

"... the menace posed to public health by "insanitary pahs"": Sir Māui Pōmare's clean up of Māori architecture

Tyson Schmidt, Ngāti Porou, wannabe architect

ABSTRACT: Apirana Ngata, Te Puea Hērangi and Wiremu Rātana each left behind what Deidre Brown calls "a major architectural movement" – Ngata staged an architectural renaissance based on traditional practices, Te Puea looked to develop a blending of building practices, and Rātana pointed to a new direction altogether. Sir Māui Pōmare, however, left no distinctive architecture that embodied his views of his people's future, and has largely been overlooked in New Zealand's architectural history as a result.

Pōmare's crusade to improve the health of Māori communities, however, did have a pervasive and direct impact on Māori architecture. His beliefs and actions provide an important counterpoint to those of his contemporaries, helping us understand the full spectrum of architectural actions taken by Māori in the early twentieth-century. This paper examines Sir Māui Pōmare's work and its architectural impact, placing it in the context of other influential Māori architectural movements of the time.

Introduction

Typhoid was still an issue in New Zealand in the 1920s despite government efforts in preceding decades. In 1922 the *Evening Post* reported 123 cases of typhoid fever in Auckland and a total of eight deaths.¹ Smaller instances also made the news, such as the admission of a Māori patient to Whangārei hospital in 1927 with pneumonia complicated by typhoid. Five nurses became infected, one of whom died less than a month later.²

In 1926 a typhoid outbreak in the Māori settlements adjacent to the city of Napier was announced as "effectively stamped out."³ After four deaths the Health Department official decided that the outbreak had been

overcome and travelled back to Wellington. Less than a week after his departure a suspected typhoid case came to light at Pakipaki, some four miles south of Hastings.⁴

Fears of such outbreaks quickly brought calls for action by the authorities. Residents of Little River near Christchurch were alarmed at the continuing epidemic of typhoid fever among Māori in the surrounding areas, and called on the Minister of Health to make urgent inspections of dwellings.⁵ Answering a similar call, the Director of Māori Hygiene visited all pā around Taupō and combed surrounding bush following 13 Māori showing symptoms of typhoid in 1927.⁶ That same year a family of five Māori were quickly

removed from their small rural village of Kerepehi by Health Department officials and isolated at the local hospital.⁷

Pōmare's return

Māui Pōmare was appointed Native Health Officer as soon as he returned to New Zealand in 1900. His medical training at the American Medical Missionary College in Chicago had finished only one year earlier, and upon completion he became the first Māori doctor. Pōmare had also spent time in Michigan, which followed his four years at Te Aute College where he was a contemporary of Apirana Ngata and Peter Buck. These four years saw him strongly influenced by theories of hygiene promoted by James Pope, the first Inspector of Māori Schools.⁸

¹ "Typhoid at Auckland" p 8.

² "Death by Typhoid" p 6.

³ "Typhoid Stamped Out" p 6.

⁴ "Suspected Typhoid" p 7.

⁵ "Typhoid Outbreak" (1928) p 12.

⁶ "Typhoid Outbreak" (1927) p 9.

⁷ "Typhoid Among Maori" p 10.

⁸ "Maui Wiremu Piti Naera Pomare" n.p.

1900 was New Zealand's "Year of the Plague."⁹ Action was taken to clean up the cities to prevent the spread of disease – filth was removed, rubbish collected, and sanitation inspections carried out. The government also hastily put together a new Department of Health, and put Sanitary Commissioner Dr James Mason in charge. While a central health body had existed in legislation for some 15 years before this, it never undertook any practical actions.¹⁰ Its replacement under Dr Mason now faced the extremely practical task of cleaning up New Zealand's burgeoning cities.

98 percent of Māori lived in rural communities at the start of the twentieth century. Michael King has stated that the Māori population at this time was "so scattered as to cause not only geographic separation of Māori from Pakeha, but also Māori from other Māori."¹¹ This separation wasn't enough to allay fears of the plague spreading rapidly through unhygienic Māori kāinga, prompting the government to add a Division of Māori Hygiene to the new

Department of Health in 1901.¹² Māui Pōmare, less than a year after being appointed Native Health Officer, became the Director of the new Division of Māori Hygiene. A sustained campaign to improve Māori health was embarked upon – an inoculation programme implemented, insanitary wells resited, education provided, and unhygienic buildings destroyed.¹³

Locating disease

"Disease exists in space before it exists for sight," according to Stuart Elden's spatial analysis of Foucault's *Madness and Civilisation*.¹⁴ At one level this is about identification, separation, and treatment (often involving isolation), and at another level it is about bringing discipline to that which is seen as confused and disordered. This view is reinforced in the opening pages of Kristeva's *Powers of Horror* – abjection is noted as not being about cleanliness or health, "but what disturbs identity, system, order. What does not respect borders, positions, rules. The in-between, the ambiguous, the composite."¹⁵

The dream of the organised and moral city had arrived in European thought by the seventeenth century.¹⁶ This dream was eventually supported by institutions designed to purify society – the prison, the workhouse, and the asylum. By the nineteenth-century the desire for an efficient city had become the driver for order, and this desire was threatened by the filth, squalor and disease that ran rampant. Typhoid spread unchecked throughout London in the 1830s, cholera broke out in 1848 and again in 1849 (killing nearly 15,000) and there was yet another outbreak in 1854.

Cleaning up the city can be read as fulfilling the political dream of a disciplined society. Those who were untrained would be corrected and that which disturbed order would be trained. In *Madness and Civilisation* the leper was the one to be controlled through separation and containment. Diseases like the plague, cholera, typhoid and tuberculosis required a different approach in the adoption of two forms of discipline – mapping and training the population in how to live, and designing the city in a way that emphasised order and clarity.

⁹ Lange *May the People Live* p 128.

¹⁰ "PUBLIC HEALTH" n.p.

¹¹ King *Penguin History of New Zealand* p 248.

¹² Sinclair *Oxford Illustrated History of New Zealand* p 330.

¹³ Sinclair *Oxford Illustrated History of New Zealand* p 330.

¹⁴ Elden *Mapping the Present* p 143.

¹⁵ Kristeva *Powers of Horror* p 4.

¹⁶ Elden *Mapping the Present* p 126.

By the nineteenth century there was a flood of suggestions on how to order the city to ensure the social ideals could be achieved.¹⁷ This flood was in large part seeking to overwhelm the degradations of the industrial city – the overcrowded slum-dwelling poor who were not finding pleasure from work¹⁸ and the filth, squalor and disease that was running rampant. New Zealand was not immune to similar shifts, albeit much later in the nineteenth century. At that time only 10 per cent of houses in Auckland had toilets, and "night soil" collections were being arranged to improve conditions. Death rates in New Zealand towns were as bad as those in cities like Manchester and London – a shock to many immigrants who left their Northern hemisphere homes to escape those exact situations.¹⁹

Crossing the Rubicon

The Young Māori Party believed in the improvement of Māori health and welfare through the adoption of European ways of life and by working within the system. From their days at Te Aute College, the Party's leaders were inspired by the views of people like the

¹⁷ Rykwert *The Seduction of Place* p 17.

¹⁸ Rykwert *The Seduction of Place* p 73.

¹⁹ King *Penguin History of New Zealand* p 273.

Inspector of Māori Schools, James Pope. One of James Pope's clearest messages was around steps needing to be taken in order that the Māori might "escape extermination."²⁰ Ngata, Pōmare and Buck adopted this view enthusiastically, particularly the health and hygiene aspects of the message. All three believed that Māori culture would need to change in order to survive and meeting the challenges of colonisation. Richard Hill sums the Party up by noting they "represented a *response* to state aspirations to incorporate Māori into economic, legal, socio-cultural and political life entirely on its own terms – a response that sought to combine "the best of both worlds" in producing a "blended culture".²¹

Despite this common base, there was a "lack of full agreement on the exact extent or type of adaptation, partnership or autonomy that should be sought" within the ranks of the Young Māori Party.²² In this context Pōmare is often seen as the most assimilationist of the Young Māori Party leaders.²³ His "Anglophile values" are held in contrast to those such as

²⁰ Dow ""Pruned of Its Dangers"" p 50.

²¹ Hill *State Authority, Indigenous Autonomy* p 46.

²² Hill *State Authority, Indigenous Autonomy* p 68.

²³ Hill *State Authority, Indigenous Autonomy* p 48.

Apirana Ngata who instead are seen to be "steeped in Māori culture."²⁴ Historians such as Ranginui Walker point to examples such as Pōmare's push for individualisation of land title (as opposed to Ngata's land consolidation schemes) and his desire for Māori to survive in the system of free enterprise as supporting this assimilationist assessment.²⁵

Pōmare's status as a medical physician is also a factor in his assimilationist assessment. Dr Damon Salesa's study of doctors in early colonial New Zealand places the medical profession as both saviour and as a tool of cultural control.²⁶ Doctors made significant gains for the Māori population in their role of healers – in the 30 years that Pōmare was involved at the highest levels of the health system the Māori population recovered from 45,500 in 1901 to 53,000 in 1916 and 67,000 in 1930.²⁷ At the same time, physicians were "wielders of a new authority ... part of a new colonial order" that treated the Māori body-politic as much as it treated Māori bodies

²⁴ Walker *Ka Whaiwhai Tonu Matou* p 180.

²⁵ Walker *Ka Whaiwhai Tonu Matou* pp 179-180.

²⁶ Salesa ""The Power of the Physician"" pp 13-40.

²⁷ "Overview - NZ in the 1920s" n.p. Sinclair *Oxford Illustrated History of New Zealand* p 330.

themselves.²⁸

These two roles were inseparable. An action aimed at achieving a health outcome for an individual Māori was carried out in the wider context of colonial endeavour. While the belief of Māori being a dying race is highly challengeable with hindsight,²⁹ it was a powerful call to action at the time the Young Māori Party was considering how to respond to the State's aspirations for Māori (as described by Hill above). Pōmare's adoption of Western medicine as a way to combat the diseases claiming the lives of a disproportionate number of Māori was always going to leave questions around how much these actions were treating, or training, the Māori body-politic. A saying of Pōmare's shows that he understood this situation - *Kua kotia te taitapu o Hawaiki* (There is no returning to Hawaiki. The Rubicon is crossed.)³⁰

²⁸ Salesa "The Power of the Physician" p 16.

²⁹ Salesa notes how the "dying Māori" notion was a local articulation or repetition of a wider process colonisers had seen elsewhere, and therefore had expected to occur in New Zealand (as opposed to being a strictly observed phenomena) pp 15-16.

³⁰ Mitira *Takitimu* p 221.

A cleansing fire

Hundreds of buildings were destroyed under Pōmare's guidance in his sustained campaign to improve the health and hygiene of Māori.³¹ Ranginui Walker counts 1,900 abandoned houses (or "pest-holes" as Pōmare called them) being destroyed by fire.³² Walker notes that these burnings took place regardless of the tapu status of the buildings, since Pōmare had no time for the traditional spiritual healing practices. Rather than leaving the buildings to decay under a cultural code of separation and exclusion, they were instead subjected to a cleansing fire.

The nature and fabric of the buildings – often sunk into the ground, clad in raupō, lacking significant ventilation etc. – was seen as below standard and a contributing factor in the susceptibility of Māori to disease. The "whare pākehā" with its wooden cladding, adequate ventilation, modern sanitary arrangements and access to water supply was the order of the day, with Pōmare eyeing a future where raupō whare would "become but a dream of the night of [Māori] unsanitariness."³³

³¹ Sinclair *Oxford Illustrated History of New Zealand* p 330.

³² Walker *Ka Whaiwhai Tonu Matou* p 181.

³³ Lange *May the People Live* p 151.

This was a significant shift from views of the nineteenth century where it was the amount of time Māori spent outside – as opposed to the design of their dwellings and layout of their kāinga – that was seen as a prime reason for their susceptibility to disease.³⁴ The result, however, was the same. The Māori way of life needed to be reorganised to ensure its survival, and architecture at the level of individual dwelling and the broader settlement played a key role in this reorganisation. As Damon Salesa states, once doctors found it difficult to treat the diseases themselves, they "began to diagnose problems with Māori "life," essentially as other kinds of pathogens."³⁵

Using fire to destroy multiple buildings at once as a way to remove the threat of disease can be seen as architectural cauterisation. Material needed to be destroyed in order to mitigate wider damage, remove undesired growth or minimise the risk of infection. The "pathogen" of unsanitary living conditions was able to be treated by cauterising existing substandard buildings and replacing these with dwellings that fitted ideas of a better

³⁴ Salesa "The Power of the Physician" p 22.

³⁵ Salesa "The Power of the Physician" p 23.

planned and organised settlement. Discipline was then able to be applied through the building of adequate dwellings and implementation of sanitation works.

History repeats

The Royal Commission into the 1918 influenza pandemic set the scene for the continued treatment of the Māori body politic through architectural methods in the 1920s. By 1922 Pōmare had become Sir Māui Pōmare, and in 1923 he was appointed Minister of Public Health. The methods he had pioneered earlier in that century were given added impetus by the Commission, who, on hearing complaints about poor sanitary conditions among Māori, had recommended using sections of the Public Health Act dealing with the sanitation of Māori settlements.³⁶

Spurred by the memories of the influenza pandemic, the 1920s are replete with reports of Māori settlements being identified as sites of possible disease outbreaks. The press would carefully locate the settlements in their articles, identifying its distance from places of significant population. The 1926 suspected

outbreak of typhoid at Pakipaki was reported as being adjacent to Napier and some four miles south of Hastings.³⁷ Its distance from modern civilisation is made even starker with statements that medical officers had to travel from Wellington to deal to the outbreak, to bring discipline to that which had disturbed order.

This locating served multiple purposes – it defined how removed the Māori settlements were from the ordered and disciplined urban centres, it measured how far any contagion would have to travel before it undermined the urban order, and it fed the feelings of abjection that the general populace felt toward those that were "outside." It created boundary markers just like those inscribed by surveyors, those other implementers of colonial policy.³⁸ Like the surveyors, Pōmare's medical approach to dealing with the insanitary pahs brought with it the general populations' fears of the Māori body-politic which had not conformed to the new urban order. Ironically, these fears of the rural unknown were contrary to the medical facts. Remoteness from urban centres actually gave significant

protection against outbreaks, including the 1918 influenza pandemic.³⁹

At the turn of the twentieth century it was the plague that had caused segments of New Zealand's population to fear unhygienic Māori kāinga. Twenty years later these fears remained in segments of the populace, though the disease driving them had switched to influenza and typhoid. Death rates improved, population improved, so it is arguably not the health aspects that are the core of these concerns. Pōmare's climb to the highest peak in the health hierarchy may have improved the statistics, but it had not changed the way Māori settlements and buildings were viewed by the rest of New Zealand. The calls in the 1920s for insanitary pahs to be cleaned up continued to be driven as much by ideals of cleanliness and ideals of a "healthy home life" as it was by genuine health concerns.⁴⁰

Walking the line

Deidre Brown notes how Ngata – through the School of Māori Arts and Crafts – had to "reconcile traditionalism with the structural

³⁶ Dow *Māori Health & Government Policy 1840-1940* p 148.

³⁷ "Suspected Typhoid" p 7.

³⁸ Byrnes "Surveying" p 85.

³⁹ McSweeney et al. "Was Rurality Protective in the 1918 Influenza Pandemic in New Zealand?" 6pp.

⁴⁰ Bryder "'Lessons' of the 1918 Influenza Epidemic in Auckland" pp 97-121.

requirements of twentieth-century Western building practice."⁴¹ These requirements were often driven by health concerns – for example, the need for improved ventilation meant several openable windows needed to be provided for, and thatch was often replaced by weatherboards or iron due not only to the fear of fire but also the fear of harbouring disease. Ngata wrote to Buck complaining about how the requirement for windows led to light coming into parts of meeting houses where it "had no business to pry into," betraying the sublime quality of Māori architecture as Brown puts it.⁴²

While it is tempting to view Ngata fighting against State-imposed regulations in an attempt to ensure the survival of traditional Māori architecture, it is a difficult argument to mount given the wider context he worked in and the bigger issues he championed. He was supportive of Māori Councils, which were expected to suppress customs regarded as dangerous by European authorities, of Pōmare's health campaigns to improve the sanitation standards of Māori settlements, and

⁴¹ Brown "The Architecture of the School of Māori Arts and Crafts" p 256.

⁴² Brown "Architecture of the School of Māori Arts and Crafts" p 256.

even voted for the Tohunga Suppression Act 1907 based on its health benefits.

Only a matter of months separated the passing of legislation to set up Ngata's School of Māori Arts and Crafts and the 1926 publication of the findings of a Commission of Inquiry into the establishment of model villages at Ohinemutu and Whakarewarewa. The Commission pointed to a need to resurvey and rebuild Whakarewarewa pā in order to improve sanitation (and also included increased inspections by the Health Department).⁴³ Proper town planning needed to be put in place and unsightly buildings removed. Ngata supported the reconstruction of Whakarewarewa pā as a model village, though in the same Parliamentary debate he did note that it was a pity that greater attention was not paid to ancient Māori customs when the original pā was constructed.⁴⁴ Here, apparently, the personal and official opinions of Ngata combine on the official record to starkly show his support for preserving what AD McKinlay has called "all the essential characteristics of the typical Māori village, so far as that is consistent with

⁴³ "Model Maori Villages" p 7.

⁴⁴ "A Model Pa" p 11.

modern needs in sanitation and convenience."⁴⁵

Brown reconciles this negotiation by separating them into Ngata's personal opinions such as those expressed to Buck, and what can be assumed to be his "official" opinions which saw him conceding that the regulations had to be observed.⁴⁶ This assessment is similar in nature to Ranginui Walker's framing of Ngata as the member of the Young Māori Party who had no illusions as to his primary allegiance and obligations,⁴⁷ despite having supported some legislation and programmes that, at best, stretched these allegiances and obligations to their limits.

Rātana's resistance

Tahupōtiki Wiremu Rātana is often seen as presenting a challenge to Māori architecture developed by the likes of Ngata and Te Puea. The Romanesque styling of his churches spoke little of tribalism or traditional aesthetics.⁴⁸ They didn't serve to support any cultural renaissance, instead looking toward

⁴⁵ McKinlay "Among the Fascinating Maoris" p 52.

⁴⁶ Brown "The Architecture of the School of Māori Arts and Crafts" p 256.

⁴⁷ Walker *Ka Whaiwhai Tonu Matou* p 180.

⁴⁸ Brown *Māori Architecture* p 84.

constructing a new identity – hybrid perhaps. Rātana's pan-tribal beliefs are part of the reason that he rejected traditional architectural forms (which therefore placed him immediately at odds with Ngata's use of meeting house architecture), but health concerns played a significant role as well.

The divinely inspired vision which encouraged him to unite Māori and turn them toward God took place at the height of the 1918 influenza epidemic.⁴⁹ Following this, Rātana studied the Bible intensely, and also closely read James Pope's *Health for the Māori* (the same as read by the Young Māori Party some 30 years beforehand).⁵⁰ Pope's text encouraged Rātana to abandon traditional building materials such as thatch – which were seen as unhealthy – and instead adopt more modern construction methods and materials. Like many of Pōmare's and Ngata's efforts, such a decision based on health benefits is difficult to detach from broader goals relating to the Māori body-politic. For example, the abandonment of thatch by Rātana also served to reinforce a break from past modes of living and instead point to a

⁴⁹ King *Penguin History of New Zealand* p 335.

⁵⁰ Brown *Māori Architecture* p 118. King *History of New Zealand* p 335.

more modern future.⁵¹

Health concerns played a more pervasive role in Rātana's movement than simply influencing construction materials and aesthetics. Ranginui Walker notes that at the dawn of the 1920s "tents and shacks sprang up as the humble beginnings of the community known as Rātana Pa."⁵² As the community grew quickly, the provision of water and sewerage infrastructure did not keep pace.⁵³ These temporary dwellings raised the interest of health authorities, ushering in more than a decade of inspections and actions by the state. Derek Dow notes that Pōmare's Health Department wrote numerous damning reports on living and health conditions at Rātana Pā, principally focussing on overcrowding and a lack of sanitary measures.⁵⁴ As late as 1926 the *Evening Post* reported on the Native Health Officer's discovery of appalling living conditions which constituted "a definite element of danger to the whole population of the country."⁵⁵

⁵¹ Brown *Māori Architecture* pp 117-118.

⁵² Walker *Ka Whaiwhai Tonu Matou* p 183.

⁵³ Brown *Māori Architecture* p 111.

⁵⁴ Dow *Māori Health & Government Policy 1840-1940* p 155.

⁵⁵ "Typhoid Among Maoris" p 11.

Discipline was quickly applied to the Rātana body-politic in response to fears of disease outbreaks. This began with attempts to control movement – the movement of people between urban and rural areas (especially the gathering of Māori at Rātana Pā, many of whom come from large urban areas, and who could return diseased),⁵⁶ but also controlling movement of water and waste through the imposition of sanitation systems. In this context sanitary works are an extension of control from above ground to below ground.⁵⁷ Such works bring order to the urban environment by virtue of their engineering, but also by reinforcing the extent of control of local and national authorities over the architectural environment above ground. Pōmare's Health Department even considered turning Rātana Pā into a "model village"⁵⁸ like those at Ōhinemutu and Whakarewarewa where proper town planning could be put in place.

A clean, well behaved community

Te Puea Hērangi embraced the idea of the

⁵⁶ Dow *Māori Health & Government Policy 1840-1940* p 154.

⁵⁷ Elden *Mapping the Present* p 144.

⁵⁸ Dow *Māori Health & Government Policy 1840-1940* p 155.

model village. At the start of the 1920s Te Puea worked to establish a settlement at Ngāruawāhia. Initial dwellings were made from tents and sacks, built next to the drains dug to firm up the swampy ground they were built on. Michael King notes how local reactions to the beginnings of this model village were strongly hostile, considering the Māori pā "an eyesore and a health hazard."⁵⁹ A year later a dozen houses were in place, and while an improvement on the tents and sack-covered dwellings, they were viewed by the disgruntled Pākehā locals as being clearly substandard. Action was taken – the Health Department inspectors called in.

These early houses were made almost entirely of traditional materials – walls and ceilings of tied raupō, pressed earth floors, thatched nīkau branches for the roof.⁶⁰ Deidre Brown points to these as hybrid structures, combining "the most favourable elements of whare and house."⁶¹ Brown implies a very active design intent in arriving at such a construction, while Michael King paints a compelling picture of economic necessity. Either way, the result was an architecture that

was perceived by the local Pākehā community as being a health risk not only to its inhabitants, but also to the rest of the wider community.

Te Puea's settlement passed the health inspection, meeting all regulations in force at the time. The inspector even noted that the standard of cleanliness and hygiene was so high that it was better than that in many of the Pākehā homes across the river.⁶² The hybridity of some of the dwellings aside, it was the type of result that Pōmare had been working toward for over two decades. His efforts, criticised for being assimilationist, were being successfully implemented by another Māori leader who in the 1920s was strongly anti-Pākehā.⁶³ Te Puea's sentiments were further entrenched by what she saw as local community resistance to her achieving exactly what was ostensibly being expected of Māori – to create model, well-behaved communities. What she found was that the expectation was less about actually being clean, but was more to do with looking what clean was supposed to be like.

Pōmare and Te Puea also shared the goal of

establishing a Māori hospital. The relationship between Māori and hospitals was not a straightforward one. Many feared attending these houses of Western medicine, and for the first decades of the twentieth-century there were significant debates about the inability of Māori to pay their hospital fees if they did attend.⁶⁴ Establishing a network of small hospitals staff by Māori was seen by Pōmare as a way to break any fears and to remove any financial debates.⁶⁵ For Te Puea, building a hospital as part of her new settlement was a way of exporting cleanliness and hygiene into the surrounding areas. Both approaches were, in Foucault's framework, part of the spatial control and discipline that was sought to shape the Māori body politic.

Neither Te Puea nor Pōmare achieved their goal. Despite having the support of some Māori leaders, and gathering initial resources in terms of sites and some funds, Pōmare never got to build a single Māori hospital – the required funding from other arms of government was never forthcoming.⁶⁶ Te Puea's goal was similarly scuttled by the

⁵⁹ King *Te Puea* p 112.

⁶⁰ King *Te Puea* p 113.

⁶¹ Brown *Māori Architecture* p 104.

⁶² King *Te Puea* p 114.

⁶³ King *Te Puea* p 114.

⁶⁴ Dow *Māori Health & Government Policy 1840-1940* pp 161ff.

⁶⁵ Lange *May the People Live* p 235.

⁶⁶ Lange *May the People Live* p 235.

authorities, ironically by the regulations of the Department that Pōmare was Minister for some three years beforehand. Māhinārangi was supposed to open in 1929 as a hospital, but Te Puea was refused permission to use it as such due to not meeting the requirements for licensing. Michael King notes that the government had tightened control over hospitals in an attempt to improve health outcomes, and in doing so had created criteria which ruled out "Mahinarangi in its homely fashion" ever operating as a hospital.⁶⁷

Conclusion

The architectural implications of Pōmare's work deserve further investigation. While his efforts did not lead to a distinct architectural movement like that of some of his contemporaries, they did shape the architectural environment more broadly – influencing perceptions of what was considered acceptable built form and framing the extent of spatial control and discipline applied to Māori settlements.

By understanding these influences we can gain a better appreciation for the context within which the significant developments in

Māori architecture of the 1920s took place. It is easy to dismiss Pōmare's efforts as being driven by assimilationist beliefs and therefore of limited value to advancing the field of Māori architecture. Of course, the reality was actually a complex negotiation between the social outcomes sought (in this case, the survival of Māori as a people) and the impacts on cultural knowledge systems such as architecture.

Ngata, Te Puea and Rātana all had to negotiate this complex path. Te Puea and Ngata's use of some traditional materials and techniques are minor compared to the pervasive changes they accepted as part of meeting regulatory requirements. Even Rātana was unable to resist for long the imposition of discipline and order that came with health and sanitation improvements. Looking at Pōmare's work in more detail – for example, his involvement in setting up temporary hospitals to treat Māori and his fight to establish Māori hospitals – would help us work through these complexities.

Doing this would go beyond historical interest. Deidre Brown writes that building regulations have created a professionalisation of architecture that must be overcome if

architectural practice is to return to the Māori community.⁶⁸ To prevail and progress we must know where this professionalization came from and how it took hold. The 1920s, and the interaction between the ideas of the likes of Pōmare, Ngata, Te Puea, and Rātana, are therefore a very important part of the understanding needed to achieve the return of architectural practice to the Māori community.

⁶⁷ King *Te Puea* p 152.

⁶⁸ Brown *Māori Architecture* p 159.

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