1927, ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.

cases' of leprosy.[161] On islands with many leper patients, a thorough 'combing of the population' took place to spot suspected cases. This process led doctors to find more patients than first expected. When too many cases were found and the vessel was full, doctors were compelled to select whom to transfer. To maximise the chances of recovery, only the less advanced cases were taken to Makogai. For example, on Manihiki island, which was visited towards the end of the journey, only two lepers could be taken because the ship was already 'uncomfortably full.' On the journey, advanced nodular cases were kept segregated from the clean nerve cases to keep the patients as healthy as possible.[162] Once the list of transferred patients was confirmed, personal information, including name, sex, age and race was gathered and sent to the CLH before the vessel's arrival.[163] Then, the patients were classified again according to the level of sickness and their island of origin.[164] Fiji authorities also requested the number of incoming lepers who were able to take care of themselves, who could manage their own gardens, and accounts for mutilation ulcers or disabilities that required treatment in the hospital.[165]

Medical staff had to be on board to attend to the patients over the journey. Given that it was a dangerous task requiring skilled personnel, suitable candidates were limited. The Cook Islands hired a medical officer for the return trip with domestic transport to and from the port of departure. Additionally, a medical assistant was hired and personal protective equipment was purchased for the medical staff. [166] In the case of the Gilbert and Ellice Islands, a Native

[161] Memorandum from J. D. Gray to the Secretary of Samoan Administration, 25 February 1926, ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.
[162] From E. P. Ellison to Sir Maui Pomare, June 1926, ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.
[163] H. Williams, List of Lepers and Suspected, ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.
[164] Lepers in Group, 10 March 1926, ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.
[165] From Coladept, Wellington to Commissioner, Rarotonga, 17 December 1925, ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.
[166] From the Acting Secretary to Mr. A. Knowles, 30 November 1925, ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.

Medical Practitioner named Malakai Veisamasama was sent from Fiji to care for the lepers in transport.[167] Malakai took his wife and child on the trip, which the WPHC covered the cost of.[168] The reason Malakai took his family is not clearly stated in the sources. It may be assumed, however, that he wanted to revisit the Gilbert and Ellice Islands, where he worked as recently as 1929, with his family on a rare opportunity of inter-island travel.[169]

Apart from medical staff, an interpreter accompanied trips when needed. In the Cook Islands, an indigenous person of Atiu named Maka Kea actively promoted himself by creating a job opportunity. Maka wrote a letter addressed to Pōmare before the government decided an interpreter was needed. He wrote, 'the doctor who goes on that journey will need an interpreter in the Cooks and until they arrive at Fiji. I would like to be that interpreter. […] And now I feel that when the Government needs an interpreter and I am capable.'[170] This letter was personally delivered to Pōmare by Lambert on his tour of the Pacific.[171] As shown in Maka's case, indigenous islanders who were neither a patient nor a medical staff had an agency to find his own career opportunities in the medical sphere.

On board, the patients were given three meals a day: breakfast, dinner, and tea. Meal plans started with fresh ingredients at the beginning of the journey. Towards the end of the journey, fresh food was replaced by dry and tinned products. Breakfast usually contained fish (mostly salmon), carbohydrates (yam, taro), fruits (at the beginning of the voyage) and tea. Dinner was rather simple, consisting of carbohydrates (yam, rice, potatoes) with biscuits or jam. Tea included a meat menu (mostly mutton) with carbohydrates (taro, kumara), biscuits

[167] From Morris Hedstrom Limited to the Secretary of the Western Pacific High Commission, 11 October 1935, WPHC9 52/10 Vol.1, WPA.
[168] *Ibid.*; From H. Vaskess to Morris Hedstrom Limited, 18 October 1935, WPHC9 52/10 Vol.1, WPA.
[169] Western Pacific Health Service Annual Report, 1929, RG5 S3 B161 F1979, Rockefeller Archive Center, 7.
[170] From Maka Kea to Sir Maui Pomare, 21 December 1925, ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.
[171] From the Secretary to the Resident Commissioner, 4 February 1926, ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.

and tea.[172] With larger vessels such as *Hinemoa*, some items for welfare could be provided, such as swing hammocks along with brandy, wine, and cigarettes as 'medical comforts.'[173]

After the patients were dropped off at Makogai, vessels went through a disinfection process. Facilities installed for the trip were all removed, including temporary greenboard lining of the hold, the wooden beds and partitions, temporary decking, partitions and houses, ropes, bridge, waterproof coverings of tanks, and machines. Basically, every surface and item that may have been in contact with the patients were removed. After this, thorough fumigation followed using liquid formalin.[174] In order to be as economical as possible, vessels often carried cargo on their way back – often fruit.[175] The cost of chartered vessels was so high that, without fruit, the shipping companies expected to make a loss.[176] Other than commercial items, mail from Australia to the Gilbert and Ellice Islands was carried on a vessel carrying the Gilbertese and Ellicean patients.[177]

These long-distance journeys required cooperation between Pacific Islands. As mentioned previously, Western Samoa and Tonga discussed sending their patients on New Zealand's vessel. Coal and water had to be replenished in the middle of a journey, too. For example, the Cook Islands' 'leper cruise' called at Apia, Western Samoa, to arrange coal and water for *Hinemoa*. In turn, they offered to pick up any 'fresh lepers' from Western Samoa not yet transferred to the CLH.[178] Logistical convenience in Fiji was also essential. All port duties

[172] N.Z.G.S. 'Hinemoa' Menu-Leper Patients, ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.
[173] From J. D. Gray to the Managing Director of Spedding Ltd., 17 April 1926, ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.
[174] From E. P. Ellison to Sir Maui Pomare, June 1926, ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.
[175] From the Managing Director of Spedding Limited to the Secretary of Cook Islands Department, 30 April 1926, ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.
[176] From the Director of the Spedding Limited to the Secretary of Cook Islands Department, 9 December 1926, ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.
[177] From the Secretary to the high Commission to Messrs. Burns, Philip and Company, Sydney, 27 September 1935, WPHC9 52/10 Vol.1, WPA.
[178] Memorandum from J. D. Gray to the Secretary of Samoan Administration, 25 February 1926, ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.

at the collection of patients were waived, and vessels proceeded straight to Makogai instead of the main port of entry, Suva.[179] As such, the CLH enabled a 'leper cruise' that connected the Pacific Islands before isolating all lepers on an island.

Racial Differences at the Central Leper Hospital

Once all lepers across were collected, transferred, and confined, the CLH became a site for racial encounters. Lepers were charged different rates and treated unequally at the CLH according to their race. A unit system was devised to count patients reflecting the existing racial hierarchies in the Pacific. A patient could be rated between one and two units depending on their race. As a standard, an indigenous islander made one unit and a European took up two units. This means a European would be provided with accommodation and rations that cost double the price of a Pacific Islander. Those who were neither indigenous to the South Pacific nor of European origin would be counted as in-between units and charged accordingly. The general policy at the Makogai Leper Colony (before centralisation) was to charge £40 per annum for a Pacific Islander as one unit. Chinese were charged £60 (1.5 units) and Europeans cost £70 (1.75 units). Mixed-race 'half-castes' were considered Europeans.[180]

During the course of centralisation, the price per unit was negotiated between participating administrations. Not all administrations had the same terms of the agreement. When Western Samoa first sent patients in 1922, fees were charged at the same rate as Fiji. It was £40 for Pacific Islanders, £60 for Chinese and £70 for 'half-castes.'[181] As the hospital drew more patients from different countries, an effort was made to charge a 'fair and reasonable

[179] Enclosure in letter to Acting Colonial Secretary, Fiji, No.3634, 1 December 1934, WPHC9 52/10 Vol.1, WPA.
[180] Enclosure No.1 Memorandum by the Chief Medical Officer, WPHC4/IV 329/1935, WPA.
[181] Appendix No.1 Memorandum by the Acting Colonial Secretary, WPHC4/IV 329/1935, WPA.

amount.' For the time being, the Chief Medical Officer of Fiji proposed to charge £40 per annum for an indigenous patient and £70 for Europeans and Chinese. The exact cost for each racial category was to be calculated after their actual hospitalisation at the CLH. During this period, the Chinese were placed in the same category as Europeans. After a year, the real-life cost per annum calculated by the Treasury was higher than expected. It cost £48.2.4 for the indigenous, £72.3.6 for 'half-castes' and Chinese, and £96.4.9 for Europeans. In this estimate, the 'half-castes' were placed in the same middle-range category as the Chinese, who were removed from the top tier where Europeans were in.[182]

New Zealand paid more for their patients.[183] When they explored the options of joining the CLH, the New Zealand government opted to pay more for units instead of building a separate accommodation for their lepers. Fiji was trusted to provide the necessary accommodation to New Zealanders. Fiji's initial offer was made at £90 for Europeans and £70 for Chinese and Māori patients. However, New Zealand decided to regard the Māori patients at the same rate as Europeans at £90, as was the case for the 'half-castes.'[184] For Chinese patients, New Zealand paid £70 per annum, as Fiji originally suggested.[185]

This decision to treat Māori patients as equal to Europeans is a significant sign showing indigenous peoples of Oceania were not all treated the same. Indeed, New Zealand's racial policy at the time was an assimilation approach, intended to turn the Māori into healthy 'brown-skinned New Zealanders'.[186] According to James Belich, a popular belief in the Aryan theory (that Māori are descendants of Aryans) even 'whitened' Māori in the late nineteenth and early

[182] *Ibid.*
[183] Enclosure No1 Memorandum by the Chief Medical Officer, WPHC4/IV 329/1935, WPA.
[184] Appendix No.1 Memorandum by the Acting Colonial Secretary, WPHC4/IV 329/1935, WPA.
[185] Enclosure No1 Memorandum by the Chief Medical Officer, WPHC4/IV 329/1935, WPA.
[186] Linda Bryder, '"They Do What You Wish; They Like you; You the Good Nurse!": Colonialism and Native Health Nursing in New Zealand, 1900–40' in Helen Sweet, Sue Hawkins (eds.), *Colonial Caring: A History of Colonial and Post-colonial Nursing* (Manchester: Manchester University Press, 2015), 98.

twentieth century.[187] Yet, in the field of healthcare, Māori in New Zealand were left disadvantaged under a dual system that differentiated them from Europeans, as Linda Bryder argued.[188] However, for leprosy treatment, they were treated equally. Fiji's racial policy was to place Europeans on a higher hierarchy than other races, which is why Fiji initially suggested lower unit scales for Māori. Fiji was already expecting New Zealand would want to treat Māori and 'half-castes' like Europeans.[189] This was because they were treated already being treated equally in Quail Island. Indeed, a patient named Parao, who protested against moving to Fiji, complained about the racial discrimination at the CLH. This led Pōmare to ask the New Zealand Prime Minister to place the Māori on equal terms with the Europeans.[190] By comparison, New Zealand's territories of Western Samoa and the Cook Islands still regarded the indigenous Pacific Islanders as one unit paying £40 per annum.

The unit system was finally standardised after all the New Zealand territories joined. Pacific Islanders, categorised as 'natives', counted for one unit. Chinese were 1.5 units. Māori, Europeans and 'half-caste of European standard' were two units, with New Zealand paying a higher price for their own people.[191] Ethnically Indian people, who made up nearly half of Fiji's population by the time, were treated the same as Fijians, categorised as 'natives.'[192] Fiji maintained its general policy of hospitalisation fees of £40 per unit. Agreements with Tonga, Western Samoa and the Cook Islands were all reached on this basis.[193]

Units determined the quality of rations and accommodation that a patient received at

[187] Belich, *Paradise Reforged*, 206–215.
[188] Linda Bryder, 'New Zealand's Infant Welfare Services and Maori, 1907–60, *Health and History*, 3/1 (2001), 86.
[189] From the Governor of Fiji to the Governor-General of New Zealand, 13 February 1925, ACGA 8280 EX8/8 Part.1 R17962833, ANZ.
[190] Kingsbury, *The Dark Island*, 141.
[191] Annexure, From the Committee to the Acting Governor, 26 January 1928, WPHC4/IV 329/1935, WPA.
[192] Enclosure No.4 Lepers at Makogai, from within the Colony of Fiji, on 31 December 1927, WPHC4/IV 329/1935, WPA.
[193] Appendix No.1 Memorandum by the Acting Colonial Secretary, WPHC4/IV 329/1935, WPA.

the CLH. The Chief Medical Officer of Fiji reported in 1933 that there were only two ration scales: two units for Europeans and one unit for the Pacific Islanders. The Chinese, or 'the Asiatics' who were charged 1.5 units previously, were moved to the European scale by that time.[194] With exceptional cases of a 'native' patient being discovered to be a 'half-caste' later, the fees were fixed from the day a patient was admitted to the CLH.[195]

At the top tier were the white Europeans, who were given a separate room for single occupancy. Those living out in the villages were allocated a larger area with spacious housing.[196] Even before moving to Makogai, Europeans received more attention from medical authorities. Reports detail European cases, for example, 'a respected woman resident of Rarotonga whose trouble has just recently been diagnosed as leprosy' while only a list of name, sex, and origin island were made for native patients.[197] Indian patients lived in an area dedicated to Indians. Chinese patients lived in a village called Ra Lailai together with Rotumans.[198] The rest of the Pacific Islanders lived in villages with accommodation built by their country of origin. Because the patients were segregated according to their ethnicities, 'disputes and clashings apparently occur between the many races there congregate.'[199]

Ration scales differentiated the Europeans and 'half-castes', the Chinese and Indians, and the Pacific Islanders. As Europeans counted as two units for hospitalisation fees, double the cost of a native, they enjoyed much more generous rations. Chinese and Indians were given ingredients better suited to their usual diet. Large differences can be noted in the provision of

[194] Minute by the Chief Medical Officer, 10 January 1933, WPHC9 52/10 Vol.1, WPA.
[195] Enclosure No.1 Memorandum by the Chief Medical Officer, WPHC4/IV 329/1935, WPA.
[196] From the Medical Superintendent of Makogai to the Chief Medical Officer, 22 September 1923, ACGA 8280 EX8/8 Part.1 R17962833, ANZ.
[197] Memorandum from the Prime Minister to the Governor-General, 26 January 1926, ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.
[198] From the Medical Superintendent of Makogai to the District Engineer, 18 November 1921, ACGA 8280 EX8/8 Part.1 R17962833, ANZ.
[199] From E. P. Ellison to Sir Maui Pomare, June 1926, ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.

milk, meat, sugar, soap, matches, kerosene and dripping. In addition to usual rations, they could receive extras through the medical authority. The Medical Superintendent could use rations for disciplinary measures, such as restricting the ration of bread, tobacco, and yaqona (traditional drink). The following table is a detailed weekly ration scale per person at the CLH in 1932.[200]

[200] Enclosure 1(a), Ration Scale, Central Leper Hospital, Mokogai, Fiji, WPHC9 52/10 Vol.1, WPA.

Item	European	Chinese	Indian	Native
Bread or Flour	7lb		3lb	3lb
Milk	3.5 pint			
Rice (or bananas and vegetables)	6lb (or 7lb)	9lb	8lb (or7lb)	7lb (or 42lb)
Dahl			7oz	
Ghee (or mustard oil)			7oz	
Curry			1.5oz	
Meat (fresh or tinned)	42oz	28oz (or 1 tin)		28oz (or 1 tin)
Fish		1 tin		1 tin
Onions	3.5oz		4oz	
Yaqona		1oz	1oz	1oz
Jam	1lb			
Salt	2oz	2oz	2oz	2oz
Sugar	2lb	lb	1lb	1lb
Tea or Cocoa	6oz	2oz	1.5oz	1.5oz
Butter	1lb			
Soap	1lb	6oz	6oz	6oz
Tobacco	2oz	2oz	2oz	2oz
Cigarette Papers	1 packet			
Matches	2 boxes	1 box	1 box	1 box
Kerosene	26oz	3oz	3oz	3oz
Dripping	8oz	8oz		

Table 5. Weekly ration by race in the CLH, 1932 [Source: WPHC9 52/10 Vol.1, WPA]

A higher unit scale, however, did not always lead to higher social status in Makogai.

The in-between people, such as Indians and Chinese, were put on a medium-high scale for fees (1.5–2 units) but faced harsher stigma than the Pacific Islanders. Most Indian patients came from indentured labour backgrounds in Fiji, which already placed them lower in the racial hierarchy of the country. Even after indenture was abolished, racial discrimination against Indians persisted in Makogai in that ethnic Indians received less attention compared to other ethnic groups. Indian villages were situated furthest away from the hospital centre, along with Chinese and Solomon Islanders, who also came from labouring backgrounds, on the opposite side of the island from the Pacific Islanders. This marginalisation at Makogai, according to Jane Buckingham, was a deliberate result of ongoing racism in Fiji.[201]

Sinophobia was notably wide-spread at the time. China was seen as a global reservoir of leprosy in the early twentieth century. As Bashford showed, there was a belief that the Chinese diaspora spread the disease in Oceania, a view which was strongly held in Australia.[202] Edmond also noted a growing anti-Chinese sentiment in New Zealand concerning leprosy.[203] Similar Sinophobia was found in New Zealand even after joining the CLH. When a Chinese was diagnosed with leprosy in 1926, New Zealand's medical authorities got incredibly anxious.[204] To get him transferred as soon as possible, New Zealand arranged *Hinemoa* for a trip to Fiji just for this patient. It cost £621.11s.5d in total, including the cost of attendants, rationing, coal, construction of a segregated cabin, disinfection, and dedicated cabin equipment.[205] The Department of Health was still very determined that it was 'infinitely more

[201] Jane Buckingham, 'Indenture and the Indian Experience of Leprosy on Makogai Island, Fiji', *The Journal of Pacific History*, 52/3, (2017) 325–342.
[202] Bashford, *Imperial Hygiene*, 81–93.
[203] Edmond, *Leprosy and Empire*, 168–170.
[204] From the Secretary to the Managing Director of Spedding Ltd., 19 November 1926, ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.
[205] Transfer Sub-voucher, December 1926, ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.

important' to get rid of him from New Zealand, even if it cost them a fortune.[206]

The sentiment was similar in the Pacific Islands. The idea that the Chinese introduced leprosy was prevalent in Western Samoa.[207] In 1920, this idea was reported to be false. Chinese indentured labour started to arrive in Western Samoa around 1903, and the first Chinese leprosy case was found in 1915. The first known case of leprosy in Western Samoa was before that in 1896 originating from Hawai'i. It was concluded that 'there is no evidence to show that any Chinaman brought any infection.'[208] Another document argued that the first medical evidence of leprosy in Samoa was found in 1892, of which one was a Hawaiian.[209] A brochure of the CLH published in 1927 specifically mentions that Hawaiians called leprosy 'the Chinese sickness.'[210] As with the Indians, Chinese patients were marginalised in a separate village far from the hospital centre. Furthermore, their names were gradually forgotten in the administrative documents. Initially, hospital documents recorded Chinese patients' names when they were transferred to Makogai. After a few years of having them at Makogai, documents started to refer to them only with their 'coolie numbers' instead of names, unlike the cases of other Pacific Islanders or Europeans.[211]

As these cases of racial discrimination show, the Pacific Islanders, white Europeans, mixed-race 'half-castes', Chinese, and Indians all encountered other races on a small island. However, even if a dedicated quarantine hospital was made for a specified disease, patients

[206] From the Secretary to the Managing Director of Spedding Ltd., ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.
[207] From the Secretary to the Administrator of Samoa, 24 March 1920, ACGA 8280 EX8/8 Part.1 R17962833, ANZ.
[208] From the Administrator to the Secretary of the Ministry of External Affairs, 17 April 1920, ACGA 8280 EX8/8 Part.1 R17962833, ANZ.
[209] Leprosy in Western Samoa, Medical Department, ACGA 8280 EX8/8 Part.1 R17962833, ANZ.
[210] Hall, *The Leper Hospital, Makogai*, 4.
[211] Samoan Lepers in Makogai Leper Asylum, May 1924, 14 July 1924, ACGA 8280 EX8/8 Part.1 R17962833, ANZ.

were strictly segregated according to the existing racial hierarchy in the Pacific.

Life as 'Unfortunate Inmates'

In the centralised environment of the hospital island, patients did not simply receive passive treatments, but maintained lives as a community. Makogai was largely divided into two towns: Dalice, where the lepers settled, and Nasau, 'the clean area', where the staff resided. Just after the CLH opened in 1927, there were 439 patients, one medical superintendent, two lay superintendents, thirteen European nurses, eight indigenous nurses, one launch driver, one mechanic, eighteen subordinate servants and three constables living in Makogai. The main leper settlement was centred around Dalice Bay. Hospitals, operating theatres, dressing rooms, female patients' quarters, and general administrative offices were located there, along with all European and 'half-caste' patients. Stretching on either side of the coast from Dalice were placed leper villages that housed all male non-European patients who did not require hospitalisation. Each village had plots attached to it for the patients to cultivate for their own use. Nurses' quarters were at the back of the main settlement of Dalice. On the other side of the island was Nasau, where the medical superintendent, lay superintendent and subordinate staff all lived. At this point, travel between Dalice and Nasau was only done by horseback on a bridle track. There was a single-line telephone that connected the nurses' quarters, administrative office and the medical superintendent's quarters.[212] The following map shows the layout of the hospital island.

[212] Annexure, From the Committee to the Acting Governor, 26 January 1928, WPHC4/IV 329/1935, WPA.

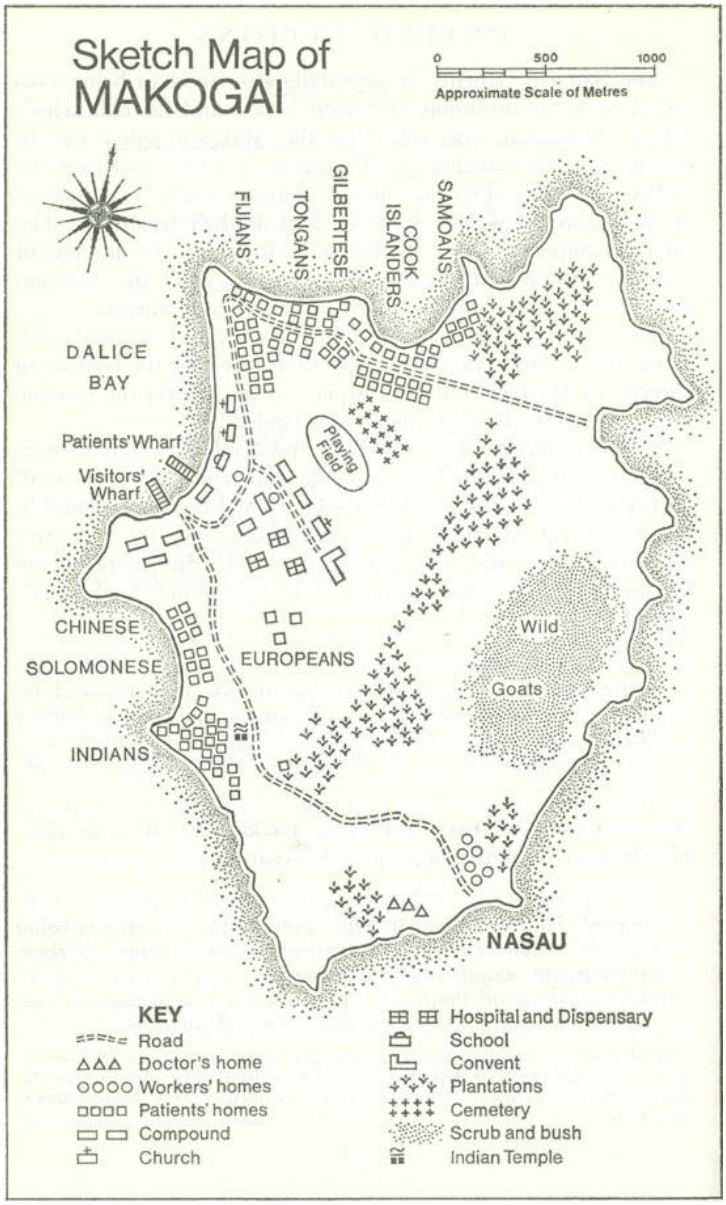


Figure 2. Map of Makogai showing villages segregated by race. [Source: Mary Stella, *Makogai: Image of Hope* (Christchurch: New Zealand Lepers' Trust Board, 1978), 74]

Lepers at the CLH were often referred to as 'the unfortunate inmates.' This partly sympathetic, partly dramatizing, and partly repressive term was found widely used in the British and New Zealand colonies.[213] At the same time, although official reports may have

[213] For example, see From A. R. Sahu Khan to the Colonial Secretary, 17 May 1945, F48/370, NAF.

contained an element of propaganda, the hospital was promoted as a paradise for lepers. Describing the life at Makogai, *The British Medical Journal* commented in 1927 that 'they are in no way behind us in Fiji, and have some attractions of which we cannot boast.'[214] A report from 1928 also stated:

> Of the general conditions obtaining at the Asylum—the cleanly appearance of the hospitals, the buildings, and grounds; the obvious air of contentment surrounding the whole institution; the manner in which these afflicted people can nevertheless enter with so lively a spirit into their many pastimes—the Committee cannot adequately speak.[215]

Perhaps such a reputation led the *Fiji Times* to frame life in Makogai as 'Isolation in Paradise' in their article published in 2019.[216]

By selling the image of 'the unfortunate inmates' isolated 'in paradise', the CLH received quite a number of donations from various countries. A donation of about £63 subscribed by the public of New Zealand, Cook Islands and Niue were handed to the Medical Superintendent when New Zealand delivered a patient to Makogai.[217] Teachers at the Avoka Girls' School in Western Samoa sent their Easter self-denial offerings, a total of £1.4s.0d. to the CLH.[218] Christmas made a particularly good occasion for the general public to donate gifts. New Zealanders who wished to show their sympathies to 'the unfortunate subjects who are inmates of the leper asylum' could make donations.[219] Common gifts included tobacco, cigarettes, pipes, fittings for model yachts, magazines and books.[220] Books were reported to

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[214] 'The Lepers of Makogai', *The British Medical Journal* 2/3480 (1927), 509–510.
[215] Annexure, From the Committee to the Acting Governor, 26 January 1928, WPHC4/IV 329/1935, WPA. 5.
[216] 'Isolation in Paradise: Makogai, Leprosy Colony's Golden Years', *The Fiji Times*, 24 November 2019, https://www.pressreader.com/fiji/the-fiji-times/20191124/283768495829157 (accessed 01 August 2022)
[217] Memorandum from the Secretary to the Minister for the Cook Islands, 12 January 1927, ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.
[218] From H. Vaskess to the Head Mistress of the Avoka Girls School, WPHC4/IV 1307/1937, WPA.
[219] From J. D. Gray to the Secretary of the Samoan Administration, 12 September 1921, ACGA 8280 EX8/8 Part.1 R17962833, ANZ.
[220] From the Medical Superintendent of Makogai to the Governor-General of New Zealand, 28 December 1921,

be very much appreciated by both indigenous Pacific Islanders and Europeans 'who live a life of isolation.'[221] The effort of the nursing staff was appreciated through larger donations. In 1943, the general public of New Zealand donated £864.1s.11d. through the Lepers' Trust Board for the nursing Sisters.[222] This fund was used to construct a building close to their convent near Levuka for the elderly and sick Sisters.[223]

Still, patients did not simply succumb to the 'unfortunate' life but actively sought to improve their living conditions. According to *The Fiji Times*, in 1913, before the CLH was established, eight patients escaped Makogai on a boat because the living conditions were 'intolerable' regardless of one's ethnicity. The newspaper called these patients the 'Makogai Eight' to place these subaltern actors as protagonists in history.[224] Even after the CLH was established, patients continuously demanded a better quality of life. Complaints about food rations are good examples. Not long after the Cook Islanders arrived at Makogai, a female patient submitted a complaint that only two tins of salmon were provided for fifteen women to share in a day. The patient appealed, 'it was much better to be sick on our own island than to be here and know what hunger is.'[225] In a different complaint, patients demanded equal rations for both sexes. Men received one tin of meat for two men to share daily, but women received much less, as the previous complaint also detailed.[226]

Erecting a mosque near the Indian male settlement also received criticism from patients for being managed unfairly.[227] Construction materials and labour support were so

ACGA 8280 EX8/8 Part.1 R17962833, ANZ.

[221] From S. J. Smith to Mrs. A. Arnes, 18 December 1925, ACGA 8280 EX8/8 Part.1 R17962833, ANZ.

[222] From the Manager of the Bank of New South Wales to the Colonial Secretary of Fiji, 28 May 1943, F48/330, NAF.

[223] From the Secretary of Lepers' Trust Board, New Zealand to the High Commissioner of the Western Pacific, 20 April 1943, F48/330, NAF.

[224] https://www.fijitimes.com/the-makogai-eight/

[225] From Hapai to Rev. h. Bond James, 8 July 1926, ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.

[226] From Ian Robertson to Sir Maui Pomare, ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.

[227] From A. R. Sahu Khan to the Colonial Secretary, 17 May 1945, F48/370, NAF.

unsatisfactory that the leader of Muslim patients at Makogai wrote an angry letter to the General Secretary of the Fiji Muslim League that 'people here are laughing on your careless and misunderstanding' and that 'under all circumstances we must have a building for the purpose but praise worthy one.' As the Fiji government refused to permit carpenters from outside Makogai to carry out the construction, the Muslim league also had to explain how the patients were physically unfit to carry out the construction labour themselves.[228] All of these cases indicate that the patients were capable of exercising their agency, even in an isolated environment.

After treatment, some of the 'unfortunate inmates' could be released from the centralised confinement at Makogai. A substantial number of people left the island under three circumstances: if they were misdiagnosed, when they recovered from leprosy, or if they were transferred to another hospital. Firstly, misdiagnosis was common. Yaws was often mistaken for leprosy.[229] A European female patient who was waiting for transfer to Makogai did not travel because she was declared free from leprosy just before the move.[230] In 1926, seven Cook Islanders (four from Mangaia and three from Ma'uke) were discharged from the CLH for being free of leprosy. All of them had skin troubles on arrival at Makogai, but they all healed after being treated with local applications and yaws injections.[231] As the Western Pacific Health Service carried out yaws campaigns, it became easier to distinguish leprosy from yaws or other skin diseases. After all, the Cook Islands had a policy of 'a case was negative until it was proved

[228] From Abdul Mazid to Anivar Shah, the General Secretary, 25 January 1947, F48/370, NAF.
[229] 'Errand of Mercy —Migration of Leper Patients', *Dominion*, 17 March 1926, ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.
[230] Memorandum from the Prime Minister to the Governor-General, 11 May 1926, ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.
[231] Diagnosis of Disease of Cook Island Patients, From the Acting Medical Superintendent to the Chief Medical Officer, 18 August 1926, ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.

positive.'[232]

Secondly, some patients were allowed to return home when the Medical Superintendent judged they met the requirements of discharge. The conditional discharge documents included patients' personal information and health status. Case No. 1262's discharge letter, for instance, compared the patient's symptoms on admission and on discharge.[233] Overseas patients, such as those from New Zealand colonies, travelled through New Zealand on their way back home. The returnees were hosted by YMCA or YWCA in Auckland at the cost of £10 per day, inclusive of separately arranged food and disinfection of the facilities until they left New Zealand.[234] As most of the patients were experiencing a cold climate for the first time, some warm clothing was provided as well.[235] The stay in Auckland became a 'big city' experience that many patients never had before. When a nine year-old boy was discharged from Makogai, he was 'so strange to the big City that he required careful attention. An incident happened yesterday when one friend took him in the tram —he was so delighted that he rushed to the back of the car to see some passing vehicles.'[236] In this way, discharging the 'unfortunate inmates' after a long period of confinement allowed the Pacific Islanders to experience another cruise across the Pacific.

Thirdly, and more rarely, patients were moved to another hospital when needed. In 1938, a female Gilbertese patient known as Ranipwani (or Ranibwena) was transferred from the CLH to the Public Lunatic Asylum in Suva for insanity.[237] The fees for her mental treatment were

[232] From E. P. Ellison to Sir Maui Pomare, June 1926, ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.
[233] Enclosed Copy, From Chief Medical Officer of Fiji to the Secretary for External Affairs, 6 April 1932, ACGA 8280 IT110/4/2 Part.2 R17963608, ANZ.
[234] From the General Secretary of the YMCA to the Secretary of the Cook Island Department, 15 November 1926, ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.
[235] From J. D. Gray to the General Secretary of YMCA, 1 October 1926, ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.
[236] From Shipping Department of Spedding Limited to the Secretary of the Cook Islands Department, 14 April 1932, ACGA 8280 IT110/4/2 Part.2 R17963608, ANZ.
[237] Enclosure in despatch to Gilbert & Ellice No.67 of 1 March 1938, WPHC4/IV 629/1938, WPA.

borne by Fiji at the cost of £50 per annum.[238] Her name was later corrected by the authorities as Nei Karabane from Onotoa Island.[239] About eight months after she was transferred to the Public Lunatic Asylum, she passed away. Her private possessions were taken by the Asylum to be credited to the Fiji government, and her funeral cost was debited to the High Commissioner.[240] Her body was not sent back to her homeland but buried in Public Grave No. 9029, General Works Native Portion at the Suva Cemetery.[241] Jacqueline Leckie notes that at least eight more patients were transferred between Makogai and the mental hospital in Suva.[242]-

If not discharged or transferred to another hospital, patients spent a lifetime of isolation on Makogai island. On the death of a patient at the CLH, the Medical Superintendent of the Central Medical Hospital reported to the Governor of Fiji, who would then inform the patient's home administration to deliver the news to the relatives of the deceased.[243] The number of those discharged from the hospital and those who died on the island are roughly similar. From 1911 to 1950, the first forty years of its history, including the Makogai Leper Colony period, 1,093 passed away, 1,013 were discharged, and 436 were repatriated.[244] Considering the administrative and logistical challenges of centralising leprosy treatment in the Pacific Islands, the CLH connected the British and New Zealand colonies in a remarkable way.

[238] From Medical Department to the Secretary of Western Pacific High Commission, 31 October 1938, WPHC4/IV 629/1938, WPA.
[239] From R. H. Garvey to the Resident Commissioner of Gilbert and Ellice Islands Colony, 22 March 1938, WPHC4/IV 629/1938, WPA.
[240] From H. Vaskess to the Acting Resident Commissioner of the Gilbert and Ellice Islands Colony, 1 December 1938, WPHC4/IV 629/1938, WPA.
[241] From Medical Department to the Secretary of the Western Pacific High Commission and the Acting Resident Commissioner of the Gilbert and Ellice Islands Colony, 22 November 1938, WPHC4/IV 629/1938, WPA.
[242] Leckie, *Colonizing Madness*, 129.
[243] From J. D. Gray to the Resident Commissioner, 14 September 1926, ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.
[244] *Fiji Leprosy Hospital*.

Conclusion

As the first in a series of centralised medical institutions, the CLH became the reference point for how countries in the South Pacific could collaborate in the field of indigenous healthcare. On the eve of the opening of the hospital, *the Dominion*, a New Zealand-based newspaper, reported that the event was 'a further step in the policy of centralising the treatment of the lepers.' It added that 'co-operation in this vital matter between Fiji and other British possessions in the Pacific shows a practical anticipation of the general co-operation.'[245] Just like the newspaper expected, the creation of the CLH signalled the beginning of medical centralisation in the South Pacific, especially between constituents of the British Empire. Dr Sylvester Lambert, the Rockefeller Foundation representative who became the Deputy Central Medical Authority of the WPHC and the Director of the Western Pacific Health Service, called it 'one of the realest jewels in the Imperial Crown.'[246]

The CLH was, therefore, an imperial project between the British and New Zealand territories. Fiji, Western Samoa, Tonga, New Zealand, and Britain all took part in its establishment and other smaller colonies joined later. Colonies with larger populations, such as the Solomon Islands or New Hebrides, and those under Australian, French, and American control were not invited at this stage. In order to meet the needs of participating countries, it was founded as a joint business for a cost-efficient, high-quality, and, for most countries, effective measure to remove leprosy from their lands. The centralisation process was not an entirely European work but indigenous medical staff and indigenous assistants such as translators participated as well. Also, it inevitably involved migration, which connected the Pacific Islands. Most patients experienced overseas travel for the first time through 'the leper

[245] 'Errand of Mercy —Migration of Leper Patients', *Dominion*, 17 March 1926, ACGA 8280 IT110/4/1 Part.1 R17963606, ANZ.
[246] Minute by the Deputy Central Medical Authority, 29 December 1932, WPHC9 52/10 Vol.1, WPA.

cruise' just before a lifetime of isolation. In Makogai, patients from across the Pacific shared the common experience of being afflicted with leprosy. According to Jane Buckingham, many former patients enjoyed the sense of community in a beautiful island.[247] Those who were discontent with the given condition could demand better treatment. Nevertheless, the hospital's unit system reflected the existing racial hierarchy and created an island discriminated by institutionalised racism. Those who did not conveniently fit in the dichotomy of 'Europeans' and 'Natives' — such as the 'half-castes', the Māoris, or the Chinese — make particularly good cases to study the racial hierarchy and its fluidity in the South Pacific. The following chapters will look at the subsequent medical institutions that emerged from this first attempt at centralisation.

[247] Buckingham, 'The Inclusivity of Exclusion', 68.

Chapter 2. The Central Medical School

When the CLH was set up, more institutions were simultaneously being centralised in the South Pacific. The other institutions tried to create a sustainable medical infrastructure to prevent disease in the long term. One of them was the Central Medical School (CMS) which trained Native Medical Practitioners (NMP). Fuelled by the desire for a cost-effective method of medical governance, the CMS was established in 1928. It was an intercolonial project, similar to the CLH, but it covered more empires. As the first centralised institution for education, the CMS was run by the government of Fiji, tutored by British doctors, attended by students from twelve colonies, financially supported by the Rockefeller Foundation (RF), and jointly operated by the empires of Britain, Australia, New Zealand, France, and the US.

Several scholars have already noted the intercolonial character of the CMS. However, most of the existing research generally treats the CMS only as a context for discussing other subjects, such as medical services or the medical profession.[248] This prevents an understanding of medical education as an imperial project that brought colonies in the region together. Works focused on the CMS itself include Margaret Guthrie's biography of the first principal of the CMS, David Hoodless, and David Brewster's general historical account of medical education in Fiji.[249] Stuart's PhD thesis contains sections discussing the relationship between the CMS

[248] Alexandra Widmer, 'Native Medical Practitioners, Temporality, and Nascent Biomedical Citizenship in the New Hebrides', *PoLAR: Political and Legal Anthropology Review*, 33 (2010), 57–80; Annie Stuart, 'Contradictions and Complexities in an Indigenous Medical Service: The Case of Mesulame Taveta', *The Journal of Pacific History*, 41/2 (2006), 125–43; Annie Stuart, 'We Are All Hybrid Here: The Rockefeller Foundation, Sylvester Lambert, and Health Work in the Colonial South Pacific', *Health and History*, 8/1 (2006), 56–79; Alexander Cameron-Smith, *A Doctor across Borders: Raphael Cilento and Public Health from Empire to the United Nations* (Canberra: ANU Press, 2019); Greg Fry, 'The South Pacific "Experiment": Reflections on the Origins of Regional Identity', *The Journal of Pacific History*, 32/2 (1997), 180–202.

[249] Margaret W. Guthrie, *Misi Utu: Dr. D.W. Hoodless and the Development of Medical Education in the South Pacific*. (Suva: Institute of Pacific Studies, University of the South Pacific in Association with the South Pacific Social Sciences Association, 1979); David Brewster, *The Turtle and the Caduceus: How Pacific Politics and*

and the RF.[250] While she suggested that the CMS was a RF project, this chapter will demonstrate that the RF was merely a significant funding source for the school, but not its governing authority.

Essentially, the CMS was another imperial project that centralised indigenous medical education in the South Pacific. Through the CMS, imperial unity was pursued in the standard of medical practitioners and the type of medicine practised in the South Pacific, encompassing the British, partly British, and non-British colonies. This chapter examines the establishment of the CMS and its early years in the context of the British Empire. By comparing each colony's cases in joining the school, this chapter argues that the CMS provided a space for colonial racial encounters that allowed imperial authorities to raise low-cost, efficient, and subordinate medical staff for the Pacific Islands. In doing so, it presents the CMS as a significant intercolonial institution in a wider centralisation scheme in the South Pacific. Here, the term 'medical education' refers to the Western biomedicine introduced by the British authorities.

Establishing the Central Medical School

Prior to discussing the centralisation process, this chapter will examine the existing imperial conditions in the development of the CMS. The imperial context is significant as it eventually led to the centralisation of medical education throughout the region. The genesis of medical education in the South Pacific can be traced through its growing links with the British Empire—new connections that brought new diseases. The mobility inherent in being part of the empire posed a threat to indigenous health in the Pacific Islands. It started with Fiji's

Modern Medicine Shaped the Medical School in Fiji, 1885-2010 (Unites States of America: Xlibris Corporation, 2010).

[250] Stuart, 'Parasites Lost?'

cession to the British Empire in 1874, when the King of Fiji, Ratu Seru Epenisa Cakobau, visited Sydney to finalise the event. Upon their return, his delegation brought back measles to Fiji, which ended up killing nearly a quarter of Fijians in 1875. Soon after, the arrival of migrant labour risked further waves of infectious diseases. The first ship carrying Indian indentured labourers to Fiji, *Leonidas*, arrived in 1879 with smallpox and cholera on board. Fijians, who had not yet fully recovered from the devastating measles epidemic, were alarmed by the additional introduction of new diseases.[251]

In a desperate attempt to protect Fijians from potential waves of epidemics, Fiji's Chief Medical Officer, Dr William MacGregor, requested the establishment of the Suva Medical School (SMS) in 1885. In the meantime, many more Indian indentured ships had arrived in Fiji following *Leonidas,* which planted fears of imported diseases in the so-called 'virgin soil' of the Pacific Islands.[252] Medical education was, therefore, a pragmatic response to the threat of newly introduced diseases. Since the prevention of epidemics was in the colonial government's interest, all students were government scholars. Their tuition, accommodation, food and clothing were covered at an annual cost of £25 per student. Admissions were made through an annual entrance examination, from which four students were selected for each cohort.[253]

In a few years, the Fiji government saw an opportunity to make use of medical students as subordinate staff of the Colonial Service. Graduates of the SMS would then qualify as Native Practitioners, appointed to local districts for the primary care of the indigenous population. In practice, they were called Native Medical Practitioners. Ethnically Indian graduates were called Indian Medical Practitioners (IMP). The NMP Ordinance of 1888 defines their duties to include

[251] Brij V. Lal, *Chalo Jahaji: On a Journey through Indenture in Fiji.* (Canberra: ANU Press, 2012), 143–145.
[252] David Hoodless, *Central Medical School, Suva, Fiji* (Suva: Government Press, 1947), 3.
[253] Plan of Training of Native Medical Practitioners at the Colonial Hospital Suva, 25 July 1919, WPHC4/IV 1326/1919, WPA.

inspection, treatment, vaccination and writing reports. NMPs were required to visit each town in their district at least once a month and submit daily diaries and quarterly reports detailing their work. Fiji asked them to pay special attention to sanitation and any signs of epidemic outbreaks. If necessary, they were assigned an assistant who would carry their luggage and cultivate food plantations. NMP salaries at this time started at £18 per annum, rising from £2 to £50 per annual increase depending on their performance. By comparison, fully qualified European medical officers received a minimum of £350 a year.[254]

The expansion of medical education at the SMS started in the 1920s as an imperial strategy to prevent long-term population decline and promote a healthy labour force. More medical staff was needed in the Pacific Islands after a series of critical epidemics. The most devastating one was the 1918 influenza pandemic, which spread across the region through a single New Zealand vessel *SS Talune* visiting Fiji, Western Samoa, and Tonga. Western Samoa suffered greatly from the influenza pandemic that killed approximately 22% of the entire population.[255] Fiji lost 5.6% of the Fijian population and one-sixth of the indigenous medical staff who took care of the people.[256] Overall population decline across Oceania was evident. To take Fiji for example, the Fijian population fell from 200,000 in 1870, before it joined the British Empire, to 83,000 in 1919, after the influenza pandemic.[257] Amid such rapid population decline, the WPHC started to vision a centralised medical governance comprising Fiji, the

[254] Rules made by the Chief Medical Officer under section 10 of Ordinance No.11 of 1888, Governing the conduct of Native Medical Practitioners, WPHC4/IV 1326/1919, WPA.

[255] Sandra Tomkins, 'The Influenza Epidemic of 1918–19 in Western Samoa', *The Journal of Pacific History*, 27/2 (1992), 181–97.

[256] *The Native Medical Practitioner 3/1* (1939), WPHC4/IV 438/1934, WPA.

[257] An article from 1875 reported about 40,000 Fijians died in the measles epidemic, one-third of the estimated Fijian population. 'Epidemic Measles at Fiji', *The British Medical Journal*, 2/770 (1875), 436; Norma McArthur states that pre-censal population estimate in Fiji varies between 100,000 to 300,000 and suggested 150,000 was used most often as the 'official' estimate, although the source was obscure. Norma McArthur, *Island Populations of the Pacific* (Canberra: Australian National University Press, 1967); Legislative Council, Council Paper No.40 Annual Medical and Health Report, Medical Department, 1938C. NAF.

Solomon Islands, the Gilbert and Ellice Islands, New Hebrides and Tonga. It was to avoid the worst-case scenario, a 'race extinction.'[258] More healthcare personnel were essential in stopping the trend of depopulation.

The need for a larger NMP Service was particularly apparent in Fiji, which required a healthy workforce to run the colonial plantation economy. While the Fijian population declined, the Indian population was growing in Fiji as many Indian labourers settled even after the indenture system was abolished in 1917. The number of permanently settled Indians reached 60,000 by 1924, matching the size of the Fijian population.[259] These ethnically Indian workers and their descendants were the ones most in need of specialist medical care in Fiji. Without the help of the government, it was impossible to find enough medical personnel to care for them.[260] The existing capacity of an average of four students per cohort at the SMS was simply insufficient.[261] In response to the demand, the WPHC agreed that a larger NMP service would be beneficial to Fiji. Moreover, NMPs could be exported to other Pacific Islands as well. Such connections to India, another British colony, were one of the reasons that the SMS was founded and they also became a factor in expanding medical education.

The British, albeit realising the need for more medical staff, did not want to invest too much of their own capital in indigenous healthcare. Hence, as early as 1922, the WPHC communicated with the RF to fund £10,000 for establishing a new and enlarged medical school for British colonies. The new school's widely imperial character and the possibility of pooling NMPs in the South Pacific were put forward as marketing points.[262] At this stage, the RF was

[258] From C. H. Rodwell to Lambert, 29 September 1923, RF RG1.1 S419 B1 F5, RAC.
[259] Chief Medical Officer, Fiji Medical School for Medical Students, 5 February 1924, RF RG1.1 S419 B1 F6, RAC.
[260] Enclosure No.1 of Council Paper No.56 Central Medical School, 1926. WPHC4/IV 3569/1926. WPA.
[261] Chief Medical Officer, Fiji Medical School for Medical Students, 5 February 1924, RF RG1.1 S419 B1 F6, RAC.
[262] Enclosure No.1 of Council Paper No.56 Central Medical School, 1926. WPHC4/IV 3569/1926. WPA.

not very responsive, and the WPHC did not make any further effort. This shows that the British authorities approached medical education in a pragmatic way, preserving as much British resources as possible.

A second attempt to gain the RF funding was made in 1924 by Western Samoa, a New Zealand territory. They pleaded how much Western Samoa was 'anxious to keep Samoa for Samoans,' but it was impossible unless 'they become a healthy and increasing race.'[263] It is notable that the Western Samoan administration, after greatly failing Samoans in the 1918 influenza epidemic, used the expression 'Samoa for Samoans', which was a popular Mau slogan, a Samoan independence movement. The Division of Medical Education of the RF was still sceptical about the project, questioning whether it would be effective given the remoteness and small population of the Pacific Islands. Medical schools for lower qualifications, such as the NMP diploma, were considered not worth investing.[264] More importantly, the RF preferred to fund university-level medical colleges in more populated countries, such as the recently opened Peking Union Medical College in China.[265]

The project gained momentum in 1925 when the third initiative came from the Kingdom of Tonga. It was timely because the Colonial Hospital in Suva was renovated as the Colonial War Memorial Hospital (CWM Hospital) in 1924, becoming the largest medical centre in the Pacific Islands, equipped with 100 beds and modern facilities. Since the SMS was attached to the hospital, this renovation offered ample resources for advanced medical education.[266] Following a discussion with the British Agent and Consul, the Premier of Tonga

[263] From George S. Richardson, the Administrator of Western Samoa to Dr. Victor G. Heiser, 3 September 1924, RF RG1.1 S419 B1 F6, RAC.
[264] Victor Heiser, 11 November 1924, RF RG1.1 S419 B1 F6, RAC.
[265] Mary Brown Bullock, *An American Transplant: the Rockefeller Foundation and Peking Union Medical College* (Berkeley: University of California Press, 1980).
[266] 1st Annual Report, Western Pacific Health Service 1928. RF RG5 S3.419 B161 F1977, RAC.

proposed to the WPHC a cooperation with other Pacific Islands to establish a joint medical school in February 1925.[267] The High Commissioner for the Western Pacific welcomed the proposal. He communicated with British territories in the South Pacific and commence official talks with New Zealand for their territories.[268] The last remaining step was to obtain the Colonial Office approval for sparing finances if the RF did not fund the project.[269] In the meantime, Western Samoa was eager to train NMPs as soon as possible, so they sent two students to the SMS in 1925.[270]

The RF eventually agreed to contribute to the medical school after the British, Tonga, and New Zealand territories agreed to establish a larger medical school. Thanks to the approaches made by other Pacific Islands, the CMS was clearly seen as an imperial project by this time. A continuous appeal made by Lambert helped the decision.[271] The RF's medical programmes let Lambert travel extensively around the Pacific Islands. During the trip, he learned that the geographically scattered environment prevented a cohesive operation of medical services. Lambert argued, 'it would be Imperially unsound and a short-sighted policy to refrain from establishing a Central Native Medical School even at double the initial cost to that now proposed.'[272] Because he identified preventable diseases as the main cause of depopulation, training more NMPs and centralised control of the NMP service seemed like an adequate solution.[273]

Lambert and the WPHC found three justifications for funding indigenous medical

[267] From the Premier to the British Agent and Consul, 7 February 1925, RF RG1.1 S419 B1 F6, RAC.
[268] Enclosure No.1 of Council Paper No.56 Central Medical School, 1926. WPHC4/IV 3569/1926. WPA.
[269] Asks to be Furnished with Information Concerning the Native Medical School at Suva. From: Governor General of New Zealand, 25 November 1925, WPHC4/IV 2856/1925, WPA.
[270] Decisions given by the Hon. Minister of External Affairs Concerning Matters Brought Forward by the Administrator of Western Samoa, December 1925, ACGA 8280 EX8/24 Part.1 R17962755, ANZ.
[271] Stuart, 'Parasites Lost?', 30–48.
[272] Council Paper No.56 Central Medical School, 1926. WPHC4/IV 3569/1926, WPA.
[273] Enclosure No.2 of Council Paper No.11 Central Medical School, 1927. WPHC4/IV 3569/1926, WPA.

education. First, there was a sense of moral responsibility for the colonial administrations to care for indigenous welfare. Peoples whom Europeans considered primitive, mostly Melanesians, were victims of large-scale slaughter and forced slavery on plantations, a practice known as blackbirding. They also believed that the introduction of western culture caused the 'decline of custom' which in turn led to the depopulation of Polynesian countries. It was the white man's mission to care for them and to ensure their survival.[274]

Second, medical education was closely connected to commercial interests. They believed that the 'natives' were the best suited to cultivate the produce from the Pacific Islands. Lack of healthy labourers would increase the number of imported workers, who were considered less productive. This point was emphasised by quoting Dr John Cumpston, the Director of Public Health of Australia, who argued 'the control of the island groups depends upon its efficient working population.' More NMPs were beneficial to the imperial economy.[275]

Thirdly, racial politics were taken into account. Quoting Cumpston again, Lambert argued that if diseases were not controlled, 'the islands will become de-populated and then re-population must inevitably lead to international conflict.' In other words, the creation of a larger medical school was ultimately intended to prevent 'a Pacific War.'[276] All involved administrations agreed that the extinction of the indigenous population and their subsequent replacement by the 'Asiatics' would disturb the international security of the Pacific.[277] Such racialised fear was likely a mixture of an acknowledgement of the expanding Japanese empire in the northern Pacific and the growing Chinese/Indian labour population in the Pacific Islands. This growing fear against Asians is known as the 'Yellow Peril.' To summarise, the RF was

[274] S. M. Lambert, Medical Care of South Sea Natives, 12 October 1923, RF RG1.1 S419 B1 F5, RAC.
[275] *Ibid.*
[276] *Ibid.*
[277] S. M. Lambert, The South Pacific, 30 July 1926, RF RG1.1 S419 B1 F7, RAC.

persuaded by the school's contribution to compensate for the British imperial history, economic value to the contemporary British Empire, and maintaining future British influence in the Pacific world.

The RF funding was decided in 1926 from its International Health Board. This meant the school was considered a public health programme, not a full medical school where the previously approached Department of Medical Education would concern. At the establishment in 1928, the RF agreed to donate £2,000 on condition that no less than £8,000 would be spent on building the school, with a training capacity of 40 students. The RF also shared the maintenance costs for the first four years in decreasing proportions: £5,445 (75%) in 1928, £4,356 (60%) in 1929, £3,267 (45%) in 1930 and £2,178 (30%) in 1931 out of the total annual budget of £7,260.[278] A further £9,472 was offered for the concurrently established joint medical service to conduct centralised medical programmes in the WPHC territories. This was called the Maximum Rockefeller Scheme.[279] As such, the RF funding was offered under a grander scheme of centralisation of medical institutions. Centralised education, treatment, and medical administration were essential to the scheme which thus created the Western Pacific Health Service in 1928 under the direction of Lambert. It is on this basis that historian Annie Stuart evaluates the medical school as Lambert's personal achievement, a Rockefeller project.[280]

However, Lambert's solo effort would not have given birth to the CMS. The school was established as an imperial institution to benefit the British Empire. The establishment process was a multi-channelled imperial initiative that created the grounds for a centralised medical system within the empire. Instead of seeing the RF as the founder of the CMS, it should

[278] Minutes of the International Health Board, 4 November 1926, RF RF1.1 S419 B1 F5, RAC.
[279] Council Paper No.11 Central Medical School, 1927. WPHC4/IV 3569/1926, WPA.
[280] Stuart, 'Parasites Lost?', 223–53.

be considered as a source of funding that the British took advantage of in the first few years. Indeed, the funding was offered only after the advancements were made with the CWM Hospital, the Tongan government's actions, Western Samoa's approach, and the WPHC's plans for extending the NMP Service. The Foundation did not even fund the full operational cost of the CMS. Even if the RF would not support the scheme, the WPHC planned for Fiji to establish the school regardless. The WPHC was already discussing the matter with the Colonial Office before the RF decision was made. Lambert himself admitted that the idea was 'in the air and everyone had it just under the surface of their mind.'[281]

Occasional donations from the RF continued irregularly beyond the first four years of the original agreement. In 1934, the RF offered £2,200 to add a bacteriological laboratory, a pathological laboratory and a post-mortem room to the CMS.[282] After the funds proved insufficient for the new facilities, an additional £1,500 was wired.[283] It also donated used medical books and arranged a bibliographic donation from the New York Academy of Medicine to fill the CMS library.[284] Considering the RF spent nearly 45 million dollars to establish the Peking Union Medical College in China, their contribution to the CMS was very small.[285] Still, the RF contribution effectively relieved financial burdens of Fiji, which was already spending 10% of its total budget on medical purposes.[286] Therefore, the establishment of the CMS was a result of a collective effort between the WPHC (including Tonga), New Zealand colonies, and the RF to supply medical staff to the British Empire. Thanks to the existing infrastructure of the SMS, centralisation took the form of exporting the Fijian NMP

[281] From Lambert to International Health Board, 20 July 1924, RF RG1.1 S419 B1 F6, RAC.
[282] Minutes of Proceedings of a Meeting of the Central Medical School Advisory Board, 13 November 1934, WPHC4/IV 103/1934, WPA.
[283] Minutes of the Rockefeller Foundation, 1–2 November 1935, RF RG1.1 S419 B1 F5, RAC.
[284] From Acting Chief Medical Officer to Lambert, 28 November 1934, RF RG1.1 S419 B1 F10, RAC.
[285] M. Margorie King, 'The Social Service Department Archives: Peking Union Medical College 1928–1951', *American Archivist,* 59/3 (1996), 341.
[286] Council Paper No.56 Central Medical School, 1926. WPHC4/IV 3569/1926, WPA.

system to neighbouring Pacific Islands.

Centralisation of Medical Education

Through the CMS, the British could standardise the practice of indigenous healthcare across its island colonies. Moreover, its scopes reached beyond the British colonies, and even the wider British Empire including Australian and New Zealand territories, to centralise medical education in the South Pacific. The Colonial Office had larger expectations for the CMS when the WPHC submitted the proposal for establishment in 1925. The Secretary of State for the Colonies, Leo Amery, responded in August 1926 with some suggestions raised by the Colonial Advisory Medical and Sanitary Committee. The committee questioned its usefulness in comparison with successful colonial medical schools such as the Kitchener School of Medicine in Khartoum, Sudan, or the Ceylon Medical College. In addition, the Colonial Office advised the WPHC to discuss with Australia the possibility of including its territories of Papua and New Guinea. Although the WPHC knew that Australia did not favour participation, they discussed the matter at the first International Pacific Health Conference held in Melbourne, December 1926.[287]

The main problem in attracting Australia was that Australian authorities found it intolerable to subordinate themselves to another administration in any joint scheme. Despite a settler-colony itself, Australia was autonomous for decisions regarding its territories of Papua, New Guinea, and Nauru. It was different with New Zealand which was generally more favourable to the British leadership. In fact, the International Pacific Health Conference was

[287] From the Secretary of State to the Governor of Fiji, 28 August 1926, Council Paper No.56 Central Medical School, 1926. WPHC4/IV 3569/1926, WPA.

organised so that Australia would define Oceania as the 'Austral-Pacific regional area.' Alexander Cameron-Smith has written that it was a framework within which Australia could unfold its ambitious medical imperialism. Another decisive factor was racism. The Australian government considered that Papuans and New Guineans did not have the intelligence to benefit from a three to four years of higher education at the CMS.[288] After it became clear that Australia will not join, the Secretary of State approved the establishment of the CMS in principle in April 1927.[289] Australian attitude shows how the British Empire was not a monolithic entity. Australia was indeed an imperial power by its own. As a result, the CMS was initially founded by the British and New Zealand territories (counting Tonga under the British influence) as a centralised medical school in the British South Pacific.

Although Britain could not arbitrarily put Australia in the scheme, the CMS was a British-led project in a British colony, staffed by British colonial officers who taught indigenous students across the British Empire in the Pacific. The composition of Central Medical School Advisory Board confirms the level of British influence in the intercolonial institution. The Chair was the Chief Medical Officer of Fiji, Dr Aubrey Montague. The second position was reserved for the RF, represented by Lambert. The remaining seats were taken by the Medical Superintendent of the CWM Hospital and the Secretary of the WPHC.[290] In short, three seats on the Advisory Board, including the Chair would be held by the WPHC staff based in Fiji. Only one place was reserved to acknowledge the donor, the RF. The Advisory Board was not very inclusive of other administrations, although they welcomed New Zealand or

[288] Cameron-Smith, *A Doctor across Borders*, 93–132.
[289] From Colonial Secretary's Office to the Western Pacific High Commission, 11 April 1927, WPHC4/IV 3569/1926. WPA.
[290] From the Colonial Secretary to the Acting Secretary of Western Pacific High Commission, 30 August 1928, WPHC4/IV 2562/1928. WPA.

participating countries to join the Board meetings when they visited Fiji.[291] The majority of regular teaching staff too, were British. The faculty comprised Dr David W. Hoodless, the first principal of the CMS who was the only full-time tutor, seven doctors and two nurses. Exceptions were Lambert, who was an American, and one Fijian NMP.[292]

Centralised operation of the CMS involved financial collaboration between participant administrations. Fiji donated the land adjacent to the CWM Hospital for the construction of the CMS, which began in August 1927.[293] Hutson, the High Commissioner, officially opened the CMS on 29 December 1928.[294] The founding members consisted of British (including Tonga) and New Zealand territories which signed an initial ten-year agreement for joint operation. All participating administrations shared the general running cost in proportion to the number of students they sent. At first, the annual cost per student was £170 regardless of each country filling their allocated quota or not.[295] However, at the request of the Solomon Islands that could not find candidates to fill the quota, this policy changed. Under the revised policy, when a country could not fill their allocated quota, the concerned country could invite other participating countries to take up the unfilled studentships. If no other country offered to send more students, the country that could not fill the quota would still pay for the general operational cost of the CMS. except for paying the student pocket money, rations, stores, clothing, books, and equipment of the unfilled number of students.[296]

Although not yet centralised, intercolonial collaboration already had precedents in the

[291] Minutes of a Meeting of the Central Medical School Advisory Board, 10 July 1928, ACGA 8280 EX8/24 Part.1 R17962755, ANZ.
[292] 1st Annual Report, Western Pacific Health Service 1928, RF RG5 S3.419 B161 F1977, RAC.
[293] From Lambert to Heiser, 31 August 1927, RF RG1.1 S419 B1 F7, RAC.
[294] 1st Annual Report, Western Pacific Health Service 1928, RF RG5 S3.419 B161 F1977, RAC.
[295] H. H. Rushton, Memorandum for Central Medical School, Suva, 26 September 1928, WPHC4/IV 2868/1928, WPA.
[296] Unfilled Studentships Central Medical School, 19 March 1929, WPHC4/IV 2868/1928, WPA.

SMS period between the WPHC territories. Because the Governor of Fiji was also the High Commissioner for the Western Pacific, arranging overseas students from other British territories was administratively convenient. The first overseas student, who graduated in 1912, was from Rotuma, a Fijian dependency.[297] Discussions to train NMPs for the Union Group began in 1911. Three students from the Union Group were fully funded by the Gilbert and Ellice Islands including tuition, accommodation, clothes and transport. Out of three, two students successfully graduated in 1916.[298] A handful of Indian descendants in Fiji also trained at the SMS. The first Indian student graduated in 1926 to serve in the Indian districts of Fiji.[299] The WPHC could also second NMPs to other territories upon request. The early cases of secondment became precedents for intercolonial NMP Service which gradually expanded in the following years.

Compared to its predecessor, the CMS expanded significantly both in size and diversity. This expansion made medical education accessible to many Pacific Islands. The CMS could accommodate 40 students at a time (i.e. average ten to thirteen per cohort), which was more than triple the capacity of twelve during the SMS period. At its inception, the CMS accepted students from the WPHC and New Zealand territories. The quota of each administration was allocated proportionate to its population. Fiji took up half of the student body, with 20 places for both Fijians and Indians in Fiji. The Solomon Islands, the Gilbert and Ellice Islands, Tonga and Western Samoa each sent four students. New Hebrides and the Cook Islands were allowed to send two students each. A few years later, Nauru and American Samoa joined the school to train some of their students.[300]

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[297] Brewster, *The Turtle and the Caduceus,* 408.
[298] Native Medical Students, Union Group. WPHC4/IV 1801/1911, WPA.
[299] Brewster, *The Turtle and the Caduceus,* 409.
[300] 1st Annual Report, Western Pacific Health Service 1928, RF RG5 S3.419 B161 F1977, RAC.

It was necessary for a centralised institution to have a common understanding of the admissions criteria. Each country autonomously selected their scholars, provided they met three minimum requirements set by the CMS: language, health, and age. The first required skill was fluent English. Since the British tutors taught in English, students had to be able to understand, read, speak and write in English. Secondly, student candidates had to be medically fit and vaccinated against smallpox, typhoid and diphtheria. A strict medical test was introduced after the death of an NMP within one year of his graduation. Thirdly, the student preferably had to be under 20 years of age, best between 16 and 18.[301] Occasionally, the CMS asked for additional signed consent from students for living in the dormitory, receiving the provided diet, and conforming with the school regulations.[302]

Racial heritage of the students was another crucial factor that determined the final acceptance to the CMS. Over the years, the Advisory Board developed a preference for NMPs 'made from students nearly or entirely full-blooded natives' instead of the European mixed-race 'half-caste' students. The 'half-caste' students were deemed not native enough to follow the CMS policy of preserving indigenous customs.[303] Students even had to submit their lineage information that contained the race of their family tree. It was only when countries like the Solomons could not find suitable candidates that the CMS accepted 'half-caste' candidates.[304] As a result, the CMS could boast that their graduates had 'pure native blood'[305]

Other than the race factor, the CMS students were generally colonial elites from good

[301] Central Medical School, Suva, Fiji, Annual Report for 1931. RF RG5 S3.419 B162 F1983, RAC; From Acting Colonial Secretary to the Prime Minister, 20 September 1935. A518, X832/1/2 Part.1, National Archives of Australia (NAA); From Acting Colonial Secretary to the Prime Minister of Australia, 14 September 1938, A518, X832/1/2 Part.1, NAA.
[302] Admission of Student into Central Medical School, Suva, 18 April 1935. A518, X832/1/2 Part.1, NAA.
[303] Memorandum to Participating Groups, 21 February 1935, ACGA 8280 EX8/24 Part.1 R17962755, ANZ.
[304] Minutes of Proceedings of a Meeting of the Central Medical School Advisory Board, 13 November 1934, WPHC4/IV 103/1934, WPA.
[305] Thomas Clunie, Abstract from *The Native Medical Practitioner*, Tropical Disease Bulletin, November 1936, RF RG5 S3.417 B161 F1975, RAC.

educational backgrounds. Selecting students that passed the criteria for a centralised medical school was not always easy because each country had a different educational infrastructure. Generally, countries east of Fiji found it easier to recruit students. Fiji held competitive entrance exams to pick the best applicants. An established reputation of 40 years of NMP history probably contributed to this popularity. Similarly, recruitment was comparatively easy in Tonga. According to Heather Leslie Young, Tonga sent the top two students from its two high schools in 1928.[306] The CMS annual report explained that the students were selected through a scholarship examination in which the top-ranked student was entitled to study in Australia, while the second and third-ranked students were offered training at the CMS.[307] The Gilbert and Ellice Islands were also able to supply competent students. In the first ten years of the CMS, three Ellicean and ten Gilbertese graduated thanks to having a good secondary school in Ocean Island.[308]

In contrast, the Solomon Islands government had a harder time recommending good students to the CMS. Richard Kane, the Resident Commissioner, reported that the Solomon Islanders are not 'lacking in brain' but he doubted whether they could make correct medical judgments.[309] Believing that 'any hesitancy for full participation would result in retrograde in retrograde islands', Lambert suggested funding Fijian students to serve in the Solomons instead.[310] This suggestion was rejected for the fear of losing highly valued Fijian NMPs through illness while working in the poor climate of the Solomons.[311] As an alternative, the Solomon Islands arranged preliminary secondary education at the Queen Victoria School, Fiji,

[306] Heather Leslie Young, 'Tongan Doctors and a Critical Medical Ethnography', *Anthropological Forum,* 13/3 (2005), 278.
[307] Central Medical School, Suva, Fiji. Annual Report for 1931. RF RG5 S3.419 B162 F1983, RAC.
[308] Minute, 10 June 1938, WPHC4/IV 1584/1937, WPA
[309] From the Resident Commissioner to the High Commissioner, 19 May 1927, WPHC4/IV 3569/1926, WPA.
[310] From the Resident Commissioner to the High Commissioner, 23 November 1927, WPHC4/IV 3569/1926, WPA.
[311] With Reference to Recruits to Medical School from Melanesia, 20 June 1927, WPHC4/IV 3569/1926, WPA.

where the Solomon Islander candidates were taught before taking the entrance examination for the CMS. In the meantime, the Solomon Islands paid for training of a batch of Fijian students for service in the Solomon Islands upon graduation.[312] Even with the special arrangement with the Queen Victoria School, some Solomon Islanders were sent back home because of their advanced age or 'low standard of intelligence.'[313] After all these difficulties, the Solomon Islands finally gained two students who could pass the admissions standard of the CMS. Still, one of them was expelled within a year. The other student was banned from boarding facilities for his misconduct but managed to graduate and became the first NMP of the Solomon Islands.[314]

Things were even more difficult in the New Hebrides, an Anglo-French Condominium. To begin with, gaining French consent was a challenge. The British therefore took a cautious approach in negotiations believing that the French authorities cared little for indigenous welfare. They reported that the eventual French concurrence for the CMS was a diplomatic decision considering their relationship with Britain.[315] Furthermore, recruiting students was difficult. There were three potential sources for students: educated chiefs, recommendations from mission teachers, and former French vessel cargo workers. The problem was, however, that the chiefs would not leave the islands. The French authorities disapproved of the suggestion of the mission teachers. Cargo workers were considered unsuitable for a medical career. In the end, New Hebrides compromised and paid for Fijian students who agreed to work in New Hebrides after graduation. It was not until 1943 that the first New Hebrides student graduated from the

[312] From Assistant Director of Education to the Secretary, 27 September 1927, WPHC4/IV 3569/1926, WPA.
[313] From the Resident Commissioner to the High Commissioner, 19 May 1927, WPHC4/IV 3569/1926, WPA.
[314] Progress of students at Central Medical School: Asks if half-yearly reports could be furnished. WPHC4/IV 609/1929, WPA.
[315] Central Medical School: Participation of New Hebrides in, and financial contribution to. WPHC4/IV 29/1929, WPA.

CMS.[316]

New Zealand territories showed a higher level of secondary education. Western Samoa selected students among 'medical cadets' who worked at the general hospital in Apia.[317] They were more mature, medically knowledgeable, and familiar with hospital duties. Naturally, they were potentially apt to be good medical students. The Cook Islands chose students from their existing scholars at Te Aute College, a Māori school in New Zealand.[318] Tokelau (former Union Group) already had NMPs from the SMS period. Niue only sent a student much later who graduated in 1950.[319] The selection process of New Zealand territories was centrally managed by Wellington. They first collected recommendations, interviewed candidates, and then considered the distribution of candidates' expertise in the colonial public service more broadly. Generally, students from New Zealand territories were academically more competent at the CMS. As an indicator of academic competency, 37.2% of the awards given between 1930 and 1938 went to students from the Cook Islands and Western Samoa.[320]

Although it was not among the founding members of the CMS, Nauru began sending students in 1934.[321] It is not clear why Australia allowed Nauru to join but there are some factors that may have influenced its decision. When the WPHC first proposed, Australia refused to join the CMS in order to maintain full control over its dependencies. Nauru was in effect an Australian colony, but officially a co-trusted League of Nations mandate between

316 Brewster, *The Turtle and the Caduceus*, 409.
317 Western Samoa had 'medical cadets' for Apia Hospital, usually a military rank. This may be the lasting signs of New Zealand's military occupation of Apia Hospital during the First World War. Even after Western Samoa turned into a civil administration, it administrators came from military backgrounds. Michael Tyquin, 'Problems in Paradise: Medical Aspects of the New Zealand Occupation of Western Samoa, 1914–1918', *Journal of Military and Veteran's Health,* 20/2 (2012).
318 Central Medical School, Suva, Fiji. Annual Report for 1931. RF RG5 S3.419 B162 F1983, RAC.
319 *History and Graduates of the Medical School known as Suva Medical School, 1888-1927, Central Medical School, 1928-1960, Fiji School of Medicine, 1961-present* (Suva, 1979).
320 *The Native Medical Practitioner, 3/1* (1939), WPHC4/IV 438/1934, WPA. 452.
321 From the Acting Colonial Secretary to the Prime Minister of Australia, A518, X832/1/2 Part.1, NAA.

Britain, Australia, and New Zealand. Therefore, it was still part of the British sphere of influence. In addition, Nauruans were categorised as Micronesians, not Melanesians whom Australia considered not intelligent enough to be educated. Moreover, the small population of about 1,500 would only require three NMPs for the entire country. It was financially affordable compared to densely populated Papua or New Guinea.[322] Acknowledging the needs of the small country, the CMS waived the usual joint administrative fee of £170 per student.[323] Nauru was only liable to pay £100 per student for the duration of the three NMP courses. Two former orderlies and one former dispenser at the Administration Hospital of Nauru attended the CMS as a result.[324]

The addition of American Samoa in 1933 excited the British authorities very much.[325] The French empire was represented through New Hebrides, but it was part of the British Empire as well. American participation could really raise the profile of the CMS to become an interimperial school. Contrary to British hopes, the excitement quickly turned into confusion about the incoherent American attitude. The admissions request for American Samoa was made in a short and rushed telegraph. The CMS had no clue how American Samoan students were selected, nor did they verify that the candidates met the required educational standards.[326] As a result, the first American Samoan ranked bottom of his year cohort. Incoherent attitudes by American authorities caused further British annoyance. In 1933, the year the American Samoa joined the CMS, the Public Health Officer of American Samoa severely criticised the NMP Service in his annual report. Nonetheless, the US Navy, in charge of administering American

[322] *The Native Medical Practitioner, 3/1* (1939), WPHC4/IV 438/1934, WPA. 456.
[323] Legislative Council, Council Paper No.40 Annual Medical and Health Report, Medical Department. 1938. NAF. 31.
[324] From the Administrator to the Prime Minister's Department, 4 July 1935, A518, X832/1/2 Part.1, NAA.
[325] *The Native Medical Practitioner, 3/2* (1939), WPHC4/IV 438/1934, WPA. 465.
[326] Council Paper No. 54, Medical Department, 1934. ACGA 8280 EX8/24 Part.1 R17962755, ANZ. 10.

Samoa, continued to make urgent requests. They abruptly withdrew the students a few years later, only to ask the CMS for readmission in another few years.[327] The short withdrawal was intended to train the students quickly in Guam for immediate service during the Second World War.[328]

To follow the Colonial Office policy promoting Anglo-American cooperation in the Pacific, the CMS chose to be taken advantage of by American Samoa.[329] Together with Nauru, New Hebrides, and Tonga, the presence of countries like American Samoa adds a stronger intercolonial character to the CMS. It was fundamentally different from other medical schools made for one country. The CMS was imperial in that it intended to expand its influence as much as possible, succeeded in reaching beyond the jurisdiction of the British Colonial Office, yet served to benefit the British Empire.

Medical Curriculum for British Colonies

The medical curriculum at the CMS reveals how the British authorities standardised NMP qualification in the Pacific Islands. The CMS curriculum was significantly advanced compared to its predecessor, the SMS. The SMS offered practice-based training to its students. The SMS students trained for three years at the Colonial Hospital in Suva, where everyone boarded at an adjoining hostel. Notably, there was no curriculum at the SMS. On weekday mornings, students attended a one-hour lecture by the Chief Medical Officer or Senior Medical Officer of Fiji. Anatomy, Physiology, Medicine and *materia medica* were taught without a

[327] From the High Commissioner to the Secretary of States for Colonies, 31 January 1945, CO 83/241/10, The National Archives of the UK (TNA).
[328] Suggested Establishment of Medical Centers in Forward Areas, 19 August 1944, File No S-37, General Administrative Files, ca. 1944–1951 Record Group 313, National Archives at College Park, College Park, MD (NACP).
[329] Letter to Mr. Sidebotham, 3 December 1945, CO 83/241/6, TNA.

fixed syllabus. The textbooks were in English, but teaching was done in Fijian because students were not proficient in English. The rest of the day after the lecture was spent working at the Colonial Hospital. Everyday duties included dressings, washing patients, seeing outpatients, rounding the wards, observing operations, carrying patients, assisting post-mortems, and tending food gardens. Students were also put on standby for any ambulance emergencies and were responsible for monitoring delirious or insane patients.[330] In short, student life at the SMS was closer to unpaid medical orderlies rather than full-time medical students.

As the CMS was established, medical education in the South Pacific came to meet the British imperial standard. This was essential for a centralised school, where the participating countries had to reach a consensus on the expected outcome of their invested education. A key consideration was to teach the same kind of medicine to students from such different backgrounds, the Western biomedicine taught by British tutors. For this reason, David Brewster, the former dean of the Fiji School of Medicine, felt that the introduction of Western biomedicine was the main historical contribution of the CMS.[331]

Also, the CMS had an explicit syllabus for each stage of education that was designed to be in line with medical schools in other British colonies. When it was established in 1928, the Colonial Office consulted the curriculum with the principals of the Medical School at Mulago, Uganda, and the College of Medicine, Singapore to assess it kept up with the imperial norm. Both principals returned stark criticisms on three main points: the insufficiency of a three-year curriculum, the lack of practical training, and the absence of Biology in the coursework. Cases outside the British Empire were also considered, noticing the impact of

[330] Plan of Training of Native Medical Practitioners at the Colonial Hospital Suva, 25 July 1919, WPHC4/IV 1326/1919, WPA.
[331] Brewster, *The Turtle and the Caduceus*, 219–26.

medical schools in French West Africa, which were 'taking the place of troops and guns.'[332] For example, the Dakar Medical School was recently established in Senegal where the French military was responsible for colonial healthcare. Raising indigenous medical staff was, therefore, a way to relieve the burden on the French military medical corps. The school was also established as a recognition of the loss of African troops in the First World War with the purpose to reduce the sickness among the Senegalese troops. According to Ann Clare Cooper, the Dakar Medical School was a 'moral conquest' that incorporated Africans into the French colonial service as 'loyal subjects.'[333]

The Colonial Office even arranged a tour of other successful colonial medical schools for Hoodless later in 1939. The plan was to visit the King Edward VII Medical College in Singapore, the Ceylon Medical School in Colombo, the Makarere Medical School in Uganda, the Kitchener School of Medicine in Sudan, and the French medical school in Dakar.[334] Although the outbreak of the Second World War interrupted the itinerary, Hoodless could still visit Africa.[335]

Following the discussions with the Colonial Office and other medical schools, Hoodless restructured the curriculum. Beginning with the cohort enrolled in 1931, the CMS provided a four-year education changed from the previous three-year course.[336] The new four-year curriculum consisted of two stages, including both theoretical and clinical education. During the junior period, which lasted one and a half years, students received full-day lectures in

[332] Correspondence on the Subjects of the Syllabus and the Four-Year Course, ACGA 8280 EX8/24 Part.1 R17962755, ANZ.
[333] Ann Clare Cooper, 'Public Health, the Native Medical Service, and the Colonial Administration in French West Africa, 1900–1944', PhD Thesis, University of Texas at Austin (2010), 118–148.
[334] Guthrie, *Misi Utu*, 43–4.
[335] Biographical Notes on and Service Records of Dr. David Winn Hoodless, O.B.E, D. W. Hoodless Papers, NAF.
[336] Enclosure No.2 of Council Paper No.11 Central Medical School, 1927. WPHC4/IV 3569/1926, WPA.

Physics, Biology, Anatomy and Physiology. This was quite a shift from the SMS that only spared one hour each day for lectures. Clinical tasks were systematically integrated into the curriculum for advanced students. Senior students spent two and a half years engaging in clinical work during the mornings and attending lectures in the afternoons. For the clinical work, students attended the medical wards, surgical wards, female wards, European wards, hospital dispensaries and outpatients.[337] Field visits to nearby villages for the Hygiene course emphasised the practical side of education.[338] What was similar to the SMS was that students made a substantial labour contribution at the CWM Hospital, to which the CMS was attached. It was to the extent that the colonial government became concerned about the lack of hospital staff when the student numbers at the CMS were not at a maximum level.[339] Through the CMS, Fiji enjoyed more dressers and clinicians at their disposal without paying salaries other than scholarships.

At the CMS, the students had to meet the academic and disciplinary standards set by the British authorities. Many students struggled to adjust to both academic and social life. Failing final exams was not uncommon. When a failure occurred, students were given a second chance or even a third chance if they were diligent. Repeated failures could result in the cancellation of their studentships.[340] Maintaining behavioural discipline was also taken seriously. To prevent costly scholarships from being wasted, some countries had students sign an agreement to obey the school regulations.[341] However, students had agency and made their own decisions about whether to follow the school's regulations or not. For example, student

[337] Legislative Council, Council Paper No.40 Annual Medical and Health Report, Medical Department. 1938. NAF. 28

[338] Central Medical School Advisory Board: Forwards copies of minutes of various meetings of. WPHC4/IV 3035/1928, WPA.

[339] Central Medical School, Suva, Fiji. Annual Report for 1931. RF RG5 S3.419 B162 F1983, RAC.

[340] From Hoodless to the Chairman of CMS Advisory Board, 14 October 1930, WPHC4/IV 3102/1930, WPA.

[341] Legislative Council, Council Paper No.40 Annual Medical and Health Report, Medical Department. 1938. NAF. 28.

Sianava was dismissed for attacking a fellow student with a knife and showing 'gross impertinence' to European nurses. The reason for the attack is not known.[342] Another student Aisea Koroitanmana struck Sister Brahne, the supervising nurse's cheek with the back of his hand and pushed a fellow student trying to stop him. He was immediately expelled but the reason for his violence was not specified in the document.[343] Student Timeci Qielevu was accused of causing a 'very serious injury' to a native obstetric nursing student, Akenisa. Temice admitted that he enticed Akenisa to his dormitory room and locked the door while they were together in the room. Both students were seen to secretly escape the room together and Temice's studentship was terminated three days after the incident. The exact relationship between Timeci and Akenisa is unclear from the primary sources.[344] The CMS authorities only let those who met both academic and disciplinary standards to graduate.

Another point that affirms the CMS followed the imperial standards of medical education is the introduction of a British-style graduation ceremony. Its first graduation ceremony took place in 1939. This year, students from five different Pacific nations knelt to take the Hippocratic Oath, which was administered by the Acting Director of Medical Services of Fiji. The graduates went on their knees again to receive their NMP diplomas from the High Commissioner for the Western Pacific, Sir Harry Luke. Luke was dressed in his scarlet Oxford DLitt gown, which he supposed was never seen before in the Pacific Islands. It was Luke's idea to hold the graduation ceremony 'in proper surroundings on a proper scale, and be made as far as possible an impressive academic affair.' The event was a showcase opportunity to

[342] From V. W. T. McGusty, the Acting Chief Medical Officer to the Acting Colonial Secretary, 14 November 1934. WPHC4/IV 103/1934, WPA.
[343] Minutes of Proceedings of an Extraordinary Meeting of the Central Medical School Advisory Board, 11 April 1934. WPHC4/IV 103/1934, WPA.
[344] Minutes of Proceedings of a Meeting of the Central Medical School Advisory Board, 4 January 1934, WPHC4/IV 103/1934, WPA.

display the achievements of the CMS, what he believed were 'the most beneficent gifts which British rule has conferred upon the native races of the Pacific.'[345]



Figure 3. Graduates taking the Hippocratic Oath in the Legislative Council Chamber, Suva. Luke is in his Oxford gown. [Source: Margaret Guthrie's Private Collection, Auckland, New Zealand].

The graduation ceremony was indeed an imperial ritual. Luke held the function at the newly built Legislative Council Chamber, one of the most important buildings owned by the colonial government. Doctors, dentists, European nurses, indigenous nurses, friends and families of the graduates, and all students from the Central Medical School were present at the ceremony. In addition, Executive Council members, Legislative Council members, WPHC staff, and a number of prominent citizens were invited to take part in the colonial spectacle.

[345] Photographs of the CMS graduation ceremony from Margaret Guthrie's private collection of David Hoodless papers in Auckland, New Zealand; Harry Luke, *From a South Seas Diary 1938–1942* (London: Nicholson & Watson, 1945), 135.

With the exception of American Samoan students, the audience represented people from across the British Empire, comprising Britain, Fiji, Rotuma, the Solomon Islands, the Gilbert and Ellice Islands, Tonga, Western Samoa, the Cook Islands, Nauru, and India.[346] It was in front of such an audience where the graduates were obliged to kneel for an ancient Greek oath and to the High Commissioner after learning Western medicine from British tutors in English with peers from other colonies.

'Westernise' or 'Nativise'

Centralisation of medical education facilitated various forms of colonial encounters. As Luke stated, the CMS was 'a microcosm of the Pacific' where the students benefited from 'mingling with other races of the Pacific and with Indian fellow-students.'[347] According to the school's annual report, in 1938, there were four races, eleven different languages and seven religions represented among the students.[348] Owing to the centralisation, imperial authorities could easily test the existing racial notions of the Pacific Islanders. The CMS was, in that sense, a laboratory for racial science that had samples from across the Pacific in a limited space for a designated period of time.

From the British perspective, there were three races in Oceania: Polynesians, Melanesians, and Micronesians. Polynesians were most admired among the three groups of people. As Maile Arvin wrote, white Europeans continuously described Polynesians as almost white, popularly suspected to be of Aryan descent. On the contrary, Melanesians were least preferred for their darker pigment, often subject to racial prejudice against other 'Black' people,

[346] From Harry Luke to the Secretary of State for the Colonies, 14 December 1939, CO 83/231/15, TNA.
[347] *Fiji Times and Herald*, 24 December1940, CO 83/235/13, TNA.
[348] Legislative Council, Council Paper No.40 Annual Medical and Health Report, Medical Department. 1938. NAF. 27.

such as Africans.[349] According to Bronwen Douglas, Micronesians were similarly racialised with association to Southeast Asians, being positioned somewhere between Polynesians and Melanesians in the European preference.[350]

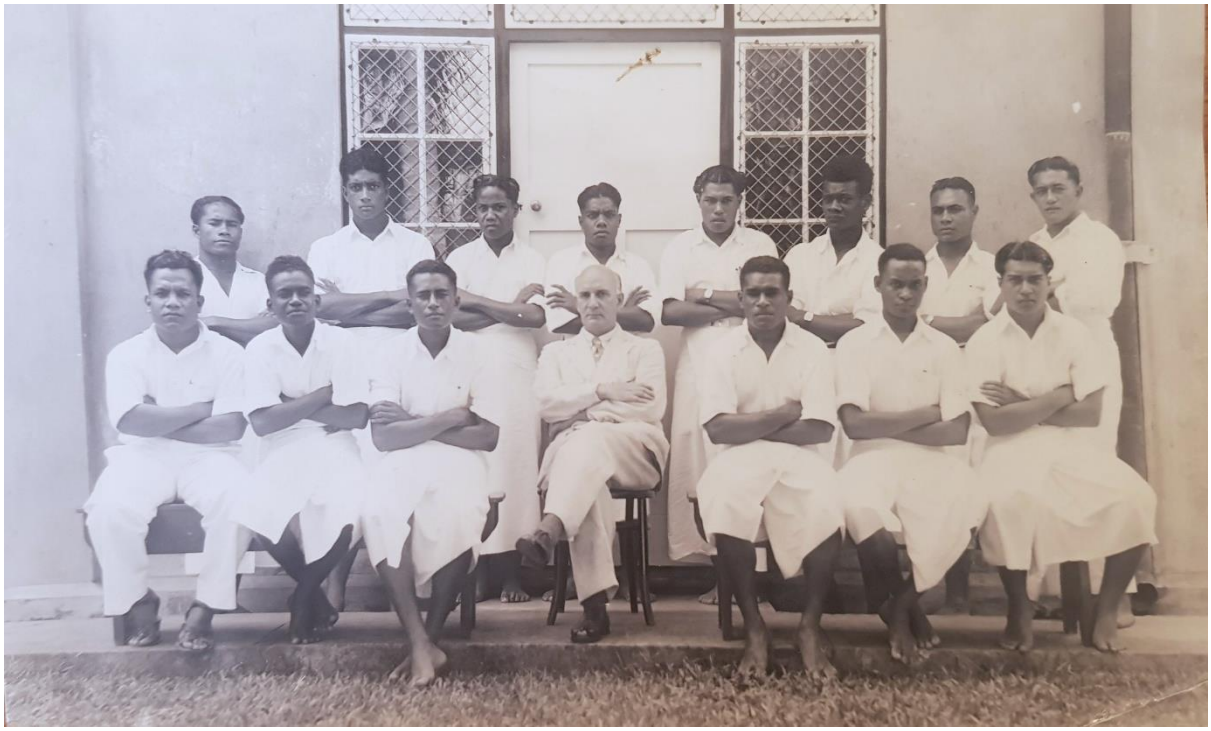


Figure 4. Group photo of Hoodless and first-year students wearing traditional-style uniform bare feet. Students' nationalities include Fiji, the Gilbert and Ellice Islands, the Solomon Islands, Tonga, Western Samoa, the Cook Islands, and American Samoa. Second from left on the second row is Ratu Sir Kamisese Mara. [Source: Margaret Guthrie's Private Collection, Auckland, New Zealand].

As such, in the centralised environment of the CMS, imperial authorities could categories students from across the Pacific Islands. The CMS reproduced racial stereotypes based on ancient humoral theory of four temperaments (sanguine, phlegmatic, choleric, melancholic). For example, the majority of the students were 'easy-going sanguine type, typical South Seas Islanders' with the exceptions of 'phlegmatic' Solomon Islanders and 'choleric'

[349] Maile Arvin, *Possessing Polynesians: The Science of Settler Colonial Whiteness in Hawai'i and Oceania* (Durham: Duke University Press, 2019) 1–34.
[350] Bronwen Douglas, 'Foreign Bodies in Oceania' in Douglas and Ballard, *Foreign Bodies*, 3–30.

Gilbertese.[351] Such stereotyping using temperaments echoes racial theories of the eighteenth century. Notably, Carl Linnaeus categorised human races into four and attached characteristic temperaments to each race: Europeans–white–sanguine, Americans–red–choleric, Asians–yellow–melancholic, and Africans–black–phlegmatic.[352] Immanuel Kant also justified racial hierarchies through the humoral temperaments.[353] Considering the racial theories and popular beliefs on the origins of the Pacific Islanders described in the paragraph above, the humoral temperaments reflected the existing racial notions among the imperial authorities, e.g. Solomon Islanders as Melanesians were 'Black' and 'phlegmatic'.

Student assessments were always framed in racial categories too. For example, Western Samoa and the Cook Islands exceeded Melanesia in terms of 'mental gifts.' Students from the Gilbert and Ellice Islands, who were Micronesians, were also considered mentally superior to Fijians, who were Melanesians. Even among the Melanesian countries, the Solomon Islands and New Hebrides students were placed at the bottom of the perceived intellectual hierarchy.[354] Such racial understanding can be confirmed by preliminary secondary education in Fiji only being offered to students from the Solomons and New Hebrides.[355]

Despite efforts to rank and stereotype the 'Pacific races', students at the CMS proved themselves to the colonial authorities that they were far more intelligent than the general European perception. The CMS authorities were surprised that Indians, presumably of a superior civilisation, were not among the brightest students at the CMS.[356] While the

[351] Legislative Council, Council Paper No.40 Annual Medical and Health Report, Medical Department. 1938. NAF. 27.
[352] Jennifer Mensch, 'Caught Between Character and Race: "Temperament" in Kant's Lectures on Anthropology', *Australian Feminist Law Journal*, 43/1 (2017), 135.
[353] Paul Kleingeld, 'Kant's Second Thoughts on Race', *The Philosophical Quarterly*, 57/229 (2007), 573–592.
[354] Enclosure No.2 of Council Paper No.11 Central Medical School, 1927. WPHC4/IV 3569/1926, WPA.
[355] From Assistant Director of Education to the Secretary of Western Pacific High Commission, 27 September 1927, WPHC4/IV 3569/1926. WPA.
[356] Correspondence on the Subjects of the Syllabus and the Four-Year Course, ACGA 8280 EX8/24 Part.1 R17962755, ANZ.

Europeans still believed Polynesians were more intelligent than Melanesians, the CMS authorities concluded that student performance was determined more by the educational system of their country of origin than by the intrinsic intellectual abilities of each race.[357] It is significant that this conclusion came in the 1930s when 'racial science' was widely popular in Europe. Many intellectuals tried to measure the level of intelligence to confirm the prestige of white Europeans, e.g. Anglo-Saxons.[358] These theories justified racial inequalities, assuming that non-white races possessed poorer mental capacities, of which Africans had the lowest level of intelligence.[359]

The centralised environment of the CMS let some students enjoy showing off their newly acquired cosmopolitan tastes. There was an apparent craze for shopping for European goods before leaving Fiji. One student shocked the tutors by appearing in full European attire immediately after graduation. It was a rebellious act because the CMS students were required to wear the traditional dress at all times.[360] Those who did not have enough money even asked for a cash advance on their salaries for shopping before they returned to their countries.[361] A student from the Gilbert and Ellice Islands, Simeona, made use of the cash advancements to purchase two dozen shirts instead of what he told the school authorities he would buy: a stethoscope, a microscope and a benzine lamp.[362] The most popular items were shirts, shorts, trousers, *sulus* [traditional clothing], blazers and European coats.[363]

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[357] Central Medical School, Council Paper No. 54, Medical Department, 1934. ACGA 8280 EX8/24 Part.1 R17962755, ANZ.
[358] Clyde Chitty, *Eugenics, Race, and Intelligence in Education* (London: Continuum International Pub. Group, 2007), 65–80.
[359] Chloe Campbell, *Race and Empire: Eugenics in Colonial Kenya* (Manchester: Manchester University Press, 2007), 19–23.
[360] From the Resident Commissioner to the High Commissioner, 25 April 1938, WPHC4/IV 1584/1937, WPA.
[361] From Acting Secretary to the High Commission to the Central Medical Authority, Fiji, 15 March 1940, WPHC4/IV 1210/1940, WPA.
[362] From Hoodless to the Secretary of Western Pacific High Commission, 13 March 1940, WPHC4/IV 1210/1940, WPA.
[363] From Hoodless to the Secretary of Western Pacific High Commission, 10 November 1947, WPHC4/IV

At the CMS, imperial authorities wanted the students to be 'native' but not be too 'native.' Given the students' desire to appear more European, it may seem like the CMS promoted Westernisation. The education was indeed expected to deliver Western medicine to remote islands where European officers would not visit. At the same time, the CMS maintained a philosophy to teach the students to 'work as a native amongst natives without ideas beyond his station.'[364] This philosophy can be reaffirmed in Sir Alexander Grantham, the High Commissioner for the Western Pacific's concern that American Samoan students sent to Guam would be 'de-nativised, but yet will not be accepted as the equal of white Americans.'[365] It was a tool to avoid spoiling the students with a comfortable lifestyle and to differentiate them from European doctors. Contradictorily, the age requirement for admissions was put in place to select young students 'before they have become completely set in the native mental mould.'[366]

Socially, graduate NMPs were asked to abstain from interfering in provincial affairs unrelated to medical practice.[367] This measure may have been set for ethical reasons, but it also contained the NMPs in the specialist sphere of medicine. Considering their elite status, many born into privileged families, NMPs could get more influential than the colonial government wanted them to be. Most NMPs followed the guidance, yet their very presence already meant more than medicine. As Alexandra Widmer analysed the case of New Hebrides, NMPs were administrators of the colonial state, demonstrating what she called a 'nascent

1210/1940, WPA.

[364] Minute, 10 June 1938. WPHC4/IV 1584/1937, WPA.

[365] Sir A. Grantham to the Secretary of State for the Colonies, 15 December 1945, CO 83/241/6, TNA.

[366] Central Medical School, Council Paper No. 54, Medical Department, 1934. ACGA 8280 EX8/24 Part.1 R17962755, ANZ.

[367] Rules made by the Chief Medical Officer under section 10 of Ordinance No.11 of 1888, Governing the conduct of Native Medical Practitioners, WPHC4/IV 1326/1919, WPA.

biomedical citizenship.'[368]

Ultimately, the apparent limitation of CMS was its inability to break through the institutionalised racism of the colonial South Pacific. 'Who's the boss?' questioned the Public Health Officer of American Samoa when he criticised the NMP Service risked Pacific Islanders being insubordinate.[369] The British, too, did not desire such a thing. By defining the NMP service as a 'subordinate medical service', the British maintained a clear hierarchy between the European medical officers and the NMPs.[370] Such a two-tiered system was already introduced by the Indian Medical Service since the early nineteenth century through their 'Sub-Medical Department' and the 'Subordinate Medical Service'. It is likely that the colonial authorities in the Pacific consulted the Indian case in designing the NMP service.[371] Basically, European doctors treated Europeans. They administered hospitals and controlled quarantine. The NMPs would just be in charge of indigenous healthcare except for emergencies. It was clear from the early years that the CMS would not become a full-fledged medical college granting degrees. Subsequently, the NMP Service could not become a regular medical service because the NMPs held inferior diplomas.[372] NMPs had to remain under European supervision in order to prevent their medical practice and behaviour from deteriorating.[373] Rebellious NMPs could be dismissed. For example, NMP Tabonteren of the Gilbert and Ellice Islands got his licence revoked for inadequate work performance and disobedience. This included him choosing to

[368] Widmer, 'Native Medical Practitioners, Temporality, and Nascent Biomedical Citizenship in the New Hebrides', 57–80.
[369] Appendix, Extract from the Annual Report for 1933-1934 of the Public Health Officer of American Samoa, ACGA 8280 EX8/24 Part.1 R17962755, ANZ.
[370] Extract from Page 42 of 'The Colonial Empire in 1937–1938' Rendered by the Secretary of State to Parliament, F48/218, NAF.
[371] Arnab Chakraborty, 'Negotiating Medical Services in the Madras Presidency: the Subordinate Perspectives (1882–1935)', *Medical History* 65/3 (2021), 247–249.
[372] Personal Note from Lambert to Mr. Berendson, 18 January 1934, ACGA 8280 EX8/24 Part.1 R17962755, ANZ.
[373] From the Secretary to the Resident Commissioner, 15 September 1937, WPHC4/IV 1584/1937, WPA.

wear 'complete European dress' and refusing to wear the uniform in traditional dress.[374] Publication and circulation of the *Native Medical Practitioner*, a semi-annual journal first published in 1930, also contributed to governing the NMPs as its purpose was to make the NMPs 'coherent and articulate.'[375]

Conclusion

After ten years of operation, the Secretary of State for the Colonies told the British Parliament that the CMS was 'specially successful.'[376] Using the case of the CMS, the Colonial Office argued that colonial healthcare should eventually be achieved through the 'progressive training of medical staffs drawn from the local inhabitants' instead of increasing the Colonial Medical Service.[377] In its first ten years, the CMS produced 209 NMPs, of which 51 individuals originated from the Pacific Islands outside of Fiji.[378] It later expanded to include a dental training course in 1945. Niue, Papua New Guinea, and the United States Trust Territories started to send students to the CMS later in the 1950s.[379]

As an imperial project that reached beyond the British Empire, the CMS successfully brought efficient solution to medical governance and financial savings to the Colonial Office. It was a product of a collective initiative between the Western Pacific High Commission, Fiji, Western Samoa, Tonga, and the Rockefeller Foundation that covered many other colonies in the region. The CMS was established to relieve British moral responsibilities to the Pacific

[374] From the Resident Commissioner to the High Commissioner, 25 April 1938, WPHC4/IV 1584/1937, WPA.
[375] Western Pacific Health Service 3rd Quarterly Report, 1930, RF RG5 S3.419 B162 F1980, RAC.
[376] Extract from Page 42 of 'The Colonial Empire in 1937–1938' Rendered by the Secretary of State to Parliament, F48/218, NAF.
[377] Extract from Official Report, 25 July 1938, F48/218, NAF.
[378] *The Native Medical Practitioner, 3/1* (1939), WPHC4/IV 438/1934, WPA.
[379] Brewster, *The Turtle and the Caduceus*, 408–12.

Islanders, to keep the indigenous people resident in the Pacific Islands, and to manage labour resource for imperial economies. The strategic importance of the school is underscored by the fact that medical schools were not founded in other small-island colonies of the British Empire until after the Second World War. With the RF's assistance in the early years, the British could achieve these goals at a lower cost. Owing to its centralised nature, the CMS became one of the few spaces in Oceania where colonial encounters happened frequently and on a large scale. The student body of the CMS was an early case of a 'Pacific community.' NMPs, who spent their youth in the 'microcosm of the Pacific', later took part in promoting regionalism in the Pacific. Many of them were present at the South Seas Conference in 1947, which resulted in the creation of the South Pacific Commission.[380] Perhaps more significantly, Pacific Islanders tried to break down the boundaries of existing racial hierarchies in the minds of colonial authorities by going against the regulations and by proving their intellectual abilities. The fact that race did not determine one's intellectual abilities was a particularly powerful realisation for the Pacific Islanders. As remarked in the memoirs of Ratu Sir Kamisese Mara, who became a long-time political leader after Fiji's independence, he learned 'the most valuable knowledge that under the skin all people are the same' during his time as a student at the CMS.[381] The CMS was intended as an imperial institution which kept the NMPs in a subordinate rank, but ironically, it became a space for discovering equality to future politicians in the Pacific.

[380] Fry, 'The South Pacific "Experiment"', 184–188.
[381] Mara, *The Pacific Way*, 18.

Chapter 3. The Western Pacific Health Service

Following the CLH and the CMS, the Western Pacific Health Service (WPHS) was established in 1928. As a health service, the WPHS conducted disease campaigns and supervised medical matters under the WPHC. It functioned more like a medical 'control tower' in the British colonies, with assistance from the RF. Its directorship was given to Lambert, the RF representative in the South Pacific. Like other centralised institutions, the WPHS operated in the WPHC territories, later including the New Zealand colonies. Just like the CLH, the administrative presence of the WPHS is barely known in the literature. Activities conducted by the WPHS are often described as Rockefeller Foundation programmes in the South Pacific. The official name of the institution is almost invisible, and the focus on its activities in relation to the RF has led to the WPHS being neglected as a colonial institution. [382] This may be due to the lack of WPHS documents in the Colonial Office archives. The WPHC documents preserved in the Western Pacific Archives are filed under titles such as 'campaigns' or 'cooperation with the RF' and are mostly a very thin collection of telegrams that do not contain any substantial information. This collection does not even contain a full series of regular reports and journal publications.[383] This chapter, therefore, relies on materials from the Rockefeller Archive Centre, which preserved a full collection of regular reports and communications

[382] For example, Richard Taylor's mentions the Rockefeller Foundation programmes without referring to the WPHS in his chapter, 'History of Public Health in Pacific Island Countries' in Milton J. Lewis, Kerrie L. Macpherson (eds.), *Public Health in Asia and the Pacific: Historical and Comparative Perspectives* (London: Routledge, 2008). Annie Stuart notices the existence of the WPHS in her thesis, but the institution is not even listed in the abbreviations list because she seldom mentions it. The WPHS also does not appear at all in two of the published articles that came out of her thesis. See: Stuart, 'Parasites Lost?'; Stuart, 'We Are All Hybrid Here', 56–79; Stuart, 'Contradictions and Complexities in an Indigenous Medical Service', 125–143.

[383] Of the sixteen files related to the WPHS in the Western Pacific Archives WPHC4/IV series (microfilmed interwar period series), eleven are under five pages including the cover page: WPHC4/IV 809/1929, 1680/1929, 1999/1929, 2010/1929, 3379/1929, 2434/1930, 3794/1930, 1422/1931, 2655/1931, 3559/1933, 1244/1934, WPA.

concerning the WPHS.

Although the institution is less visible in the Colonial Office files, the WPHS was clearly a colonial department whose director was the Deputy Central Medical Authority of the British territories in the South Pacific. The medical staff of the WPHS were also NMPs or colonial medical officers. This chapter primarily examines the medical campaigns led by the WPHS, its functions of medical governance, and their study of the 'Pacific race.' It also pays attention to roles of NMPs and indigenous resistance to medical programmes as signs of indigenous agencies. Instead of simply viewing the WPHS campaigns as humanitarian aid from the private sector, this chapter shows that the British Empire relied on external funding and indigenous staff to provide indigenous healthcare. Although it was an important part of the WPHS programme, this chapter will not discuss the CMS as it was introduced in the previous chapter.

Partnership with the Rockefeller Foundation

In its final report of 1938, the WPHS argued that medical care was the most critical work of colonial administrations in the South Pacific. This was because the institution viewed severe depopulation as the region's paramount problem. The WPHS pointed out three main causes for depopulation: commercial exploitation by white imperialists, decay of custom combined with the lack of a 'racial will to survive', and introduced epidemics.[384] In short, contact with the Western world had doomed the 'Pacific race' to extinction. This common social-Darwinist perspective was encapsulated in the idea that 'fatal impact' made by

[384] The Central Medical School, RF RG5 S3.417 B161 F1975, RAC. 1.

Europeans caused critical consequences to colonial population.[385] Among the three causes, imperialist exploitation and the decay of customs were difficult to stop. What could be alleviated, however, was the burden of disease, and the WPHS was created for this very purpose: disease-control.

As a centralised health service, the WPHS was envisaged as an economical solution to disease control for participating countries. The geographically scattered nature of Oceania meant that communication between islands was difficult, even between the British colonies. Ships running between Fiji and the Ellice Islands operated once every three months. A vessel connecting Fiji and the Solomon Islands or New Hebrides operated only through Sydney at six weekly intervals.[386] Such remoteness not only discouraged hiring good medical staff in the Pacific Islands but made implementing public health programmes a daunting challenge. In the long-term, this prevented introducing any preventive health measures. Medical services in the WPHC were in a 'socialised system', which provided free medical services to the local population.[387] Medical accessibility could be increased through intercolonial cooperation in the Pacific Islands. New Zealand territories were already cooperating in running the CLH and the CMS, which meant that the institutional centralisation of medical services could be done easily.[388]

The first annual report of the WPHS stated the four main objectives of the institution, which clearly indicated its role in centralisation. First, the WPHS made the Chief Medical Officer of Fiji the Central Medical Authority for the WPHC. This measure centralised medical services of all British territories in the South Pacific under one authority. Second, it appointed

[385] James Belich, 'Race', in David Armitage, Alison Bashford (eds.), *Pacific Histories: Ocean, Land, People* (Basingstoke: Palgrave Macmillan, 2014), 268–269.
[386] Western Pacific Health Service Annual Report, 1928, RF RG5 S3.419 B161 F1977, RAC. 1.
[387] The Central Medical School, RF RG5 S3.417 B161 F1975, RAC. 11.
[388] Western Pacific Health Service Annual Report, 1930, RF RG5 S3.419 B162 F1981, RAC. 13–14.

a Travelling Medical Officer of Health to supervise the NMPs working in remote districts. This position could connect the scattered NMP service and maintain it under imperial control. Third, it enlarged the CMS to accommodate other administrations. In other words, it was in charge of centralising medical education in the South Pacific. Lastly, the WPHS coordinated disease campaigns in the Pacific Islands.[389] All four objectives aimed at centralising medical governance in the South Pacific. Essentially, the WPHS directed education and disease-campaigns for the WPHC, which later encompassed New Zealand territories.

By the time the WPHS was founded, the British Empire already had strong ties with the RF, which played a geopolitical role in 'mapping international health' in the interwar years.[390] Wickliffe Rose, the first director of the International Health Commission (later the International Health Board and the International Health Division) of the RF, set up ties with the Colonial Office in 1913 for hookworm campaigns in the British tropical colonies, including in the Pacific. This was very much welcomed by the Colonial Office, which found medical programmes expensive. The RF was a lucrative source of cash that funded medical programmes on behalf of colonial governments. Stewart Firth evaluates the hookworm campaign during this period as a loss of colonial resources to a disease of marginal significance.[391] It was an 'empire on the cheap', as John Farley put it, advising on health matters in the colonies rather than acting on them. According to Farley, colonial policies limiting the collection and circulation of knowledge made it impossible for the British colonies to have public health services.[392]

[389] Western Pacific Health Service Annual Report, 1928, RF RG5 S3.419 B161 F1977, RAC. 4–5.
[390] Anne-Emanuelle Birn, Elizabeth Fee, 'The Art of Medicine: The Rockefeller Foundation and the International Health Agenda', *The Lancet,* 381 (2013), 1619.
[391] Stewart Firth, 'Colonial Administration and the Invention of the Native' in Denoon (et al.), *The Cambridge History of the Pacific Islanders*, 279.
[392] John Farley, *To Cast Out Disease: A History of the International health Division of the Rockefeller Foundation, 1913–1951,* (Oxford: Oxford University Press, 2004), 61–62.

The establishment of the WPHS proved that a public health service existed in the British South Pacific. By having the institutional protection conferred by the WPHC, Lambert could easily lead public health campaigns and collect medical knowledge in Oceania for the RF. Stuart viewed the WPHS more or less as a Rockefeller project in this respect.[393] However, Lambert's works were implemented through the colonial institution, using the WPHS letterhead for his correspondence. As a department under the WPHC, the WPHS was an institutional platform that benefited both the Colonial Office and the RF. This was an unusual case because, as Nancy Stepan notes, the Foundation's philosophy was to work with governments, not run public health departments by themselves.[394]

In the WPHS, Lambert had entire control over the WPHS campaigns. Although the WPHS's objectives included centralising medical services and education in the region, the results of these objectives fell under the jurisdiction of the Medical Departments and the CMS. What the WPHS did independently in its own name were disease control campaigns. For this, Lambert, an American staff member of the RF, was placed in a directing position in the British colonial service. As the director of the WPHS, Lambert was also made the Deputy Chief Medical Authority in the WPHC. He even represented the WPHC in international meetings, such as the Intergovernmental Conference on Far Eastern Countries on Rural Hygiene in Java, 1937.[395] This way, the British Empire outsourced their public health department to the RF.

Financially, the WPHS was heavily funded by the RF and supported by the British colonies. Upon the establishment of the WPHS, the RF bore 75% of its budget and the WPHC covered 25%. Additional support was provided by colonial authorities. Transport costs were so expensive in their extensive medical campaigns that the WPHS could not have afforded it

[393] Stuart, 'Parasites Lost?'
[394] Nancy Leys Stepan, *Eradication: Ridding the World of Diseases Forever?* (London: Reaktion, 2011), 69–70.
[395] Western Pacific Health Service 1st Semi-Annual Report, 1937, RF RG5 S3.417 B161 F1971, RAC.

without help. Government vessels were provided for inter-island transport and local communities helped with intra-island transport.[396] Sometimes the WPHS lacked supplies of essential drugs and medical departments covered the rest of the expense. The Solomon Islands and Ellice Islands offered the services of their medical officers at no cost. Fiji contributed free printing and stationery for the WPHS office in Suva.[397] Western Samoa extended yaws tests by themselves in 1933 without financial help from the WPHS.[398]

In addition to governmental support, voluntary assistance from the private sector was common in the WPHS campaigns. For example, the Colonial Sugar Refining Company in Fiji provided a subsidy of £4,000 just for the transport of the Travelling Medical Officer of Health between 1929 and 1930.[399] Missionaries in New Hebrides and Fiji helped the hookworm campaigns.[400] The fact that such governmental and private financial support was essential in carrying out the WPHS activities proves that it was indeed a colonial department, not just a RF project.

Early Campaigns, 1928–1931

Most of the WPHS resources in the early years were invested in eradicating endemic diseases, such as hookworm, in the South Pacific. This was in line with the RF's continuous effort to eradicate diseases that are technically solvable.[401] In the early years, they focused on hookworm infection and yaws. Hookworm was something the RF was good at, while yaws was a disease the Foundation wanted to acquire more information on. For an effective campaign

[396] Western Pacific Health Service Annual Report, 1928, RF RG5 S3.419 B161 F1977, RAC. 12.
[397] *Ibid.*, 33.
[398] Western Pacific Health Service 1st Quarterly Report, 1933, RF RG5 S3.417 B161 F1962, RAC.
[399] Western Pacific Health Service Annual Report, 1928, RF RG5 S3.419 B161 F1977, RAC. 32.
[400] Western Pacific Health Service 4th Quarterly Report, 1929, RF RG5 S3.419 B161 F1978, RAC.
[401] Stepan, *Eradication*, 75–76.

against both diseases, the WPHS adopted a 'mass treatment method' that was used used globally by the RF. Heavy infection rates justified this approach. According to a RF survey in 1921, 66–100% of the Solomon Islanders were infected with hookworm, with an average of more than 166 worms per person.[402] The infection rate led to a consensus on the need for mass treatment and the RF carried out a hookworm campaign in Fiji that became a model for future campaigns.[403]

Fiji-style mass treatment was based on compact and mobile 'units' that travelled across islands. This unit method was another popular approach taken by the RF, which manifested differently in each country. For example, health units in Mexico were a group of medical staff attending to pressing health problems of the region it was based in.[404] It was a geographical constituent of up to 100,000 people in Sri Lanka, where standard public health work was routinely carried out.[405] In China, a health unit was a demonstration station that had duties of both treatment and education.[406]

WPHS units resembled the Chinese model in the sense that it was charged with both relief and demonstrative education duties. The crucial difference was mobility. For mobility, units maintained a comparatively small size. Typically, a country with smaller medical services, like the Solomon Islands or New Hebrides, had 1–2 staff per unit. Countries with larger medical services had larger units of 3–4 personnel. In the model country, Fiji, a unit consisted of a directing European medical officer, one NMP, one indigenous servant and one indigenous

[402] Western Pacific Health Service Annual Report, 1928, RF RG5 S3.419 B161 F1977, RAC. 15–16.
[403] Western Pacific Health Service Annual Report, 1928, RF RG5 S3.419 B161 F1977, RAC. 4.
[404] Anne-Emanuelle Birn, *Marriage of Convenience: Rockefeller International Health and Revolutionary Mexico* (Rochester; University of Rochester Press, 2006), 117–120.
[405] Soma Hewa, 'The Alma-Ata Declaration, Rockefeller Foundation and Development of Primary Health Care in Sri Lanka: A Model for Health Promotion' in Liping Bu, Darwin H. Stapleton, Ka-che Yip (eds.) *Science, Public Health and the State in Modern Asia* (London: Routledge, 2012), 71–92.
[406] Darwin H Stapleton, 'Removing the Obstacles to Public Health Work: Context for the Rockefeller philanthropies and public health in China and Japan, 1920–1940' in Bu, Stapleton, Yip (eds.) *Science, Public Health and the State in Modern Asia*, 93–112.

dresser. These units travelled to districts of each country to set up bases for campaigns. In larger districts, sub-bases were made within a district. Base sites were selected in accessible areas. Preferably, a seaside village with easy water transport was chosen. In a village, tax-houses allowed convenient access from both inland and coastal settlements. After a campaign in a district was completed, transport between bases was supported by government vessels. For transport between a base and sub-bases, local communities provided indigenous carriers or canoes.[407] The size or duration of campaigns varied depending on local conditions.[408]

Campaign work started by consulting village constables, who helped the WPHS list all villages in the district. A unit treated a maximum of 300 people per day. The logistical challenge was to arrange one day for every village while keeping the number of treatments below 300. Once the village list was confirmed, constables announced the news with allotted days for each village. It usually took a couple of days for the news to spread. In the meantime, the campaign unit prepared treatment houses. As people arrived for treatment, the officer in charge recorded the census with name, age, gender and results of medical examinations. Then, units tried to treat both hookworm and yaws at the same time. During the initial census, everyone was treated for hookworm while signs of yaws were looked for. Those not infected with yaws could return home after hookworm treatment, while those infected received injections the following day.[409]

An integral part of the campaign was public health education that would 'instill into the native mind a horror of filth.' Mass treatment was a good chance to give lectures at the same time. Unit staff taught people the bio-medical causes of disease, concepts of infection, and sanitation. Significantly, the lectures challenged traditional beliefs, for example, that

[407] Western Pacific Health Service Annual Report, 1928, RF RG5 S3.419 B161 F1977, RAC. 12.
[408] Western Pacific Health Service 3rd Quarterly Report, 1929, RF RG5 S3.419 B161 F1978, RAC. 1.
[409] Western Pacific Health Service Annual Report, 1928, RF RG5 S3.419 B161 F1977, RAC. 13.

disease was caused by evil spirits in the form of a snake.[410] Other than lectures, the WPHS translated and distributed the 'Thomas Ezekiel Brown and Auntie Eliza Bush-Tea' story series, renaming Thomas Ezekiel Brown as Emirami Tambakau.[411] The series was part of a widely popular monthly bulletin *Jamaica Public Health*, written by Benjamin Washburn, the RF representative in Jamaica.[412] It was chosen because both areas were thought to share common medical superstitions.

Even though hookworm and yaws were treated in the same campaign, the diseases were approached differently. Hookworm treatment was straightforward, using the mass treatment method.[413] After census and examination, the campaign unit treated everyone that did not have underlying medical conditions that would risk side effects. Chenopodium, carbon tetrachloride or tetrachloridethylene pills were used. Asymptomatic cases made the treatment of yaws more complicated than the hookworm. Only 50–75% of yaws patients showed symptoms, while in other cases the infection was quiescent. The majority of the infected patients were children, whom the WPHS believed 'kept the disease alive', presumably as reservoirs of infection.[414] Unlike hookworm, many cases required 2–3 injections of neo-arsphenamine to be fully treated. The results for this skin disease were immediately visible and successful results made the treatment popular.[415] The WPHS reported that the response was so enthusiastic that even those free of yaws asked for injections.[416] As a result, the WPHS concluded that mass treatment did not require further justification because it brought definite

[410] *Ibid.*, 9.
[411] *Ibid.*, 30.
[412] Margaret Jones, *Public Health in Jamaica 1850–1940: Neglect, Philanthropy and Development* (Kingston; University of the West Indies Press, 2013) 126–136.
[413] Packard, *A History of Global Health*, 37.
[414] Western Pacific Health Service Annual Report, 1928, RF RG5 S3.419 B161 F1977, RAC. 20.
[415] Western Pacific Health Service Annual Report, 1930, RF RG5 S3.419 B162 F1981, RAC. 5.
[416] Western Pacific Health Service Annual Report, 1928, RF RG5 S3.419 B161 F1977, RAC.14.

improvement in indigenous health.[417]

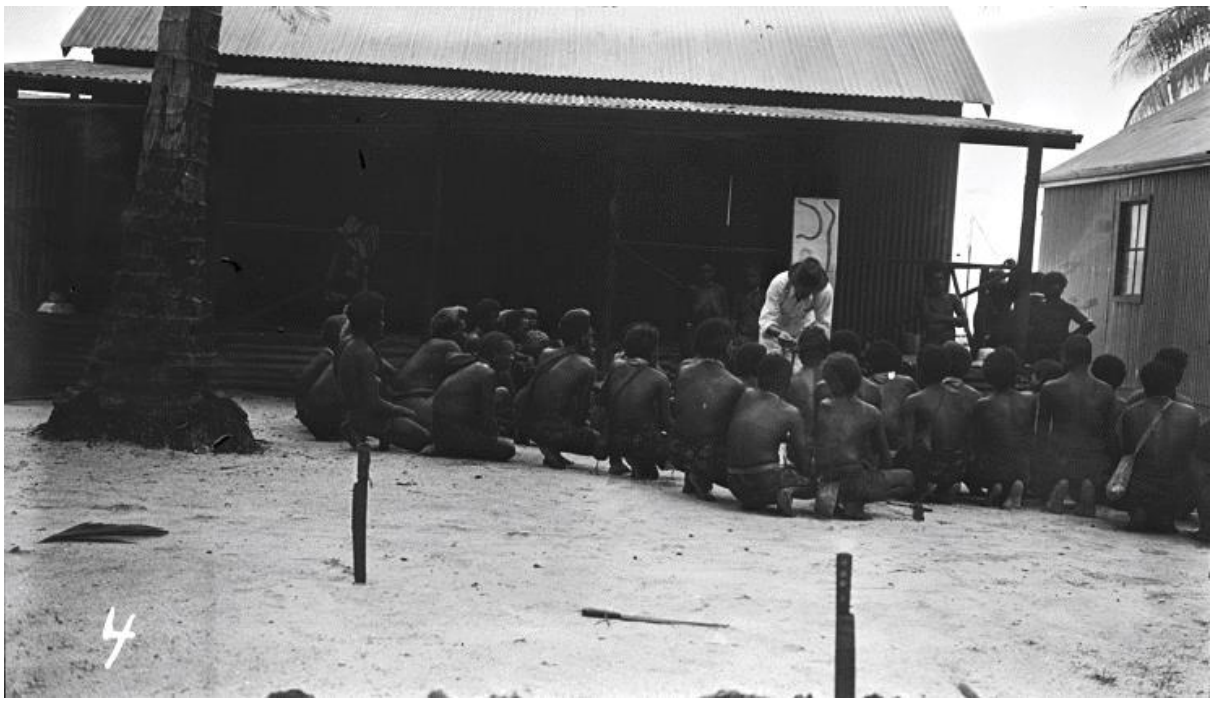


Figure 5. Hookworm lecture in the Solomon Islands. Behind the lecturer is a panel with drawings of hookworm. [Source: Health Education Hookworm Lecture at Liapari Plantation, Vella Lavella, 1919–1939, Sylvester M. Lambert Papers. MSS 682. Special Collections & Archives, UC San Diego]

In addition to the regular hookworm and yaws campaign, Fiji benefited from extra local campaigns as the home of the WPHS. Next to hookworm and yaws, ringworm became a priority in Fiji for occupying too many beds in provincial hospitals. The Fiji government wanted to reduce the hospitalisation rate to reduce overall healthcare costs. Since Fiji offered free hospital treatment to indigenous people, the disease rate closely affected the government budget. The high rate of hospitalisation was blamed on the NMPs, who allegedly delayed treating infected cases.[418] Ironically, Fiji's campaign was led by NMPs too. Ringworm treatment was arranged in tandem with the hookworm and yaws campaign. Campaign units looked for signs of ringworm infection when they gave yaws injections the day after hookworm

[417] Western Pacific Health Service 1st Quarterly Report, 1930, RF RG5 S3.419 B162 F1980, RAC. 3.
[418] Western Pacific Health Service Annual Report, 1928, RF RG5 S3.419 B161 F1977, RAC. 26.

treatments. At first, the WPHS instructed to put the whole body of an infected patient in a box of sulphur fumes for treatment. From 1929, the treatment changed to painting saturated salicylic acid solution in a tincture of iodine over the infected area.[419]

Fiji also had a child welfare programme. One European doctor and six European nurses (three hired by the government and three temporarily hired by missions) led the programme with the assistance of an NMP assigned for the work full-time. As the programme developed, the WPHS recognised that the future of indigenous welfare lay in specialised training of NMPs and indigenous nurses. District NMPs, Native Nurses, and local women's committees cooperated with the WPHS in maternity education, which proved central to promoting the programme. This experience later led to the establishment of the Central Nursing School.[420] As Firth noted, both the child welfare programme and nursing education provided leadership opportunities for Fijian women. Besides these campaigns, the WPHS also advised vaccinations for quarantine ships arriving in Fiji, mostly carrying Indian labourers.[421]

Additionally, the WPHS directed latrine campaigns in Fiji. This was an expansion of the RF's smaller latrine projects previously implemented in 1911, 1917 and 1922 in Indian districts. The WPHS reported that existing latrines were of 'the most primitive character, when any at all existed.'[422] In 1928, following the visit of Dr Victor G. Heiser, the RF Director for East of the International Health Board, the WPHS started a large trial campaign.[423] As the Director of Health under the American military government in the Philippines, Heiser had experiences of leading hookworm and latrine campaigns.[424] Heiser argued latrines were badly

[419] Western Pacific Health Service Annual Report, 1929, RF RG5 S3.419 B161 F1979, RAC. 4.
[420] Western Pacific Health Service Annual Report, 1931, RF RG5 S3.419 B162 F1983, RAC. 14.
[421] Western Pacific Health Service Annual Report, 1928, RF RG5 S3.419 B161 F1977, RAC. 31.
[422] Fiji Soil Sanitation Campaign, 1932–1935, RF RG5 S3.417 B161 F1967, RAC.
[423] Western Pacific Health Service Annual Report, 1928, RF RG5 S3.419 B161 F1977, RAC. 30.
[424] Anderson, *Colonial Pathologies*, 104–120.

needed in Suva, the main port of entry, and its suburbs to prevent cholera and dysentery, which were imported from vessels carrying Indian labourers. Dysentery outbreaks occurred almost annually in the hot season and typhoid epidemics made the situation worse.[425] The WPHS concluded that the only sustainable solution to these epidemics was a nationwide latrine campaign combined with education.[426] During the trial campaign, the WPHS installed about 3,000 bored-hole latrines in Suva suburbs by 1931.[427] Campaign activities included re-drained houses, covered polluted wells, and improved usable wells at the same time.[428]

During the first four years from 1928 to 1931, the WPHS campaigns were limited to the British colonies: Fiji, the Solomon Islands, the Gilbert and Ellice Islands, and New Hebrides. Travelling units treated 106,039 people with hookworm infections and gave 400 hookworm lectures to 52,904 people. They gave initial yaws treatment to 122,598 people with a total of 222,931 injections. For ringworm infections, 1,386 people were given 3,115 treatments in total.[429] Overall, the total cost per treatment reduced over the years from 13.5 pence in 1928 to 7.77 pence in 1931. For example, in 1931, it cost 4.2 pence per treatment in Fiji, 5.2 pence in the Gilbert and Ellice Islands, 9.5 pence in the Solomon Islands, and10.7 pence in New Hebrides. The difference in overall cost was determined by each colony's population size, transport and medical personnel. Fiji could spend much less than other countries by hiring NMP Malakai, whose salary was small compared to European medical officers, to lead the Fiji campaign. Campaign cost for the first four years in as the following table.[430]

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[425] Western Pacific Health Service Annual Report, 1929, RF RG5 S3.419 B161 F1979, RAC. 8–9.
[426] Western Pacific Health Service 1st Quarterly Report, 1930, RF RG5 S3.419 B162 F1980, RAC. 5.
[427] Fiji Soil Sanitation Campaign, 1932–1935, RF RG5 S3.417 B161 F1967, RAC.
[428] Western Pacific Health Service 1st Quarterly Report, 1931, RF RG5 S3.419 B162 F1982, RAC. 2.
[429] Western Pacific Health Service Annual Report, 1928, RF RG5 S3.419 B161 F1977, RAC. 20; Western Pacific Health Service Annual Report, 1929, RF RG5 S3.419 B161 F1979, RAC. 3; Western Pacific Health Service Annual Report, 1930, RG5 S3.419 B162 F1981, RAC. 5; Western Pacific Health Service Annual Report, 1931, RF RG5 S3.419 B162 F1983, RAC. 5.
[430] Western Pacific Health Service Annual Report, 1930, RF RG5 S3.419 B162 F1981, RAC. 8–9; Western Pacific Health Service Annual Report, 1931, RF RG5 S3.419 B162 F1983, RAC. 12.

Year	Cost per Treatment (pence)	Total Treatments
1928	13.5	65,984
1929	12	87,762
1930	10.95	95,726
1931	7.77	85,610

Table 6. Treatment costs for WPHS campaigns, 1928–1931. [Source: RF RG5 S3.419 B161 F1983, RAC]

As its scope of operation shows, the WPHS brought the British colonies under one institution. The WPHC territories was controlled by the Central Medical Authority and connected through the travelling medical units. With the RF support, the British Empire succeeded in centralising health services (to an extent) between the British colonies.

Later Campaigns, 1932–1939

As medical services in the British colonies were being reorganised, the WPHS entered a new phase to include New Zealand territories. By the end of 1931, the first batch of students from the CMS graduated as NMPs, and the curriculum was revised into four years. The Travelling Medical Officer position, which was already incorporated into the child welfare scheme in Fiji, was left vacant as it was considered too expensive.[431] The global depression shrunk the medical services of the Solomon Islands to one Senior Medical Officer, two NMPs, and two missionaries subsidised by the government. Only one hookworm and yaws unit remained. The WPHS claimed the unit was the sole close-contact channel with the indigenous people for welfare. New Hebrides discontinued campaigns as well. New Hebrides had only two doctors hired for port duties, one British and one French, with a couple of newly appointed

[431] Stuart, 'Parasites Lost?', 268–269.

NMPs. The Gilbert and Ellice Islands limited the hookworm and yaws campaign to the Ellice Islands. Fiji, abundant of NMPs, continued campaigns with NMPs. Judging from the decline of medical programmes, the WPHS was convinced that an expansion of the NMP service was the best solution for public health in the South Pacific.[432]

With the Solomon Islands and New Hebrides withdrawn from the campaigns, the WPHS shifted its attention to Polynesia, where New Zealand's colonies were situated. New Zealand was historically notorious for being very 'independent' in its colonial governance and ignorant about the health conditions in Western Samoa.[433] A change was brought by their participation in the CLH and the CMS, combined with Lambert's continuous negotiations, after which New Zealand could see the positive outcome of health campaigns. The WPHS redefined itself in 1932 as an agency in which the South Pacific Groups and the RF cooperated.[434] It still remained under the Central Medical Authority of the WPHC.[435]

Most of the WPHS efforts after 1932 were geared towards improving living conditions in countries that could afford the cost. By this time, the RF was scrapping its global hookworm programmes after realising that eradication was impossible without a fundamental development of social hygiene.[436] Accordingly, the WPHS argued that once parasitic infections were removed from communities, people took an interest in living environments.[437] Improving the source of hookworm infection, i.e. polluted soil, latrine campaigns became the WPHS's main area of effort along with yaws treatment.

While hookworm campaigns were scrapped, the WPHS still kept a focus on yaws, an

[432] Western Pacific Health Service Annual Report, 1931, RF RG5 S3.419 B162 F1983, RAC. 13.
[433] Soil Sanitation in the Pacific, RF RG5 S3.417 B161 F1975, RAC.
[434] Western Pacific Health Service Annual Report, 1932, RF RG5 S3.419 B162 F1985, RAC. 1.
[435] Western Pacific Health Service Annual Report, 1934, RF RG5 S3.417 B161 F1965, RAC. 1.
[436] Taylor, 'History of Public Health in Pacific Island Countries' in Lewis, Macpherson (eds.), *Public Health in Asia and the Pacific*, 287.
[437] Soil Sanitation in the Pacific, RF RG5 S3.417 B161 F1975, RAC.

infectious skin disease mainly found in tropical climates. It is common among children under the age of 15 in rural and isolated environments.[438] One big question surrounding yaws at the time was whether it was the same disease as syphilis. Although the debate is ongoing today, there have been attempts to distinguish the two diseases in the British Empire since the eighteenth century.[439] Both diseases were caused by the same species of bacterium in different subspecies. The symptoms are very similar and a person's previous infection with yaws seemed to provide immunity to syphilis.[440] In the South Pacific, almost everyone was affected by yaws in early childhood. This resulted in the WPHS viewing the South Pacific as an ideal space for yaws research. The WPHS used salvarsans to treat yaws in countries with better medical support systems, such as Fiji, the Gilbert and Ellice Islands, Tonga, Western Samoa and the Cook Islands. In contrast, the situation in the Solomon Islands and New Hebrides was left unchecked. According to Lambert, attempting to treat 'the whole of a primitive population for a disease with an expensive drug is almost appalling.'[441]

Yaws was a major concern in Western Samoa and the bad situation there was blamed on the Mau, an indigenous non-cooperation movement against New Zealand.[442] When the Mau movement began, Western Samoa funded its medical services through a newly introduced medical tax that charged £1 for every male over 17 years of age. According to Ian Campbell, the tax was intended to promote self-help among the indigenous people.[443] The medical tax

[438] Corinne Capuano, Masayo Ozaki, 'Yaws in the Western Pacific Region: A Review of the Literature', *Journal of Tropical Medicine*, 2011 (2011). 1–15.
[439] Katherine Paugh, 'Yaws, Syphilis, Sexuality, and the Circulation of Medical Knowledge in the British Caribbean and the Atlantic World', *Bulletin of the History of Medicine,* 88/2 (2014), 225–252.
[440] Jacqueline Leckie, 'Missing or Misdiagnosed? General Paralysis of the Insane, Yaws, and Syphilis in Fiji, 1884–1940', *The Journal of Pacific History*, 55/1 (2020), 37–57.
[441] S. M. Lambert, 'Yaws in the South Pacific', *American Journal of Tropical Medicine and Hygiene 1–9,* 6 (1929). 429–434.
[442] Report on Western Samoa Yaws Campaign, 1932–1934, RF RG5 S3.417 B161 F1965, RAC.
[443] I. C. Campbell, 'New Zealand and the Mau in Samoa: Reassessing the Causes of a Colonial Protest Movement', *New Zealand Journal of History* 33/1 (1999). 96–97.

grew increasingly unpopular among Samoans, seeing it as an unnecessary expense when many lived far from hospital centres. Mau supporters did not pay taxes, register births and deaths, or participate in any government projects. This was to follow the Mau slogan '*Samoa mo Samoa* (Samoa for Samoa)', which James Davidson interpreted as 'Samoa without the New Zealanders.'[444]

In 1932, Western Samoa launched a two-year yaws campaign with the WPHS. The WPHS supported New Zealand, arguing that the Mau ruined the ongoing 'fine work' of healthcare. The campaign had three objectives. First, to bring the number of yaws patients under control; second, to acquire a complete census of Western Samoa; and third, to promote preventive medicine. Samoan NMPs Ielu, Togamau, and Fatu led the yaws units with assistants. These three NMPs made two tours each year throughout the entire country and reported the results to the WPHS. Kahn tests taken on the campaign showed that nearly every Samoan had had yaws at some point. Population centres of Apia and Falevao were most heavily infected, having 91% of positive cases compared to the national average of 58%. Campaign reports claim that they were enthusiastically welcomed. The units examined 88.8% of the estimated population, of which 97.7% received injections.[445] In the second year, however, fewer people turned up for treatments for unknown reasons.[446] By the end of 1933, the WPHS suspected a revival of the Mau movement, triggered by the return of a Mau leader in exile, caused a reduction of patients attending treatments.[447] This leader was not named, but it is most probably Ta'isi Olaf Fredrick Nelson, a prominent Mau leader who returned to Western Samoa

[444] J. W. Davidson, *Samoa Mo Samoa: The Emergence of the Independent State of Western Samoa* (Melbourne; Oxford University Press: 1967). 122–123.
[445] Report on Western Samoa Yaws Campaign, 1932–1934, RF RG5 S3.417 B161 F1965, RAC.
[446] Western Pacific Health Service 3rd Quarterly Report, 1933, RF RG5 S3.417 B161 F1962, RAC.
[447] Western Pacific Health Service Annul Report, 1933, RF RG5 S3.417 B161 F1963, RAC. 5.

in May 1933.[448]

Other than yaws, the WPHS mainly focused on latrine campaigns following the trial campaign in Fiji. Heiser, who recommended the latrine campaign in the Pacific Islands, had previously led latrine campaigns in the Philippines, where the Americans attempted to extend their authority over indigenous bodies. Warwick Anderson referred to the Philippines campaign as 'excremental colonialism', meaning that indigenous people were seen as 'primitive' and 'uncivilised' by the imperial authorities for lacking proper latrine systems and their legitimacy derived in part from providing these facilities and training in their use.[449] The Latrine campaign in the Pacific Islands was similar in the sense that it was started at the suggestion of Heiser but the WPHS campaigns were different in that they were designed to meet the needs of each community and involved indigenous contribution to the project. The primary goal of this campaign was to manufacture and distribute concrete slabs to every household in the subject area. With advantages of permanency and adaptability, concrete slabs were expected to replace existing latrine systems. Concrete slabs were presumably easier to maintain hygienic conditions too. Western Samoa, the Cook Islands and Fiji were selected for the campaign based on their need and feasibility, such as funding and maintenance. Of the rest of the countries, the Gilbert Islands were nearly free of hookworm. The Ellice Islands had a moderate level of infection. Niue already had good latrines. American Samoa was only cooperating with the WPHS for experimental cooperation in the CMS. The Solomon Islands and New Hebrides were left out for having 'primitive cultures' that supposedly required 'another hundred years' before even raising the issue of soil sanitation would be worthy.[450]

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[448] Patricia O'Brien, *Tautai: Sāmoa, World History, and the Life of Ta'isi O. F. Nelson* (Honolulu: University of Hawai'i Press, 2017) 255.
[449] Warwick Anderson, 'Excremental Colonialism: Public Health and the Poetics of Pollution', *Critical Inquiry,* 21/3 (1995), 640–669.
[450] *Ibid.*

The Cook Islands commenced a three-year latrine campaign with the WPHS in 1932. Half of the cost was borne by the Cook Islands administration and the remainder was covered by the WPHS.[451] They designed latrines with holes three feet in diameter and at least ten feet deep covered with slabs. Then, rising concrete pedestals, concrete seats, and ventilating pipes were installed.[452] This type of latrine with seating was more expensive. Challenges to the campaign rose from the natural environment of the Cook Islands, which had a coral volcanic soil composition. Rock formations had the WPHS loan a compressor plant for drilling and blasting. Disappointingly, the borrowed compressor broke down in Mangaia in January 1934. Explosives were used as an alternative, but they soon ran out. As a result, indigenous communities were mobilised to drill manually with axes and bars until every household had a functioning latrine.[453] In islands with harder rock formations like Ma‘uke, more explosives were used. On Atiu, reefs made transporting equipment ashore dangerous and difficult that some pedestals and slabs were lost.[454] Despite such challenges, the Cook Islands campaign finished nine months sooner than expected. The plan was fully delivered, installing 2,119 latrines in total for every household, school and public meeting venue.[455] These were reportedly the finest latrines in the South Pacific.[456] The WPHS owed the successful outcome to the support of the Resident Commissioner and his team, which was ‘unusual in tropical heat and very refreshing.’[457]

Among the British colonies, Fiji was the main field for WPHS works after 1932. Travelling units continued the campaign under NMPs. This was funded entirely by the Fiji

[451] Fiji Soil Sanitation Campaign, 1932–1935, RF RG5 S3.417 B161 F1967, RAC.
[452] Western Pacific Health Service 3rd Quarterly Report, 1932, RF RG5 S3.419 B162 F1984, RAC. 9.
[453] C. F. Cowley, Progress Report on Work Carried Out on Sanitation Scheme, Western Pacific Health Service 1st Quarterly Report, 1934, RF RG5 S3.417 B161 F1963, RAC.
[454] Western Pacific Health Service 3rd Quarterly Report, 1934, RF RG5 S3.417 B161 F1964, RAC.
[455] Western Pacific Health Service Annual Report, 1934, RF RG5 S3.417 B161 F1965, RAC. 4–5.
[456] Fiji Soil Sanitation Campaign, 1932–1935, RF RG5 S3.417 B161 F1967, RAC.
[457] Western Pacific Health Service Annual Report, 1933, RF RG5 S3.417 B161 F1963, RAC. 4.

government and was conducted by the WPHS for administrative convenience. NMP Malakai showed the colonial authorities how versatile and capable NMPs can be.[458] In 1933, the districts treated by Malakai's unit had rarer open yaws lesions.[459] In addition to leading campaign units, he tested anthelmintics in the Lunatic Asylum, joined a tuberculosis expedition for the Solomons, and treated hookworm in Lomaiviti. He used a demonstrative method of education to raise awareness of hookworm infections in Lomaiviti. This included collecting bowel motions, straining them to expel hookworms from the substance, and showing the worms to the people.[460] In the following year, Malakai led drug trials for ringworm in Wainibokasi and yaws in Rotuma. Particularly, his work in Rotuma was so remarkable that it had to be praised by the Chief Medical Officer of Fiji. During his two and a half months visit, he treated 577 yaws cases, 1,333 scabies and skin disease, took 566 exams for filarial infection, inoculated 2,333 people against typhoid, treated 1,296 tuberculosis cases and surveyed leprosy.[461] Malakai's outstanding work convinced the WPHS that a good NMP could be highly effective in the circumstances of the Pacific Islands.

Fiji started a three-year latrine campaign for Viti Levu in 1932. The previous trial campaign got the WPHS to redesign latrines this time. The WPHS argued that Fijians were enormous eaters and accordingly produced very large bowel motions. Fijian custom of wiping with coconut husks, reeds, bamboo, stones or sticks would fill latrine holes too quickly.[462] According to the WPHS, a typical family would fill a hole in a few months and even weeks if the household was larger. This was why the WPHS chose squatting latrines with larger and deeper holes for Fijians. By contrast, the standard-size bored hole latrine was judged to be

[458] Stuart, 'Contradictions and Complexities in an Indigenous Medical Service', 130.
[459] Western Pacific Health Service Annual Report, 1933, RF RG5 S3.417 B161 F1963, RAC. 9
[460] From Malakai to the Western Pacific Health Service, 10 January 1934, RF RG5 S3.417 B161 F1963, RAC.
[461] Western Pacific Health Service Annual Report, 1934, RF RG5 S3.417 B161 F1965, RAC. 6–8.
[462] Western Pacific Health Service 2nd Quarterly Report, 1932, RF RG5 S3.419 B162 F1984, RAC. 2–3.

suitable for Indians, who were seen as small eaters and used water to cleanse. White Europeans in Fiji would instal latrines with concrete risers, polished wooden seats, flap covers and a ventilating pipe at an extra cost.[463] The difference with the Cook Islands is that Fijians paid for the material cost of slabs themselves. Manufacture and construction cost was subsidised by the WPHS.[464] As a result, a total of 14,374 latrines were newly bored or dug.[465]

Fiji faced challenges in the latrine campaign, like the Cook Islands. Firstly, geographical features blocked installation works. The Rewa delta had sandy soil, which required extra care during construction. Supply transport was difficult in the mountainous districts of Namosi, Ra, Colo North, Colo West, and Colo East where construction equipment had to be carried up for miles in steep hills.[466] The second challenge was pest control. Flies bred in great numbers and cockroaches frequently appeared in latrines with concrete risers. The WPHS reported that the construction was flawless, but the sanitary standards of users attracted pests.[467] Lastly, not everyone could afford the material cost. Poorer districts of Colo North, Colo East and Ra had to raise loans from the government to continue the campaign. The WPHS argued that the cost was intentionally not subsidised by the government out of the belief that Fijians better appreciated what they had paid for.[468]

After 1935, the WPHS only continued routine healthcare in Fiji besides carrying out its supervisory functions. New Zealand territories that completed latrine and yaws campaigns did not start any further campaigns with the WPHS. Fiji extended the previous latrine campaign to other parts of the country in 1936. Additional latrines were installed for the new gold mine

[463] Western Pacific Health Service Annual Report, 1932, RF RG5 S3.419 B162 F1984, RAC. 4–5.
[464] Western Pacific Health Service 1st Quarterly Report, 1933, RF RG5 S3.417 B161 F1962, RAC. 2.
[465] Fiji Soil Sanitation Campaign, 1932–1935, RF RG5 S3.417 B161 F1967, RAC.
[466] Western Pacific Health Service Annual Report, 1934, RF RG5 S3.417 B161 F1965, RAC. 1.
[467] Western Pacific Health Service Annual Report, 1935, RF RG5 S3.417 B161 F1968, RAC.
[468] Fiji Soil Sanitation Campaign, 1932–1935, RF RG5 S3.417 B161 F1967, RAC.

in Tavua and mountainous regions left out in the 1932–1935 campaign.[469] Vanua Levu was slowly equipped with latrines, starting with the sugar plantations in Labasa.[470] As the campaign came to an end, the importance of public health education was stressed. The WPHS argued the taboo of discussing bodily excreta was 'strangling basic preventive health measures.'[471] By referencing the campaign results showing greater public interest in soil sanitation and lower soil pollution level, the WPHS pressed the Fiji government to vigorously pursue the latrine campaign throughout the entire colony.[472]

Drug Trials and Medical Surveys

The WPHS valued efficiency highly, even at the cost of compromising safety. As shown in its mass treatment approach, the WPHS pursued cost-efficient, effective, and knowledge-collecting campaigns. In doing so, the WPHS aimed to demonstrate the superiority of Western medicine. This was essential in gaining the trust of the indigenous people for the ultimate transplantation of Western biomedicine in the South Pacific. However, problems were inevitable when new drugs were used on the entire population for less-researched tropical diseases. In fact, the efficacy of new drugs was determined through mass treatment. The WPHS campaigns resembled modern-day human trials in this respect. Adverse side effects were ignored in the advantages of efficiency of mass treatment. Occasional fatalities were blamed on careless administration or on the victim's idiosyncratic response. The unlucky ones were sacrificed for the majority.[473] Such attitude can be noted in other RF campaigns as well, which

[469] Western Pacific Health Service 1st Semi-Annual Report, 1937, RF RG5 S3.417 B161 F1971, RAC.
[470] Western Pacific Health Service Annual Report, 1936, RF RG5 S3.417 B161 F1970, RAC. 1.
[471] Western Pacific Health Service Annual Report, 1935, RF RG5 S3.417 B161 F1968, RAC. 2.
[472] Western Pacific Health Service 1st Semi-Annual Report, 1936, RF RG5 S3.417 B161 F1969, RAC.
[473] Western Pacific Health Service Annual Report, 1928, RF RG5 S3.419 B161 F1977, RAC. 14–28.

Steven Palmer called the 'meta-experimentalism.'[474]

The mass treatment process reveals how the WPHS hoped to understand the 'Pacific race' through disease campaigns and drug trials. Over the first four years, WPHS gave 106,029 hookworm treatments using both tetrachloroethylene and carbon tetrachloride. They specifically looked out for 'racial drug characteristics', arguing that carbon tetrachloride was safe for Melanesians and Polynesians, and when used with Chenopodium, safe for Indians.[475] Carbon tetrachloride was the preferred hookworm drug in the RF circle since 1922.[476] While Pacific Islanders did not show adverse reactions, the WPHS noticed some fatalities among Indians after carbon tetrachloride treatment. The matter was simply considered to be caused by the Indians' low-calcium diet that possibly led to parasitical infection and was not investigated further.[477]

Hookworm drugs started to change in 1929 when the WPHS tried tetrachloroethylene in the Solomons and New Hebrides. This trial later expanded to Fiji in 1930.[478] According to the WPHS quarterly report, some people given tetrachloroethylene became 'groggy' and 'giddy.' They had already given the drug to over 20,000 people at the time. Polluted drugs were pointed as a potential cause of the symptoms.[479] The annual report of 1930, however, only reported cerebral symptoms caused by tetrachloroethylene in the Solomon sand New Hebrides. Without a mention of possible contamination of drugs, the WPHS argued such symptoms were already common 'especially among low grade intelligences.'[480] The WPHS still insisted that

[474] Steven Palmer, 'Toward Responsibility in International Health: Death Following Treatment in Rockefeller Hookworm Campaigns, 1914–1934', *Medical History* 54/2 (2010), 150.
[475] Western Pacific Health Service Annual Report, 1931, RF RG5 S3.419 B162 F1983, RAC. 3
[476] Stuart, 'Parasites Lost?', 117–122.
[477] Western Pacific Health Service Annual Report, 1928, RF RG5 S3.419 B161 F1977, RAC. 18.
[478] Western Pacific Health Service Annual Report, 1929, RF RG5 S3.419 B161 F1979, RAC. 2–3.
[479] Western Pacific Health Service 1st Quarterly Report, 1930, RF RG5 S3.419 B162 F1980, RAC. 2.
[480] Western Pacific Health Service Annual Report, 1930, RF RG5 S3.419 B162 F1981, RAC. 3–4.

tetrachloroethylene, despite the side effects being 7.5 times higher than carbon tetrachloride, was safer and more desirable because there were no deaths.[481]

When drugs yielded side effects, Pacific Islanders did not receive treatments unquestioningly, but sometimes chose to refuse. Following the side effects of tetrachloroethylene, 3,468 out of 18,138 people refused hookworm treatment in Malaita. Initially, the WPHS considered the Solomon Islanders refused tetrachloroethylene because they preferred easier injections and avoided sitting in hookworm lectures.[482] Only after seeing another 433 refusals in 1931 did the WPHS report that it was the 'primitiveness' of the refusers who were too scared of side-effects.[483]

Yaws injections, too, had issues. After the WPHS was launched in 1928, the Solomon Islands and Fiji reported negative responses to regular neo-arsphenamine injections. New dosage and intervals were instructed after the WPHS tested new solutions in the Solomons and New Hebrides.[484] Neo-arsphenamine use became particularly problematic in 1932 when paralysis was reported in Western Samoa. According to a quarterly report, the WPHS suggested that the paralysis might have been caused by stocking drugs in tropical climates for too long. But injections continued.[485] This story got distorted in the 1932 annual report. Instead of neo-arsphenamine, the WPHS stated that peroxyl was used for yaws. The report also claimed that only sixteen people refused treatment because of 'false information', not adverse side-effects from drugs.[486] Still, there were sixteen people who made their own decisions in choosing whether they will take the drug.

[481] Western Pacific Health Service Annual Report, 1931, RF RG5 S3.419 B162 F1983, RAC. 4.
[482] Western Pacific Health Service Annual Report, 1930, RF RG5 S3.419 B162 F1981, RAC. 4–5.
[483] Western Pacific Health Service Annual Report, 1931, RF RG5 S3.419 B162 F1983, RAC. 5.
[484] Western Pacific Health Service Annual Report, 1928, RF RG5 S3.419 B161 F1977, RAC. 23–24.
[485] Western Pacific Health Service 3rd Quarterly Report, 1932, RF RG5 S3.419 B162 F1984, RAC. 1.
[486] Western Pacific Health Service Annual Report, 1932, RF RG5 S3.419 B162 F1981, RAC. 22.

Details of the paralysis incident were provided in a report written by the Chief Medical Officer of Western Samoa. Six weeks into yaws campaign in May 1932, children started to suffer from paralysis after being given buttock injections. Samoans tried to stop the campaign, suspecting that 'the Government were poisoning the people.' NMPs Ielu and Togamau were given duties to examine 127 paralysed children in Savai'i and Upolu by September the same year. Even after discovering so many cases, both Western Samoa and the WPHS could not figure out what exactly caused the paralysis and why most cases were from Savai'i. By the time the amended guidelines arrived, only three schools were left for examination. New instructions were to strictly avoid buttocks injections, take Kahn tests and use peroxyl tablets for treatments.[487] It took two more years for the WPHS to find out that the unfortunate paralysis was indeed a poliomyelitis epidemic. Only after learning this did the WPHS argue that the Samoan yaws campaign was nullified by a 'rumour' that yaws injections caused paralysis.[488]

To the WPHS, the yaws campaign was more than giving injections. It was a process of obtaining medical knowledge. As the South Pacific was free from syphilis but had universal yaws infection, the WPHS saw the region as an exceptionally good laboratory for syphilis research.[489] The symptoms of both diseases were very similar and required medical examination to be distinguished.[490] The WPHS used newly developed Kahn tests to 'bring out information for all the yaws world.' Nearly 3,000 Kahn tests given in Western Samoan schools, gave hints to the cure of yaws. Based on the accumulated mass treatment data, the WPHS concluded that neo-arsphenamine, the primary drug used in its campaigns, closed infectious

[487] Yaws Campaign in Western Samoa 1932–1933, RF RG5 S3.419 B162 F1985, RAC.
[488] Report on Western Samoa Yaws Campaign, 1932–1934, RF RG5 S3.417 B161 F1965, RAC.
[489] *Ibid.*
[490] Lambert, 'Yaws in the South Pacific', 434.

lesions but did not fully cure yaws.[491] As a follow-up research, comparisons were made between neo-arsphenamine, peroxyl, and spirocide. Peroxyl tablets made the most satisfactory result of the three drugs. However, the WPHS still preferred neo-arsphenamine for mass treatment, arguing that with peroxyl, the indigenous people 'would not be trusted to take the dosage, or in the proper way.'[492]

New treatments were tried in the ringworm campaign as well. In the early years of the WPHS, a saturated salicylic acid solution in a strong iodine tincture was painted on the body, face and shaven scalp of patients. This solution was tested in Fiji on 483 people over 1,392 times. After six months of trial, this method was not as effective as the previous treatment method of putting a person's body in a box of sulphur fumes.[493] To find a better treatment, WPHS reached out to other colonies of the British Empire. In 1929, the WPHS learned that the Calcutta School of Medicine was trying an experimental method using dyes.[494] The two institutions closely communicated information and shared specimens of scales or spores of patients for testing.[495] At the same time, the WPHS researched the patterns of infection in Fiji. According to the WPHS, ringworm infection rates were fewer near medical centres and grew where 'western medicine was not very dominant.' Based on this information, the WPHS argued that infection levels were higher in humid regions as opposed to the indigenous knowledge explaining that the further away from the sea, the higher the cases of disease.[496] Whether the precipitation rate was higher in the inland compared to the seaside was not considered.

Mass treatment not only benefited the drug trials but also made health surveys easier.

[491] Western Pacific Health Service 1st Quarterly Report, 1933, RF RG5 S3.417 B161 F1962, RAC.
[492] Report on Western Samoan Yaws Campaign, 1932–1934, RF RG5 S3.417 B161 F1965, RAC.
[493] Western Pacific Health Service Annual Report, 1928, RF RG5 S3.419 B161 F1977, RAC. 28.
[494] Western Pacific Health Service 3rd Quarterly Report, 1929, RF RG5 S3.419 B161 F1978, RAC.
[495] Western Pacific Health Service 4th Quarterly Report, 1929, RF RG5 S3.419 B161 F1978, RAC.
[496] Western Pacific Health Service Annual Report, 1931, RF RG5 S3.419 B162 F1983, RAC. 10.

Health surveys were done by Lambert himself or by NMPs when more convenient. Lambert toured extensively across the South Pacific for this purpose, visiting almost all island groups. To make the most of this rare opportunity, Lambert recorded general observations alongside health conditions. The Rotuma survey report is a good sample. It begins with general information on geography, administration, medical facilities, vital statistics, census and survey methods, followed by disease cases (eye conditions, tuberculosis, adenitis, Pott's disease, scabies, ringworm, leprosy, typhoid, dysentery, filaria, smallpox vaccination, yaws, bismuth for yaws, venereal diseases, hookworm disease).[497] These records allowed Lambert to observe the development of medical infrastructure overtime when he visited a place for the second time. For example, Lambert visited the Solomons in 1921 and again in 1930. Then, he could compare the medical development of the colony, as shown in the following table.[498]

Category	1921	1930
Medical Officers	1	3
Subsidised Medical Staff	0	4
District Hospitals	0	5
Tulagi Hospital Beds	40	114

Table 7. Comparison of medical infrastructure in the Solomon Islands. [Source: RF RG5 S3.419 B162 F1980, RAC]

As Sunil Amrith pointed out, imperial drives to collect and analyse medical knowledge from the colonies were high.[499]Because travelling was so difficult, the WPHS designed health surveys to acquire as much information as possible. NMPs, who could communicate with the local people closer, were particularly important in this type of work. Every disease condition

[497] Dr. S. M. Lambert, Health Survey of Rotuma, RF RG5 S3.419 B161 F1977, RAC.
[498] South Pacific —Western Pacific Health Service, 2nd Quarter 1930, RF RG5 S3.419 B162 F1980, RAC.
[499] Amrith, *Decolonizing International Health*, 22.

was recorded, however large or small. For instance, NMP Vakatawa's tuberculosis survey in Fiji aimed at more than looking for tuberculosis. It was intended to provide an accurate picture of disease conditions, to locate fields requiring special attention, and to gauge medical advancement in Fiji.[500] His reports were so detailed that he even included the number of missing teeth, caries, and pyorrhea in the dental conditions section. While the WPHS argued poor dental conditions were due to dietary changes, an integral part of 'a process of native adjustment to western life', the detailed report could raise more interest in the headquarters. Vakatawa also reported elephantiasis, eye conditions (including blindness, cataract, entropion, pterygium, internal strabismus, conjunctivitis, trachoma, ptosis, the opacity of cornea), yaws, filariasis, paralysis, enlarged glands, goitre, seborrhea, kyphosis, cyst, abscess, deaf, dumb, hydrocele, glossitis, talipes valgus, hernia, otorrhea, imbecile, lordosis, tumour, ulcers, tinea, and scabies.[501]

Tuberculosis surveys were devised to obtain reliable morbidity data in the South Pacific. Fiji specially trained NMP Vakatawa to examine faeces, sputum and lungs to detect tuberculosis. The survey found an interesting case of the Tavua gold mine. While 83% of workers tested positive for tuberculin, there were no cases of pulmonary tuberculosis. With no evidence that gold mining could increase pulmonary tuberculosis, the WPHS suspected the close-contact environment of miners caused the high positive rate.[502] In the Solomons, the tuberculosis survey became part of one of the famous expeditions of the *Zaca*, a luxury yacht owned by Templeton Crocker. Lambert, Malakai and the Solomon Islands Medical Department joined the group to conduct a large-scale tuberculosis survey. Other members on board included an anthropologist, a botanical collector, an entomological collector, a surgeon and a

[500] Western Pacific Health Service 1st Semi-Annual Report, 1937, RF RG5 S3.417 B161 F1973, RAC.
[501] Western Pacific Health Service Annual Report, 1938, RF RG5 S3.417 B161 F1974, RAC. 3–4.
[502] Western Pacific Health Service Annual Report, 1937, RF RG5 S3.417 B161 F1971, RAC.

photographer.[503] Like the RF, the Crocker expedition is another case of the British Empire benefitting from American funding, which, in return, collected scientific knowledge in the Pacific.

Tropical islands were good locations in which to examine mosquito-borne diseases. Dengue research led to a circulation of entomological knowledge throughout the Pacific. After a dengue epidemic affected the entire Fijian population in 1930, the WPHS started to pay more attention to studying mosquitos.[504] In order to develop this research, a full list of mosquitos found in the South Pacific was made. This list and mosquito samples were sent to Johns Hopkins University, another RF-funded institution. Johns Hopkins University returned a detailed report, which, in turn, was distributed to interested colonial administrations in the region.[505] As such, primary data was collected in the colonies, centrally processed by the WPHS, analysed in the US, and then redistributed throughout the region.

Another mosquito-borne disease in which the WPHS took an interest was filariasis. When they examined Guadalcanal in 1931, nocturnally transmitted filariasis was found in the west of 170° longitude. Diurnal filariasis was confined to the east of it.[506] Existing filarial knowledge was challenged when the WPHS found *Aedes Variegatus* mosquitos in 1933. The mosquito variety was a known vector for diurnal filariasis, commonly found in the Solomons and New Hebrides, which was west of 170° longitude. As diurnal filariasis was previously thought to be absent there, filariasis transmission theories had to be reconstructed after the discovery.[507]

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[503] 'The Templeton Crocker Expedition to the Solomon Islands', *Science, New Series*, 79/2050 (1934), 344–345.
[504] Western Pacific Health Service 1st Quarterly Report, 1930, RF RG5 S3.419 B162 F1980, RAC. 5.
[505] Western Pacific Health Service Annual Report, 1934, RF RG5 S3.417 B161 F1965, RAC. 12.
[506] Western Pacific Health Service Annual Report, 1931, RF RG5 S3.419 B162 F1983, RAC. 15.
[507] Western Pacific Health Service Annual Report, 1933, RF RG5 S3.417 B161 F1963, RAC.

After New Zealand territories joined the WPHS in 1932, more surveys could be done in Polynesia. The WPHS organised a tuberculin survey for Western Samoa and the Cook Islands in 1932.[508] In 1938, Lambert visited Niue, a small New Zealand colony of 4,500 population. There he surveyed general disease conditions, medical personnel, hospital facilities and education standards there. Lambert believed the generally healthier conditions of Niue were owing to the island's remoteness. Niue was only accessed by one boat running every four weeks. This presumably protected the island from introduced epidemics.[509] However, Margaret Pointer suggests Niue's healthier environment was achieved by the administration's constant effort combined with its geographical isolation. For example, Niue held 'Cleanest Village' competitions and increasingly promoted Western medicine in the 1930s.[510] Although these countries were not campaign fields, Lambert's surveys were still included in the WPHS activities, as documented in their regular reports.

Finally, a major poliomyelitis survey started in 1934 following the epidemic in Western Samoa. Since it was an uncommon disease in the Pacific Islands, a history of poliomyelitis in the region was first investigated. The Solomon Islands had poliomyelitis outbreaks in 1925, 1929, 1932, and 1933 among plantation labourers. The Gilbert and Ellice Islands had seven cases in 1933. Tonga and Fiji most likely had cases but reported none. Then, the survey report traced the poliomyelitis outbreak in Western Samoa back to February 1932, when seven cases occurred in American Samoa. American Samoa quickly closed its borders to contain the disease. Nevertheless, shortly after travels resumed between American Samoa and Western Samoa, poliomyelitis spread through a London Missionary Society conference held

[508] Western Pacific Health Service Annual Report, 1932, RF RG5 S3.419 B162 F1985, RAC.
[509] Western Pacific Health Service 1st Semi-Annual Report, 1937, RF RG5 S3.417 B161 F1973, RAC. 2–4.
[510] Margaret Pointer, *Niue, 1774–1974: 200 Years of Contact and Change* (Dunedin; Otago University Press, 2015), 221–223.

in Upolu. Initially linked with the yaws campaign, Western Samoa's had a total of 138 cases. In the end, the WPHS concluded that poliomyelitis must have entered Western Samoa before 1920, referring to American Samoa's record of the disease as early as 1919.[511] In that case, the Western Samoan administration did not detect poliomyelitis for twelve years. It also failed to diagnose the disease for at least another year after a large epidemic. In contrast, American Samoa responded successfully, echoing the results of the two countries for the 1918 influenza pandemic.[512]

As such, while the travelling medical units connected the Pacific Islands, the WPHS successfully centralised as a disease-control institution. The drug trials and medical surveys show that the WPHS viewed the Pacific Islands as a tropical laboratory to test drugs and collect medical knowledge. Its campaigns, trials, and surveys ultimately contributed to the understanding of indigenous race in the Pacific.

Understanding the 'Pacific race'

The WPHS persistently tried to categorise and stereotype the 'Pacific race'. While historians today largely criticise Dumont d'Urville's arbitrary classification of races in Oceania, it was used unquestioningly in the WPHS.[513] The most notable pattern shown in the WPHS reports is a strong preference for Polynesians. As a general rule, Polynesians were at the top of the indigenous racial hierarchy in Oceania, sharply differentiated from the Melanesians, who

[511] Report on Western Samoan Yaws Campaign, 1932–1934, RF RG5 S3.417 B161 F1965, RAC.
[512] For comparison between Western Samoa and American Samoa, see: Ryan McLane, 'Influenza and Quarantine in Samoa' in Alison Bashford (ed.), *Quarantine: Local and Global Histories* (London: Palgrave MacMillan, 2016), 136–153.
[513] Paul D'Arcy, 'Cultural Divisions and Island Environments since the Time of Dumont d'Urville', *The Journal of Pacific History*, 38/2 (2003), 217.

were called the 'Oceanic Negroes'.[514] Specifically, the WPHS liked Polynesians because they were perceived to be intelligent and, therefore, more compliant with colonial rule. While there is a logical leap in connecting intelligence and compliance, the WPHS always attached racial labels in describing Polynesian compliance. For example, Elliceans as 'pure Polynesians' were 'easier to control.'[515] The Cook Islanders 'who are Polynesians' were 'cooperative' and interested in WPHS campaigns.[516] Rotumans, 'highly intelligent Polynesians', were willing to help with medical investigations.[517] Niueans, with a healthy environment, were 'more enterprising almost than any other Polynesian.'[518] Such comments cannot be found on Melanesians or Micronesians.

Another reason the WPHS admired Polynesians was their physiological and physical superiority. Polynesia was free from malaria, whereas it was prevalent in Melanesia. Hookworm infections were comparatively lower in Polynesia compared to Melanesian countries. Also, Polynesians were relatively taller and larger than other races in Oceania. To the WPHS, admirable Polynesian physique naturally justified medical work in Polynesian countries. The Western Samoan yaws campaign reported that 'it was sickening to the point of nausea to see these lovable Samoan children relapsing into the loathesome diseases which mars their beauty and destroys their bodies.'[519] Their Māori survey concluded by calling for better healthcare, education and social care for the Polynesians despite them being a 'primitive coloured group.'[520] The physical appreciation was never made for Melanesians or Micronesians.

[514] Douglas, Ballard. *Foreign Bodies*, 3–30.
[515] Western Pacific Health Service Annual Report, 1928, RF RG5 S3.419 B161 F1977, RAC. 15.
[516] Western Pacific Health Service Annual Report, 1932, RF RG5 S3.419 B162 F1985, RAC. 3.
[517] Western Pacific Health Service Annual Report, 1928, RF RG5 S3.419 B161 F1977, RAC. 21.
[518] Western Pacific Health Service 1st Semi-Annual Report, 1937, RF RG5 S3.417 B161 F1973, RAC. 2–4.
[519] Report on Western Samoa Yaws Campaign, 1932–1934, RF RG5 S3.417 B161 F1965, RAC
[520] Western Pacific Health Service Annual Report, 1937, RF RG5 S3.417 B161 F1971, RAC. 7–8.

Racialising Pacific Islanders ultimately contributed to exotifying Oceania. The WPHS wrote in its first annual report, 'the field of tropical medicine is full of romance.' By telling the story of a District Officer being killed at work in the Solomon Islands, the WPHS celebrated the heroic white men risking their lives under 'native conditions' for the 'primitive race.'[521] A similar type of depiction was common in the European imagery of the Pacific Islanders as 'ignoble savages' since the nineteenth century.[522] Sexualised descriptions of indigenous women added a romantic frame for Oceania. Lambert frequently writes of female nudity in the Pacific Islands. For example, the women of Rennell and Bellona 'presented a striking picture of aboriginal pulchritude', and their 'plump breasts were of course revealed, as were her shapely limbs.'[523] In essence, the Pacific Islands were portrayed as where white men become heroes of dramas alongside attractive naked women.

The exotic environment was even more emphasised with the indigenous primitiveness. The WPHS complained how practising Western medicine was difficult among such 'primitive race.' Publicity was difficult because 'all primitive people' had 'inherited prejudice from primitive times.'[524] The WPHS also found it impossible to conduct many projects in 'primitive sanitation' since 'too many new ideas at a time discourage the primitive.'[525] The Pacific Islanders were all argued to be 'in the Neolithic stage of civilisation' before European intervention, even though the WPHS praised Polynesians over Melanesians and Micronesians[526] Only Polynesians and Fijians could take their place among 'any coloured race

[521] Western Pacific Health Service Annual Report, 1928, RF RG5 S3.419 B161 F1977, RAC.
[522] For example, George Baxter's prints depicting massacre of missionaries. More images can be consulted in Bernard Smith, *European Vision and the South Pacific* (New Haven: Yale University Press, 1988), 317–332.
[523] Sylvester M. Lambert, *Back to the Beginning*, RF RG1.1 S419 B1 F1, RAC. 31.
[524] Western Pacific Health Service Annual Report, 1928, RF RG5 S3.419 B161 F1977, RAC. 21, 31.
[525] Soil Sanitation in the Pacific, RF RG5 S3.417 B161 F1975, RAC. 4.
[526] Thomas Clunie, Abstracts from *The Native Medical Practitioner*, Tropical Disease Bulletin, November 1936, RF RG5 S3.417 B161 F1975, RAC.

in the world', which did not include white Europeans.[527] Such primitive frame was consistently found throughout the entire period the WPHS operated.

Latrine campaigns exemplify how racial ideas permeated the work of the WPHS. As explained earlier, the WPHS argued that Fijians were large eaters who filled toilets too quickly. Further, the WPHS thought 'simple people like Fijians and Indians' required regular inspection by a European to implant a new latrine system, which was essential for preventing dysentery and hookworm. This argument was based on the case of northwest Viti Levu, where latrines seriously deteriorated in 1933, eleven years after Indians were trusted with inspection duties. By comparison, the WPHS referred to the Cook Islands, where new latrines could be left in the hands of indigenous communities. The Cook Islanders, who were Polynesians, were 'highly intelligent people and in many ways the most modern natives in the Pacific and most ready to adapt themselves to modern life.'[528]

As these racialised notions suggest, the WPHS contributed to the reproduction and distribution of racial ideas in the Pacific. Francis Galton had argued that each group of people should be represented by 'its best specimens' and they should be left 'to work out their common civilization in their own way.'[529] Echoing Galton, Lambert argued that indigenous people should not be civilised but left 'to work out their own destiny.'[530] Except for intervention in healthcare, any efforts to westernise indigenous customs may cause 'the decline of primitive cultures.' Keeping them as a 'native reserve' in their pure state was the most desirable.[531] This approach is was in the tradition of the 'indirect rule', designed by Sir Arthur

[527] Enclosure No.2, Correspondence on the Subjects of the Syllabus and the Four-Year Course for Students of the Central Medical School for the Information of the Administrations Concerned, RF RG5 S3.419 B162 F1980, RAC.
[528] Western Pacific Health Service Annual Report, 1934, RF RG5 S3.417 B161 F1965, RAC. 3–5.
[529] Francis Galton, 'Eugenics: Its Definition, Scope, and Aims', *American Journal of Sociology*, 10/1 (1904), 2.
[530] Sylvester M. Lambert, *Back to the Beginning*, RF RG1.1 S419 B1 F1, RAC. 49.
[531] *Ibid.* 183–184.

Hamilton Gordon, the first Governor of Fiji, who hoped to insulate Fijians from Western cultures for an ultimate 'preservation of race.'[532] It reminds dyarchy, which divided colonial governments into reserved and transferred subjects administered by either British or indigenous officials in the British Empire.[533] Just like environmental conservation areas, a certain 'primitiveness' had to be preserved and prevented from advancing. According to Lambert's logic, 'simple natives' were not unfortunate because they enjoyed their primaeval homes.[534] As Sloan Mahone has shown, such an idea was also found in the British African colonies — the notion that some Africans developed psychological problems as a result of being 'detribalised' through contact with Western cultures.[535]

Moreover, an obsession for racial purity was highly visible in the WPHS documents. For example, the WPHS specifically states that Rennell island was inhabited by 'a pure Polynesian population that by some freak has been left almost untouched by either Melanesian or white people for centuries.'[536] Rotumans were 'the only pure Polynesian peoples in that Colony that differ radically from the Fijian.'[537] Racial purity mattered because it was used as a barometer of intelligence. In the case of Ellice Islanders, the WPHS saw them as 'pure Polynesians' who were 'literate' and 'intelligent.'[538] A popular theory of the time even suggested that Polynesians could be 'potentially more intelligent than the white race', just stuck in a primitive state of development. In contrast to the 'pure Polynesians', Melanesians were

[532] Brij V. Lal, Robert C. Kiste, *Broken Waves:A History of the Fiji Islands in the Twentieth Century* (Honolulu: University of Hawai'i Press, 2022) 13–14.
[533] Stephen Legg, 'Dyarchy: Democracy, Autocracy, and the Scalar Sovereignty of Interwar India', *Comparative Studies of South Asia, Africa and the Middle East* 36/1 (2016), 44–45.
[534] Sylvester M. Lambert, *Back to the Beginning*, RF RG1.1 S419 B1 F1, RAC.
[535] Sloan Mahone, 'The Psychology of Rebellion: Colonial Medical Responses to Dissent in British East Africa', *Journal of African History*, 47/2 (2006), 241–58.
[536] Western Pacific Health Service Annual Report, 1928, RF RG5 S3.419 B161 F1977, RAC. 21.
[537] S. M. Lambert, *Health Survey of Rotuma*, RF RG5 S3.419 B161 F1977, RAC.
[538] Western Pacific Health Service Annual Report, 1928, RF RG5 S3.419 B161 F1977, RAC. 15.

considered to have 'some negroid blood', therefore, were impure.[539] If not a pure Polynesian, being fully indigenous was still desired. As Vicki Luker described, mixed-race 'half-castes' were seen as a threat in the Pacific Islands such as Fiji, where the colonial policy was based on indigenous interests.[540] Such preference of the so-called 'pure blood' is also noted in the admissions of the CMS that discouraged 'half-castes' from enrolling.[541]

Governing the South Pacific

Margaret Jones explains that the motivation that developed colonial medicine was not for the welfare of the colonised but rather to promote European health in the colonies, maintain healthy colonial labour, and justify colonisation through the 'civilising' function of Western medicine.[542] Arguably the most influential international health organisation at the time with the exception of the League of Nations Health Organisation, the RF was operating in dozens of British tropical colonies.[543] In case of the South Pacific, the RF was provided with a formal authority through the WPHS and conducted health programmes for indigenous health. These programmes still served to promote the 'civilising' functions of Western medicine and meet the needs of the participating islands.

The WPHS shaped its policies against such a background. Rather than using the 'rule of fear', the British had the WPHS campaign units treat diseases. Lambert argued it was a better, saner, speedier way of gaining the confidence of indigenous people (for colonial rule), which

[539] New Medicine Men in Fiji, Fiji, RF RG5 S3.417 B161 F1975, RAC.
[540] Vicki Luker, 'The Half-Caste in Australia, New Zealand, and Western Samoa between the Wars: different problem, different places?' in Douglas, Ballard, *Foreign Bodies*, 307–335.
[541] The Central Medical School, RF RG5 S3.417 B161 F1975, RAC. 13.
[542] Margaret Jones, *Health Policy in Britain's Model Colony: Ceylon (1900–1948)* (Hyderabad: Orient Longman, 2004) 5–6.
[543] Packard, *A History of Global Health*, 32–34.

was ‘best for the native’ at the same time.[544] Western medicine and the WPHS would save the Pacific Islanders who would otherwise ‘die like flies.’[545] The WPHS thought this strategy was successful. The Solomon Islands reported that the civilising influence of Western medicine had changed indigenous people's ‘mental attitude’ towards the government, although they did not provide concrete evidence for the report.[546] Western Samoa also evaluated the yaws campaign to have pacified political instability in the wake of the Mau movement. The political benefits were so great that Western Samoa, previously reluctant to indigenous healthcare, wanted future collaborations with the WPHS.[547]

Despite these successes, the WPHS could not penetrate everywhere. The people of Bellona wanted ‘no government, no missions, no doctors, no medicine.’ To them, what the WPHS framed as ‘civilisation’ meant the introduction of gonorrhoea, tuberculosis, greed and dishonesty. When faced with such strong opposition from indigenous communities, the WPHS could not force treatment.[548] In that case, the WPHS just collected as much medical and anthropological information as possible on the island.

The first step to strengthening the governing functions of indigenous healthcare was training NMPs as colonial elites. The WPHS argued that pursuing a medical career in the South Pacific was a process of ‘codifying British ethics in the native races.’[549] Indeed, when the first batch of students graduated from the CMS, they were evaluated as ‘well-educated gentlemen, who are respectful and self-respecting.’[550] When the first cohort of students qualified as NMPs out of a four-year curriculum, the WPHS reconfirmed that NMPs were ‘assuming responsible

[544] Sylvester M. Lambert, *Back to the Beginning*, RF RG1.1 S419 B1 F1, RAC. 9–14.
[545] Western Pacific Health Service Annual Report, 1928, RF RG5 S3.419 B161 F1977, RAC. 31.
[546] *Ibid.*, 5–7.
[547] Soil Sanitation in the Pacific, RF RG5 S3.417 B161 F1975, RAC. 9.
[548] Sylvester M. Lambert, *Back to the Beginning*, RF RG1.1 S419 B1 F1, RAC. 105–106.
[549] Western Pacific Health Service Annual Report, 1928, RF RG5 S3.419 B161 F1977, RAC. 5–7.
[550] Western Pacific Health Service Annual Report, 1931, RF RG5 S3.419 B162 F1983, RAC. 13.

and respectable positions in their communities.'[551] These comments indicate that the WPHS differentiated the NMPs, as colonial 'gentlemen', from the general public who were described as 'primitive.'

Once the NMPs were raised, keeping them under control was crucial. Limits on the advanced training of NMPs were one way to achieve this. The WPHS argued that medical conditions in Oceania were too simple that the opportunity for elaborate surgery would almost never occur. Even letting Pacific Islanders train for full medical qualifications turned out to be disappointing to the WPHS. Ratu J. A. R. Dovi (Ratu Dovi) was sent to New Zealand on a scholarship to become the first fully qualified Fijian doctor. The plan was to appoint Ratu Dovi as the Travelling Medical Officer, a position that ceased operation in 1931. The WPHS considered Ratu Dovi's chiefly background would give him enough status to supervise the NMPs, whereas he would be native enough to take on the physically challenging work.[552] Contrary to expectations, Ratu Dovi chose to work as a District Medical Officer in a European-populated centre upon arrival instead of simply conforming to what the colonial authorities wanted him to do.[553]

Another way to control the NMPs was through the semi-annual journal, *Native Medical Practitioner*, published by the CMS from 1930. The journal contained contributions written by European medical officers or NMPs on disease conditions, scientific findings, region-specific medicine and personal essays concerning the South Pacific. The WPHS states the aim of the journal was to keep the NMPs 'coherent and articulate' through circulating medical knowledge.[554]

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[551] Western Pacific Health Service Annual Report, 1934, RF RG5 S3.417 B161 F1965, RAC. 8.
[552] Western Pacific Health Service 2nd Quarterly Report, 1935, RF RG5 S3.417 B161 F1966, RAC.
[553] The Central Medical School, RF RG5 S3.417 B161 F1975, RAC. 7–10.
[554] Western Pacific Health Service 3rd Quarterly Report, 1930, RF RG5 S3.419 B162 F1980, RAC. 1.

Control over the Pacific Islanders reached beyond the colonial elites, such as the NMPs, through census-taking. As Bernard Cohn wrote, the systematic collection of census data was a means of colonial governance.[555] Benedict Anderson also showed that the quantification of the colonial population, as an institution of power, let colonial governments categorise the colonised race through an arbitrary lens.[556] In the South Pacific, the WPHS campaign units served as census-takers. The mass treatment method enabled travelling units to visit every island subject to the campaign, which colonial officials could only estimate the populations previously. In the Solomons, hookworm units took a census of Malaita and Guadalcanal, where the interior was little known.[557] The New Hebrides campaign supposedly acquired the most accurate census ever taken.[558] In a successful census report, the WPHS claimed that both countries had never been penetrated before except for punitive expeditions or missionaries. As the first colonial officials to thoroughly travel the Pacific Islands, the medical staff of the WPHS functioned as government agents and collectors of colonial knowledge.[559]

Census was such a beneficial side-achievement that Western Samoa defined it as one of the purposes of their yaws campaign. Before the campaign, Western Samoa estimated its population to be 43,147. After the yaws campaign in 1933, the WPHS reported a total of 48,300, likely an undercount, estimating about 50,000 for the Western Samoan population. The WPHS unit obtained a census of the whole country by island, district, village, age and sex.[560] The gap was presumably a result of government functions on pause throughout the Mau movement since 1926. In the meantime, Western Samoan population was increasing by 1,200– 1,500 per

[555] Bernard S. Cohn. *An Anthropologist Among the Historians and Other Essays* (Delhi: Oxford University Press, 1990), 224–254.
[556] Benedict R. O'G. Anderson. *Imagined Communities: Reflections on the Origin and Spread of Nationalism* (London: Verso, 2006), 163–170.
[557] Western Pacific Health Service 1st Quarterly Report, 1930, RF RG5 S3.419 B162 F1980, RAC. 2–3.
[558] Western Pacific Health Service Annual Report, 1931, RF RG5 S3.419 B162 F1983, RAC. 5.
[559] Western Pacific Health Service 3rd Quarterly Report, 1930, RF RG5 S3.419 B162 F1980, RAC. 1–2.
[560] Report on Western Samoa Yaws Campaign, 1932–1934, RF RG5 S3.417 B161 F1965, RAC.

year.[561] With the new census, Western Samoa was compelled to cancel its withdrawal plan from the CMS. They needed more NMPs for a larger population.[562]

The WPHS ultimately viewed indigenous healthcare as colonial capital management. This attitude is clearly revealed in the prioritisation of economically productive regions. In the Solomon Islands, Malaita was exclusively chosen for the initial hookworm campaign field because the country's plantation labour was practically entirely drawn from the island.[563] The second round of hookworm campaigns also started in Malaita, the most valued island by the colonial government.[564] In another case, the Colonial Sugar Refining Company in Fiji made financial contributions to the WPHS as an investment for healthy plantation labour. In addition to donations, the company provided free transport to the WPHS on their railroad and covered the expense of installing latrines in their estates.[565] The WPHS praised the company's support as 'the farsighted acumen of a successful business.'[566]

To ensure the WPHS programmes were carried out smoothly, the police force assisted campaigns at times. The tuberculosis survey in Fiji was a hopeful project that the WPHS expected to round the whole country. When NMP Vakatawa started the survey in 1938, people in Colo East tried to evade examination, fearing they might have tuberculosis. The WPHS arranged with the police to help Vakatawa to visit Colo East again to fulfil the purpose of his work. Following Colo East, Vakatawa was accompanied by a police officer to help with the survey for the rest of the year. The WPHS reported that the police company brought the full cooperation of the people.[567] Whether this was because the police were respected or feared is

[561] The Central Medical School, RF RG5 S3.417 B161 F1975, RAC. 11.
[562] Western Pacific Health Service 3rd Quarterly Report, 1932, RF RG5 S3.419 B162 F1984, RAC. 1.
[563] Western Pacific Health Service Annual Report, 1928, RF RG5 S3.419 B161 F1977, RAC. 6.
[564] Western Pacific Health Service Annual Report, 1929, RF RG5 S3.419 B161 F1979, RAC. 6.
[565] Western Pacific Health Service Annual Report, 1932, RF RG5 S3.419 B162 F1985, RAC. 3–4.
[566] Western Pacific Health Service Annual Report, 1928, RF RG5 S3.419 B161 F1977, RAC. 32.
[567] Western Pacific Health Service Annual Report, 1938, RF RG5 S3.417 B161 F1974, RAC. 3.

not stated in the report, but it is clear that the police presence helped.

Discussions on further centralisation started when New Zealand territories joined the WPHS. As a prelude, the Director-General of Health of New Zealand, Michael Watt, surveyed health conditions in the Pacific Islands and advised Fiji on the matter in 1934.[568] Unfortunately, the WPHS closed down when Lambert retired in 1939, which marked the end of the RF funding. The coincidental outbreak of the Second World War prevented colonial finances from being used for indigenous welfare. However, the idea survived and was eventually reignited during the war, giving birth to the South Pacific Health Service in the post-war period.

Conclusion

The WPHS was a centralised disease-control institution in which the British colonies and New Zealand territories were grouped together in one system. Largely funded by the RF, it conducted mass treatments, developed sanitation systems, and provided education in public health. In carrying out such health campaigns, the Pacific Islands became an excellent field for drug trials. The WPHS was arguably the only government body that had close contact with such a large number of indigenous communities across the region, which resulted in the WPHS gaining a racialised understanding of the Pacific Islanders. The accumulated experience of centralisation through the CLH, the CMS, and the WPHS gave rise to an idea of a fully centralised medical service encompassing the entire South Pacific region. Thanks to the success of the three institutions, a larger project of centralisation seemed feasible. Indeed, Lambert had ambitions to fully unify the medical services of the British, New Zealand, Australian, French,

[568] Western Pacific Health Service 3rd Quarterly Report, 1934, RF RG5 S3.417 B161 F1964, RAC.

and even Dutch empires.[569] The WPHS, in this sense, was a pilot project for a more ambitious scheme.

However, it was not a scheme imposed entirely from above. Indigenous agency can be observed in the WPHS programmes, as well as in the CLH and the CMS. Fijian and Samoan NMPs showed that NMPs were capable of leading medical campaigns and surveys. Fijian women took part in medical programmes. Ratu Dovi proved that indigenous islanders were sufficiently capable to become fully qualified doctors and to choose the type of work theywanted to do. Solomon Islanders and Samoans could refuse the drugs given by the medical authorities. All of these cases demonstrate that the medical centralisation in the Pacific Islands was not a simple one-way delivery by white Europeans. Rather, it was a process of negotiation between various actors including colonial governments, private philanthropy, indigenous medical staff, and local population.

[569] Western Pacific Health Service Annual Report, 1934, RF RG5 S3.417 B161 F1965, RAC. 11.

PART II

Chapter 4. The Fiji Military Forces

Medical centralisation in the South Pacific entered a new phase with the outbreak of the Second World War. The grand scheme of full medical centralisation between Pacific Islands was put on pause. Instead, medical services were centralised within the Allied forces to take part in the war. During the war, the British Empire in the Pacific was invaded by the Japanese. The British Gilbert Islands, the British and Australian Solomon Islands, Nauru and Australian New Guinea were all captured and occupied by the Japanese. In response, Fiji, the Gilbert and Ellice Islands, the Solomon Islands, Tonga, and Australia Papua New Guinea raised military forces to join the war effort. Countries that could not do so (e.g. New Hebrides) became military bases for Allied forces. Significantly, the WPHC transferred military responsibilities of strategically vital islands, Fiji and Tonga, to New Zealand. These were again transferred to the US after it joined the war.[570] Fiji and islands to the east were not captured by the Japanese but the threat seemed imminent in the early stages of the war.

This chapter has a narrower focus on the Fiji Military Forces (FMF) and their relationship with New Zealand. Other British colonies were either occupied by Japan or did not have a medical corps with their military. Not much literature has been written on the FMF. Notable works include Stewart Firth and Ashley Jackson's chapters on the wartime contribution of the Pacific Islands.[571] The official history of the FMF compiled by R. A. Howlett and Asesela Ravuvu's book are also good guides to Fiji's military organisations during the Second World War.[572] Most studies on the Second New Zealand Expeditionary Force (2NZEF) contain

[570] Ashley Jackson, *The British Empire and the Second World War* (London: Hambledon, 2006) 513–516.
[571] Stewart Firth, 'The War in the Pacific' in Denoon (et al.), *The Cambridge History of the Pacific Islanders,* 289–323*;* Jackson, *The British Empire and the Second World War,* 513–524.
[572] Robert A. Howlett, *The History of the Fiji Military Forces, 1939–1945: Complied from Official Record and*

sections for New Zealand activities in Fiji but do not discuss the FMF.[573] Research on the medical arrangements of the FMF is much rarer. One of the most dedicated series of works on medical conditions in the wartime Pacific is a special issue of *Health and History*, 'Health and Medicine during and after the Pacific War: Pacific Islanders and Medical Infrastructure.' Still, this issue did not have an article on Fiji.[574] None of these works discuss the medical arrangements of the FMF at length.

As discussed in the previous chapter, the WPHS effectively closed down after the termination of the RF's financial support to the region in 1939. The British government was unable to fund the institution due to wartime constraints. The absence of the WPHS, as a supervisory institution that promoted the unification of medical services, seemingly creates a void in the history of medical centralisation before the advent of the South Pacific Health Service after the war. However, medical centralisation did in fact continue into the war, albeit with a new focus in the military sphere.

Medical institutions were placed in the centralised system of the Allied forces. Fiji's military was under New Zealand's command and New Zealand followed US directions. The same kind of centralised command and control applied medical units of the military forces.[575] As Mark Harrison has argued, treating war as an exceptional event that happens beyond ordinary society prevents an understanding of the relationship between war and medicine.[576]

Diaries (London: Crown Agents for the Colonies on behalf of the Government of Fiji, 1948)*;* Asesela Ravuvu, *Fijians at War* (Suva: South Pacific Social Sciences Association, 1974).

[573] T. Duncan M. Stout, *Medical Services in New Zealand and the Pacific: In Royal New Zealand Navy, Royal New Zealand Air Force and with Prisoners of War* (Wellington: War History Branch, Department of Internal Affairs, 1958); T Duncan M. Stout, *War Surgery and Medicine* (Wellington: War History Branch, Department of Internal Affairs, 1954); E. V. Sale, *Shovel, Sword and Scalpel: A Record of Service of Medical Units of the Second New Zealand Expeditionary Force in the Pacific* (Wellington: A. H. and A. W. Reed, 1945); Reg Newell, *Pacific Star: 3NZ Division in the South Pacific in World War II (Auckland: Exisle Publishing, 2015)* 22–24.

[574] Widmer, Winter (eds.), *Health and History*, 23/2 (2021), 1–84.

[575] Firth, 'The War in the Pacific' in Denoon (et al.), *The Cambridge History of the Pacific Islanders*, 300–301.

[576] Mark Harrison, 'Medicine and the Management of Modern Warfare: An Introduction' in Roger Cooter, Mark Harrison, Steve Sturdy (eds.), *Medicine and Modern Warfare* (Amsterdam: Wellcome Institute Series in the

To bridge the interwar years and the post-war years, medical centralisation should be considered in a military context. This history will demonstrate that medical centralisation in the South Pacific was a continuous feature of the first half of the twentieth century.

Following Harrison's footsteps in writing the history of British military medicine, this chapter will go some way to filling an historiographical gap in the case of Fiji, this being the first history of the Fiji Medical Corps.[577] It aims to show how the centralised control of medical staff during the Second World War was carried out, paying particular attention to the role of fully qualified medical officers and subordinate indigenous medical staff. This wartime experience is important because it became the basis for post-war attempts at centralisation. Analysing the cooperation and tension between Fiji and New Zealand, the chapter will show how Fiji navigated the changing currents of the war.

Formation of the Fiji Medical Corps

The defence of Fiji was weak when Britain declared war on Germany. With the prospect of war looming in the Pacific, New Zealand started to expand the humbly sized Fiji Defence Force (FDF) with its own resources. According to the official history, the 1936 British Overseas Defence Committee presumed that New Zealand would take on the defence of Fiji in case of war because the colony did not have sufficient resources to fight an invasion. In 1938 at the Committee of Imperial Defence, New Zealand Chiefs of Staff agreed that Fiji was more likely to be attacked by the Japanese than other islands. By April 1939, the chiefs of all three forces agreed that an enemy force established in Fiji 'could subdue and contain Auckland and

History of Medicine, Brill Academic Publishers, 1999), 1.

[577] Harrison, *Medicine and Victory*.

most of the North Island by air' and that surface craft and submarines could paralyse shipping lanes and communication between Australia, New Zealand, and the US.[578] This is why New Zealand took control of the defence of Fiji, not only to protect the colony but also because it was vital to the defence of New Zealand.

By 1940, New Zealand deployed more than 3,000 troops of its B Force to Fiji, which became 8 Infantry Brigade Group and, later, the core of the 3NZ Division of the 2NZEF. The Commander of New Zealand forces in Fiji was also made Commandant of the FDF in November 1940.[579] From then on, Fiji was formally tied with New Zealand militarily and medically. With New Zealanders occupying the higher ranks of the FDF, decisions for Fiji required New Zealand's approval. The FDF changed its name to the Fiji Military Forces by the end of 1942 and became the largest full-time professional military in the WPHC territories.[580]

One of the first tasks in an expanding military was the medical examination of new recruits. Having seen unfit recruits during the First World War, the British took the fitness of soldiers entering the war seriously.[581] In the British Empire, the standards used in the First World War became the basis for examinations. Correct examination was emphasised because it determined pension schemes after war service.[582] To examine recruits, Fiji obtained its standards from a New Zealand guidebook published in 1938.[583] During a preliminary exam, NMPs assessed recruits based on the conditions of their eyes, ears, teeth, and a minimum height requirement of 5 feet 8 inches. They also checked for evidence of major diseases, such as

[578] Oliver A. Gillespie, *The Pacific: Official History of New Zealand in the Second World War, 1939–45,* (Wellington: War History Branch, Department of Internal Affairs, 1952), 19–20.
[579] Newell, *Pacific Star,* 22–24.
[580] Howlett, *The History of the Fiji Military Forces, 1939–1945,* 38.
[581] Mark Harrison, 'Medicine and the Management of Modern Warfare', *History of Science,* 34/4 (1996) 399–400.
[582] From the Director of Medical Services to the Colonial Secretary, 23 February 1940, F8/101 Part.1, NAF.
[583] From the Acting Director of Medical Services to the Colonial Secretary, 18 June 1940, F8/101 Part.1, NAF.

ringworm, scabies, yaws, hernia, hydrocele, varicocele, varicose veins, elephantiasis.[584] Fijian candidates for the Royal New Zealand Air Force were examined in Fiji by New Zealand officers, who were experienced in carrying out tests prescribed by the Air Ministry.[585]

The more the FDF was starting to look like a fully constituted military, the more the burden of medical care fell on the Medical Services of Fiji. Caring for the health of the FDF, supervising camp sanitation, and examining recruits were all additional duties given to civilian medical officers after the war broke out. All the doctors based in Suva, for example, had to make time for military service on top of their usual hospital work and teaching responsibilities. Private practitioners were also fully occupied with existing work. It is natural, therefore, that medical officers became upset when recruits due for examinations did not appear. On behalf of angry doctors, the Medical Department of Fiji insisted that details of men subject to examinations be provided to medical officers at least one-week before the examination.[586] Furthermore, the Medical Board meetings were reduced to a minimum and all recruits awaiting examination were asked to appear on the day of the Board meeting.[587]

During this early period, medical officers worked with the military without receiving commissions. For example, a pathologist attended sick parades at the Old Government Buildings. The Medical Officer of Health was responsible for inspecting camp sanitation. The medical officer of the Sigatoka area attended stations near him.[588] NMPs also worked in the military but as medical orderlies and dressers.[589] Most NMPs served as non-commissioned

[584] From the Director of Medical Services to All Native Medical Practitioners and Indian Medical Practitioners, 24 May 1940, F8/101 Part.1, NAF.
[585] From the Acting Director of Medical Services to the Colonial Secretary, 20 June 1940, F8/101 Part.1, NAF.
[586] From the Acting Director of Medical Services to the Headquarters, Fiji Defence Force, 13 September 1940, F8/101 Part.1, NAF.
[587] From the Colonial Secretary to the Headquarters, Fiji Defence Force, 1 November 1940, F8/101 Part.1, NAF.
[588] From the Acting Director of Medical Services to the Colonial Secretary, 20 June 1940, F8/101 Part.1, NAF.
[589] From Medical Officer -Schools and Troops to the Director of Medical Services, 9 September 1940, F8/116, NAF.

officers (NCO).[590] When the FDF grew in size, more NMPs were attached to each unit as Medical Orderly Sergeants.[591]

Dr I. H. Beattie was the first to take over the military medical service in Suva, the main military area. He was already a Surgeon Lieutenant of the Royal Navy who retained his commission from the First World War in the Reserve, remaining liable for duty in any emergencies.[592] Beattie had to care for three regular units: Coast Defence Battery at Suva Battery, the Headquarters and a Company of the 1 Battalion at Old Government Buildings, and a Company at Nasese, temporarily quartered on Nukulau Island. He was provided with an inspection room, an NMP and a dresser subordinate to his orders.[593] Beattie started his service as a Captain despite objections made by himself, arguing he should be given a rank higher than a Major with his seniority. He received payment of 22 shillings a day, as fixed by King's Regulations for the Royal Navy surgeons.[594]

The 'makeshift' setup was revised in January 1941 to allow closer collaboration with New Zealand. More New Zealand troops arrived in Fiji and better medical defence plans were needed to meet both the military and civilian needs. In order to keep the military and civilian spheres separate, civilian healthcare remained with the Medical Department of Fiji. Military medical care was put under the New Zealand Medical Corps (NZMC). Matters of common concern, such as public health issues, were decided as a result of a liaison between the Fiji Government and the New Zealand Army. The main part of the revision was appointing a full-time Medical Officer (MO) for the FDF.[595]

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[590] Extract from Minutes of a Meeting of the War Council, Held at Government House at 3pm on Tuesday, 15 October 1940, F8/101 Part.1, NAF.
[591] Extract from Letter from O. C. Troops, 28 February 1941, F8/101 Part.1, NAF.
[592] From Dr I. H. Beattie to Major Magrane, 23 October 1940, F8/101 Part.1, NAF.
[593] From Staff Officer of Fiji Defence Force to Dr I. H. Beattie, 22 October 1940, F8/101 Part.1, NAF.
[594] From Dr I. H. Beattie to Major Magrane, 26 October 1940, F8/101 Part.1, NAF.
[595] From the Director of Medical Services to the Colonial Secretary, 20 January 1941, F8/101 Part.1, NAF.

The selection process for the FDF's MOs began the following month, February 1941. The Fiji government short-listed suitable candidates among their government medical officers. Then, the best candidate to join the military service was selected. Those who were chosen would receive payment no less than the equivalent of their previous salary plus increments, allowances, and privileges accompanying their rank in the military. For logistical reasons, single officers were preferred over those with families. Ratu Dovi, the first Fijian fully qualified doctor who recently returned from New Zealand, was not invited for voluntary military service at this stage. This was because the Fiji government considered his existing civil work more important. After consideration, Dr Humphrey Silvester Evans, who also served in the First World War, was selected as the best candidate.[596] Evans was 'peculiarly suited' to the post because of his knowledge of Fiji, understanding of Fijians, and experience of the First World War.[597]

While Fiji offered Evans a salary equivalent to his existing one with the Fiji government plus £150 of allowances for lodging and messing, his commissioned rank was unusually low. Whether he would be commissioned in the FDF or the NZMC was undecided at this point but it was clear that he would be under the orders of the Senior Medical Officer (SMO) of the NZMC.[598] Evans offered his service but he did not hide his dissatisfaction with his commissioned rank. Like Beattie, Evans was a very senior officer with much experience in Fiji. He argued the given rank was one of the most junior in the Army Medical Service. Since Evans was an SMO at the Corps Heavy Artillery during the First World War, being commissioned at a lower rank after decades of a professional career was distasteful to him. He

[596] From the Director of Medical Services to the Colonial Secretary, 13 February 1941, F8/101 Part.1, NAF.
[597] From the Director of Medical Services to the Colonial Secretary, 24 May 1941, F8/101 Part.1, NAF.
[598] Extract from Letter from O. C. Troops, 28 February 1941, F8/101 Part.1, NAF.

suggested Ratu Dovi in his place, who was reportedly anxious for war service.[599] Despite Evans and the Fiji government's appeal to commission him at the rank of Major or above, it was decided that he should start as a Captain, the MO for the FDF, following the directions of the SMO of NZMC, Lieutenant-Colonel Davie.[600]

To commission Evans, the Governor of Fiji asked the Secretary of State for the Colonies 'to create in the Fiji Defence Force the nucleus of a medical corps analogous to the RAMC and to the New Zealand Medical Corps' in May 1941. The FDF had expanded to nearly 2,000 men by this time.[601] Because the norm was to commission Medical Officers into the Royal Army Medical Corps, not directly in combatant units, it was impossible to commission Medical Officers without a dedicated medical corps.[602] At the Secretary of State's approval, the Medical Section of the FDF, which later became the Fiji Medical Corps, was formally established.[603] With effect from 15 July 1941, Evans was granted a commission as a Captain.[604] Then, the FDF consulted Evans on the plans to form the Fiji Medical Corps, which consisted of Evans and four NMPs.[605]

As the war accelerated after the Pearl Harbour attack, the FDF expanded. More medical officers were needed. Ratu Dovi finally joined the FDF at the beginning of 1942.[606] His commission was arranged at the request of the Commandant of the FDF, Brigadier Cunningham, who wished to hire an MO fluent in Fijian.[607] With Evans and Dovi both stationed in Suva, the entire western area of Lautoka, where both New Zealand and Fiji forces

[599] From H. Silvester Evans to McGusty, 17 May 1941, F8/101 Part.1, NAF.
[600] From McGusty to Evans, 15 May 1941, F8/101 Part.1, NAF.
[601] From the Governor to the Secretary of State, 28 May 1941, F8/101 Part.1, NAF.
[602] From the Acting Director of Medical Services to the Colonial Secretary, 20 June 1940, F8/101 Part.1, NAF.
[603] From the Secretary of State to the Governor, 31 May 1941, F8/101 Part.1, NAF.
[604] From the Colonial Secretary to Dr H. S. Evans, U/C Commandant, Fiji Defence Force, 13rd July 1941, F8/101 Part.1, NAF.
[605] Memorandum for the Colonial Secretary, 12 June 1941, F8/101 Part.1, NAF.
[606] From the Director of Medical Services to the Colonial Secretary, 9 January 1942, F8/101 Part.1, NAF.
[607] Memorandum for the Colonial Secretary, 12 December 1941, F8/101, NAF.

were expanding, was left uncovered. To tackle the issue, the Medical Services of Fiji, the NZMC, and the FDF held a conference in January 1942 to discuss the relocation of medical personnel. Usually, Fiji's government medical officers and NMPs worked in allocated districts for civilian healthcare. Directing medical staff for military purposes meant that some districts would be left without medical officers. Because Ba, Sigatoka, and Savu Savu had more private practitioners to handle emergencies, medical officers could be drawn from these districts.[608] As a result, Dr William George MacNaughton, a 40-year-old New Zealander graduate of the University of Glasgow, was selected. He was ideal because he was a bachelor and had good knowledge of Fiji and the Fijian language.[609] MacNaughton was formally requested to release from his civilian duties for military service as a Captain in the FDF in March 1942. Simultaneously, Evans was promoted to Major, acting as an SMO of the FDF.[610]

Meanwhile, commissions were arranged for the Territorial Force of the FDF. Married officers could be commissioned as Captains in the Territorial Medical Corps. To allow the military to have doctors ready for service in the event of hostilities, the FDF wanted a couple of doctors at the CWM Hospital in the Territorial Medical Corps.[611] In the event of hostilities, those with a commission could not work outside the hospital. From the Fiji government's perspective, the commission of CWM Hospital doctors was helpful because their services would be essential inside the hospital when war comes to Fiji.[612] Anxious about risking the

[608] From the Director of Medical Services to the Colonial Secretary, 19 January 1942, F8/101 Part.1, NAF.
[609] From the Director of Medical Services to the Commandant, Fiji Defence Fore, 24 January 1942, F8/101 Part.1, NAF.
[610] Memorandum for the Colonial Secretary, 28 March 1942, F8/101 Part.1, NAF.
[611] Memorandum for the Colonial Secretary, 4 February 1942, F8/101 Part.1, NAF.
[612] Unsent letter from the Colonial Secretary to the General Officer Commanding, Fiji, February 1942, F8/101 Part.1, NAF.

quality of civilian medical care, the Medical Services of Fiji approved with the condition that the CWM Hospital doctors undertake their military duties in their spare time.[613]

To enhance medical strength, the FDF required at least six MOs: one SMO, two Regimental Medical Officers, one attached to the Field Ambulance, and two attached to the CWM Hospital. In early 1942, Evans was the SMO. Ratu Dovi was a full-time Regimental Medical Officer with the 1 Battalion. The 2 Battalion was with the Territorial Force. Dr G. T. Barnes was commissioned as a part-time officer. MacNaughton was commissioned when the 3 Battalion was being formed. Fiji Medical Corps still lacked two MOs. Fiji's medical service was 'already overtaxed and without its normal reserves,' so it could not spare more staff for the military.[614] All of the medical staff in Suva were overworked, carrying out usual duties and giving additional help to domestic and overseas military forces.[615] Later in November 1942, Dr George Ratcliffe Hemming was appointed as a Lieutenant in the Fiji Medical Corps to serve with the 4 Battalion.[616] For more officers, the FDF had to ask New Zealand through the NZMC.[617]

Founding members of the Fiji Medical Corps did not serve for the duration of the war. MacNaughton was examined in Grade 4 by the Medical Board and retired from the military in April 1943.[618] Evans retired from his military duties as an SMO and went back to his civil occupation in June 1943. After the two leading MOs retired, Fiji introduced a new policy to appoint medical officers who did not yet serve in the military on a rotation of a 3–6

[613] From the Director of Medical Services to the Colonial Secretary, 29 January 1942, F8/101 Part.1, NAF.
[614] Note of Discussion on Fiji Defence Force Medical Arrangements in the Office of the Director of Medical Services, Fiji, 19 February 1942, F8/101 Part.1, NAF.
[615] Guthrie, *Misi Utu*, 44.
[616] Memorandum for the Colonial Secretary, 4 November 1942, F8/101 Part.1, NAF.
[617] From the Senior Medical Officer to the Officer I/C Administration, Fiji Defence Force, 29 September 1942, F8/101 Part.1, NAF.
[618] From Administrative Headquarters, Fiji Military Forces to the Colonial Secretary, 2 April 1943, F8/101 Part.1, NAF.

months cycle.[619] Dr Thomas Clunie of Ba district was the first to be hired under this new policy because Ba had three private practitioners to deal with medical emergencies. It was administratively easier because Clunie was already commissioned for service with the 2 Territorial Battalion from April 1943.[620] After three months, Clunie retired as he was too old for full-time military service. Then, Dr A. G. Hemsley of Sigatoka district was appointed, leaving Sigatoka with no medical officer for the duration of his service because it had no private practitioners.[621] Hemsley took over the care for the 3 Battalion.[622]

As discussed, the process of making the Fiji Medical Corps involved establishing centralised control over doctors. Commissioning, assigning duties, and circulating posts could not be done before the emergency of the war. It was introduced at the decision of the military headquarters for war purposes. This policy was maintained throughout the war and became one of the aspects that allowed the future South Pacific Health Service to pool medical staff.

Medical Arrangements for the Fiji Military Forces

In addition to medical staff, medical resources were mobilised for military purposes. Medical arrangements for the FDF started with the attempt to secure enough hospital beds. The CWM Hospital and Lautoka Hospital, the two main hospitals in the east and west of Viti Levu, were designated as military hospitals in Fiji.[623] The Technical School on Skylark Hill was made available for use as an emergency hospital. No new military hospital was built.[624]

[619] From the Director of Medical Services to the Colonial Secretary 29 May 1943, F8/101 Part.1, NAF.
[620] Memorandum for the Colonial Secretary, 3 April 1943, F8/101 Part.1, NAF.
[621] From the Director of Medical Services to the Colonial Secretary, 30 June 1943, F8/101 Part.1, NAF.
[622] Howlett, *The History of the Fiji Military Forces, 1939–1945*, 161.
[623] From the Acting Director of Medical Services to the Headquarters, Fiji Defence Force, 13 September 1940, F8/101 Part.1, NAF.
[624] From the Director of Medical Services to the Colonial Secretary, 13 February 1941, F8/101 Part.1, NAF.

Treatment at the two military hospitals was free. According to the Public Hospital Ordnance of 1884, public hospitals such as the CWM Hospital and those in Levuka, Lautoka and Labasa received out-patients free of charge. Those entitled to free treatment include government officials whose salaries were less than £100, police officers whose ranks were below Assistant Commissioner, prison officers, hospital staff, NMPs and IMPs, native nurses, anyone detained in the hospital for public safety, all native Fijians and Indians who resided in Fiji for more than three years, former members of the British military who served in the First World War, families of the veterans, and lastly, members and former members of the British military serving in the war.[625] This list, in effect, covers all the indigenous population, settled Indian immigrants and lower-rank civil servants. It thus excluded immigrant Europeans either in the private sector or in high-rank government positions who could afford private practitioners.[626]

As detailed in the Public Health Ordnance, medical care for military services was also ensured within the colonial law. This free-treatment policy introduced 'socialised medicine' in the Pacific colonies as early as the nineteenth century. According to Brij Lal, citing Nicholas Thomas and Atu Bain, such medical care was a way to get the Fijians to conform with British values through the official policy of 'benevolent protectionism.'[627] By comparison, such a universal healthcare system was not settled in the imperial metropole until the post-war establishment of the National Health Service.[628] It was during the Second World War that Britain experienced the benefits and efficiency of the Emergency Medical Service, that paved way for the National Health Service for the UK.[629]

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[625] 1 Bearer Company FMC, Routine Order No.1/46, 17 March 1945, ADQZ 18886 DAZ491.1/1/XXVII R26222666, ANZ.
[626] From the Acting Director of Medical Services to the Headquarters, Fiji Defence Force, 13 September 1940, F8/101 Part.1, NAF.
[627] Lal, Kiste, *Broken Waves*, 15.
[628] Harrison, *Medicine and Victory*, 6.
[629] Charles Webster, *The National Health Service: A Political History* (Oxford: Oxford University Press, 2002),

To meet the excess medical expenses, Fiji and New Zealand centralised military finances, creating the Pool Fund. It was to pay for items that could not be supplied through Army Stores, such as false teeth or new glasses, which could be provided at no personal expense through the pool arrangements. Since specialised dental care was not included in general hospital treatment, it could also cover the cost of soldiers referred to local dentists and opticians.[630]

Of the costs covered by the Pool Fund, dental care raised concern from early on. At the beginning of the war, the only free dental treatment available for the FDF was tooth extraction. Dental treatment, however, was taken seriously by the British Army. The experience of the First World War taught them that dental care was necessary to maintain military strength.[631] Like the British Army, the FDF proposed a dental care scheme in August 1940. Any soldier who required dental care could be examined by a government medical officer, who, in turn, could refer them to a dentist at the approval of his unit. The treatment invoice could be forwarded to the FDF Headquarters for payment. This privilege was limited to those in active full-time service. It was not extended to the Territorial Force that trained part-time.[632] The scheme was taken up by the Governor of Fiji, who wished to procure free dental treatment when the FDF proceeded overseas on active service.[633] At the time, Fiji was yet to send its men overseas.

Soon, dental problems started to overwhelm hospitals near military centres. It was particularly problematic in the Lautoka area, where three forces were based: A Company of the

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630 From the Administrative Headquarters, Fiji Military Forces to the Accountant-General, 1 March 1943, F8/101 Part.1, NAF.

631 Harrison, *Medicine and Victory*, 20.

632 From Headquarters, Fiji Defence Force to the Colonial Secretary, 14 August 1940, F8/101 Part.1, NAF.

633 From the Colonial Secretary to the Headquarters, Fiji Defence Force, 28 September 1940, F8/101 Part.1, NAF.

2 Territorial Battalion with part-time soldiers; the Natabua Camp with full-time soldiers; and New Zealand forces constructing the Namaka Camp in Nadi. All units of the three forces constantly sent patients with dental troubles. The medical officer of Lautoka complained that free dental treatment merely resolved into 'the wholesale extraction of teeth many of which could be saved by proper attention' from a specialised dentist.[634] In response to the 'haphazard foundation' of military medical care, Fiji proposed New Zealand undertake medical supervision of the troops based in Fiji, including dental care.[635] After all, New Zealand had more men in Fiji than the FDF.[636] Dental care problems remained unresolved for another year until free treatment for all regular members of the FDF was arranged in November 1941.[637]

Hospitalisation arrangements developed after the US joined the war and the FDF started to expand. A comprehensive hospitalisation plan was devised following a meeting between the 2NZEF, the FDF, and the Medical Services of Fiji in February 1942. First, they reconfirmed the arrangements for the CWM Hospital and Lautoka Hospital. These hospitals continued to treat civilians as they did in peacetime and simultaneously functioned as military hospitals for the duration of the war. The two hospitals had 100 beds and 72 beds each. More beds were needed for the FDF. In response, the Dudley House School was made an Emergency Hospital with 90 beds. In Suva, Beattie's private house was reserved for the installation of 40 beds dedicated to military use. An additional isolation block with 40 beds was attached to the Emergency Hospital for both civil and military use. In Lautoka, a block of 40 beds was added at the Lautoka Hospital. Plans for another military hospital of 40 beds in Ba and Tavua area

[634] From Medical Officer, Lautoka to the Acting Director of Medical Services, 28 October 1940, F8/101 Part.1, NAF.
[635] From the Acting Director of Medical Services to the Colonial Secretary, 6 November 1940, F8/101 Part.1, NAF.
[636] Newell, *Pacific Star*, 26.
[637] Memorandum for the Colonial Secretary, 29 November 1941, F8/101 Part.1, NAF.

were also made. Under this new scheme, the Suva area had 270 beds for both civil and military patients. Lautoka had 112 beds, and Ba/Tavua area would get 40 beds. In total, 422 beds were procured in Fiji for both civil and military use in the military areas.[638]

For a sudden and forced centralisation of military forces, frictions were inherent in the institutional union. Most notably, Fiji and New Zealand increasingly disagreed because medical care remained unsatisfactory (as far as the Fiji authorities were concerned) six months after the hospitalisation scheme was drawn up.[639] Because the FDF was directed by the 2NZEF, the leadership of the FDF including the Commandant, represented New Zealand interests. On the other hand, the Medical Services of Fiji were in charge of medical arrangements for the FDF, including staffing the Fiji Medical Corps. This explains why Fiji and New Zealand's interests clashed within the FDF. Medical decisions were thus made as a result of negotiations between the Director of Medical Services of Fiji, V. M. T. McGusty, and the Commandant of the FDF, seconded by the 2NZEF.

In an attempt to find better medical attention, Fiji requested an investigation and a subsequent report written by the SMO of the FDF, a Fiji government officer. The Commandant of the FDF, a New Zealand officer, responded with a summary of the medical organisation without an investigation, as Fiji expected. The summary was simple. Medical care of military personnel was the sole responsibility of the military until the patient was admitted to hospitals. Then, civil authorities took over treatment. In case of hostilities in Fiji, the CWM Hospital would be turned into a full military hospital which the Medical Services of Fiji were still responsible for staffing. Civil patients would be evacuated by Army ambulances. It was for this reason that the Commandant asked Fiji to commission doctors and nurses at the CWM Hospital

[638] Note of Discussion on Fiji Defence Force Medical Arrangements in the Office of the Director of Medical Services, Fiji, 19 February 1942, F8/101 Part.1, NAF.
[639] Extract from Letter from the Director of Medical Services, 16 September 1942, F8/101 Part.1, NAF.

with the Territorial Force and the Territorial Army Nursing Service. Finally, he wrote that Fiji was 'very much better off than the British or New Zealand Units' in terms of medical staff. According to the document, regular FDF Battalions had one MO and at least three NMPs, whereas British or New Zealand units had one MO with one partly trained Medical Orderly.[640]

Unsatisfied with this response, Fiji demanded relief from the strains put on its hospitals and doctors. The main problem was that military arrangements almost entirely depended on civil medical resources. Public hospitals were pressed with too much work. MOs for the FDF were seconded from civilian duties, leaving some districts without medical attention. NMP service was also reduced to spare personnel for military service. The staff shortage was so serious that dismissed NMPs and dismissed medical students were hired as medical orderlies.[641] In short, New Zealand was responsible for evacuation from the forward area while commanding the FDF but did not provide medical staff and hospitalisation.

As a solution, Fiji proposed a 'Medical Centre' for the FDF in October 1942. The proposed Medical Centre would have five functions: Sick Bay, examination site for recruits, training grounds of medical personnel, Central Aid Post, and office for the SMO and his staff. However, 2NZEF disapproved, arguing that no such organisation existed in the British Army. They also considered it needless. First, New Zealand understood the Sick Bay as hospitalisation, which was in the sphere of civil responsibility. If hospital accommodation was insufficient, beds could be added in military hospitals. Second, recruit examination could take place at the Nasese camp or Old Government Buildings. Third, medical personnel were being trained by Battalion MOs in each camp. If a new Bearer Company or a Field Ambulance was formed in

[640] Memorandum for the Colonial Secretary, 5 October 1942, F8/101 Part.1, NAF.
[641] From the Director of Medical Services to the Colonial Secretary, 4 January 1943, F8/101 Part.1, NAF.

the FDF, a camp would be provided for necessary training. As for the Central Aid Post, Unit Aid Posts could deal with each unit's sick. Finally, the SMO already had an office.[642]

Fiji objected to New Zealand's objection. Again, McGusty argued that hospital facilities were 'totally inadequate' and 'extremely unsatisfactory' because it was made when the FDF was a third of its size. Pointing to Regulations for the Medical Services of the Army No.338, No.340, No.347, and No.348, he pushed for a Medical Centre for the FDF. With the Medical Centre, the Sick Bay would function as both Dressing Station at the Base and a Field Ambulance in the field, which he believed was essential for training medical personnel. Existing military hospitals had no room for further extension. Recruit examination was exceedingly complicated that ample and stable site was needed. In addition, venereal disease was expected to increase in the future. A designated venereal disease hospital at the Medical Centre was necessary.[643] In essence, the Medical Centre was an establishment of treatment, training, and administration in one place. It was an site to centralise medical care for the FDF.

Instead of constructing a Medical Centre, the Commandant of the FDF suggested reopening the convalescence hospital on Nukulau Island. Its buildings were still intact after closing from its temporary operation for men suffering from minor illnesses and those discharged from hospitals but still unfit for service.[644] This suggestion was made without considering the value of Nukulau to Fiji. Nukulau has historically been used as a dedicated quarantine island for incoming vessels, mostly indentured labour ships from India.[645] These ships often delivered epidemic diseases to Fiji, to which the indigenous population was very vulnerable. It was more important during the war when thousands of foreign troops in the

[642] Memorandum for the Colonial Secretary, 5 October 1942, F8/101 Part.1, NAF.
[643] From the Director of Medical Services to the Colonial Secretary, 16 October 1942, F8/101 Part.1, NAF.
[644] Memorandum for the Colonial Secretary, 5 October 1942, F8/101 Part.1, NAF.
[645] Lal, *Chalo Jahaji*, 355.

country posed an epidemic threat, having cerebrospinal meningitis on the rise.[646] Cerebral meningitis commonly occurred when troops were raised and concentrated in one space, such as in Britain at the beginning of the First World War.[647] Considering Fiji experienced devastating losses of the population in the 1875 measles, the 1918 influenza, and many waves of introduced epidemics, the Nukulau quarantine was vital to protecting Fijians. Therefore, Fiji opposed making a convalescent hospital there.

After these negotiations failed, Fiji continuously reported a lack of space and staff in both military and civilian medical care. There were no regular sanitary staff and no accommodation available for those who could not be treated at the General Hospital. Training medical staff was also difficult without the proposed Medical Centre. Fiji requested a Medical Centre again to help relieve the strains on the existing medical staff. Finally, in January 1943, four small huts with ablution facilities and septic tanks at Nasese camp were given to the SMO to start a 'medical training centre' as well as a 'short-term hospitalisation centre.'[648] As the negotiations show, while Fiji and New Zealand pooled finances for medical treatments and shared hospitalisations, there were inherent frictions in the medical centralisation.

2NZEF's active medical support of the FMF (formerly the Fiji Defence Force) started with the Solomon Islands campaign. In December 1942, the Governor of Fiji requested that the Prime Minister of New Zealand send three MOs to care for seven units of the FMF that lacked an MO.[649] New Zealand initially responded that only one officer could be spared.[650] New Zealand's stance changed in May 1943, as some FMF units directly came under New Zealand

[646] From the Director of Medical Services to the Colonial Secretary, 16 October 1942, F8/101 Part.1, NAF.
[647] Harrison, *The Medical War*, 126.
[648] From the Administrative headquarters, Fiji Military Forces to the Colonial Secretary, 11 January 1943, F29/659, NAF.
[649] From the Governor to the Prime Minister of New Zealand, 30 December 1942, F8/101 Part.1, NAF.
[650] From the Prime Minister of New Zealand to the Governor, 9 February 1943, F8/101 Part.1, NAF.

for the Solomon Islands campaign. Through a conference, New Zealand decided to support Fiji's personnel and equipment, including three MOs, as requested before. Two NCOs of NZMC were also arranged to conduct anti-malarial training with the Colonial Medical Service of Fiji. These NCOs would be attached to the FMF Battalions to raise anti-malarial squads. The decision came after seeing Captain Ratu Dovi and his 1 Battalion arriving in the Solomons unprepared for malaria. Anti-malaria pamphlets and circular information were shared with the FMF Headquarters too. In addition, a hygiene officer was also sent from the 2NZEF in New Caledonia to be attached to the FMF Headquarters.[651]

However, New Zealand's medical support for the FMF withdrew with the 2NZEF in 1944. This caused a problem with dental care, which Fiji relied on the New Zealand Dental Corps. Royal New Zealand Air Force remained in Fiji but did not fully assume dental responsibilities. In July 1944, they declared that only New Zealanders and 'full Europeans in the FMF who show evidence of having received from the Dental Detachment the same treatment as the NZEF' would be offered treatment.[652] The decision to treat 'all but the purely European' was delivered to Fiji without any prior discussion. Having one government dentist in the country, Fiji suddenly had to start the dental examination, treatment, and maintenance of all mixed-race and indigenous troops of the FMF. What was more regretted was that the government dentist, Ratu Vosailagi, was just beginning to develop dentistry in Fiji. He was fully occupied in clinics and teaching students at the CWM Hospital. Having his clinical work and education interrupted was a 'blow to the dental work of Government.'[653]

[651] Assistant Director of Medical Services, Report on Fiji Military Forces, 18 May 1943, ADQZ 18908 K1/2 R25843840, ANZ.
[652] From D. L. Sinclair to Dr McGusty, 13 July 1944, F8/101 Part.1, NAF.
[653] From the Director of Medical Services to the Colonial Secretary, 18 July 1944, F8/101 Part.1, NAF.

Instead of viewing the dental care of soldiers as an essential service in the military, New Zealand presented it as a beneficent act. New Zealand Army Headquarters argued that 'the service rendered by the NZDC over the last 3 years amongst the Native and European members of the FMF has been considerable and will have a far-reaching effect not only upon their dental but also their general health since at the moment, for the first time in their lives, they are free from dental caries.' Pointing out that dental equipment and facilities were left in Fiji, they argued it was manageable for the government dentist. New Zealand was planning to despatch the NZDC to the UK for work at prisoners of war repatriation camps which meant that no dentist could be left in Fiji.[654] Eventually, the government dentist could not handle military work while working part-time. Dental patients were sent to few existing private practitioners in Fiji.[655]

In addition to New Zealand, the FMF worked with the US military stationed in Fiji. For example, the 18 General Hospital of the US was established there as an affiliated unit of the Johns Hopkins Hospital. From August 1942, it occupied the grounds of Queen Victoria School. Medical staff attached to the hospital, originally Johns Hopkins Hospital staff, frequently visited the CWM Hospital and offered consultation to Fiji medical authorities. In return, the CWM Hospital offered the 18 General Hospital staff opportunities to investigate yaws treatment and trachoma in the CWM Hospital dispensaries and wards. Students at the CMS were given chances to conduct ward rounds with Johns Hopkins doctors.[656] In May 1943, it was decided that battle casualties among indigenous personnel would be treated in US General Hospitals. The arrangement did not include sickness acquired outside battle situations,

[654] From Administrative Headquarters, Fiji Military Forces to the Director of Medical Services, 31 August 1944, F8/101 Part.1, NAF.
[655] Financial Secretary, Note: Dental Treatment-FMF Personnel, 11 October 1944, F8/101 Part.1, NAF.
[656] R. Carchichael Tilghman, *L.O.D.- Yes: An Odyssey of the Army's 18th General Hospital* (Baltimore: The Johns Hopkins Alumni Association, 1948), D807. F5T5, NAF.

such as malaria, which the CWM Hospital would continue to be in charge of.[657] The US still offered help when the FMF needed extra beds.[658] For example, to relieve the burden on the CWM Hospital taking care of troops returning from overseas, the US hospitals started to admit malaria cases. By the end of February 1944, the hospitalisation of Fijians was split between the CWM Hospital and the 142 General Hospital of the US.[659] Finally, as the US forces advanced north, the 18 General Hospital was handed over to the FMF in October 1944 and was run as an addition to the CWM Hospital.[660]

Tensions with the CWM Hospital reflect further frictions in the centralisation of medical services during wartime. In August 1943, the CWM Hospital complained that military vehicles frequently obstruct the free flow of traffic at the hospital entrance, which is essential for emergency patients. At this complaint, the FMF published an order asking all military vehicles visiting the CWM Hospital to move away from its entrance immediately after unloading out-patient personnel.[661] A second complaint was made by the CWM Hospital in December 1943 for visiting troops displaying 'particularly bad' behaviour at the hospital. Another order was published warning the soldiers to behave well. Otherwise, the Commandant of FMF had no other option than to take further action.[662] Finally, the FMF personnel was banned from the CWM Hospital in June 1944. Hospital authorities reported that members of the 4 Battalion and other 'Guerrillas' have torn down barbed wire and insulted a Native Nurse.

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[657] Memorandum for the Force Surgeon, Headquarters, U.S. Army Forces in Fiji, 14 February 1944, ADQZ 18899 8/1/1 R20591372, ANZ.
[658] Memorandum for D.M.S., Colonial Medical Service, 8 February 1944, ADQZ 18899 8/1/1 R20591372, ANZ.
[659] Memorandum for D.M.S., Colonial Medical Services, 26 February 1944, ADQZ 18899 8/1/1 R20591372, ANZ.
[660] Record of a Meeting Held in the Colonial Secretary's Office on 2 October to Consider Arrangements in Connection with the Taking Over of the Nasinu Hospital, ADQZ 18899 8/1/1 R20591372, ANZ.
[661] 1 Bearer Company FMC, Routine Order No.19, 4 August 1943, ADQZ 18886 DAZ491.1/1/VIII R26222664, ANZ.
[662] 1 Bearer Company FMC, Routine Order No.28, 14 December 1943, ADQZ 18886 DAZ491.1/1/VIII R26222664, ANZ.

The reason that troops acted out was not specified in the primary sources. However, gendered violence against indigenous nurses can be repeatedly found in the history of the CMS and the FMF. From this point, the CWM Hospital was designated out of bounds to all other-ranked personnel and loitering on the roads near the hospital was prohibited.[663] Patients requiring medical attention were still treated at the CWM Hospital. As such, medical arrangements for the FMF were made as a result of military centralisation and negotiations between Fiji, New Zealand, and the US.

The Work of 1 Bearer Company

While officers of the Fiji Medical Corps were mostly Europeans except for Ratu Dovi, 1 Bearer Company added a multi-ethnic dimension to the institution. 1 Bearer Company was established in December 1942 and was commanded by New Zealanders and staffed with and Fijians. The Company started small with three officers, one private, and five other ranks who came from New Zealand. In a couple of weeks, 27 Rotumans and 17 Fijians arrived to form the core of the Company.[664] 1 Bearer Company expanded in June 1943 when one Sergeant and 27 recruits arrived from Rotuma. By this time, the unit strength reached 77 in total consisting of 50 Rotumans, 19 Fijians, two officers and six other ranked New Zealanders.[665]

Additional recruits from Rotuma arrived just in time for a major dengue outbreak in Fiji. The nursing of dengue patients in June 1943 was the first medical work of 1 Bearer

[663] 1 Bearer Company FMC, Routine Order No.6/44, 7 September 1944, ADQZ 18886 DAZ491.1/1/XXI R26222665, ANZ.
[664] The war diary of 1 Bearer Company recorded 2 Lieutenant James Gardner's death on 23:15pm, 30 January 1943. Howlett's *History of the Fiji Military Forces, 1939–1945* writes that Lieutenant T. Gardner was fatally injured the next day of the accident; War Diary, December 1942–January 1943, ADQZ 18886 DAZ491.1/1/I R26222660, ANZ.
[665] War Diary, June 1943, ADQZ 18886 DAZ491.1/1/VI R26222664, ANZ.

Company. To treat the patients, a Unit Emergency Hospital was established using a newly erected marquee. Starting with one patient on the first day of operation, ten dengue cases were admitted to the Unit Emergency Hospital in the same month. Patients came from all types of units, including the 1 Indian Battalion and the Administrative Headquarters.[666] The Unit Emergency Hospital remained open for the treatment of excess patients that could not be admitted to larger hospitals. The hospital proved particularly useful for another mosquito-borne disease, malaria. When the FMF troops started to return from the Solomons in February 1944, malaria cases from the 1 Commando Fiji Guerrilla occupied the hospital beds to the full extent.[667] The hospital had to be reconstructed after storm damage in March 1944.[668]

Although 1 Bearer Company was under the Fiji Medical Corps of the FMF, it was accommodated in the Fiji Section of 2NZEF adjoining the Nasese camp.[669] This arrangement may have been made because there were only New Zealand personnel when it was founded in December 1942. Equipment and ambulance cars for 1 Bearer Company were also sourced from New Zealand.[670] The camp moved from Nasese to Kasavu in September 1943.[671] It moved again to Tamavua in January.[672] In October 1944, the Company took over the 18 General Hospital of the US and renamed it Nasinu Hospital. Accordingly, 1 Bearer Company moved its base to the Nasinu Hospital with its staff, patients, vehicles, and equipment.[673]

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[666] 1 Bearer Company FMC, Routine Order No.15, 7 July 1943, ADQZ 18886 DAZ491.1/1/VII R26222664, ANZ.

[667] Howlett's *History of the Fiji Military Forces, 1939–1945* states that the 1 Bearer Company received first malaria cases of the returned 1 Battalion from January. War Diary records show that it was full of malaria cases of 1 CFG from February onwards with no mention of 1 Battalion; War Diary, February 1944, ADQZ 18886 DAZ491.1/1/XIV R26222664, ANZ.

[668] War Diary, March 1944, ADQZ 18886 DAZ491.1/1/XV R26222664, ANZ.

[669] War Diary, December 1942–January 1943, ADQZ 18886 DAZ491.1/1/I R26222660, ANZ.

[670] Assistant Director of Medical Services, Report on Fiji Military Forces, 18 May 1943, ADQZ 18908 K1/2 R25843840, ANZ.

[671] War Diary, September 1943, ADQZ 18886 DAZ491.1/1/IX R26222664, ANZ

[672] War Diary, January 1944, ADQZ 18886 DAZ491.1/1/XIII R26222664, ANZ

[673] War Diary, October 1944, ADQZ 18886 DAZ491.1/1/XXII R26222665, ANZ.

1 Bearer Company did not just treat troops returning from overseas but went overseas themselves. In March 1944, Sergeant J. E. Rigamoto and thirteen other ranks marched out to join US troops in the Bougainville campaign.[674] In June, Lieutenant A. R. Hines, Staff Sergeant Elliott and 28 other ranks left for special duties at 4 General Hospital of 2NZEF in New Caledonia.[675] Both groups returned to Fiji in August after months of overseas service. Particularly, the Bougainville group returned with valuable experience. According to Rigamoto, the bearers did not serve the roles the FMF initially envisioned for them in the American-led environment. They spent six weeks on camp construction, followed by a period dedicated to small arms training. The training bearers received in Fiji did not satisfy American commanders in Bougainville because they lacked training in combat and patrol duties. After five months, the group returned with men experienced in handling many different types of casualties in the forward area.[676] The US also trained them in plasma transfusion, which the FMF argued was useful yet less efficient than blood transfusion technology used by the British Army.[677]

After the experience from overseas, there were some notable changes in 1 Bearer Company training. First, training became more comprehensive and organised. In place of 'routine training' or having no record of training at all, details on actual training content started to appear in war diaries.[678] These war diaries from September 1944 were compiled by Lieutenant Hines, who had recently returned from New Caledonia. Secondly, small arms training and mosquito control first started to take place in September. For example, training in the month of September included rifle instruction, rifle drill, stretcher drill, respirator drill, hygiene lecture, jungle bivouac lecture, nursing lecture, circulatory system lecture, route march,

[674] War Diary, March 1944, ADQZ 18886 DAZ491.1/1/XV R26222664, ANZ.
[675] War Diary, June 1944, ADQZ 18886 DAZ491.1/1/XVIII R26222664, ANZ.
[676] War Diary, August 1944, ADQZ 18886 DAZ491.1/1/XX R26222665, ANZ.
[677] Harrison, *Medicine and Victory*, 276.
[678] War Diary, August 1944, ADQZ 18886 DAZ491.1/1/XX R26222665, ANZ.

bandaging and roller bandaging, splinting, ambulance loading, shock treatment, fractures treatment, wound dressing, and first field dressing.[679] For evacuation training, a hammock-type sack stretcher was found useful to move casualties from the bush, as seen in the Solomons.[680]



Figure 6. A Fijian medical orderly is administering an emergency plasma transfusion in Bougainville. [Source: British Medical Services in the Second World War, IWM NZ 1445, Imperial War Museum].

Besides routine training, 1 Bearer Company regularly held field exercises to practice prompt evacuation in the natural environment of the tropics. The bearers reportedly showed 'great aptitude for improvisation' in difficult country environments.[681] Field exercises became

[679] War Diary, September 1944, ADQZ 18886 DAZ491.1/1/XXI R26222665, ANZ.
[680] War Diary, January 1945, ADQZ 18886 DAZ491.1/1/XXV R26222666, ANZ.
[681] *Ibid.*

longer and more complex over time. Early in 1943, two-day field exercises were organised weekly in groups smaller than 30.[682] By the end of 1943, exercise groups grew to approximately 40 people.[683] In 1944, there was a five-day exercise and a ten-day exercise held with other combat units.[684] Such exercises focused on carrying out tasks 'over heavy bush country.'[685]

During the last few months of the war, routine training and camp maintenance took up most of the work. Once victory over Japan was confirmed, the Victory Ceremonial Parade was held in Albert Park of Suva, where 1 Bearer Company was responsible for the evacuation of casualties.[686] Plans for demobilisation began in September 1945 and the camp prepared for closure. One of their last medical duties to care for 32 indigenous personnel at Nasinu Hospital following an influenza outbreak from Samabula camp. Later in September, NZEF personnel departed for New Zealand. Final dental treatment was given for the indigenous members of 1 Bearer Company before discharge.[687] According to available documents, a total of 2,131 patients were carried by the unit ambulances between March and September 1945. On average, 11–12 patients a day and 355.6 patients each month were carried by the unit ambulance.[688] The Brigade Headquarters declared the end of the existence of 1 Bearer Company on 22 October 1945.[689]

[682] Field Exercises, War Diary, June 1943, ADQZ 18886 DAZ491.1/1/VI R26222664, ANZ.
[683] Field Exercises, War Diary, November 1943, ADQZ 18886 DAZ491.1/1/XI R26222664, ANZ.
[684] War Diary, April–May 1944, ADQZ 18886 DAZ491.1/1/XVI–XVII R26222664, ANZ.
[685] War Diary, February 1944, ADQZ 18886 DAZ491.1/1/XIV R26222664, ANZ.
[686] War Diary, August 1945, ADQZ 18886 DAZ491.1/1/XXXII, R26222667 ANZ.
[687] War Diary, September 1945, ADQZ 18886 DAZ491.1/1/XXXIII R26222668, ANZ.
[688] War Diary, March–September 1945, ADQZ 18886 DAZ491.1/1/XXVII–XXXIII R26222666–R26222668, ANZ.
[689] War Diary, October 1945, ADQZ 18886 DAZ491.1/1/XXXIV R26222669, ANZ.

Ambiguous Status of Fijians and Hospitals

Local conditions in Fiji did not always fit into the New Zealand system. 2NZEF tried to have the FMF follow New Zealand policies even if they varied with existing conventions. A representative example is changing Fijian names. In 1943, when the FMF and 2NZEF were more closely integrated, all units of the FMF were ordered to write the name of Fijian personnel in their Christian names (if they had one).[690] Many indigenous names, therefore, changed to the Fijian version of European names, such as Jimi, Nataniela, Alfreto, Vitori, or Solomone.[691] Similarly, the status of indigenous medical personnel and military hospitals turned out to be ambiguous in the New Zealand-led FMF in at least three areas: the rank of licensed NMPs, the inclusion of dismissed NMPs and medical students, and the status of Fiji's military hospitals.

Firstly, NMPs could not find a rank in the military that suited their status in the civil medical service. The NMP system produced doctors in the Pacific Islands but not 'full' doctors in the eyes of white Europeans. According to McGusty, NMPs were 'glorified dressers' despite the title of medical practitioners before the establishment of the CMS. Significantly, the four-year curriculum at the CMS raised the standards of NMP qualifications. In a conference held between doctors in Fiji, it was unanimously agreed that NMPs, by the time of the Second World War, were 'rateable as qualified doctors within areas in which they are permitted to practice.' NMPs could even teach the St. John Ambulance Brigade Overseas movement, where none but fully qualified doctors could lecture. However, an NMP was not allowed to be commissioned as an MO. Fiji considered this problematic because NMPs were not only regarded as doctors, but many also came from chiefly backgrounds in Fiji. Considering that the FMF commissioned

[690] 1 Bearer Company FMC, Routine Order No.21, 26 August 1943, ADQZ 18886 DAZ 491.1/1/VIII R26222664, ANZ.

[691] 1 Bearer Company FMC, Routine Order No.23, 13 September 1943, ADQZ 18886 DAZ491.1/1/IX R26222664, ANZ.

those from lower social status than average NMPs and the consensus among full doctors, McGusty proposed a commission of NMPs in June 1943. For differentiation from the European doctors, they could be commissioned as Second Lieutenants.[692]

In fact, the drive to promote NMP status in the military originated from the NMPs themselves. One of the most senior and chiefly NMPs, Savenaca Veikoso, decided to volunteer for military service. Sensing that there was something more than a patriotic desire, McGusty learned that it was an act of protest against the status of NMPs within the Army. With his seniority as an NMP and chiefly status in the Fijian society, he expected that receiving an NCO rank would quickly raise a debate about the status of NMPs in the FMF. McGusty's proposal to commission NMPs was made because he sympathised with Savenaca Veikoso and other NMPs.[693]

The proposal was rejected by the Commandant of the FMF, Brigadier Wales of 2NZEF, on the grounds that it would be 'unsound and wrong.' In his opinion, the CMS was incompetent to train fully qualified physicians or surgeons. If anyone was fully qualified, like Ratu Dovi, a graduate of the University of Otago, a commission would be granted. NMPs, he emphasised, 'cannot put up their plates as fully qualified medical men.'[694] He had previously acknowledged that the NMPs were well-trained graduates of the CMS whose work has been 'outstandingly good', better than the newly or partly trained medical orderlies with the British or New Zealand units.[695] While NMPs were indeed better trained to provide medical care than newly recruited orderlies, they were still not fully qualified doctors.

[692] From the Director of Medical Services to the Colonial Secretary, 12 June 1943, F8/178, NAF.
[693] From the Director of Medical Services to the Colonial Secretary, 12 June 1943, F8/178, NAF.
[694] From the Commandant, Fiji Military Forces to the Colonial Secretary, 21 June 1943, F8/178, NAF.
[695] Memorandum for the Colonial Secretary, 5 October 1942, F8/101 Part.1, NAF.

Not all NMPs were praised for their performance. The reports of the Assistant Director of Medical Services (ADMS) of the 2NZEF in Pacific in May 1943 shows a critical view. The ADMS pointed out that the admission rate of New Zealand officers to hospitals was 100–200% higher where there was an NMP instead of an MO. He wrote, 'I am convinced from my own experience with the 1st Fiji Battalion in Guadalcanal that an NMP is very rarely capable of taking medical charge of a Battalion.' He further suggested that NMPs were unsuitable as medical officers, although needed as interpreters and dressers.[696] In another document on Tonga Defence Force, written on the same day by the same person, the ADMS called a Lieutenant named Alo 'a brilliant NMP and a most intelligent officer.'[697] This means in the Tonga Defence Force, which was also under New Zealand command, an NMP was commissioned as a Lieutenant. The reason for commission and Alo's full name and background are not mentioned in the document. Based on the given information and medical circumstances in Tonga at the time, it is most likely that he was NMP Alokihakau Eva, who graduated from the CMS in 1934.[698]

In a second attempt to commission NMPs, McGusty started to reframe NMPs as 'doctors.' He argued, 'if a doctor was recruited for the Army Medical Service he was immediately given commissioned rank.' Then, he sarcastically criticised New Zealand's decision that 'apparently this practice has changed, and even a doctor entering the Army as a doctor does so with the rank of private.' McGusty also negotiated the terms again by adding a condition that NMPs could be commissioned as First Lieutenant at the highest rank.[699]

[696] Assistant Director Medical Services, Report on Fiji Military Forces, 18 May 1943, ADQZ 18908 K1/2 R25843840, ANZ.
[697] ADMS, Report on Tonga Defence Force, 18 May 1943, ADQZ 18908 K1/2 R25843840, ANZ.
[698] *History and Graduates of the Medical School known as Suva Medical School, 1888–1827, Central Medical School, 1928–1960, Fiji School of Medicine, 1961–present* (Suva:1979)
[699] From the Director of Medical Services to the Colonial Secretary, 15 July 1943, F8/178, NAF.

McGusty's effort seemed unsuccessful when the request was made. However, two NMP names can be located in the Nominal Roll of the officers of the FMF who served in the Fiji Medical Corps as Lieutenants.[700]

Secondly, the use of dismissed NMPs and medical students and their subsequent reemployment in Fiji reflected the ambiguity of being an NMP in the military. NMPs in the military were not all "real" NMPs. Due to the shortage of medical staff, the military hired dismissed NMPs and medical students as non-commissioned officers. Dismissed NMPs were called NMPs in the military despite their certificates being cancelled. Dismissed medical students were also called NMPs and were given the work other NMPs did in the military. The problem was that they did not have an NMP certificate issued by the Medical Services of Fiji. Officially authorised NMPs with decades of professional experience and expelled students were all given the same NMP status in the military. If being an NMP could not represent a standardised level of professionalism, the starkly different remarks made by the New Zealand commanders are understandable in some respects. Despite the objection of the Medical Services of Fiji, the FMF insisted on using dismissed personnel as NMPs due to staff shortage while not commissioning NMPs as MOs.

Thanks to the FDF hiring dismissed personnel as NMPs, some of them could restore their status as recognition for war service. The first case was an Indian Medical Practitioner, Manzoor Beg. Beg got his IMP certificate cancelled in 1941 for a conviction of crime not detailed in the document.[701] In recognition of his work in the military that was 'of a value which it would be hard to exaggerate,' his certificate was restored with entitlement to rations

[700] The Nominal Roll of the FMF shows that L. Volavola and J. Daunibau were Lieutenants of regular service in the Fiji Medical Corps who served overseas during the war. They are presumably Livai Volavola and Isikeli Daunibau, graduates of the CMS in year 1933 and 1938 each. Isikeli was the only Fijian NMP in 1945 that had the surname of Daunibau.; Howlett, *The History of the Fiji Military Forces, 1939–1945*, 163.

[701] From P. A, Snow to the Director of Medical Services, 13 February 1945, F29/659, NAF.

and quarters at the Nasinu Hospital.[702] His name can also be found in the Honours and Awards of the FMF list under the 'Mention in Despatches' section.[703]

After Manzoor Beg's case, concerns grew for other dismissed NMPs who 'would suffer acute humiliation and dismay at the recognition of one alone where the service of all has been so great.' Sekove Ravoka and Lakepa Buadromo were recommended for serving a far longer time under more onerous conditions.[704] Sekove Rovoka was dismissed in 1935 for a 'lapse' that was not detailed in the reports. Lakepa Buadromo was dismissed in 1933 for being an 'incorrigible yaqona drinker.' Both joined the FMF earlier in the war when there the medical section was basically the SMO. No unit had an MO when they joined. Their 'ungrudging service and loyalty' was highly praised.[705] But confidential letters written by commanding officers were critical. Both only worked when they were specifically told to work on a particular task. Lakepa Buadromo was free of addiction when he was recommended, but Sekove Rovoka was reported fond of liquor. Yaqona addiction did not prevent them from being NMPs in the FMF. However, the Governor of Fiji did not approve the restoration of their certificates.[706]

Dismissed medical students also worked in the FMF. This was considered particularly detrimental, objectionable, demoralising, and subversive to the discipline of regular NMPs and medical students. In the case of dismissed student Toamanang working at the CWM Hospital, the CMS Advisory Board requested the military to terminate the practice of employing dismissed medical students. His dismissal was after 'a very serious offence of

[702] Dismissed NMPs, Re-employment, DMS to Hon: C.S., 8 January 1945, F29/659, NAF.
[703] Howlett, *The History of the Fiji Military Forces, 1939–1945*, 155.
[704] NMPs-Dismissed, DMS to Hon: C.S., 26 February 1945, F29/659, NAF.
[705] Sekove Ravoka, 26 February 1945, F29 659, NAF; Lakeba Buadromo, 26 February 1945, F29/659, NAF.
[706] Confidential Reports on Sekove Ravoka and Lakepa Buadromo, Former Civil Native Medical Practitioners, 5 April 1945, F29/659, NAF.

cheating in examinations.'[707] The FMF argued that dismissed NMPs or students were the only source of staff with medical experience. To manage thousands of patients at the CWM Hospital, the existing staff of four NMPs was not enough. Moreover, Toamanang apparently has 'saved an impossible situation' with his remarkable ability as a records clerk. The FMF commanders were only willing to let go of him if an NMP of proven clerical ability replaced his position.[708] After an additional appeal from the CWM Hospital and McGusty, he was finally replaced.[709]

Like the dismissed NMPs, restoration of studentship was discussed for three dismissed students. Uraia Naqasima, Tevita Fotu, and Lasiasa Naigulevu were recommended for readmission to the CMS on the grounds of meritorious service with the FMF in both Fiji and overseas. Three students were dismissed together in 1939 for repeated 'intoxication and invasion of the Native Nurses hostel' even after severe reprimand and warning. Uraia Naqasima and Tevita Fotu were nearly finishing their final year, and Laisiasa Naigulevu was in his third year. Unlike the case of reemploying NMPs, the background of students was noted in assessing the possibilities for readmission. Uraia Naqasima's uncle was a Native Magistrate, and his brother was killed in action. Tevita Fotu and Laisiasa Naigulevu were both sons of very senior and highly respected NMPs, each in Grade I and Special Grade, the highest rank in government service.[710]

The dismissed students were strongly recommended by the ADMS of FMF, Lieutenant-Colonel D. L. Sinclair of NZMC, from as early as 1942. His confidential report on their service details their service in the military. Uraia Naqasima was attested on 10 July 1940, promoted to Corporal in October 1940, and was a Sergeant-major when he was discharged

[707] From the Director of Medical Services to the Colonial Secretary, 29 December 1942, F29/659, NAF.
[708] From the Administrative Headquarters, Fiji Military Forces to the Colonial Secretary, 11 January 1943, F26/659, NAF.
[709] From J. P. Magrane to K. V. Macquire, 13 February 1943, F26/659, NAF.
[710] Dismissed Students, DMS to Hon: C.S., 2 November 1945, F29/659, NAF.

from the military in January 1945. He was 'the first NMP' (without an NMP certificate) who went overseas to the Solomons with the Commandos. During his overseas service, he reportedly brought back interesting and valuable information on bush conditions. He worked as an NMP at the Colonial Barracks and was also the liaison Non-commissioned Officer at the CWM Hospital. In four and a half years, he had no charges except for a reprimand for not wearing his rank. Sinclair described Uraia Naqasima as 'popular, reliable, cheerful, steady, likeable, and very dependable.'[711]

Tevita Fotu enlisted in July 1940, was promoted to Corporal in October 1940, became Staff-Sergeant in February 1942, and Sergeant-Major in August 1942. He was recommended for promotion to Warrant Officer 1 by three successive SMOs, but it was refused for his lack of an NMP qualification by Ratu Sir Lala Sukuna, the highest-ranking indigenous Fijian in the FMF. His overseas service lasted from September 1943 to August 1944 and was reportedly excellent at the Forward Base. There was one charge in his records in August 1940 for breaking out of the barracks. The ADMS depicted his character as 'emotionally unstable but likeable and popular.' His 'clinical notes are clear and detailed', and he showed 'remarkable powers of accurate observation.'[712]

Laisiasa Naigulevu had more medical experience than the other two before joining the military. He had three years of education at the CMS, one year of working at an aid post at gold mines, and ten months at the pathological department of the CWM Hospital as a clerk. He was promoted to Corporal in June 1942 and became temporary Staff Sergeant in April 1944. He was the last among the three to leave for overseas service with the 3 Battalion, Fiji Infant

[711] D. L. Sinclair to Medical Headquarters, F.M.F, Uraia Naqasima, 5 October 1945, F29/659, NAF.
[712] D. L. Sinclair to Medical Headquarters, F.M.F, Tevita Fotu, 5 October 1945, F29/659, NAF.

Regiment from May 1944 to September 1944. Although he 'has not a strong personality,' the ADMS reported that his conduct sheet was clear. He was well-liked, capable, and reliable.[713]

The readmission of these students was debated at the CMS Advisory Board meeting, where highly respected Ratu Sir Lala Sukuna was present. The students were dismissed for gross misconduct, after given a first warning for entering Native Nurses' Quarters in September 1939. When a second offence of the same nature happened in the following month, they were dismissed. After discussion, the finalists, Uraia Naqasima and Tevita Fotu were allowed to sit for their final exams in view of their war service. However, Laisiasa Naigulevu's readmission was rejected. As a third-year, he had a year and a half of clinical training left. More importantly, he was dismissed from his temporary appointment as a clerk at the CWM Hospital in1942 for entering the Native Nurses' Quarters again. It was his third offence.[714] As a borderline case, the decision was made on the assumption that 'he was not likely to develop into a good NMP.'[715]

Finally, the question of drawing red cross marks on hospitals reflected the subordinate status of Fiji's military hospitals. They were military hospitals but not "full" military hospitals. At the beginning of the war, the main hospitals in Suva and an Indian Poor House were marked with a red cross at the start of the war. Hospitals in smaller cities such as Lautoka, Nadi, and Labasa were not given any directions concerning the use of the red cross. As the US joined the war in December 1941, the Director of Medical Services advised hospitals at risk of air raids, notably Lautoka Hospital and Nadi Hospital, that marking the red cross would be advisable.[716] One month later, military authorities directed that red crosses be

[713] D. L. Sinclair to Medical Headquarters, F.M.F, Laisiasa Naigulevu, 5 October 1945, F29/659, NAF.
[714] Minute of Proceedings of a Meeting of the Central Medical School Advisory Board, 10 January 1946, F29/659, NAF.
[715] A. C. S. to C. S., 28 January 1946, F29/659, NAF.
[716] From the Director of Medical Services to the Colonial Secretary, 24 December 1941, F115/68, NAF.

marked solely on military hospitals since the red cross could call attention and put civilian hospitals in danger.[717] According to the Geneva Convention, the Red Cross Emblem was authorised to mark military hospitals and military medical establishments. Since no civil hospital in the UK had the sign, the same applied to Fiji.[718] Display of the red cross on civil hospitals could also let the enemy justify their disregard for the red cross on military hospitals.[719] This was the case with Germany on the Western Front earlier in the war. The Japanese in Southeast Asia later showed the same disregard for the Geneva Convention.[720]

The problem was that Fiji displayed a red cross on its military hospitals, the CWM Hospital and the Lautoka Hospital, where civilians were also treated. Red cross flags were only displayed on the sections where they treated military patients. Other sections, including nurses' quarters, administrative departments, and official residences did not carry a red cross.[721] After a few months, the military withdrew the permission of a red cross on CWM and Lautoka Hospital because it breached the Geneva Convention. To the New Zealand authorities, these hospitals were not 'military hospitals' because they received both civilian and military patients.[722] Fiji responded with sarcasm. McGusty argued that if the two hospitals are not going to be 'military hospitals' anymore for also treating civilians, the hospitals should stop receiving military personnel. He did not know how alternative hospitalisation for military casualties could be arranged.[723]

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[717] From the Colonial Secretary to the Director of the Medical Services, 10 January 1942, F115/68, NAF.
[718] From the Secretary of State to the Governor, 20 February 1942, F115/68, NAF.
[719] From the Director of Medical Services to All Medical Officers and Other Persons in Charge of Hospitals, 12 January 1942, F115/68, NAF.
[720] Harrison, *Medicine and Victory*, 40, 187.
[721] From the Director of Medical Services to All Medical Officers and Other Persons in Charge of Hospitals, 12 January 1942, F115/68, NAF.
[722] From the Colonial Secretary to the Director of Medical Services, 18 May 1942, F115/68, NAF.
[723] From the Director of Medical Services to the Colonial Secretary, 6 May 1942, F115/68, NAF.

McGusty wanted to protect Fiji's military hospitals. At the same time, Fiji did not have any hospital entirely dedicated to military purposes. Such an arrangement was a result of an agreement between Fiji and New Zealand when the hospitalisation plan was devised. The Attorney General insisted that 'only purely military establishments were "protected" under the Geneva Convention.'[724] McGusty protested against this order and kept the red cross on the CWM Hospital for several more months. It was there for so long that the Governor of Fiji repeatedly requested the removal of the red cross after inspecting the CWM Hospital himself.[725] Still thinking that the military hospitals of Fiji should be eligible for a red cross, McGusty did not agree. He instead took a different strategy and requested that the issue be raised with the Secretary of State, explaining the vulnerability of hospitals in Fiji. In his perspective, the CWM hospital was such a prominent feature in the landscape, which resembled either barracks or factories. It risked becoming a target in the event of an air raid.[726] However, New Zealand authorities claimed that they never agreed to the use of the red cross on the CWM Hospital. McGusty was unable to take this issue any further and Fiji's hospitals could not use the red cross.

The NMPs were commonly accepted as doctors in the Pacific Islands but were not recognised as doctors in the FMF. Dismissed NMPs and medical students were not "real" NMPs but became NMPs in the FMF. Fiji's hospitals were military hospitals but could not enjoy the same level of protection as the military hospitals of New Zealand. These cases show that New Zealand commanders, in imposing New Zealand ways of operating the military, did not have much consideration for Fiji-specific conditions.

[724] From the Colonial Secretary to the Director of Medical Services, 6 June 1942, F115/68, NAF.
[725] From the Medical Officer in Charge, Colonial War Memorial Hospital to the Director of Medical Services, 27 July 1942, F115/68, NAF.
[726] From V. W. T. McGusty to A. T. Newboult, 27 October1942, F115/68, NAF.

Conclusion

Mark Harrison argued that the success of medical arrangements in the Second World War depended to a considerable extent on the 'medical consciousness' of commanders.[727] The FMF was unsuccessful in that sense. New Zealand commanders were reluctant to give more medical support unless it directly concerned the welfare of New Zealanders. Fiji, although it was a smaller and weaker country, argued with New Zealand commanders to obtain as much as they could for their military.

Fiji was not in a leading position. But this chapter has shown that medical centralisation clearly took place in the military sphere. Under this centralised system, Fiji continuously sought ways to make the most of its participation in the war. Materially, Fiji acquired medical equipment that New Zealand and the US left behind, including hospital buildings. A representative case is the Tamavua Hospital of 2NZEF, which became the 71 Station Hospital and then the 142 General Hospital of the US.[728] This still exists today as the P J Twomey Hospital.[729] In terms of human resources, Fiji obtained men trained as medical orderlies through 1 Bearer Company and the Fiji Medical Corps. A large proportion of them were from and returned to Rotuma, a Fijian dependency that had a small medical staff.

Fijians gained the experience of having thousands of New Zealanders and Americans stationed in Viti Levu and fighting together overseas. Through the military, more indigenous Fijians, Indians, and Rotumans gained experience in medical work. The cases of negotiating the terms of employment show that MOs, NMPs, and dismissed personnel took action by demanding of New Zealand the ranks they wanted with the support of McGusty. Asesela

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[727] Harrison, *Medicine and Victory*, 275–283.
[728] Allison Young, 'World War II Archaeology in Fiji: Assessing the Material Record', *Nebraska Anthropologist*, 27 (2012), 89.
[729] https://fijisun.com.fj/2011/10/31/hospital-celebrates-100-years-of-care/

Ravuvu argues that this multi-racial environment in the battle front led Fijians to think that they were the equal of white men. In this sense, the war was an experience of building their skills and confidence towards decolonisation. Yet, because the wartime experience strengthened ties with Britain, Fiji remained in the British Empire despite some demands for independence.[730] The war revealed that the racial framework in which ability was determined was quite flexible and that indigenous personnel found ways to develop their careers in the military.

[730] Ravuvu, *Fijians at War*, 58.

Chapter 5. The Second New Zealand Expeditionary Force in the Pacific

The Second World War necessitated the development of a centralised medical system between the Allied forces in the Pacific theatre. New Zealand experienced wartime medical centralisation in two ways. The first of these was through the FMF, over which New Zealand had control. Its status as a dominion in the British Empire and its historical ties with Fiji, made it natural for New Zealand to assume administrative responsibility for Fiji during the war. In turn, New Zealand would benefit from training in Fiji's tropical environment with Fijian troops. By the Solomon Islands campaign, New Zealand's military was better adapted to jungle conditions in the forward area compared to the Americans.[731] Secondly, for tactical reasons, New Zealand adopted medical practices, protocols, and procedures from the US. As a rule, Allied personnel were 'to be treated in any hospital irrespective of Nationality.' Therefore, the reasoning was that adopting the same medical protocol would increase efficiency in treating the US personnel in New Zealand facilities or having New Zealanders cared for by the US authorities. Moreover, a close association with the US would make it easier for New Zealand to source medical supplies from the US.[732] Due to a significant proportion of medical supplies coming from the US, it was easier to administer medical procedures according to US standards.

In order to examine how medical centralisation took place in the New Zealand military, this chapter will focus on New Zealand's cooperation with neighbouring countries and the US and its during the war. Numerous works have been written on the operational aspects of the war in the Pacific. There is also plenty of literature assessing the shift of hegemony in the Pacific (and the world), with a focus on the hard power of the US. However, there is little

[731] Bennett, *Natives and Exotics*, 15.
[732] Memorandum for Officer i/c Administration, FMF, 7 January 1944, ADQZ 18899 13/1/2 R20591379, ANZ.

research on New Zealand's military medicine during the Second World War, apart from official histories.[733] Although they make great references for factual information, official histories have limitations in offering analytical perspectives on historical backgrounds, social contexts, motivations of individuals, and the conditions in operationally less significant areas. General historical accounts or personal memoirs of the war sometimes touch upon medical provisions but do not treat it as the main topic.[734] Existing secondary literature on military medicine are not focused on the New Zealand forces.[735] It is even rarer to find research explaining how wartime medicine was affected by the changing dynamics of imperial and international relations.[736] By discussing in the ways in which New Zealand established medical ties with the US, Fiji, New Caledonia, and the Solomon Islands during the war, this chapter aims to elucidate the role of medical services within the historiographies of war and international relations in the Pacific.

New Zealand's military forces in the Second World War are known as the 2NZEF. In the early period before the US joined the war, New Zealand sent its forces to Fiji to defend the South Pacific and New Zealand. This force was initially a brigade group called the B Force, later named the 8 Infantry Brigade Group. In February 1942, the forces were given the title of Pacific Section 2NZEF, otherwise known as 2NZEF in the Pacific (NZEFIP). A few months

[733] Official histories are the most informative accounts on the medical organisation of New Zealand military. See: Stout, *Medical Services in New Zealand and the Pacific*; Stout, *War Surgery and Medicine*; Sale, *Shovel, Sword and Scalpel*.

[734] Newell's *Pacific Star* has a chapter describing health conditions of the 3NZ Division; Malcolm Foord's memoir shows some of his personal experience of illness in Tonga. See *The Fortunate Soldier: With the New Zealand Army on Tongatabu, 1943* (Dunedin: M. R. R. Foord, 1996); John Crawford (ed.) *Kia Kaha: New Zealand in the Second World War* (Oxford: Oxford University Press, 2000) is a collection of essays on New Zealand's general involvement in the war.

[735] Harrison's *Medicine and Victory* provides a good overview of the British military medicine; Bennett's *Natives and Exotics* concerns the US military; An American doctor's experiences in New Caledonia and New Hebrides can be read in Arthur G. King, *Vignettes of the South Pacific: The Lighter Side of World War II*, (Ohio: Kinko's Copy Center, 1991).

[736] John Armstrong argues how the Second World War was an internationalising experience to New Zealand doctors in his article 'The Common-Health' and Beyond: New Zealand Medical Specialists and the International Medical Network, 1945–85', *Health and History*, 14/1 (2012), 165–186.

later, this force in Fiji was renamed the Third Division (3NZ Division) to embark on the Solomon Islands campaign. With additional men to form a larger force, the majority of 3NZ Division moved the headquarters to New Caledonia in October 1942 where they stayed throughout the Solomon Islands campaign. Then, the forces left in Fiji were then known as the Fiji Section. For simplicity's sake, this chapter will address the 2NZEF forces in Fiji as the Fiji Section, the forces that went to the Solomons as 3NZ Division, and the commanding headquarters of the 2NZEF in New Caledonia as the NZEFIP.[737]

Medical Arrangements for the Fiji Section

New Zealand closely cooperated with Fiji in two main areas during the war: commanding the FMF and stationing the Fiji Section in Fiji. Fiji was a tropical training ground for New Zealand troops. Medical arrangements for the Fiji Section, therefore, show how New Zealand prepared for active warfare in tropical islands. Later, when the Fiji Section became the nucleus of 3NZ Division, experience gained in Fiji proved invaluable in the Solomon Islands campaign. As noted by the Deputy Director of Medical Services (DDMS) of New Zealand, Brigadier J. M. Twhigg, those who were attached to Fiji Section had already 'acclimatised to island conditions.'[738]

When the Fiji Section first arrived in Fiji, 7 Field Ambulance was the primary institution catering for the medical needs of New Zealanders. A Field Ambulance (FA) is a mobile unit that works relatively close to the battlefield, treating those injured in forward areas. Its work typical involved the re-dressing and cleaning of wounds, resuscitation and sometimes

[737] For the changing names of the New Zealand forces, see 'Note on Nomenclature' in Newall, *Pacific Star* and John Crawford, 'A Campaign on Two Fronts: Barrowclough in the Pacific' in Crawford (ed.) *Kia Kaha,* 140–162.
[738] Brigadier J. M. Twhigg, 'Foreword' in Sale, *Shovel, Sword and Scalpel*, 6.

minor operations. FAs also handled medical cases such as those suffering from disease. On embarkation, 7 FA's strength was at 281. This later became the Base Hospital in Tamavua, known as Tamavua Hospital, in August 1941 in Suva, serving the Eastern Area of Viti Levu. The second Base Hospital, Namaka Hospital, was established in May 1941 on the other side of Viti Levu Island to serve the Western Area around Nadi. Base hospitals are stationary medical units that received casualties from FAs and other forward units, as well as dealing with medical cases and injuries sustained around the base. They were capable of more complex surgery and often had specialist facilities. In addition to Tamavua and Namaka Hospitals, there was a Communicable Disease Hospital (CD Hospital), mainly treating venereal diseases.[739] The Fiji Section also had a temporary Convalescence Depot at Nukulau Island, which was reported to be 'a great boon and it is very popular.'[740] Average daily admissions between November 1940 to December 1941 to Tamavua Hospital ranged from 3.5 to 8.1, with most months showing 5–6 cases. For Namaka Hospital, it was between 1.4 to 3.3.[741]

The government of Fiji cooperated with the Fiji Section of 2NZEF in many ways. Primary support was provided by the CWM Hospital at the courtesy of the government of Fiji. According to New Zealand reports, McGusty, who was also the Acting Governor of Fiji for a while, wanted to 'rule out any idea of payment' for using the CWM Hospital. It was because McGusty realised that the 'Fijian Government is getting more than it is giving.'[742] Hospitalisation of troops was free and no payment records were found for using the Pathological Laboratory at the CWM Hospital. The laboratory analysed specimens that were

[739] Stout, *Medical Services in New Zealand and the Pacific*, 3–20.
[740] From C.O. 7th Field Ambulance N.Z.M.C. to the Director General of Medical Services, Army Headquarters, 6 March 1941, AAYS 8638 314/10/9 Part.1 R22438489, ANZ.
[741] Minute Sheet, Hospital Admissions-Pacific Force, 2 February 1942, AAYS 8638 314/10/9 Part.1 R22438489, ANZ.
[742] From C.O. 7th Field Ambulance N.Z.M.C. to the Director General of Medical Services, Army Headquarters, 6 March 1941, AAYS 8638 314/10/9 Part.1 R22438489, ANZ.

not processed at the Tamavua Hospital, including gastric analysis, faeces for organisms, faeces for worms, ovaries and cysts, and blood for Kahn tests, which were used to diagnose yaws and syphilis.[743] Yet some fees were charged throughout the war, such as using the CWM Hospital's laundry facilities. In September 1941, an average of 294 articles per day were washed at the CWM Hospital at the total cost of £33.12.2 per month.[744]

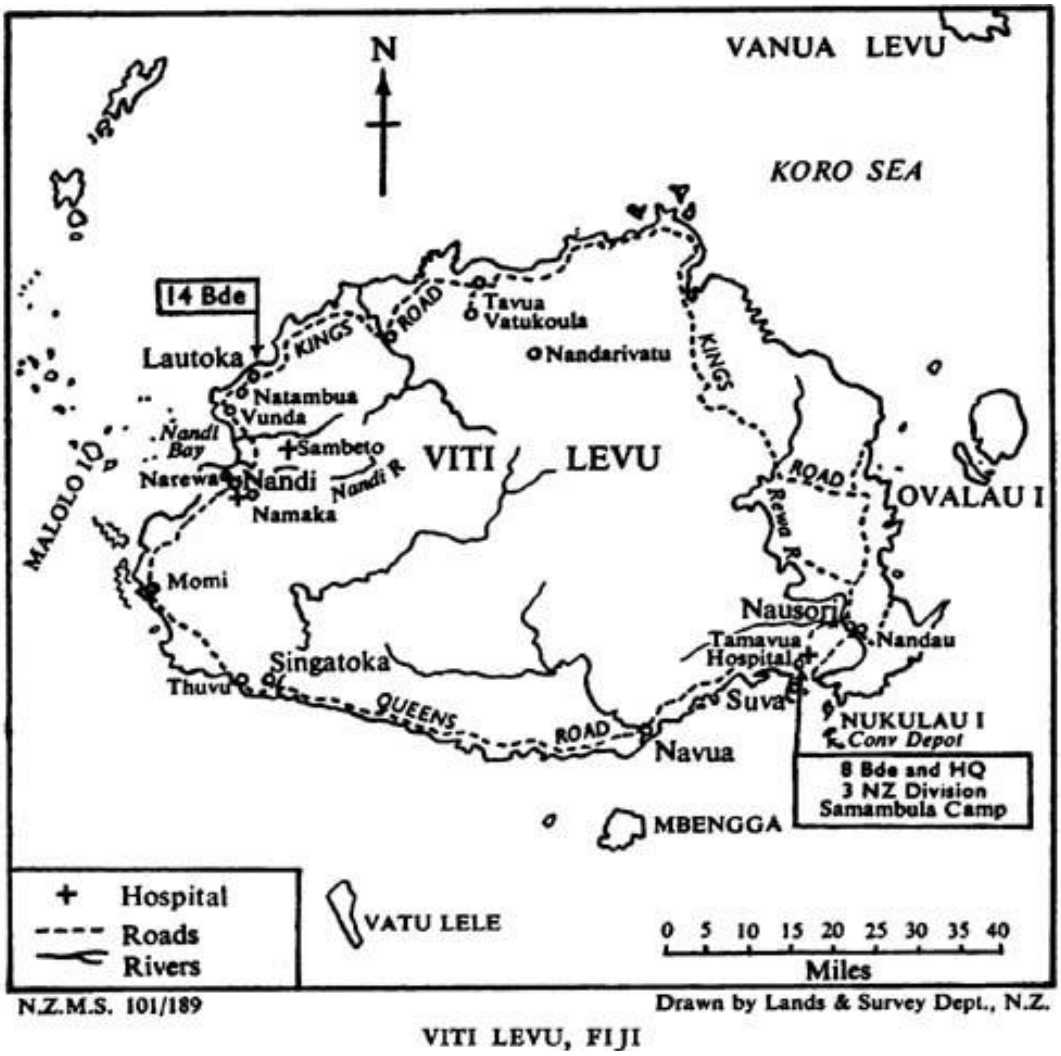


Figure 7. Positions of medical units in Viti Levu, Fiji. [Source: T. Duncan M. Stout, *Medical Services in New Zealand and the Pacific* (Wellington: War History Branch, Department of Internal Affairs, 1958), 5]

[743] From Bacteriologist Technician, Military Hospital to C.O. 7th Field Ambulance, Military Hospital, 3 March 1942, AAYS 8638 314/10/9 Part.1 R22438489, ANZ.

[744] Report of Laundering Carried Out at the C.W.M. Hospital for the Period 1/9/41 60 30/9/41, AAYS 8638 314/10/9 Part.1 R22438489, ANZ.

Hospital sites for the Fiji Section required the support of Fijian schools. Until the Tamavua and Namaka Hospitals were built, New Zealand was granted the right to use and replace school facilities as necessary. Schools in good locations near military areas were evacuated for use as New Zealand hospitals. In 1940, the 7 FA occupied the Girls' Grammar School in central Suva. In return, 2NZEF paid for the rent of the Girl Guides' Hall for use as a new school site and the accommodation cost of staff and boarding students. Upon evacuating the school building, New Zealand agreed to fumigate and paint the building as required by the Fiji medical authorities.[745] The final cost of providing education for the Girls' Grammar School while 7 FA occupied its original site added up to £725.13.10.[746] Similarly, 2NZEF took over Votualevu School as an auxiliary hospital when it constructed the Western Area.[747]

Cooperation with the government of Fiji was essential to the successful medical organisation of the Fiji Section. As detailed in the previous chapter, New Zealand commanded and staffed the FMF, including New Zealand MOs serving with the Fiji Medical Corps. At the same time, Fiji Section hired indigenous staff for medical work. Fijian NMPs were attached to New Zealand units wherever possible. Overall, the NMPs were found satisfactory, being reported 'the Fijian boys are physically strong, and capable of great endurance, and this promises to be a first class Brigade.' However, New Zealand officers evaluated the NMPs as 'not endowed with outstanding initiative.' Due to the 'lack of comprehension or lack of moral responsibility,' NMPs were seen to require constant European supervision.[748] In addition to the NMPs, some 'native cleaning gangs' were hired as cleaners of urinals, latrines, showers,

[745] From J. B. to Y. E., 22 October 1940, ADQZ 18899 8/1/1 R20591372, ANZ.
[746] From the Colonial Secretary to the A.A. and Q.M.G., Brigade Headquarters, Suva, 3 October 1941, ADQZ 18899 8/1/1 R20591372, ANZ.
[747] From A.D.M.S. 8th. Brigade Group, Medical Headquarters to "B" Force Headquarters, 9 January 1941, ADQZ 18899 8/1/1 R20591372, ANZ.
[748] Memorandum for D.G.M.S., Report on Medical Situation in Fiji by Lt. Col. W. D.S. Johnston, 22 March 1943, AAYS 8638 314/10/9 Part.1 R22438489, ANZ.

and ablutions of New Zealand medical facilities.[749] Workers were also hired for kitchen and mess duties, although it saw some complaints that 'the natives in the Mess still cause trouble by their disregard for ordinary hygiene.'[750]

For sanitary control, New Zealand inspected civilian areas near New Zealand camps in Fiji. The move was triggered by some private properties near New Zealand camps being reported as unsanitary and 'disease-breeding', which had the potential to undermine the health of troops. These properties were mostly owned by immigrant settlers in Fiji. For instance, an open drain of wastewater from a Chinese laundry ran through a New Zealand camp. A 'worse example' was an Indian house situated on the boundaries of the camp without a specified reason seen on documents. Knowing that the Public Health Ordinance and the Public Health Regulations of Fiji could appoint sanitary inspectors, the New Zealand military asked Fiji for the authority to inspect the precincts of Samabula Camps (sometimes spelt Samambula) and the Tamavua Hospital in February 1942. An inspector could issue orders to civilians to eliminate unsanitary conditions. Before approval, Fiji required New Zealand to submit full details of the inspecting personnel and inspection results to the Medical Department of Fiji.[751]

The medical services of the Fiji Section were reorganised at the beginning of 1942, shortly after the Pearl Harbor attack. Fiji was one of the places expected to be attacked next. Factors affecting the health of troops were reviewed again. This included an examination of the natural environment, climate, food, water, disease conditions, estimated casualties and evacuation resources. Then, plans for preserving the health of troops and the evacuation process

[749] Memorandum for the Commanding Officer, 7th Field Ambulance, N.Z.M.C., Ambulance Headquarters, 1 March 1942, AAYS 8638 314/10/9 Part.1 R22438489, ANZ.
[750] Memorandum for the D.G.M.S., Medical Headquarters, 30 September 1942, AAYS 8638 314/10/9 Part.1 R22438489, ANZ.
[751] Memorandum for the Commanding Officer, 7th Field Ambulance, N.Z.M.C., Ambulance Headquarters, 1 March 1942, AAYS 8638 314/10/9 Part.1 R22438489, ANZ.

were drawn up. The most important points in the preservation of health were keeping strict sanitary measures, maintaining an adequate level of cleanliness, preventing mosquito bites, and providing early treatment of injuries and skin conditions. As for evacuation, each unit's duty, hospital posts, and evacuation route were planned.[752] Upon reorganisation, it was considered 'very necessary to have complete reciprocity with the civilian hospital in case one or the other is in difficulties through enemy action.'[753]

The reorganisation resulted in the establishment of Namaka Hospital in early 1942. Built as the second hospital in Fiji for the Western Area, Namaka Hospital had 300 beds and was expandable to 600 beds. New Zealand was already treating American patients in their hospitals before the Western Area was completely constructed. Namaka Hospital was also expected to make provisions for Americans. In view of the fact that gaining hospital materials from New Zealand was difficult and Americans had to be treated as well, all the equipment for Namaka Hospital was planned to be sourced from the US.[754] The hospital was built on the evacuated Votualevu School, which housed an admission unit, operating theatre, storage, laboratory, and kitchen blocks. Beds were placed outdoors under tentage.[755]

At the same time, the CD Hospital extended its service to other forces. From early 1942, the CD Hospital was open to most military personnel based in Fiji, including the 2NZEF, the RNZAF, the RNZ Navy, the US shore forces, and members of other defence services when approved by Force Headquarters.[756] During the early stages of the war, from November 1940

[752] Enc. 1 Medical Appreciation of Suva Area, Memorandum for Army Headquarters, New Zealand Military Forces, 26 January 1942, AAYS 8638 314/10/9 Part.1 R22438489, ANZ.
[753] Minute Sheet, Reorganisation, Medical Service, Fiji, 4 February 1942, AAYS 8638 314/10/9 Part.1 R22438489, ANZ.
[754] From A.D.M.S. "B" Force, Medical Headquarters to Force Headquarters, 26 January 1942, AAYS 8638 314/10/9 Part.1 R22438489, ANZ.
[755] From A.D.M.S., 'B' Force, Medical Headquarters to B.Force Headquarters, 25 January 1942, AAYS 8638 314/10/9 Part.1 R22438489, ANZ.
[756] C. D. Hospital, Samambula, Memorandum for the Commanding Officer, 7th Field Ambulance, N.Z.M.C, Ambulance Headquarters, 1 March 1942, AAYS 8638 314/10/9 Part.1 R22438489, ANZ.

to September 1941, the venereal disease rate was low, having 50 admissions to the hospital with just one case of syphilis.[757] By April 1942, when the US forces were settled in Fiji, the rate increased to twenty admissions in one month. In the same month, six Americans were transferred to an American hospital after receiving treatment there. The advantage of having American patients was that it enabled the CD Hospital to obtain sulphathiazole tablets from the US. The disadvantage of having 'the influence of other than NZEF personnel in the hospital' was an increase in disciplinary issues. For example, two Americans were involved in 'one instance in which six patients were charged with breaking bounds and in two cases consorting with natives.'[758]

Between June and July 1942, 2NZEF withdrew most of its forces from Fiji to focus its strength on the Solomon Islands campaign, just leaving the personnel attached to the FMF and two anti-aircraft batteries. As a result, New Zealand's military facilities were handed over to the US authorities. The US took over Tamavua Hospital to use as 71 Station Hospital and Namaka Hospital for use as 142 General Hospital.[759] These two hospitals swapped buildings later in 1943, with 71 Station Hospital becoming 142 General Hospital and *vice versa*.[760] After the handover, all remaining New Zealand personnel in Fiji were treated in US hospitals. In exceptional circumstances, New Zealanders could seek medical help in other hospitals. In the first quarter of 1943, there were only four cases of New Zealand personnel treated in the CWM Hospital and Lautoka Hospital.[761] Similar arrangements were made for New Zealand personnel in Tonga.

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[757] Stout, *Medical Services in New Zealand and the Pacific*, 15.
[758] Memorandum for the A.D.M.S, Pacific Section, Divisional Headquarters, Report on C.D. Hospital-April 1942, 1 May 1942, AAYS 8638 363/1/45 R22440642, ANZ.
[759] Stout, *Medical Services in New Zealand and the Pacific*, 20.
[760] Robert Lowry, *Fortress Fiji: Holding the Line in the Pacific War, 1939–45* (Sutton, N.S.W: R.W. Lowry, 2006), 70.
[761] Memorandum for D.G.M.S., AHQ, 19 April 1943, AAYS 8638 314/10/9 Part.1 R22438489, ANZ.

Contrary to New Zealand and Fiji, which treated their troops free of charge, the US hospitals imposed 40 cents per day for all officers and warrant officers except for the day of discharge.[762] It was a policy from Washington that the US Army was obliged to comply with. New Zealand patients, too, were not exempted from the fees. Patients paid the cost compulsorily and had the receipt reimbursed by the 2NZEF later.[763] The US explained that the cost was used to cover additional rations for higher ranks.[764] 2NZEF did not consider it too costly. Based on the hospitalisation records of January 1943, the number of New Zealand patients in US hospitals was, on average, 36 a month, entailing a monthly cost of about $432 US Dollars.[765]

However, the Treasury of New Zealand questioned the payment. Under its agreement with the US, New Zealand was only to cover the salary and allowances of its own personnel in Fiji. Therefore, the Treasury claimed the hospitalisation cost should either be met by the US authorities or debited to New Zealand on a Lend-Lease basis.[766] The US insisted on cash payment, arguing that it could not be debited on a Lend-Lease basis. For the personnel attached to the FMF, Fiji agreed to meet the hospitalisation cost. About 650 New Zealanders who remained to serve with the two 2NZEF anti-aircraft batteries were entirely paid, rationed, and quartered by New Zealand as before.[767] The New Zealand Treasury was still unhappy with the decision and argued that the US should treat hospitalisation on a Lend-Lease basis.[768]

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[762] N. C. Finney, Hospital Funds, 3 January 1943, AAYS 8638 330/5/130 R22439131, ANZ.
[763] Memorandum for Army Headquarters, NZ Military Forces, 15 February 1943, AAYS 8638 330/5/130 R22439131, ANZ.
[764] F. B. Dwyer, Memorandum for the Secretary to the Treasury, N.Z.E.F Patients in U.S. Army Hospitals in Fiji, 16 April 1943, AAYS 8638 330/5/130 R22439131, ANZ.
[765] Memorandum for the Hon. Minister of Defence, N.Z.E.F. Patients in U.S. Army Hospitals in Fiji, 25 March 1945, AAYS 8638 330/5/130 R22439131, ANZ.
[766] Secretary to the Treasury, N.Z.E.F. Patients in U.S. Army Hospitals, Fiji, 2 April 1943, AAYS 8638 330/5/130 R22439131, ANZ.
[767] F. B. Dwyer, Memorandum for the Secretary to the Treasury, N.Z.E.F Patients in U.S. Army Hospitals in Fiji, 16 April 1943, AAYS 8638 330/5/130 R22439131, ANZ.
[768] Memorandum for the Army Secretary, N.Z.E.F. Patients in U.S. Army hospitals: Fiji, 20 May 1943, AAYS

As military casualties would have been treated in US hospitals in the forward area, it was not difficult to ask the US hospitals in Fiji to accept military casualties.[769] In May 1943, an agreement was made with the US regarding the hospitalisation of casualties from the forward area in addition to the casualties that occurred in Fiji. All Allied personnel, comprising New Zealanders, European Fijians, and indigenous Fijians, were to be taken to US hospitals for treatment. The charge for hospitalisation was eventually met by the Reverse Lease-Lend to New Zealand and Fiji.[770] From July 1943, all officers of the 2NZEF and the FMF were only treated and hospitalised in American hospitals to relieve the burden on the CWM Hospital.[771] By October 1943, the US and Allied Forces had more than 2,500 beds available in Fiji.[772]

After treating patients in US hospitals, medical records had to be shared with New Zealand. Initially, records from US hospitals in the Pacific, notably in Fiji and Tonga, were just sent to the Surgeon General of the US military in Washington DC. New Zealand forces such as the 2NZEF Fiji Section or the NZEFIP could only obtain clinical abstracts for cases treated in New Caledonia. In February 1943, New Zealand and the US agreed on a mutual exchange of original medical records to cope with the developing war situation in the Solomon Islands campaign.[773] Complete Medical Field Records of New Zealanders treated in the US hospitals outside New Zealand were mailed to the ADMS in the Headquarters of the NZEFIP upon completion of hospitalisation. The record of cases treated in US hospitals within New Zealand was forwarded to the Medical Branch of the Army Headquarters in Wellington. In return, records of the US personnel treated in New Zealand hospitals were forwarded to the Senior

8638 330/5/130 R22439131, ANZ.

[769] Memorandum for the Colonial Secretary, 14 May 1943, ADQZ 18899 8/1/1 R20591372, ANZ.

[770] Memorandum for the Colonial Secretary, 27 May 1943, ADQZ 18899 8/1/1 R20591372, ANZ.

[771] Memorandum for All Medical Officers, N.M.P.'s, and I.M.P., 20 July 1943, ADQZ 18899 8/1/1 R20591372, ANZ.

[772] Lowry, *Fortress Fiji*, 70.

[773] From NZEFIP to Army HQ, NZ, Medical Case Records, 18 March 1943, AAYS 8638 330/5/130 R22439131, ANZ.

Surgeon of the US Army in the island where the relevant New Zealand hospital was located. These records were thence forwarded to each of the units concerned in the US.[774]

Such mutual exchange of medical records was, however, inefficient as far as the New Zealand forces in Fiji or Tonga were concerned. Even though patients from the New Zealand forces in Fiji or Tonga would be treated in the US hospitals in Fiji or Tonga, the US sent records of discharged patients to the NZEFIP Base in New Caledonia or the Army Headquarters in Wellington. They did not directly deliver the documents to their neighbouring New Zealand camps in Fiji and Tonga.[775] It was 'impossible to arrange with US Authorities for anything short of a comprehensive mutual arrangement.' Although New Zealand found it unsatisfactory, no other arrangement could have ensured that they would receive records of their patients treated in US hospitals.[776] After some time, the US finally agreed to instruct its hospitals in Fiji and Tonga to transfer Medical Case Records directly to the headquarters of the FMF and the Tonga Defence Force in May 1943. If New Zealand personnel were treated in US hospitals in Fiji or Tonga and then returned to their units in Fiji or Tonga, the SMOs in each country would forward the documents to the DDMS in the headquarters of NZEFIP.[777]

Thus, the arrangements for the Fiji Section reflects New Zealand's relationships with other militaries and civilian governments. Armed forces in another country represents an act of imperial expansionism and New Zealand stationed its troops in Fiji. While both countries belonged to the British Empire, New Zealand's command over the FMF and the presence of

[774] From Charles R. Pearce Headquarters, USAFISPA to the Commanding Generals and Commanding Officers All Service Commands, island Commands, and Base Commands, South Pacific Area (Attention: Their respective Surgeons), 18 February 1943, AAYS 8638 330/5/130 R22439131, ANZ.
[775] Minute, Exchange of Med. Records, 9 April 1943, AAYS 8638 330/5/130 R22439131, ANZ.
[776] From NZEFIP to Army HQ, NZ, Medical Case Records, 18 March 1943, AAYS 8638 330/5/130 R22439131, ANZ.
[777] From DDMS NZEFIP to the Director-General of Medical Services, Army Headquarters, 15 May 1943, AAYS 8638 330/5/130 R22439131, ANZ.

the Fiji Section marks a definite sub-imperialism in medical centralisation of the South Pacific.

Medical Support for 3NZ Division

Fiji Section's role remained supportive after 3NZ Division went to the Solomon Islands. Like all campaigns, medical planning for 3NZ Division was essential. The Solomon Islands campaign was challenging to New Zealand in two significant ways. First, adequate medical support was crucial to enter what was thought as the 'notoriously unhealthy' area of the Solomons.[778] The Director-General of Medical Services (DGMS) considered that health problems in the Solomons were 'very much greater even than in the Middle East and every effort should be made to get the most complete information on all the tropical islands of the South West Pacific.'[779] In addition to environmental challenges, such as jungle warfare and malaria, 3NZ Division 'had to work within the American framework' in every aspect of the war, as Reg Newall remarked. Medically, New Zealand was constantly aware of the American provisions in the Pacific theatre and tried to be in line with US medical practices.[780]

In September 1942, the initial plan of 3NZ Division was drawn up. For medical support, it was decided to supply Regimental Medical Officers, eight MOs for each FA, MOs for a Base Reception Hospital of about 300 beds, and a malarial control unit.[781] Such an arrangement seemed inadequate without US support.[782] Therefore, measures involving cooperation with the US were considered. One easier option was to ask the US Navy to take full responsibility

[778] Minute Sheet, 3NZ Division-Medical Requirements, 22 September 1942, AAYS 8638 330/5/120 R22439117, ANZ.
[779] Brigadier, D.G.M.S. (Army and Air), Minute Sheet, 22 September 1942, AAYS 8638 330/5/120 R22439117, ANZ.
[780] Newall, *Pacific Star*, 158.
[781] Minute Sheet, 3NZ Division-Medical Requirements, 22 September 1942, AAYS 8638 330/5/120 R22439117, ANZ.
[782] From Maj. Gen. Comd. 3NZ Div to Army HQ, Wellington, 4 November 1942, AAYS 8638 330/5/120 R22439117, ANZ.

for evacuation, treatment, and hospitalisation of all sick and wounded New Zealanders. The US had already offered New Zealand to 'make the fullest use of the hospital ship; transport planes (they have about 112 already flying between the Solomons and New Zealand); and the U.S. hospitals in New Hebrides, Noumea.' Another option was for New Zealand to run its own medical services with seconded MOs from the US. It was expected that New Zealanders would prefer to be treated in their own hospitals. However, American assistance was favoured, noting that 'sentiment must give way to the material.'[783]

3NZ Division had to prepare for amphibious warfare, malaria, tropical diseases, and cope with having placed under the US Army, which had totally different equipment. Under such conditions, 'the fullest co-operation' with the US was stressed. The US arrangements in Guadalcanal became a standard reference. To make the medical services similar to the US, New Zealand decided to have FAs, Field Dressing Stations, Field Surgical Units, a Blood Transfusion Unit, a Malarial Control Unit (MCU), and a Hygiene Section for 3NZ Division. Although the US did not have a Casualty Clearing Station, largely relying on rapid evacuation to their advanced base, it was normal practice for the British Army to have one. New Zealand later established 2 Casualty Clearing Station (CCS) in Guadalcanal. The US was also responsible for the evacuation of 3NZ Division.[784] In February 1943, the US offered full medical assistance to New Zealand, which was accepted.[785]

Generally, FAs and other field units treated battle wounds and injuries from the forward area. Field medical units, including the Blood Transfusion Unit and the MCU, followed the combat units as the war advanced in the forward area. Therefore, these units were

[783] Minute Sheet, 3NZ Division-Medical Requirements, 22 September 1942, AAYS 8638 330/5/120 R22439117, ANZ.
[784] Minute Sheet, G.O.C. Conference-3NZ Division. Medical Reorganization, 19 February 1943, AAYS 8638 330/5/120 R22439117, ANZ.
[785] Minute Sheet, 3NZ Division, 23 February 1943, AAYS 8638 330/5/120 R22439117, ANZ.

mobile and changed locations according to the battle conditions. Once casualties were initially treated in the field, they were moved to a CCS. CCSs were situated fairly close to forward areas but usually at a safe distance from the fighting. They performed urgent treatments and surgeries that the field units could not provide. Ultimately, casualties were sent to a General Hospital, further back from the forward area, normally at the base. General Hospitals were the largest of medical units and likely to be housed in a permanent building.[786]

The General Officer Commanding (GOC) of NZEFIP decided to set up the Advanced Base Headquarters of NZEFIP and supporting medical facilities in New Caledonia. This was done after referencing experiences of the US in the South Pacific Area, Australian and American reports from the South West Pacific Area, and suggestions by the ADMS, who consulted senior MOs with experience in the Solomon Islands.[787] In New Caledonia, public health and sanitation of Allied forces in the Noumea area were vested in the US Department of Public Health.[788] Then, the 4 General Hospital, an Advanced Base Hospital, was set up for New Zealanders. It was deliberately kept away from the combat zone in accordance with US practice and to save 3NZ Division from equipping hospitals for 'unhealthy areas, namely, New Guinea, Guadalcanal, etc.'[789]

Evacuations were carried out by both air and sea.[790] The type of aircraft or ships carrying casualties was not specified in the casualty analysis reports. Transport would have been provided by the US since it was responsible for casualty evacuations and all sorts of transport in the South Pacific. According to the official history, the general policy was to

[786] For more detailed explanation of British medical units, see Mark Harrison, *Medicine and Victory*, 284–287.
[787] From G.O.C. 2 N.Z.E.F. I.P. to Army Headquarters, 11 February 1943, AAYS 8638 330/5/120 R22439117, ANZ.
[788] Enforcement of Sanitary Regulations, CAJM 22899 W5726 R21387228, ANZ.
[789] Minute Sheet, 3NZ Division, 15 February 1943, AAYS 8638 330/5/120 R22439117, ANZ.
[790] App. XXV, From Transit Camp, Noumea to N.Z.E.F.I.P, 4 January 1944, CAJM 22899 W5726 R21387228, ANZ.

evacuate casualties using hospital ships or surface craft between the Solomon Islands and New Caledonia.[791] Based on American records, most evacuations in the area were carried out by Landing Ship Tank boats (LSTs), and later South Pacific Combat Air Transport hospital planes.[792]

For staffing the Medical Services of 3NZ Division, experience in Fiji was important. The DGMS preferred officers previously stationed in Fiji because its climate conditions were considered similar to the Solomons.[793] Four out of eleven surgeons selected for 3NZ Division had experience in one of the Base Hospitals (Tamavua or Namaka) with the Fiji Section.[794] Many of the nursing orderlies at 4 General Hospital in the earlier period were also made up of those who had trained in Fiji. These orderlies were moved to Auckland Hospital for further training before transfer to Field Dressing Stations. This was because they were familiar with tropical conditions.[795] In this respect, 4 General Hospital was the 'child' of Tamavua and Namaka Hospitals, which was itself born of 7 FA, all of which were in Fiji.[796]

Number 4 General Hospital was first established in the Boguen Valley, in a flat, low area bordered by the Boguen River.[797] In the wet season, this area became very swampy and NZEFIP Headquarters was aware that the site was far from ideal. However, it was the area that New Zealand forces were allotted, being the only site available for tactical reasons. Consequently, it suffered from a 'plague of mosquitos' to the extent that nurses could not

[791] Stout, *Medical Services in New Zealand and the Pacific*, 31–33.
[792] Ross T. McIntire, U.S. Navy Medical Department Administrative History, 1941–1945: Narrative History, Vol.1, Parts I and II, 1946, Container 13 Accession Number 63-2, Papers of Ross T. McIntire, Franklin D. Roosevelt Presidential Library, , New York (FDR Library). 132–134.
[793] Minute Sheet, Medical Arrangements, 3NZ Division (Memo. From O.C., 3NZ Division of 4th Nov.), 11 November 1942, AAYS 8638 330/5/120 R22439117, ANZ.
[794] Surgeons-3 N.Z. Division, 20 February 1943, AAYS 8638 330/5/120 R22439117, ANZ.
[795] Minute Sheet, G.O.C. Conference-3NZ Division. Medical Reorganization, 19 February 1943, AAYS 8638 330/5/120 R22439117, ANZ.
[796] Sale, *Shovel, Sword and Scalpel*, 40.
[797] Boguen is frequently misspelled as Beguen or Bougan in the primary documents.

concentrate on their work properly. It was clear that the hospital was built on a bad site but with great effort put in for the construction of the roads, wards, and administrative tents, it was not easy to move the hospital. With the clearing of jungle and anti-mosquito measures, they hoped the mosquito nuisance and swampy conditions would go away.

The prospect for a healthier new site emerged when US forces departed from New Caledonia, making available a Station Hospital. A proposal that 4 General Hospital should take over this site was strongly supported by the ADMS and the DDMS. This site had good drainage, a stream supplying plentiful water, and it was situated on a hillside which was drier and cooler in the summer. Most importantly, it was free from mosquitos. Yet it was still in a central position to support the spread-out divisional area. It was nearer to Plaine des Gaiacs where hospital cases arrived or departed by air, and closer to the port of Nepui, in case of sea evacuation. Since 3NZ Division Base was in New Caledonia, it was also important to choose a healthy site for a prolonged period of war.[798]

4 General Hospital eventually moved to Dumbea, near Noumea, not the previously proposed American hospital site near Plaine des Gaiacs. The new site was in a better environment. It consisted of staff quarters, operating theatres, anaesthetic room, X-ray department, workroom, plaster room, laboratory, administration block, cookhouses, and wards. The wards were put on the terraces, one below another, having excellent ventilation systems.[799] The original site in Boguen operated as a detachment of 4 General Hospital in the process of moving the patients to the new site.[800]

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[798] Minute Sheet, Report on N.Z.E.F. I.P., 17 May 1943, AAYS 8638 330/5/120 R22439117, ANZ.
[799] Appendix 1, D.G.M.S., Memorandum for Adjutant General (through Acting D.G.M.S.), Army Headquarters, 26 January 1944, AAYS 8638 330/5/120 R22439117, ANZ.
[800] Appendix 2, D.G.M.S., Memorandum for Adjutant General (through Acting D.G.M.S.), Army Headquarters, 26 January 1944, AAYS 8638 330/5/120 R22439117, ANZ.

The following is a summary of the medical organisation of 3NZ Division, for example, during active operations. In December 1943, 21 officers were attached to 4 General Hospital in Dumbea, New Caledonia, including Boguen Detachment. Each FA had eleven officers. 7 FA was in the Treasury Islands, where New Zealand most recently landed, 22 FA was in Vella Lavella and 24 FA was in Guadalcanal. Two officers each formed Field Surgical Units attached to FAs in the Treasury Islands and Vella Lavella. 2 CCS was based in Guadalcanal with eleven officers. Four officers worked with the 2 Convalescence Depot at Kalavere. One officer made the 6 Field Hygiene Section and the Advance Depot Medical Stores. Four officers were attached to 1 MCU for malaria control, with more officers attached to combatant units spread in Vella Lavella and Treasury Islands.[801]

To run this diverse array of medical units, cooperation with Fiji was necessary. Larger Army hospitals usually required extra civilian labour (mostly indigenous) but suitable labour could not be found in New Caledonia. The GOC of NZEFIP suggested outsourcing labour personnel from Fiji. About twenty 'boys' (probably general labourers) and two NCOs were requested for work in 4 General Hospital. Since NZMC was responsible for treating the Fijian troops in the South Pacific Area, and the US evacuated all British personnel, including New Zealanders and Fijians, to the 4 General Hospital, it made sense that Fiji contributed to running 4 General Hospital. A number of 4 General Hospital staff who served in Fiji had a high opinion on the use of Fijian 'boys' working in New Zealand hospitals. It was expected the addition of 'Fijian Ward Boys' would greatly help run the hospital and relieve pressure on New Zealand soldiers who were engaged in cleaning and other duties.[802] As a result, a detachment from 1

[801] Appendix XV, Disposition of Medical Units and Officers NZMC, CAJM 22899 W5726 R21387228, ANZ.
[802] Appendix XXI, GOC NZEFIP, Employment of Fijians in NZEF Hospitals, 17 April 1944, CAJM 22899 W5726 R21387229, ANZ.

Bearer Company of the FMF came to work in New Caledonia until September 1944.

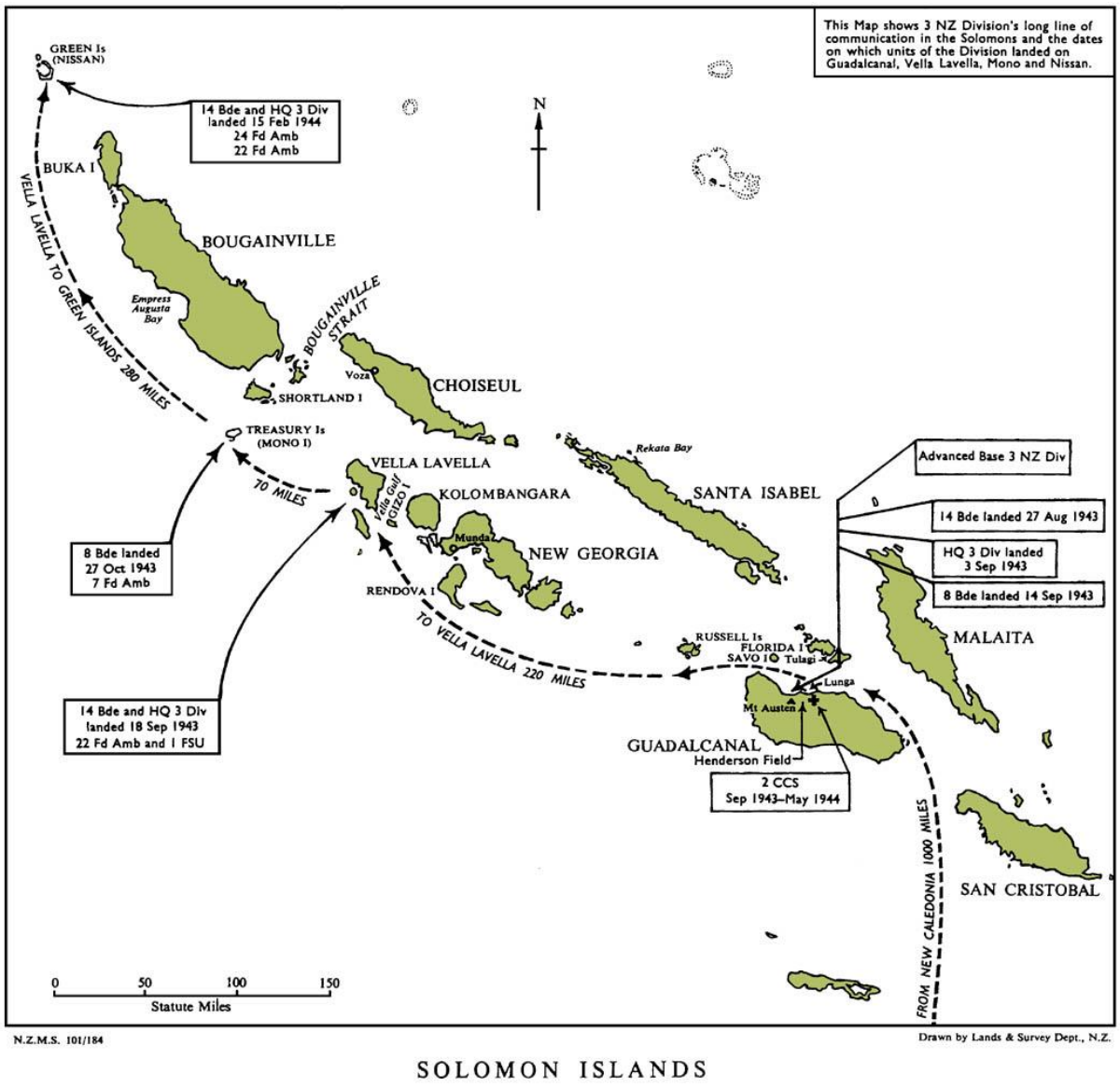


Figure 8. Map of the Solomon Islands showing the positions of medical units and long line of communication. [Source: T. Duncan M. Stout, *Medical Services in New Zealand and the Pacific* (Wellington: War History Branch, Department of Internal Affairs, 1958), 17]

Almost all medical equipment for 3NZ Division referred to American practice. For example, the ADMS suggested using portable Picker X-Ray machines in forward units, as used in all forward American hospitals. Tentage was used by Americans in the forward areas and field medical units. New Zealand also used tentage but a sturdier version. Further back,

Americans used prefabricated wards for hospitals, as did New Zealand, in New Caledonia, where they had a fixed Base. American hospital staff believed that kerosene incubators were most efficient and necessary in forward medical units. Hence, 4 General Hospital used kerosene incubators. Refrigerators were also the same model as those used in US hospitals in Guadalcanal, while metal folding beds were considered best for hospitals, again following American practice.[803]

New Zealand also relied on the US for medical supplies throughout the Solomon Islands campaign. Necessary items could be sourced through 17 US Medical Depot and, in some cases, through the US Naval authorities. Items obtained from US sources for reserve stock were maintained at three months' requirements. Shipments from New Zealand were too slow and delayed that most supplies were sought from the US sources.[804] One of the important items obtained through the US was the suppressive malaria drug Atabrine (known as Atebrin in NZEFIP).[805] New Zealand's FAs had 1,000-gallon tanks on loan from the Americans for shower purposes.[806]

At times, the US asked New Zealand for medical supplies. Before the US landings in Guadalcanal, the US Navy experienced 'an acute shortage of sulphanilamide' (used to treat bacterial infections) which was rectified by New Zealand's Abbot Drug Company. Deficits of Hospital Corps pouches and identification tags were also filled through New Zealand Army Stores.[807] After New Zealand entered the Solomon Islands, 7 FA and Medical Stores Section

[803] Minute Sheet, Report on N.Z.E.F. I.P., 17 May 1943, AAYS 8638 330/5/120 R22439117, ANZ.
[804] Appendix XV, Monthly Report for March 1944, 5 April 1944, CAJM 22899 W5726 R21387229, ANZ.
[805] Newall, *Pacific Star*, 144.
[806] HQ 24 (NZ) Fd Amb, 3 (NZ) Div, Monthly Report-November 1943, 1 December 1943, CAJM 22899 W5726 R21387228, ANZ.
[807] Ross T. McIntire, U.S. Navy Medical Department Administrative History, 1941–1945: Narrative History, Vol.1, Parts I and II, 1946, Container 13 Accession Number 63-2, Papers of Ross T. McIntire, FDR Library. 59.

of NZEFIP supplied the US Army and Navy units whenever needed until December 1943. This brought the number served by the Medical Stores Section of 3NZ Division up to 32,000. Although this put a considerable amount of work onto the Medical Stores Section, all issues to the US units were made well.[808]

All New Zealand troops across the South Pacific were on American rations, which were unpopular. New Zealanders disliked the diet of preserved meat, such as Spam, and complained that the rest of the ration was 'all pap' and 'nothing to bite on.' Although the American ration was supposed to be nutritionally well-balanced, if the troops continuously refuse to eat, there was a risk of serious vitamin deficiency. Nurses and engineers at 4 General Hospital actually suffered from anaemia caused by vitamin deficiency. To fix the nutritional problem, the ADMS recommended that wherever possible, New Zealand troops receive substitute rations of frozen meat, butter, and bacon. As a result, troops stationed in Fiji and Tonga regularly received supplementary rations from New Zealand. Fijian troops in the Solomons also received American rations. Because the Fijians missed their usual diet with tea and *dala* [likely to be a misspelling of *dalo*, taro root], the Corps General promised to provide all available tea to Fijians in lieu of coffee with a prospect of issuing yams, which could substitute for *dalo*.[809]

Medical practice also followed the American example. New Zealand originally followed British practice for tetanus prophylactic inoculations, which took one year to complete full immunisation. New Zealand was steadily progressing in inoculations with the FMF at the British pace of one year. However, in 1944, the US procedure was modified so their

[808] Medical Stores Section, Monthly Report for Month ending 31 Dec 43, 3 December 1943, CAJM 22899 W5726 R21387228, ANZ.

[809] Assistant Director of Medical Services, Preliminary Report on Health, Diet, and Living Conditions of New Zealand Military Forces in Pacific Islands, 15 May 1943, AAYS 8638 314/5/31 R22438464, ANZ.

troops could ‘complete active immunity’ prior to departure for theatres of operations. To conform with the US requirements, inoculations of reinforcement troops going out to active theatres of operations had their inoculations advanced by six months.[810] The third dose of inoculation was advanced 1–12 months.[811]

Similarly, New Zealand stopped suppressive malaria treatment of troops returning from malarious areas to Fiji, a malaria-free country, in January 1944. Instead, curative treatment was adopted in the place because NZMC saw no advantages in continuing suppressive treatment, hoping to cure a large proportion of infected men.[812] However, this change of policy also seems to have followed the US precedent of stopping Atabrine on the US troops in Fiji.[813] The US reversed its position and restarted suppressive treatment in January 1944.[814] Reports from May 1944 show that the policy for the FMF also changed to place troops under suppressive Atebrin once more.[815]

In the forward area, New Zealand managed to offer good medical care to its troops. Ross McIntyre, the Surgeon General of the US Navy during the war, praised New Zealand’s medical arrangements in the Treasury Islands landing. The medical department accompanying the first wave of 3NZ Division ‘was performing major surgical procedures’ only seven hours after they landed. McIntire quotes an action report from Bougainville stating, ‘this is the only instance known in this area where adequate medical facilities have been completed in a combat zone prior to the arrival of a succeeding echlon of LSTs.’ Because the US often evacuated the

[810] Memorandum for Officer i/c Administration, FMF, 7 January 1944, ADQZ 18899 13/1/2 R20591379, ANZ.
[811] Senior Medical Officer, Fiji Military Forces & Fiji Section, 2nd N.Z.E.F., 24 January 1944, ADQZ 18899 13/1/2 R20591379, ANZ.
[812] Memorandum for Officer i/c Administration, FMF, 6 January 1944, ADQZ 18899 13/1/2 R20591379, ANZ.
[813] The suppressive malaria drug had a trade name of Atabrine in the US and was called Atebrin in New Zealand. It is also known as Mepacrine or Quinacrine.
[814] Robert J T Joy, ‘Malaria in American Troops in South and Southwest Pacific in World War II’, *Medical History*, 43 (1999), 205.
[815] From O IC Administration, F.M.F. to HQ FMF, 17 May 1944, ADQZ 18899 13/1/2 R20591379, ANZ.

wounded still in need of surgical care, New Zealand's arrangement was evaluated as 'an exception.'[816]

Cooperation with other forces was more important because the operation line was stretched in the Pacific theatre. By early 1944, 3NZ Division campaign had advanced from Vella Lavella through the Treasury Islands, making way to Nissan Island. At this point, the detachments of 3NZ Division were scattered over 1,000 miles with a prospect of further extension. Patients from Vella Lavella and forward areas were sent to 2 CCS in Guadalcanal and 4 General Hospital in New Caledonia. These units would normally move further forward to support active operations in other theatres of war. However, with the line of medical support stretched over a thousand miles, it was impossible to move these hospitals every time units advanced. These larger units were considered of greater use where they were, with the increasing rate of air evacuations proving useful.[817]

Red cross marks on hospitals also required American cooperation. In December 1942, the War Office reported that the enemy disregarded usage of the red cross in international law. The red cross could even attract deliberate bombing attacks unless the subject hospitals were of use to the enemy.[818] Usually, it would be more efficient to concentrate hospital buildings in one place, removed from areas occupied by troops. However, this was considered 'most unwise' if the enemy targeted military hospitals. In these circumstances, one option was for the hospital to be dispersed, each marquee distanced from another by about 200 yards. However, this was inconvenient and required additional equipment. To determine the Japanese attitude towards the red cross, 3NZ Division requested the Army to officially ask the US for any authentic

[816] Ross T. McIntire, U.S. Navy Medical Department Administrative History, 1941–1945: Narrative History, Vol.1, Parts I and II, 1946, Container 13 Accession Number 63-2, Papers of Ross T. McIntire, FDR Library. 135.
[817] Minute Sheet, Report on N.Z.E.F. I.P., 17 May 1943, AAYS 8638 330/5/120 R22439117, ANZ.
[818] G. W. Lambert, 6 December 1942, ADQZ 18899 8/1/1 R20591372, ANZ.

reports on instances of the enemy disregarding or respecting the red cross.[819]

As it was concluded that the red cross mark could not protect hospitals, medical staff in the Pacific theatre were armed. The decision to arm NZMC personnel was largely based on the experiences of US forces. To an extent, it was also based on New Zealand's experience of finding Japanese patrols 'infiltrating into lines of the medical units.'[820] Considering the experience of 7 FA during the Treasury Islands operation and reports of active Japanese hostility towards medical organisations, it was thought necessary to arm all medical personnel at their request so that they could protect patients and themselves. Additional rifles and hand grenades were distributed to all medical personnel who wished to carry them.[821]

Medical facilities were often shared between the Allied forces for the hospitalisation of troops and civilians. For instance, 7 FA treated US personnel and indigenous people on Mono Island in the Treasury Islands.[822] 24 FA had also operated on two indigenous civilians for inguinal abscesses.[823] In its early period of operation between October 1943 and January 1944, 2 CCS admitted 45 Allied Forces and four civilians in the hospital out of a total of 1,135 admissions.[824] In New Caledonia, 4 General Hospital admitted French civilian patients for urgent treatment such as accidental injuries. Civilians with permanent disabilities repeatedly visited the hospital for treatment because they did not have adequate local medical services.[825] 2 Convalescent Depot accepted eleven civilian outpatients in March 1944.[826] The RNZAF

[819] From Major-General Comd 3 Div to Army Headquarters, 3 October 1942, AAYS 8638 330/5/120 R22439117, ANZ.
[820] Appendix XXXVI, DDMS to Headquarters, NZEF IP, Arming of NZMC Personnel, 15 April 1944, CAJM 22899 W5726 R21387229, ANZ.
[821] ADMS, Report for Month of December 1943, 14 January 1944, CAJM 22899 W5726 R21387228, ANZ.
[822] Monthly Report on 7 NZ Field Ambulance for the Month of February 1944, 1 March 1944, CAJM 22899 W5726 R21387229, ANZ.
[823] Appendix IX, Monthly Report, 24th NZ Field Ambulance, April 1944, CAJM 22899 W5726 R21387229, ANZ.
[824] App.V, Unit Monthly Report, 31 January 1944, CAJM 22899 W5726 R21387228, ANZ.
[825] 4 N.Z. General Hospital-Dumbea, Monthly Report for January '44-Medical Division, CAJM 22899 W5726 R21387228, ANZ.
[826] Monthly Report for month ending 31 March 44, 2 NZ Convalescent Depot & Kalavere Hospital, 3 April 1944,

could usually make use of Army medical units run by the NZEFIP, especially 2 CCS and 4 General Hospital. Records show that the US medical units accepted some RNZAF patients too.[827] Even in New Caledonia, New Zealanders were sent to the US hospitals when the number of patients was very high.[828]

FMF casualties from the forward area were treated together until they were eventually evacuated to Fiji. The identities of FMF casualties (including Fijians, Tongans, WPHC personnel, and seconded 2NZEF personnel) were reported to the Colonial Secretary of Fiji and the WPHC.[829] The destination country of the initial evacuation was often not notified to the FMF.[830] According to Ravuvu, the FMF only learned the exact locations of the evacuated personnel after months, unless the evacuation was done with the New Zealand casualties.[831] It is difficult to know the exact rate of Fijian (and Tongan) casualties as many records from the forward area only show the total number of casualties. Some documents do count Fijian casualties in a separate category but did not differentiate Tongans who were attached to the FMF.[832]

The casualty report of April 1944 from the Bougainville campaign is a good case to see how casualties moved through the line of evacuation. Out of a total of 235 patients received from forward area, 55 cases were members of the FMF. Notably, 23 cases of battle casualties were all from the FMF.[833] Fijian casualties received initial emergency treatment at

CAJM 22899 W5726 R21387229, ANZ.

827 D.G.M.S., Memorandum for Adjutant General (through Acting D.G.M.S.), Army Headquarters, 26 January 1944, AAYS 8638 335/5/120 R22439117, ANZ.

828 From DDMS, NZEFIP to Surgeon, 1 Island Command, 2 March 1944, CAJM 22899 W5726 R21387229, ANZ.

829 From the Colonial Secretary to the Commanding Officer, F.R.N.V.R., 21 July 1943, WPHC11 S.F9/34, WPA.

830 For example: From H. Vaskess to the Agent and Consul, Tonga, 28 July 1943, WPHC11 S.F9/34, WPA; From Acting Resident Commissioner, British Solomon Islands Protectorate to the High Commissioner, 24 July 1943, WPHC11 S.F9/34, WPA.

831 Ravuvu, *Fijians at War*, 40.

832 App. XXVI, From Transit Camp, Noumea to N.Z.E.F.I.P, CAJM 22899 W5726 R21387228, ANZ.

833 Appendix XXXII, Analysis of Casualties Received from Forward Area: April 1st-30th 1944, CAJM 22899

Bougainville, seemingly from the US medical services. Then, they were moved to 2 CCS where they received treatment for compound fractures. They were evacuated to 4 General Hospital for recovery before they returned to units or were finally evacuated to Fiji.[834]

Apart from the handful of civilians (most likely Europeans) admitted in NZEFIP hospitals, 3NZ Division offered medical care to Solomon Islanders. Treatment of people in the Simbo Group was partly a goodwill mission, partly a general health survey, and partly for the collection of intelligence. In November 1943, about 30 all ranks from 3NZ Division HQ formed a patrol for Simbo Group in the south of Vella Lavella. The Deputy ADMS accompanied the patrol party for that purpose. In a day and a half, he examined about 50 people out of an estimated 400–500 indigenous population of the Simbo Group.[835] The medical mission continued beyond Vella Lavella, including all operation areas of the Treasury Islands (Mono Island) and Green Islands (Nissan Island and Pinipel Island). MOs made regular weekly visits to villages to give mapharson and Bismuth injections for yaws, which was widely prevalent. They also dressed ulcers and tropical sores and treated other conditions as requested. It was reported that these patients had shown great improvement in their health, 'both mentally and physically.'[836]

W5726 R21387229, ANZ.

[834] Monthly Report for No2 M.F.I.S. att 2 NZ CCS, 30 April 1944, CAJM 22899 W5726 R21387229, ANZ.

[835] ADMS, Report for Month of November, 11 December 1943, CAJM 22899 W5726 R21387228, ANZ.

[836] ADMS, Monthly Report for March 1944, 8 April 1944, CAJM 22899 W5726 R21387229, ANZ.



Figure 9. Surgical station, Guadalcanal, Solomon Islands, [Source: New Zealand Department of Internal Affairs. War history Branch. Ref: 1/2-041591-F. Alexander Turnbull Library, Wellington, New Zealand. /records/22732070]

NZEFIP withdrew from an active role in the Pacific theatre in May 1944.[837] Consequently, 4 General Hospital was closed in August 1944. New Zealand patients returned to New Zealand and other British personnel (those from the British Empire) were asked to return to their countries.[838] Fijian casualties at 4 General Hospital were eventually evacuated to Fiji through RNZAF aircraft, which stopped by New Caledonia to pick up Fijian patients *en route* from New Hebrides to Fiji.[839] If necessary or desirable, discharged patients could be

[837] DDMS, Report for the Month of April 1944, CAJM 22899 W5726 R21387229, ANZ.
[838] Hospitalisation, Evacuation, and Return to Duty of New Zealand and Other British Personnel who are Hospitalised in US Army Facilities, 9 August 1944, AAYS 8638 330/5/130 R22439131, ANZ
[839] Appendix XXXVIII, Evacuation of Personnel of Fiji Military Forces, 17 April 1944, CAJM 22899 W5726 R21387229, ANZ.

hospitalised in US Army facilities. The US Army medical records and reports were forwarded to the US with the patients at this point.[840]

Tropical Conditions and 1 Malaria Control Unit

Warfare in the Pacific Islands was unfamiliar and challenging to white European troops, who mostly came from temperate climates. The prospect of fighting in jungle environment was particularly daunting. Jungle warfare was new to many Allied forces and the Japanese seemed to have mastered it already.[841] Managing tropical diseases in the Pacific Islands was, therefore, considered crucial to maintaining fighting strength.[842] While the Pacific Islands were 'unhealthy', temperate climates were generally considered healthy.[843] Particularly, malaria caused many deaths in tropical environment in until the first half of the twentieth century.[844] In addition to malaria, soldiers sent to this theatre faced a range of infectious diseases, including skin diseases, which were one of the main causes of trouble in the Pacific.

As taught in the first lecture of a training course for anti-mosquito squads, 'malaria has proved the greatest single obstacle to successful military operations' since the beginning of the war in the Pacific. Noting that malaria was as troublesome to enemies as it was to the Allies, NZEFIP emphasised 'malaria can be a powerful ally' when put under good control. New Zealand had already seen that the Australian Papua campaign resulted in 21,600 malaria

[840] Hospitalisation, Evacuation and Return to Duty of New Zealand, Fijian and other British and Allied Military Personnel who are hospitalised in U.S. Army facilities, 1 October 1944, AAYS 8638 330/5/130 R22439131, ANZ.
[841] H. Rowan-Robinson, *Jungle Warfare* (New York: Hutchinson & Co, 1944), 9–14.
[842] ADMS, Report for Month of December 1943, 14 January 1944, CAJM 22899 W5726 R21387228, ANZ.
[843] From Senior Medical Officer, Fiji Military Forces & Fiji Section 2 N.Z.E.F. to Army H.Q., Re: I. Amoebiasis II. Filariasis, N.Z.E.F. personnel in Fiji, 18 November 1943, ADQZ 18899 13/1/2 R20591379, ANZ.
[844] G. Dennis Shanks, 'Malaria-Associated Mortality in the Australian Defence Force during the Twentieth Century', *The American Society of Tropical Medicine and Hygiene*, 97/2 (2017), 544–547.

admissions to hospitals, excluding the cases treated in the front lines. By comparison, there were only 6,154 battle casualties.[845] Similarly, a high rate of malaria casualties was then occurring in the Burma-India theatre.[846] Malaria conditions were expected to be similar in the Solomon Islands, where 3NZ Division would enter. The DGMS's position was that prevention was 'far more important than the diagnosis or treatment' for malaria.[847] For effective malaria prevention, NZEFIP formed a malaria control unit, 1 MCU.

Malaria and tropical diseases were the first issues discussed when the GOC planned medical support for 3NZ Division. Since it was expected that high sickness casualties were inevitable in the Solomons, 3NZ Division's medical plan had to be prepared for a surge in malaria. First, malaria diagnosis would be made at FAs and, as long as the tactical situation permitted, they would also treat malaria cases. For this work, at least two MOs in each FA were to receive special training in malaria. More serious malaria cases and urgent surgical cases that could not be managed by FAs would be moved to 2 CCS or equivalent facilities which had larger surgical/medical teams and beds. If 3NZ Division were employed as a holding force, the plan was to retain malaria cases in the forward areas instead of evacuating them. With adequate malaria control measures, it was thought manageable. Otherwise, most serious cases would be evacuated to 4 General Hospital in New Caledonia.[848]

Malaria control involved cooperation with other countries, especially the US. In addition to information supplied by New Zealand sources, the 1 MCU received copies of

[845] Lecture 1 Malaria, Refresher Course in Malaria Control for Unit Squads (Commencing 13 Dec. 1943), CAJM 22899 W5726 R21387229, ANZ.
[846] Arthur M. Smith, Craig Hooper, 'The Mosquito can be More Dangerous than the Mortar Round', *Naval War College Review*, 58/1, (2005) 77–87.
[847] Fred To. Bowerbank, Memorandum for the Assistant Director of Medical Services, 28 October 1942, AAYS 8638 330/5/120 R22439117, ANZ.
[848] From G.O.C. 2 N.Z.E.F. I.P. to Army Headquarters, 11 February 1943, AAYS 8638 330/5/120 R22439117, ANZ.

literature and instructions on malaria control from the US medical authorities. Fiji Section of 2NZEF and the FMF, directed by New Zealanders, also communicated with the Force Surgeon of the USMC regarding the Atebrin dosage and malaria control for Fijian troops going into active operation. The principle 'at all times co-operation and reciprocity are maintained with U.S. Med. Services' included malaria control in the forward area.[849] When both New Zealand and US troops were in the same operation, the two countries designated areas in which they were each responsible for malaria control. Information, equipment, and training were shared with one another. For example, the US offered to send a truck for malaria work to the Treasury Islands.[850] During the Green Islands operation, the US changed its weekly dose of Atabrine from 0.4 to 0.6 grams. To stay in accord with the US policy, 3NZ Division also changed the dose of Atebrin for New Zealand troops.[851]

Despite strong warnings about the threat posed by malaria, 1 MCU was surprised to see far lower malaria cases than expected. Throughout the entire period of active operation in the Solomon Islands until April 1944, 3NZ Division reported a 1.45% of malaria rate.[852] 1 MCU identified several factors that may have contributed to the low rate of malaria among New Zealand troops in November 1943. First, they were lucky with the climate and natural environment. New Zealand troops entered the Solomons in the dry season and November was just the beginning of a transition to the wet season. Since rainfall was comparatively low, malaria mosquitos could not breed too much. The low number of malaria vectors was confirmed by night catches that showed very few anopheline mosquitoes around.[853]

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[849] Memorandum for Officer i/c Administration, F.M.F., 11 March 1944, ADQZ 18899 13/1/2 R20591379, ANZ.
[850] Report on Treasury Group to OC 1 NZ Malaria Control Unit, 27 January 1944, CAJM 22899 W5726 R21387228, ANZ.
[851] ADMS, Report for Month of January 1944, CAJM 22899 W5726 R21387228, ANZ.
[852] ADMS, Monthly Report for April '44, 11 May 1944, CAJM 22899 W5726 R21387229, ANZ.
[853] App. VII, From 1 (NZ) Malaria Control Unit to ADMS 3 NZ Div, Report for Month Ending 30 Nov. '43, 1 December 1943, CAJM 22899 W5726 R21387228, ANZ.

Secondly, the anti-malaria effort proved effective. Campsites were chosen in good places to avoid mosquitoes. Anti-mosquito squads did a thorough job controlling mosquito breeding places. Atebrin was continuously administered to keep malaria suppressed. Individually, malaria discipline was reasonably well-kept, although breaches were often observed. The blame was put on the Americans, who did not have good dress discipline, which in turn affected the New Zealanders living alongside American troops. It was also difficult to prevent the troops from swimming at night. Since mosquitos breed near water and are active at night, this was problematic.[854]

Thirdly, the 'reservoir of infection' was not high. In other words, New Zealand troops did not come in close contact with too many malaria-infected people. The 'reservoir of infection' included two groups: American troops and the indigenous population. Some American units were reported to be heavily infected in the Solomon Islands. These troops were, however, moved from Vella Lavella and Guadalcanal shortly after 3NZ Division arrived in the islands. As for the indigenous population, there were not many residing near New Zealand camps. Children, usually 'the most potent source of infection', were rarely seen. 1 MCU supposed that indigenous people were not too heavily infected anyway as before, quoting a blood survey done on local people. This was likely a result of indigenous migration to the hills during the Japanese occupation period, which was far from troop areas.[855]

New Zealand's policy with the indigenous population was to avoid 'the reservoir of infection' as much as possible. The MCU identified a chain of infection that started from 'natives to mosquitos to troops.' Naturally, the aim of malaria control was to 'break the chain of infection.' The first step was to 'avoid the natives' who were the first part of the chain. All

[854] *Ibid.*
[855] *Ibid.*

indigenous populations and the Japanese were assumed to be infected with malaria. Therefore, they had to be avoided. The second chain, mosquitos, could be broken by removing the mosquitos and breeding places. Lastly, troops had to be protected from mosquito bites through personal dress discipline, covering up as much skin as possible, and taking Atebrin.[856] 1 Malarial Control Unit's main activities dealt with the second and third stages of breaking the chain of infection.

Framing 1 MCU's works in another way, malaria control activities can be categorised as being of two types: knowledge collection and disease prevention. The first step was to collect environmental knowledge of the Solomon Islands. A comprehensive malaria mapping system involved the collection of environmental knowledge of the islands where New Zealand landed. Mapping included marking troop areas and indigenous settlements. Areas of anti-malaria work areas controlled by 1 MCU and the US equivalent unit were coloured. All natural landmarks, such as corals, hills, mountains, rivers, and jungles were also marked. In an attempt to provide a clearer idea of the natural environment, maps included captions describing the natural environment. Examples of expressions used in maps include 'covered with coconut palms', 'coconut plantation with heavy undergrowth', 'thickly wooded spur', 'coastal mangrove swamp', and 'heavy jungle' as opposed to just 'jungle.' Most importantly, anopheline breeding places were identified and marked in red.[857]

Entomological knowledge was acquired through the collection and examination of mosquito samples. The entomologist of NZMC, Lieutenant L. J. Dumbleton received regular reports from islands where New Zealand troops were based. Mosquito specimens were also

[856] Lecture 3 Malaria Control Part One, Refresher Course in Malaria Control for Unit Squads (Commencing 13 Dec. 1943), CAJM 22899 W5726 R21387229, ANZ.
[857] 1 (NZ) Malaria Control Unit Monthly Report for November 1943, Maps of Vella Lavella, Guadalcanal, Treasury Showing Mosquito Breeding etc., CAJM 22899 W5726 R21387228, ANZ.

collected and forwarded to Dumbleton for analysis, who would then report the findings to the MCU. Other than identifying anopheline species for each island, he also studied the breeding size and period. For example, he reared a few *A. Punctulatus var. Moluccensis* from egg to adult to learn that the developmental period could be as short as fifteen days. This was almost identical results that was secured from New Hebrides. Similarly, *Bironella (Brugella) sp.* showed a minimum developmental period of 22 days. The research reached the conclusion that spraying insecticides once a week was safe enough.[858]

Clinically, New Zealand gained much experience in examining, diagnosing, and treating malaria in the Solomon Islands. When troops arrived on a new island, the indigenous population was tested to determine the malaria rate. In Vella Lavella, for example, smears of 93 people of all ages were taken from Maravari and Supato village, of which seven returned positive for malaria. Routine smears were done on all patients admitted to 22 and 24 FAs as well as 2 CCS. Five infections were detected through routine testing. Malaria types were also studied. In the Solomons, falciparum was the predominating type among New Zealanders, which broke through Atebrin more easily. By comparison, American troops on Vella Lavella showed a correspondingly great predominance of vivax, which had a higher tendency to relapse but was generally less serious. Through the comparison, the dominance of vivax in 'well-salted troops' and falciparum in fresh, in other words, 'unsalted troops' was confirmed.[859]

In addition to gathering intelligence, 1 MCU prevented the disease through various measures employing their anti-mosquito squads. Comparatively temporary measures focusing on pest control were carried out on a weekly basis, which was considered satisfactory.[860]

[858] From Lieut. L. J. Dumbleton to OC 1 (NZ) Malaria Control Unit, 2 December 1943, CAJM 22899 W5726 R21387228, ANZ.
[859] App. VII, From 1 (NZ) Malaria Control Unit to ADMS 3 NZ Div, Report for Month Ending 30 Nov. '43, 1 December 1943, CAJM 22899 W5726 R21387228, ANZ.
[860] From Lt. W. M. Miller to O.C. 1 (NZ) Malaria Control Unit, Engineer's Report for Month Ending 30 Nov '43,

Oiling was done in all ponds, puddles, fox-holes, ruts, drains, wells, backwaters, and relatively slow steam waters in a radius of three-quarters of a mile from the camps.[861] A more permanent type of disease prevention involved environmental engineering, such as draining or clearing breeding areas. For example, in November 1943, anti-mosquito squads drained an area with several sinkholes. Vertical drains were blasted to remove contained water on an abandoned road. To stop traffic ploughing through wet areas, rails and permanent roadblocks were installed. A considerable extent of larger riverbanks was also cleared. These works, however,

2 December 1943; App. VII, From 1 (NZ) Malaria Control Unit to ADMS 3 NZ Div, Report for Month Ending 30 Nov. '43, 1 December 1943, CAJM 22899 W5726 R21387228, ANZ.

[861] Malaria Control Part 2, Refresher Course in Malaria Control for Unit Squads (Commencing 13 Dec. 1943), CAJM 22899 W5726 R21387229, ANZ.

required more effort and resources and could not be done on a very large scale.[862]



Figure 10. New Zealand medical orderly treating locals of Nissan Island prior to their evacuation. [Source: New Zealand Department of Internal Affairs, War History Branch, Ref: 1/2-041783-F. Alexander Turnbull Library, Wellington, New Zealand. /records/22702459]

[862] From Lt. W. M. Miller to O.C. 1 (NZ) Malaria Control Unit, Engineer's Report for Month Ending 30 Nov '43, 2 December 1943; App. VII, From 1 (NZ) Malaria Control Unit to ADMS 3 NZ Div, Report for Month Ending 30 Nov. '43, 1 December 1943, CAJM 22899 W5726 R21387228, ANZ.

Another semi-permanent measure involved migration of the indigenous population, 'the reservoir of infection.' For the Green Islands operation, the majority of indigenous people were evacuated from Nissan Island and moved to Guadalcanal in February 1944. It is unclear from the sources whether the evacuation was a voluntary request or forced upon the indigenous people. Approximately 1,200 were evacuated. About 60 to 70 'of the healthiest males' were left behind to work for the Salipal Ration Dump. The ADMS reported, 'the removal of this reservoir of infection has solved many would-be problems for the medical services.'[863] Having removed the indigenous population, Green Islands made a great laboratory to test the notion of malaria being infected through the indigenous population.

For those who were not evacuated from the Green Islands, remaining as a labour force for the military, smears were done on 48 adults on Nissan, the largest island in the Green Islands. Two of them returned positive for malaria. On Pinipel Island, a much smaller island near Nissan, 50 children were given blood smears to detect malaria parasites, of which 48% returned positive. The children were also given spleen examinations, of which 69% were positive. To determine whether malaria was endemic, anopheline breeding places were looked for. It was found in a well near a village. Through the extremely high rate of parasites among children, New Zealand learned that malaria can be hyperendemic when permanent breeding places are close to human settlements, even on a small island with less water and low anopheline density. In comparison, Nissan was larger with higher anopheline density but the people were mostly evacuated. The two positive cases were therefore thought to have acquired malaria from combatant troops in the area. For a better understanding of the malaria rate in relation to the indigenous population and anopheline density, New Zealand asked the US to conduct a malaria

[863] ADMS, Monthly Report for February 1944, 15 March 1944, CAJM 22899 W5726 R21387229, ANZ.

survey on the evacuees of Nissan in Guadalcanal if possible. [864]

Eventually, New Zealand units conducted research themselves on Nissan evacuees in Guadalcanal to gain more information on the relationship between malaria and the indigenous population.[865] In March, 494 people were examined for enlarged spleens (a sign of malaria infection) and 1,000–1,200 thick blood smears were taken on 304 people. Examination results were compared with previous data gained from examining 523 people from Guadalcanal. Examinations showed that the spleen rate was considerably lower among Nissan Islanders compared to people from Guadalcanal. As for malaria, the positive percentage was similar in both groups, but there was much less *Plasmodium malariae* among the Nissan Islanders, which was usually rare in other locations as well. Interestingly, 39% of the positive children had gametocytes in their blood, whereas none was found among the adults. Also, no microfilariae (the cause of the disease filariasis) were found in any of the smears. Before the examinations, the evacuees had received four injections (three injections of mapharsen and one Bismuth) for yaws treatment which was highly present in the group.[866]

According to Mary Ellen Condon-Rall, the 'triumph over malaria was one of the most important victories of allied forces in the Southwest Pacific during World War II.'[867] Malaria control in the Pacific Islands was more than just taking pills and wearing long sleeves. It involved more fundamental measures such as altering the landscape, the migration of islanders, and medical research. As a result of the exchange, New Zealand extracted from the Solomon Islands an enhanced knowledge of tropical diseases and malaria.

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[864] Malaria and Malaria Control in Nissan Group, 17 March 1944, CAJM 22899 W5726 R21387229, ANZ.
[865] ADMS, Monthly Report for February 1944, 15 March 1944, CAJM 22899 W5726 R21387229, ANZ.
[866] Malaria Survey of Natives Evacuated from Green (Nissan) Is, 31 March 1944, CAJM 22899 W5726 R21387229, ANZ.
[867] Mary Ellen Condon-Rall, 'Allied Cooperation in Malaria Prevention and Control: The World War II Southwest Pacific Experience', *The Journal of the History of Medicine and Allied Sciences* 46/4 (1991), 493–513.

Although malaria was a huge problem in some islands, for 3NZ Division the official history stated that 'the only real medical problem was caused by skin infections.'[868] To take the example of the Fiji Section, the average proportion of sick parade with skin infections and septic sores was 55% in the 2NZEF during March 1943. This was significantly higher to 26% of the FMF.[869] The most common type of skin disease was septic sores. Boils were also 'numerous' with a strong tendency for all cuts and abrasions to turn septic.[870] Mosquito bites, very common in the tropical climate, were especially apt to become septic.[871] Due to the 'climate' and heavy work the men were engaged in, recovery from septic sores was difficult.[872] Continued moisture from perspiration did not let foot infections (chiefly fungal) improve quickly.[873] There were also reports on Dhobie's Itch, a fungal infection of the groin.[874] Ringworm and heat eruptions were common.[875] Some cases of rubella and mumps also spread among troops in Fiji.[876]

Furthermore, there were perceived diseases borne out of fear among the New Zealand troops. There was a belief that tropical 'glare' harmed eyes. The idea that sunrays and hot winds affected white European eyes had been in the South Pacific since the arrival of settlers in the

[868] Stout, *Medical Services in New Zealand and the Pacific*, 83.
[869] Memorandum for D.G.M.S., HQ, Wellington, NZ, 22 March 1943, AAYS 8638 314/10/9 Part.1 R22438489, ANZ.
[870] Memorandum for the Commanding Officer, 7th Field Ambulance, N.Z.M.C, Ambulance Headquarters, 1 March 1942, AAYS 8638 314/10/9 Part.1 R22438489, ANZ.
[871] Enc. 1 Medical Appreciation of Suva Area, Memorandum for Army Headquarters, New Zealand Military Forces, 26 January 1942, AAYS 8638 314/10/9 Part.1 R22438489, ANZ.
[872] Memorandum for the Commanding Officer, 7th Field Ambulance, N.Z.M.C, Ambulance Headquarters, 1 March 1942, AAYS 8638 314/10/9 Part.1 R22438489, ANZ.
[873] From C.O. 7th Field Ambulance N.Z.M.C. to the Director General of Medical Services, Army Headquarters, 6 March 1941, AAYS 8638 314/10/9 Part.1 R22438489, ANZ.
[874] From Assistant Director of Medical Services, Brigade Headquarters to Director-General of Medical Services, Army Headquarters, 8 November 1941, AAYS 8638 314/10/9 Part.1 R22438489, ANZ.
[875] Memorandum for the Commanding Officer, 7th Field Ambulance, N.Z.M.C, Ambulance Headquarters, 1 March 1942, AAYS 8638 314/10/9 Part.1 R22438489, ANZ.
[876] From captain F.G. Barrowclough, Military Hospital, Tamavua to C.O. 7th Field Ambulance, Headquarters, 21 October 1941, AAYS 8638 314/10/9 Part.1 R22438489, ANZ.

early nineteenth century.[877] This is why New Zealanders wore tinted glasses to counteract the 'glare' in the Pacific Islands during the war.[878] Then, the 'trachoma scare' began in January 1945.[879] Mass examinations showed a 70% positive rate of trachoma, an eye disease that may lead to blindness.[880] The possibility that practically all New Zealanders stationed in Fiji could turn blind created alarm and the DGMS, the Air Force DMS, and two ophthalmologists flew to Fiji to investigate.[881] After their investigation, it was concluded that no case of trachoma was found among the New Zealanders.[882]

The scare arose from the fact that trachoma was spreading among white troops.[883] When it was suspected, it was considered that no race was immune to the disease.[884] Reports provided by the Fijian government supported the belief that 'no race is exempt' but connected the disease to intelligence —the disease rate low where 'the people are of higher degree of intelligence.'[885] Once New Zealand specialists discovered that no New Zealand personnel had trachoma, the Minister of Defence claimed in his press statement that trachoma was common in places such as Fiji, Egypt, China, and among Māoris, but 'so rare amongst the purely British peoples.' He added that eye diseases and conjunctivitis were generally much more common in tropical countries, caused by dust, dirt, or indeed, the 'glare.'[886]

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[877] Anderson, *The Cultivation of Whiteness*, 16–17.
[878] Stout, *War Surgery and Medicine*, 441.
[879] Memorandum for the Commandant, F.M.F., 25 January 1945, AAYS 8638 330/9/20 R22439196, ANZ.
[880] Memorandum for D.G.M.S., A.H.Q Wgton, 1 February 1945, AAYS 8638 330/9/20 R22439196, ANZ.
[881] From Army HQ Wn to HQ Fiji Military Forces, 5 February 1945, AAYS 8638 330/9/20 R22439196, ANZ.
[882] From HQ Fiji Military Forces to Army HQ Wellington, 10 February 1945, AAYS 8638 330/9/20 R22439196, ANZ.
[883] Appendix I, Conference of Medical Officers Convened by D.G.M.S., 6 February 1945, of Minute Sheet, Report by D.G.M.S. on Visit to Fiji, 14 February 1945, AAYS 8638 330/9/20 R22439196, ANZ.
[884] Maj.-Gen, D.G.M.S (Army and Air), Re: Trachoma, 1 February 1945, AAYS 8638 330/9/20 R22439196, ANZ.
[885] Appendix II, Extract Taken from Dr. Stuppel's Report, 1930, of Minute Sheet, Report by D.G.M.S. on Visit to Fiji, 14 February 1945, AAYS 8638 330/9/20 R22439196, ANZ.
[886] Statement to the Press by Hon. Minister of Defence on Visit of Director-General of Medical Services (Army and Air) to Fiji in Connection with the So-Called Epidemic of Trachoma, 13 February 1945, AAYS 8638 330/9/20 R22439196, ANZ.

In the forward area, skin diseases were as prevalent as in Fiji. During the active operation on Treasury Islands, skin disease was the 'only outstanding feature and this is increasing in extent' other than battle injuries.[887] The difference with Fiji was that insects caused more trouble in the Solomons, most notably a mite that was identified as *Trombicula schuffneri*. It was concerning because the species was known to be a vector of scrub typhus in Southeast Asia. The larval mite was particularly affecting the legs of troops, causing severe itching. Scratching, in turn, would lead to secondary infection and subsequent septic sores. A preliminary survey suggested that it was confined to Sterling Island, which was also considered a strange phenomenon. In order to prevent bites on the skin, mosquito repellents and insecticide powder were suggested. The insecticide powder was acquired from the US Navy in New Hebrides for body crawling lice, targeted to prevent chigger and tick bites.[888]

On Nissan Island of the Green Islands, an unusual type of skin disease badly affected some units. It was caused by contact with a small red-brown coloured caterpillar with long furry hair covering the body. Wherever the caterpillar crawled or touched the skin, an intensely irritating erythematous reaction followed. The extremely severe pruritus lasted for several days. Scratching, which was irresistible, often left excoriations that became infected and caused temporary disability. Whether the skin condition was caused by the hair or the fluid on its ventral surface was unclear. The caterpillars had largely disappeared after a short period of causing trouble.[889]

[887] ADMS, Monthly Report for Month of November, 11 December 1943, CAJM 22899 W5726 R21387228, ANZ.
[888] Extract from Report for Week Ending 16 Jan. '44 From OC 8 Bde. Malaria Control Section, 2 February 1944, CAJM 22899 W5726 R21387228, ANZ.
[889] ADMS, Monthly Report for April '44, 11 May 1944, CAJM 22899 W5726 R21387229, ANZ.

Conclusion

The Second World War was a medically internationalising experience at both institutional and personal levels for the New Zealand military. As Judith Bennett argued, New Zealand was 'the junior partner' in the Pacific under American command.[890] For practical and tactical purposes, it adopted US medical practices for its troops in the Pacific. Considering that New Zealand conformed to British standards before the war and on the Western Front and the Western Desert during the war, cooperation with the US on the Pacific Front provided a perspective outside the standards of the British Empire. Americans were the new leaders On the other hand, the war became a chance for New Zealand to work with Pacific Islanders, as shown in the case of the FMF. New Zealand maintained a close relationship with Fiji for decades before the war. Frances Steel considers such close relationship as New Zealand's imperial aspirations beyond countries of formal territorial rule using the case of transport and tourism industry. Calling for attention to 'soft' matters in addition to 'hard power', Steel considers New Zealand as a 'pivot between Britain's formal empire and America's informal commercial empire in the Pacific', in the sense that New Zealand steered its transport industry amid British and American interests in Fiji.[891] Indeed, this thesis has shown thus far that medical institutions were where British, New Zealand, and American interests overlap. Wartime military medicine exhibits both 'soft' and 'hard' power beyond New Zealand's formal territorial rule, through which New Zealand became a 'pivot' between British and American empires.

[890] Judith A. Bennett, 'War Surplus? New Zealand and American Children of Indigenous Women in Sāmoa, the Cook Islands, and Tokelau' in Pickles, Coleborne (eds.), *New Zealand's Empire* (Manchester: Manchester University Press, 2016), 181.

[891] Frances Steel, '"Fiji is Really the Honolulu of the Dominion": Tourism, Empire, and New Zealand's Pacific, ca. 1900–35' in Pickles, Coleborne (eds.), *New Zealand's Empire,* 160.

In the Pacific Islands, especially the Solomon Islands, New Zealand actively sought to study and respond to tropical conditions. Partly because New Zealanders had to live in the Pacific Islands themselves, 3NZ Division offered medical care to its indigenous people. The Solomon Islands was, along with New Hebrides, one of the countries where the WPHS practically gave up on indigenous healthcare. Even during the war, a WPHC official complained that 'the ignorance which prevails here about conditions in the Solomons and so on is simply fantastic.'[892] The war brought medical services to the Solomon Islands not from the imperial centre of the WPHC but rather from New Zealand. Consequently, New Zealand raised its status in the British colonies in the South Pacific. This increased influence continued into the post-war period, during which New Zealand exercised a sub-imperial medical authority.

[892] From Trafford Smith to Trevor, 20 July 1942, Papers of Trafford Smith, Box 2 File 2, Mss. Brit. Emp. s.530, Oxford, Bodleian Libraries.

PART III

Chapter 6. The South Pacific Health Service

The South Pacific Health Service (SPHS) was established in 1946 to pool the medical resources and staff of the British and New Zealand territories. Such regional centralisation had precedents in Africa, where the West African Medical Staff and East African Medical Service had brought together the medical services in 1902 and 1921, respectively.[893] What differentiated the SPHS from the African cases was that it embraced the medical services of New Zealand, a dominion and an imperial power in its own right. Discussions leading to the establishment of the SPHS show that it tried to become an interimperial institution by bringing in the US and Australia. In the end, it simply became an imperial health service, bringing the British and New Zealand colonies under one system. The SPHS is also a product of the Second World War that paved the way for medical centralisation between British and New Zealand colonies.

Colonial Office documents from 1946 remarked that the SPHS had been overshadowed by the publicity of the South Pacific Commission and did not receive the attention it deserved.[894] This also remains the case in the historiography. In the few cases where the SPHS is mentioned, its significance as an imperial health service is often neglected. Annie Stuart discusses the centralisation effort led by the RF but stops before the war when major developments were made to the SPHS.[895] Sarah Clare Hartley's dissertation introduces the WPHS as the medical authority governing the British territories in the Pacific. Hartley's attention, however, was on the programmes of the South Pacific Commission (SPC) and the

[893] Anna Greenwood, 'Introduction: Looking Beyond the State' in Anna Greenwood (ed.), *The Colonial Medical Service in British Africa* (Manchester: Manchester University Press, 2016), 4.
[894] From Price to K. E. Robinson, 6 May 1946, CO 83/241/7, TNA.
[895] Stuart, 'Parasites Lost?'

World Health Organization (WHO) in Fiji.[896] Michael Haas also called the SPHS as one of the first regional institutions before 'the Pacific Way' was instituted and the last regional organisation dedicated to public health in the twentieth century. He positioned the SPHS as one of the remnants of colonialism that the Pacific Islanders hoped to remove but did not explain how it was formed as an imperial institution.[897]

With the existing scholarship, it is difficult to understand the imperial character of the SPHS. Perhaps it is because post-war histories, often focused on the emerging international relations (related to decolonisation), tend to overlook the lasting imperial control in the former colonies. This chapter demonstrates that the SPHS was an imperial governing body established by the British colonial authorities. Although Stuart portrayed the movement for the unification of medical services in the South Pacific as Lambert's personal project, Lambert and the RF's role was marginal, only providing assistance at most. This chapter also challenges Hartley's description of the SPHS as straightforward, uncontroversial, and less present in the Colonial Office files. It was, in fact, the opposite. The existence of extensive documents drawn from the Western Pacific Archives, Archives New Zealand, National Archives of Australia, and the National Archives at Kew prove that the process of establishing the SPHS caused a series of debates over decades among imperial powers. Finally, this chapter regards the SPHS as an extension of previous intercolonial health projects such as the CLH, the CMS, and the WPHS. The SPHS was not the first case of regional cooperation, as Haas saw, but a result of an accumulated effort for fuller cooperation in the field of medicine.

[896] Sarah Clare Hartley, *The Role of Maternal and Child Health in Decolonisation in Fiji, 1945–1970*, PhD Thesis, University of York (2018).

[897] Michael Haas, *The Pacific Way: Regional Cooperation in the South Pacific,* (New York: Praeger, 1989), 19–25.

Initial Attempt for a Centralised Medical Service

The SPHS may appear as an entirely new post-war project of international cooperation, if the interwar history of centralising medical institutions is not considered together. The drive to centralise medical services in the British and New Zealand territories started in 1931. In the same year, the WPHS completed its first phase of the hookworm and yaws campaigns and the CMS extended its curriculum to four years. Sir Murchison Fletcher, the Governor of Fiji and the High Commissioner for the Western Pacific, reached a consensus on the idea during his tour of the region in 1931. According to Fletcher, all countries involved – including the Gilbert and Ellice Islands, the Solomon Islands, Tonga, and New Zealand – enthusiastically supported the scheme.[898] As the Director of the WPHS, Lambert also discussed the matter with New Zealand authorities in early 1931.[899] Indeed, Lambert had always been a strong advocate of a centralised system for the Pacific. It was his efforts from the early 1920s that helped establish the CMS and the WPHS. At Lambert's persuasion, the RF's grant for new laboratories was made on the basis that it would serve the new centralised medical service.[900]

The state of medical organisation in New Zealand territories was poor when the question of centralisation was raised in 1931. For example, the Cook Islands could not attract good medical officers as their medical service was too small, isolated, and lacked urban amenities. Such working conditions could only draw officers such as recently qualified young doctors, who were neither experienced in tropical medicine nor in working with Pacific Islanders. Even if suitable officers were acquired, they tended to leave the Pacific Islands or show slackness after a few years. It was reported that Tonga had 'exactly the same difficulties'

[898] From M. Fletcher to Sir P. Cunliffe-Lister, 23 July 1932, ACHK 8604 1933/1130 R24577145, ANZ.
[899] Minister of External Affairs, Memorandum for the Administrator of Western Samoa, 20 April 1932, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.
[900] From S. M. Lambert to Berendsen, 6 November 1934, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.

and Western Samoa shared similar problems. Although Fiji and the WPHC were staffed through the Colonial Office, they also had difficulty attracting good medical officers. If the medical services of these countries could be unified, the problem could be fixed, it was thought. As a larger organisation, suitable medical officers would be pooled to avoid the drawbacks of the existing system, so that it could be a more 'attractive service.'[901]

Frustrated with slow progress, Western Samoa took up the issue of centralisation in April 1932. The Administrator of Western Samoa directly asked Fletcher how the centralisation idea was progressing.[902] At the same time, Western Samoa approached the Minister of External Affairs of New Zealand to emphasise their difficulties in obtaining suitable medical officers.[903] Following up on the matter, the Prime Minister of New Zealand wrote to the Governor-General of New Zealand to ask if any progress had been made from the British side.[904] Then, the Governor-General wrote to the High Commissioner for the Western Pacific for information.[905] At this stage, the idea was to amalgamate the medical services of all British-controlled islands in the Pacific.[906]

Two months later, Fletcher submitted a proposal to establish a centralised medical service to the Secretary of State for the Colonies. The plan at this stage was to unify the medical services of Fiji, the WPHC territories, Tonga, Western Samoa, and the Cook Islands. A new feature of the proposal was to have recently appointed medical officers receive a tropical

[901] Extract from Letter from the Secretary for the Cook Islands to the Minister for the Cook Islands, 15 January 1931, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.
[902] From H. Hart to Sir Murchison Fletcher, 2 April 1932, ACHK 8604 1933/1130 R24577145, ANZ.
[903] Administrator of Western Samoa, Memorandum for the Minister of External Affairs, 2 April 1932, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.
[904] Prime Minister, Memorandum for the Governor-General, 28 April 1932, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.
[905] From the Governor-General to the High Commissioner for the Western Pacific, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.
[906] Prime Minister, Memorandum for the Governor-General of New Zealand, 28 April 1932, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.

medicine course before leaving the UK. Upon arrival in the Pacific, new officers would first be posted to Suva to experience other centralised medical institutions. They could then be appointed to stations as the Chief Medical Officer deemed appropriate. In cases where officers were transferred to another district or region, they were able to serve in Suva for a while between appointments in remote areas to prevent isolation and familiarise themselves with the central administration.[907]

The advantages of centralisation were clear in the proposal sent to the Secretary of State. First, it would allow better conditions to attract competitive medical officers. At that time, officers posted anywhere other than Fiji were expected to face 'the certainty of a life of isolation and often ill-health and hardship, with little hope of a career.' A centralised system could offer officers an opportunity in a larger service, prospects of promotion, and an assurance that 'he will not be permanently debarred from the ordinary amenities of civilized life.' Secondly, indigenous healthcare could be better coordinated under a central administration compared to how it was done before. Thirdly, since Lambert was so eager to establish a unified medical service, it was expected to benefit from the RF's contributions. Lastly, the scheme made total sense from an imperial perspective, as already agreed by the Executive Council of Fiji.[908]

The main obstacle to centralisation was private practice. The average income from private practice in Fiji varied between £100–150 in remote stations and £250–600 in better-paid districts, occupying a considerable proportion of medical officers' salaries. Most of them were hired by the Colonial Sugar Refining Company to serve European patients. Because the Colonial Sugar Refining Company required that medical officers should not be absent for more

[907] From M. Fletcher to Sir P. Cunliffe-Lister, 23 July 1932, ACHK 8604 1933/1130 R24577145, ANZ.
[908] *Ibid.*

than seven days, regular visits to local villages were not done well. With extra benefits of food, petrol, and other items supplied at a wholesale price, medical officers were further bonded to the Colonial Sugar Refining Company. Fletcher was opposed to private practice because, as long as it was allowed, the interests of the local population would always be subordinate to those of the European minority. The Chief Medical Officer of Fiji also reported that he had 'never been able to put the public advantage in the forefront' because medical officers adhered to private practice.[909]

The Secretary of State approved the proposal in principle in May 1933. For full approval, he required financial agreement on pensions, travel, and training fees between participating administrations. In view of the possibility of a prolonged negotiation, the Secretary of State suggested centralisation first commence between the British colonies. Medical officers could be seconded or transferred to Tonga, Western Samoa or the Cook Islands from there if needed.[910] While the approval signalled the scheme would go forward, New Zealand was unhappy with the decision. It was understood as an exclusion of the New Zealand voice from the inception. New Zealand authorities feared that the centralised service would be satisfactory to the British, especially on financial terms, but not to New Zealand. Therefore, no further action was taken by New Zealand to see how the experimental service between Fiji and the WPHC took off.[911]

Communications between Lambert and Berendsen, the Secretary of the Department of External Affairs of New Zealand, clearly show that New Zealand was upset with the Secretary of State's decision. Lambert figured the Secretary of State 'evidently wanted to get Something

[909] *Ibid.*
[910] From P. Cunliffe-Lister to the Officer Administering the Government of Fiji, 3 May 1933, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.
[911] C. A. Berendsen, Memorandum for the Secretary of the Samoan Administration, 18 August 1933, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.

going.' He also argued that the WPHC had been centralised in principle since 1928.[912] The CLH, the CMS, and the WPHS were all centralised institutions that started operating around 1928. In the same year, the Director of Medical Services of Fiji was made the Central Medical Authority of the WPHC, having all British territories under one authority. A centralised medical service would just bring intercolonial collaboration to a fuller extent. However, Berendsen complained that once all parties agreed in principle, the terms and conditions should have been discussed with New Zealand. He emphasised that it would be much harder for New Zealand territories to join at a later stage because the British financial standard was unaffordable.[913]

Among the New Zealand territories, Western Samoa was especially anxious about the financial terms for the centralised medical service. Agreeing to the obvious advantages of pooling medical officers, Western Samoa informed the Department of External Affairs of New Zealand that it was economically unable to participate.[914] The Department of External Affairs replied to Western Samoa that New Zealand was not invited to join the scheme, 'indeed we are specifically excluded.' New Zealand thought the exclusion at the early stages 'will render it immensely more difficult for us ever to be included.'[915] To express their disappointment and concern, Berendsen wrote to Lambert that the centralisation based on the existing financial standards of Fiji and the WPHC would surely make conditions more difficult for New Zealand territories to join later.[916]

Western Samoa's financial situation was also affecting its participation at the CMS. In

[912] From S. M. Lambert to Berendsen, 20 February 1934, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.
[913] From C. A. Berendsen to S. M. Lambert, 1 March 1934, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.
[914] A. C. Turnbull, Memorandum for the Secretary of the Department of External Affairs, 18 September 1933, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.
[915] C. A. Berendsen, Memorandum for the Secretary of Samoan Administration, 5 October 1933, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.
[916] From C. A. Berendsen to S. M. Lambert, 13 October 1933, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.

1933, they argued that there were enough NMPs to meet the medical needs of Western Samoans. This was not true because Western Samoa only had four fully qualified medical officers, all based in Apia. Seven NMPs managed the remaining 48,000 Samoans.[917] The Mau Movement supposedly made administration in Western Samoa worse.[918] In the end, the CMS Advisory Board refused to accept the withdrawal request and Western Samoa was obliged to participate in the CMS until the initial ten-year agreement was over in 1938.

Unlike Western Samoa, which was a mandate territory, the Cook Islands was more cautious of New Zealand losing jurisdiction over medical services. The main problem was the proposed headquarters in Fiji, which would be under Colonial Office control. The Cook Islands Department opposed centralisation because they 'would not favour relinquishing the control of the Medical Services of the Cook Islands – one of the most important functions of the New Zealand Government in that territory, which is an integral part of New Zealand.' The Cook Islands agreed to the scheme in 1931 under the assumption that New Zealand still controlled its medical services.[919] Indeed, in 1931, the Cook Islands was so enthusiastic about the idea that they proposed a merger between New Zealand territories and Tonga, even if the British-controlled territories did not participate.[920] The Cook Islands was reluctant to lose medical sovereignty, while Western Samoa was bothered by finance.[921] This stance regarding the Cook Islands as 'an integral part of, and within the boundaries of, New Zealand' continued into the post-war period leading up to decolonisation.[922]

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[917] From S. M. Lambert to Berendsen, 18 January 1934, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.
[918] From S. M. Lambert to Berendsen, 20 February 1934, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.
[919] Secretary, Notes on Proposed Pacific Medical Service, 3 March 1934, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.
[920] Extract from Letter from the Secretary for the Cook Islands to the Minister for the Cook Islands, 15 January 1931, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.
[921] From C. A. Berendsen to Lambert, 29 March 1934, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.
[922] Caroline J. McDonald, 'An Exemplary Leader?: New Zealand and Decolonization of the Cook Islands and Niue', *The Journal of Pacific History,* 55/3 (2020), 397.

Meanwhile, Fiji and the WPHC came up with a detailed plan to centralise medical services as advised by the Secretary of State. Tentatively named the Pacific Medical Service, the centralised institution had its headquarters in Fiji. Significantly, it was treated as 'an integral whole' where the concept of regional transfer did not exist. Because appointment to the WPHC territories was 'tantamount to official exile', it was critical that medical officers understood that Fiji, the Solomon Islands, and the Gilbert and Ellice Islands were regarded as one administration from a medical point of view. The new service aimed to offer unified control, central organisation, and expert advice to participant territories with headquarters in Fiji. To the medical staff, it would offer a wider field of service for career development. It also aimed to abolish two undesirable features of the existing system: private practice and having medical officers isolated in out-stations for a long time. For this purpose, all officers would first be posted to Fiji for a year before being assigned to other stations. The maintenance costs would be divided in proportion to the strength of each country. Fiji would bear roughly 75% of the cost (i.e. 20/26), with the rest split between the Gilbert and Ellice Islands and the Solomon Islands (i.e. 3/26 each). The plan included revised titles and salary scales, estimated income without private practice, pension, travel expenses, leave policy, and conditions of appointment. A full list of existing medical officers' salary conditions and estimated cost for the upcoming fifteen years were attached.[923]

Based on this plan, Fletcher had a conference in New Zealand with the New Zealand Prime Minister, the Minister of Health, the Director of Medical Services, the Public Service Commissioner, and the Secretary of External Affairs. The idea was completely approved in principle. However, as far as Western Samoa and the Cook Islands were concerned, financial

[923] R. H. Garvey, Memorandum, The Pacific Medical Service, 3 January 1934, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.

expense and medical sovereignty were pointed out as difficulties.[924] New Zealand still considered it desirable to participate in the centralisation scheme. Before concluding on a final decision, its Prime Minister requested Fletcher to supply 'with the fullest possible information as to the financial commitments' for the territories under New Zealand control with a long questionnaire asking specific details about finance.[925] The request was delivered to the Secretary of State in May 1934.[926] After seven months, frustrated that the Secretary of State did not reply, New Zealand suggested approaching the Colonial Office directly. However, Fiji advised New Zealand against direct communication with London and discussion stagnated from this point.[927]

At this early stage, Lambert played an active role in liaising with the British authorities in Fiji and New Zealand. He advocated the unification of medical services in the Pacific as early as 1922 and his efforts are evident in his communications with the New Zealand authorities. When New Zealand was upset with the possibility of exclusion from the centralised system, Lambert promised Berendsen that he would 'remain the unofficial voice of New Zealand' in other centralised institutions in Fiji.[928] As the centralisation progress was slow, Lambert visited Wellington and London in June 1935 to discuss the matter with the Colonial Office.[929] By this time, New Zealand was convinced that centralisation would be beneficial.[930]

Centralisation of the British territories did not happen at this stage. In 1934, the

[924] C. A. Berendsen, Memorandum for the Secretary of Samoan Administration, 8 February 1934, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.
[925] Prime Minister, Memorandum for the Governor-General, 29 March 1934, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.
[926] From M. Fletcher to the Governor-General of New Zealand, 8 May 1934, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.
[927] From C. A. Berendsen to S. M. Lambert, 18 July 1938, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.
[928] From Lambert to Berendsen, 9 April 1934, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.
[929] From S. M. Lambert to Berendsen, 15 April 1935, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.
[930] On behalf of the Prime Minister to S. M. Lambert, 22 May 1935, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.

medical officers hired by the Colonial Office had to follow the terms and regulations of the newly established Colonial Medical Service.[931] In order to determine the transferability of medical officers, each officer's contract details were examined. Most officers could be transferred within the British territories but not to those under New Zealand control.[932] Also, Fletcher asserted that the question of private practice was the crux of centralisation. Officers were tied to the Colonial Sugar Refining Company and their work could not be directed to indigenous healthcare.[933] Moreover, for the new centralised medical service to join the Colonial Medical Service, overall revision of salaries was inevitable. A sudden raise of medical officers' salaries from £500–725 to the proposed £600–920 would bring strong opposition from local governments.[934] The British could not find a solution to contract conditions, ban private practice, and raise salaries. Coincidentally, the reorganisation of civil services of the Solomon Islands and the Gilbert and Ellice Islands started in 1934. The centralisation plan was postponed as a result.[935]

Development of the Centralisation Plan

According to the Department of Island Territories, the early stage of the centralisation scheme was a New Zealand initiative. Indeed, New Zealand put forward proposals for a unified medical service for the British and New Zealand territories, including Tonga. When the discussion was revived in 1938, however, the main effort came from Fiji.[936] Lambert was

[931] From Malcolm MacDonald to the Officer Administering the Government of Fiji, 2 August 1935, CO 83/211/2, TNA.
[932] Medical Officers Required to Serve If Necessary in Either Fiji or the Western Pacific, ACHK 8604 1933/1130 R24577145, ANZ.
[933] Note of a Meeting held in Sir John Shuckburgh's Room at 11.45 on 25th June 1935, CO 83/211/2, TNA.
[934] From M. Fletcher to P. Cunliffe-Lister, 7 May 1934, CO 83/211/2, TNA.
[935] Note of 15 March 1939, CO 83/227/13, TNA.
[936] Acting Secretary of the Department of Island Territories, Memorandum for the Secretary for External Affairs, 6 January 1944, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.

planning for his retirement when McGusty was appointed as the Director of Medical Services for Fiji and the Central Medical Authority for the WPHC in 1938. According to Lambert, McGusty was willing to push the centralisation scheme 'with all his vigour' and started discussions with New Zealand.[937] Berendsen reported that nobody had lost interest in the centralisation scheme as long as Fiji was ready to make progress.[938] With McGusty's enthusiasm, Fiji was preparing a proposal to create a medical service large enough to cover the New Zealand territories, given that New Zealand would accept the Colonial Office's terms and conditions.[939] New Zealand's new Labour government at the time took a keen interest in healthcare, even attempting to implement a radical free healthcare policy.[940] However, New Zealand still demanded the answer from the questionnaire sent in 1934 before negotiating the terms.[941]

A renewed centralisation proposal was submitted to the Colonial Office in March 1939. The Secretary of State for Colonies had changed several times since the scheme was approved by Sir Philip Cunliffe-Lister. The High Commissioner of the Western Pacific, likewise, had changed many times since Fletcher made his proposal. But the medical situation in the South Pacific had changed little. New Zealand still welcomed the amalgamation because it could not obtain good medical officers to work in remote territories and the need to pool medical personnel remained. The renewed proposal therefore advocated a central medical authority to control human resources in the British and New Zealand territories. Medical officers would be seconded and transferred from the British colonies to New Zealand territories or Tonga.[942]

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937 From S. M. Lambert to Berendsen, 7 July 1938, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.
938 From C. A. Berendsen to S. M. Lambert, 9 August 1938, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.
939 From S. M. Lambert to C. A. Berendsen, 26 September 1938, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.
940 Dow, *Safeguarding the Public Health*, 120–122.
941 From C. A. Berendsen to S. M. Lambert, 1 October 1938, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.
942 Memorandum on Proposed Unification of Medical Service in Western Pacific, 15 March 1939, CO 83/227/13, TNA.

However, the centralisation discussion stopped again at this point.

The momentum for establishing a centralised medical service came during the Second World War. Fiji invited Michael Watt, the Director-General of Health of New Zealand, and Mary I. Lambie, the Director of the Division of Nursing of New Zealand, to examine the medical conditions of Fiji in 1943.[943] After an extensive investigation in Fiji, Watt and Lambie submitted a report reviewing Fiji's medical conditions. This report came to be known as the Watt-Lambie report in future discussions and called for closer coordination of all medical services in the South Pacific for healthcare. In summary, it suggested plans for an enlargement of public health and hospital facilities, special attention to tuberculosis, and the eventual establishment of a 'Medical Centre for the South West Pacific' with its own unified 'South Pacific Medical and Nursing Services.' The unified medical service would revolve around the new medical centre in Suva to serve the British and New Zealand territories.[944]

This idea of a unified medical service was similar to the suggestions made by Lambert during the interwar years.[945] As Derek Dow discussed in his book, Lambert and Watt communicated with each other while in office, especially for Lambert's 1937 Māori health survey. But the two doctors did not always agree with each other concerning indigenous healthcare and environmental hygiene.[946] It is noteworthy that the Watt-Lambie report came after Lambert's retirement and his subsequent departure from the South Pacific. In place of Lambert, Watt and Lambie took on a leading role in the centralisation plan.

From Sir Philip Mitchell's perspective, as the High Commissioner, the most important

[943] Acting Secretary of the Department of Island Territories, Memorandum for the Secretary for External Affairs, 6 January 1944, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.
[944] Summary of Recommendations Made by Dr. Watt and Miss Lambie with Alternative or Additional Recommendations by Dr. McGusty, 29 August 1943, CO 83/248/4, TNA.
[945] Stuart 'Parasites Lost?', 141–155, 332–366.
[946] Derek A. Dow, *Maori and Government Policy, 1840–1940* (Wellington: Victoria University Press, 1999), 161–200.

feature of the Watt-Lambie report was a new general hospital to be placed in the Medical Centre. The main hospital in Fiji was the CWM Hospital, to which Mitchell attached great political importance. Pointing out that the hospital was of 'great sentimental value to the Fijian public since it was built to commemorate the sacrifices made in the First World War by the people of Fiji', he objected to the report suggesting it be closed down. Instead, Mitchell suggested the hospital be rebranded under the name of 'Winston Churchill South Pacific Hospital.' He claimed that 'our freedom to plan, in undisturbed security and with confidence of fulfilment, the establishment of such an institution is due to the magnificent leadership and indomitable courage of the Prime Minister.'[947] The new name would still carry great political significance in colonial Fiji.

Meanwhile, a separate proposal to centralise medical services under the New Zealand leadership was made in December 1943. It was written by J. C. Lopdell, who was a medical officer in Tonga who later became the Director of Medical Services of Western Samoa. The main difference with the British proposal was that this centralised service would be based in and directed by New Zealand, with a new research centre for tropical medicine. Lopdell mentioned that similar institutions already existed in the UK and Australia (probably referring to London School of Hygiene and Tropical Medicine, Liverpool School of Tropical Medicine, and School of Public Health and Tropical Medicine in Sydney). Considering New Zealand was building more experience in tropical medicine during the war, Lopdell was perhaps suggesting that New Zealand should raise its profile in tropical medicine to rival other countries. The proposal was limited to the islands east of 170 degrees longitude (Western Samoa, the Cook Islands, Niue, Māori areas in New Zealand, French Polynesia, Fiji, the Gilbert and Ellice

[947] Improvement of Medical Services in Fiji, From Sir Philip Mitchell to the Secretary of States for the Colonies, 29 August 1943, CO 83/248/4, TNA.

Islands, Tonga, and American territories).[948]

Three justifications were given for excluding the Melanesian countries. Firstly, the 170-degree-line divided the malarious zones. Since malaria prevailed in the islands west of 170 degrees longitude, medical resources could be saved by excluding the malarious countries. Secondly, the line would limit the service to Polynesia, with the exception of Fiji. This way, it would be easier to pool and transfer medical officers without them having to acquire new knowledges of people every time they move. Lastly, the line marked the Australian and New Zealand spheres of trade and rule in the Pacific. The service would leave Australia to take care of their 'Austral-Pacific Regional Zone' while New Zealand would control their own sphere of influence.[949]

The proposal aimed at promoting the 'unity of the Islands and New Zealand' and problematised Māori health conditions in New Zealand. He argued, 'The Polynesian has been irrevocably torn away from the past, but has many shreds still attached; he must advance to western ideas, since there is no hope of returning to the old culture.'[950] This approach contradicts Lambert's argument that the WPHS should only provide healthcare to keep the Pacific Islanders remain in their 'neolithic' civilisation. Lopdell's idea was an active intervention for Westernisation from the imperial government. Yet it does not claim that the Māori should be given the same type of healthcare as the white New Zealanders.

Lopdell's proposal was discussed by the New Zealand Prime Minister, the Minister of Health, the Director-General of Health and the Administrator of Western Samoa. Peter Fraser, the new Prime Minister and former Minister of Health, was especially interested in the scheme.

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[948] J. C. Lopdell, A Combined Medical Service for the S. W. Pacific, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.
[949] *Ibid.*
[950] *Ibid.*

With personal passion, he was willing to explore the possibility of centralising the medical services of New Zealand territories to be based in New Zealand even if Fiji and the WPHC did not join. The British were blamed for their 'disinclination to come in' despite Lambert's previous efforts. This way, they could simplify the difficulties in reaching a consensus with the British authorities.[951] However, the eventual centralisation discussion developed based on the Watt-Lambie report under the British leadership.

Watt-Lambie and Lopdell's reports were made in the context of war. The Watt-Lambie report was specifically prepared as a post-war reconstruction plan. As shown in previous chapters, medical services of New Zealand and Fiji were very closely connected throughout the war. Even before the war, Fiji and the Pacific Islands were already considered essential for New Zealand's defence. New Zealand was always keen on cooperation with the British concerning Pacific Islands.[952] Indeed, the Royal New Zealand Air Force planned that a number of landing fields would radiate from Fiji throughout the Pacific so that aircraft could fly in any direction: the Gilbert and Ellice Islands, the Phoenix Islands, Samoa, the Cook Islands, Line Islands, and Tonga.[953] This plan was confirmed in the memorandum prepared by Foss Shanahan, Assistant Secretary to the War Cabinet, for the Prime Minister of New Zealand. According to the memorandum, Fiji became 'a major port on the Pacific air routes' for military aviation during the war and would remain that way in the post-war period. Therefore, the War Cabinet argued that it was 'essential' that Fiji have an effective medical service to 'ensure that the possibility of tropical and endemic diseases being introduced into New Zealand, inter alia,

[951] Acting Secretary of the Department of Island Territories, Memorandum for the Director-General of Health, 29 December 1943, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.
[952] Sean Phillips, 'Examining "The Eye of the Earth": The Pan-Pacific Idea and the British Dominions, c. 1910–1940', DPhil Thesis, University of Oxford (2021), 302–304.
[953] Gillespie, *The Pacific*, 20.

is reduced to a minimum.'[954]

Lopdell's proposal was also influenced by wartime experience. The proposal suggested delivering medical services to remote islands through air ambulances and flying surgeons, which come into being in wartime. It was timely to 'swing into action immediately in the post-war reconstructive period.' A strong centralised medical service could not only re-employ returned medical officers but also bring a 'great post war expansion of trade in Pacific.' It could also bring together the Allied nations to 'encourage further co-operation post-war and counteract tendencies towards isolationist policies.'[955] In other words, the centralisation of medical services could promote regionalism and international cooperation between the Pacific nations.

Other than the reports, a big step for healthcare in the Pacific Islands was taken with the Australia-New Zealand Agreement, commonly known as the Canberra Pact. The agreement was ratified in January 1944 between Australia and New Zealand to take joint responsibilities for the care of the Pacific Islands. It was in line with the principles laid out in the Atlantic Charter of 1941, which pioneered joint efforts to enhance international security and welfare in the post-war world. The Australia-New Zealand Agreement resulted in the creation of the South Seas Regional Commission, later the South Pacific Commission.[956] According to Peter Fraser, it was necessary 'in order to satisfy world public opinion, and especially the US.'[957] Since the Australia-New Zealand Agreement set grounds for regional cooperation, it made

[954] Foss Shanahan, Memorandum for the Prime Minister, 11 March 1944, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.
[955] J. C. Lopdell, A Combined Medical Service for the S. W. Pacific, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.
[956] http://dfat.gov.au/about-us/publications/historical-documents/Pages/volume-07/26-australian-new-zealand-agreement-1944.aspx (accessed 29 October 2022)
[957] Note of a discussion with Mr. McIntosh of New Zealand Department of External Affairs held in the Colonial Office, 23 May 1944, CO 83/241/5, TNA.

sense to establish a centralised medical service.

Many more wartime policies paved the way for a centralised medical service. Firstly, and most importantly, medical officers were banned from private practice during the war.[958] Secondly, while it was generally desired that secondments should be restricted in both number and period, wartime conditions led to their extension. It seemed inevitable that secondments on a more frequent and extensive scale than previously would have to continue for some time after the war.[959] Simply keeping wartime policy would enable the central authority to transfer medical officers to remote areas. Thirdly, the Colonial Development and Welfare Act of 1940 brought financial aid to medical development in the colonies. A circular from the Secretary of State regarded the new Act 'as marking the dawn of a new era in Colonial Administration.'[960] As the operation of a centralised medical service was beyond the colonial capacity, 'substantial help from England' was needed. McGusty visited London to work out the centralisation plan based on the suggestions made in the Watt-Lambie report.[961]

Wartime ideas for centralisation were not limited to medical services. The Colonial Office even discussed a proposal to establish a 'Joint Administrative Service' that formally unified Fiji and the WPHC colonies. The argument supporting a unified colonial service was practically identical to those for a centralised medical service. Administrative officials sent to the Gilbert and Ellice Islands or the Solomon Islands were especially 'depressed at the thought of getting stuck there without opportunity to widen their experience, thus never becoming eligible for transfer to a more advanced Colony, and a "career" in the Colonial Service.' There

[958] From the Secretary of Sates for the Colonies to Government of Fiji, 17 January 1946, CO 83/241/7, TNA.
[959] From G. H. Hall to A. Grantham, 20 May 1946, CO 83/241/7, TNA.
[960] Copy of Circular from Lloyd, the Secretary of State for the Colonies, 10 September 1940, Papers of Trafford Smith, Box 2 File 3, Mss. Brit. Emp. s.530, Oxford, Bodleian Libraries.
[961] From P. Mitchell to the Prime Minister of New Zealand, 19 February 1944, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.

were cases of the WPHC officials turning alcoholic, marrying indigenous women, or even committing suicide. Given that Rotuma was already a dependency of Fiji, other smaller colonies with few resources could also be absorbed into Fiji for ultimate governance from Suva.[962] Although colonial unification did not happen, the proposal shows that the idea of administrative centralisation of the Pacific Islands was discussed among the colonial authorities.

All of these wartime developments led to the final agreement between Fiji, the WPHC, and New Zealand. The need for a central organisation had been apparent for decades, for Lambert had advocated a unified medical service since 1922. Formal discussions between the British and New Zealand governments also date from 1931. However, it was only after the emergency of the war that such an institutional unification could happen. New Zealand and Fiji were operating as one force in the military. Most officers from Fiji who took part in the centralisation discussion were also serving in the Fiji Medical Corps with the officers of the 2NZEF. Problems in private practice, pooling policy, finances, leadership, and the understanding of the need for indigenous healthcare were all solved during the war. Finally, momentum was gained through Fiji's request for the Watt-Lambie report, which led to a definite invitation to New Zealand for centralisation.[963]

The Establishment of the South Pacific Health Service

The SPHS was at the intersection of imperialism and regionalism. By embracing the New Zealand territories under British leadership, the British Empire created a sub-imperial

[962] Trafford Smith, Note on Some Questions Affecting the Proposed Fiji and Western Pacific Joint Administrative Service, 7 October 1941, Papers of Trafford Smith, Box 1 File 8, Mss. Brit. Emp. s.530, Oxford, Bodleian Libraries.

[963] From D. G. Sullivan to H. V. Evatt, Minister of External Affairs, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.

medical block in the Pacific. Working plans for centralisation began in March 1944 and the centralisation was agreed upon in Wellington. From the British side, the High Commissioner for the Western Pacific and the Director of Medical Services of Fiji attended. From New Zealand, the Parliamentary Under-Secretary to the Prime Minister, the Minister of Health, the Director-General of Health, the Director of the Division of Nursing, and the Acting Secretary of the Department of Island Territories were present. The conference agreed on a centralised medical service, a Health Centre based in Suva, the instalment of a Board, the status of the medical staff, duties of the director of the Board, and costs.[964]

In London, the Colonial Office considered that having such functional authorities in colonies was at variance with the usual policy. However, it was 'inevitable if regionalism is to be developed', which was the Colonial Office policy for the post-war period.[965] Finally, in June 1944, New Zealand formally agreed on the establishment of the SPHS.[966] The new service would not only pool medical staff but also function as an umbrella institution for other intercolonial projects such as the CLH and the CMS.[967]

However, the name of the service was debated. When it was proposed by the British in 1944, it was called the Joint Pacific Medical Services, as wartime conditions made 'Joint Services' seem appropriate. However, specifying regional dimensions created some difficulties. The regional scope largely corresponded with the WPHC areas, which justified the use of 'Western Pacific.' The Colonial Office considered the provisional area for the new service to correspond more with the South Pacific Area than the South West Pacific Area, as designated

[964] Fiji and Pacific Health Services, Attachment to the letter from A. G. Osborne to the Minister of Health, 17 March 1944, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.
[965] Letter to Sir G. Gater, 2 May 1944, CO 83/241/5, TNA.
[966] From D. G. Sullivan to the Governor of Fiji and High Commissioner for the Western Pacific, 12 June 1944, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.
[967] Appendix I, II, VI, Minutes of a Meeting of a Conference Held in Suva on the 9th and 11th July, 1945, WPHC9 82/7/1 Vol.1, WPA.

by the Allied command to indicate theatres of war. The South Pacific Area covered territories east of Australia and south of Hawai'i, such as New Zealand, Solomon Islands, Gilbert and Ellice Islands, New Hebrides, New Caledonia, Fiji, Tonga, Samoa, and the Cook Islands. The South West Pacific Area was south of China and west of New Zealand, which included the Philippines, Borneo, the Dutch East Indies, East Timor, Australia, Papua New Guinea, and parts of the Solomon Islands. Finally, the Colonial Office chose 'South Pacific' following the suggestion of the Dominion Office.[968]

During the period after the agreement, the service was tentatively called the South Pacific Medical Service. This title can be found in the letterheads created by the working director of the service and was referred to as such in primary sources. Later in early 1946, before the formal establishment, New Zealand suggested replacing the term 'medical' with 'health.' This way, the organisation would appear to place emphasis on the positive aspects of the scheme.[969] Generally, New Zealand seemed to prefer using 'health' over the term 'medical.' New Zealand had the Ministry of Health, while Fiji had the Medical Department. New Zealand also pioneered the international understanding of 'health' and preventive medicine over the interwar years through ministerial and legal institutions.[970] In the end, the South Pacific Health Service was agreed upon as the name of the newly centralised medical services.

The SPHS headquarters was situated in Suva. It was an obvious and natural choice thanks to Fiji's geographical, political, and medical centrality. Fiji was the largest populated British colony in the South Pacific and the home of the WPHC. The Watt-Lambie report suggested Suva too 'because of its geographical location, excellent climate, freedom from

[968] From Mr. Shannon to Mr. Sidebotham, 26 May 1944, CO 83/241/5, TNA.
[969] From Government of Fiji to the Secretary of State for the Colonies, 2 January 1946, CO83/241/7TNA.
[970] Margaret Tennant '"Missionaries of Health": The School Medical Service During the Inter-war Period', in: Linda Bryder (ed.), *A Healthy Country: Essays on the Social History of Medicine in New Zealand* (Wellington: Bridget Williams, 1991) 128–149.

malaria and other tropical diseases, and previous cooperative works done.' By virtue of its position, Fiji was expected to be an important junction for air services. It would, therefore, be vital in the sanitary control of air traffic, particularly the prevention of the spread of mosquito-borne diseases.[971] Politically, Fiji's centrality would eventually do more than simply connect the Pacific Islands. It was expected that the WPHC territories would 'no doubt, be more directly administered from Suva, probably by flying boat.'[972] Health conditions in Fiji were also comparably better than in other colonies. Fiji had one hospital bed for every 300–400 population and the funds for healthcare were double the amount Fiji spent on education. For comparison, India had one bed for 1,000 people and spared half the amount spent on education on medicine.[973] Above all, the most important reason for selecting Suva as the 'public health capital' was that other centralised medical institutions were also in Fiji.[974]

The official agreement for the establishment of the SPHS was ratified on 7 September 1946. It was signed by the High Commissioner, Sir Alexander Grantham, for Fiji, the Gilbert and Ellice Islands, and the Solomon Islands. Peter Fraser signed on behalf of West Samoa, the Cook Islands, and Tokelau. Accordingly, the South Pacific Board of Health was established. The Board members included the Inspector-General (chairman); the Director of Medical Services, Fiji; the Director-General of Health, New Zealand; the Director of the Division of Nursing, New Zealand; a person appointed by the High Commissioner for the Western Pacific; and an RF representative if the Foundation desired representation.[975] As the RF did not

[971] Post-war Reconstruction: Fiji and Western Pacific Public Health and Medical Services, 1944, CO 83/241/5, TNA.
[972] Trafford Smith, The Western Pacific High Commission Territories, 21 July 1941, Papers of Trafford Smith, Box 1 File 8, Mss. Brit. Emp. s.530, Oxford, Bodleian Libraries.
[973] Letter from Sir A. Grantham to Mr. Sidebotham of the view of Sir Raghunath Parenjpye, 18 May 1946, CO 83/241/7, TNA.
[974] South West Pacific Medical Service, CO 83/241/6, TNA.
[975] Agreement for the Establishment of a South Pacific Health Service, 7 September 1946, CO 83/241/7, TNA.

participate in the end, the Board consisted of five members.

The functions of the Board generally benefited both the British and New Zealand Territories. The agreement document stated nine functions: (a) to advise on all health matters (b) to collect information in regard to the incidence of disease and to ensure transmission of relevant information (c) to draw up a standard code for quarantine procedures for the guidance (d) to assist in maintaining adequate medical, nursing and sanitary staff (e) to nominate a person or persons to act on behalf of the Board in selecting candidates for appointments to the South Pacific Health Service (f) to encourage, coordinate and if necessary initiate medical research (g) to advise in all matters relating to the training of NMPs (h) to make recommendations on conditions of service, including salary scales, of all grades of medical and health personnel (i) generally to carry out such inquiries and to do all such things or act as in the opinion of the Board are necessary for the purpose of assisting the participating administrations in the more effective control of disease and promotion of health.[976]

The initial agreement for the SPHS was made for two years, during which it gained more participants. At the end of the initial agreement, the SPHS Board agreed that the SPHS had already provided important benefits to participating territories. They noted that the South Pacific Commission did not obviate the need for the SPHS. There were mutual benefits gained through collaborations between the two organisations. Therefore, the Board decided that the SPHS agreement should be ratified on a permanent basis. The Governor of Fiji emphasised that the permanency of the SPHS had political significance.[977] New Zealand was 'fully satisfied' with the SPHS too and agreed that it should continue on a permanent basis.[978] As a

[976] Sarah Clare Hartley, 'Interweaving Ideas and Patchwork Programmes: Nutrition Projects in Colonial Fiji, 1945-60', *Medical History*, 61/2 (2017), 200–224.
[977] From the Governor to the Secretary of State, 25 November 1949, WPHC9 82/7/1 Vol.2, WPA.
[978] From the Governor to the Secretary of State, 2 December 1949, WPHC9 82/7/1 Vol.3, WPA.

result, a renewed agreement was signed to be in force from June 1951, after the first five years of its operation, and it was regularly renewed.[979]

The creation of the position of Inspector-General reflects strong British interest in the SPHS. The Inspector-General would chair the Board and would be the chief decision-maker. In the early stages, it was suggested that the Director of Medical Services of Fiji, who was the Central Medical Authority of the WPHC territories at the same time, would directly administer the 'Joint Pacific Medical Service.'[980] This was why Fiji considered the title Director-General more appropriate. However, New Zealand argued that the role of the chief administrator of the SPHS should be closer to an inspector than a director.[981] Finally, it was agreed that an Inspector-General position would be created as independent from existing British services.

The Inspector-General position was created because it was undesirable for an officer from Fiji to have supreme medical command over New Zealand territories. A higher-level position was necessary. The Inspector-General was expected to work in equal measure for all territories and not be regarded as an officer of any single administration. Still, the Inspector-General was nominated by the Secretary of State for the Colonies and reported directly to the Governor of Fiji and the High Commissioner for the Western Pacific, who represented the Secretary of State. In Board meetings, the Inspector-General had a deliberative vote and, in case of an equal division of votes, a casting vote. However, he was to consult with the representatives of New Zealand before making decisions.[982] Thus, although the Inspector-General was expected to behave fairly and justly, he could still further British interests. It is

[979] Agreement for the Continued Operation of a South Pacific health Service, Made Between the Government of New Zealand, the Government of Fiji and the Western Pacific High Commission [in Force 11 June 1951], WPHC9 82/7/1 Vol.3, WPA.
[980] Letter to Sir G. Gater, 2 May 1944, CO 83/241/5, TNA.
[981] M. H. Watt, Memorandum for the Minister of Health 23 March 1944, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.
[982] Agreement for the Establishment of a South Pacific Health Service, 7 September 1946, CO 83/241/7, TNA.

therefore unsurprising that, even before the formal establishment of the SPHS, it was decided that the Fiji government would be 'the channel for all correspondence from overseas' on matters relating to the SPHS.[983]

The Colonial Office appointed John Cecil Rankin Buchanan, the Deputy Director of Medical Services of Uganda, as the first Inspector-General of the SPHS.[984] Buchanan arrived in Fiji in April 1945 to start setting up the SPHS.[985] After Buchanan's arrival, his position was defined in relation to the Director of Medical Services of Fiji. McGusty hoped the Inspector-General and the SPHS would be 'completely divorced from' the medical services of Fiji, which he was in charge of. Also, McGusty wanted that 'under no circumstances should the Inspector General deputise for the Director of Medical Services.' However, Buchanan claimed the functions of the Central Medical Authority of the WPHC were already absorbed into those of the Inspector-General. He also argued that the Director of Medical Services should communicate closely with the Inspector-General, who 'must have a very considerable say' in other intercolonial medical institutions.[986] This was approved by the WPHC and the position of the Central Medical Authority was terminated as of Buchanan's arrival in Suva.[987] The position of Director of Medical Services of Fiji was eventually combined with that of the Inspector-General from October 1946.[988] Consequently, the SPHS 'had the virtual effect of permanency' as separating the two posts in future would be difficult to justify.[989]

It was agreed that financial contributions would correspond to the relative population

[983] From the Colonial Secretary to the Secretary of Western Pacific High Commission, 19 February 1946, WPHC9 82/7/1 Vol.1, WPA.
[984] From H. F. Batterbee to A. D. McIntosh, 10 October 1944, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.
[985] From J. C. R. Buchanan to the Colonial Secretary, 12 April 1945, WPHC9 82/7/1 Vol.1, WPA.
[986] From J. C. R. Buchanan to the Colonial Secretary, 16 April 1945, WPHC9 82/7/1 Vol.1, WPA.
[987] From H. Vaskess to the Colonial Secretary, 10 May 1945, WPHC9 82/7/1 Vol.1, WPA.
[988] From the Acting Financial Secretary to the Secretary of the Western Pacific High Commission, 30 September 1946, WPHC9 82/7/1 Vol.1, WPA.
[989] From the Governor to the Secretary of State, 12 March 1946, WPHC9 82/7/1 Vol.1, WPA.

of each country, which allowed the Colonial Office to carry most of the burden. Countries that could not afford an expensive health service could still take advantage of the SPHS at a lower cost. Half of the total cost was paid by Fiji, which had an approximate population of 250,000. One-third was borne by the WPHC with a population of 204,000. New Zealand only had to bear one-sixth of the budget for Western Samoa, the Cook Islands and Niue, and Tokelau, having a population of 78,500.[990] The salary of the Inspector-General occupied a substantial proportion of the outlay. As the Director of Medical Services was amalgamated with the Inspector-General, Fiji paid three-fifths of the Inspector-General's salary in return for his services concerning Fiji. The remaining two-fifths of his salary were again divided between participating countries (Fiji 1/2, WPHC 1/3, New Zealand 1/6).[991] In 1947, of the total budget of £3,624, Fiji contributed £1,812, the WPHC paid £1,208, and New Zealand contributed £604.[992]

When Buchanan worked out the specifics for creating the SPHS, he set East Africa as the standard. For interchangeability in the Colonial Medical Service, the Secretary of State wanted the salary scales of the SPHS to be raised to the equivalent of East African levels. Perhaps this was the reason why Buchanan was appointed, as he had twenty years of experience in East Africa. Buchanan noted that the net pensionable salary of the Senior Medical Officer of the Gilbert and Ellice Islands, the Solomon Islands, and Tonga was less than the maximum scale for medical officers in East Africa. The sole specialist appointment in the South Pacific also had a salary approximate to the maximum of a medical officer in East Africa. In summary, the Pacific salary was on a minimal level, which made recruiting extremely difficult. This way,

[990] Standing Committee on Finance South Pacific Medical Service, 10 May 1946, WPHC9 82/7/1 Vol.1, WPA.
[991] From the Acting Financial Secretary to the Secretary of the Western Pacific High Commission, 30 September 1946, WPHC9 82/7/1 Vol.1, WPA.
[992] Standing Committee on Finance South Pacific Medical Service, 27 September 1946, WPHC9 82/7/1 Vol.1, WPA.

it was likely that promising officers only use the SPHS as a stepping-stone for a promotion elsewhere.[993] For the NMPs, a conference between Buchanan, Fiji, and New Zealand officials agreed on a uniform salary starting from £100 up to £240.[994]

In the inaugural Board meeting, the SPHS decided on some changes. One was to continue nursing education and public health in each country, instead of centralising. Watt and Lambie, both on the SPHS Board, had been making efforts to improve nursing services in New Zealand for some time, especially for Māori areas.[995] However, the Board acknowledged the plan for centralising nursing education in the Pacific Islands had been discarded. Instead, nurses would be trained locally. The other change was to adopt a uniform nomenclature for the medical staff. Buchanan preliminarily collected a consensus before the meeting to change the title NMP and IMP to 'Assistant Medical Practitioner.' It was more race-neutral and intended to prevent any prejudice against administrations in designating medical staff. Accordingly, other titles previously including 'Native' also changed to 'Assistant' Dental Officer, 'Assistant' Health Inspector, 'Assistant' Laboratory Technician, and 'Assistant' Pharmacist. Previous titles of Native Medical Assistant would change to just Medical Assistant. 'Native Nurse' would also just be called 'Nurse.' European nurses could be differentiated by calling them 'Nursing Sister' or 'Health Sister.'[996]

Unfortunately, not everything the SPHS planned for was realised. The SPHS failed to recruit capable doctors from the UK or New Zealand as expected. Instead, the vacancies led

[993] J. C. R. Buchanan, Memorandum on the Conditions of Service in the South Pacific Medical Service, 22 May 1945, WPHC9 82/7/1 Vol.1, WPA.
[994] Minutes of a Meeting of a Conference Held in Suva on the 9th and 11th July, 1945, WPHC9 82/7/1 Vol.1., WPA.
[995] Dow, *Safeguarding the Public Health*, 121–150.
[996] Minutes of the First Meeting of the South Pacific Board of Health, Held at Suva, Fiji, on the 25th, 28th and 31st October, 1946, GB 0809 Nutrition/17/05/01/01, London School of Hygiene and Tropical Medicine Archives (LSHTM).

the SPHS to a new connection with Canada, which had also held dominion status within the British Empire. In 1949, the SPHS hired central European doctors through the Colonial Office, but the number of medical staff 'reached a dangerously low ebb.' To supplement the medical staff, Buchanan obtained doctors from Canada. As a matter of urgency, the SPHS hired Canadian doctors and requested the Secretary of State to overlook the breach of Colonial Regulations on hiring from dominions.[997] The Secretary of State's approval came with the condition that candidates consulted with the Colonial Service Liaison Officers, that the applications should be copied to the Colonial Office, and the vacancies should not be advertised to the Colonial Office.[998] Moreover, nursing education was not fully centralised and the Central Nursing School only became moderately intercolonial. The proposed rebranding of the CWM Hospital after Winston Churchill never happened. The hospital still operates under the same name. Consequently, a new medical centre, was not established.

Adjusting the Needs of Participating Administrations

Creating an imperial medical block was far from easy and discussions lasted decades. The main partner, New Zealand, was deeply involved in the SPHS from its inception and grew stronger after the SPHS was established, with Fraser personally engaging in working communications.[999] But British colonies did not uniformly welcome the SPHS. The standardisation of salary was particularly problematic because salaries for officers from the UK or dominions serving in the tropics were fixed at an attractive rate. Mitchell worried that

[997] From the Governor of Fiji to the Secretary of State for the Colonies 18 August 1950, WPHC9 82/7/1 Vol.3, WPA.
[998] From the Secretary of State for the Colonies to the Office Administering the Government of Fiji, 13 September 1950, WPHC9 82/7/1 Vol.3, WPA.
[999] Letter to Sidebotham, 3 April 1945, CO 83/241/6, TNA.

the Pacific Islands would be forever burdened with a much higher rate, 'in fact beyond its capacity to pay.' Yet, if the salary remained low, they could only afford candidates of lesser quality or 'central European refugees' until indigenous medical officers were raised. To solve this problem, Mitchell initially suggested adopting the Palestinian model using a standard salary scale for all officers doing the same work. He suggested £500 on first appointment with some expatriation benefits for officers from the UK or New Zealand.[1000] However, with such low salary scales, the SPHS could not meet East African standards as intended.

The Gilbert and Ellice Islands expressed doubts over financing the SPHS. If the salary scales were raised as proposed to match the East African level, the Gilbert and Ellice Islands would have to spend an extra £2,000. With an annual medical budget of £16,000, the Resident Commissioner argued that they simply could not afford it. The East African salary level was unfeasible as far as they were concerned. In order to follow the Inspector-General's policy, the Gilbert and Ellice Islands proposed limiting their medical service to young officers who cost less without a Senior Medical Officer. Once the 'policy of nativization comes to fruition', the Senior Medical Officer position was expected to fade out in any case.[1001] Buchanan objected to this idea. Unlike a district officer, the Senior Medical Officer was needed for each country to frame medical policies and to deal with international issues such as quarantine and communicable disease reporting.[1002]

On the contrary, the Solomon Islands proactively welcomed the East African salary scale. The Resident Commissioner could not see 'how medical officers can otherwise be obtained.' Even more, he proposed higher incentives for officers appointed to the Solomon

[1000] Minute by His Excellency the Governor of Fiji, 15 July 1944, WPHC9 82/7/1 Vol.1, WPA.
[1001] From the Resident Commissioner, Tarawa to the High commissioner, Suva, 31 July 1945, WPHC9 82/7/1 Vol.1, WPA.
[1002] Internal note from J. C. R. Buchanan to the Secretary, W.P.H.C, 21 August 1945, WPHC9 82/7/1 Vol.1, WPA.

Islands. Life in the Solomons was so harsh that officers sought to transfer to 'places with more amenities and fewer difficult living factors to contend with.' For example, the Senior Medical Officer of the Solomon Islands could get paid £1,050 when the same position in the Gilbert and Ellice Islands offered £794. Changing the title of Senior Medical Officer to the 'Principal Medical Officer' or a 'Chief Medical Officer' to denote a superior office was also suggested. He also proposed that all officers appointed to the Solomon Islands receive a minimum of £50 allowance.[1003] This proposal was unaccepted in order to preserve the principle of standardisation throughout the SPHS territories.[1004] However, the response from the Gilbert and Ellice Islands and the Solomon Islands led the WPHC to feel that they 'will have to pay whatever rates are necessary to get the type of men we require.'[1005]

Tonga had been perceived as a potential participant in the SPHS since 1931, even it if was not a British colony. Mitchell suggested the Premier of Tonga to join the SPHS in 1945, stressing the benefits Tonga could gain from centralisation. Mitchell definitely stated that Tonga would not pay more than it was at the moment. Nevertheless, when Buchanan approached Tonga with working plans, the British Agent and Consul in Tonga responded that Tonga was unlikely to join. For Tonga, 'which depends for its existence on a small copra industry and a still smaller banana industry, and nothing else' the East African salary rate 'cannot possibly be justified,' he insisted. Simply put, the advantages of the SPHS were obvious but Tonga could not afford it.[1006]

The Tongan attitude changed after the SPHS was formally established. Buchanan

[1003] From the Resident Commissioner of the British Solomon Islands Protectorate to the High Commissioner for the Western Pacific, 7 August 1945, WPHC9 82/7/1 Vol.1, WPA.
[1004] Internal note from H. Vaskess to the Inspector-General, S.P.M.S., 27 August 1945, WPHC9 82/7/1 Vol.1, WPA.
[1005] Minute by the Secretary, Western Pacific High Commission, 10 September 1945, WPHC9 82/7/1 Vol.1, WPA.
[1006] From H. B. M.'s Agency and Consulate, Tonga to H. H. Vaskess, 17 June 1945, WPHC9 82/7/1 Vol.1, WPA.

visited Tonga and met with the ministers who were favourable to the SPHS. As the SPHS contributions were proportionate to population, Tonga's estimated share was small.[1007] In September 1946, the High Commissioner formally requested the British Agent and Consul in Tonga to invite the country to join the SPHS as part of the WPHC territories. The population of the WPHC territories, including Tonga, was 155,000, the Tongan population being counted at 30,000. Therefore, the Tongan share was 30/155 of the WPHC contribution, which was agreed as one-third of the total budget of the SPHS.[1008] As this was affordable, the Premier of Tonga agreed to join the SPHS from 1 January 1947.[1009]

The case of the New Hebrides was more complicated. When the issue was raised in 1945, the Resident Commissioner reported that a monetary contribution would 'almost certainly be unacceptable' to the French authorities. To have New Hebrides in the SPHS, the funds had to be drawn from the UK. No further action was taken at this stage.[1010] In April 1947, partial participation was discussed at a conference between Buchanan, the Acting British Resident Commissioner, the Condominium Medical Officer, and the Chief Medical Officer of New Hebrides representing the French Resident Commissioner.[1011] Buchanan believed this was 'a real step forward' which all parties would benefit from, i.e. more formal and permanent cooperation between the British and the French. Because New Hebrides would not pool medical staff, they were not considered a 'full partner in the same sense as Tonga.' Buchanan tentatively suggested half participation for half of the population, just like how the condominium was run. New Hebrides would be treated as part of the WPHC because it was

[1007] From J. C. R. Buchanan to the Secretary, the Western Pacific High Commission, 9 September 1946, WPHC9 82/7/1 Vol.1, WPA.
[1008] From A. G. Grantham to the Agent and Consul, Tonga, 30 September 1946, WPHC9 82/7/1 Vol.1, WPA.
[1009] Ata, Premier, Agreement, 17 January 1947, WPHC9 82/7/1 Vol.2, WPA.
[1010] Memorandum to the Secretary of the Western Pacific High Commission, 7 November 1945, WPHC9 82/7/1 Vol.1, WPA.
[1011] From B. F. Blackwell to the Resident Commissioner for the French Republic, 18 April 1947, WPHC9 82/7/1 Vol.2, WPA.

'within the zone of influence.' Hence, an estimated share of the budget for 1947 was £162, i.e. for 24,000 population of the WPHC population of 190,000, including New Hebrides.[1012]

After that, progress was slow. The British Residency was so busy that discussions with the French were unable to advance.[1013] Buchanan was anxious to have the issue finalised before the South Pacific Commission began to operate. He believed the South Pacific Commission would not be able to provide the 'almost familial attention' that the SPHS could, which was emphasised as one of the main advantages of the service. Also, Buchanan argued that a stronger link was needed between the 'Territories in the East of the South Pacific zone', presumably referring to the countries east of New Hebrides, to occupy a stronger position over the western countries, presumably referring to Papua and New Guinea.[1014]

Although Buchanan urged progress, a decision from New Hebrides was difficult. In New Hebrides, all matters concerning colonial governance had to be agreed upon with the French, although the condominium practically functioned as two separate administrations.[1015] According to Trafford Smith, the French policy before De Gaulle was 'to do everything possible to oust the British' in New Hebrides. This explains why the colony was known as a 'pandemonium.'[1016] R. D. Blandy, the Resident Commissioner, complained the situation, questioning 'if anybody could conceive what a complete madhouse the Pandemonium is now becoming!'[1017] The newly changed staff at the French Residency caused 'an even greater bottle neck.' Blandy was convinced that 'the Condominium system, if it has not already done

[1012] From J. C. R. Buchanan to G. D. Chamberlain, 14 July 1947, WPHC9 82/7/1 Vol.2, WPA.
[1013] Internal note from R. S. Stapledon to I. G., S.P.H.S., 18 August 1947, WPHC9 82/7/1 Vol.2, WPA.
[1014] From J. C. R. Buchanan to the Chief Secretary of the Western Pacific High Commission, 25 August 1947, WPHC9 82/7/1 Vol.2, WPA.
[1015] Kate Stevens, '"The Law of the New Hebrides is the Protector of their Lawlessness": Justice, Race and Colonial Rivalry in the Early Anglo-French Condominium', *Law and History Review*, 35/3 (2017) 601.
[1016] Mr Trafford Smith's Report, 21 July 1941, Papers of Trafford Smith, Box 1 File 8, Mss. Brit. Emp. s.530, Oxford, Bodleian Libraries.
[1017] From R. D. Blandy to G. D. Chamberlain, 2 September 1947, WPHC9 82/7/1 Vol.2, WPA.

so, is about to break down completely.' This was due to administrative work being 'almost totally paralysed' as the French had not been able to deal with anything other than the Tonkinese (Vietnamese) unrest.[1018] At the time, there were Tonkinese labourers demonstrating at the French Residency in demand of repatriation.[1019]

At the request of the WPHC, Blandy pressed the French to agree to partial participation. Claiming that £162 was an insignificant amount for the benefits, he appealed that 'in view of the ever increasing tightness of the bonds of co-operation and friendship which are uniting our two Empires, I suggest that the co-operation of the Condominium in the important sphere of health would be a worthwhile gesture.'[1020] Thanks to Blandy's effort, the matter was taken to the French High Commissioner.[1021] The approval from the French High Commission was finally given in May 1948.[1022]

Membership of Australia and the US

The SPHS hoped to embrace other imperial powers in the region as well. The lack of Australian representation concerned British and New Zealand authorities from the beginning. For diplomatic relations, methods of approach to Australia were debated by the Colonial Office and the New Zealand Government. As a general rule, Australia and the US responded more favourably to the UK than to New Zealand.[1023] Nevertheless, New Zealand approached

[1018] From R. D. Blandy to J. C. R. Buchanan, 2 September 1947, WPHC9 82/7/1 Vol.2, WPA.
[1019] Miriam Meyerhoff, 'A Vanishing Act: Tonkinese Migrant Labour in Vanuatu in the Early 20th Century', *Journal of Pacific History*, 37/1 (2002) 53.
[1020] From R. D. Blandy to A. Ménard, the Resident Commissioner for the French Republic, 2 September 1947, WPHC9 82/7/1 Vol.2, WPA.
[1021] From the British Resident Commissioner, New Hebrides to the High Commissioner, 26 September 1947, WPHC9 82/7/1 Vol.2, WPA.
[1022] From the Acting Inspector General to the Chief Secretary, Western Pacific High Commission, 10 May 1948, WPHC9 82/7/1 Vol.2, WPA.
[1023] From Shannon to Sidebotham, 26 May 1944, CO 83/241/5, TNA.

Australia in 1944 to suggest taking part in the SPHS. The grounds for the SPHS were already prepared because they explained the proposed centralisation in the discussions leading up to the Australia-New Zealand Agreement.[1024] To respect this Agreement, New Zealand was compelled to communicate on the establishment of the SPHS with Australia.[1025] Australia had been 'somewhat put off' by New Zealand's proposal because Australia was not associated with the planning of the SPHS from the beginning.[1026] New Zealand was also aware of Australian endeavours to become a dominant medical power in the Pacific by exercising control over the 'Austral-Pacific Regional Zone.'[1027]

Later, the fact that Papua New Guinea was heavily affected by war became the trigger for considering Australian participation in the SPHS. Australia and New Zealand started discussing the matter at a conference held in Wellington in October 1944. The Department of Health of Australia considered immediate problems during the post-war reconstruction period and called for 'an administration of a special character.' For example, district officers and medical officers purposely operated as a team in Papua and New Guinea. Medical officers possessed magisterial powers and duties in some areas and Australia felt this system was important for reconstruction. The SPHS system that followed the Colonial Medical Service regulations would be incompatible.[1028] The question was, 'would the Suva scheme provide immediate medical aid?' where medical care was 'extremely urgent' as a result of the devastating war.[1029]

[1024] Proposed South Pacific Medical Service, Record of Discussion with Mr. McIntosh of the New Zealand Government held in Mr. Gent's Room, 21 June 1944, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.

[1025] D. G. Sullivan to the Governor of Fiji and High Commissioner for the Western Pacific, 12 June 1944, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.

[1026] From Trafford Smith to Boyd Shannon, 10 May 1944, CO 83/241/5, TNA.

[1027] Alexander Cameron-Smith, 'Australian Imperialism and International Health in the Pacific Islands', *Australian Historical Studies*, 44/1 (2010), 57–74.

[1028] Annex (a) Native Welfare – South Seas Commission, Notes on Collaboration in Regard to Medical and Health Services, Wellington Conference 1944, A518, AG815/1/1, NAA.

[1029] Notes on the Proposal that Australia Support a Simple Medical Control Based on Fiji for the Western Pacific,

Papua and New Guinea were administered separately before the outbreak of the Second World War. After the Japanese occupation, the civil administrations of Papua and New Guinea were taken over by the Australian New Guinea Administrative Unit. Civil administration was restored in October 1945 when the Papua-New Guinea Provisional Administration Act took effect. Under this Act, Papua and New Guinea were provisionally administered together for external affairs until they formally reached an administrative union in 1949. In discussions over their participation in the SPHS, Papua and New Guinea were often referred together as Papua New Guinea.

Australian officials did not all share the same opinion. Tom D'Alton, Australian High Commissioner in New Zealand, favoured participation. In January 1945, he discussed the matter with New Zealand after visiting Fiji to inspect existing medical establishments. By the time he visited Fiji, the architectural plan for the new 'Winston Churchill Memorial Hospital' was already approved. He praised the CMS which had achieved 'wide fame' for finding the solution to the provision of medical services to Pacific Islanders in remote areas. Discussions with Hoodless confirmed that Melanesians were as capable of receiving a medical education 'as those of any other Pacific race.' He was also very impressed with the CLH and the successful training of indigenous nurses in Fiji. Overall, D'Alton praised all the major medical institutions in Fiji as a model that Australia could study for Papua New Guinea.[1030] Moreover, D'Alton was well aware that Fraser was 'personally deeply interested' in the SPHS. He felt that 'New Zealanders have received the impression that the Australian Health Authorities are unwilling to go very far in the direction of co-ordinating health and medical services in the Pacific.' Therefore, D'Alton urged the Australian Department of External Affairs to seriously

A518, AG815/1/1, NAA.

[1030] From Tom D'Alton to H. V. Evatt, Minister for External Affairs, 9 January 1945, A518, AG815/1/1, NAA.

consider participation.[1031]

From Canberra, J. H. L. Cumpston, the Australian Director-General of Health, discussed the SPHS question with the Department of External Affairs of Australia. Critically, Cumpston viewed Papua New Guinea as a territory that 'Australian troops have won back for Australia.' He could not find any justifications for putting medical services of Australian territories, which Australia was responsible for, 'completely outside Australian control.' In addition, he noted that plenty of Australian doctors had gained experience in wartime Papua New Guinea. The School of Public Health and Tropical Medicine in Sydney was argued to be good enough for training medical orderlies.[1032] He therefore wished to staff Australian medical services 'entirely by Australians with full medical qualifications.'[1033] To this end, Cumpston advised John Curtin, the Prime Minister of Australia, that the SPHS proposal was potentially dangerous to Australian interests.[1034] A few months later, J. M. Fraser, the Minister for Health and Social Services of Australia, also confirmed his opinion to J. B. Chifley, the Acting Prime Minister, that owing to the 'fundamentally different' conditions of Australian territories, Australia should not be a full participant of the SPHS.[1035]

The question of participating in the SPHS rose again in February 1946. New Zealand exploratorily and informally discussed the issue with Edward Ward, the Minister for External Territories and the Minister for Transport of Australia, when he visited New Zealand.[1036] Later, Buchanan visited Australia to personally discuss the question with the Department of External

[1031] Extract from Despatch from Australian High Commissioner in New Zealand, March 1945, A518, AG815/1/1, NAA.
[1032] J. H. L. Cumpston, Memorandum for the Secretary, Department of External Affairs, 22 January 1945, A461, AG347/1/1, NAA.
[1033] Meeting in 16th January between Mr. Shannon, Mr. McIntosh, Mr. Sidebotham, Dr. Wilson Rae, Mr. Webber and Mr. K. E. Robinson, 18 January 1946, CO 83/241/6, TNA.
[1034] From J. H. L. Cumpston to J. Curtin, 23 January 1945, A461, AG347/1/1/, NAA.
[1035] From J. M. Fraser to J. B. Chifley, 11 May 1945, A461, AG347/1/1, NAA.
[1036] From the Minister for External Affairs, Wellington, NZ to the High Commissioner, 14 February 1946, WPHC9 82/7/1 Vol.1, WPA.

Territories.[1037] Full participation in the SPHS was still unacceptable to Australia for largely two reasons. First, they thought conditions in Papua New Guinea varied from the British and New Zealand territories. The country had over a million population with different medical problems. More significantly, medical sovereignty was a problem. During the immediate post-war period, Australia had plans to unify Papua and New Guinea under Australia. The UK''s directions, through Fiji, on Australian external territories were unacceptable to Australia.[1038]

For Australia, the primary advantage of joining the SPHS was training NMPs at the CMS. As Donald Denoon remarked, Australians perceived Papuans and New Guineans 'through a miasma of racist and sexist stereotypes' and their capacities were never recognised.[1039] This is reflected in Australia's previous objection to participating in the CMS. Australia had four reasons: the educational standard of Papua New Guinea was considered too low; the curriculum was believed to be beyond the capacity of Papua New Guineans; they thought it was better to focus on first aid work; and they argued there was an 'absence of social organization amongst the natives.' Instead of NMPs, a very small number of students were trained as medical *tultuls* or medical assistants at the School of Public Health and Tropical Medicine in Sydney. This system was still inadequate to supply enough medical staff in the post-war period.[1040]

In June 1946, just before the signing of the agreement for the SPHS, the Australian Prime Minister J. B. Chifley, informed Fraser that Australia 'could not surrender to another authority the right to appoint and control officials in Australian territories.'[1041] A 'very great

[1037] From the Officer Administering the Government of Fiji to the Secretary of State for the Colonies, 9 July 1946, WPHC9 82/7/1 Vol.1, WPA.
[1038] Proposed Pacific Health Scheme – Fiji and Western Pacific, 14 February 1946, CP637/1, 35, NAA.
[1039] Denoon, *Public Health in Papua New Guinea*, 57.
[1040] Proposed Pacific Health Scheme – Fiji and Western Pacific, 14 February 1946, CP637/1, 35, NAA.
[1041] From J. B. Chifley to the Prime Minister of New Zealand, 14 June 1946, CO 83/241/7, TNA.

difficulty' was also expected if the pool of medical officers were appointed to Australian territories in the post-war reconstruction period. Partial membership was understood in that sense. The SPHS welcomed Australia's partial participation as it would 'greatly strengthen the standing of the Board', especially regarding the Solomons 'where the boundary between the Australian and the WPHC territory is a political rather than a geographical or ethnological one.'[1042] With the Australian expression of interest, the official agreement to establish the SPHS added a final clause at the last minute to open the possibility of future Australian membership.[1043]

In 1948, Australia decided not to participate in the SPHS at all. In the meantime, it sent six students from Papua New Guinea to the CMS and planned to establish a medical school in Port Moresby with a two-year curriculum.[1044] The main reason was that Australia could not 'surrender to the Board of the appointment and posting of medical staff in all areas within the jurisdiction of the scheme.'[1045] The Department of Health of Australia maintained the same stance that there are 'no material advantage' from the SPHS other than the opportunity to train students at the CMS.[1046]

Another country the Colonial Office was most concerned in cooperating with on the SPHS was the US. During the war, the so-called 'special relationship' of the Anglo-American alliance grew very tight.[1047] The British government hoped to continue the close relationship

[1042] From the Officer Administering the Government of Fiji to the Secretary of State for the Colonies, 9 July 1946, WPHC9 82/7/1 Vol.1, WPA.
[1043] Agreement for the Establishment of a South Pacific Health Service, 24 September 1946, WPHC9 82/7/1 Vol.1, WPA.
[1044] From J. T. Gunther to the Government Secretary, 28 January 1948, A518, AG815/1/1, NAA.
[1045] Attachment to the Memorandum from Prime Minister's Department to the Secretary of the Department of External Territories, 19 May 1948, A518, AG815/1/1, NAA.
[1046] A. J. Metcalfe, Memorandum to the Secretary of the Department of External Territories, 22 June 1948, A518, AG815/1/1, NAA.
[1047] Alan P. Dobson, Steve Marsh, 'Introduction' in Alan P. Dobson, Steve Marsh (eds.), *Anglo-American Relations: Contemporary Perspectives* (London: Routledge, 2013), 1–25.

with the US as much as possible in the post-war period. Therefore, when the US approached the Colonial Office for future medical cooperation, British authorities were most excited. The US proposal came through the Medical Intelligence Division, which was newly established in the Preventive Medicine Service of the Office of the Surgeon General of the United States Army. Medical Intelligence 'operated on the theory that it must be prepared to furnish information about any area at any time' to respond to potential disease threats in a truly global war.[1048] For this purpose, overseas military attachés were instructed to collect medical information where possible.[1049]

Medical Intelligence had seen newspaper coverage on the establishment of the SPHS, then called the South Pacific Medical Service. Major Greeley, the Acting Military Medical Attaché at the US Embassy in London, had two meetings with the Colonial Office in June 1945 to ask for more information on it. When asked why the SPHS was particularly partnered with New Zealand, the Colonial Office explained the historically close relationship between Fiji and New Zealand. Reportedly, Greeley showed 'the greatest interest' in the SPHS and 'he could see the United States interest as he supposed they were keeping some of the Pacific islands — at least he hopes so!'[1050]

As a result, in November 1945, the US proposed to the Colonial Office closer cooperation in the development of the CMS.[1051] The US foresaw a substantial increase in the demand for medical practitioners in American territories in the Pacific in the post-war period. Mentioning that American Samoan students were already training at the CMS, the US called

[1048] Gaylord W. Anderson, 'Medical Intelligence in the United States Army', *Canadian Journal of Public Health,* 36/2 (1945), 65–69.
[1049] Jonathan D Clemente, 'The Fate of an Orphan: The Hawley Board and the Debates over the Postwar Organization of Medical Intelligence', *Intelligence and National Security,* 20/2 (2006), 264–287.
[1050] South Pacific Medical Service, Notes of a Meeting with Major Greeley (U.S. Embassy), 25 June 1945, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.
[1051] Note of Meeting with Major Greeley, 4 July 1945, CO 83/241/6, TNA.

for consideration of plans whereby the two governments might jointly run the school to meet the needs of all British and American-administered islands. If the experimental cooperation proved successful, similar cooperative ventures could follow. The US and the UK were obliged to furnish 'native welfare' according to the United Nations Organisation Charter in any case.[1052] As detailed arrangements for the SPHS were already being made, this proposal could be extended to full American participation in the SPHS. The Colonial Office and the Foreign Office both welcomed it at first. They argued, 'we should do everything in our power to encourage it.' The Colonial Office regarded it as the 'the beginnings of the much-discussed regional organisation on practical and non-political levels, which is probably the best means by which ultimate full political cooperation may be developed.'[1053]

The US was already collaborating with medical institutions in Fiji. During the Second World War, the US military was stationed in Fiji, establishing a number of hospital facilities on Viti Levu. By the end of 1944, Admiral Laning of the US Navy, the Director of Medical Services for the South Pacific Area, visited Suva to investigate the potential training of NMPs from Guam and the Marianas. This was because the US discovered that the Japanese had trained indigenous medical staff, although short-lived. They were anxious to train indigenous people in the recovered territories by themselves. While Hoodless reportedly commented the Micronesians were 'somewhat different temperamently' from other Pacific Islanders, Fiji welcomed the US in the CMS. At the same time, American Samoa joined the CLH. The first batch of eight patients arrived in December 1944. Accompanying American doctors reportedly showed considerable interest in the Makogai establishment.[1054]

The incoherent attitudes of the US authorities, however, brought tension. Just before

[1052] Aide Memoire, CO 83/241/6, TNA.
[1053] Letter to Mr. Sidebotham, 3 December 1945, CO 83/241/6, TNA.
[1054] From Tom D'Alton to H. V. Evatt, Minister for External Affairs, 9 January 1945, A518, AG815/1/1, NAA.

the State Department of the US proposed to the Colonial Office a close collaboration in the CMS, American Samoa, under US Navy control, suddenly withdrew their students from the School. The US Navy decided to establish a separate medical school in Guam, where the Samoan students had been taken.[1055] These students had been admitted to the CMS just a year before at the urgent request of the US Authorities, most likely to be a result of Admiral Laning's visit. Since it had been the general policy of the West Pacific High Commission to meet the needs of the Americans in the Pacific under wartime conditions, the students were accepted despite the heavy strains that the sudden addition put on the school facilities.[1056]

As the High Commissioner, Grantham had mixed feelings about US participation. He reported it was 'clearly most desirable to meet the wishes of the US Authorities having regard to the aim of making Suva the centre of medical training in this area.'[1057] However, he was concerned that American participation might entitle them to a controlling voice, with detriment to the existing set-up of the SPHS and British prestige.[1058] He also worried that the graduates of the new medical school in Guam would become 'de-nativised, but yet will not be accepted as the equal of white Americans' and that 'no greater disservice could be done to the Islanders than this.'[1059] As the most important philosophy of the CMS was to maintain the students' collective identity as Pacific Islanders, the American policy of assimilation of the indigenous population was seen as undesirable. New Zealand also expressed concern that it did 'not wish the Americans to swamp the school' and 'above all, desire that the UK control should not be impaired and its identity and special characteristics should be retained.' The Cabinet insisted

[1055] From Sir A. Grantham to the Secretary of States for Colonies, 15 December 1945, CO 83/241/6, TNA.
[1056] Richard Frost, *Enigmatic Proconsul: Sir Philip Mitchell and the Twilight of Empire* (London: Radcliffe Press, 1992), 147–150.
[1057] From Sir A. Grantham to the Secretary of States for Colonies, 31 January 1945, CO 83/241/10, TNA.
[1058] Meeting in 16th January between Mr. Shannon, Mr. McIntosh, Mr. Sidebotham, Dr. Wilson Rae and Mr. K. E. Robinson concerning US Aide Memoire. 18 January 1946, CO 83/241/6, TNA.
[1059] Sir A. Grantham to the Secretary of State for the Colonies, 15 December 1945, CO 83/241/6, TNA.

that British control of the SPHS be maintained as well.[1060]

American efforts at assimilation in medical education failed in Guam. Later in 1951, the US abruptly sent students back to the CMS as the School of Medical Practitioners attached to the US Naval Medical Center discontinued operation following the Department of Interior taking over the administration of Guam. The Commanding Officer of the US Naval Medical Center called the school a 'noble experiment' but the curriculum was beyond the capacity of the students to be assimilated. Dorothy Richard reckoned the transfer of students to Fiji to be 'one of the most unfortunate results' of the change of administration to the Department of Interior. The issue of participation in the SPHS by the US Trust Territory Administration was again raised, but the US participation was limited to the CMS.[1061] While the official history recorded that 57 students were flown from Guam to Suva, the SPHS minutes state that 31 medical students and 21 dental students were admitted to the CMS.[1062]

The last potential partner wanted by the Colonial Office was the RF. The Rockefeller representation in the SPHS would not only bring financial advantage but was symbolically important.[1063] The RF had a history of funding the CMS and substantially backing the WPHS campaigns in the Pacific Islands. The inception of the SPHS was also fuelled by the RF representative, Lambert. More significantly, the Colonial Office expected the RF to be a non-political link with America.[1064] However, the RF's direct presence in the British Pacific ended with Lambert's retirement and the closure of the WPHS in 1939. They did not join the SPHS

[1060] From A. D. McIntosh to C. Costley White, 24 April 1946, CO 83/241/7, TNA.
[1061] Dorothy E. Richard, *United States Naval Administration of the Trust Territory of the Pacific Islands Vol.3* (Washington: U.S. Office of Chief of Naval Operations, 1957), 920–939.
[1062] Minutes of the Meeting Held at Suva, Fiji, on the 5th–12th September, 1951, The South Pacific Board of Health, PMB1284, Pacific Manuscripts Bureau, Australian National University.
[1063] Conference Held in the Office of the Minister of Health, Hon. A. H. Nordmeyer, to Discuss the Establishment of a Large Medical Centre in Suva. 20 March 1944, CO 83/241/5, TNA.
[1064] From Sir Philip Mitchell to the Secretary of States for the Colonies, 17 March 1944, CO 83/241/5, TNA.

Board nor offer financial support to the SPHS. Subsequently, the SPHS deleted a clause in the previous version of the agreement acknowledging that the service had been established 'on the recommendation of the International Health Division of the RF.'[1065] From this point, the SPHS was instituted as an entirely British imperial project. A friendly relationship was still maintained with the SPHS as seen in their advice on the architectural design of the new 'Winston Churchill South Pacific Hospital.'[1066]

Representing the British Empire in International Health

As an imperial institution, the SPHS represented a block of British and New Zealand colonies in the field of international health. Its imperial identity can be seen in its relationship with the South Pacific Commission. The SPC was a result of the Australia-New Zealand Agreement in 1944 and was established in 1947. It was essentially an interimperial union between Australia, New Zealand, the UK, the US, France, and the Netherlands. While the SPHS was heavily subsidised and led by the British Colonial Office, the largest funding body for the SPC was Australia, bearing 30% of the budget.[1067] Naturally, Australia was more interested in the SPC and carried a strong voice in the SPC.

The prospect of the SPC was the central question surrounding Australian participation in the SPHS for Papua New Guinea. J. Gunther, the Director of Public Health of Papua New Guinea, visited Suva in November 1946 to discuss the terms for participation in the SPHS. This was after the SPHS was formally established without Australia.[1068] In Australia, the

[1065] Minutes of a Meeting of a Conference Held in Suva on the 9th and 11th July, 1945, WPHC9 82/7/1 Vol.1, WPA.
[1066] From Sir Philip Mitchell to the Secretary of States for the Colonies, 2 October 1944, CO 83/241/9, TNA.
[1067] Agreement Establishing the South Pacific Commission, 12 February 1947, A518, AG815/1/1, NAA.
[1068] Notes of a Discussion between Dr J. Gunther, Director of Public Health, Papua-New Guinea Administration, and Dr. J. C. R. Buchanan, Inspector General/Director of Medical Services, on the Possible Participation of

Department of Health was consistently opposed to joining the SPHS. The first reason was that the SPHS, the SPC, and the WHO, all concerned with indigenous healthcare, would potentially result in overlapping functions and authority. Second, as argued previously, Papua New Guinea's larger land, population and varied climate were argued as quite different from that of the SPHS territories, which had 'a more advanced native population.' Third, the Department considered pooling medical staff would not improve medical efficiency and Australia did not want to risk losing medical staff to other countries. Most importantly, it was 'very undesirable' to have the Inspector-General of the SPHS have control over Papua New Guinea.[1069]

In contrast, Papua New Guinea preferred participation. Gunther pointed out that the SPC's plan for healthcare was through a research committee. Mere research could not compare to what the SPHS can offer as a 'more intimate' organisation. Further, Gunter argued that the SPHS could strengthen 'an initial British Voice' in the SPC. Representation of 'a strong voice that can bring pressure to bear in the Commission' on other imperial powers was necessary. Therefore, Gunther recommended immediate participation in the SPHS.[1070] The Department of External Affairs, too, had been interested in 'the building up of British Commonwealth co-operation in the Pacific' as well as promoting collaboration with New Zealand.[1071] Despite Gunther's appeals to strengthen the British imperial influence in the SPC, Australia still did not participate in the SPHS.

To international organisations outside the Pacific, the difference between the SPHS and the SPC was unclear. Regular renewals of the SPHS agreement were sent to the WHO to

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Australia (in Respect of Papua-New Guinea) in the South Pacific Health Scheme, 31 December 1946, WPHC9 82/7/1 Vol.2, WPA.

[1069] A. J. Metcalfe, Memorandum, South Pacific Health Scheme, 15 April 1947, A518, AG815/1/1, NAA.

[1070] From J. T. Gunther to the Government Secretary, Co-ordination in Public Health in the South Pacific –The Necessity for a Basic Advisory Organization, 24 April 1947, A518, AG815/1/1, NAA.

[1071] Secretary of the Department of External Affairs, Memorandum to the Secretary, Department of External Territories, 21 November 1946, A518, AG815/1/1, NAA.

help them understand the place of the SPHS in comparison to the SPC. Fresh documentation would also keep organisations such as the WHO or the United Nations informed that the SPHS was still active.[1072] Considering the main difference was that the SPHS was an imperial governance institution, and the SPC was an international organisation, this would remind members of the WHO that the British held control over their Pacific colonies. In order to let the WHO clearly see the status of the SPHS and the SPC, New Zealand suggested the renewal agreement be registered under the United Nations Organizations Charter.[1073] The Secretary of State for Colonies concurred in the registration in 1950.[1074]

Tensions between the SPHS and the SPC also show that the SPHS endeavoured to maintain an imperial medical authority in the SPHS territories. In 1950, the SPHS urged that the SPC programmes on nutrition, maternal health, and child health in Fiji be terminated. As Sarah Hartley wrote, the SPHS felt that the SPC was 'interfering' with the colonial administration. Then, the SPC was told to stay away from the SPHS territories. While any financial aid was welcome from the SPC, the SPHS wanted to conduct their own programmes with their own expert personnel.[1075]

As a result, a resolution was made at the SPHS Board annual meeting in 1952. The meeting confirmed that the Inspector-General of the SPHS possessed administrative, executive, and advisory powers concerning healthcare in all British and New Zealand territories. In a strong tone, the Board resolved to advise the SPC to communicate with the Inspector-General in the first instance before contacting any SPHS countries. Also, the SPHS territories should not communicate directly with the SPC without referring to the Inspector-General beforehand.

[1072] From J. M. Cruikshank to the Governor, 19 May 1950, WPHC9 82/7/1 Vol.3, WPA.
[1073] From the Governor to the Secretary of State, 29 May 1950, WPHC9 82/7/1 Vol.3, WPA.
[1074] From the Secretary of State to the Governor, 4 June 1950, WPHC9 82/7/1 Vol.3, WPA.
[1075] Hartley, *The Role of Maternal and Child Health in Decolonisation in Fiji, 1945–1970*, 127–136.

All communications must go through the Inspector-General, who would keep the SPC informed of the health programmes done by the SPHS. The Board argued it was to prevent any waste of resources from overlapping projects. This would, in turn, free the SPC to focus more on the non-SPHS countries lacking health experts.[1076] This resolution did not lead to a formal request to the SPC. However, it reflects how the SPHS aimed to be represented as an imperial institution in international health organisations.

Not all members of the SPHS were content with the resolution. The Inspector-General, J. M. Cruikshank, was quite disturbed when some of the (unnamed, but probably New Zealand territories) SPHS territories made direct requests to the SPC without informing the SPHS.[1077] Upset at the situation, he wrote to the UK Commission at the SPC about the Board resolution made in 1952.[1078] On the contrary, the New Zealand Senior Commissioner at the SPC did not entirely support the resolution. New Zealand was 'happy to see copies of any correspondence' and would consult the SPHS when approaching the SPC but did not promise to keep the resolution made by the SPHS Board. Besides, New Zealand was also seeking help from the WHO for health activities in Western Samoa, the Cook Islands, and Niue.[1079] This shows that although New Zealand health authorities were represented in the SPHS Board, the Board resolution was more advantageous to extending the British authority in the institution, which was not welcomed by the New Zealand government.

In the SPC, the SPHS request to direct all health-related communications to the

[1076] J. M. Cruishank, South Pacific Health Board Resolution Re S.P.C. Activities in Fields of Health, 18 August 1953, WPHC9 37/6/61, WPA.
[1077] From J. M. Cruikshank to the Secretary-General, South Pacific Commission, 24 June 1953, WPHC9 37/6/61, WPA.
[1078] J. M. Cruishank, South Pacific Health Board Resolution Re S.P.C. Activities in Fields of Health, 18 August 1953, WPHC9 37/6/61, WPA.
[1079] From C. McKay to L. Brian Freeston, Secretary-General, South Pacific Commission, 20 July 1953, WPHC9 37/6/61, WPA.

Inspector-General seemed to be 'restricting the right of territorial Administrations, or the heads of their Medical Departments.'[1080] As a result, a uniform procedure of communications was agreed between the British colonies.[1081] The correspondence could be copied to each concerned territory and no commitment was made without the agreement of the territory. This was limited to UK territories, not New Zealand.[1082] Although the SPHS was established as an imperial medical block, this shows that having one British imperial voice in international health had become difficult by the early 1950s.

Conclusion

In the inaugural meeting of the SPHS's Board in 1946, Grantham argued that the SPHS was a model for all administrations in the South Pacific.[1083] The discourse leading up to the establishment of the SPHS shows how the different interested powers negotiated their terms. The British led the discussions for an efficient system that centralised health services of the region. Western Samoa and Tonga wanted affordable health services. Australia and the Cook Islands was concerned with control in island territories. Papua New Guinea and the US wanted to utilise an existing medical infrastructure proven to be useful in the British colonies. The RF did not join. Regional cooperation in the SPHS was, as in the case of the WPHS, shaped through multi-channelled efforts. It was, however, not entirely egalitarian but influenced by British interests to bring the empire under one umbrella.

As a product of the war, the SPHS was created to bring a group of British and New

[1080] H. Vaskess, Second Commissioner, 11 August 1953, WPHC9 37/6/61, WPA.
[1081] From the Chief Secretary to the 2nd Commissioner for the U.K. in the South Pacific Commission, 10 December 1953, WPHC9 37/6/61, WPA.
[1082] From H. Vaskess to the Secretary-General, 14 January 1954, WPHC9 37/6/61, WPA.
[1083] Minutes of the First Meeting of the South Pacific Board of Health, Held at Suva, Fiji, On the 25th, 28th and 31st October, 1946, GB 0809 Nutrition/17/05/01/01, LSHTM.

Zealand colonies under a centralised indigenous healthcare system. Medical authorities in Fiji and New Zealand were well aware of what the 'present world conditions were having on health conditions in the tropical island territories' when establishing the SPHS.[1084] Wartime developments remained visible even after the establishment of the SPHS. For example, the Inspector-General of the SPHS could use the training flights of the RNZAF, which remained in Fiji after the war, to make frequent short visits to the SPHS territories.[1085] As such, wartime emergencies led to an enhanced and enduring connection between the British and New Zealand territories.

Changes in racial ideas were also notable through the establishment process. Compared to the interwar years, there was an increased awareness of institutional racism. As explained in this chapter, the SPHS changed the titles of medical staff to erase the racial undertone in the word 'native.' When the salary scales were discussed, they tried to standardise salary regardless of background. Doctors born in the colonies were 'often coloured, so that the controversy takes on a racial aspect.' If doctors from the UK or New Zealand received a better salary, the SPHS carried 'the risk of being accused of racial discrimination and there will in fact be an inevitable appearance of racial discrimination.'[1086] These changes were not only happening in the SPHS territories. At around the same time, New Zealand enacted the Māori Social and Economic Advancement Act in 1945 and the Māori Purposes Act in 1947, which changed the official term from 'native' to 'Māori'. Lopdell's argument to base the centralised medical service in New Zealand was also because of the 'colour question.' Having a history with the Māori people, New Zealanders were different from other Europeans who 'frequently

[1084] Minutes of a Meeting of a Conference Held in Suva on the 9th and 11th July, 1945, WPHC9 82/7/1 Vol.1, WPA.
[1085] J. M. C., Report of a Meeting Held in the New Zealand Department of External Affairs Re the South Pacific Health Service, 13 April 1950, WPHC9 82/7/1 Vol.3, WPA.
[1086] Minute by His Excellency the Governor of Fiji, 15 July 1944, WPHC9 82/7/1 Vol.1, WPA.

show a fundamental conviction of superiority over the Polynesian.'[1087]

The SPHS was also shaped to reflect the changing international politics relating to decolonisation in the post-war period. Unlike the interwar years, the colonial population started to be referred to as 'non-self governing peoples' as found in the Agreement for the Establishment of the South Pacific Commission.[1088] Increased funds to run the SPHS were seen as necessary because otherwise the South Pacific would 'remain in our pre-war backwater amongst Colonial Administrations', which would result in 'inefficiency and the retardation of the development of the native peoples towards the goal of self-Government.'[1089] The term 'empire' was formally abandoned in London. 'Colonial Practitioners' were retitled as 'Commonwealth Practitioners.'[1090] Based on these changes, the SPHS can be interpreted as an institution made to prepare for the eventual decolonisation of the South Pacific while keeping the Pacific Islands under British influence

[1087] J. C. Lopdell, A Combined Medical Service for the S. W. Pacific, ACGA 8280 EX8/34 Part.1 R17962897, ANZ.
[1088] Agreement Establishing the South Pacific Commission, 12 February 1947, A518, AG815/1/1, NAA.
[1089] Internal note from H. Vaskess to Y. E., the Governor of Fiji, 16 August 1945, WPHC9 82/7/1 Vol.1, WPA.
[1090] Extract from the 'Crown Colonist' Dated February 1948, No.195, Vol.18 – Topics of the Month, F129/11, NAF.

Chapter 7. The Central Nursing School and the Suva Medical Centre

As noted in the previous chapter, Fiji wanted to make Suva the medical hub of the South Pacific. For this purpose, two new institutions were created to serve Fiji and the South Pacific. One was the Central Nursing School, which was, as its name suggests, an attempt to put the indigenous nursing service in line with other centralised institutions. The other one was the Suva Medical Centre scheme that would add physical and material facilities to the centralisation effort, which resulted in the establishment of the SPHS. Unfortunately, the plans for establishing them were discouraged with the advent of the war. In the post-war period, medical institutions developed differently than how they were envisioned before the war, being less intercolonial or international.

The literature on this topic is largely centred around maternal health. Vicki Lukere and Margaret Jolly's edited volume is a good introduction to reproductive health and obstetric nursing in the Pacific Islands. Lukere's chapter on Fiji offers an overview of the history of indigenous nurses trained in western medicine from the late nineteenth century to the interwar years.[1091] Margaret Jolly and Sarah Hartley's works are important references on the history of motherhood and child welfare in colonial Fiji during the interwar years and the post-war years.[1092] Lukere's PhD thesis provides a deeper analysis of the development of obstetric nursing in Fiji.[1093] Dow's account of the history of the New Zealand Department of Health explained how Watt and Lambie viewed nursing education as essential for promoting public

[1091] Vicki Lukere, Margaret Jolly (eds.), *Birthing in the Pacific: Beyond Tradition and Modernity?* (Honolulu: University of Hawai'i Press, 2002)
[1092] Margaret Jolly, 'Other Mothers: Maternal "Insouciance" and the Depopulation Debate in Fiji and Vanuatu, 1890–1930' in Kalpana Ram, Margaret Jolly (eds.) *Maternities and Modernities* (Cambridge: Cambridge University Press, 1998); Hartley, 'Interweaving Ideas and Patchwork Programmes'.
[1093] Lukere, 'Mothers of Taukei'.

health.[1094] However, within the scope of these works, women's place in the centralisation scheme is neglected. Nursing's relationship with the war and the RF is also missed.

Without considering the centralising efforts for nursing education and the associated medical centre scheme, the full scope of centralisation plan cannot be drawn. This chapter builds on previous work to examine nursing education and public health in the centralised medical system. In particular, it will show how nursing education became a racial centralisation project within Fiji, bringing the ethnically Indian population into the nursing profession, as well as how it was less intercolonial than the CMS. At the same time, the chapter will explain the tension between the RF and colonial authorities surrounding the funding of nursing education and an associated medical centre. Finally, this chapter will briefly outline the post-war outcome of the centralised medical institutions discussed in the earlier chapters.

Development of the Central Nursing School

Established in 1941, the Central Nursing School was devised in line with the general movement to centralise medical services and infrastructural facilities based in Fiji. Aiming to train a subordinate nursing service, the CNS was an enlargement of the existing Nurses' Training School which trained both European and indigenous nurses at a different level of qualification. Lectures were only offered once a week on obstetric nursing, up to about 44 hours in a year, while most of the training was through practical work.[1095] The Nurses' Training School was set up by colonial authorities to raise nurses who would fill the gap in healthcare that male NMPs could not cover. An entirely male workforce would have been less suited to

[1094] Dow, *Safeguarding the Public Health*, 92–150.
[1095] Copy of a Report on the Training of Fijian Nurses by Miss M. I. Lambie, From F.A. 29/12, F48/168 Part.1, NAF.

maternal welfare and suppressing the high infant and child mortality rate in Fiji. Female nursing education in Fiji started at the initiative of M.C. Anderson, who first taught indigenous nursing students in fluent Fijian language. In the earlier period, students were attached to the Colonial Hospital (later the CWM Hospital) to learn obstetric nursing while working as auxiliaries in the wards. After two years of training, graduates qualified as a Native Obstetric Nurse or, in short, a Native Nurse. The first six Native Obstetric Nurses were certified in March 1909.[1096] Lukere points to these graduates as the 'first of an uninterrupted line of Fijian nurses to the present.'[1097]



Figure 11. Anderson and Fijian nurses in 1929. [Source: Fiji Museum P19.2/2]

[1096] L. M. Lea, An Historical Note on the Suva Central Nursing School, F48/4/26, NAF.
[1097] Vicki Lukere, 'Native Obstetric Nursing in Fiji' in Lukere, Jolly (eds.), *Birthing in the Pacific*, 107.

The development of nursing education started in 1934, following the publication of the WPHS annual report that same year, which argued the need for centralised nursing education. The Executive Council discussed the matter in January 1935. Then, the governor of Fiji suggested the termination of training European nurses in Fiji. Instead, European candidates could be given scholarships to train in New Zealand.[1098] The decisive year for promoting nursing education in Fiji was 1936. L. M. Lea, the matron of the CWM Hospital, was very impressed at the potential of indigenous nurses. Lea arranged with the Education Department to select nursing students through a competitive examination, which stressed candidates' proficiency in English. At the same time, the curriculum of nursing training was reorganised. Although the duration of the course was still two years, the educational standard and expected competence of new nurses greatly improved in all aspects. As before, training methods focused on practical work in hospital wards.[1099]

In the same year, a more significant change occurred after the intervention of external nursing professionals. Elizabeth Tennant, a nursing professional from the RF, and Lambie from New Zealand inspected nursing conditions in the region on separate occasions. Initially, Tennant inspected nursing conditions in the British territories and Tonga, accompanied by Lambert.[1100] Tennant judged that the existing child welfare scheme in Fiji lacked a 'strong medical leadership.'[1101] She had a positive impression of indigenous nurses' abilities. When Hoodless asked her if 'primitive people' could make progress as in Central Europe, she answered that Fijians are as capable as Central Europeans.[1102] Central Europe must have been used as a comparator because the RF was simultaneously promoting public health nursing

[1098] Indian Girls–Training as Nurses, 27 January 1937, F48/168 Part.1, NAF.
[1099] L. M. Lea, An Historical Note on the Suva Central Nursing School, F48/4/26, NAF.
[1100] From S. M. Lambert to H. H. Vaskess, 20 July 1936, WPHC23 2226, WPA.
[1101] Victoria Lukere, 'Mothers of the Taukei', 207.
[1102] Extract from *Fiji Times and Herald*, Report of Address by Miss Tennant, July 1935, F48/168 Part.1, NAF.

(including new health centres and nursing schools) across Central and Eastern Europe.[1103] Judging that Fiji's problem was the poor state of nursing education, Tennant called for 'an immediate change.' She also recommended that a 'Native Nursing Centre to include girls from the whole of the Pacific should be set up in Fiji at once.'[1104] The idea was another centralised medical institution for nursing.

Lambie's opinion was different. She reportedly 'crossed swords' with Tennant who went to New Zealand after her Pacific tour. Particularly, she opposed a 'Pan-Pacific institution' in nursing education until Fijian nurses were proven capable.[1105] Towards the end of the year, Lambie inspected all hospitals in Viti Levu. Then, she submitted a report suggesting reforms 'for the better training of coloured local girls.' Instead of the existing system that trained both European and indigenous nurses, she offered to take in candidates from Fiji, 'if possible European', to be trained in New Zealand as fully qualified nurses.[1106] For Fijians, Lambie suggested a higher standard for admissions. The capacity of the school could also be expanded.[1107] Her report included a rough curriculum for a three-year course which covered both theoretical and practical training. As for Indians in Fiji, the scheme could potentially be extended to include them in the future at a separate school preserved for Indians only.[1108]

Following the recommendations of Tennant and Lambie, the Executive Council proposed a scheme to train 'non-European girls' to work under the supervision of European nurses to the Secretary of State. Candidates would be selected at the age of fourteen and remain

[1103] Paul Weindling, 'Public Health and Political Stabilisation: The Rockefeller Foundation in Central and Eastern Europe between the Two World Wars', *Minerva* 31/3 (1993), 261–262.
[1104] Executive Council No.96, Training of Non-European Nurses, May 1937, F48/168 Part.1, NAF
[1105] Internal Note Numbered 17, Titled Training of Non-European Nurses, Addressed to Y.E., Presumably Written by the Colonial Secretary, F48/168 Part.1, NAF
[1106] V. McGusty, Minute by Director of Medical Service, Extract from (151) in F29/12, 3 December 1936, F48/168 Part.1, NAF.
[1107] Copy of a Report on the Training of Fijian Nurses by Miss M. I. Lambie, From F. A. 29/12, F48/168 Part.1, NAF.
[1108] Executive Council No.96, Training of Non-European Nurses, May 1937, F48/168 Part.1, NAF.

in school for two more years of secondary education funded by the government. Nursing training would last for three years, starting at the age of sixteen. Because Fiji was a multi-ethnic country, the racial aspect of the scheme was a significant consideration at the Executive Council. It was unanimously agreed that the scheme would greatly improve the status of Fijian women. As for Indians, two candidates were selected to train experimentally in India. European education in Fiji would gradually discontinue. Alternatively, selected European candidates could train in New Zealand. The proposal to the Secretary of State did not specify the position of 'half-castes', but the council agreed that 'individual application for training should be considered on its merits for inclusion in the European or Fijian training.'[1109] The Secretary of State approved the scheme in September 1937.[1110] Finally, the governor started preparing for the school to be opened at the beginning of 1940. [1111]

During this period, nurses were desired not only for public health but also as future wives of the NMPs. In its annual report for 1938, the WPHS argued that colonial nurse training served 'a double purpose.' One was to 'carry health into the native home' and the other was to 'mark a great step forward in the education of native girls giving them a new career and helping raise the social standard of Fijian natives.' This was based on the idea that 'the race only advances as the women advance, unless one furnishes women equally as educated as the men, these are pulled back to the women's standard.' The report points out that educated men who were not married to an equally educated woman would 'slip further and further back into native ways.' Ideally, all graduating NMPs would leave the CMS with a nurse as a wife. That way, NMPs could 'maintain higher social standards' and married nurses would not be lost to

[1109] Executive Council, Extract from Minutes of Meeting of 7th June, 1937, 10 June 1937, F48/168 Part.1, NAF.
[1110] From the Secretary of State to the Governor, 1 September 1937, F48/168 Part.1, NAF.
[1111] Executive Council No.96, Training of Non-European Nurses, May 1937, F48/168 Part.1, NAF.

community but become 'an unsalaried government representative' this way.[1112]

It was a progressive yet discriminatory idea of social engineering. The idea that social progress depended on the extent of women's progress was an old notion that spread among Europeans as early as the Enlightenment era. Similar views can be found in relation to Māori and Australian Aborigine societies during the nineteenth century.[1113] Perceiving nurses married to NMPs as 'unsalaried government representatives' also confirms that NMPs were regarded as agents that represented the colonial government. Indeed, according to Tom D'Alton, the Australian High Commissioner in New Zealand, many of the married nurses 'usually exert a strong influence in their villages, especially if, as often happens, they marry a Native Medical Practitioner, preacher or chief.' However, it should be noted that most of the Fijian nursing students already came from chiefly ranks, who could afford secondary education and marry into prominent families.[1114]

The CNS opened in July 1940 after years of planning. It had to wait until M. M. Cleary, selected Tutor Sister for the school, finished her fellowship training at the RF for nearly two years.[1115] This opening was temporary, for official recognition of the school did not occur until August 1941, with a visit by the Governor of Fiji, Luke.[1116] At its establishment, the CNS was expanded from 26 pupils to 50 pupils and the school took over the former European nurses' quarters at the CWM Hospital to accommodate the extra students. This expansion was also a temporary arrangement because the construction of a new building was 'frustrated by the war.'

[1112] Western Pacific Health Service Annual Report, 1938, RF RG5 S3.417 B161 F1974, RAC.

[1113] Patricia Grimshaw, Helen Morton, 'Theorizing Maori Women's Lives: Paradoxes of the Colonial Male Gaze' in Robert Borofsky (ed.), *Remembrance of Pacific Pasts: An Invitation to Remake History* (Honolulu: University of Hawai'i Press, 2000), 272–273.

[1114] From the High Commissioner for Australia to the Minister for External Affairs, 9 January 1945, A518, AG815/1/1, NAA.

[1115] From S. M. Lambert to V. W. T. McGusty, 3 October 1938, F48/168 Part.1, NAF.

[1116] Address by His Excellency the Governor Sir Harry Luke, K. C. M. G. to the Students of the Native Nurses' School, 7 August 1941, F48/168 Part.1, NAF.

Its original plan was to expand to at least 100 pupils, with about 80 seats for Fiji and 20 positions for other countries.[1117] By 1945, the school expanded to having 85 pupils.[1118]

The nursing curriculum was entirely revised. The CNS course was extended to three years, including both theoretical and practical education. Theoretical courses included medicine, surgery, anatomy, physiology, personal hygiene, bacteriology, bandaging, nutrition, principles and practices of nursing, community hygiene, tuberculosis nursing, and public health nursing. They also learned domestic sciences such as house craft and cooking. From the end of their first year, the students were trained in a children's ward and spent a minimum of six months in obstetric wards. In their final year, students gained experience in all branches of the hospital, including the Out-patient Department and worked in district public health works.[1119]

Admissions standards for the CNS were expected to be the same as for students entering the CMS.[1120] Yet it was made clear that indigenous nursing students 'should not be treated as a medical student' and 'still do the drudgery associated with the profession.' Even though in the 'tropical East' European Nursing Sisters were 'relieved of most of the drudgery by native servants', indigenous nurses did not enjoy the privilege.[1121] The CNS wanted the students to retain their 'native' status after graduation for this purpose.[1122] In this respect, the general education philosophy of raising subordinate staff for colonial service was similar to the CMS.

The establishment of the CNS should be understood in the context of the Second World

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[1117] V. W. T. McGusty, A Memorandum for the Post War Development of the Medical Department of Fiji, and Containing References Also to Medical and Public Health Problems in Neighbouring Pacific Islands, RF RG1.1 S419 B1 F13, RAC.
[1118] From the High Commissioner for Australia to the Minister for External Affairs, 9 January 1945, A518, AG815/1/1, NAA.
[1119] L. M. Lea, An Historical Note on the Suva Central Nursing School, F48/4/26, NAF.
[1120] Memorandum on the Training of Non-European Nurses, 5 March 1936, F48/168 Part.1, NAF.
[1121] Executive Council No.96, Training of Non-European Nurses, May 1937, F48/168 Part.1, NAF.
[1122] L. M. Lea, An Historical Note on the Suva Central Nursing School, F48/4/26, NAF.

War. Its first annual report in 1942 begins with the following sentence: 'At a time when the world is torn asunder by wars, and when humanity is suffering as never before in the whole of its history, it is a very exceptional privilege to write about a subject which is essentially concerned with the alleviation of suffering and the preservation of life.'[1123] After the publication of the report, McGusty noted, 'judged by recent pronouncements by the Secretary of State and others such institutions are certain to play a very important part in the scheme of post war development.'[1124] Although it was proposed and approved before the war, the school opened its doors during the war. Due to the wartime financial strains, it had to be on a smaller scale than its original ambition.[1125]

Branches of the school were set up later. In 1946, a branch was established in Lautoka Hospital, which covered the western part of Viti Levu. Then, Labasa Hospital on Vanua Levu started training nurses. Until then, Labasa Hospital had nursing aides, whose performance were unsatisfactory to the medical authorities. To relieve the strains on accommodation in hospitals on Viti Levu and to let the Labasa Hospital benefit from better-trained nursing students, the Director of Medical Services proposed training the CNS students in Labasa. [1126] Expected to be welcomed by the people of Vanua Levu, the scheme was approved in February 1950.[1127]

Significant developments at the school occurred in the early 1950s. In 1953, adopting training standards to the New Zealand registration level was discussed.[1128] They wanted to recruit twelve students each year for a four-year course.[1129] To avoid 'any allegation of discrimination', this course would be open to all races who possessed a Cambridge

[1123] *Ibid.*
[1124] From the Director of Medical Services to the Colonial Secretary, 30 June 1943, F48/4/26, NAF.
[1125] L. M. Lea, An Historical Note on the Suva Central Nursing School, F48/4/26, NAF.
[1126] From the Director of Medical Services to the Colonial Secretary, 4 February 1950, F48/168 Part.2, NAF.
[1127] From the Colonial Secretary to the Director of Medical Services, 17 February 1950, F48/168 Part.2, NAF.
[1128] Standing Committee on Finance, Training of Pupil Nurses, 22 March 1954, F48/494, NAF.
[1129] From the Colonial Secretary to the Director of Medical Services, 29 December 1953, F48/494, NAF.

certificate.[1130] By that time, accommodation conditions at the CWM Hospital would have improved so that they could take in nursing candidates 'without raising any bogies of racial discrimination.'[1131] Examination papers could be acquired from New Zealand and returned to New Zealand for marking.[1132] In the meantime, the CNS finally moved to the new Tamavua site in 1954.[1133] Four-year training to the New Zealand standard was deferred to 1955 to wait until the move to Tamavua was complete and all facilities were available for use.[1134]

Teaching at the CNS until the early 1950s was more of a vocational training for hospital workers than a properly instituted education until the early 1950s. Nursing students were most commonly referred to as 'girls', 'trainees', or 'probationers' instead of students in the early period. The term 'under-graduate nurses' or 'post-graduate' could be found only after 1950. Unlike the medical students who received scholarships and pocket money, nursing candidates received salaries for working at the hospital. Moreover, institutionally, the CNS was subordinate to the CWM Hospital. Fiji assigned nursing education funding as part of the allocations for the CWM Hospital. This confirms that the school was functioning administratively as a training unit of the hospital. The separation of financial provisions for the CNS was first raised following the discussion of accepting postgraduate students from other SPHS territories in 1951. Accounting could be arranged similarly to the CMS or the CLH should the school be internationalised.[1135] Yet separate accounting was postponed until after the school was reopened in Tamavua in 1954.[1136]

[1130] From the Director of Medical Services to the Financial Secretary, 2 November 1953, F48/494, NAF.
[1131] Internal Note from E. J. C. to A. C. S., 23 December 1953, F48/494, NAF.
[1132] From the Director of Medical Services to the Colonial Secretary, 22 April 1954, F48/494, NAF.
[1133] Director of Medical Services, Application for Additional Provision, 18 January 1955, F48/467, NAF.
[1134] From the Director of Medical Services to the Colonial Secretary, 22 April 1954, F48/494, NAF.
[1135] From the Colonial Secretary to the Director of Medical Services, 10 October 1951, F48/467, NAF.
[1136] From the Director of Medical Services to the Colonial Secretary, 1 September 1952, F48/467, NAF.

Overseas Students and Indian Training

The CNS did not become as intercolonial and international as other centralised medical institutions. After Lambert's retirement, it was organised according to Lambie's suggestions as a primarily Fijian institution. The advent of the war did not help, either. Countries that would have participated otherwise were 'prevented from doing so by the war.'[1137] Later, the SPHS decision (influenced by Lambie) to train indigenous nurses locally confirmed that the CNS was not going to be fully intercolonial.[1138]

In any case, the CNS was not going to train the entire nursing staff for participating countries but only to 'train the nucleus' of the nursing staff of participating countries, leaving the bulk of subordinate staff to be raised locally.[1139] Compared to the two-tiered medical service, composed of fully qualified doctors and NMPs, the idea was for a three-tiered nursing service, as is shown in Tongan records. Before nursing education was decided to be localised, Tonga had plans to send four students to the CNS in January 1945.[1140] At this time, the top tier of the Tongan service was to be occupied by a Senior District Nurse who was fully qualified, mostly likely from New Zealand. The intermediate grade would be made of graduates of the CNS. 'Girls of suitable character and education' were to be trained as government scholars in the three-year curriculum at Suva. Upon graduation, they could be appointed as public health nurses, nurses-in-charge at provincial hospitals, or as an assistant to the matron of the Nuku'alofa Hospital. The lowest grade would compose of Tongan nurses trained at a local

[1137] V. W. T. McGusty, A Memorandum for the Post War Development of the Medical Department of Fiji, and Containing References Also to Medical and Public Health Problems in Neighbouring Pacific Islands, RF RG1.1 S419 B1 F13, RAC.

[1138] Minutes of a Meeting of a Conference Held in Suva on the 9th and 11th July, 1945, WPHC9 87/7/1 Vol.1, WPA.

[1139] V. W. T. McGusty, A Memorandum for the Post War Development of the Medical Department of Fiji, and Containing References Also to Medical and Public Health Problems in Neighbouring Pacific Islands, RF RG1.1 S419 B1 F13, RAC.

[1140] Ata, Premier, Excerpt from a Copy of Letter from Premier of Tonga, 11 January 1945, WPHC23 52/57/2, WPA.

nursing school.[1141]

As the Tongan plans imply, the CNS did not remain an entirely Fiji institution. The greatest advocate of intercolonial nursing education was perhaps Lambert. When the expansion of the Nurses' Training School was discussed, Lambert promoted the idea through his work as the Director of the WPHS. The WPHS annual report in 1934 states that cooperation for a nursing school was 'applauded by many of the groups which participate in the Central Medial School.' According to the report, Western Samoan nursing education at Apia Hospital lacked clinical and theoretical teaching facilities. The Gilbert and Ellice Islands had no facilities at all for nurse training. Tonga and the Cook Islands 'might also welcome such an addition to the education for their young women.' Provided the school can offer dormitory facilities, the additional cost of instituting an intercolonial nursing school was not too high.[1142]

While individual student records could not be found, there were fragmented records of overseas students in the early period of the CNS. Michael Haas noted that the Nurses' Training School offered services to Western Samoa, American Samoa, and Nauru in addition to Fiji and the WPHC territories.[1143] When the CNS was first officially recognised in 1941, a newspaper clipping reported several students 'represent other races in the Pacific.' Considering a concert programme celebrating Luke's visit included Gilbert dance, Samoan dance, Rotuman dance, Tahitian dance, and Ellicean dance, it may be assumed there were students from Gilbert and Ellice Islands, Samoa, or French Polynesia.[1144] A Colonial Office document in 1941 recorded that there were four students from other Pacific administrations.[1145] Also, a document from

[1141] Excerpt from a Report by Dr. V. W. T. McGusty, C. M. G., O. B. E., on Medical and Public Health Matters in the Kingdom of Tonga with Recommendations, WPHC23 52/57/2, WPA.
[1142] Western Pacific Health Service Annual Report, 1934, RF RG5 S3.417 B161 F1965, RAC.
[1143] Haas, *The Pacific Way*, 19.
[1144] Extract from *Fiji Times and Herald*, 9 August 1941, F48/168 Part.1, NAF.
[1145] Extract from Official Report of 31st March 1943, F48/168 Part.1, NAF.

1945 stated that Tongans, Gilbertese, Elliceans, and Rotumans were training at the CNS.[1146]

Intercolonial cooperation developed further after the war. Although basic nurse training was done locally, the SPHS territories were advised to send students to the CNS for postgraduate education in 1951. Subsequently, the Cook Islands sent four nurses to the CNS to train in their postgraduate course in ward administration.[1147] An 'unofficial enquiry' was also made by the US Trust Territories if they could send nursing students to the CNS. This was the same year that the US transferred medical students from Guam to the CMS. At this point, Fiji expected more international students from the SPHS territories 'concurrent with the development of Fiji as the hub of the South Pacific.'[1148]

While the CNS received fewer overseas students, Fiji's nursing service was fully international, mainly relying on New Zealand. In 1934, Fiji's nursing service was amalgamated with New Zealand, drawing all fully qualified nurses through New Zealand's Health Department.[1149] In 1942, New Zealand agreed to 'relieve Fiji of the responsibility' of maintaining a higher-grade nursing school at the CWM Hospital.[1150] This marked the termination of training European nurses in Fiji, of which many were from New Zealand.[1151] After the establishment of the SPHS, the pool of Nursing Sisters (fully qualified nurses) for the SPHS territories was supplied by New Zealand. Records also contain cases of indigenous nurses of lower qualifications being seconded between the SPHS territories. For example, New Hebrides requested two Fiji-trained nurses for the Presbyterian Mission Hospital at Vila, which

[1146] H. S. Evans, Acting Director of Medical Services, Indian Nurses, 7 May 1945, F48/168 Part.1, NAF.
[1147] The South Pacific Board of Health, Minutes of the Meeting Held at Suva, Fiji, 19–22 August 1953, PMB 1284, Pacific Manuscripts Bureau, Australian National University.
[1148] From the Director of Medical Services to the Colonial Secretary, 10 October 1951, F48/467, NAF.
[1149] From the Colonial Secretary to S. M. Lambert, 10 March 1938, F48/179, NAF.
[1150] V. W. T. McGusty, A Memorandum for the Post War Development of the Medical Department of Fiji, and Containing References Also to Medical and Public Health Problems in Neighbouring Pacific Islands, RF RG1.1 S419 B1 F13, RAC.
[1151] New Zealand stopped facilitating New Zealand students applying to receive nurse training at the CWM Hospital from 1941. See: [Nurses] — Nursing Services, Suva, AAFB 632 W3464 21/83/2 R1885781, ANZ.

was subsidised by the UK Government.[1152]

Significantly, the CNS took in overseas students but not Indians at this point, unlike the CMS. Given that Indians comprised nearly half of the population in Fiji, the need for Indian nurses was apparent. However, there were many cultural reasons behind the difficulty of finding Indian nursing candidates. The Indian Reform League first requested that Indians should be trained at the CWM Hospital in 1933. While Fijians were not against mixed-gender education, Indians generally preferred having girls separated from boys from an early age. Since it was difficult to establish Indian girls-only schools, women's education among Indians in Fiji had 'hardly begun' by then.[1153] In Fiji, this was why many of the nursing candidates were graduates of the Methodist Mission's school, Matavelo.[1154] Moreover, nursing occupation was closely associated with prostitution. Students had to be removed from families for years to train at schools and hospitals, which were often in urban centres. Nursing work also involved night shifts and taking care of male patients' bodies. In other words, becoming a nurse could be seen as leaving families to engage in intimate care of men at night.[1155]

Another reason contributing to the lack of nursing candidates was that nursing work conflicted with the role of 'the old *dai*.'[1156] *Dai* refers to a traditional Indian midwife who usually came from hereditary low castes. The British considered *dai* unclean and unscientific, responsible for the high Indian mortality rate.[1157] According to David Arnold, replacing the 'barbaric' *dai* practice was one of the ways to 'incorporate women into a colonizing medical

[1152] From Jamieson, Surrey Hills, Victoria to Blandy, Vila, N.H., 17 May 1950, WPHC9 52/131, WPA.
[1153] Extracts from a Report on Education in Fiji by Mr. A. I. Mayhew, C. M. G., C. I. E., F48/168 Part.1, NAF.
[1154] Lukere, 'Native Obstetric Nursing in Fiji' in Lukere, Jolly (eds.), *Birthing in the Pacific*, 109.
[1155] Madelaine Healey, *Indian Sisters: A History of Nursing and the State, 1907–2007* (New Delhi: Routledge, 2013), 47–48.
[1156] Indian Girls–Training as Nurses, 27 January 1937, F48/168 Part.1, NAF.
[1157] Seán Lang, 'Drop the Demon *Dai*: Maternal Mortality and the State in Colonial Madras, 1840–1875', *Social History of Medicine* 18/3 (2005), 363–365.

discourse.'[1158] Colonial authorities understood that the practices of traditionally low caste *dais* caused trained nurses in India to be limited to mostly Europeans, Anglo-Indians, Eurasians (mixed-race) or Christian Indians. Fiji authorities argued that Indian nursing could not progress unless Indian men could 'adopt a purer, chivalrous attitude to young unmarried women who try to do something for the community.' It was the European notion of 'chivalry' that was key to freeing Indian girls who always had to be chaperoned.[1159] Indeed, such an attitude seems to be a continuous feature from the nineteenth century when the British approached *dai* training as a question of extending western civilisation.[1160]

Even if candidates were found and trained, a significant number of Indian nursing candidates chose marriage over training. The recommended age to enter nursing training was around sixteen. After three years of training, students graduated around the age of nineteen. According to statistics, 84% of Indian girls were married before nineteen compared to less than 10% of Fijian girls married by that age.[1161] Securing unmarried Indian graduates willing to pursue a nursing career was a challenge to the government.

The final hurdle to Indian training was racial. Indians and Fijians did not usually mix in Fiji. Medical authorities considered that this caused 'racial difficulties' at the CWM Hospital which was primarily attended by Fijians.[1162] Consequently, Indian nurse training in Fiji was driven by political causes, with the Indian community attempting to raise their racial status in Fiji. In March 1934, the Legislative Council discussed the question 'to have Indian girls admitted to the Hospital on the same terms as Europeans.' The governor refused to commit any funding, but the Indian community offered to 'subscribe the cost of additional accommodation

[1158] Arnold, *Colonizing the Body*, 257.
[1159] A. W. McMillan, Female Indian Nurses, Training of, 29 August 1945, F48/328, NAF.
[1160] Mark Harrison, *Public Health in British India*, 90–91.
[1161] Memorandum on the Training of Non-European Nurses, 5 March 1936, F48/168 Part.1, NAF.
[1162] Indian Girls–Training as Nurses, 27 January 1937, F48/168 Part.1, NAF.

necessary.' As a result, a building to accommodate two Indian students was prepared. The governor considered it 'both politically and practically an excellent move.' The Executive Council approved training eligible Indians at the CWM Hospital in July 1934. At this point, medical authorities agreed on 'equal opportunities' for both Fijians and Indians but 'an equal footing with European nurses' was not guaranteed. The Indian community refused to accept the Fijian-level training and demanded 'equality in social status with Europeans.' They believed it could only be reached through training at the CWM Hospital. However, the Fiji government thought that it would bring insuperable racial difficulties to hospital administration.[1163] As explained earlier, Indians did not mix with Fijians and were not 'willing to work in a men's ward.'[1164]

Fiji was convinced that Indian communities' motivations were 'purely social and political,' i.e. to have Indian girls 'to work on social equality with the Europeans.'[1165] In January 1935, the Executive Council discussed training Indians and another Indian deputation was made in two months' time, after which the governor suggested training Indians at the Methodist Mission Hospital in Ba. McGusty was confident that it would not be acceptable to the Indians 'as their real ambition was to enter the C.W.M.H. and to associate there on equal terms with European nurses.' Midwife training opportunities were already available in Ba but that was 'beneath their dignity' to Indians that despised low-caste occupations. In November 1935, Fletcher discussed with the Indian representative a proposal to train two nurses in India for future employment at Lautoka Hospital. Eventually, after discussing the matters with the Indian government, Fiji decided to experimentally send students to Irwin Hospital in New

[1163] *Ibid.*
[1164] A. W. McMillan, Female Indian Nurses, Training of, 29 August 1945, F48/328, NAF.
[1165] Memorandum on the Training of Non-European Nurses, 5 March 1936, F48/168 Part.1, NAF.

Delhi.[1166] Indian nursing education, therefore, was a result of continuous effort from the Indian community.

Further discussions on Indian nurses were triggered by the recommendations made by Tennant and Lambie. The Director of Medical Services and the Director of Education worked out a new training system, including the Indian question. In response to that, the Secretary for Indian Affairs agreed that European training in Fiji should be gradually replaced with non-Europeans. Noting the plan to send Indians to train in India, he saw 'no reason why a beginning should not be made with Fijian nurses alone.' The Colonial Secretary disagreed, arguing that Indian girls should be trained in Fiji and that Indians in Fiji were 'almost a different race, that the connection with India should not be the deciding factor.'[1167]

Momentum developed when the school for European nurses closed and a decision was made to send selected students to New Zealand for training. 'Although not specifically announced', the New Zealand opportunity was 'open to selected girls of all races.'[1168] In April 1943, four Indians seized the opportunity and applied to train as nurses in New Zealand. New Zealand was ready to assist their training under the condition that they return to work in Fiji.[1169] Fiji was compelled to support the application because no overseas-trained Indian nurses had yet returned to Fiji. Two students who went to India got married and remain in India.[1170] The motivation behind their marriage is unclear, for example, if it was an individual choice or decisions made by parents and social pressure. However, the result was that Indian students did not return as Fiji would have wanted them to. Despite such a low rate of success, Fiji still tried to train Indian nurses 'in hope that eventually traditional Indian prejudices will be broken

[1166] Indian Girls–Training as Nurses, 27 January 1937, F48/168 Part.1, NAF.
[1167] Executive Council No.96, Training of Non-European Nurses, May 1937, F48/168 Part.1, NAF.
[1168] From the Director of Medical Services to the Colonial Secretary, 28 December 1942, F48/179, NAF.
[1169] Letter from the Department of Health Head Office, 1 April 1943, F48/328, NAF.
[1170] A. W. McMillan, Female Indian Nurses, Training of, 29 August 1945, F48/328, NAF.

down and nursing recognized as a proper career for Indian women.'[1171]

Indeed, training Indians with Europeans in Fiji was difficult. According to McGusty, 'the hospital is always the limelight of local politics, particularly on questions of racial discrimination.' In 1943, Fiji authorities thought 'the racial feeling' was too high 'to admit Indians to the Nurses' Homes' and such contentious issues of racism to be avoided.[1172] Similar racial tensions were found in other tropical colonies. Warwick Anderson argued the Philippine General Hospital was 'an allegory for the colonial polity' in which white Americans imposed an imperial authority over indigenous nurses.[1173] Because of the racial problems, the Watt-Lambie report tried be racially neutral for nursing education. It stated that 'any girl, whether European or non-European, wishing to train as a nurse in New Zealand from Fiji who has the educational qualifications and whom the Administration is prepared to sponsor, provided she passes the necessary medical examination, will be found a vacancy in a Training School for nurses in the North Island.'[1174] The expectation was that Indians would 'enjoy the sense of racial equality with other nurses' in New Zealand or Australia without feeling the 'definitely critical attitude that exists among their own people here.'[1175] Afterwards, Fiji sent two Indian students to train in New Zealand every year until 1954.[1176]

The actual move to train Indians in Fiji only started in 1945. Until then, Indian training in Fiji was confined to the Methodist Mission Hospital in Ba where they had no male patients. The hospital offered three years of general training, qualifying an average of one graduate per

[1171] From the Colonial Secretary to the Director of Education, 25 September 1945, F48/328, NAF.
[1172] Extract from Letter from the Director of Medical Services to Miss Lambie Director of Nursing, N. Z., 3 April 1943, F48/328, NAF.
[1173] Warwick Anderson, 'Modern Sentinel and Colonial Microcosm: Science, Discipline, and Distress at the Philippine General Hospital', *Philippine Studies,* 57/2 (2009), 153–177.
[1174] Extracted from Part II of Dr Watt's and Miss Lambie's Draft Report on Med. Services and Public Health in the Colony of Fiji, F48/328, NAF.
[1175] A. W. McMillan, Female Indian Nurses, Training of, 29 August 1945, F48/328, NAF.
[1176] H. S. Evans, Acting Director of Medical Services, Indian Nurses, 7 May 1945, F48/168 Part.1, NAF.

year since 1932. Most graduate nurses chose marriage and there were only two graduates working at the CWM Hospital and a few at the Methodist Mission Hospital at the time. Students who went to New Zealand for training reportedly experienced great difficulties in the higher standard of education and some struggled to qualify. To improve the output of the Indian nurses, a proposal to train Indians at the Lautoka Hospital as a branch of the CNS was made in 1945.[1177]

Indian training at Lautoka Hospital finally started in 1946 'after years of doubts & indecision.' It was not an entirely Indian school as the Lautoka branch had about 40 students and nurses in 1948, where the Indian students were 'happily intermingled, both in work & in dormitories' with Fijian students. Owing to the lasting cultural reluctance, Indian students were still drawn from 'the abnormal category of Mission-trained Christian Indian girls.' As the medical authorities were very satisfied with the 'happy inter-racial association', the idea of making the school an entirely Indian branch was discarded. At the same time, the racial balance at the branch was carefully managed.[1178] The Colonial Secretary informed the Director of Medical Services that the percentage of Fijians should not fall below 45% without consulting the government.[1179] The rate was calculated presuming the racial composition would be at 45% Fijians, 45% Indians, and 10% part-Europeans (mixed-race).[1180] As such, the establishment and the early years of the CNS were much of a process of expanding nursing education within Fiji.

Suva Medical Centre Scheme

An associated scheme to the CNS and the SPHS was to create a comprehensive

[1177] *Ibid.*
[1178] H. S. Evans, Indian Nurses Training, 29 May 1948, F48/168 Part.1, NAF.
[1179] From the Colonial Secretary to the Director of Medical Services, 23 June 1948, F48/168 Part.1, NAF.
[1180] Internal note by the Acting Colonial Secretary, 23 June 1948, F48/168 Part.1, NAF.

medical centre in Suva. When Tennant visited the South Pacific in 1936, she suggested a health centre as part of her recommendations to reform nursing education. Tennant's idea was to instal a public health centre 'for the better instruction of medical and nursing students.' The governor of Fiji welcomed the idea and ordered a health centre scheme with the CNS as an expansion of the CWM Hospital.[1181] At the inception stage, the expansion plan included new accommodation for European nurses, the CNS, and a public health centre.[1182] McGusty developed the scheme to serve as a 'co-ordinating point of the health services already established in Suva', proposing the Out-patient Department of the CWM Hospital become the nucleus of the proposed health centre.[1183]

In April 1937, the Executive Council decided to name the health centre 'King George V Health Centre' to commemorate the late king. The council also agreed that the cost of building the health centre should be borne by the government and not be drawn from the Fijian public.[1184] This was specifically noted because a significant amount of the medical progress made in Fiji was 'the result of assistance deriving from non-Governmental sources.' The CWM Hospital was 'built with equal contributions from the Government and the public of Fiji.' Its children's ward was donated by the directors of the Tavua Gold Mines and most of the valuable equipment at the hospital was donated by prominent citizens. The Colonial Sugar Refining Company funded infant welfare programmes and maintained public hospitals in sugar growing regions. Finally, the RF contributed to the CMS, the WPHS, the Pathological Laboratory, and

[1181] Extract from Note on Interview with His Excellency the Governor on the Subject of Improvements to the Colonial War Memorial Hospital–Held at Government House, 22 December 1936, F48/179, NAF.
[1182] Extract from Acting Governor's Address to Legislative Council, 23 October 1936, F48/179, NAF.
[1183] Extract from a Memorandum by the Acting Director of Medical Services to the Honourable the Colonial Secretary, 29 December 1936, F48/179, NAF.
[1184] Extract from Minute of a Meeting of the Executive Council Held at Government House, 23 April 1937, F48/179, NAF.

raising interest to public health throughout the region.[1185]

Fiji had to figure out a way to fund the building. The RF had hinted at the possibility of funding the scheme,[1186] And in June 1937, Fiji formally proposed the RF for assistance in meeting the construction costs, which were estimated at about £50,000–60,000. The proposal explained how the scheme was related to Tennant's recommendations for a new nursing school, which was being developed, and linked to the expansion of the CWM Hospital. In this proposal, plans were developed further to include new quarters for nurses, a new dormitory for medical students, a new children's ward, a new obstetrical ward, and a new mental pavilion. Once construction was completed, the old dormitory for medical students would be turned into an out-patients department.[1187] The RF agreed to contribute $20,000 for the health centre.[1188]

Later, financial support from the RF became problematic. Health centres that promoted public health and medical training were an integral part of the Foundation's international health programmes.[1189] Previously, a Rockefeller representative in Java had defined a health centre as an advisory institution for obstetric and infant care. Based on this definition, the funding offer was made on the condition that the health centre was entirely separate from the CWM Hospital. McGusty did not agree. He did not want to confine health centre's functions to infant and maternal welfare but to 'embrace all aspects of hygiene and extend un-avoidably even into curative medicine.' That way, he thought the health centre could confer great benefit on the local population and become 'the best means of teaching practical public health work' to

[1185] V. W. T. McGusty, A Memorandum for the Post War Development of the Medical Department of Fiji, and Containing References Also to Medical and Public Health Problems in Neighbouring Pacific Islands, RF RG1.1 S419 B1 F13, RAC.
[1186] Extract from a Memorandum by the Acting Director of Medical Services to the Honourable the Colonial Secretary, 29 December 1936, F48/179, NAF.
[1187] Letter to Lambert, 10 June 1937, F48/179, NAF.
[1188] From Lambert to Juxon Barton, 17 June 1937, F48/179, NAF.
[1189] Shirish N. Kavadi, *The Rockefeller Foundation and Public Health in Colonial India, 1916–1945: A Narrative History* (Pune/Mumbai: Foundation for Research in Community Health, 1999), 126.

students. He believed that for 'a small Colony like Fiji', the distinction between curative and preventive medicine should be flexible. Therefore, McGusty was against receiving Rockefeller funding if such a condition was imposed.[1190]

Until then, the RF involvement in the British colonies in the South Pacific did not come with strict conditions. In this way, the British Empire enjoyed the financial benefits of American philanthropy while keeping control over its colonial institutions. But when the RF's approach conflicted with colonial interests, it was not welcomed. In the field of public health nursing education, the RF not only pressed Fiji but Britain and other nations to adopt 'American standards.'[1191] This approach caused tensions in British Malaya, where the Foundation insisted that nurses be trained in the US before being placed to work in the Straits Settlements.[1192] Similarly, India had a disagreement with Tennant, who represented the RF, for raising standards of nurse training beyond the immediate need in the colony.[1193]

Arising from the scope of the health centre, Lambert's employment became an issue. During the discussion process in 1938, Lambert offered to postpone his retirement to assist the establishment of the health centre in Fiji.[1194] According to McGusty, Lambert said that the RF might not fund the health centre unless he was needed in Fiji for another three years. This contradicted Lambert's long-term expression of desire to leave Fiji after his planned retirement in March 1939. Only after McGusty claimed that Fiji did not need a resident Rockefeller staff did Lambert come 'out into the open' and admitted that he needed a job for personal financial

[1190] From the Acting Director of Medical Services to the Colonial Secretary, 18 February 1938, F48/179, NAF.
[1191] Anne Marie Rafferty, 'Internationalising Nursing Education During the Interwar Period' in Paul Weindling (ed.), *International Health Organisations and Movements, 1918–1939* (Cambridge: Cambridge University Press, 1995), 277.
[1192] Rosemary Wall, Anne Marie Rafferty, 'Trouble with "Status"" Competing Models of British and North American Public Health Nursing Education and Practice in British Malaya' in Hans Pols, C. Michele Thompson, John Harley Warner (eds.), *Translating the Body: Medical Education in Southeast Asia* (Singapore: NUS Press, 2017), 73–78.
[1193] Kavadi, *The Rockefeller Foundation and Public Health in Colonial India, 1916–1945*, 131.
[1194] From S. M. Lambert to V. W. T. McGusty, 11 January 1938, F48/179, NAF.

reasons.[1195] Since Lambert was the director of the WPHS, which was under the auspices of the WPHC, his extended employment probably had to be justified by the British colonial administration.

McGusty was strongly against having Lambert for several more years. Claiming that Fiji was 'competent to undertake its essential services un-aided', he found it 'unable to justify and therefore unable to recommend' extending Lambert's term.[1196] McGusty preferred not to construct a new building than to 'admit the need for supervision by the Foundation.' Even as a last resort to keep the Rockefeller representative, he wanted 'new blood' rather than to retain Lambert.[1197] The reasons for Lambert's additional financial needs and McGusty's firm conviction against Lambert are not recorded in official documents. According to an oral interview with Margaret Guthrie, Lambert was half-forced to leave the RF due to his gambling debt, which was widely known among the European residents in Fiji.[1198] Based on his personal correspondence with his wife, Lambert indeed frequently played bridge and poker.[1199] Given that Guthrie's story is true, McGusty's attitude is understandable. It is convincing because Lambert applied for retirement in October 1938 after his negotiations with McGusty failed. His official reason for retirement was his worsening eye condition.[1200] Lambert finally retired in March 1940 after using up his accumulated leave and sick leave.[1201]

As a result, the Colonial Secretary insisted that Fiji adhere to two principles for the

[1195] From the Director of Medical Services to the Colonial Secretary, 11 August 1938, F48/179, NAF.
[1196] From the Acting Director of Medical services to the Colonial Secretary, 18 February 1938, F48/179, NAF.
[1197] From the Director of Medical Services to the Colonial Secretary, 11 August 1938, F48/179, NAF.
[1198] Based on notes taken from an oral interview with Margaret Guthrie on 17 September 2019 at her house in Auckland, New Zealand. Guthrie is the daughter of David Hoodless, the first principal of the Central Medical School.
[1199] Mentioned in multiple letters found in Box 1 Folder 26, Lambert, Eloise Tays (wife) 1938–1942, of Sylvester M. Lambert Papers, 1883–1959 (bulk 1918–1947), MSS 682, Special Collections and Archives, University of California San Diego Library.
[1200] From S. M. Lambert to W. A. Sawyer, 4 October 1938, RF RG15 S1 B17 F1, RAC.
[1201] From S. M. Lambert to W. A. Sawyer, 16 August 1939, RF RG15 S1 B17 F2, RAC.

health centre scheme. One was that Fiji would not strictly partition types of medical efforts. It was the centralisation of medical efforts that Fiji aimed for. The second principle was not defining a demarcation line between preventive and curative medicine, which was the opposite of the RF's principles. This was to achieve 'the optimum physical fitness of the race.'[1202] Fiji later compromised and altered the construction plan to separate areas for preventive and curative medicine in one building as the RF still insisted on its principle of 'complete separation of the curative from the preventive aspects of medicine.'[1203] After that, the RF promised to support the cost of training personnel and furnish enough equipment to the health centre 'to the last jot and tittle' in addition to $20,000.[1204]

The cost of building projects changed over time. In June 1939, the estimated cost for building a combined health centre and an Out-patient Department of the CWM Hospital was £12,500. With the $20,000 donation from the RF, the Fiji government had only to meet about £7,790.[1205] By comparison, construction of the new CMS combined with its new dormitory buildings was estimated at about £28,500. A new hospital for Ba district would cost £50,000.[1206] In April 1940, plans changed to generally enlarge the health centre and to include additional staff quarters and a dental clinic, leading to an increase in the estimated cost to £37,000. Although the new plan was promoted as 'a most appropriate memorial to His Majesty King George V', it was not approved by the Secretary of State.[1207] Wartime conditions meant that funds were restricted and Fiji was instructed to avoid costly commitments. Instead,

[1202] From the Colonial Secretary to S. M. Lambert, 10 March 1938, F48/179, NAF.
[1203] Interview between the Honourable the Colonial Secretary and Dr. Strode, A Director of the International Health Division of the Rockefeller Foundation –Dr. Lambert, Representative in the South Pacific of the Foundation, and the Director of Medical Services were also Present, F48/179, NAF.
[1204] From S. M. Lamber to the Director of Medical Services, 18 January 1939, F48/179, NAF.
[1205] From the Director of Medical Services to the Colonial Secretary, 23 June 1939, F48/179, NAF.
[1206] From the Governor to the Secretary of State, 24 April 1940, F48/179, NAF.
[1207] From the Director of Medical Services to the Colonial Secretary, 1 May 1940, F48/179, NAF.

application to the new Colonial Development and Welfare Fund was suggested.[1208]

Construction of the health centre was affected by related projects that consisted the larger scheme to improve medical services in Fiji. First, the priority for construction was given to creating new dormitory buildings for the CMS students.[1209] The second step of the scheme was to set up the newly developed CNS. The health centre was the final step of the bigger scheme.[1210] With the educational institutions built first, the health centre could train both medical and nursing students together in 'a modern course in public health nursing.'[1211]

During the Second World War, the health centre scheme changed into a medical centre scheme. Wartime focuses on disease control and treatment may have contributed to the term 'medical' seeming more appropriate than 'health,' which had connotations of preventive medicine and long-term healthcare. Indeed, before New Zealand suggested the use of 'health' in naming the SPHS, the South Pacific Medical Service was being developed with an associated 'medical centre' in Suva. The change of term also signals a divergence from the RF policies to keep the functions of a health centre limited to preventive medicine. 'Medical' was a better description of McGusty's idea of a centre that embraced hygiene, curative medicine, and education.

The medical centre proposal is first noted in a memorandum written by McGusty submitted to the Colonial Office in 1942. According to this document, construction plans for the health centre, the CMS and the CNS were already approved. Unfortunately, the CWM Hospital did not have any space for the associated institutions to be attached to. A new site would be 'the only permanent and satisfactory solution.' In addition, there were fears that

[1208] From the Secretary of State to the Governor, 16 May 1940, F48/179, NAF.
[1209] From the Director of Medical Services to the Colonial Secretary, 23 June 1939, F48/179, NAF.
[1210] From McGusty to the Colonial Secretary, 13 December 1940, F48/179, NAF.
[1211] Western Pacific Health Service Annual Report, 1938, RF RG5 S3.417 B161 F1974, RAC.

diseases and 'the revolutionary changes in living habits which are likely to result from the war' might 'wipe out the indigenous inhabitants of Fiji and of those other South Western Pacific Islands.' Therefore, a general improvement in medical services was necessary for the region. All of the approved construction and a new general hospital to replace the CWM Hospital's position could be concentrated in one site. In doing so, Fiji could establish 'a composite medical centre conforming with the increasingly important place with Suva must take as the medical centre of the South West Pacific.' The new medical centre proposal included hospitals, schools, laboratories, staff quarters, and a public health centre.[1212]

Military campsites were considered as possible sites for the new medical centre. Samabula camp was an excellent site because it was centrally located. Tamavua hospital, where the New Zealand and US military set up their General Hospitals, was slightly outside central Suva and was more suitable for a 'combined isolation and tuberculosis hospital.' Nasinu hospital was further outside Suva and was not in permanent construction.[1213] After the Watt-Lambie report, the medical centre was considered in line with the establishment of the SPHS. The name 'King George V Health Centre' was not mentioned anymore.

Even after the SPHS was launched, the creation of a medical centre did not start until 1950. After all, Tamavua Hospital turned into a tuberculosis hospital, with the CMS and the CNS built next to it. The schools were constructed with a portion of Fiji's Colonial Development and Welfare Fund allocation. The rest of the funding was revised and was put under the Suva Medical Centre scheme.[1214] A large sum of the Colonial Development and Welfare Fund, in total £245,942, was used to expand the CWM Hospital and the employment

[1212] V. W. T. McGusty, A Memorandum for the Post War Development of the Medical Department of Fiji, and Containing References Also to Medical and Public Health Problems in Neighbouring Pacific Islands, RF RG1.1 S419 B1 F13, RAC.
[1213] *Ibid.*
[1214] Internal Note from A.C.S to F. S., 2 December 1953, F48/467, NAF.

of a dietitian to teach medical and nursing students.[1215] Although the RF agreed to support $20,000 if the scheme was implemented in the future, the connection with the RF terminated after Lambert's retirement.[1216]

Instead of a new site, Fiji acquired land adjacent to the CWM Hospital to turn into a medical centre. Fiji exchanged about three acres of Crown Land in Suva with two and a half acres of land owned by the Roman Catholic Mission.[1217] Additional land was acquired from civilian housing between 1950 to 1952. Altogether, the medical centre comprised the area between Brown Street, Extension Street, and Waimanu Street which the CWM Hospital still occupies today.[1218] This became a larger version of the CWM Hospital rather than the medical hub of the South Pacific, as initially intended. As such, both the CNS and the Suva Medical Centre scheme could not fulfil their original ambitions to centralise nursing education and medical practice in the South Pacific.

Notably, McGusty's memorandum of 1942 was almost identically echoed in the Watt-Lambie Report, which was printed in 1944.[1219] Central features of the Watt-Lambie report, such as a medical centre in Suva or a centralised nursing service, had been discussed and prepared in Fiji for years. While there is no documentary evidence to prove that McGusty influenced the content of the Watt-Lambie report, this chapter and previous chapters have shown that the report's core ideas were already circulating in the South Pacific. Therefore, it is likely that the WPHC pitched a centralisation plan to the Colonial Office with the help of New Zealand's increasing medical influence in the region.

[1215] Hartley, 'Interweaving Ideas and Patchwork Programmes', 203.
[1216] From McGusty to the Colonial Secretary, 13 December 1940, F48/179, NAF.
[1217] From the Director of Lands to the Colonial Secretary, 10 January 1951, F48/436, NAF.
[1218] Records can be found in a folder titled 'Suva Medical Centre –Land Acquisition', F48/436, NAF.
[1219] V. W. T. McGusty, A Memorandum for the Post War Development of the Medical Department of Fiji, and Containing References Also to Medical and Public Health Problems in Neighbouring Pacific Islands, RF RG1.1 S419 B1 F13, RAC.

Post-war Developments

Imperial connections between New Zealand and British colonies tightened over the war years. The expansion of intraimperial relations between members of the British Empire could not only be found in nursing but also in military medical institutions and the SPHS system. This was a definite change from the interwar years when Lambert and the RF led the development of medical institutions in the region. John Farley explained that the Colonial Development and Welfare Act, accompanied by the American pressure to decolonise, made the British Empire less dependent on the RF. In the post-war period, Farley argued, British colonies were 'to be prepared for quasi independence' with the British taxpayers' money.[1220]

The war ground the scheme to develop healthcare facilities in Fiji 'to a standstill.' All of the intertwined schemes to improve medical facilities had to stop when the British Empire directed its colonial resources to total war.[1221] In order to 'keep up with the times' and to provide adequate medical provisions, the expansion of medical infrastructure had to be implemented 'immediately after the war.'[1222] As the Allies recovered territories from Japan in 1943, 'rehabilitation of medical services' became the biggest concern for the British authorities. To help the countries previously occupied by Japan, McGusty was determined that Fiji should strain the government 'to the utmost to play the part of the big sister.' NMPs could be loaned, even at the cost of depleting the Fiji service, to 'tide the Solomon Islands over their immediate difficulties.' Fiji could train a larger number of medical personnel and send them 'for service in the backward islands until those islands are capable of producing their own material.' [1223]

[1220] Farley, *To Cast Out Disease*, 273.
[1221] V. W. T. McGusty, A Memorandum for the Post War Development of the Medical Department of Fiji, and Containing References Also to Medical and Public Health Problems in Neighbouring Pacific Islands, RF RG1.1 S419 B1 F13, RAC.
[1222] Medical Department, Annual Report for the Year 1942, RF RG1.1 S419 B1 F13, RAC.
[1223] From V. W. T. McGusty to Strode, 28 May 1943, RF RG1.1 S419 B1 F13, RAC.

In the post-war years, the presence of women slowly increased in the centralised medical institutions. In addition to the CNS and all of the SPHS territories training indigenous nurses, female students were admitted to the CMS. In 1946, three female students at the Lelean Memorial School expressed hope to apply for the CMS in the following year when the school was still a male institution. The Central Medical School Advisory Board at the time resolved that 'the time was not yet ripe for the admission of female students to the School.'[1224] The issue was raised again at the Council of Chiefs in 1950, moved by AMP Vilikesa Ramaqa and seconded by Ratu E. T. Cakobau. The council passed a unanimous resolution that 'the time is now ripe for Fijian girls to be trained as Assistant Medical Practitioners.'[1225] It was still difficult to find suitable candidates because not many girls received secondary education to the required Cambridge Certificate level.[1226] However, the fact that demands for female education came from female students and Fijian leaders demonstrate that Fijians had the agency to seek for gender equality.

The CMS was built next to the Tamavua Hospital, the former New Zealand and US General Hospital building during the war. It was officially opened by Queen Elizabeth II on her first Commonwealth tour as queen on 17 December 1953. She was received by the Inspector-General of the SPHS, who formally requested her to open the school at the event. The opening ceremony started with a prayer by the Bishop in Polynesia and was followed by the presentation of representative students from each country to the Queen and the Duke of Edinburgh.[1227] One year later, the CNS opened at Tamavua site in 1954, marking Fiji's

[1224] A. S. Frater, Extracted from the Minutes of a Meeting of the Central Medical School Advisory Board Held on the 7th October, 1948, 21 October 1948, F48/450, NAF.
[1225] Council of Chiefs 1950 Resolution 4, F48/450, NAF.
[1226] From the Director of Medical Services to the Colonial Secretary, 10 October 1950, F48/450, NAF.
[1227] *Official Programme. The Visit of Her Majesty Queen Elizabeth II and His Royal Highness The Duke of Edinburgh to Fiji: December 17th to 19th 1953* (Suva: Government Press, 1953).

discontinuation of sending nursing candidates to New Zealand.[1228]

The end of colonial rule in Fiji and the South Pacific brought an end to much of the existing intercolonial, interimperial, and international medical efforts in the South Pacific. Today, the CMS and the CNS remain as the College of Medicine, Nursing, and Health Sciences of the Fiji National University. The school facilities are attached to the CWM Hospital and the old Tamavua Hospital, which is now the P. J. Twomey Hospital. Close to Fiji's independence in 1970, the CLH at Makogai closed and moved its patients to the P. J. Twomey Hospital.[1229] Thanks to new drugs (antibiotics), it was no longer necessary to segregate leprosy patients on an island. The SPHS, which oversaw the operation of all of these institutions, also stopped in 1969 as part of preparations for Fiji's independence.[1230] Therefore, the withdrawal of British-led centralised medical institutions could be regarded as a signal of medical decolonisation, although other British territories in the region gained independence after 1978.

Conclusion

This chapter has offered a perspective on the place of Fijian and Indian women in the centralised medical system devised by British colonial authorities. The establishment of the CNS was supported by the idea that the improvement of women's status (and health) determined a society's progress, as Vicki Lukere has noted.[1231] The issue of Indian students proves that the development of the CNS was motivated by political and racial relations in the colony. This confirms Sheryl Nestel's remarks that colonial nurses were 'deeply entangled in

[1228] From the Director of Medical Services to Messrs. Lodhia & Company, 23 February 1945, F48/354 Part.2, NAF.
[1229] Stella, *Makogai, Image of Hope,* 165.
[1230] Medical Department, Annual Report, 1969, Council Paper No.23 of 1970, NAF.
[1231] Lukere, 'Native Obstetric Nursing in Fiji' in Lukere, Jolly (eds.), *Birthing in the Pacific,* 101.

the politics of class, race and gender.'[1232] The discussions and inclusion of Indian students into nursing education also confirm the existence of an imperial connection between the Pacific and Indian worlds. As Tony Ballantyne put it, 'imperial systems folded space and time, creating new pathways that meant that India was threaded through the fabric of the British Pacific.'[1233] Yet there were limitations. Under the SPHS system, the centralisation of medical and nursing services was limited to fully qualified doctors, fully qualified nurses, and NMPs. The education of indigenous nurses was uneven, their qualifications were subordinate, and their staffing was not pooled.

Moreover, this chapter has further explained how lateral connections were made between British colonies and New Zealand in the field of nursing. Existing works on the global history of nursing tend to consist of book chapters that discuss a single nation or vertical relationship between the metropole and its colonies.[1234] However, this chapter has highlighted intercolonial connections and, in particular, New Zealand's influence over the wider centralisation scheme, which replaced the supervisory position that the RF previously occupied. The Watt-Lambie report put forth ideas for centralised nursing and public health services. Lambie's suggestions shaped educational standards in the Pacific. And New Zealand trained Fiji's students in higher nursing qualifications and supplied fully trained nurses to SPHS territories. Therefore, in addition to military services and the SPHS, the CNS and the unrealised Suva Medical Centre scheme were areas in which New Zealand exercised its medical influence within the British Empire.

[1232] Sheryl Nestel, '(Ad)ministering Angels: Colonial Nursing and the Extension of Empire in Africa', *The Journal of Medical Humanities,* 19/4 (1998), 262.

[1233] Tony Ballantyne, 'Imperial Futures and India's Pacifics: Space, Temporality, and the Textures of Empire' in Warwick Anderson, Miranda Johnson, and Barbara Brookes (eds.), *Pacific Futures: Past and Present* (Honolulu: University of Hawai'i, 2018), 174.

[1234] For example: Helen Sweet, Sue Hawkins (eds.), *Colonial Caring: A History of Colonial and Post-colonial Nursing* (Manchester: Manchester University Press, 2015); Lukere, Jolly (eds.), *Birthing in the Pacific*.

Conclusion

Centralised medical institutions were sites of multi-layered, multi-channelled, and multi-directional imperial relations. Just as Linda Colley has urged historians to analyse empires using diverse, comparative, and plural approaches, this thesis has shown various types of relationships made in the British Empire.[1235] British, New Zealand, American 'empires' connected and overlapped through the process of centralising medical institutions in the South Pacific. New Zealand's formal and informal empire overlapped with Britain's colonial empire. Both empires formed part of the wider framework of the British Empire, which was constituted of a multiplicity of territorial entities and spheres of informal influence. Australia, France, and the US territories in the Pacific, forming both formal and informal empires, connected with the British Empire to a limited extent. During the war, the wider British Empire was incorporated into the American sphere of influence for military purposes. Meanwhile, the Rockefeller Foundation pursued their own 'imperialistic' programmes.[1236] Tony Ballantyne rightly pointed out that empires are inherently relational in nature, that imperial histories consist of more than simple dichotomies of metropole-periphery relations or coloniser-colonised framework.[1237] Using his expression, this thesis analysed the medical 'webs of empire' in which various colonies, empires, states, individuals, and private institutions engaged with each other.

Regional cooperation, at least in the field of health, was an imperial project for the British empire. As shown in this thesis, the centralisation of medical institutions demonstrates the extent to which imperial projects in the South Pacific were built around the provision of

[1235] Linda Colley, 'The Difficulties of Empire: Present, Past and Future', *Historical Research*, 79/205 (2006), 380.
[1236] Harrison, *Disease and the Modern World, 147;* E. Richard Brown, *Rockefeller Medicine Men: Medicine and Capitalism in America* (Berkeley: University of California Press, 1979).
[1237] Ballantyne, *Webs of Empire*, 46.

healthcare. The various attempts at centralisation encountered and strove to circumvent similar challenges that spanned interwar, Second World War, and post-war years in the British South Pacific. Colonialism took on a motley assortment of constitutional forms in the Pacific Islands, exhibiting the complex nature of imperial policy in this region. There were colonies, protectorates, mandates, overseas territories, a condominium, a dependency of a colony, and the territories of dominions —an assemblage almost as diverse as the people they sought to administer. At times, the British Empire relied on the Rockefeller Foundation to relieve the financial and administrative burdens placed on colonial governments. It was a process that, at various times, involved quarantine, education, disease-control, military medicine, preventive medicine, curative medicine, and health services. Together, centralised medical institutions inaugurated an imperial healthcare system in which elements of the British Empire engaged in both hierarchical and lateral relationships.

Medical centralisation did not always occur strictly within the boundaries of the British Empire. The Pacific Islands became a place of regional cooperation because it was at the peripheries of empires. French New Hebrides, Australian-administered Nauru, Australian Papua New Guinea, American Samoa, the American Trust Territories, and Tonga all made use of centralised medical institutions, apart from territories held by the British and New Zealand governments. As Bronwen Douglas has noted, 'the Pacific Islands were always insignificant in official British imperialism.'[1238] Because the South Pacific was also considered remote and insignificant in other empires, these imperial powers cooperated in medical initiatives. Compared to its benefits, the cost of medical centralisation was considered acceptable, even if it meant that the institutions were led by the British. It was, in fact, the peripheral status of the

[1238] Bronwen Douglas, 'Imperial Flotsam? The British in the Pacific Islands' in Robin Winks (ed.), *The Oxford History of the British Empire Volume V: Historiography* (Oxford: Oxford University Press, 1999), 368.

Pacific Islands that made the region the centre of imperial cooperation.[1239]

In this respect, the Pacific Islands can be considered a medical frontier of the British Empire, where unusual intercolonial, interimperial, and intraimperial encounters happened. This thesis has shown that the centralisation process for every institution involved consulting and negotiating the terms with every administration involved. Sometimes, colonial interests did not always align with those of the imperial or sub-imperial metropole. While this thesis has emphasised British leadership in the centralisation process, it has also acknowledged the active role that New Zealand played in the creation of a system of imperial healthcare. As W. David McIntyre argued, British imperial expansion in the Pacific Islands often stemmed from the dominions.[1240] This thesis demonstrates that the British Empire was very much present and active in the Pacific world. British imperial aspirations in the Pacific Islands were expressed through its ambitious medical centralisation scheme designed to bring together not only the British Empire but also territories under other empires. By engaging with the under-researched region of Oceania, this thesis thus fills a considerable gap in the scholarship of imperial history, medical history, and Pacific history.

The process of centralisation began with the creation of a leprosy quarantine station, the Central Leper Hospital at Makogai Island. The hospital centralised leprosy treatment in the British and New Zealand colonies in Oceania, with its services extended to Tonga, and later, even American Samoa. As Alison Bashford has noted, leprosy was regarded as an 'imperial danger' and the segregation of lepers had been viewed as essential for 'imperial hygiene' in British Pacific colonies since the nineteenth century.[1241] Quarantine islands that contained

[1239] Sasha Davis, *Empires' Edge: Militarization, Resistance, and Transcending Hegemony in the Pacific* (Athens: University of Georgia Press, 2015), 18.
[1240] W. David McIntyre, *Winding Up the British Empire in the Pacific Islands* (Oxford: Oxford University Press, 2014), 17.
[1241] Bashford, *Imperial Hygiene*, 81–114.

leprosy patients were thus places of imperial interest where state authority was exercised.[1242] The Central Leper Hospital is thus an example of a quarantine facility used to secure 'imperial health' in British and New Zealand colonies by concentrating leprosy patients on an island.

At the same time, the British devised a more sustainable way of providing healthcare in the Pacific Islands by establishing a subordinate indigenous medical service: the Central Medical School. The graduates of the school qualified as Native Medical Practitioners, specifically to serve in remote stations that were previously out of the reach of European medical officers. Students from Tonga, Nauru, American Samoa, Papua New Guinea, and the US Trust Territory of the Pacific Islands studied with those from the British and New Zealand territories. Its curriculum was designed to raise up subordinate colonial elites who went through a process of 'codifying British ethics' through training at the Central Medical School. The school was assisted by a widely influential organisation that led international health during the period, the Rockefeller Foundation, through donations and supervision on educational philosophy.[1243] In short, the school was shaped to institutionalise imperial medical education in this region.

A more short-term direct healthcare measure was developed in concurrence with the Central Medical School. The Western Pacific Health Service was established under the Western Pacific High Commission to run mass-treatment campaigns for hookworm and yaws, initially in British colonies and later in New Zealand colonies. The campaign units travelled extensively, visiting every district in the designated field and, at the same time, collecting medical, scientific, census, and environmental knowledge on behalf of imperial authorities.

[1242] Alison Bashford, 'Maritime Quarantine: Linking Old World and New World Histories' in Bashford (ed.), *Quarantine*, 1–12

[1243] Paul Weindling, 'Introduction: Constructing International Health between the Wars' in Paul Weindling (ed.), *International Health Organisations and Movements, 1918–1939* (Cambridge: Cambridge University Press, 1995), 2–3.

The service was funded and directed by the Rockefeller Foundation. It was a rare case in which a private institution directly administered a colonial department. The British could gain healthier colonial populations on a budget and the Rockefeller Foundation obtained experience in the Pacific Islands to enhance their expertise in tropical medicine. This relationship proves that international health organisations worked in colonial frameworks during the period as Iris Borowy has stated.[1244] It also recalls Roger Cooter and Steve Sturdy's observation that such public health programmes were 'rationalizations of capital and philanthropy,' in this case concerning indigenous health.[1245]

Roger Cooter and Steve Study use Max Weber's notion of rationalisation to explain a process of unification and uniformity in the field of medicine.[1246] Wartime experiences and post-war centralisation of medical institutions in the Pacific are good examples of medical rationalisation. As shown in this thesis, the war extended medical centralisation to the military sphere. New Zealand took on the responsibility for defence in the region, commanding the military forces of Fiji and Tonga, countries that were considered vital to the defence of New Zealand. As part of its efforts to raise Fiji's military capability, New Zealand created the Fiji Medical Corps. This brought a new type of medical relationship within the British Empire. Previously, imperial governments such as Britain, New Zealand, Australia, and the US made decisions for their colonies and territories to participate in centralised medical institutions. However, the war brought a British colony, Fiji, to directly engage in a centralised system with a dominion, New Zealand. During this period, medical centralisation became more of an intraimperial project.

[1244] Iris Borowy, *Coming to Terms with World Health: The League of Nations Health Organisation, 1921–1946* (Frankfurt am Main: Peter Lang, 2009), 15–16.
[1245] Roger Cooter, Steve Sturdy, 'Of War, Medicine and Modernity: Introduction' in Roger Cooter, Mark Harrison, Steve Sturdy (eds.) *War, Medicine, Modernity* (Stroud: Sutton, 1998), 9.
[1246] *Ibid.*, 1.

The war obliged New Zealand to cooperate with the Allied forces in military actions in the South Pacific. The Second New Zealand Expeditionary Force was under US command and reliant on the US for medical supplies, while commanding Fiji and Tongan military forces. At the same time, thousands of New Zealanders went overseas to the British colonies of Fiji and the Solomon Islands for military duties. Troops were also sent to Tonga, as the country was under the British protection. As a result, New Zealand experienced a wartime centralisation of medical resources with another imperial power, the US, and colonies that were not under their rule but part of the British empire. In this respect, New Zealand acted as a middle manager in the imperial healthcare system during a time of emergency.

The pinnacle of medical centralisation was a fully unified medical service borne out of the war. British and New Zealand colonies (including Tonga) unified their medical services and brought existing medical institutions under the South Pacific Health Service. The wartime experience of mobilising medical officers, centrally appointing staff duties, banning private practice, and sharing medical resources enabled a fuller degree of centralisation to happen. Each colony would no longer have separate medical services but would come under one institution that managed all health-related matters. The South Pacific Health Service was heavily funded by the British Colonial Office and was directed by an Inspector-General appointed by the Secretary of State. Although New Zealand actively participated in the establishment and occupied major positions on the South Pacific Board of Health, it was fundamentally an imperial institution that gave the British an authority over both British and New Zealand colonies.

Another centralised medical institution, the Central Nursing School, was also founded during the war in Fiji to train indigenous nurses. These nurses were assigned to a subordinate nursing service under the supervision of fully qualified European nurses. Indigenous nurses

were primarily in charge of maternal and child welfare in rural districts. Initially, the school was envisioned to follow the footsteps of the Central Medical School to become a widely intercolonial institution that centralised nursing education in the Pacific Islands. However, wartime financial difficulties prevented capital investment in nursing education. Existing gender perceptions in the South Pacific also contributed to an idea that 'girls' should not spend many years far from their homes, where they were exposed to cosmopolitan cultures. Nevertheless, the school set standards of nursing education in the South Pacific Health Service territories and became a centre of postgraduate nursing education in the Pacific Islands. Along with the South Pacific Health Service, the Central Nursing School marked a divorce with the Rockefeller Foundation in direct administration of colonial institutions.

Together, these centralised medical institutions indicate an agenda to create a sub-imperial medical block in the South Pacific. However, existing studies rarely acknowledge the relationship between these different centralised institutions. Even when it has been recognised, the full extent of the scheme is not appreciated. This thesis contends that these institutions must be examined together in order to understand the dynamics of healthcare in the Pacific Islands. Institutional names are good indications of the possible connections between them. The Central Leper Hospital's role in the centralisation process is lost in literature that has only focused on the institution itself, popularly known as Makogai Leper Colony. Without the word 'Central' in the name, it is hard to imagine its connections to other centralised institutions. The Western Pacific Health Service is not even acknowledged as an institution but simply known as a Rockefeller-funded programme. The fact that the institution's regional designation, 'Western Pacific', actually referred to its connection with the imperial administration of Western Pacific High Commission is also often overlooked. More significantly, if the Western Pacific Health Service is not recognised as a precursor of the South Pacific Health Service, it would be

difficult to understand the similarities and linkages between the two institutions.

Another important contribution of this thesis is that it bridges the interwar and post-war periods by discussing the imperial experience of wartime medical centralisation. Many histories of the twentieth century usually consider the first half and the second half of the century as totally separate. In this case, it is clear that they are not. Also, histories often consider the war years between 1939 and 1945 as unique and unconnected to other periods. However, the war was only a stage – albeit a very important one – in a long-term process of centralisation. Medicine and healthcare were prominent factors that contributed to the ability of military forces to maintain imperial regimes during the war or to recover imperial control over lost territories after the war.[1247] As Hoodless wrote later in his article for the Pacific Science Congress, 'extraordinary changes caused by the War' contributed to so-called 'bush-doctoring' to be gradually replaced by European medicine in the region.[1248] In this respect, it is natural that plans for further medical centralisation between the British and New Zealand colonies emerged during the war.

In all of these medical institutions, there was a constant effort to racialise, categorise, and stereotype the Pacific Islanders. Medicine was a form of imperialism that collected colonial knowledge and extended imperial authority over indigenous peoples.[1249] There were clear imperial ambitions to establish and maintain racial authority in the centralisation process. The entire 'Pacific race' – including the imperially constructed categories of Polynesians, Melanesians, and Micronesians – were subject to racial studies. Sometimes, these studies also included Indians, Chinese, and the mixed-race 'half-castes'. This thesis has discussed

[1247] David Arnold, 'Introduction: Disease, Medicine and Empire' in Arnold (ed.), *Imperial Medicine and Indigenous Societies*, 19.
[1248] D. W. Hoodless, 'Medical Education and Employment of Native Doctors and Nurses' in *The Proceedings of the Seventh Pacific Science Congress, Vol.VII* (Wellington: R. E. Owen Government Printer, 1953), 47–48.
[1249] Arnold (ed.), *Imperial Medicine and Indigenous Societies*, 17.

numerous examples of such attitudes and policies. The Central Leper Hospital discriminated against its patients by race. The Central Medical School stereotyped students according to their ethnic origins. The Western Pacific Health Service reported racial characteristics in drug trials. During the Second World War, Fijian medical staff were discriminated in the military. The South Pacific Health Service was established with the prospect of maintaining the British imperial prestige in the region – a system in which indigenous medical services remained subordinate. The Central Nursing School emerged from a debate on where to place Indians in the racial hierarchy of the Pacific Islands. While there were moves towards appearing more egalitarian in the post-war years, it is clear that medical institutions actively collected, distributed, and reproduced racial knowledge and hierarchies in the South Pacific.

Finally, this thesis has identified an imperial system of healthcare for a group of colonies. Centralised medical institutions are excellent cases to study the complexities and contentions in imperial relations between constituents of the British Empire in the Pacific. There relations were both hierarchical and lateral within the British Empire, sometimes involving external powers. Most of the literature considering the context of empire in medical history consists of works or collections of works on colonial medicine, with a focus on a single territory.[1250] Studies on 'imperial medicine' have thus far tended to have a focus on the medicine of the imperial metropole (such as tropical medicine in London) or on the imperialists in the colonies (such as military and tropical medicine)..[1251] Histories of a single medical system imposed on a group of colonies are yet unknown. This thesis is, therefore, a pioneering

[1250] For example: MacLeod, Lewis (eds.), *Disease, Medicine and Empire*; Vincente Navarro (ed.), *Imperialism, Health and Medicine* (London: Routledge, 1982).

[1251] For example: Chakrabarti, *Medicine and Empire*; Suman Seth, *Difference and Disease: Medicine, Race, and the Eighteenth-Century British Empire* (Cambridge: Cambridge University Press, 2018); Haynes, *Imperial Medicine*; Alsop, 'Warfare and the Creation of British Imperial Medicine, 1600–1800', 23–50; Charters, *Disease, War, and the Imperial State*.

study to identify and explain an organised imperial agenda to bring a group of colonies under one medical system.

The scope of this thesis is limited to the period between circa 1927 and 1953. Because it has mostly focused on discussions leading to the centralisation of medical institutions and racial discourses found within them, it does not discuss the activities of the South Pacific Health Service after its early years. In several ways, the period after 1953 marked a watershed for the Pacific Islands, the beginning of a period when much of the medical centralisation discussed in the thesis slowly unravelled. A new monarch was crowned in Britain, the Western Pacific High Commission moved to Honiara, international conflicts in the Cold War were escalating in East Asia, and empires were falling apart across the world. Future studies may well examine the relationship between the de-centralisation of medical services and decolonisation in the Pacific Islands.

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WPHC4/IV 2562/1928	Central Medical School: Appointment of an Advisory Board of.From : The Honourable, The Colonial Secretary, Fiji.No : 1711.Date : 30th August, 1928., 1928 - 1928

WPHC4/IV 2655/1931	Medical Campaign, Rockefeller Assisted:- Adjustment of expenditure re. From : The Ag. Resident Commissioner, New Hebrides.No : 199Date : 28th August, 1931. , 1931 - 1931
WPHC4/IV 2856/1925	Asks to be furnished with information concerning the Native Medical School at Suva. From: Governor General of New Zealand.No:Date: 25th November, 1925., 1925 - 1925
WPHC4/IV 2868/1928	Central Medical School: Proposed apportionment of Capital cost & cost of maintenance.From : Colonial Secretary, Fiji.No : 1929/3455/28.Date : 27th September, 1928., 1928 - 1928
WPHC4/IV 3035/1928	Central Medical School Advisory Board: Forwards copies of minutes of various meetings of.From : The Colonial Secretary, Fiji.No : 2105/3989/28.Date : 20th October, 1928., 1928 - 1928
WPHC4/IV 3102/1930	Central Medical School:- Remarks of Ag. Tutor, of, upon examination results of 3rd quarter, 1930 and suggestions for modification of syllabus of. From : Acting Chief Medical Officer, Fiji.No :Date : 14th October, 1930., 1930 - 1930
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WPHC9 52/10 Vol.1	[GI] Leper Patients in Gilbert and Ellice Islands Colony:- (a) question of local treatment or treatment at Makogai (b) Transfer to Makogai, 1932–1954
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WPHC9 82/7/1 Vol.1	South Pacific Health Service:- Organization of, 1945–1952
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WPHC11 S.F9/34,	Casualties of Armed Forces, 1943–1944
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