

**HUMANITARIAN, INTERNATIONAL NURSING AND
THE NEW ZEALAND RECIPIENTS OF THE
FLORENCE NIGHTINGALE MEDAL,
1920-1999**

by

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**A thesis submitted to the Victoria University of Wellington
in partial fulfilment of the
requirements for the degree of
Masters of Arts (Applied)
in Nursing**

Victoria University of Wellington

2001

ABSTRACT

The purpose of this study was to explore the history of the Florence Nightingale Medal and in particular its New Zealand recipients. New Zealand nurses have, over many years, contributed to international nursing by providing service during conflicts and disasters. Several have worked with the Red Cross and, of these nurses, twenty-two have been awarded its highest honour, the Florence Nightingale Medal.

This thesis related the history of the Red Cross and Red Crescent Movement, and its place in humanitarian and international nursing. It traces New Zealand nursing's involvement in this, and offers a history of the New Zealand recipients of the Florence Nightingale Medal, 1920-1999. The personal and professional stories of five New Zealand nurses who were awarded the medal between 1969 and 1999 were gathered through oral history interviews. Their stories are used to consider in more detail the motivations and experiences of nurses who work in these circumstances, and the way in which humanitarian nursing practice and Red Cross principles shaped and challenged their practice.

The thesis therefore documents the work of five New Zealand nurses who have demonstrated exceptional courage, dedication, and commitment to humanitarian causes and international nursing practice. As an exploratory and descriptive study which has drawn on both historical and contemporary sources of information, it raises awareness about the Red Cross and its nurses, humanitarian nursing practice in particular, and international nursing in general.

ACKNOWLEDGEMENTS

The completion of this thesis would not have been possible without the support and assistance of participants, family and friends. I am deeply indebted to the five participants, Ngaire, Megan, Glenys, Wendy and Louisa who gave so generously of their time, experiences, stories, and memories. I dedicate this study to them.

My supervisor, Dr Pamela Wood has encouraged, counselled, humoured, and given academic guidance at regular intervals over the past year which has been greatly appreciated. Other teaching and administrative staff at the Graduate School of Nursing Studies and Midwifery at Victoria University of Wellington have always been ready to support and advise as well.

Isabelle Raboud of the International Committee of the Red Cross, Grant Mitchell of the International Federation of Red Cross and Red Crescent Societies, and Greg Clewley of the New Zealand Red Cross provided key archival information without which it would not have been possible to complete this study. I extend my sincere thanks to them.

Linda Evans and staff at the Oral History Centre at the Alexander Turnbull Library arranged the lending of tape recording and transcribing equipment on request, and at short notice, which was appreciated.

Assistance with the formatting of this thesis was given by Susan Knight, and I am grateful for her skills and patience.

Finally, to my husband Tim Caughley, friends Prue Densem and Marion Lineham, and numerous other friends who have endured months of unsociable behaviour without complaint, I am most appreciative of their encouragement, interest, and support.

TABLE OF CONTENTS

CHAPTER 1: HISTORICAL BEGINNINGS	1
Background	3
History of the Florence Nightingale Medal	9
 CHAPTER 2: THE RED CROSS AND RED CRESCENT MOVEMENT	 16
History of the Red Cross and Red Crescent Movement	16
Principles and values of humanitarian law and humanitarianism	21
The Geneva Conventions and their development	26
Protocols Additional to the Geneva Conventions	29
The Geneva Conventions and relevance to nursing	30
Rights and duties of medical personnel	32
Humanitarian law and human rights	35
War as a health issue	37
 CHAPTER 3: INTERNATIONAL NURSING	 43
Historical development	43
International courses	45
New Zealand nurses' involvement	50
Towards a concept of international nursing	58
 CHAPTER 4: METHODOLOGY	 65
Historiography	66
Documentary primary and secondary sources	68
Oral history primary source	70
Ethical considerations	75
Oral history method	77
 CHAPTER 5: NEW ZEALAND FLORENCE NIGHTINGALE MEDAL RECIPIENTS 1920-1999	 83
Florence Nightingale Medal recipients 1920-1965	83
Florence Nightingale Medal recipients 1969-1999	90

CHAPTER 6: STORIES FROM THE FIELD: INTERVIEWS WITH FIVE FLORENCE NIGHTINGALE MEDAL RECIPIENTS	100
Ngaire Simpson	100
Megan Crisp	110
Glenys Checchi	119
Wendy Smith	137
Louisa Akavi	151
 CHAPTER 7: DISCUSSION	 169
The nurse	169
Humanitarian nursing practice	188
Nursing and Red Cross principles	206
 CHAPTER 8: CONCLUSION	 216
 APPENDICES	
1. New Zealand Florence Nightingale Medal recipients: 1920-2001	224
2. Florence Nightingale Medal recipients: 1969-1999	225
3. Participant information sheet	227
4. Consent form	229
6. Florence Nightingale Medal recipients: 1920-1965	230
 ILLUSTRATIONS	
Figure 1: Florence Nightingale Medal	231
Figure 2: Florence Nightingale	232
Figure 3: Florence Nightingale Medal Award	233
Figure 4: Ngaire Simpson	234
Figure 5: Megan Crisp and Louisa Akavi	235
Figure 6: Glenys Checchi	236
Figure 7: Wendy Smith	237
 REFERENCES	 238

CHAPTER 1

HISTORICAL BEGINNINGS

New Zealand nurses have for many years sought to enhance their professional and personal experiences by nursing and studying in other countries. For some, this has been an act of service during conflict or disasters. They have worked with international organisations and made a small but important contribution to international nursing through their involvement with these organisations.¹ It is difficult to evaluate the nature and extent of this contribution as much of the nursing is carried out in remote areas and in difficult and dangerous situations beyond the vision and comprehension of most people in New Zealand. As a consequence, it is even more difficult to examine their nursing practice.

Some of these nurses, especially those who have worked with the International Committee of the Red Cross, have been recognised by the New Zealand Red Cross Society for their nursing contribution overseas. These are the recipients of the Florence Nightingale Medal, which is the highest nursing honour that can be bestowed on a nurse by the International Committee of the Red Cross. It is awarded to fifty nurses every two years to honour those who have demonstrated exceptional courage, dedication and commitment to humanitarian causes and international nursing practice.

Although these nurses have contributed to international nursing, in some cases at considerable personal risk, there has been no previous study or substantial writing about the Florence Nightingale Medal and its recipients. This represents a gap in New Zealand nursing history and its contemporary landscape. New Zealand nurses have made their mark on Red Cross nursing and are eagerly sought by the International Red Cross for their professionalism, skills, competence and ability to work in any situation. This study addresses the lack of information and writing about Florence Nightingale Medal recipients, who they are, what makes them outstanding nurses, and what motivates them to work for the Red Cross.

¹ M.Burgess, *Nursing in New Zealand Society*, Longman Paul, Wellington, 1984, p.162.

This study also honours New Zealand nurses who have achieved international recognition for their work. They provide good role models and inspiration to the next generation of nurses who aspire to work overseas. As in many historical inquiries, the sense of connectedness or continuity with the past by those in the present can engender a sense of pride especially in being associated with the former visionaries.² This is exemplified by membership of the distinguished group of New Zealand Florence Nightingale Medal recipients who include Hester Maclean (1920), Flora Cameron (1947), and among contemporary nurses, Ngaire Simpson (1975), Megan Crisp (1981), Glenys Rodger-Checchi (1987), Wendy (Woodward) Smith (1993), and Louisa Akavi (1999).³ Historical inquiry provided the methodology for examination of the connectedness between these generations.

As this study was undertaken in part as historical research, it draws on primary sources of information through oral history interviews. Other primary sources were identified in Red Cross archival documents, especially the applications proposing candidates for the award. As these applications only briefly note the nurse's contribution, oral history interviews provided more detailed and personalised primary sources of information about their nursing experiences.

Access to other sources, particularly archival sources of International Red Cross material was limited because this material is held in the Red Cross Headquarters in Geneva and although every encouragement was given to visit the archives, time and cost prohibited this possibility. Secondary sources of information, particularly contemporary Red Cross sources, were extensively used.

This chapter introduces the reasons and justification for the research, and outlines the objectives of the study. It documents the background and history of the Florence Nightingale Medal, its evolution and changes over time, and provides a literature review of the history of the Florence Nightingale Medal and recipients.

² S.K. Davis, 'A mandate for Nursing History in Nursing Curricula,' *Journal of Nursing Education*, Vol. 34, No. 9, (1995), p.472.

³ ICRC list of National Society Funds and Medals New Zealand Red Cross, created on 04/05/1998, modified, 21/08/2001, ICRC, Geneva.

To understand the context of this award, other chapters are structured to describe the history of the International Red Cross and Red Crescent Movement and its component parts,⁴ humanitarian principles, humanitarian law, the Geneva Conventions and their relevance to nursing as background and contextual information. International nursing is discussed from a broad framework, and includes the relationship between the Red Cross, Florence Nightingale and nursing. Historical methodology is outlined and the process of gathering primary sources of information by oral history interviews is described along with the management of data, ethical considerations and practical implications of this method of study. The interviews document the Red Cross nursing experiences of the participants in chronological order, with narrative transcriptions drawn from the interviews providing examples of their work and other experiences. Discussion arising from the interviews follows in three areas: the nurse, their practice and nursing and Red Cross principles.

Background

Since the late 1960s when I was a student nurse in my second year of a hospital-based nursing programme, I first considered the idea of nursing in an international context. My awareness was raised during publicity about the war in Biafra in 1968. This was probably the first exposure to such a disaster that many of us had through the television pictures of starving children. It marked the first time the media played a decisive role in drawing public attention to such atrocities and continues to play a pivotal role today.⁵ It evoked emotional responses with a strong desire to do something practical and professional even though I was a student nurse. There was a naivety and little appreciation at the time that the health personnel required in such a disaster would need to be highly skilled, experienced and professional, as well as mature.

⁴ Note, the International Red Cross and Red Crescent Movement consists of the International Committee of the Red Cross (referred to as the ICRC in this study), the International Federation of Red Cross and Red Crescent Societies (referred to as the Federation, formerly the League) and National Red Cross or Red Crescent Societies.

⁵ C. Moorehead, *Dunant's Dream, War, Switzerland and the history of the Red Cross*, Harper Collins, London, 1998, p. 614.

This first spark of interest in 1968 culminated in this study being undertaken in 2001, and led to my own Red Cross nursing experiences spanning two decades. In the late 1980s I worked for the International Committee of the Red Cross as a surgical nurse with victims of war and refugees from Cambodia and Afghanistan, and I was a staff member of the New Zealand Red Cross Society for three years. In the 1990s I was a nursing tutor and health educator in the Cook Islands, and a development delegate⁶ for the International Federation of the Red Cross and Red Crescent Societies in the South Pacific region.

International nursing as a concept, Red Cross nursing and humanitarian nursing in particular, have continued to interest me and have challenged my way of thinking about nurses' contribution to global health issues arising out of wars or natural disasters. These interests are linked with concerns about human rights and humanitarian issues. This is reflected in my current focus on the Florence Nightingale Medal recipients and their stories.

While the Florence Nightingale award is of the past, it is also of, and contiguous with the present. Since its inception in 1920, it has been awarded to twenty-two New Zealand nurses who have distinguished themselves through exceptional courage and devotion in times of war and peace, demonstrating qualities of Florence Nightingale herself. (See Appendix I for a list of these recipients). Their work and lives have not been documented in this way before.

Five New Zealand recipients of the Florence Nightingale Medal were selected for interview. The interviews were analysed within a framework comprising; the nurse, their practice, and nursing and Red Cross principles. My philosophy as a former Red Cross nurse encompasses humanitarian values and the Red Cross fundamental principles (which are described in Chapter 2), and is the lens through which this study is viewed. An historical research methodology was applied to this study and is outlined in Chapter 4.

⁶ Note, delegate is the term used by the Red Cross for its field workers, including nurses, and will be used throughout this study.

New Zealand nursing history has gained a new impetus in 2001 because of the marking of 100 years of nursing registration and New Zealand's historical place as the first country in the world to register nurses. This historical event has been celebrated in many diverse ways across the country and documented by the publications such as the Nursing Council's souvenir publication, and 'Safety to Practice: Reflections of Chairpersons of the Nursing Council of New Zealand 1871-200'.⁷ These add to other historical information developed over the years such as biographies written by or about prominent nurses, for example, Hester Maclean, Mary Lambie,⁸ NERF oral histories,⁹ histories relating to hospital training¹⁰ or hospital centennials, publications noting events such as the seventy-fifth anniversary of the New Zealand Nurses Association in 1983¹¹ and academic writings by Pamela Wood, Jan Rogers, and Annette Stevenson¹² and the comprehensive overview of Nursing in New Zealand Society by Burgess¹³ taking nursing history up to the 1980s. However, there is a dearth of historical information about individual nurses and their actual nursing practice, especially those who are not well known or who through choice have worked overseas for their majority of their professional lives, such as New Zealand Red Cross nurses. And there has been no historical study into the Florence Nightingale Medal.

Research about Florence Nightingale Medal recipients has not been undertaken in New Zealand before, and while there are journal articles about individual nurses and media

⁷ *Nursing New Zealand Centenary Souvenir, 1901-2001*, Nursing Council of New Zealand, Wellington, 2001. P.J. Wood, E. Papps, *Safety to Practice: Reflections of Chairpersons of the Nursing Council of New Zealand 1971-2001*, Nursing Council of New Zealand, Wellington 2001.

⁸ M.Lambie, *My Story: Memoirs of a New Zealand Nurse*, Peryer, Christchurch, 1956. H.Maclean, *Nursing in New Zealand, History and Reminiscences*, Tolan Printing Company, Wellington, 1932.

⁹ NERF (Nursing Education and Research Foundation), Oral History Project, coordinated by Marie Burgess, held at the Oral History Centre, Alexander Turnbull Library, Wellington.

¹⁰ A. McDonald and C. Tulloch, *Wellington Hospital Educating Nurses for more than a Century, 1883-1991*, Wellington Hospital Nurses Reunion Committee, 1994.

¹¹ M. Gibson Smith, and Y. Shadbolt eds., *Objects and Outcomes*, New Zealand Nurses' Association 1909-1983, New Zealand Nurses Association Inc., Wellington, 1984.

¹² See for example, P.J. Wood, 'The sick child, humanitarian narratives and the getting of hospitals; An historical research brief', *Nursing Praxis in New Zealand*, Vol. 11, No. 3, (November 1996), pp.50-4. J. Rodgers, 'Potential for professional profit: the making of the New Zealand Army Nursing Service 1914-1915', *Nursing Praxis in New Zealand*, Vol. 11, No. 2, (July 1996), pp.4-12. A. Stevenson, *Realities and rhetoric in New Zealand 1945-1960*, M.A. thesis, Victoria University of Wellington, 1997.

¹³ M.Burgess, *Nursing in New Zealand Society*, Longman Paul, Wellington, 1984.

interviews by nurses who have worked overseas, there has been no previous attempt to write specifically about the Florence Nightingale Medal and its recipients from an historical research perspective. Nor has there been an attempt to draw together a comprehensive range of experiences of Red Cross nursing, demonstrating its diversity and evolution over time in changing environments. I have begun explicating the concept of humanitarian nursing practice in this study. However, I consider it still requires further development.

The international political environment which has evolved in the 1990s, the recent conflicts and disasters in the Pacific region, and the events of 11 September 2001, make it even more imperative to have an understanding of humanitarian law, nursing's contribution to humanitarian care, and the context in which this occurs.

This study covers a period of time of considerable geopolitical power shift and changes in the nature of the conflicts and humanitarian response from the Vietnam War in the 1960s to Bosnia in the 1990s. An examination of this provided a valuable backdrop to assessing how nursing has adapted and altered to meet the changing demands and challenges of the geopolitical environment. This is covered in Chapters 2, 6 and 7.

This study aimed to generate knowledge about the history of the Florence Nightingale medal and the New Zealand nurses who were awarded it between 1969 and 1999. The specific objectives of the study were to:

- explore the history of the Florence Nightingale Medal;
- describe the criteria for the award and examine how applications were assessed against these by the New Zealand Red Cross, in its process of making nominations to the International Committee of the Red Cross;
- examine the nursing background, personal characteristics, and motivation for nursing overseas, of five recipients between 1969 and 1999;
- describe the nursing practice of five of the medal recipients from 1969 and 1999; and

- explore the significance of the humanitarian principles of the Red Cross for these nurses.

The 9th International Conference of the Red Cross held in Washington in 1912, endorsed a resolution for the establishment of a Florence Nightingale Fund and Medal, with six medals to be awarded once every two years.¹⁴ However, it was not until 1920 following World War I, that the first award was made. This marked, on 12 May 1920, Florence Nightingale's hundredth birthday anniversary.¹⁵ In 1934 it was decided to make thirty-six awards every two years. This was changed in 1981 to fifty awards every two years.

Awarded by the International Committee of the Red Cross (ICRC) to honour the spirit of the life and work of Florence Nightingale, the medal was received by a total of twenty-two New Zealand nurses between 1920 and 2001. Between 1969 and 1999, eleven New Zealand nurses were recipients, the majority of them through their work primarily with the International Committee of the Red Cross (Appendix II).

The time frame 1969 – 1999 was selected because it marked a period during which all the New Zealand Florence Nightingale Medal recipients were registered nurses involved in field operations overseas. It represented a time when personnel worked with the New Zealand Red Cross or with its international parent organisations in emergency arenas and contexts, in conflicts, natural disasters, and with belligerents, civilians and refugees. This is in contrast to the earlier period when nurses and Voluntary Aid Detachments (VADs) were involved in various ways with New Zealand's military efforts, particularly during World Wars I and II, or were active in New Zealand rather than overseas. Further details of the recipients from 1920 to 1965 are discussed in Chapter 5.

The Florence Nightingale Medal is awarded to nurses or voluntary nursing aids through nomination of candidates submitted by National Red Cross Societies (such as the New

¹⁴ Florence Nightingale, Notes on the History of the Florence Nightingale Medal, ICRC document, DD/DCM 97/210 – pda / ira, p.3.

¹⁵ Florence Nightingale, Evolution of the Regulations and Distribution of Medals, ICRC Document, DD/DCM 97/210, p.4.

Zealand Red Cross), to the ICRC. The structure and component parts of the Red Cross are described in Chapter 2.

A literature search to clarify how the achievements and practices of these nurses had been recorded, and/or documented revealed that there were some rich sources of information especially from New Zealand Red Cross sources. However, the sources lacked in-depth detail about what the New Zealand Red Cross believes is one of the most “tangible contributions to humanity”,¹⁶ namely the work of overseas nurse delegates and the delegates themselves.

It was noted by Maggs that detailed nursing practice and its scope were omitted in historical accounts.¹⁷ He commented that most histories of nursing have been about histories of nurses, the reformers and leaders, or the institutionalisation of nursing care. He added that we know more about nurses than the practice of nursing.¹⁸ This was evident in the sources for this topic, particularly prior to the 1960s and was one of the reasons for undertaking this study. In a later article, Maggs claimed that the ‘new historiography’ had failed to discuss or recognise the complexity of the concept of nurse or nursing. He suggested that a major gap existed between the practice of nursing and its historical construction because most nursing historians cannot address the history of nursing and caring.¹⁹ Although this study focussed on the Florence Nightingale Medal, an award, and the nurses who received it, it was not at the expense of their humanitarian nursing practice, which was explored through oral history interviews. Furthermore, their practice was contextualised, a deficiency noted by Chinn in her observations about the histories of nursing.²⁰ More is said about this in Chapter 7.

¹⁶ ‘Our hands reach out to need’, *Red Cross News*, issue 2, (1988), p.9.

¹⁷ C. Maggs, ‘A General History of Nursing: 1800-1900’, in *Companion Encyclopaedia of the History of Medicine*, Vol 2, eds., W.F. Bynum, R. Porter, Routledge, London and New York, 1993, p.1311.

¹⁸ C. Maggs, ‘A General history of Nursing’, p.1311.

¹⁹ C. Maggs, ‘A history of Nursing: a history of caring?’ *Journal of Advanced Nursing*, (1996), p.632.

²⁰ P. Chinn, ‘Liberating Nursing History’, editorial, *Advances in Nursing Science*, Vol 12, No. 4, (July 1990), p. viii.

Therefore, further study of primary sources was necessary. This could be achieved by undertaking oral history interviews with recipients of the award during the period under study.

History of the Florence Nightingale Medal

The Florence Nightingale Medal has its genesis in 1907 at the 8th International Conference of the Red Cross.²¹ Count Csekonics of the Hungarian Red Cross submitted the following resolution:

This great, incomparable name of Florence Nightingale, who has earned eternal recognition for her achievements in the humanitarian field and who has elevated the previously humiliating practice of nursing to the art of charity, imposes on the 8th International Conference the noble duty of paying tribute to those achievements by: (1) warmly expressing in its report the veneration in which she is held; (2) creating a Florence Nightingale foundation to offer an international medal to ladies having especially distinguished themselves in the noble mission of caring for the sick and wounded.²²

While the first proposal was endorsed, the second was deferred until the next International Conference in 1912 to allow time to solicit suggestions. When the establishment of the Florence Nightingale Fund and Medal together with a set of regulations were endorsed in 1912, the ICRC wanted the award to be given every two years so as not to diminish its significance. However, the regulations for the award in the ICRC Circular No. 154 of December 1913, stated it was to be awarded annually to “the six most qualified nurses chosen by the International Committee of the Red Cross from among applicants submitted by National Red Cross Societies”.²³ It also stated that “applicants must be qualified nurses holding nursing diplomas delivered by their

²¹ *ICRC Annual Report 1995*, ICRC, Geneva, 1995, p.300.

²² Count Csekonics from the Report on the 8th International Conference of the Red Cross London, 1907, referred to in Florence Nightingale, ICRC document, DD/DCM 97/210 – pda/ira, p.3.

²³ Annex 1, ICRC Circular no. 154, Geneva, 3 January 1914, Regulations for the Florence Nightingale Medal of 24 December 1914, in Florence Nightingale, ICRC document DD/DCM, 97/210 – pda/ira, p.9.

countries' civilian or military medical services".²⁴ When the first medals were about to be awarded in 1914, war broke out and they were postponed until 1920.

The medal was to be in silver-gilt, engraved with a portrait of 'the Lady of the Lamp' with the words, "Ad memoriam Florence Nightingale 1820-1910".²⁵ On the reverse side, it was to be inscribed with "Pro vera misericordia et cara humanitate perennis decor universalis"²⁶ ("true and loving humanitarianism – a lasting general propriety").²⁷ A picture of the Florence Nightingale Medal is included in the illustrations (Figure 1).

In 1919, it was announced that fifty medals would be distributed. On 12 May 1920, Florence Nightingale's birthday, forty-one names were announced. The next ICRC Circular, 199 of 22 July 1920²⁸ stated that a second award could be made and ten new names were added to the list. One recipient in 1920 was Hester Maclean, the Director, Division of Nursing, in the New Zealand Department of Health. She was amongst those announced in the first award for 1920, as the Wellington Branch of the Trained Nurses Association had invited her to a reception on 25 June 1920 to congratulate her on receiving the award, prior to the announcement of the second award.²⁹

The award is administered by the Florence Nightingale Commission of the International Committee of the Red Cross, which at its inception, had a membership of nine from seven countries, of which four members were women, including Miss Mabel Boardman of the American Red Cross.³⁰

²⁴ Annex 1, ICRC Circular no. 154, Geneva, 3 January 1914, Regulations for the Florence Nightingale Medal of 24 December 1914, in Florence Nightingale, ICRC document DD/DCM, 97/210 – pda/ira, p.9.

²⁵ Appendix 1, Regulations for the Florence Nightingale Medal, Florence Nightingale, ICRC document, p.9.

²⁶ Appendix 1, Regulations for the Florence Nightingale Medal, ICRC document, p.9.

²⁷ Appendix 1, ICRC document, p.9.

²⁸ Evolution of the Regulations and distribution of Medals, ICRC document, p.4.

²⁹ 'Reception to Miss Maclean, R.R.C.', *Kai Tiaki*, Vol. XIII, No.3, (July 1920), p.108.

³⁰ Florence Nightingale, ICRC document, p.10.

An amendment was made to the regulations in 1921 to include nurses who had died on active service, reflecting the post war environment, and in 1925 a clarification was added to this to cover death on active service in the event of an epidemic or disaster.³¹ This latter amendment may have related to the influenza epidemic of 1918. On 28 October 1928, the 13th International Conference decided to increase the number of medals that could be awarded annually from six to eighteen, so that six were available in peace time and twelve in times of full scale war.³²

In 1933, the ICRC proposed a review to the regulations and National Red Cross Societies were asked to convey their suggestions. On the basis of these, the regulations were amended in 1934 and adopted at the 15th International Conference to read as follows:

The Florence Nightingale Medal may be awarded to:

- (a) trained nurses who have distinguished themselves exceptionally by their great devotion to the wounded or sick in time of war or peace.
- (b) matrons or nursing organisers who have rendered exceptional services in connection with the sick or wounded.
- (c) voluntary aides duly registered with the Red Cross, who have distinguished themselves exceptionally by their great devotion to the sick or wounded in time of war or of disasters.
- (d) nurses or voluntary aides of any one of the above categories who have fallen on active service.³³

This broadened the scope of recipients beyond registered nurses to voluntary aids and to other disasters and reflected the changing realities of the International Red Cross service

³¹ Evolution of the Regulations and distribution of medals, ICRC document, p.4.

³² Evolution of the Regulations, ICRC document, p.5.

³³ Additional Regulations proposed by the ICRC International Conference of the Red Cross in Tokyo, 1934, ICRC document, p.11.

prior to the Second World War. The distribution of the medal took place every two years and not more than thirty-six were issued at any one distribution.³⁴

Over the years, further significant changes were made to the regulations, in particular in 1981 and 1991. In 1981, at the 24th International Conference in Manila, a new set of regulations was adopted containing a clearer and less restrictive definition of whom the award might be given. These new regulations provided for the medal to be awarded to trained nurses and Red Cross voluntary aides who had distinguished themselves exceptionally in promoting health or preventing disease. It was at this time that the number of medals was increased from thirty-six to fifty.³⁵ This increase was a response to the increase in the number of National Red Cross Societies. The amendment, including the reference to health promotion, coincided with the Alma Ata Declaration in 1978 and the adoption at the World Health Assembly in 1981 of the strategy of 'Global Health For All by the Year 2000'.³⁶ This increased the scope of nursing activities for the award.

However, it was not until 1991, that the regulations were amended to remove the discriminatory clause that excluded men from eligibility. This was done by the Council of Delegates³⁷ in Budapest, held there ironically as the 26th International Conference was postponed because of governments (States party to the Geneva Conventions) failure to agree on the form of Palestinian participation.³⁸ The exemplary services qualifying for the award were no longer restricted to those accomplished in wartime or situations of natural disaster and the criteria were refined to take account of the present scope of nursing tasks while maintaining the award's exceptional character which included:

- the exceptional course taken by a candidate's career,

³⁴ Additional Regulations proposed by the ICRC International Conference of the Red Cross in Tokyo, 1934, ICRC document, p.11.

³⁵ Evolution of the Regulations and distribution of medals, ICRC document, p.6.

³⁶ *Facts about WHO*, World Health Organisation, Geneva, 1990, p.5.

³⁷ Note, the Council of Delegates include representatives of the ICRC, the Federation and delegates of all Red Cross and Red Crescent National Societies.

³⁸ Y. Sandoz, '26th International Conference of the Red Cross and Red Crescent: Myth and Reality', *International Review of the Red Cross*, No. 305, (1995), p.133.

- the element of personal sacrifice within the context of a given mission or professional activity,
- the candidate's creativity and pioneering spirit,
- his or her contribution to nursing education.³⁹

These amendments which came into force on 3 August 1992,⁴⁰ signified changes in attitudes to male nurses who are part of the nursing profession in most countries and have been involved in international nursing for several decades. Seymer noted that at the Conference in 1863 when the Red Cross was established and was encouraging the development of Aid Societies, mention was made only of male nurses to be trained (infirmiers volontaires)-female nurses (infirmieres) were only included in a resolution in 1869.⁴¹ It is ironic from these historical beginnings that it took so long for male nurses to be recognised by the award of the Florence Nightingale Medal.

The amendments also recognised the significance of primary health care and public health concepts in modern nursing and health (especially since the HIV/AIDS epidemic). In addition, they acknowledged the increasing numbers of disaster situations where government authorities were unable to cope with providing basic needs for large populations and delegated these responsibilities to humanitarian agencies such as the Red Cross.⁴² These are the all too familiar television images of refugees and displaced people, from conflicts in countries such as Cambodia and Afghanistan, and famines in Ethiopia and Sudan, countries in which the 1969-1999 New Zealand medallists have worked.

The first male nurse to receive the Florence Nightingale Medal, in 1995, was from an Islamic country, a member of the Jordanian Red Crescent Society. That year the total

³⁹ Notes on the history of the Florence Nightingale Medal, Florence Nightingale, ICRC document, p.7.

⁴⁰ Notes on the history of the Florence Nightingale Medal, ICRC document, p.7.

⁴¹ L. R. Seymer, *A General History of Nursing*, 4th edition, Faber and Faber Ltd, London, 1956, p.107.

⁴² P. Perrin, *War and Public Health A Handbook on War and Public Health*, ICRC, Geneva, 1996, p.302.

number of medals awarded reached 1,105.⁴³ New Zealand's first male nurse to receive the award was Geraldo Cruz Pires-Ribeiro in 2001, who came to New Zealand in 1974 from Brazil as a political refugee.⁴⁴ An experienced Red Cross nurse of many overseas missions he was abducted in May 1999 in the northern Caucasus.⁴⁵ His award thus reflected the most recent changes in the regulations in 1992 on two accounts: gender and personal sacrifice.

As applications for nominations for the Florence Nightingale Medal are the prerogative of the National Red Cross and Red Crescent Societies, from time to time these Societies are reminded by the ICRC to make a careful and judicious choice of the candidates they propose. The 20th International Red Cross Conference in Vienna in 1965 had adopted a resolution recommending that National Societies only propose those who fully met the criteria laid down in the Regulations. Further to this came the strong message that the medal was instituted "not to crown a career, however deserving of merit, but to reward outstanding acts of devotion and as a recognition of exceptional moral and professional qualities".⁴⁶ The phrase "regardless of the person's age or experience" was added in the International Committee of the Red Cross message in 1996.⁴⁷ This suggested that some National Societies have interpreted the criteria with a degree of latitude and variance. This would make a fascinating study in itself, and is beyond the scope of this inquiry.

New Zealand Red Cross has always upheld the special significance of this distinction and spirit in which the Florence Nightingale Medal is awarded. In the past some New Zealand Red Cross branches have submitted nominations for the award, the National Office not always acceding to requests. However, it was not until 1993 that in order to demonstrate its transparent process, it adopted a set of criteria as policy. The criteria approved were based on a minimum of ten years of service to the New Zealand Red Cross, exclusive of time also spent under direct contract to either the International

⁴³ 'Thirty-fifth award of the Florence Nightingale Medal', Geneva 12 May 1995, Circular No. 580, *International Review of the Red Cross*, (September-October, 1995), p.570.

⁴⁴ 'Red Cross Worker honoured', *Red Cross News*, Vol. 89, No. 3, (August 2001), p.13.

⁴⁵ E. Reumann, 'High Risk Mission', *Red Cross Red Crescent*, issue 2, (2000), p.7.

⁴⁶ Submission of Applications for the Florence Nightingale Medal, (30th award: 12 May 1985), circular 530, 24 August 1984.

⁴⁷ Application for the Florence Nightingale Medal (36th award - 12 May 1997), September 1996.

Committee of the Red Cross or the International Federation of Red Cross and Red Crescent Societies in Geneva, and a minimum of thirty months field experience (equivalent to some five, six-month missions).⁴⁸ Even though the ICRC Florence Nightingale amendments of 1992 lifted the war and disaster constraints and broadened the scope of possible recipients, the New Zealand Red Cross has adhered to the overseas service criterion. New Zealand Red Cross makes its candidate nomination decisions on the basis of the post-mission reports on individual nurses it receives from the ICRC or the Federation, as well as its own criteria and those of the Florence Nightingale Medal Regulations.

The International Council of Nurses (ICN) is actively involved in the selection for the Florence Nightingale Award.⁴⁹ This is through the Florence Nightingale Commission, an International Red Cross Commission whose role it is to study the candidates submitted by National Red Cross Societies. It is made up of six members who have equal rights. The Committee may invite people who are not members to its meetings, and at least one of those must be from the nursing profession. A member of the ICN is therefore able to participate in the selection of recipients.⁵⁰

This chapter has outlined the history of the Florence Nightingale Medal, its evolution and the New Zealand recipients. Emphasis has been placed on tracing the amendments to the regulations governing the award, and the reasons for the changes. As the medal is an award of the ICRC given to Red Cross nurses, the following chapter provides background information about the structure and humanitarian philosophy of the Red Cross and its work, in particular the three components of the International Red Cross and Red Crescent Movement and the Geneva Conventions in relation to nursing.

⁴⁸ New Zealand Red Cross Florence Nightingale Award: New Zealand Red Cross Nomination Criteria, 1993. Note, the term mission refers to Red Cross overseas assignments and is used throughout this study.

⁴⁹ M. Styles 'International Nursing on the threshold of the third millennium', Chapter 3, A modern humanitarian profession, *Profession: Nurse, (Images 1900-1930)* Museum of the International Red Cross and Red Crescent, Geneva, 1995, p.123.

⁵⁰ Email correspondence with I. Raboud, Member of the Division for Policy and Cooperation within the Movement, ICRC, 20 September, 2000.

CHAPTER 2

THE RED CROSS AND RED CRESCENT MOVEMENT

To further understand the work of the Florence Nightingale Medal nurses and locate their practice within an humanitarian context, an understanding of the concept of humanitarianism, humanitarian law and its historical development is necessary. Humanitarian law is codified in the Geneva Conventions, and Protocols Additional to the Geneva Conventions. These have relevance to nursing, especially for nurses who work in situations where there is armed conflict, the work environment for many of the Florence Nightingale Medallists. In these situations, nurses have specific rights and duties incumbent upon them under humanitarian law. This is to ensure appropriate protection and care is given to those in need, and in return, for nurses to be protected and allowed to perform their duties, and assert their rights to practice.

In this chapter, particular emphasis is placed on the concept of humanitarianism. An outline of the Geneva Conventions and Additional Protocols are given with reference to the rights and duties of nurses which is then reflected in nursing practice of the Florence Nightingale Medallists described in Chapters 6 and 7. This is set against the historical background of the Red Cross (a history that goes back to the early 1860s), its various component parts and their roles, together with the philosophy and values of the organisation and its people.

History of the Red Cross and Red Crescent Movement

The Red Cross has its genesis in the 1860s when Swiss businessman, Henry Dunant who was travelling in Northern Italy in 1859 unwittingly witnessed the Battle of Solferino fought between French and Austrian armies. With over 40,000¹ dead and injured in the battle, he was horrified to see there was no organised system to collect or care for the wounded and sick on the battlefield and arranged for people from the

¹ *Discover the ICRC*, ICRC, Geneva, March 2001, p.7.

nearby village to render assistance to those in need regardless of their nationality.² The women of the local village of Castiglione, seeing his example of not making a distinction between nationalities, tended to the wounded men repeating, “tutti fratelli”³ or that they were all brothers in their efforts to assist the wounded.

Henry Dunant’s descriptions of the horrors of Solferino were recounted in his book, *A Memory of Solferino*.⁴ He advocated for agreements to be signed by nations to govern how the wounded should be treated in wartime, and argued for the establishment in peace time of societies of neutral medical relief workers who should be trained to provide relief when needed.⁵

In 1864, twelve countries signed the First Geneva Convention for the Amelioration of the Condition of the Wounded in Armies in the Field and marked the historical development of written international humanitarian law in armed conflicts.⁶ The most basic principle contained in this law was that of protection for all wounded and those who cared for them. The symbol chosen to signify relief activity and personnel was a red cross on a white background, the Swiss flag in reverse, and was displayed on vehicles, armbands or as a flag.⁷ The red crescent was also accepted as an emblem for Islamic countries.

From these beginnings, the Red Cross developed into a large private organisation comprising the original institution, the International Committee of the Red Cross, (ICRC); the League of Red Cross Societies which became known as the Federation of Red Cross and Red Crescent Societies in 1991,⁸ and the National Red Cross and Red Crescent Societies in over 180 countries of the world. Collectively these three

² *The Red Cross and the Geneva Conventions*, Australian Red Cross, IHL Instructors course, (May 1999), p. 9.

³ H. Dunant, *A Memory of Solferino*, ICRC, Geneva, 1986, p.72.

⁴ H. Dunant, *A Memory of Solferino*, ICRC, Geneva, 1986.

⁵ H. Dunant, p.115.

⁶ *Discover the ICRC*, p.7.

⁷ G. Kewley, *Humanitarian Law in Armed conflicts*, Australian Red Cross, 1993, p.6.

⁸ C.Moorehead, *Dunant’s Dream, War, Switzerland and the history of the Red Cross*, Harper Collins, London, 1998, p.695.

constituent parts comprise the International Red Cross and Red Crescent Movement, each with its own specific characteristics and activities.⁹ The ICRC for example, is an impartial, neutral and independent organisation with an exclusive humanitarian mission to protect the lives and dignity of victims of war and internal violence through humanitarian assistance. It coordinates and directs the Movement's international relief activities in conflict situations and promotes and strengthens humanitarian law and universal humanitarian principles.¹⁰

The first National Red Cross Societies developed in France and Germany in 1870. Twenty-three other Red Cross Societies were also established around this time.¹¹ At the end of the First World War, National Red Cross Society workers wanted to continue the provision of humanitarian assistance in peacetime and to extend the work of the Red Cross to deal with issues such as public health, eradication of disease, and child welfare. This led in 1919, to the establishment of the League of Red Cross Societies in Paris by five major Red Cross Societies (American, British, French, Italian and Japanese)¹² with a mandate to do in peace, what the International Committee had done in war.¹³

The League was transferred to Geneva in 1939 where it remains today.¹⁴ In 1991 it was renamed the International Federation of Red Cross and Red Crescent Societies.¹⁵ The main activities of the Federation in peacetime are to promote humanitarianism through programmes to improve the situation of vulnerable people. This is achieved by coordinating and directing international assistance to victims of natural and technological disasters, to refugees, and in health emergencies. As well as international relief activities, its development programme aims to strengthen National Societies, in

⁹ *Guide for National Red Cross and Red Crescent Societies to activities in the event of conflict*, ICRC, 1990, p.14.

¹⁰ A global humanitarian organisation, *World Disasters Report 2001*, International Federation of the Red Cross and Red Crescent Societies, 2001, front inset page.

¹¹ C. Moorehead, *Dunant's Dream*, p.61.

¹² K. Ramsperger, 'Marking 75 years', *Red Cross Red Crescent*, (January-April, 1994), p. 6.

¹³ C. Moorehead, *Dunant's Dream*, p. 263.

¹⁴ A., Baccino-Astrada, *Manual on the Rights and duties of medical personnel in armed conflict*, ICRC and League of Red Cross Societies, Geneva, 1982, p. 19.

¹⁵ 'League becomes International Federation' *Red Cross Red Crescent*, (January-April 1992), p.8.

turn to build the capacity of individuals and communities.¹⁶ The International Federation also cooperates with National Societies and strengthens their capacities to prepare for disasters and to undertake health and social programmes.¹⁷

Today, the Federation's mission is "to improve the lives of vulnerable people by mobilising the power of humanity"¹⁸ through its nearly 180 National Red Cross and Red Crescent Societies and more than sixty delegations supporting its activities around the world. In Federation terms, vulnerability refers to "those at greater risk from situations that threaten their capacity to live with a minimum of social and economic security and human dignity".¹⁹ It is a complex concept, and rather than labelling specific groups or individuals as vulnerable and so stigmatise them further, the Federation prefers to speak of vulnerabilities and to identify them. For example, the Federation uses proximity and exposure, poverty and exclusion/marginalisation as global indicators to measure vulnerability and has developed a vulnerability/capacity assessment framework for identifying vulnerabilities and assess people's capacities to prevent or cope with the threat.²⁰

National Red Cross and Red Crescent Societies act as auxiliaries to public authorities in their own countries both in war and peace, and provide services to the most vulnerable in their communities through disaster relief, health and social programmes.²¹ Much of this work is done through volunteers in the spirit of Henry Dunant's vision of Red Cross humanitarian work being carried out by "devoted and thoroughly qualified volunteers".²² Volunteering is the essence of the Red Cross and is embodied in one of its fundamental principles which are mentioned below. The New Zealand Red Cross as one example, undertakes community services including meals on wheels, first aid

¹⁶ A global humanitarian organisation, *World Disasters Report 2001*, front page inset.

¹⁷ *Discover the ICRC*, 2001, Geneva, p. 11.

¹⁸ *Annual Review 2000*, The International Federation of the Red Cross and Red Crescent Societies, Geneva, 2000, p.2.

¹⁹ L. Graz, 'A question of vulnerability', *Red Cross Red Crescent*, issue 3, (1997), p.7.

²⁰ *Vulnerability and Capacity Assessment, A Federation Guide*, International Federation of Red Cross and Red Crescent Societies, Geneva, 1993, p.3.

²¹ *Discover the ICRC*, p.11.

²² H.Dunant, *A Memory of Solferino*, ICRC, 1986, p.115.

training and emergency preparedness, tracing and family reunification services, and refugee support. It currently relies on the goodwill of approximately 9,000 volunteers and 220 staff members operating throughout New Zealand.²³ It upholds its obligations to disseminate humanitarian law to a diverse range of New Zealand audiences often using the experiences of its overseas delegates such as the Florence Nightingale Medallists, to illustrate its practical application.²⁴ These delegates in turn may fulfil that role during their overseas work, as discussed in Chapters 6 and 7. In 2001, it sent a total of twenty three delegates overseas,²⁵ nine of whom were nurses.²⁶ The New Zealand Red Cross also supports Pacific Red Cross Societies' programmes in Fiji, Vanuatu, Samoa, and the Cook Islands.

In 2001 there were over 180 National Red Cross or Red Crescent Societies with an estimated membership of 100 million members and volunteers throughout the world.²⁷ The fundamental principles of the Red Cross are humanity, impartiality, neutrality, independence, voluntary service, unity and universality. They are a general expression of the ideals of the Movement and guide its humanitarian action in all circumstances and in all places.²⁸ In 1965, these principles were formally adopted by the Red Cross and Red Crescent Movement at the 20th International Conference in Vienna.²⁹ The Geneva Conventions and Additional Protocols reflect in particular the principles of humanity, impartiality and neutrality. These principles apply equally to the people of the Red Cross as well as to its institutions themselves.

The ICRC, the Federation and National Societies are all independent organisations. They meet every two years at the Council of Delegates. They also meet with the

²³ *Red Cross Annual Review 2001*, mobilising the power of humanity, New Zealand Red Cross Society, 2001, p.3.

²⁴ *Red Cross Annual Review 2001*, New Zealand Red Cross p.8.

²⁵ *Red Cross Annual Review 2001*, p.14.

²⁶ Email communication with Greg Clewley, International Programmes Coordinator, New Zealand Red Cross, 17 January 2002.

²⁷ *Discover the ICRC*, p. 8.

²⁸ A. Baccino-Astrada, *Manual on the Rights and Duties of Medical Personnel in Armed Conflicts*, ICRC, Geneva, 1982, p.17.

²⁹ *Discover the ICRC*, p.9.

representatives of the States party to the Geneva Conventions every four years for an International Conference of the Red Cross and Red Crescent Societies.³⁰ This meeting was referred to in Chapter 1 as being the forum where amendments to the Florence Nightingale Medal regulations were adopted. It is important to appreciate that this relationship between a private organisation and States is unique, but not without difficulties, as experienced from time to time with cancellation of International Conferences due to political interference by the States. For example the South African government delegation was expelled in 1986, and in 1991 the Conference was postponed because of the failure to agree on the form of Palestine's participation.³¹

The principles and values of humanitarian law and humanitarianism

Laws of war have been in existence for centuries. Modern laws of war have their origins in medieval Europe as customary rules. They were influenced by the Christian church and medieval notions of chivalry. At the time of the industrial revolution, a time of poverty, overcrowding and disease,³² and new inventions in warfare technology, a spirit of humanitarianism began to pervade Europe. There was less tolerance of the suffering resulting from warfare and poor public health conditions. The latter gave rise to a spirit of "new humanity"³³ which started a multitude of philanthropic and public health activities to improve and protect the population. The former gave rise to humanitarian law as distinct from the laws of war because of the obvious need to protect those not taking a direct part in a conflict.³⁴ Thus the Geneva Conventions codified the existing rules of warfare which had been in operation for centuries, and are based on the notion of humanitarianism. Humanitarianism according to law describes a way of doing things that is impartial, neutral and independent in its action.³⁵

³⁰ *Discover the ICRC*, p.10.

³¹ Y. Sandoz, 'The 26th International Conference of the Red Cross and Red Crescent: myth and reality', *International Review of the Red Cross*, No.305 (March–April 1995), p.133.

³² A. Brainard, *The Evolution of Public Health Nursing*, W.B. Saunders Company, Philadelphia, 1922, p.4.

³³ A. Brainard, *The Evolution of Public Health Nursing*, p.49.

³⁴ G. Kewley, *Humanitarian Law in Armed Conflicts*, Australian Red Cross, 1993, p.2.

³⁵ *World Disaster Report 1997*, International Federation of Red Cross, Red Crescent, Oxford University Press, p.26.

‘Humanitarianism’ may be defined as “a person who seeks to promote human welfare, or advocates or practices humane action”.³⁶ Humanitarianism is about people and addressing human suffering. It is concerned with defending people whose rights and needs are ignored, their voices unheard because of war, or for reasons of poverty or exclusion.³⁷ In Red Cross terms, humanitarian action in conflict situations is in conformity with the principle of humanity, inspired by the desire to assist the victims and mitigate the effects of war. Furthermore, such action should treat victims strictly in accordance with their needs and vulnerability, without racism, or discrimination, and in conformity with the principle of impartiality. The principle of neutrality means that humanitarian action should keep outside the political arena to ensure it remains acceptable to all parties in an armed conflict.³⁸ By extension, it is a non-coercive way of working. Relief activity, however well intentioned or effective, is not humanitarian unless conducted in this way.³⁹

These principles are those of the Red Cross as an organisation. They are embodied in international humanitarian law, the legal instruments, and they are the humane values of the people who work in such situations. In addition, individuals such as medical and nursing humanitarian workers are also guided by their professional ethical codes, both national and international codes which are compatible with humanitarianism. (Nursing codes of ethics are discussed further in Chapter 7).

Despite these ethical guidelines, over the past twenty years the increase in disasters, humanitarian needs, and what has been described as a “vast, unruly humanitarian bazaar”,⁴⁰ of competing agencies from increasingly diverse backgrounds, has challenged humanitarian organisations to adopt more professional approaches and to look at their ethical standards. The aim is to protect and assist victims, to offer assistance, and for

³⁶ *Complete Wordfinder*, Readers Digest, Oxford, 1993, p.727.

³⁷ D.Eade, ‘Development for Survival’, *Red Cross, Red Crescent*, (1995), p.21.

³⁸ Y. Sandoz, *The International Committee of the Red Cross as guardian of international humanitarian law*, ICRC, Geneva, 1998, p.4

³⁹ *World Disasters Report 1997*, International Federation of Red Cross and Red Crescent Societies, Oxford University Press, 1997, p.24.

⁴⁰ M. Ignatieff, *The Warriors Honour, ethnic war and the modern conscience*, Chatto and Windus, London, 1998, p.124.

those in need to have the right to receive it. These are notions reflected in the development of principles which guide the actions of organisations involved in humanitarian action. They are documented in the Code of Conduct for the International Red Cross and Red Crescent Movement and Non-governmental Organisations (NGOs) in Disaster Relief.⁴¹ The fundamental principles of the Red Cross and Red Crescent provide the basis of this humanitarian ethic, in particular the principles of humanity, impartiality and neutrality.⁴² In pragmatic terms, it serves the interests of both the aid worker and their beneficiaries.

Further to this, in 1997 the Sphere Project was launched to set up universal minimum standards in core areas of humanitarian assistance and to enhance the quality of accountability of the humanitarian system in disaster response. The results of several years of inter-agency collaboration resulted in an Humanitarian Charter and Minimum Standards for example, in water supply and sanitation, nutrition, food aid and health services.⁴³ This is based on the core belief that all possible steps should be taken to alleviate human suffering arising out of conflict and calamity, and that those affected by disaster have a right to life with dignity and therefore a right to assistance. The charter is based on the principles and provisions of humanitarian law, refugee law and the Code of Conduct for the International Red Cross and Red Crescent Movement and NGOs in Disaster Relief. This marks a move from the basic needs approach of disaster relief to a rights-based approach in which people affected by disasters from whatever cause have a right to humanitarian assistance.

Despite this increasing professionalism, a more cynical view of humanitarian action has arisen in the 1990s. This has resulted from the changing nature of conflict and the blurring of lines between humanitarian and military action, a consequence of collapsed states and anarchy, particularly prevalent in the post Cold War era.⁴⁴ To some extent, humanitarianism has filled a void and assumed an important role in the 1990s

⁴¹ Code of conduct for International Red Cross and Red Crescent Movement and Non-Governmental Organisations (NGOs) in Disaster Relief, Geneva, 1997.

⁴² P. Perrin, *War and Public Health Handbook*, ICRC, Geneva, 1998, p.427.

⁴³ The Sphere Project, *Humanitarian charter and minimum standards in disaster response*, Geneva, 2000, p.1.

⁴⁴ *World Disaster Report 1997*, p.23.

diplomacy as a response, a supplement to, or a substitute for political ideology of the Cold War. Humanitarianism gained importance as a response to the conflicts resorted to for ethnic or religious identity reasons.⁴⁵ The United Nations fifty-fold increase in Security Council Resolutions attests to this.⁴⁶ In this respect, the media had a particular role in generating humanitarian responses through vivid and instantaneous images on television, which lead to public outcry that “something must be done”⁴⁷ with pressure being put on the United Nations in particular, to act.

Furthermore, indiscriminate use of the term can provide a means for governments to abrogate their responsibilities and exploit humanitarian operations, to avoid making hard political decisions or actions, as they are seen to be taking humanitarian action instead.⁴⁸ For example, governments assisting in the maintenance of refugee camps rather than letting refugees settle permanently in their country, can be politically preferable.⁴⁹ This was seen in 2001, when the Australian government faced with the imminent arrival of refugees on board the ship *Tampa*, made arrangements for them at considerable cost, to be processed in Nauru and Papua New Guinea rather than allowing them to set foot on Australian territory.

The combination of military action or intervention with humanitarian assistance may appear to be a pragmatic solution to situations where relief convoys are impeded or there is a threat of kidnap to workers. However it is fraught with difficulties. Where humanitarian action and United Nations peace keeping operations were combined to provide protection for the latter, the action had to be abandoned in Somalia in 1992, Rwanda in 1994, and Bosnia in 1995.⁵⁰ Nor was military intervention and humanitarian assistance able to prevent ethnic cleansing or massacres it sought to prevent.

⁴⁵ A. Roberts, ‘The role of humanitarian issues in international politics in the 1990s’, *International Review, of the Red Cross*, Vol.81, No.833, (March 1999), p.19.

⁴⁶ *World Disaster Report 1997*, p.23. A. Roberts, ‘The role of humanitarian issues in international politics in the 1990s’, p.25.

⁴⁷ W. Shawcross, *Deliver us from evil, warlords and peacekeepers in a world of endless conflict*, Bloomsbury, London, 2001, p.30.

⁴⁸ W. Shawcross, *Deliver us from evil*, p.9.

⁴⁹ A. Roberts, ‘The role of humanitarian issues’, p.24.

⁵⁰ A. Roberts, ‘The role of humanitarian issues’, p.34.

The ICRC has been reluctant to associate humanitarian activity with military protection and intervention because of jeopardising its neutral status. However, it did resort to the use of armed protection in Somalia in 1992 when it employed 2,600 gunmen to protect its delegates, convoys and warehouses.⁵¹

The use of the term 'humanitarian intervention' further confuses the issue, and when applied to military action it is contradictory.⁵² In its classical meaning, it implies the use of force because something is being imposed. Military intervention in a State means without approval of authorities with the purpose of preventing widespread suffering or death of inhabitants.⁵³ Military personnel whether connected to a nation, the United Nations or regional organisation, are connected to political governance. They cannot therefore be neutral or impartial and thus do not qualify as being humanitarian. This has been highlighted in the 1990s and in 2001, continuing into 2002, by the actions of the United States military in Afghanistan with the use of the term humanitarianism in relation to military intervention. Bombing the country on the one hand, and dropping food parcels of 'humanitarian relief' for the people affected by interruptions of the food aid caused by the bombing, is another source of confusion about humanitarianism.

This discussion is necessary to highlight the context in which humanitarian workers in the civil wars of the 1990s work and have been exposed to greater risks than previously. These are greatest when an international organisation or government carries out political, military and humanitarian actions simultaneously.⁵⁴ A new vulnerability of humanitarian workers has been exposed and the politicisation of humanitarian action is a threat to all workers, and in particular to an apolitical organisation like the Red Cross. The security of humanitarian personnel depends on the combatants' perception of their neutrality, impartiality and independence.⁵⁵ As the combatants of the last decade are no

⁵¹ C. Moorehead, *Dunant's Dream*, p. 685.

⁵² *World Disasters Report 1997*, p. 24.

⁵³ A. Roberts, 'The role of humanitarian issues', p.35.

⁵⁴ T. Gurtner, 'Working Separately Together', *Red Cross News*, Vol. 85, No.1, (February 2000), p.11.

⁵⁵ P Comtesse, 'The new vulnerability of humanitarian workers: what is the proper response?', *International Review of the Red Cross*, No.317, (March-April 1997) p.150.

longer distinguishable from civilians, their leadership is morally erratic, they never learnt the rules of war, and their violence knows no limits,⁵⁶ the likelihood of respect for basic humanitarian values and understanding of the role of humanitarian workers is greatly reduced.

However, by upholding the principles of neutrality, impartiality and independence, the Red Cross has gained access to people in regions in Africa and Asia other more political agencies are excluded from because they have remained true to the traditional spirit of humanitarianism. The Red Cross has been able to obtain access to numerous people suffering in countries such as Liberia, North Korea, Rwanda, and the Caucasus, when access was denied to all agencies with political affiliations, including armed forces.⁵⁷ On the other hand, neutrality and impartiality means that Red Cross can only attend to the effects of conflicts, and is not in a position to begin to address some of the underlying causes. ICRC delegates cannot give evidence in courts about the atrocities they have witnessed, as this would compromise confidentiality and neutrality for their right of access to people.⁵⁸

Humanitarianism is embodied in the Red Cross, humanitarian law and the work of its staff and volunteers. It is exemplified in the stories and the nursing practice of the Florence Nightingale Medal nurses as described in Chapters 6 and 7.

The Geneva Conventions and their development

The Geneva Conventions of 1949, their Additional Protocols of 1977, together with the law of The Hague, make up the body of international humanitarian law. The latter is also referred to as the law of armed conflict, or law of war, particularly by military personnel. It is law which is applicable in situations of armed conflict and defines the limits and means of warfare and the protection of those not part of, or no longer taking part in the hostilities. International humanitarian law forms a major part of public

⁵⁶ J.-L. Chopard, 'Dissemination of the humanitarian rules and cooperation with National Red Cross Societies for the purpose of prevention', *International Review of the Red Cross*, No. 306, (May-June 1995), p.247.

⁵⁷ *World Disaster Report 1997*, p.25.

⁵⁸ A. Roberts, 'The role of humanitarian issues', p.36.

international law which also includes amongst others; human rights law, law of the sea, and environmental law.⁵⁹ The guiding principles of humanitarian law seek to preserve a measure of humanity in war by defining limits on how warfare is conducted and on the behaviour of combatants.⁶⁰

Prior to the development and adoption of international humanitarian law as it is known today, the first laws of war can be traced back several millennia to ancient texts such as the Mahabharata, the Bible and Koran, which contain rules advocating respect for the adversary. The First Geneva Convention therefore codified and strengthened ancient, fragmentary and scattered laws protecting the wounded and those caring for them.⁶¹ Public conscience had defined the limits of war, but they have only been laid down in public treaties in the late nineteenth century.

The first Geneva Convention was being drawn up in the 1860s at the same time as the New Zealand Wars and the American Civil War were being fought.⁶² Maori chiefs fighting the British near Tauranga at Gate Pa drew up a code of regulations for the conduct of fighting. This document was found in the trenches later at Te Ranga and had set out that “barbarous customs should not be practised, the wounded should be spared, and the dead not mutilated; also that non-combatants or unarmed persons should not be harmed”.⁶³

The battle of Gate Pa is also significant for the humanitarian behaviour of Heni Pore⁶⁴ (married to Te Arawa chief, Te Kiri-karamu) who was described as a “blend of Amazon and *vivandiere*, was as compassionate as she was brave”.⁶⁵ She was the only woman

⁵⁹ *International humanitarian law, Answers to your questions*, ICRC, 1998, p.5.

⁶⁰ *Discover the ICRC*, p.2.

⁶¹ *International humanitarian law, Answers*, p.9.

⁶² K. Keith, ‘Significance of the Hague Peace Conferences in the Asia Pacific Region: the South Pacific, including New Zealand’. Paper presented at the Commemoration of the Centenary of the 1899 Hague Peace Conference and the 50th Anniversary of the 1949 Geneva Conventions. Asia Pacific Conference, University of Melbourne 18-20 February, 1999, p.1.

⁶³ J.Cowan, *The New Zealand Wars, A history of the Maori campaigns and the pioneering period*, volume I, 1845-1864, Government Printer, Wellington, 1983, p.422.

⁶⁴ ‘Heni, Henare, and Henry- towards Humanitarian Principles’, *Red Cross News*, No.4, (1989), p. 14.

⁶⁵ J. Cowan, *The New Zealand Wars*, p.431.

permitted to remain with the men, fighting beside her brother, as she was recognised as a “fighting-woman”.⁶⁶ Under fire, and in full view of the foe, she took water to Colonel Booth and other wounded soldiers in response to their distressed cries, out of a sense of ‘pity’, and according to the rules that had been made “that if any person asked for any service to be performed, the request must not be refused”.⁶⁷ These examples underscore the universality of humanitarian principles, expressed by people in New Zealand at the same time as being formalised in Geneva. While the rules may have contained a religious underpinning, they arise from deeper human values.⁶⁸

Since 1864, the International Conferences of the Red Cross, Red Crescent (held every four years) have extended and developed humanitarian law as the nature of war and technology have changed. The laws tend to be retrospective rather than prospective. The Second Geneva Convention signed in 1906, covered wounded and shipwrecked sailors.

The Third Geneva Convention of 1929 gave protection to prisoners of war in particular, setting down rules by which they should be treated humanely. After World War II, the new horrors of genocide of Jews, mass aerial bombardment of cities, and an increase in civilian war casualties to over 50% saw the need for further changes to the law. Revision of the first three Conventions and the adoption of the Fourth Geneva Convention occurred on the 12 August 1949.⁶⁹ Article 3, common to all the Conventions, extended their scope to civil wars and other non-international conflicts and set out minimum provisions to be applied. Most importantly it gave the International Committee of the Red Cross the right of initiative to offer its services to all parties to a conflict.⁷⁰

By December 2001, 189⁷¹ States had become signatories to the four Geneva Conventions. The Conventions represent almost universal accepted minimum standards

⁶⁶ J. Cowan, *The New Zealand Wars*, p. 425.

⁶⁷ J. Cowan, p.431.

⁶⁸ K. Keith, ‘Significance of the Hague Peace Conferences’, p.2.

⁶⁹ G.Kewley, *Humanitarian law in armed conflict*, p.12.

⁷⁰ *International humanitarian law, Answers*, p.21.

⁷¹ Email communication from Greg Clewley, New Zealand Red Cross on 17 January 2002.

of rules of war and are written into the domestic and military law of the countries that are signatories.⁷²

Protocols Additional to the Geneva Conventions

With an increase in internal conflicts and guerrilla warfare during the 1970s, and an accompanying increase in civilian casualties, two Additional Protocols were added to the Conventions in 1977 to take account of this changing environment.

The Protocols extended and enhanced the provisions of the Conventions. Protocol I, in particular strengthened the protection of victims of international armed conflict.⁷³ Protocol II strengthened the protection of victims of non-international, or internal conflicts.⁷⁴

The United States of America has not ratified the Additional Protocols because of its concern that the ICRC's presence gives legitimacy to the insurgents of internal wars at the expense of sovereign states.⁷⁵ However, this does not mean that countries will not honour the principles and spirit which is embodied in the law. The Gulf War of 1991 is an example of a conflict in which all sides paid attention to the laws of war and gives evidence of the compatibility of humanitarian law with military effectiveness.⁷⁶ However, it could be argued that the ongoing suffering of Iraqis and the so called 'collateral damage' have been deliberately minimised in the language of the media and political rhetoric, especially in relation to the non-coalition casualties and the effects of the ensuing economic sanctions against Iraq.⁷⁷ So despite fighting by the rules, both

⁷² *International humanitarian law, Answers*, p.14

⁷³ *Discover the ICRC*, p.16.

⁷⁴ *Discover the ICRC*, p.16.

⁷⁵ M. Inatoeff, 'The Warriors Honour', p.128. C. Moorehead, *Dunant's Dream*, p.636.

⁷⁶ A. Roberts, 'The role of humanitarian issues', p.20. M. Ignatieff, *The Warriors Honour*, p.125.

⁷⁷ J.S. Boyle, S.M. Bunting, 'Horsemen of the Apocalypse: Lessons from the Gulf War', *Advances in Nursing Science*, Vol. 21, No.2, (1998), p.32. J. Hall, P. Stevens, 'A Nursing View of the United States-Iraq War: Psychosocial Health Consequences', *Nursing Outlook*, Vol. 40, No.3, (May/June 1992), p.115.

military and humanitarian, there is still considerable suffering and it continues long after the fighting has subsided.

While there is a close historical link between the Red Cross Movement and international humanitarian law, the Red Cross is a private, independent and neutral humanitarian organisation, but not a non-governmental organisation. It is the States and their governments which are responsible for humanitarian law and its application.⁷⁸ It is the responsibility of these parties to the Geneva Conventions and Protocols to inform their citizens about the provisions of international humanitarian law. Ratification carries with it the obligation to disseminate knowledge as widely as possible in times of peace as in times of armed conflict.⁷⁹ As a Party to these laws and its own domestic law, the New Zealand government through the Geneva Conventions Act, 1958 and the Geneva Conventions Amendment Act, 1987, has a responsibility to include the study of the Conventions and Protocols in military instruction and to encourage the civilian population to be fully acquainted with them.⁸⁰

In December 2001, 159 countries had ratified Protocol I, and 151, Protocol II.⁸¹ The New Zealand government signed the Protocols in 1987.⁸² New Zealand Nurses engaged in international humanitarian work therefore need to know their rights and duties with respect to humanitarian law.

The Geneva Conventions and their relevance to nursing

Nurses have always made up the largest part of the International Red Cross active health and rescue forces. They are in direct contact with victims, prisoners, the wounded, the sick and the displaced.⁸³

⁷⁸ A. Baccino-Astrada, *Manual of Rights and Duties of Medical Personnel in Armed Conflicts*, ICRC, Geneva, 1982, p. 17.

⁷⁹ A. Baccino-Astrada, p.11.

⁸⁰ *Basic Rules of the Geneva Conventions and their Additional Protocols*, 1983, edited by the ICRC, p.12.

⁸¹ Email correspondence from Greg Clewley, New Zealand Red Cross, 17 January 2002.

⁸² Geneva Conventions Amendment, No. 144, An Act to amend the Geneva Conventions Act 1958, 10 July 1987.

⁸³ C. Sommaruga, 'News', *International Nursing Review*, Vol. 46, No. 2, (1999), p.37

The past President of the International Committee of the Red Cross, Cornelio Sommaruga, made this statement to the ICN in recognition that large numbers of nurses were involved in international humanitarian assistance. The environment in which this occurs is both war and peace, disasters and development, and these are the contexts in which the Florence Nightingale Medal nurses have worked.

The International Council of Nurses, as the largest international nursing organisation has reaffirmed its support of the Geneva Conventions of 1949 and the Additional Protocols, in particular the protection and care of those no longer taking an active part in hostilities so that they shall be treated humanely.⁸⁴ The ICN has also worked closely with the International Federation of the Red Cross to create a teaching module on the Geneva Conventions and ethical dilemmas for nurses.⁸⁵ This resource, which was developed in 1984 has not been revised and updated, according to enquiries I made to the ICN and the ICRC.⁸⁶

As noted previously, the New Zealand government, as a party to these laws and its own domestic law, has a responsibility to include the study of the Conventions and Protocols in military instruction and to encourage the civilian population to be fully acquainted with them.⁸⁷ Part of this responsibility is delegated to the New Zealand Defence Forces for whom humanitarian law has a particular practical application and relevance. In the case of the civilian population, it may delegate this responsibility to an organisation such as the New Zealand Red Cross Society which has taken up the challenge with alacrity particularly in the past year. At present in New Zealand, international humanitarian law dissemination is largely confined to military learning, academic courses such as international law, and to Red Cross personnel, in particular the overseas delegates such as nurses and some interested members of the public.

⁸⁴ 'Nurses, Caring and Torture', ICN Statement presented at the Commission on Human Rights, 54th Session, 3 April, 1998, p.9.

⁸⁵ M. Styles, 'International nursing on the threshold of the third millennium', *Profession: Nurse, (Images 1900-1930)* Museum International of the Red Cross and Red Crescent, Geneva 1995, p.123.

⁸⁶ 'The Nurse, the Geneva Conventions and Human Rights', The League of Red Cross and Red Crescent Societies, International Council of Nurses, 1984.

⁸⁷ *Basic Rules of the Geneva Conventions and Additional Protocols*, p. 12

New Zealand nurses in general are not currently taught about international humanitarian law in a formal educational context and may only learn about it through a returned Red Cross nurse delegate, or a member of the New Zealand Red Cross Society. This represents an omission in nursing education, especially when the ICN reiterates its concern to national nurses associations to take measures to ensure that members understand what is expected of them in conflict situations.⁸⁸

Viewed from an international perspective, there are both international legal and practical imperatives for all nurses to be informed about the Conventions and Protocols because they may become involved in conflicts in a variety of ways. Their country may be at war with another state or states, it may be occupied by a foreign power, or it may be embroiled in a civil war.⁸⁹ In New Zealand these scenarios are highly unlikely. It is more likely that New Zealand civilian nurses would be seconded through the ICRC to work in war zones, or military nurses could be part of a multinational peace keeping force deployed with the United Nations, such as in East Timor. The Pacific region, in which New Zealand is a key player both in terms of development and humanitarian assistance was once regarded as peaceful, but has now seen conflict over recent years in Papua New Guinea (Bougainville), Fiji, and the Solomon Islands, and has become involved in these conflicts in a number of political, military and humanitarian ways. The recent events in Afghanistan, the continuing violence in the Middle East and other areas, have made global security and stability less predictable and more precarious and an understanding of the basics of humanitarian law even more important.

Rights and duties of medical personnel

In the Geneva Conventions and Protocols, the definition of medical personnel includes all persons assigned to medical purposes or units, administration and medical transports on a permanent or temporary basis. They can be military or civilian, but civilian

⁸⁸ 'The Nurse, the Geneva Conventions and Human Rights', *International Nursing Review*, Vol. 39, No. 2, 1992, p.61

⁸⁹ Y. Sandoz, 'Protection and Nurses', *International Review of the Red Cross*, (1977). p. 299.

personnel are not afforded special protection under humanitarian law relating to medical personnel unless they are assigned to assist specifically for the party to the conflict.⁹⁰

To be assigned rights carries responsibilities, privileges and protection. Medical personnel can be assigned to a party to the conflict by a non-party or to a Red Cross Society or the ICRC.⁹¹ The duties of nurses are related to the rights of the wounded and sick under their care, who may be either military or civilian. These people's rights and the consequent nurses' duties towards them are, respect (the right not to be harmed), protection (the right to receive assistance), and humane treatment (the right to receive the best medical care which their condition requires). These rights are inalienable and care should be given to protected persons irrespective of religion, race or any other category. Medical reasons alone are the only criteria for priority in treatment and care.⁹²

Furthermore, any kind of reprisal against the sick, wounded or prisoners is prohibited. Nurses must not be involved in acts of violence against people in their care and should oppose such acts.⁹³ Increasingly, the International Council of Nurses is articulating the principles embodied in humanitarian law in position statements. For example, in 1998 a statement by the ICN entitled, *Nurses, Caring and Torture*⁹⁴ drew attention to the global violation of human rights and the professional and ethical role of nurses in providing care to victims of torture. Further to this, the statement expressed concern that health professionals are often themselves imprisoned, tortured and detained for assisting those in need.⁹⁵

Protection in the Geneva Conventions has been enhanced in the Additional Protocols (1977) to provide for fundamental guarantees applicable in armed conflict to all people who do not enjoy wider protection.⁹⁶ For example, they include the prohibition of

⁹⁰ *Basic Rules*, p.18.

⁹¹ A. Baccino-Astrada, *Manual on the Rights and Duties*, p.28.

⁹² Y. Sandoz, 'Protection and Nurses', p.300.

⁹³ Y. Sandoz, 'Protection and Nurses', p.300.

⁹⁴ 'Nurses, Caring and Torture', ICN Statement, 3 April, 1998, p.3.

⁹⁵ 'Nurses Caring and Torture', ICN Statement, p.3.

⁹⁶ Y.Sandoz, 'Protection', p.300.

endangering the physical or mental health of persons, including ‘outrages’ upon personal dignity and enforced prostitution (rape is implied) and of performing any medical act which might harm the patient. Women and children are the object of special respect.⁹⁷

Protocol II, Article 14, prohibits starvation of civilians as a method of combat. It is also prohibited to attack or destroy objects indispensable for survival of the civilian population and production of foodstuffs and water.⁹⁸

Protection to health care workers is contained in the Geneva Conventions and Protocol I Article 16, and Protocol II, Article 10 which state that medical personnel shall be able to carry out medical activities compatible with medical ethics (nursing ethics) and they shall not be compelled to carry out acts contrary to rules of ethics.⁹⁹ They cannot consent to perform tasks unrelated to their duties, such as spying, or they will lose their rights.¹⁰⁰ This also includes not being compelled to give out information concerning the sick or wounded under their care, if such information would prove harmful to the patient or their families. Regulations for compulsory notification of communicable diseases are still respected in this Article. In this respect national law is not overridden.¹⁰¹

The rights of medical personnel are connected with the obligation of States to organise relief. However, if this is beyond their resources they can ask the Red Cross to play an auxiliary role, or seek its international assistance.¹⁰²

Rights conferred on medical personnel may not be renounced (Conventions I-III, Article 7, IV, Article 8). This is to ensure they are completely protected but it also serves to

⁹⁷ *Basic Rules*, p.42.

⁹⁸ Protocols Additional to the Geneva Conventions of 12 August 1949, ICRC, Geneva, 1977, p.97.

⁹⁹ *Basic Rules*, p.54.

¹⁰⁰ Y.Sandoz, ‘Protection’, p.302.

¹⁰¹ Protocols Additional, p.15.

¹⁰² A. Baccino-Astrada, *Manual of Rights*, p.29.

protect the patient from claims that they gave consent to justify a breach.¹⁰³ The rights of nurses are attached to their humanitarian function, and not to their person. Medical and nursing personnel have as much right to respect and protection as the wounded and sick, but they must be recognisable by the distinctive red cross emblem and carry an identification card.¹⁰⁴

When captured, medical personnel may not be detained. They may only be retained if their services are required to tend prisoners of war of their own party and cannot be compelled to carry out other work. They must be released when no longer required. These restrictions are for the benefit of the sick. Similarly, requisition by the occupying power of a civilian hospital is not absolutely forbidden as long as the welfare of the existing sick and wounded has been attended to first.¹⁰⁵

The contribution of nurses and other health workers towards the care and health of victims of armed conflict goes beyond their professional skills and is protective. Their mere presence also helps to promote the safety of the victims who might otherwise be subjected to acts contrary to international humanitarian law such as abduction, forced displacement and rape. On the other hand, their presence may be used to project a positive picture of authorities to the world at large.¹⁰⁶

Humanitarian law and human rights

It is important to place international humanitarian law in an international legal context. After World War II, two international legal treaties were adopted which symbolised the moral aspirations of the international community.¹⁰⁷ In 1948, one year before the four Geneva Conventions, the Universal Declaration of Human Rights was adopted. Human rights and humanitarian law were regarded as separate fields of law, but they are

¹⁰³ A. Baccino-Astrada, p.67.

¹⁰⁴ Y. Sandoz, 'Protection', p. 302.

¹⁰⁵ *Basic Rules*, p. 16.

¹⁰⁶ P.Perrin, *War and Public Health Handbook*, p.392.

¹⁰⁷ D. Forsythe, '1949 and 1999: Making the Geneva Conventions relevant after the Cold War', *International Review of the Red Cross*, Vol. 81, No. 834, (1999), p.265.

complementary as they both seek to restrict the power of state authorities and protect the fundamental rights of the individual, although they do so in different circumstances and in different ways.¹⁰⁸

Human rights law is primarily concerned with relations between States and their nationals in peacetime, whereas humanitarian law protects the rights of the individual though established basic rules for humanitarian behaviour in war.¹⁰⁹ Human rights must be applied and respected in all circumstances, although some rights may be suspended in time of emergency. For example, in June 1999 a state of emergency was declared in Honiara on Guadalcanal in the Solomon Islands.¹¹⁰ But international humanitarian law may not be abrogated under any circumstances. In internal armed conflict, international humanitarian law and human rights law apply concurrently.¹¹¹

Adoption of the United Nations Charter in 1945 confirmed that war should be outlawed. However, it upholds the right for individual or collective self defence. In contrast, international humanitarian law does not consider the rights or wrongs of war or denunciation of guilty parties. Its prime concern is for the humanitarian concerns of victims.¹¹²

The value of the fundamental principles of the Red Cross goes beyond their original scope and significance. Humanity in war, compassion and respect for human dignity, and non-discrimination, can, and must also be adopted as basic values in peace time, if there is to be any real impact on the reduction of suffering and prevention of the violations of war.

While the Red Cross is not a peace brokering or promoting organisation as is, for example, the United Nations, humanitarian law contributes to the restoration of peace

¹⁰⁸ *International humanitarian law: Answers to your questions*, p.40.

¹⁰⁹ D. Forsythe, '1949 and 1999: Making the Geneva Conventions relevant after the Cold War', p.265.

¹¹⁰ Regional Survey of the world. *The Far East and Australasia 2001*, 32nd edition, Europa Products, London, p.994.

¹¹¹ H-P. Gasser, 'International humanitarian law and the protection of war victims', ICRC, Geneva, 1999, p.4.

¹¹² H-P Gasser, 'International humanitarian law', p.1

by helping to maintain an “humanitarian oasis”¹¹³ during conflict and to protect the rights of individuals.

War as a health issue

Over the past century, three significant events have made dramatic changes to the landscape of war and politics. The first was World War I, the second was the end of colonialism after World War II, and the third was the fall of the Berlin Wall with the implosion of the Soviet Union.¹¹⁴ This latter event signalled the end of an ideology which held alliances together for strategic purposes. Hopes of peace in a new world order at the beginning of the 1990s were soon shattered with the fragmentation of states, as nations tore themselves apart for ethnic, identity, religious or cultural reasons.¹¹⁵ Globalisation has contributed to the problem by widening the gap between social groups and levels of development within countries and between nations.

What is most disturbing is not so much the number of conflicts as the form they take, arising as they do from all manner of irreconcilable claims, obsessions with nationalism and ethnic identity, and an upsurge towards all types of fundamentalism....This increasing political instability is exacerbated by economic and social problems which create a fertile breeding ground for illegal activities in the guise of organised crime....Without any doubt, the extreme poverty which is currently affecting whole segments of humanity and which is increasingly associated with environmental devastation is the greatest challenge facing the world at the end of the second millennium.¹¹⁶

This was said in 1998 by the then president of the ICRC, in recognition of the complexities of the current situation and as a representative of the world's largest humanitarian organisation which has had to deal with much of the humanitarian

¹¹³ P. Perrin, p.386.

¹¹⁴ W. Shawcross, *Deliver us from evil*, p.27.

¹¹⁵ J. de Corten, 'The new humanitarian challenges', Keynote address to the Heads of Military Training, Geneva, 14-17 October, 1997, p. 1

¹¹⁶ C. Sommaruga, Message from the President, *Key Facts and Figures*, ICRC, 1998, pp.2-3.

suffering. The relationship between the development levels of a country and the numbers of people killed or affected by disasters are seen in the statistics. It is estimated that over the past decade, of the 2.3 million people reported as killed by conflict from 1991-2000, over three-quarters were from nations of low human development. Of the 665,600 reported killed by natural disasters over the same time, two-thirds were from low human development nations. Of the 86,923 deaths reported from technological disasters, 64% were in nations of medium human development.¹¹⁷

While conflict was responsible for the majority of deaths between 1991-2000, natural disasters reportedly affected on average 211 million people per year, seven times the average of the more than 31 million people annually affected by conflict. In total, an average of 242 million people a year are killed and affected by disasters and conflicts. The total killed and affected by natural disasters is higher than the total killed and affected by conflict.¹¹⁸

As a comparison, in World War I it was estimated that 20 million were wounded and 13 million had died over a period of four years affecting 28 countries.¹¹⁹ World War II had an estimated 50-60 million killed, 25 million in the Soviet Union alone, although the figure may have been higher. Six million Jews were murdered in the Holocaust.¹²⁰

Civilian casualties have increased over the century. In the First World War, 15% of the casualties were civilians. This was increased to 65% in World War II, and today is it estimated to be 90%.¹²¹

Statistics only give a quantitative picture. War affects people profoundly on every level and has catastrophic effects on human health especially for women, children, and the

¹¹⁷ *World Disasters Report 2001*, p.165.

¹¹⁸ *World Disasters Report 2001*, p.165.

¹¹⁹ C. Moorehead, *Dunants' Dream*, p.256.

¹²⁰ C. Moorehead, p.496.

¹²¹ G. Reid, 'An Insult to Humanity', *Red Cross Red Crescent*, (January-April 1991), p. A2.

elderly.¹²² It does not only affect people through death, injury, hunger, disease and psychological trauma. The damage is widespread to all sectors where infrastructure and services, such as health and education, break down. In the long term, the socio-economic destabilization due to war cancels out the development efforts of the previous twenty years,¹²³ and development is not possible under conditions of unrest or political instability.

For many people in developing countries, daily survival is already a challenge in peaceful conditions. In war, this is magnified and with it goes the concomitant lack of security and political instability which makes the quest for meeting basic survival needs more complicated and precarious. This may be used as a strategy to exert pressure on civilian populations for political aims, or to cause them to flee to other parts of the country or across international borders, creating displaced or refugee populations. Increasingly there are 'environmental refugees, estimated to be about 25 million at the end of the 1990s.¹²⁴

From a health perspective and therefore a nursing concern, war not only causes injuries and sickness, but deterioration in living conditions and disrupted socio-economic and cultural life. It inflicts populations with poverty and causes death in the most vulnerable people.¹²⁵ The consequences such as polluted water, food shortages, environmental damage, disease, injuries and death from land mines, and deprivations of economic sanctions, all continue for many years.

Landmines, for example, not only cause death and mutilation, they make entire areas inaccessible for agriculture and livelihood for decades. This in turn can cause poverty and famine.¹²⁶ In Poland between the end of World War II and the mid-1970s, some

¹²² J. Boyle, S. Bunting, 'Horsemen of the Apocalypse: Lessons from the Gulf War', *Advances in Nursing Science*, Vol. 21, No. 2, (1998), p. 33.

¹²³ P. Perrin, *Handbook on War and Public Health*, p. 338.

¹²⁴ *World Disasters Report 2001*, p.11.

¹²⁵ R. Russbach, 'Health Protection in armed conflict', *International Review of the Red Cross*, No. 284, (September 1991) p.468.

¹²⁶ *Landmines: time for action*, International humanitarian law, ICRC, 1994, p. 4.

4,000 civilian deaths and 9,000 injuries were attributed to mines.¹²⁷ Cambodia is said to have the worst record of any country in relation to landmines and their effects on the population. It has a ratio of one amputee to every 236 members of the population, based on an estimate of 36,000 amputees and a population of 8.5 million people.¹²⁸ Several of the Florence Nightingale medallists who worked in ICRC surgical hospitals treated landmine victims, in particular Cambodians, Afghans and Vietnamese. Their experiences are outlined in Chapters 6 and 7.

Radical change and dislocation occurs in the social structure of families, which is particularly difficult in many societies. For example, women bear the burden of being the only bread winner and source of unity for the family.¹²⁹ Sexual violation is one of the most serious violations encountered in wartime, and a violation of humanitarian law. Stories of the 'comfort women' from World War II such as the moving account in "50 years of Silence"¹³⁰ are now emerging. In recent times, rape has been used as a systematic weapon to terrorise, humiliate or destroy communities.¹³¹ There are ongoing psychological effects from rape and sexual abuse, especially for women and children. There is also the problem of how to integrate disaffected former combatants, how to regain trust, especially in small communities where people see the perpetrators daily and are continuously reminded of the violence, death and depravation. In countries such as South Africa, Truth Commissions have been introduced to assist the healing. On Bougainville, Papua New Guinea, trauma counselling and vocational training have helped heal the community.

There are financial costs of war in terms of death, injury, damage and disruption to life. More specifically vast amounts are devoted to war that could have improved health and education. For example, the Gulf War is estimated to have cost US\$ 1 billion a day. The

¹²⁷ *Landmines: time for action*, p.6.

¹²⁸ *Landmines: time for action*, p.16.

¹²⁹ *Civilians in war*, XXVI International Conference of the Red Cross Red Crescent, Geneva, 1995, p. 6.

¹³⁰ J. Ruff-O'Herne, *50 Years of Silence*, Imprint, Sydney, 1997.

¹³¹ *Civilians in war*, p.6.

cost of ten days of war could have immunized all the children of the Third World against vaccine preventable diseases over ten years.¹³²

As well as dealing with the results of war, Boyle and Bunting believe that nurses can play an important role in prevention of war by influencing policies, nationally and internationally.¹³³ At community level they can be role models as peacemakers, and peace educators in the family. At work they can use non-violent conflict resolution. At a professional level, nursing should discuss, educate and share information about international efforts to protect human rights and, as previously suggested, expose the language and euphemisms used as justification for war.¹³⁴ This is also articulated by WHO in its concept of 'Health as a Bridge for Peace'¹³⁵ with the explicit notion that health workers are in a unique position to understand the need for, and contribute to peace building. These concepts could be discussed alongside humanitarian law and humanitarian nursing practice, and are addressed further in Chapter 7.

This section has focussed primarily on war as a health issue because most of the Florence Nightingale Medallists between 1969 and 1999 worked with the ICRC and people affected by war. However, in general and at a macro level, disasters result from a number of catastrophes, war being just one of them. Others factors can be climate change, poorly planned development, structural poverty, and uneven globalisation of economies and opportunities.¹³⁶ These factors all make earthquakes, floods, famine, cyclones and other disasters worse for vulnerable people and impact on their health.

With conflicts expanding and increasingly affecting civilians, public health and environmental problems (such as polluted water, epidemics, and especially resistant strains of tuberculosis and malaria), there is a shift in emphasis of the ICRC's medical

¹³² The State of Human Development, *Human Development Report 1991*, UNDP, New York, 1991, p. 22.

¹³³ J.Boyle, S.Bunting, 'Horsemen of the Apocalypse', p.37

¹³⁴ J.Boyle, S.Bunting, 'Horsemen', p. 37.

¹³⁵ 'Conflict and Health', Working paper, presented at the international seminar, Preventing Violent Conflict – The Search for Political Will, Strategies and effective Tools, Krusenbergl, 19-20 July 2000, p.2. Document 20/06/00, <http://www.who.org>.

¹³⁶ *World Disasters Report 2001*, p.29.

work to these areas.¹³⁷ This section has given a broad overview of the effects of war on health. More details on the nursing care required in such situations are outlined in the chapters on the Florence Nightingale Medallists' nursing practice, Chapters 6 and 7.

The following chapter positions humanitarian nursing within the international arena and outlines the historical development and evolution of international nursing from the contributions of Florence Nightingale, Henry Dunant and New Zealand Nurses over the years.

¹³⁷ C. Moorehead, 'The new humanitarian worker', *Red Cross Red Crescent*, issue 4, (2001), p.7.

CHAPTER 3

INTERNATIONAL NURSING

The New Zealand Florence Nightingale Medal recipients have contributed to international nursing in a distinctive way, and represent one aspect of it. This chapter traces the history of international nursing from its modern day beginnings in the late nineteenth century, discusses New Zealand nurses and their contribution to international nursing and how Red Cross or humanitarian nursing fits into its broad concept.

Historical development

Several military events occurred in the late 1850s which link Florence Nightingale, the Red Cross, nursing education and international nursing. The first was the improvements of firearms in the 1840s. New weapons were acquired by European countries in the 1850s and were first demonstrated in the Crimean war in 1854. The resulting slaughter was denounced and condemned by the British public and Florence Nightingale was dispatched to Scutari to become the “General Superintendent of the Female Nursing Establishment of the Military Hospitals of the Army”.¹ In 1860, several years after her return to Britain, she opened a training school for nurses at St Thomas’s Hospital in London. This contributed significantly to the birth of the professionalisation of nursing which endures today.

Around the same time another military disaster was to have profound implications for nursing. This was the Battle of Solferino in Italy, June 1859, which was witnessed by Henry Dunant and led to the development of the Red Cross.²

Although Florence Nightingale and Henri Dunant were said never to have met, their achievements have changed the lives of nurses and the nature of nursing. Dunant paid

¹ J.Guillermand, ‘Historical Background’, *Profession: Nurse, (Images 1900-1930)*, p.75.

² J.Guillermand, ‘Historical Background’, p.77.

homage to Nightingale in a lecture in London in 1872³ which was reported in The Times on 7 August that year. In it he declared,

That although I am known as the founder of the Red Cross, it is to an English Woman that all the honour of the convention⁴ is due. What inspired me to go to Italy was the work of Miss Nightingale in the Crimea.⁵

Nightingale was said to be involved in the drawing up of the recommendations taken by the British to the International Congress in Geneva, where in 1864 the Red Cross was launched.⁶

From Dunant's ideas of voluntary relief societies (Red Cross) and trained volunteers, the Red Cross has been involved in nurse training and international nursing from the 1860s. Wars in Europe and America over this time provided a catalyst, demonstrating the need for the training of nurses and volunteers. The newly created Red Cross Societies were able to respond. In Germany, for example, the Baden Women's Association provided its members with basic nursing instruction. In 1866, it affiliated with the German Red Cross to provide competent volunteers to serve in field hospitals near the closing battles of the Austro-Prussian War.⁷ Nursing Schools were established by the Swiss Red Cross in Berne in 1899, in France in 1896, Russia, in 1906, Italy 1908, and Japan in 1891. In the First World War, a combination of civilian and military nurses, and other volunteers from a number of Red Cross Societies, were part of the massive mobilisation to assist in the care of the wounded.⁸

When the League of Red Cross Societies was formally established as a federation of National Red Cross Societies after a medical conference held in Cannes in 1919, it was

³ S.Bruschweiler, Annex II, Florence Nightingale, *Profession: Nurse, (Images 1900-1930)*, p.172.

⁴ Note, this refers to the first Geneva Convention, 1864.

⁵ Cited by A. Lloyd Still, The Florence Nightingale Foundation, March 1934, p. 51. New Zealand Red Cross Archive K13-1/3.

⁶ A. Lloyd Still, The Florence Nightingale Foundation p.51.

⁷ J Guillermand, 'Historical Background', p.78.

⁸ J. Guillermand, p.87.

with the purpose of extending its humanitarian activities during peacetime. In this post war period of devastation and deplorable health conditions, it formed a Bureau of Public Health with a Nursing Division, headed by a graduate nurse⁹ and assumed an international coordinating role. Resolutions adopted at the Cannes conference laid the foundations for the League's commitment to furthering the education of nurses and public health.¹⁰ A concern about professional standards was manifested in its desire to establish Red Cross nursing courses in each country.¹¹

International courses

Of particular significance were the international nursing courses. In 1920 it undertook to prepare nurses to organise and carry out public health nursing by establishing an international public health course in conjunction with the United Kingdom College of Nursing, initially at King's College, University of London, and then transferred to the Bedford College for Women in 1921.¹² It offered free scholarships to Red Cross Societies.¹³ Other students paid for themselves or acquired scholarships. Two international post graduate courses were launched in London, one in 1920 for public health training, and one in 1924, to prepare nursing directors and tutors.¹⁴

It is in relation to these courses that the legacies of Florence Nightingale and Henri Dunant once again intersect. Florence Nightingale provided the inspiration, Red Cross the tangible means. In time, assistance and involvement was sought from the Florence Nightingale International Foundation and the ICN. The atmosphere of social change which had taken place in the late nineteenth century when organised nursing had swept across Europe and America, was also instrumental in providing the necessary context.

⁹ L.R. Seymer, *A General History of Nursing*, 4th edition, Faber and Faber, London, 1956, p.111.

¹⁰ L.R. Seymer, *A General History of Nursing*, p. 110.

¹¹ S. Quinn, *The Lamp Still Burns*, a short history of the Florence Nightingale Foundation, London, 1996. p. 5.

¹² L.R. Seymer, *A General History*, p.283.

¹³ I. Kalnins, 'Sowing the seeds of public health nursing – 1920-39', *International Nursing Review*, Vol. 46, No. 2, (1999), p.48.

¹⁴ I. Kalnins, 'Sowing the Seeds', p. 49. L.R. Seymer, p.284.

Ethel Bedford Fenwick, one of the founders of the ICN (in 1900), had proposed the establishment a Foundation as a memorial to Florence Nightingale in 1912, within two years after her death. It was to be a living memorial and not a museum. An endowed foundation for post graduate nursing education was suggested.¹⁵ The matter was not pursued because of the war. At a meeting of the ICN in 1929, it was raised again. In June 1932, the inaugural meeting of the Florence Nightingale Memorial Committee of Great Britain took the first step to establish a permanent memorial.¹⁶

It became evident in 1930 that the League could not continue to carry the burden of funding and managing the international courses because of budgetary constraints, an outcome of the depression. They would have to be closed in 1932 unless funding from outside sources could be secured.

Through fortuitous timing in 1931, the ICN adopted a resolution to establish the Florence Nightingale Foundation in London. From this resolution and an informal suggestion, it was decided that the League courses could provide the basis on which to build the proposed memorial to Florence Nightingale and the continuation of the international courses as the Florence Nightingale International Courses.¹⁷ An interim arrangement from 1932 to 1933 pending the formal introduction of the constitution of the International Florence Nightingale Foundation, allowed for the Foundation to be governed by a Grand Council comprising the representatives of the ICN, League, and delegates from countries participating in the scheme. Florence Nightingale Committees were to be formed through joint initiatives of national Red Cross Societies and national nurses associations which would assist in maintaining the financial future of the Foundation.¹⁸ The League relinquished its full responsibilities for the courses in 1933, but continued to be represented on the interim committee and the governing body. In

¹⁵ 'To commemorate Florence Nightingale, Towards a Florence Nightingale International Foundation', dated October 1932, p. 331, the Florence Nightingale International Foundation, NZRC archive document K13-1/3, S. Quinn, *The Lamp Still Burns*, p.4.

¹⁶ 'To commemorate Florence Nightingale, Towards a Florence Nightingale International Foundation', p.331.

¹⁷ 'To Commemorate Florence Nightingale', p 333. S.Quinn, *The Lamp*, p.5.

¹⁸ 'To commemorate Florence Nightingale', p.334.

1934, the Florence Nightingale International Foundation became an autonomous organisation under British law with its own governing body.¹⁹

From its original purpose of developing public health nurses, the international courses ultimately evolved into preparation for positions of leadership, particularly for nurse administrators and teachers.²⁰ Nurses who graduated from the course were known as 'Old Internationals' and an alumni society was founded in 1925.²¹ These nurses were testimony to the value of the course's aim of advancing nursing education, seen in the "powers of leadership"²² that they had developed on the course, and demonstrated in the work in their own countries, the characteristics of the "trained mind".²³ Old Internationals held leading posts in their own countries and proved what "an immense contribution able women backed by such training could make".²⁴ Those concerned in a university education, and those concerned with humanitarian work, were brought together with the shared objective of raising the standards of nursing and public health administration throughout the world.²⁵

During the period 1920 to 1933, 221 students from forty-one countries took one or other of the courses. Of these, seventy-one went on to hold positions with National Red Cross Societies, forty were employed by the state, and the remainder, aside from those who retired or married, worked with private organisations.²⁶

¹⁹ S. Quinn, p.6.

²⁰ Historical Summary of The Florence Nightingale International Foundation undated (?1944), p.1. New Zealand Red Cross Archive K13-1/17. A. Lloyd Still, The Florence Nightingale International Foundation, March 1934, p.51.

²¹ L.R. Seymer, p.283, & p.284. S. Quinn, p.7.

²² G. Jebb, H. Reid, The International Courses at Bedford College, Bedford College for Women, dated January 1934, p.18, NZRC Archive document K13-1/3.

²³ G. Jebb, H. Reid, The International Courses at Bedford College, p.18.

²⁴ 'To Commemorate', p.332.

²⁵ League Headquarters Notes, Presentation of Certificates to Graduates of International Courses, *Bulletin of the League of Red Cross Societies*, dated September 1933, p.185, New Zealand Red Cross Archive.

²⁶ International Courses, The Florence Nightingale International Foundation Prospectus 1937-38, List, pp. 17-24.

The courses were suspended at the outbreak of war in 1939. Due to difficulties in securing funding and currency restrictions, they were not reinstated in their original form. However, nurses still continued to benefit from the Foundation, and were able to attend any existing post-graduate course which was recognised internationally instead of being constrained to one course in London. Mary Lambie, New Zealand's Director of Nursing in the Department of Health, was elected President of the Grand Council of the Foundation in 1946 when it was decided that a study into the future form of the Foundation should be undertaken.²⁷ In 1949, the study recommended that the Florence Nightingale International Foundation amalgamate with the ICN and function as the Educational Division of the ICN with the aim of improving nursing throughout the world through improvements to nursing education.²⁸ The Florence Nightingale International Foundation formally became the Florence Nightingale Education Division of the ICN in 1957.²⁹

The first New Zealand nurse who attended the original year-long course in 1921 was Edith Webster.³⁰ The second nurse to attend, in 1922-23, was Catherine. R. Clark of Wellington who at the time was secretary of the New Zealand Memorial Scholarship Committee and Dominion Secretary of the Registered Nurses Association. In a newspaper interview around 1934, she was quoted as saying that the value of the course was a means to keep nurses in New Zealand up to date and up to standard, as it was an opportunity to learn what was happening in other countries.³¹ Those who had attended had been utilised as teachers on their return. Between 1921 and 1936, seven New Zealand nurses attended the post graduate course, including Janet Moore in 1924-1925 as preparation for her (unrealised) role of lecturer in the proposed nursing diploma course at Otago University. She had been one of the first 50 nurses to go overseas with

²⁷ M. Lambie, *My Story*, Memoirs of a New Zealand Nurse, Peryer, Christchurch, 1956, p. 131.

²⁸ L.R. Seymer, p. 293.

²⁹ S. Quinn, p.13.

³⁰ International Courses, The Florence Nightingale International Foundation Prospectus, p.17.

³¹ Newsclip, Founder of Nursing, Nightingale Memorial, Post Graduate Scholarship, undated, (?1934), New Zealand Red Cross archive.

Hester Maclean in 1915³² and become an instructor at the Post-graduate School in Wellington in 1936.³³

It is noted that the relationship between the ICN and Red Cross was not always good, especially in the 1920s when the ICN's educational vision was challenged by the Red Cross's nurse training courses, some short term. These included the work of the Red Cross as well as nursing education and were already in existence in a number of countries. These courses differed from the ICN's proposed standardisation of a three-year nurse training programme. In addition, the Red Cross facilitation of national and international organisation of nurses ran counter to the goal of the ICN's. Some concerns were also expressed about the standards of the international courses.³⁴ Fortunately the ICN president, Sophie Mannerheim of Finland, who had links with the Red Cross was able to forge relationships with international nurses and mediate through the morass of nursing politics in the post war period.³⁵

Red Cross Societies' contributions, however, were not to be underestimated as they had endeavoured to maintain standards and to improve public health, largely due to the positive influence of the League and the ICRC.³⁶ In some countries, notably Switzerland, Japan, Germany, France and Norway, the Red Cross represented a large professional body of nurses and it was in control of nursing education in twenty-five countries until the 1950s.³⁷ It is unclear how many Red Cross nursing courses continue today. This was unable to be verified by the Federation, although there is evidence of Federation General Assembly Resolutions relating to nursing up until 1973.³⁸ The Red Cross was also involved in public health activities in Chile, Finland, Italy, the United

³² H. Maclean, *Nursing in New Zealand*, history and reminiscences, Tolan Printing Company, Wellington, 1932 p.139.

³³ M.Lambie, *My Story*, p.125.

³⁴ S.Quinn, p.5.

³⁵ G. Boschma, M. Stuart, 'ICN During Wartime: 1912-1947', *International Nursing Review*, Vol. 46, No. 2, (1999), p.44. J. Lynaugh, B. Brush, 'The ICN Story – 1899-1999', *International Nursing Review*, Vol. 46, No.1, (1999), p.5.

³⁶ L.R. Seymer, p.112.

³⁷ L.R. Seymer, p.112.

³⁸ Email communication with Grant Mitchell, Head, Information Resources Department, International Federation of Red Cross and Red Crescent Societies, 14 February 2002.

States of America, the USSR and many Eastern European countries in the 1950s.³⁹ These activities have continued through the work of National Red Cross and Red Crescent Societies in different forms over the years. The primary health care concept of the 1980s was incorporated in the Federation's health policy in the 1990s to meet the new challenges such as HIV/AIDS.⁴⁰

After World War II, the Red Cross continued its involvement in the provision of relief to devastated countries in Europe and Asia. In addition, there was the issue of displaced people in Europe. Many nurses, for example through the British Red Cross, were sent to help in former concentration camps such as Belsen, and also undertook care for tubercular children and welfare work of about 250,00 displaced persons until 1949.⁴¹

Florence Nightingale might not have "preached internationalism in so many words"⁴² but the idea was implicit in her writing and actions as they were disseminated throughout the world. From its beginnings as a war time activity and service, international nursing evolved professionally through educational courses, international cooperation at an institutional level through the ICN, and World Health Organisation, and through bilateral partnerships. International nursing has expanded on a number of levels and now embraces a range of perspectives. New Zealand Florence Nightingale Medal recipients have been involved in these activities in different ways. Their contributions have been both visible and invisible.

New Zealand nurses' involvement

As Burgess has remarked, New Zealand nurses have worked overseas for many years for a variety of professional, educational and personal reasons. Their influence on the development of the nursing profession on their return to New Zealand has been valuable. In turn they have contributed to international nursing.⁴³ The greatest number

³⁹ L.R. Seymer, p.113.

⁴⁰ 'Heath: prevention is better than cure', *Review 1991*, International Federation of the Red Cross and Red Crescent Societies, 1991, p.15.

⁴¹ L.R. Seymer, p.113.

⁴² A. Lloyd Still, p.52.

⁴³ M. Burgess, *Nursing in New Zealand Society*, p.163.

of nurses were involved in the international nursing arena through military nursing until the middle of the 1900s. This started with an involvement in the Boer War at the end of the 1899-1902, which saw around twenty-five New Zealand nurses serve with the British Nursing services.⁴⁴ Then in 1914, six nurses left with troops bound for Samoa⁴⁵ to attend to the civilian population. After the New Zealand Military Service had been formed, Hester Maclean, New Zealand's first Florence Nightingale Medal recipient, took fifty nurses overseas. Throughout the war, more than 600 served with the New Zealand Army Nursing Service on hospital and troop ships across the world.⁴⁶ During World War II, more than 600 New Zealand nurses served overseas. Several hundred others, who were in England at the outbreak of war, worked for the war effort.⁴⁷

New Zealanders were also active in the Voluntary Aid Detachments (VADs), and about 500 assisted in clerical and other duties overseas in World War II.⁴⁸ Consistent with the Red Cross role of training volunteers to be ready to act as auxiliaries to government services, it provided the means for women in particular who were wanting a proper role as medical auxiliaries. Many New Zealand women served as VADs with the British Red Cross initially and with the New Zealand War Contingent Association in 1916.⁴⁹ In 1918 they were brought under the auspices of the New Zealand Red Cross.⁵⁰

Comments have already been made about the attitude of nurses towards amateur women tending to soldiers, especially at the outbreak of World War I when New Zealand military nurses were trying to establish their professional place within a male dominated

⁴⁴ M. Burgess, *Nursing in New Zealand Society*, p.17. J. Rodgers, 'Potential for professional profit: the making of the New Zealand Army Nursing Service, 1914-1915', *Nursing Praxis in New Zealand*, Vol.11, No.2, (July 1996), p.5.

⁴⁵ S. Kendall, D. Corbett, *New Zealand Military History, A History of the RNZNC Boer War to the present day*, published by Kendall and Corbett, Auckland, 1990, p.19. J. Rodgers, 'Potential for professional profit', p.8.

⁴⁶ M.Burgess, p.17.

⁴⁷ M.Burgess, p.22.

⁴⁸ M.Burgess, p.22.

⁴⁹ L. Edmond, C. Milward eds., *Women in Wartime, New Zealand Women tell their Story*, Government Printing Office, Wellington, 1986, p. 260

⁵⁰ S. Upton, Voluntary Aid Detachments (VADs), in *The Oxford Companion to New Zealand Military History*, ed., Ian MacGibbon, Oxford University Press, Auckland 2000, p.566.

system.⁵¹ Ettie Rout's Volunteer Sisterhood scheme did not help the situation and intensified the prejudice that trained nurses had about amateurs.⁵² This may also have had a lingering negative impact on the VADs, as they became formally established in the 1920s and became more prominent in the Second World War.

The New Zealand government signed an agreement with the New Zealand Red Cross and Order of St John that they were the only two organisations recognised as recruiting and training volunteers for assistance with medical services.⁵³ In World War II, VADs became part of the Army Nursing Service and worked as nurse aids, clerical assistants in hospitals or occupational therapists. They formed a valuable part of the workforce to cope with the nursing shortage, particularly in New Zealand where they enabled the release of trained nurses to take care of wounded and sick servicemen overseas.⁵⁴

After World War II, the VADs continued to be actively involved in first aid duties, home nursing and rehabilitation of convalescing soldiers and refugees arriving in New Zealand. The emphasis then moved to disaster preparedness and having contingents of trained volunteers for disasters and community welfare within New Zealand.⁵⁵

It is in relation to the work and training of the VADs that several New Zealand nurses and VADs were awarded the Florence Nightingale Medal. For example, seven of the ten medal recipients between 1920 and 1965 were involved in training of VADs. Three of these recipients were not nurses.⁵⁶ This is discussed further in Chapter 5.

In the post war years, nine New Zealand nurses worked with the United Nations Relief and Rehabilitation Administration. This organisation was established in 1943 by the allied nations to help organise the resumption of normal services and avoid the

⁵¹ J.Rodgers, 'Potential for professional profit': p. 8.

⁵² J. Rodgers, 'Ettie Rout's other war', *Women Studies Journal*, Vol.13, No.1, The Women's Studies Association of New Zealand and the University of Otago Press, (Autumn 1997), p.96.

⁵³ M.Lambie, p.116.

⁵⁴ M.Lowrie, *The Geneva Connection*, Red Cross in New Zealand, New Zealand Red Cross Society, Wellington, 1981, p.59.

⁵⁵ M.Lowrie, *The Geneva Connection*, Red Cross in New Zealand, p.90 & 92.

⁵⁶ S.Kendall, D. Corbett, *New Zealand Military Nursing*, p.228-229.

outbreaks of epidemics that had occurred at the end of the First World War.⁵⁷ One of these nurses was Alice Fieldhouse who worked as a nurse in a camp for displaced persons in Germany. She trained nurse aids and conducted refresher courses for people who had already had nursing experience.⁵⁸

At an international institutional level, New Zealand nurses have participated in and networked with international organisations such as the World Health Organisation (WHO), the International Labour Organisation and other United Nations agencies.⁵⁹ Membership of the International Council of Nurses has provided the opportunity to participate at a global level with other national nursing associations representing over a million nurses. It transcends national boundaries and cultures and gives a sense of shared concern about nursing and the professional development of national nurses associations, the improvement of the standards of nursing and competence of nurses, and the improvement of the status of nurses.⁶⁰

New Zealand nurses have had strong links with the ICN. Over the decades eminent individuals have held positions of responsibility. This began with Grace Neill who in 1899 attended the Matron's Council meeting out of which the ICN evolved. Neill became a foundation member. Flora Cameron the 1959 Florence Nightingale Medal recipient, was a member of the ICN nursing education committee.⁶¹ Margaret Lythgoe held the position of nurse advisor on the executive staff of the ICN from 1968 until 1971.⁶² Gay Williams was a recent ICN vice-president.

As a Pacific neighbour, New Zealand has made a practical contribution to the development of nursing education programmes and health services in a number of South

⁵⁷ M. Burgess, p.173.

⁵⁸ C. MacLennan, 'Limited Options', *Nursing New Zealand Centenary Souvenir: 1901-2001*, p.26.
Note, the Graduate School of Nursing and Midwifery at Victoria University of Wellington is housed in the Fieldhouse Centre, named in recognition of the contribution Alice Fieldhouse and her husband made to the development of the nursing profession.

⁵⁹ L. Sivyer, 'International Nursing', editorial, *New Zealand Nursing Journal*, Vol. 81, No. 9, (September 1987), p.2.

⁶⁰ M. Burgess, p.166.

⁶¹ M. Burgess, p.168.

⁶² M. Burgess, p.170.

Pacific nations since the early part of the twentieth century. For example, it has been involved in Samoa, Fiji, Tonga, as well as the Cook Islands and Niue.⁶³ With the latter two, New Zealand has a special constitutional relationship. Mary Lambie, who went to Samoa in 1934 for three months to reorganise the nursing services described her experiences in her autobiography. Descriptions such as, "there was no copy of a planned curriculum, no classroom, no teaching equipment and nothing to make instruction interesting",⁶⁴ resonate with my own observations on the post-conflict Island of Bougainville more than sixty years later, and unfortunately could still apply to some of the more remote islands of the Pacific and to countries which have experienced war. Lambie was also asked to assist with the development of nursing education in Fiji and beyond the Pacific, in Shanghai in the International Settlement, where New Zealand nurses were seconded for a three-year period of employment. Several nurses took advantage of this opportunity until the war intervened.⁶⁵

Nursing education programmes and support for clinical services in Pacific Island countries continued with funding from the Ministry of Foreign Affairs and Trade, and continue to day as part of the bilateral Official Overseas Assistant Programme (NZODA). In 1996, the ICN initiated a Leadership for Change project in response to requests from member associations to prepare nurses for management and leadership roles in a rapidly changing environment and a context of health reforms.⁶⁶ In the Pacific region, five countries are involved, the Cook Islands, Fiji, Kiribati, Samoa and Tonga, with funding provided by the New Zealand government as part of its official development assistance programme to the region.⁶⁷ The project is managed by New Zealand nurse and ICN nurse consultant, Sally Shaw.

New Zealand nurses have also been involved over the decades in the World Health Organisation which is a specialised agency of the United Nations. This grew out of the

⁶³ M.Burgess, p.17.

⁶⁴ M.Lambie, *My Story*, p. 84.

⁶⁵ M. Lambie, p.90.

⁶⁶ 'Preparing nurse leaders for the new millennium', *International Nursing Review*, Vol. 46, No.5, (1999), p.140.

⁶⁷ S. Shaw, 'The ICN Leadership for Change Project', *International Nursing Review*, Vol. 46, No.5, (1999), p143.

Health Organisation of the League of Nations which had existed from the early 1920s until 1946.⁶⁸ It was formally constituted in April 1946 and since then has regional offices around the world which promote the objectives of the organisation. Its aim is “the attainment of all peoples of the highest possible level of health”⁶⁹ From the first international health meeting in Paris in 1851,⁷⁰ collaboration in international health has been formalised through the United Nations, in particular through its agencies such as the WHO, and represents over one hundred years of international health cooperation.

New Zealand nurses have acted as WHO consultants. Rita MacEwan established schools of psychiatric nursing in Singapore and Iran. She later worked in Cairo, Egypt lecturing in a psychiatric nursing component of a four-year programme.⁷¹ New Zealand itself received this service in 1970 through WHO consultant Dr Helen Carpenter, whose review of the system of nursing education led to its transfer from hospital schools of nursing to tertiary institutions in 1973.⁷²

The adoption in 1981 of the WHO global strategy of ‘Health for All by the Year 2000’,⁷³ following the Alma Ata declaration on primary health care in 1978, set the scene for a new world view of health and strategies for delivery of health care. These were ambitious, if not controversial, as they refocussed approaches to health, to community involvement and self reliance, to public health as well as secondary or tertiary institutions, and to prevention rather than just cure. Health was therefore viewed as an integral part of social and economic development. Responsibility was transferred from the doctor as healer, to primary health worker as partner.⁷⁴

⁶⁸ M. Burgess, p.172.

⁶⁹ *Facts about WHO*, World Health Organisation, Geneva, 1990, p.5.

⁷⁰ G. Walt, ‘Globalisation of International Health’, *The Lancet*, No. 351, (February 7 1998), p.434.

⁷¹ C. MacLennan, p. 27.

⁷² M. Burgess, p.175.

⁷³ *Facts about WHO*, p.5.

⁷⁴ D. Barnes, C. Eribes, T. Juarbe, M. Nelson, S. Procter, L. Sawyer, M. Shaul, A.I. Meleis, ‘Primary Health Care and Primary Care: A Confusion of Philosophies’, *Nursing Outlook*, Vol. 43, No. 1, 1995, p.7.

The public health movement of the early 1900s aimed to deal with hygiene and cleanliness, and the outbreaks of infectious diseases during and after the two World Wars. The re-emergence in the 1990s of some of the formerly controlled diseases such as malaria and tuberculosis, and new diseases such as HIV/AIDS and Ebola, as well as continuing poor sanitation and lack of clean water supply for millions of people, remain enduring public health problems in the new millennium.⁷⁵

The WHO promoted primary health care as one area in which international nursing could have a positive effect. International collaboration with the WHO on primary health care was taken up by the ICN, “to assist national nurses associations in becoming a major thrust for nursing in the Primary Health Care movement is an immediate priority of the ICN”.⁷⁶

The Red Cross demonstrated its commitment to the concept and strategies of primary health care by its membership of the non-governmental organisation group on primary health care. This was also confirmed in resolutions adopted at several international Red Cross meetings and by the number of Red Cross and Red Crescent Societies actively involved in primary health care programmes.⁷⁷

The ICN also worked with the League of Red Cross Societies on a programme for the preparation of community health workers, in which national nurses associations were to collaborate with National Red Cross Societies. From 1981 to 1987, New Zealand Florence Nightingale Medal nurse (1969) Moya McTamney worked as the community health advisor in the Health Department of the League of Red Cross Societies. During this she published *First Aid Guidelines for Instructors, Somalia*, and a *Course for Healthy Living*.⁷⁸

⁷⁵ ‘The world wide health crisis’, 27th International Conference of the Red Cross and Red Crescent, 31 October-6 November, Geneva, 1999, pp.12-13.

⁷⁶ D. Krebs, Nursing in Primary Health Care, *International Nursing Review*, 30, 5, 1983, p.144. M.Styles, International Nursing on the threshold of the new millennium, *Profession: Nurse, (Images 1900-1930)*, International Museum of the Red Cross, Red Crescent, 1995, p.123.

⁷⁷ The Red Cross and Primary Health Care, League of Red Cross and Red Crescent Societies, document 02, Medico-Social Services Section, February 1883, p.5.

⁷⁸ M. Burgess, p.199.

Red Cross nurse and 1993 Florence Nightingale Medal recipient, Wendy (Woodward) Smith, has had a long involvement in international nursing starting from 1969 when she attended the ICN Congress in Montreal as President of the New Zealand Student Nurses Association. As a Red Cross delegate, she has had a variety of experiences overseas over the decades. Her comprehensive range of skills has meant that she has worked in situations providing humanitarian relief, (for example with refugees from Cambodia in camps in Thailand), in the development of Pacific Red Cross Societies; health programmes in Red Cross Societies in Vanuatu, Papua New Guinea, and Sri Lanka, and as Head of International Federation delegations in Namibia, Mongolia and Laos.⁷⁹ More recently, 1999 medallist Louisa Akavi has been involved in ICRC health activities in the Solomon Islands during civil unrest.

Other Red Cross nurses have been involved in public health and primary health care programmes, in particular from the late 1960s, with refugees and displaced people. In these programmes the emphasis was placed on malnutrition, water or sanitation problems, or caring people for affected by epidemics of diseases such as malaria, cholera, measles or AIDS.⁸⁰ New Zealand Red Cross nurses and Florence Nightingale Medallists in particular have worked in places such as the Thai-Cambodia border,⁸¹ Pulau Bidong in Malaysia, and with displaced people in Vietnam,⁸² safe water programmes in Sri Lanka,⁸³ and nutritional assessments in Africa.⁸⁴

The New Zealand Red Cross Society in 1989 was the first National Red Cross Society to integrate the principles of primary health care into a framework for its health and community services. This represented more a change in emphasis and approach than a

⁷⁹ Oral History interview with Wendy Smith, 24 October 2001.

⁸⁰ R. Russbach, 'A final word, nurses in wartime', *Profession: Nurse*, p.157.

⁸¹ 'New Zealand Nurses join Red Cross Teams', *New Zealand Nursing Journal*, Vol.73, No. 1, (January 1980). Interview with Philippa Parker, Khao-I-Dang, *Red Cross News*, September, 1987, p.14.

⁸² 'Vietnam, a profound experience', *New Zealand Red Cross News*, Vol. 79, No. 3, July 1995, p.4.
'Refugee Welfare in South Vietnam, a programme completed', New Zealand Red Cross Society, *The New Zealand Nursing Journal*, Vol. LXIII, No.1, (January 1970), pp.13-16.

⁸³ Delegate profile (Louisa Akavi), *Central Circular*, Newsletter of the New Zealand Red Cross Central Region, issue 5, March 1998, p. 2. 'Primary health care in Sri Lanka', *The Year in Review, 1989-90*, New Zealand Red Cross Society, p.20.

⁸⁴ 'Sudan: taking the measure of suffering', *Red Cross News*, issue 1, (1989), p.12-14.

radical refocussing of services. It was facilitated because there were three nurses on the national office staff, all of whom had worked overseas with the Red Cross. In addition, a number of nurses were Red Cross health coordinators and first aid instructors scattered across New Zealand through the Red Cross network. It was most tangibly demonstrated in the establishment of a Red Cross Nurses' Clinic in Wanganui, staffed by registered nurses with Plunket, public health, midwifery and post graduate qualifications in community health.⁸⁵ The initiative was introduced by a former Red Cross nurse who had worked in Thailand. She was keen to use her overseas experiences for the benefit of her local community. The Red Cross first aid courses were also modified to include a strong emphasis on health promotion and prevention of diseases.

However, the change met with resistance from some quarters of the organisation whose experiences dated back to the war years and a welfare model of operation. This reflected the age of the membership (86% were over 60 years of age)⁸⁶ rather than a reluctance to change. There was also strong objection to the initiative from the local medical association.

Towards a concept of international nursing

In terms of international nursing, Red Cross nursing is defined by the organisation's philosophy of humanitarianism, the environment and context in which it occurs, and the people it assists. Red Cross nurses work in disaster environments, caused by natural phenomenon such as cyclones, earthquakes or floods, civil war or international conflicts. In these contexts, the nurses are providing humanitarian assistance. They may work at the village level providing nursing care, work in support of local health professionals, or in field hospitals or refugee camps. The milieu may also be development rather than disaster relief. This is a longer term and less emergency charged situation in which development is a process by which people increase their personal and institutional capacities to mobilise and manage resources, so that sustainable and justly distributed improvements occur consistent with their own

⁸⁵ 'Health Initiative in Wanganui', *Red Cross News*, No. 4, (1989), p.10.

⁸⁶ 'Where are the Women?', *Red Cross News*, No. 4, (1989), p.14. (Study undertaken by Jane Smith, NZRC, Women in Development, Women's Role in Red Cross/Red Crescent Movement for the Henry Dunant Institute, July 1989).

aspirations.⁸⁷ The recipients of the nurses' care are people affected by war (wounded combatants, civilians and prisoners, refugees and displaced people) and those affected by natural disasters, requiring basic needs for survival or assistance to rebuild their lives, health programmes and communities.

The impacts and effects of disasters on people are related to and in many cases the result of, failures of development. It is the goal of nursing and the Red Cross to reduce peoples' vulnerability to the effects of disasters and to increase and improve their coping capacities through development strategies which are both people-centred and institutional. Examples of this type of nursing are described in Chapters 6 and 7.

Red Cross is not the only organisation which sends nurses to work overseas. Nurses also work with Volunteer Service Abroad, World Vision, Medicine Sans Frontieres, and Save the Children. Of the numbers of New Zealand nurses who work overseas every year little is known or recorded about the nature of their work or the situations in which they practice. Nor is there any indication of the type of educational preparation for their international nursing practice. This raises important questions of how well they are prepared for their roles and responsibilities, what international legal or regulatory instruments give them a mandate to practise, and most importantly, if they practise in a culturally and clinically safe way. These questions were also alluded to in an article in 1991 about working in the Third World.⁸⁸ The thorough exploration of these questions is beyond the scope of this study, but they are addressed to a small extent through the examples of the Florence Nightingale Medallists in Chapters 6 and 7.

The Nursing Council of New Zealand was unable to provide specific information on the number of nurses working overseas. New Zealand Red Cross statistics available showed that between 1980 and 1986 almost 140 personnel were sent on overseas missions. Nurses at 84, were the largest group, on average fourteen a year over that period. In 1985 for example, New Zealand Red Cross provided twenty-nine of the 284 National

⁸⁷ Korten, D., *Getting to the 21st Century: voluntary action & the global agenda*, Kumerian Press, West Hartford, Conn., 1990, p. 67

⁸⁸ A. Bramwell-Huntington, J. Gilmour, 'Third World work rewarding', *New Zealand Nursing Journal*, Vol. 84, No.2 (March 1991), p.17.

Society personnel supplied to the ICRC, representing approximately 10% of the total expenditure of National Society personnel for ICRC operations.⁸⁹

Between 1989 and 2001 (excluding 1993), there were 189 nursing assignments overseas with the Red Cross, an average of 15.75 nurses per year.⁹⁰ These figures did not discriminate between those who did several missions a year and those who undertook once only missions. Over more than a ten year period, however, it is a consistent number. This also excludes the numerous New Zealand nurses who are on direct contract to the Federation or the ICRC.

VSA has on average of four to six nurses on a two year development assignments most years.⁹¹ World Vision has from time to time, individual nurses working overseas with its parent organisation, but at present (February 2002) there are no New Zealand Nurses working for World Vision.⁹²

New Zealand nurses involved in the defence force activities overseas vary according to the need. Apart from the contributions during World Wars I and II mentioned previously, two New Zealand nurses served in Vietnam⁹³ and several worked with the New Zealand Government civilian team in Qhi Nhon,⁹⁴ which is where 1975 Florence Nightingale Medallist Ngaire Simpson worked on her first mission to Vietnam. No New Zealand nurses served in Korea. In the Gulf war of 1991, six nurses served in the Royal New Zealand Nursing Corps with the 1st New Zealand Army Medical Team.⁹⁵ Today, nurses of the Royal New Zealand Nursing Corps work as part of a unit. For example a medical team of six army nurses, one volunteer nurse, four medical assistants, and four doctors went to Vanimo in Papua New Guinea for twelve days to assist with caring for

⁸⁹ 'The Right Stuff', *Red Cross News*, (July 1986), p.5.

⁹⁰ Email correspondence with Greg Clewley, New Zealand Red Cross, International programmes coordinator, 17 January 2001.

⁹¹ Personal communication with Carolyn Mark, Recruitment and Training Manager, VSA, 18 February 2002.

⁹² Email communication with Barbara Ruck, World Vision, 1 February 2002.

⁹³ 'On duty in South Vietnam', *The New Zealand Nursing Journal*, Vol. XI, No. 8, (August 1968), p. 22.

⁹⁴ 'Helping Hand', *The New Zealand Nursing Journal*, Vol. LXI, No. 12, (December 1968), p. 14.

⁹⁵ K. Stodart, 'Nurses in the Gulf', *New Zealand Nursing Journal*, Vol. 84, No.2, (March 1991), p.17.

tsunami survivors.⁹⁶ In December 1997, a nurse was selected to go with a team consisting of a doctor, three medical assistants, a dentist and dental assistant to be part of the New Zealand Defence Force Truce Monitoring Group on Bougainville.⁹⁷ At the time of writing, two nurses were working in East Timor as part of New Zealand's contribution to peacekeeping.⁹⁸

Initially military nurses and VADs were the most visible contribution to international nursing, but from the late 1960s onwards, apart from nurse advisors to WHO or the ICN, or nurses working privately for personal gain, the evidence suggests that Red Cross nurses became the most numerous nurses working internationally.

In defining international nursing, DeSantis describes it as a broad term operating at a macro level, across national settings, by nurses functioning in cultures and countries other than their own.⁹⁹ It includes the socio-economic, political, educational and cultural forces impinging on the health care system in general, and nursing in particular. She adds that international nursing incorporates all aspects of nursing relating to administration, education and research, including the promotion of nurses' organisations and nurses' welfare across the globe.¹⁰⁰ However, she does not include clinical practice, although it must be noted that the description relates to North American nurse consultants working internationally, two thirds of whom are not involved in clinical care,¹⁰¹ most of their involvement is of an advisory nature and much of it short term.¹⁰²

⁹⁶ 'Helping tsunami survivors extends nursing skills', *Kai Tiaki: Nursing New Zealand*, Vol 4., No.8, (September 1998), p.8.

⁹⁷ 'Making a difference on Bougainville', News and Events, *Kai Tiaki: Nursing New Zealand*, Vol. 4, No. 3, (April 1998), p. 9.

⁹⁸ Personal communication with Lt. Colonel Diane Swap, Royal New Zealand Army Nursing Corps, Wellington, 4 February 2002.

⁹⁹ L. DeSantis, 'The Relevance of Transcultural Nursing to International Nursing', *International Nursing Review*, Vol.35, No. 4, (1988), p.110.

¹⁰⁰ L. DeSantis, 'The Relevance of Transcultural Nursing to international nursing', p. 110.

¹⁰¹ L.DeSantis, 'The Relevance of Transcultural Nursing', p.110.

¹⁰² M. Andrews, 'U.S. Nurse Consultants in the International Marketplace', *International Nursing Review*, Vol. 33, No.2, (1986), p.53.

Literature from North American nurses, though sparse, provided a brief insight into the 1980s, a time when American nurses were being increasingly asked for assistance overseas and foreign nurses were studying in the United States making their influence both geographical and ideological.¹⁰³ In 1987, approximately 22,000 American nurses were engaged in international nursing of one sort or another.¹⁰⁴ The picture of where nurses were working and what they were doing in the international arena was documented in one study.

In 1985, Andrews undertook an exploratory/descriptive study using two sets of data of United States nurses who had engaged in international consultation for the previous seven years.¹⁰⁵ Her findings showed that the median length of time of consultation was six weeks. Of the 92 informants who responded, the nature of advice ranged from areas of nursing practice (98%), nursing education (90%), research (45%) and administration (39%).¹⁰⁶ She found that of those in the latter category, only 1% worked in disaster situations. One possible explanation for this might be that in the 1980s doctors and nurses from the United States were not used for humanitarian field work as they were too closely identified with one side in the conflict, a hangover from the Vietnam war. This was my personal observation in the 1980s in relation to the Red Cross on the Thai-Cambodia border. In an earlier article, she reported that their motivation for international consultancy was because they enjoyed people of other cultures (72%), travel (72%), and desire to serve was bottom of the list, at 10%.¹⁰⁷

A British article written four years ago stated that every week about six nurses travelled to poverty-stricken or war torn locations to work for months or up to two years. It noted that some visited projects, others took part in exchange schemes and yet others worked for international agencies such as the Red Cross, Medicine Sans Frontieres (MSF) or

¹⁰³ M. Andrews, 'U.S. Nurse Consultants in the International Marketplace', p.50.

¹⁰⁴ P.Hickman, D.Gobble, 'Educating Community Health nurses for International Practice', *Nursing Outlook*, Vol. 35, No.1, (1987), p.26.

¹⁰⁵ M. Andrews, 'US Consultants in the International Marketplace', p.50.

¹⁰⁶ M. Andrews, 'International Consultation by United States Nurses', *International Nursing Review*, Vol.32, No.2, (1985), p.52.

¹⁰⁷ M. Andrews, 'International Consultation by United States Nurses', p.51.

Medical Emergency Relief International (Merlin). Some were motivated by religion, others compelled to action by a news article.¹⁰⁸

Canadian nurses' interest in international development work was reported as prospering in the late 1990s possibly because of Canada's official overseas assistance policy or because of poor employment prospects in Canada. Requests for information from the Canada Nurses Association had increased by 25% in 1997, with motives documented as being a mix of humanitarian concerns and pursuit for adventure.¹⁰⁹

Thorne recorded that the nursing literature relating to international nursing included a considerable body of personal accounts by nurses of their experiences working abroad and indicated a wide range of nursing roles.¹¹⁰ This was also seen in the British journals and in the New Zealand Nursing Journal. However, Thorne commented that one of the disadvantages of this type of writing was that it offered no critical analysis of the experience in a theoretical or conceptual framework, nor did it analyse motivation or elucidate the attitudinal shifts needed if nursing was to meet the pressing global challenges ahead.¹¹¹ This is a valid comment and would make a valuable research topic.

Further to this, concern was expressed by a number of writers about nurses' Western values and beliefs in international nursing practice being perpetuated in their practice and their advice. The effects of their interventions in relation to their values and ethnocentrism needed to be questioned.¹¹²

¹⁰⁸ A. Whyte, 'Mercy Mission', *Nursing Times*, (1998), p.24.

¹⁰⁹ B. Sibbald, 'Beyond Our Borders, how to get involved in international development', *The Canadian Nurse*, (May, 1997), p. 24.

¹¹⁰ S. Thorne, 'Global Consciousness in Nursing: An Ethnographic Study of Nurses with an International Perspective', *Journal of Nursing Education* Vol.36, No. 9. (November 1997), p.438.

¹¹¹ S. Thorne, 'Global Consciousness in Nursing', p.438.

¹¹² B. Parfitt, 'Working Across cultures: a model for practice in developing countries', *International Journal of Nursing Studies*, No. 36, (1999), p.371. C. Holleran, 'Nursing Beyond National Boundaries: the 21st century', *Nursing Outlook*, Vol. 32, No. 2, 2001. S. Thorne, 'Global Consciousness in Nursing', p.440. M. Comerford Freda, 'International Nursing and World Health, Essential Knowledge for the 21st century nurse', *American Journal of Maternal Child Nursing*, Vol.23, No. 6., (November/December, 1998), p. 332. M. Leininger, 'Transcultural Nursing', in *Current Issues in Nursing*, eds. J.C. McClosky, H.K Grace, 3rd edition, C.V. Mosby Co., St Louis, 1990, p.534. M. Andrews, 'U.S. Nurse Consultants in the international marketplace', p.51.

Critical reflection is needed on what nurses contribute to international nursing. Ogilvie has reminded us that it is the improvement of the health status of populations, based on their needs, which is at stake in international nursing, and not simply the raising of the status of nurses at home and abroad. This is particularly apt for humanitarian nursing.¹¹³

International nursing and modern nursing has its roots in military events in the latter part of the nineteenth century. This is particularly evident in Florence Nightingale's actions in the Crimea and subsequent introduction of professional training for nurses, the development of public health and in the establishment of the Red Cross as a relief organisation. Red Cross nursing or humanitarian nursing is an integral component of a broader international nursing framework. This encompasses education, practice, research, global health awareness, and collaboration or partnerships. It also reflects the role of institutions such as the International Council of Nurses, the World Health Organisation. With an increasing numbers of disasters, both natural and conflicts, with a resurgence of old health problems such as tuberculosis and the emergence of new infections such as HIV/AIDS, nurses will continue to be needed across national borders and to support and collaborate with other nurses in global solidarity.

All nurses engaged in humanitarian, international nursing make a valuable contribution but some are singled out for the award of the Florence Nightingale Medal. To find out more about humanitarian nursing practice and the Florence Nightingale Medal recipients, 1969-1999, oral history interviews were undertaken with five nurses. The next chapter outlines historiography as a methodology, and oral history interviews as a method of gaining quality primary sources of information. It also describes the processes of gathering historical information and some of the issues relating to it.

¹¹³ L. Ogilvie, 'Nursing in an International Context', *The Canadian Nurse*, (December 1991), p.24.

CHAPTER 4

METHODOLOGY

This chapter outlines historical methodology in general with an emphasis on oral history as a method of gathering primary sources of evidence. It discusses the way in which oral history interviews were used to study the New Zealand Florence Nightingale Medal recipients, 1969 to 1999. Details about the method of data collection and analysis and management are given with consideration for confidentiality and ethical issues in relation to the participant interviews.

As human beings, we have a concept of the past, present and future, in other words, an historical consciousness.¹ This consciousness is both individual and collective, and relies heavily on memory which if lost, means loss of our past and a part of ourselves. Historical memory is important to nursing's professional identity and culture, giving a sense of connectedness with the past and its visionary leaders, and engendering a pride and self esteem in what has been achieved, the cornerstone of individual and collective efforts.²

In simple terms, history could perhaps be summarised in the statement, "the past is the present time of our memory, the present of today lies with action, the future of the present time is imagination".³ This was said in a Red Cross context. However, it could equally apply to historical study and where Maggs might envisage the past in an imaginative way,⁴ history also gives us the opportunity to imagine the future on the basis of understanding the past. History is thus a dynamic and creative process.

¹ A.S. Woolley, 'Doing History', *Journal of Professional Nursing*, Vol. 13, No. 1, (January-February 1997), p.5.

² S.K. Davis, 'A Mandate for Nursing History in Nursing Curricula', *Journal of Nursing Education*, Vol. 34, No.9, (1995), p.427.

³ F. Grunewald, 'Action before and after the crisis, the experience of the ICRC in retrospect', *International Review of the Red Cross*, No. 306, (May-June 1995), p.263.

⁴ C. Maggs, 'A history of Nursing: A history of caring?', *Journal of Advanced Nursing*, No. 23, (1996), p.631.

Historical research aims to discover new knowledge about what happened in the past in relation to specific events, people or points of interest.⁵ As a contribution to knowledge development, historical inquiry gives nursing the opportunity to ask questions about the nature of nursing, and its relationship with the world in which it exists.⁶ It is not just a chronology of dates and events, it must be described and interpreted in the context of time, continuity, discontinuity and change. It also informs and shapes views of contemporary life.⁷ The process of doing this is historiography.

Historiography

Historiography is the methodological approach of historical inquiry and involves investigation, reasoned argument, interpretation and prose.⁸ It involves the critical examination of historical documents, official records, articles, and nurses' experiences in written sources in search for 'truth', of which there are many facets and multiple witnesses as well as multiple realities. History provides a composite of the narrator's multiple realities as opposed to a single true reality,⁹ for them it is their truth. It includes what happened and why, interpretation and understanding, and issues of relevance and implication, the 'so what' factor or social utility of history.¹⁰ It is an appropriate methodology for this study because it explores each nurse's own reality through their narratives which are derived from a range of experiences and perceptions over time and in different contexts. These are explored against more formal and historical documentation. Its social utility is in describing an area of nursing which is not commonly known or valued in the New Zealand context, but of considerable relevance and value in an international environment, a legitimate part of nursing's historical legacy. Furthermore, the concept of humanitarian nursing has not been described in the

⁵ K. Roberts, B. Taylor, *Nursing Research Processes: an Australian perspective*, Nelson, Melbourne, 1998, p.115.

⁶ D.B. Hamilton, 'The idea of History and the History of Ideas', *Image: Journal of Nursing Scholarship*, Vol. 25, No. 1 (Spring 1993), p.45.

⁷ D.B. Hamilton, 'The idea of History and the History of Ideas', p. 48.

⁸ D.B. Hamilton, 'The idea of History and the History of Ideas' p.45.

⁹ A. R. F. Rafael, 'Advocacy oral history: A research methodology for social activism in nursing,' *Advances in Nursing Science*, Vol. 20, No. 2, (December 1997), p.41.

¹⁰ O.M. Church, 'Using Historical Sources', in N.F. Woods and M. Catanzaro, eds., *Nursing Research: Theory and Practice*, C.V. Mosby, St Louis, 1988, p.349.

literature. As it is only able to be outlined in this study, further research about it would make a valuable contribution to nursing knowledge and practice.

As noted by Lynaugh and Reverby,¹¹ historical scholarship rests on what it is possible to find. But unlike natural sciences, historical data relies on evidence in documents, or people's recollections and is inherently subjective.¹² The historian's task is to find and evaluate the evidence and then interpret it. This involves intellectual thought processes and adherence to validity and reliability as in any scientific study. Thus history is a scientific undertaking, (is also an art as it is creative) not least because it requires precise structures and techniques of criticism.¹³ Interpretation of findings, however, must remain tentative because of many witnesses and interpretations of events, and the people involved.¹⁴ These occur through the lens or filters of human experience and unlike empirical studies cannot be predicted, duplicated or generalised in the way of traditional scientific or quantitative research.¹⁵ Or as Lynaugh and Reverby explain, "history is distilled through the researcher's concept of reality and explanation of chosen evidence".¹⁶

The challenge to anyone undertaking historical study then is to work with incomplete and uneven data to find the best explanation for human events.¹⁷ In historiography, data is referred to as source, either primary or secondary. Interviews are oral histories, and interviewees are participants. The importance of quality of sources, in particular primary sources, is emphasised.¹⁸ These are first hand accounts of events or people and are found in written sources, archival and official documents and through oral testimony.

¹¹ J. Lynaugh and S. Reverby, 'Thoughts on the Nature of History', *Nursing Research*, Vol. 36, No. 1, (January/February 1987), p.4.

¹² S. Cramer, 'The nature of history: Meditations on Clio's craft', *Nursing Research*, Vol. 41, 1, (January 1992), p.4.

¹³ S. Cramer, 'The nature of history', p.5.

¹⁴ O.M. Church, 'Using Historical Sources', p.348.

¹⁵ S. Cramer, p.6.

¹⁶ J. Lynaugh, S. Reverby, 'Thoughts on the nature of History' p.4.

¹⁷ J. Lynaugh and S. Reverby, 'Thoughts', p.4.

¹⁸ L. Russell, 'Historiography: A methodology for nurse researchers', Guest editorial, *Australian Journal of Advanced Nursing*, Vol. 16, No. 1 (September-November 1998), p.5.

First hand evidence is more credible and is therefore preferred as a source.¹⁹ In this study, complete or incomplete documentary sources were drawn together and enhanced through the oral history interviews and secondary sources.

Documentary primary and secondary sources

In this study, primary sources of information were derived in the first instance from the written applications for candidate nomination for the Florence Nightingale Medal, documents submitted by the New Zealand Red Cross to the ICRC. This information is held in New Zealand Red Cross archives in the National Office in Wellington. They outlined the professional qualifications, record of service and the positions or roles undertaken by the nominees and in which country. Descriptions of personal qualities such as courage, leadership, sense of vocation, high regard for Red Cross and its principles, and some indication of degree of risk or exposure to danger and tenacity were given.²⁰ This primary source of information was in fact only available for recipients from 1981 until the present day and left a gap in details about actual nursing practice.

Archival documentation in the New Zealand Red Cross archives was useful in giving an historical overview about the Florence Nightingale Medal, but had scant details about the early recipients, except in list form or in references in minutes of meetings. Another valuable source was the ICRC in Geneva which provided a complete list of New Zealand recipients, a short history of Florence Nightingale and an outline of the evolution of the award from its inception until the present day.²¹ This document was used extensively in Chapter 1 in recounting the history of the medal.

Secondary sources are written accounts which can further illuminate the ideas of the primary source and are valuable for communicating underlying issues or thoughts which may not have been conveyed in the original writing, or in this case, in the oral

¹⁹ O.M. Church, 'Using Historical Sources,' p.350.

²⁰ Applications for the Florence Nightingale Medal, New Zealand Red Cross candidate nominations to the ICRC within the time frame of this study.

²¹ Florence Nightingale, ICRC Document, DD/DCM 97/210-pda/ira.

interviews.²² Secondary sources can also construct and reconstruct memories to serve interests as is evidenced in the narratives surrounding Edith Cavell.²³ It is difficult to go beyond the horror and outrage of her execution to find the true version of her story as her life was constructed to serve various interests on a number of levels.²⁴ It is interesting in the light of this particular study, to note that Cavell did not comply with Red Cross neutrality and put lives at risk. However, this fact was over looked because of her heroism and the prestige she afforded nursing.²⁵ This example is a reminder that when examining historical evidence, there must be an understanding of the circumstances prevalent at the time, and to critically examine them without an emotional and political agenda. Historical evidence becomes more useful, not only to serve the interests of the researcher but also of other historians, if it is put in context and has wider appeal.²⁶

Secondary sources of general information about nursing history most commonly utilised for this study were historical books by Burgess, Kendall and Corbett, Seymer, Lambie, and Maclean, and these were supplemented by ICRC or Federation publications such as journals newsletters or guidelines.²⁷ Of the nursing journals which provided the richest source of secondary information, especially about the nurses, was the *New Zealand Red Cross News*, a regular publication distributed to its membership. *Kai Tiaki* or the *New Zealand Nursing Journal* was the other main secondary source and has constituted a long and unifying thread in a tapestry of “the international idea” first enunciated by Ethel Bedford Fenwick in the late 1800s.²⁸ The Red Cross continues to promote the

²² D. Hamilton ‘The idea of history’, p.47.

²³ K. Pickles, ‘Edith Cavell–Heroine. No hatred or bitterness for anyone?’, *History Now*, Vol. 3, No. 2, (October 1997), p.1.

²⁴ K. Pickles, ‘Edith Cavell–Heroine’, p.4.

²⁵ K. Pickles, ‘Edith Cavell’, p.6.

²⁶ T. Lummis, *Listening to oral history: the authenticity of oral evidence*, Hutchison Education, London, 1987, p.22.

²⁷ M. Burgess, *Nursing in New Zealand Society*, Longman Paul, Wellington, 1984. S. Kendall, D. Corbett, *New Zealand Military Nursing, A history of the RNZNC Boer War to the present day*, Published by Kendall and Corbett, Auckland, 1990. L.R. Seymer, *A General History of Nursing*, 4th edition, Faber and Faber, London, 1956. M. Lambie, *My Story: Memoirs of a New Zealand nurse*, Peryer, Christchurch, 1956. H. Maclean, *Nursing in New Zealand, history and reminiscences*, Tolan Printing Company, Wellington, 1992.

²⁸ B. Salmon, ‘The International idea’, *Objects and Outcomes*, New Zealand Nurses Association 1909-1983, New Zealand Nurses Association Inc, 1984, p.118.

international idea, by publishing topical information about the Florence Nightingale Medal, Red Cross nurses, and stories about their work and the environment in which it occurred. *Kai Tiaki* was the only general nursing journal until *Nursing Praxis in New Zealand* was first published in 1985 and has been the only written medium available to New Zealand nurses in relation to the Florence Nightingale Medallists. Other sources were newspaper articles, several of which were provided by the participants themselves.

Oral history primary source

Historically, even with written information, some authors still liked to gather eyewitness accounts, as did Herodotus and Thucydides in the histories of the Peloponnesian war²⁹ from 431 to 404 BC.³⁰ Medieval chroniclers of the 12th century incorporated first hand testimonies with oral sources.³¹

Oral history interviews as a method of gathering historical evidence has burgeoned since World War II especially for use in biographies, articles and theses.³² It has always had its place in history but has been regarded by academics as less objective and reliable than documentary evidence. In pre-literate societies, oral evidence had a unique importance, and the oral tradition is still alive in many cultures, for example in Polynesia as a way passing on stories about life, culture, and genealogy between generations. The 'oral tradition' is not the same as oral history as its purpose is different.

Over the past four decades the development of technology such as portable tape recorders and cassette tapes, and greater exposure to interview techniques witnessed through television, have led to interviewing becoming professional and more able to elicit the kind of information required for historical documentation. However, oral

²⁹ A. Seldon, J. Pappworth, *By Word of Mouth: Elite Oral History*, Methuen, London, 1983, p.6.

³⁰ G. Palmer ed., *The Times Atlas of World History*, second compact edition, Times Books, London, 1997, p.30.

³¹ M. Hutching, *Talking history, A short guide to oral history*, Bridget Williams Books, Wellington, 1993, p.57.

³² A.Seldon, J. Pappworth, *By Word of Mouth*, p.6.

history as a method is currently under utilised by nurses in New Zealand, and Australia.³³

Fyfe and Manson³⁴ define oral history as a record of information gathered in oral form usually by electronic means, as a result of a planned interview. Lummis provided a similar definition but referred to it as oral evidence and added the element of memory by saying that it was an account of first hand experience recalled retrospectively.³⁵ Prins said it was history written with evidence gathered from a living person rather than from an inanimate document.³⁶ He also acknowledged that most professional historians regard it with scepticism.

According to Sarnecky, historiography enhances “professional unity and integrity and embellishes the artistic side of disciplinary practice, enabling nurses to view humanity more fully from an holistic perspective.”³⁷ Thompson believes oral history makes for better human beings.³⁸ These sentiments were reinforced through the evidence of nurses who have witnessed the “dark side of the human condition”³⁹ but who have contributed to and participated in the full spectrum humanitarian nursing practice.

Hutching noted that there are two main types of oral history interview, life history, and topic-based interviews to acquire information about a specific subject.⁴⁰ The second type (topic-based interview) was the appropriate approach to take to learn more about

³³ N. Biedermann, ‘The voices of days gone by; advocating the use of oral history in nursing’, *Nursing Inquiry*, Vol. 8, No. 1, (2001), p.62.

³⁴ J. Fyfe, H. Manson, *Oral history and how to approach it*, Alexander Turnbull Library, Oral History Centre, National Library of New Zealand, Wellington, revised 1997, p.1.

³⁵ T. Lummis, *Listening to history: the authenticity of oral evidence*, Hutchison Education, London, 1987, p.27.

³⁶ G. Prins, ‘Oral History’, Chapter 6, in *New Perspectives on Historical writing*, ed. Peter Burke, Polity Press, Cambridge, 1991, p.115.

³⁷ M.T. Sarnecky, ‘Historiography: a legitimate research methodology for nursing’, *Advances in Nursing Science*, Vol. 12, No.4, (1990) p.3.

³⁸ P. Thompson, *The Voice of the past, Oral History*, 3rd edition, Oxford University Press, Oxford, 2000, p.24.

³⁹ D. Hamilton, ‘The idea of History’, p.45.

⁴⁰ M. Hutching, *Talking History*, p.5.

nursing practice of the Florence Nightingale Medal recipients. Oral history can also be an instrument for social change, by transforming both the purpose and focus of history itself,⁴¹ or as Rafael suggests, oral history informed by critical social theory can be used for social activism.⁴² These approaches were not an appropriate framework for this study, but their social and political dimensions are relevant as the context which describes nursings' relationship with the world⁴³ and are referred to in Chapter 7. In many instances, oral history gives a voice to those previously denied the chance to make their contribution to history,⁴⁴ thus leading to history 'from the bottom up', a revisionist process. This I believe is one of the values of this study, paradoxically, the Florence Nightingale Medallist have achieved international acclaim, however, at the same time, they and their nursing work are not well known in contemporary nursing in New Zealand.

Oral evidence acts as raw historical data which can stand alone or be synthesised with other sources for analysis and interpretation.⁴⁵ One of its major advantages is that it is an adjunct and supplement to fill in gaps not found in written evidence.⁴⁶ At the same time secondary sources were used to add to the oral history accounts, a process of revolving and evolving discovery.

The importance of the planned interview needs to be emphasised as it requires more deliberate and purposeful questioning to elicit missing information not contained in other sources. Oral history is a method of gathering evidence rather than a branch of history. The result of that process which may be recorded on tape or become a printed version.⁴⁷

⁴¹ P. Thompson, *The Voice of the Past, Oral History*, p.2.

⁴² A.R, F. Rafael, 'Advocacy Oral History: A Research Methodology for Social Activism in Nursing', p.32.

⁴³ J. Morse, P. Field, *Nursing Research*, 2nd edition, Chapman and Hall, London, New York, 1996, p.27.

⁴⁴ J. Fyfe, H. Manson, *Oral history and how to approach it*, p.1

⁴⁵ K. Roberts, B., Taylor, *Nursing Research Processes: an Australian perspective*, p.115

⁴⁶ N. Biedermann, 'The voices of days gone by; advocating the use of oral history in nursing', p.61.

⁴⁷ M. Hutching, *Talking History*, p.1.

Proponents of oral history are not without their critics. As a method, it has several shortcomings. For example, the reliability of evidence is dependent on memory and memory is notoriously unreliable and untrustworthy compared with written documents, (although the trustworthiness of these is also open to question).⁴⁸ There are two types of memory systems, short term and remote.⁴⁹ They are dependent on perception and learning. In turn this is dependent on comprehension, with information fitting together and reconstructed in the future, in some form approximating what was comprehended.⁵⁰ As people age, their short term memory is less efficient than their remote memory because of changes in biochemical and intellectual processes that store and recall information. They may take more time or be less efficient at recall. Other influences such as subsequent experiences, or emotions attached to an event, are filters through which memory is recalled. Memory in relation to dates and time of events is less reliable, making written documents more reliable than oral evidence in this sense. Background research can help test the accuracy of the participant's memory.⁵¹ In relation to this research, as the participants were aged between forty-six and seventy-five it is reasonable to assume that their recollections were reliable. They were also recalling vivid experiences, arguably well remembered.

Other factors such as whether experiences were pleasant or unpleasant, may lead to better recall because they are continually remembered, but can also be imperceptibly modified or selective in recall. Facts and events may be remembered but feelings and attitudes may be forgotten or reviewed over time to ease the pain.⁵² This is of relevance to this study as several of the participants had experienced traumatic episodes which could affect their recollections of events, and the recall could act as an unpleasant trigger. The interviews were conducted with this in mind and every effort was made not to expose the participants to unnecessary discomfort.

⁴⁸ G. Prins, 'Oral History' in *New Perspectives*, p.131.

⁴⁹ M. Hutching, *Talking History*, p.58.

⁵⁰ P. Thompson, *The Voice of the Past, oral history*, p.129.

⁵¹ J. Hoopes, *Oral History an introduction for students*, University of Northern Carolina Press, Chapel Hill, 1979, p.15.

⁵² D. Henige. Oral History: testimony on the recent past, *Oral Historiography*, Longman, London, New York, 1982, p.110.

This subjectivity or embodiment of emotions in the past is both a strength and a weakness of oral evidence. Spoken memories and reminiscences are essentially human, they reveal inner sources, motives, and feeling and are more likely to be elicited through oral interview than writings. But as research is predicated on objectivity, the goal is to reduce biases of both the researcher and participant to achieve an accurate and precise account of the historical event or people.

Another criticism is contained in the Latin statement ‘testis unus, testis nullus’, or one witness is no witness.⁵³ Unless oral evidence is supported by other evidence, its credibility may be questioned but can be strengthened by references to other sources. Strength grows when many sources are harnessed to pull together. Each serves as a check for other sources. It may even stimulate the historian to reanalyse other data in fresh ways.⁵⁴

One advantage of oral over written history is that the interviewer actively participates in creating the oral document, and can try and get the information needed rather than relying on written documents which may relate specifically to the topic and which may be incomplete. On the other hand, the interviewer must guard against biases, or consciously or unconsciously fabricate the document to say what they want it to say.⁵⁵

Oral history has value today in relation to recording personal experiences. Unlike our ancestors, people today are less likely to leave written documents such as diaries or letters of an intimate nature as much communication is done by telephone⁵⁶ and, increasingly, electronic mail which is usually brief and to the point and interspersed with ‘text messages’.

As the documentary primary sources of information in relation to the nurses were limited, and details of their nursing practice were not well described, it was deemed that oral history would be an appropriate method to gather quality primary sources. The

⁵³ G. Prins, ‘Oral history’ in *New Perspectives*, p.115.

⁵⁴ G. Prins, ‘Oral History’, p.119.

⁵⁵ J. Hoopes, *Oral History an introduction for students*, p.12.

⁵⁶ J. Hoopes, *Oral History an introduction for students*, p.9.

other advantage of this, was that official records do not necessarily reveal the experiences of nurses in the way they can be captured in an oral history. Voices can convey, in a matter of fact and often humorous way, what it was like to be there, living through experiences, caring for patients during wars or famines. It brings the profession alive in a way that the written word is unable to do.⁵⁷ This was the experience in this study as each time the audiotapes were listened to, the depth and richness of the experiences came alive. The interviews helped to clarify the nature of nursing practice, in particular humanitarian practice over time, which has not been undertaken in New Zealand before.

Ethical considerations

As in any research, ethical issues are of fundamental importance. Permission to carry out research must be sought at institutional levels and through ethics committees, and at another level from communities, participants and informants. Access to archival material held at the New Zealand Red Cross National Office in Wellington was obtained. Care was taken with all material, in the physical handling, and in maintaining the integrity of storage systems.

Preservation of participants' rights and dignity and a guarantee to do no harm to anyone involved in the research process must be upheld. The historical researcher maintains confidentiality of participants and their details during the study, but it may not be necessary or possible to safeguard their identity in the written report. Identifying participants by name is usual practice in oral history research and is considered a way of honouring their gift, but this is still governed by the wishes of the participants.

The identity of the person or persons who participate in an oral history interview are usually clearly identified, unlike those interviewed for general qualitative research whose identity remains confidential and protected from identification. However, in her study into the wartime experience of Australian Army nurses in Vietnam, Biedermann found that participants requested the use of pseudonyms to protect their identity from

⁵⁷ M. Burgess, 'NERF Oral History Collection', *Kai Tiaki*, Vol. 77, No. 12, (1984), p.22.

their association with painful memories.⁵⁸ This kind of discretion may also be more of a concern for military people in relation to security and military strategy, and not necessarily a concern of civilians.⁵⁹ For Red Cross nurses, it could be an issue on both counts, and they were offered the opportunity to use a pseudonym. This was made clear to the participants both in the written information sheet, the consent form and through discussion. It was carefully explained that as one of a small group of New Zealand Florence Nightingale Medallists, their names were on public record, and identity would be not be easy to protect. They agreed to having their names used.

The informed consent process included the voluntary nature of the interview, the ability to stop the tape at any time and withdraw from the process at any time until analysis of the material was completed. Confidentiality of material and who would have access to it was clarified. Storage of the tapes and documents was discussed. The participant information sheet (Appendix 4) outlined some of the above issues and these were discussed fully with the participants.

In addition, the guidelines about how to uphold the standards of oral history which are outlined in the National Oral History Association of New Zealand (NOHANZ) Code of Ethical and Technical Practice, were applied throughout this study.

As for any research data, historical evidence must be subjected to critical analysis to test its reliability and validity and to eliminate the possibility of risks of error in historical or archival sources. To achieve this the researcher applies external and internal criticism.

External criticism is concerned with authenticity of the document itself, for example, if it was written by the person purported to have written it. As there was minimal reliance on documents of this nature for primary evidence in this study, this was not an issue. Primary documentary sources used were the New Zealand Red Cross application for nomination of candidates for the Florence Nightingale Medal. As these were held and accessed from the New Zealand Red Cross archives at the National Office in Wellington, their authenticity is verified.

⁵⁸ N. Biedermann, K. Ussher, A. Williams, and B. Hayes, 'The wartime experience of Australian Army nurses in Vietnam, 1967-1971', *Journal of Advanced Nursing*, Vol. 35, No. 4, (2001), p.544.

⁵⁹ A. Seldon, J. Pappworth, *By Word of Mouth: Elite Oral History*, Methuen, London, 1983, p.20.

Extensive use was made of secondary sources from Red Cross official publications and historical accounts which were assumed to be accurate because of the credibility of the organisation and its reputation for accuracy in impartial reporting.

For internal criticism, the content is assessed in relation to the accurate reporting or veracity of the content and the witness's account compared with other sources.⁶⁰ This was relevant to the study in relation to the primary archival source of information for this topic. The possibility of inaccuracy for example of dates, were checked against other sources in the Red Cross files and with the nurses themselves. In terms of the oral history interviews, a number of sources of information were referred to, to check the veracity of content, for example nursing history books, Red Cross accounts and general historical references. Oral evidence was used as a means of corroborating other forms of evidence, and other forms used to corroborate the oral history accounts. The final outcome was oral evidence which had been internally tested for reliability and validity.

As with any study, it is necessary to reduce the possibility of the researcher's personal bias having an impact on the study as they see the events and issues through their own lens of experience and perspective. An awareness of this potential and its consequences is important and can be dealt with by balancing the evidence and presenting the findings as objectively as possible.⁶¹ In this respect, I have declared my personal interest in this topic and the individuals concerned as a former Red Cross nurse myself, and friend of several of the participants in this study. I acknowledge that my perspective is coloured by the humanitarian principles of the Red Cross and work within the Red Cross Movement.

Oral history method

Oral history interviews were undertaken with five participants drawn from the list of 1969-1999 Florence Nightingale Medal recipients in Appendix 2. The participants were selected to represent the broadest possible cover within the timeframe.

⁶⁰ C.H. Seaman, 'Descriptive and Historical Research Designs', chapter 11 in *Research methods, principles, practice and theory for nursing*, 4th edition, Appleton and Lange, Norwalk, Conn., 1987, p.187.

⁶¹ O.M Church, 'Using Historical Sources', p.351.

There was a choice of ten nurses to be the interviewed, but the ultimate decision was based on availability. At the time of the study at least four of the recipients were thought to be working overseas and one was deceased. Five of the remaining six were approached with the request to participate in an interview. Recipients for the years 1975, 1981, 1987, 1993 and 1999 were available for interview. This led to interviews with five nurses who received the medal at almost six-yearly intervals.

Success of interviewing depends on the relationship of trust and mutual respect between the interviewer and the participant.⁶² This in turn is dependent to a considerable extent on the preliminary planning. The first step was to seek ethical approval from the Victoria University Human Ethics Committee. The application was approved on 29 August 2001. I then made contact with the potential participants, initially by telephone, and posted to them the participant information sheets which gave an overview of the study and areas to be covered in the interview (Appendix 4), and a consent form (Appendix 5). We had agreed that I would make contact again after they had had the opportunity to examine the information, and consider issues of confidentiality and identity, as well as consent.

I had met and knew all except one of the participants as we had been involved in various Red Cross activities over the years. I believe that an element of trust had been established prior to this study, which made the approach and interview easier in many respects, but had some disadvantage in others. I had also worked with two of them while staff members at the New Zealand Red Cross Headquarters. Further comments about these relationships are made later.

Telephone contact was again made to explain the process, answer any questions about the information I had previously sent (and to ascertain if they would participate in the interviews). This communication also served to set up an interview time. Verbal consent was initially sought and issues of privacy and safe storage of the tapes discussed. All those approached agreed to be interviewed.

⁶² J. Fyfe, H. Manson, *Oral History*, p.1

An assessment of the interview venue for potential problems in sound recording would have been useful if the interviews were to be used for an oral history archival collection. However, this was not the intention of the interview process. As it turned out, there were a few interruptions, several telephone calls and some background traffic noise, but these did not interfere with the quality of the audiotape for research purposes or the flow of the interview.

With interview times arranged and a tape recorder hired from the Oral History Centre of the National Library in Wellington, interviews were conducted between September and October 2001. The interviews were carried out at a mutually agreed venue in an environment where participants felt comfortable and safe. With the exception of one interview, all took place in the homes of the participants, the other taking place in my home which was well known to the participant. Access to supporting information, such as photographs and news clips, as well as the opportunity to view the individual's Florence Nightingale Medal and its inscription were given.

On arrival at the interview venue, and initial greetings completed, the equipment was set up with consideration to comfortable seating, proximity to the microphone and to avoid ambient noise. The procedure was explained, written consent obtained and clarification of the information already provided.

Background research had been carried out on each participant prior to the interview, drawing from the primary sources in Red Cross archives, journal articles and my own knowledge of the participants. While there was a common list or framework of questions to be covered, specific questions had been designed for each participant.

The interviews were conducted using a Sony Walkman WMD6C professional tape recorder and Sony ECM144 clip on microphones recorded on to C60 'normal' cassette tapes. The interviews lasted between one to two hours and were followed by a period of further discussion, viewing of mementos, photographs, the Florence Nightingale Medal and other relevant material. Participants were generous with their time, hospitality and most significantly their experiences and memories. The interviews were guided by the three standards of oral history interviewing to ensure the proper collection of oral history material. For example, the technical, interview, and ethical standards were

adhered to as outlined in Fyfe and Manson.⁶³ I followed up the interviews with a letter of thanks and have maintained regular contact ever since to keep them in touch with progress and to clarify any information.

Each interview was abstracted as outlined according to history convention in the suggested convention of historical inquiry.⁶⁴ The abstract is similar to the table of contents of a book, noting topics discussed at each part of the interview. The purpose of the abstract is to serve as a guide and to assist the researcher to listen to the interview and the subtleties of language, nuance of meaning and tone of voice. It provided a rapid retrieval system to listen to the tapes for the purpose of analysis.

The recorded interviews and information were analysed with particular concern for the identifying themes, or patterns of personal characteristics, professional experience, nursing background and overseas nursing experience. As mentioned previously, this was contextualised in the geo-political environment and how this affected the nurses and their practice in these different situations.

As a means of obtaining primary sources of information, the oral history interview process was time consuming, but satisfying. The successful completion of an interview and the opportunity to listen to the stories of the participants time after time was a privilege and professionally stimulating. The stories came alive again upon each hearing, and the depth and range of experiences were further enhanced with additional research.

As I knew four of the five participants, three for more than ten years, and had worked with two of them, the interviews were more relaxed. On the other hand, as we knew people in common and had shared some of the events over the years in different ways, there was less need to explain some areas in detail. This meant that some aspects of their practice or experience were not recorded in the level of detail that a different interviewer might have obtained, as it was familiar and known to both the participant and myself. I also was fully aware of the philosophy and humanitarian work of the Red

⁶³ J. Fyfe, H. Manson, *Oral History*, p.1

⁶⁴ M. Hutching, *Talking History*, p.45.

Cross, and there may have been some omissions in explanations about the response of the Red Cross in certain circumstances. I became conscious of this issue and tried to compensate in the later interviews. In relation to the participant whom I had not met, I found that our nursing and Red Cross backgrounds transcended any difficulties that might have arisen in undertaking an interview with an unknown person which covered intensive and emotionally charged experiences. I appreciated her warmth and acceptance of me.

Most of the participants were able to recall their experiences without obvious difficulty. It helped that they had received my information sheet and interview topics which triggered memories, and all had taken considerable effort to find old notes, photographs, news clips, and Florence Nightingale documents. During the interviews, historical recollections moved around as one thing triggered other memories, and were returned to. This did not present any problem for reviewing the interviews as the abstract identified key areas. No-one used the interview as a means of promoting their own agenda or using it to criticise people or organisations, as can sometimes be the case in oral history interviews.⁶⁵

It is interesting to reflect on the fact that Red Cross nurses are encouraged to become adept at describing their work, rather than explaining what they think or feel about a situation. They are encouraged to refrain from discussing matters that could be construed as political or partial in nature. This means denying some of their feelings in the process. To some extent this was noted in the interviews, but I found the participants willing to say what they felt, particularly in revealing and exposing their own vulnerabilities, weaknesses, and fears. Political issues did arise and are more fully discussed in Chapter 7.

One of my major concerns was about revisiting painful memories, particularly for one participant. While I did not want to avoid the topic, I was also conscious of not creating distress and further discomfort. We were able to discuss the situation and draw some positive strength from it. For the other participants, all had been affected by a death of a colleague, and their own security had been compromised by virtue of the kinds of

⁶⁵ A. Seldon, J.Pappworth, *By Word of Mouth*: p.19.

situations they were working in. They were able to discuss this at length and with honesty.

One of my abiding impressions was the openness and honesty with which the participants shared their experiences and impressions, and their generosity of spirit, especially towards people they had nursed and worked with over the years - complete strangers. It was with considerable humility that I listened to the stories again and again and was particularly impressed by their humanity, competence and professionalism which was implicit in their work in all situations. Their modest responses to being awarded the Florence Nightingale Medal was moving and said much about their levels of self awareness and sense of place within the Red Cross Movement.

Without the opportunity to do these oral history interviews as part of a nursing degree, stories such as these would only be known to a few people and would be a loss to nursing history.

Historiography therefore, involves processes for finding, analysing and interpreting existing material. The oral history process enables the researcher to add to this material. The goal of the researcher, once the facts are found, analysed, and interpreted is to produce as unbiased a report as possible in an integrated and interesting manner.⁶⁶ The results of research with documentary primary and secondary sources are presented in Chapter 5. The results from the oral history interviews are presented in Chapter 6.

⁶⁶ O.M. Church, p.351.

CHAPTER 5

NEW ZEALAND FLORENCE NIGHTINGALE MEDAL RECIPIENTS

This chapter discusses findings from documentary primary and secondary sources. It is organised into two parts. The first considers the Florence Nightingale Medal recipients from 1920 to 1969. The second, the Florence Nightingale Medal recipients from 1969 to 1999, the main focus of this study.

New Zealand Florence Nightingale Medal recipients 1920-1965

The first New Zealand nurse to receive the Medal and the first recipient in the Southern Hemisphere was Hester Maclean in 1920.¹ She was instrumental in establishing the New Zealand Army Nursing service in 1911, although the service was not officially recognised until after the war.² Hester Maclean travelled overseas with the first contingent of fifty nurses to leave New Zealand in World War I in her capacity of Matron-in-Chief of the New Zealand Army Nursing Service.³ She also received the Royal Red Cross which was the first British military order solely for women⁴ instituted by Royal Warrant on 23 April 1883 but not confined to British nurses alone.⁵ Florence Nightingale was also awarded the Royal Red Cross soon after its institution.⁶

Between 1920 and 1965, nine New Zealand recipients were awarded the medal for a variety of war-related activities in which New Zealand military forces were actively

¹ H. Maclean, *Nursing in New Zealand, history and reminiscences*, Tolan Printing Company, Wellington, 1932, p.216.

² M. Burgess, Hester Maclean Memorial Oration, *Kai Tiaki*, Vol. 75, No. 6, (June 1982), p.13

³ J. Rodgers, 'Potential for Professional Profit: the making of the New Zealand Army Nursing Service', *Nursing Praxis in New Zealand*, (1996), p.10.

⁴ 'The Queen Honours Nursing', *The New Zealand Nursing Journal*, Vol. LVIII, No.7, (July 1965), p.5.

⁵ S. Kendall, D. Corbett, *New Zealand Military Nursing, A history of the RNZNC, Boer War to the present day*, published by Kendall and Corbett, Auckland, 1990, p.226.

⁶ L.R. Seymer, *A General History of Nursing*, 4th edition, Faber, London, 1956, p.116.

involved. At least seven of them were involved with the Voluntary Aid Detachments (VADs) in roles such as Commandants, patient transport, New Zealand Red Cross representatives, or trainers of VADs. Others recipients served on hospital ships or were involved in New Zealand based activities for the war effort or disasters.⁷ Of the nine, six were registered nurses and three were VADs (Appendix 6).

From 1969 onwards, the Florence Nightingale Medal recipients were all registered nurses and were involved in working for the International Committee of the Red Cross (ICRC) overseas for the majority of their missions, or the International Federation of Red Cross and Red Crescent Societies (Federation) with one exception which is discussed later.⁸

The New Zealand Nursing Journal (Kai Tiaki) has made a significant contribution to documenting information about the Florence Nightingale Medal and its recipients over the years. Evidence of this is in the number of references made to the recipients of the medal, commencing in January's edition in 1920 informing readers that the ICRC was to make the first medal award that year.⁹ A later edition announced Hester Maclean's award, and described the reception put on by the Wellington Branch of the Trained Nurses Association given to congratulate her on her award.¹⁰ The October edition also named nine British recipients because "some of these nurses will have been known to our readers who were on active service".¹¹ Other issues in the 1920s also referred to nurses from Australia receiving the award. A Miss Conyers, of the Australian Imperial Force Nursing Service, was described as a New Zealander, who trained in Victoria where she had been for years.¹² In 1929, another Australian member of the Australian Army Nursing Service was noted as the third Australasian recipient.¹³

⁷ S. Kendall, D. Corbett, *New Zealand Military Nursing*, p.228-229.

⁸ ICRC Applications for Florence Nightingale Medal, 1980, 1986, 1990, 1992, 1994, 1996, 1998.

⁹ *Kai Tiaki*, Vol. XIII, No. 1, (January 1920), p.39.

¹⁰ 'Reception to Miss Maclean, R.R.C.' *Kai Tiaki*, Vol.XIII, No.3, (July, 1920), p.108.

¹¹ 'Florence Nightingale Medal', *Kai Tiaki*, Vol. XIII, No.4, (October, 1920), p.170.

¹² 'Investitures', *Kai Tiaki*, Vol. XIV, No.2, (April 1921), p.89.

¹³ 'Florence Nightingale Medal', *The New Zealand Nursing Journal*, Vol. XXII, No.4, (November 2 1929), p.207.

In 1937, Mrs Maynard L. Carter, Director of the Division of Nursing of the League of Red Cross Societies, was awarded the medal.¹⁴ The article announcing this was accompanied by the statement, “never before has this distinction been conferred on a better known or more internationally popular member of the nursing profession”.¹⁵ This award is significant on two counts. Firstly, because it marked a change in the regulations in 1934 which permitted the award to be given to “matrons or nursing organisers,” and “in time of peace”.¹⁶ The previous regulations required that the recipient had served on battlefields or in disaster situations. Secondly, the League established the post graduate courses at Bedford College, London University which were attended by New Zealand nurses, hence the expected interest in Mrs Maynard’s award on this side of the world. (The Bedford College courses were discussed under the section on international nursing in Chapter 3).

Between 1920 and 1947, no Florence Nightingale Medals were awarded to New Zealand nurses, the award having been postponed between 1940 and 1947 because of the war.¹⁷ During these two decades (1920-1940) New Zealand also experienced the Hawkes Bay earthquake in 1931, World War II, and other disasters in which New Zealand nurses and Voluntary Aid Detachments were involved, the latter having been formed in 1924 in readiness for such emergencies.¹⁸

Most of the recipients during that time, and up until 1965, were involved in these disasters and war-time activities. When the award was reintroduced in 1947, the New Zealand recipient was Irene Flora Campbell, who as a VAD and not a trained nurse was

¹⁴ ‘The Florence Nightingale Medal’, *The New Zealand Nursing Journal*, Vol. XXX, No. 5, (September 15, 1937), p.226.

¹⁵ ‘The Florence Nightingale Medal’, p.226.

¹⁶ Additional Regulations proposed to the ICRC International Conference of the Red Cross Tokyo, 1934, ICRC document, Florence Nightingale, DD/DCM, 97/210, p.11.

¹⁷ New Zealand Red Cross document to announce renewal of award from 1947, from ICRC circular 376, undated (?1947).

¹⁸ M. Lowrie, *The Geneva Connection*, Red Cross in New Zealand, New Zealand Red Cross Society Incorporated, 1981, p.27.

Commandant of the Hawkes Bay Red Cross. She was the first New Zealand Red Cross recipient and it was considered a great honour by the Society.¹⁹

Her award went unrecorded in the *New Zealand Nursing Journal*. The following recipient, Helen Iris Crooke who was Director of the Red Cross Voluntary Aids, was awarded the medal in 1949 and mentioned in the journal.²⁰ Further recipients, Edna Jean House, a VAD (1951), and Catherine Lynette Wells, a trained nurse (1957), were not recorded in the journal.

In 1955, in an article about the medal, reference was made to the nurses who “are well known internationally”²¹ commenting that the nursing profession in those countries concerned had reason to be proud of their colleagues whose services to nursing had been recognised. This is interesting because that sense of pride about the Florence Nightingale medal nurses has been continued by the *New Zealand Nursing Journal* to mark the award today, but is it questionable if nurses in general share in this pride. The journal is, however, read widely by New Zealand nurses. Furthermore, in 1980, the fourteen New Zealand nurses going to Kampuchea were congratulated and thanked by the New Zealand Nurses Association.²² This subject is discussed further in Chapter 7.

Between 1959 and 1965, all the New Zealand Florence Nightingale medal recipients were mentioned in the nursing journal in various ways. Flora Jean Cameron thanked the Association for the flowers sent to her and said that it was “gratifying to know that the service given so gladly by nurses has been so recognised and that such an honour can be shared by us all”,²³ a sentiment also expressed by Hester Maclean when she received her award in 1920.²⁴ Doris Ramsay in 1961 thanked the New Zealand Registered

¹⁹ New Zealand Red Cross document to announce renewal of award from 1947, from ICRC circular 376, undated (?1947).

²⁰ *The New Zealand Nursing Journal*, (June 15 1949), p.114.

²¹ ‘Notes from Here and There’, *The New Zealand Nursing Journal*, Vol. XLVIII, No. 6, (December 1955), p.204.

²² ‘New Zealand Nurses join Red Cross Teams’, *New Zealand Nursing Journal*, Vol. 73, No.1, (January 1980), p.10.

²³ ‘Award to Director, Division of Nursing’, *The New Zealand Nursing Journal*, Vol. II, No. 3, (June 1959), p. 99.

²⁴ ‘Reception to Miss Maclean, R.R.C., p.108. H. Maclean, *Nursing in New Zealand*, p.236.

Nurses Association for their message of congratulations and added, “I feel very honoured to receive such a message from the registered nurses – a mere voluntary aid – and I do appreciate your thinking of me”.²⁵ This last comment is an expression of inferiority reflecting the long standing dissent between registered nurses and aids about training and professionalism which had its origins in the early 1900s and Hester Maclean’s concern that untrained women might be given priority over trained nurses in war.²⁶ Recipients Mary Gidall in 1963²⁷ and Muriel Jessie Jackson in 1965²⁸ were noted in the journal with an outline of their nursing experiences as army nurses, the former as a Red Cross Lady Superintendent of the VADs, the latter as a Supervising tutor sister at Auckland Hospital.

The New Zealand Nursing Journal also ran articles about the Red Cross and VADs. For example, the July 1927 issue included a section on “The Red Cross as an Organisation”²⁹ in which it outlined its objectives, its work in New Zealand (which “was initiated in the Dominion in 1915”³⁰ as a branch of the British Red Cross Society), its war and peacetime activities (including reference to the courses at Bedford College, London) and New Zealand classes in first aid, home nursing and hygiene and sanitation. It was added that through attending classes, “many of the better types of girls discover they have a taste for nursing and take their general training”.³¹ This form of recruitment was mentioned again in an article in 1941, when it was said that although the VAD hospital work of sixty hours was primarily a measure of national security, “it has proved

²⁵ Letters to the Editor, *The New Zealand Nursing Journal*, Vol. LIV, No.9, (September 1961), p.5.

²⁶ J. Rodgers, ‘Potential for Professional Profit: The making of the New Zealand Army Nursing Service 1914-1915’, *Nursing Praxis in New Zealand*, July 1996, Vol. 11, No. 2, p.7.

²⁷ ‘Florence Nightingale Medal for New Zealand Nurse’, *The New Zealand Nursing Journal*, Vol. LVI, No. 5, (July 1963), p.29.

²⁸ ‘Florence Nightingale Medal’, *The New Zealand Nursing Journal*, Vol. LVIII, No. 8, (August 1965), p.27.

²⁹ ‘The Red Cross as an Organisation’ in 5 minute Papers, III The Nurse in Industry, *Kai Tiaki*, Vol. XVI, No.3, (July 1927), p.119.

³⁰ ‘The Red Cross as an Organisation’, p.119.

³¹ ‘The Red Cross as an Organisation’, p.119.

the best method of recruitment for the nursing profession that has yet to be evolved in this country”.³²

An article in 1939, entitled “An Auxiliary Nursing Service”³³ also referred to the Red Cross, and to Red Cross nurses. It was noted that in United States, Red Cross nurses had been made by Congressional enactment the “Reserve of the Army and Navy Nursing Corps”,³⁴ a voluntary service but with an obligation to serve. The New Zealand Army Nursing Reserve Service obviated the need for Red Cross nurses, with VADs being trained to assist nurses. Red Cross nurses and Red Cross training schools were in existence in European countries from the late 1800s and were discussed in Chapter 3 in conjunction with international nursing. VADs were described in an article, written by Florence Nightingale medallist, Iris Crooke.³⁵

The VADs were established in Britain in 1909 to recruit volunteers, men as stretcher-bearers and drivers, and women as nurses and cooks. They were formed by territorial associations and operated through local branches of the British Red Cross. By 1914, they were so popular that 50,000 had joined the VADs.³⁶ The New Zealand Red Cross, as a branch of the British Red Cross until 1931,³⁷ established its VADs in 1924³⁸ and in 1925 they assisted the staff in Wellington Hospital with the infantile paralysis epidemic with over 100 volunteers. They existed in only a few centres in New Zealand prior to World War II, but by 1939-1940 they were fully established throughout the country. This may have been the reason for Hester Maclean’s comment that the Red Cross was

³² E. Tennant, ‘N.Z. Red Cross Voluntary Aid Detachment’, *The New Zealand Nursing Journal*, Vol. XXXIV, No. 8, (August 15, 1941), p.272.

³³ ‘An Auxiliary Nursing Service’, *The New Zealand Nursing Journal*, Vol. XXXII, No. 3, (April 15, 1939), p.114.

³⁴ ‘An Auxiliary Nursing Service’, p.116.

³⁵ H. I. Crooke, ‘New Zealand Red Cross Voluntary Aid Detachments’, *New Zealand Nursing Journal*, Vol. XL, No. 7, (December 15 1947), p.223.

³⁶ C. Moorehead, *Dunant’s Dream*, p.213.

³⁷ M. Lowrie, *The Geneva Connection*, Red Cross in New Zealand, p.36.

³⁸ M. Lowrie, *The Geneva Connection*, p.27.

not fully ready to undertake its responsibilities in the Hawkes Bay earthquake in 1931 and the Health Department had to fulfil this role instead.³⁹

Following the British Red Cross broad outlines, VADS areas of activity and training were in nursing, transport and domestic work. Nursing was the largest section, and before becoming qualified as a VAD, 'she' had to obtain her elementary home nursing, first aid, hygiene and sanitation certificates as well as spending sixty hours training in a hospital.⁴⁰ VADs were active in New Zealand in a wide range of activities for example in hospitals, old people's homes, orphanages, making prisoner of war parcels,⁴¹ assisting in caring for returned soldiers, providing occupational therapy,⁴² and assistance to Hungarian refugees in the mid 1950s.⁴³

Overseas, New Zealand women initially served as VADs with the British Red Cross until 1918 when they came under the New Zealand Red Cross in World War I.⁴⁴ They were incorporated into the Women's Auxiliary Army Corps (WAACs) Medical Section and in 1941, two hundred qualified VADs were sent to serve overseas under the Women's War Service Auxiliary, 100 from St John's Ambulance and the same number from the Red Cross.⁴⁵ While under the WAACs, they were under the overall control of the New Zealand Army Nursing service.⁴⁶ VADs also served overseas as part of the Council of Organisations for Relief Services Overseas (CORSO) which went to Greece in 1944 to assist in war relief and rehabilitation.⁴⁷ The 1949 medallist, Iris Crooke, was one of the founders of CORSO.⁴⁸

³⁹ H. Maclean, *Nursing in New Zealand*, p.231.

⁴⁰ H. I. Crooke, 'New Zealand Red Cross Voluntary Aid Detachments', p.223.

⁴¹ H. I. Crooke, 'New Zealand Red Cross Voluntary Aid Detachments', p.223.

⁴² M. Lowrie, p.50.

⁴³ M. Lowrie, p.83.

⁴⁴ *Women in Wartime, New Zealand women tell their story*, ed Lauris Edmond with Carolyn Milward, Government Printing Office Publishing, Wellington, 1986, p.263.

⁴⁵ H. I. Crooke, 'New Zealand Red Cross Voluntary Aid Detachments', p.223.

⁴⁶ *Women in Wartime, New Zealand women tell their story* p.267.

⁴⁷ M. Lowrie, *The Geneva Connection*, p.70.

⁴⁸ M. Lowrie, p.77.

While the VADs fulfilled an important role during wars, disasters and crises, they were a threat to registered nurses as some did similar work. Concern for their discipline and professionalism was expressed on many occasions.⁴⁹ They were also thought to receive inadequate training, lacked adaptability and showed a tendency to refuse their services in an epidemic for fear of becoming infected.⁵⁰ For the Red Cross, they were fulfilling Henry Dunant's vision of trained volunteers augmenting the work of the professional service providers, whether they were military or civilian, in helping to relieve suffering. The Red Cross placed a high value on its training and discipline. The New Zealand government officially recognised that the Red Cross and Order of St John were the only two organisations recognised for assistance in medical services.⁵¹

The New Zealand Nursing Journal ran a number of articles about the Florence Nightingale Medal and recipients,⁵² and the Red Cross.⁵³ However, while informative, the articles did not elaborate on registered nurses' nursing practice. More detailed information was provided about VAD activities and training. This is evident in the articles until the late 1960s when the Vietnam War became a preoccupation and new focus of interest.

New Zealand Florence Nightingale Medal recipients 1969-1999

This section makes reference to general sources of information about the recipients within this time frame derived from secondary sources such as the *New Zealand Red Cross News*, the *New Zealand Nursing Journal* and newspaper articles. Chapters 6 and 7 also contain references to information from these publications.

⁴⁹ K. Stodart, 'Proving themselves at war', *Kai Tiaki: Nursing New Zealand*, (April 1995), p.30.

⁵⁰ 'An Auxiliary Nursing Service', *New Zealand Nursing Journal*, Vol. XXXII, No. 3, (April 15 1939), p.115.

⁵¹ M. Lambie, *My Story*, p.116.

⁵² Articles in 1920, 1921, 1929, 1937, 1949, 1959, 1961, 1963, 1965 as previously footnoted.

⁵³ 'Henry Dunant-Founder of Red Cross', *The New Zealand Nursing Journal*, Vol. XLII, No. 4, (June 15, 1949), pp.103-104. 'The Red Cross', text of a talk by W.J. Phillips, MBE, Director of the Bureau of Organisation and Development and Member of the Central Directorate of the League of Red Cross Societies, *New Zealand Nursing Journal*, Vol. XLVIII, No. 1, (February, 1955), p.15. 'Red Cross as an Organisation', *Kai Tiaki*, Vol. XVI, No.3, (July 1927), p.119-129.

Existing primary sources of information about the 1969-1999 New Zealand recipients of the Florence Nightingale Medal were contained in the application forms for candidate nominations submitted to the ICRC. These are held in New Zealand Red Cross archives in Wellington. However, information from this source was not available for the 1969 and 1975 recipients. As a source of primary information, it outlined the professional qualifications, record of service, the positions or roles undertaken by the candidates and in which country they worked.

An analysis of the language and detail used to describe the achievements of the Florence Nightingale Medal candidates in this primary source of information was undertaken against the criteria outlined in the Florence Nightingale Medal Regulations. Criteria listed in the regulations before the 1982 amendments applied to the first three recipients in this study. The regulation changes in 1982 applied to the 1987 and 1991 recipients. From 1992, the criteria were broader. They still included reference to exceptional courage, but included creativity and pioneering spirit, and exemplary services in the areas of public health and nursing education as well as personal sacrifice.⁵⁴

The New Zealand applications make reference to the criteria using the same terms to describe the individual, such as 'devotion, dedication, compassion and commitment.'⁵⁵ Other qualities such as professionalism and leadership relate to nursing expertise and capability, and comments about commitment to the Red Cross ideals and willingness to share experience with others, especially the Red Cross constituency and nursing sorority, are noted. Accounts of 'exceptional acts of devotion' or 'exceptional service' were not specifically detailed in the primary source. Rather, they were implied by length of service, number of overseas assignments, degree of risk and comments about returning to Red Cross service after adversity. For example, Margaret Bryson returned to active service overseas after being injured when the car in which she was travelling was struck by a land mine.⁵⁶ Details about exceptional service and devotion were not

⁵⁴ Evolution of the Regulations and distribution of medals, Florence Nightingale, ICRC document, p.7.

⁵⁵ Applications for 31st, 33rd (2), 34th Florence Nightingale Medal, ICRC.

⁵⁶ Speech notes New Zealand Red Cross, on Margaret Bryson's Florence Nightingale award, May 1999, New Zealand Red Cross archive.

able to be expanded upon by the nurses themselves in oral history interviews. This is further discussed in Chapter 7.

From 1995, the applications for nomination contained subtle changes in detail about the people the nurses cared for, (for example war wounded, those with tropical diseases, and prisoners/detainees), and some of the activities undertaken. Of particular note were setting up hospitals⁵⁷ and repatriation of detainees, evacuation of people for medical treatment and crossing lines to work in clinics, treat or move wounded and sick people.⁵⁸

These latter descriptions denoted a change in the regulations in 1992, but more significantly the theatre of work of conflict situations, which reflected the changing world politics in the 1990s. The references to the level of personal risk or hazard was a distinctive feature in later applications. All four candidates' applications from 1995 onwards contained a reference and some indication of degree of risk or exposure to danger.⁵⁹ They also marked a change in staff at New Zealand Red Cross and changes in the Red Cross Movement from the 1980s in its approach to health problems caused by conflict and its response to them.⁶⁰

The vulnerability of humanitarian workers became a concern of the Red Cross particularly in the post Cold War era with the breakdown of state structures and proliferation of warring parties acting on their own account. Civil war, ethnic strife and the accompanying chaos and anarchy characterised the conflicts of the 1990s.⁶¹ The unprecedented increase of attacks on International Committee of the Red Cross representatives, in particular the six who were murdered in Chechnya in December 1996,⁶² including the New Zealand nurse and 1997 Florence Nightingale Medal

⁵⁷ Application for 35th and 37th Florence Nightingale Medal.

⁵⁸ Application for 35th, 36th, 37th (2) Florence Nightingale Medal.

⁵⁹ Applications for 35th, 36th, 37th (2) Florence Nightingale Medal.

⁶⁰ R. Russbach, *Profession: Nurse*, p.153.

⁶¹ C. Sommaruga, Keynote address, 26th International Conference, Red Cross Red Crescent, *International Review of the Red Cross*, (January-February 1996), No. 310, p.24.

⁶² P. Comtesse, 'The new vulnerability of humanitarian workers: what is the proper response?' *International Review of the Red Cross*, No. 317, (1997), p.143.

recipient, Sheryl Thayer, was a consequence of this era where war and banditry became inextricably linked.

From 1969 onwards, the *New Zealand Nursing Journal* articles relating to Red Cross nurses overseas became more expansive and comprehensive in describing aspects of nursing and the context in which it was taking place, in contrast to earlier editions. For example, almost four pages were dedicated to an article on the New Zealand Red Cross programme in South Vietnam.⁶³ It described 1969 medallist, Moya McTamney, and her work with Montagnard hill tribes people displaced by the war, and the New Zealand programme implemented by a multi-disciplinary team, including sanitation officers and agriculturalists.

The New Zealand Nursing Journal ran a two page article in 1987 on Jennifer McMahon who was to receive the medal in 1991, in which she described her work as a nurse-nutritionist for the Red Cross in Southern Sudan.⁶⁴ The article provided insights into the people Jennifer was caring for and assisting, and some details of her nursing practice, such as the feeding programme for severely malnourished people, and teaching first aid. But, as in other publications, more emphasis was placed on painting a picture of a life and people in contrast to New Zealand. The article was more anthropological and sociological in nature than specifically about nursing practice in that context. The previous year, McMahon was held up in Khartoum on her way to southern Sudan, by rebels threatening to shoot down aircraft providing famine aid.⁶⁵

The New Zealand Red Cross team bound for Peshawar in 1982 included a photograph of Florence Nightingale medallist, Glenys Rodger-Checchi. An article mentioned her and included her photograph but gave few details except that it was part of a surgical team.⁶⁶

⁶³ 'Refugee Welfare in South Vietnam, a programme completed', *The New Zealand Nursing Journal*, Vol. LXIII, No. 1, (January 1970), pp.13-16.

⁶⁴ N. Sherwood, 'Victims of drought and war, Jennifer McMahon in Southern Sudan', *New Zealand Nursing Journal*, Vol. 80, No. 2, (February 1987), pp.14-15.

⁶⁵ 'Live aid nurse', *The New Zealand Nursing Journal*, Vol. 79, No. 9, (September 1986), p.7.

⁶⁶ 'NZRC Medical Team for Pakistan', *New Zealand Nursing Journal*, Vol. 75, No.8, (August 1982), p.23.

A comprehensive article in 1980 described the teams of nurses and doctors which had just left to assist Kampuchean (Cambodian) refugees who had crossed the border into Thailand.⁶⁷ This was a time when the New Zealand Red Cross sent fourteen nurses in three teams to assist the refugees. It also marked a time of cooperation by the employing authorities, as the nurses were given leave without pay and their positions were held open for their return. The article, which included Wendy Woodward (now Smith), one of the two 1993 Florence Nightingale medal recipients, described the professional background of the nurses. All were registered general nurses and midwives, with at least nine to ten years post basic nursing experience, in either paediatrics, public health or obstetrics. What they would be doing and the common conditions they were likely to be caring for and treating, such as malaria and malnutrition, were mentioned as were some personal comments by the nurses themselves. For example one nurse said “This is the ultimate in nursing, to see the need and to offer practical help. We have the skills that are needed and are happy to go under the umbrella of the Red Cross.”⁶⁸

This reference to using professional skills resonates with what Jan Rodgers found in her studies about nurses who went to the Boer War and World War I. She commented that they were keen to use the opportunity to prove themselves professionally, building on gains made through though registration and recognised training.⁶⁹

Further evidence of the motivation to use professional skills was provided in an article about officers of the Royal New Zealand Nursing Corps. They were enthusiastic about the opportunity to serve in the Gulf War because of the opportunity to use skills they had perfected.⁷⁰ At that time there were many inquiries from nurses, civilian and military and offers to serve with New Zealand medical units. Those turned down were

⁶⁷ ‘New Zealand nurses join Red Cross Teams’, *New Zealand Nursing Journal*, Vol. 73, No. 1, (January 1980), pp.9-10.

⁶⁸ W. Woodard (now Smith), quoted in ‘New Zealand Nurses join Red Cross Teams’ p.9.

⁶⁹ J. Rodgers, ‘Potential for Professional Profit: the making of the New Zealand Army Nursing Service, 1914-1915’, *Nursing Praxis in New Zealand*, (July 1996), p.4.

⁷⁰ K. Stodart, ‘Nurses in the Gulf’, *New Zealand Nursing Journal*, Vol. 84, No. 2, (March 1991), p.16.

disappointed. The enthusiasm to serve was so great in the United States that it became an issue, as it strained an already severe nursing shortage.⁷¹

Burgess has also referred to motivation to serve during conflicts or disasters by non-military nurses.⁷² Voluntary service is one of the fundamental principles of the Red Cross, although not everyone who offers is selected for overseas service. Philippa Parker said that “New Zealand nurses consider it an honour to be given a Red Cross assignment”.⁷³ One of the more pragmatic explanations came from Louisa Akavi who survived the Chechnya massacre of Red Cross workers in 1996. After two months in New Zealand following the experience she was ready for her next assignment. She explained the need to put some positive experiences between her and her time in Chechnya, saying it was like “getting back on the horse after you’ve fallen off”.⁷⁴ She has since worked in Sri Lanka and the Solomon Islands. Judith Owen became ‘hooked’ on her first assignment in 1980 and is still working with the Red Cross.⁷⁵ Further discussion on voluntary service is included in Chapter 7.

Rodgers also wrote about the employment of amateur war-time workers to undertake nursing duties - an unpopular move with qualified nurses. These VADs were encouraged and trained by the Red Cross until the 1970s.

Megan Crisp, who in 1981 was awarded the Florence Nightingale Medal, had been actively involved in their training through the New Zealand Red Cross and is credited with disbanding the VADS with “diplomacy and foresight”.⁷⁶

Although the VADs were still in existence until the 1970s, by the late 1960s the New Zealand Red Cross was committed to work overseas being undertaken by professional and experienced nurses. My own experience attests to this. In 1968, upon hearing about

⁷¹ K. Stodart, ‘Nurses in the Gulf’, p.16.

⁷² M. Burgess, *Nursing in New Zealand Society*, p.162.

⁷³ P. Parker, quoted in *The Year in Review, 1989-90*, New Zealand Red Cross Society, 1990, p.14.

⁷⁴ L. Akavi, quoted in ‘Getting on with life’ in *New Zealand Red Cross News*, Vol. 81, No. 1, (March 1997), p.11.

⁷⁵ ‘Florence Nightingale for Judith Owen’, *New Zealand Red Cross News*, Vol. 79, No. 4, (September 1995), p.11.

⁷⁶ Application for Florence Nightingale Medal, 28th award, circular 516, 1980.

the war in Biafra as a student nurse, I offered my unqualified and inexperienced services to the New Zealand Red Cross. I was admonished with the suggestion to come back when registered and with at least five years nursing experience to my name. By the time I went on my first Red Cross overseas mission in 1985, I had had sixteen years nursing experience.

All eleven of the 1969-1999 Florence Nightingale Medal nurses trained in hospital schools of nursing between the years 1948 and 1979. All were general and obstetric nurses, six were midwives and five had tertiary qualifications such as post-graduate diplomas or degrees.⁷⁷

It was difficult to get an impression about the nurses themselves, apart from their professionalism and dedication. A full page article about Wendy Woodward (Smith), written by Sharon Crosbie in a Sunday newspaper in 1988, described Wendy's work in a number of countries.⁷⁸ In admiration, Crosbie noted that "armed with a measuring stick, a notebook, a decent briefing and Red Cross behind her, she could be dropped down anywhere to sort out the problem". Furthermore, she commented that New Zealand Red Cross workers are acceptable internationally because they exude a "calm pragmatic compassion"⁷⁹ that was easy to work with. This could describe all the Florence Nightingale medal recipients in this study.

New Zealand Red Cross's expectation of overseas delegates is very high, not only that they go overseas with particular capabilities, but that they will achieve and do well as Red Cross people.⁸⁰ Such is the regard the nurses are held in that when the Red Cross could only get four nurses instead of five at short notice, Gwen Pragnell wanted Geneva to be advised that four "would be as good as five from anywhere else".⁸¹ In the end five nurses were mobilised at 24 hours notice, including 1987 medallist, Glenys Rodger-Checchi. Internationally, the New Zealand delegates are highly respected as the

⁷⁷ Applications for Florence Nightingale Medal, 1969-1999.

⁷⁸ S. Crosbie, 'A Woman of Impact', *Dominion Sunday Times*, 26 June 1988, p.16.

⁷⁹ S. Crosbie, 'A Woman of Impact', p 16.

⁸⁰ 'The Right Stuff', *Red Cross News*, (July 1986), p.5.

⁸¹ N. Sherwood, 'A long time field worker returns'... *Red Cross News* (1988), p.13.

president of the ICRC said on a visit to New Zealand in 1993, “you send many fine delegates to missions right around the world risking their lives in the name of humanity, you should be very proud of them”.⁸²

In the New Zealand context respect for these nurses is evidenced by the fact that several of the Florence Nightingale medal recipients have also been awarded New Zealand honours. From the group of recipients from 1920 to 1965, two have national honours.

In the group in this study, (1969 to 1999 recipients), Moya McTamney⁸³ and Jennifer McMahon have been awarded the MBE,⁸⁴ Ngaire Simpson, was awarded the OBE in 1992,⁸⁵ Philippa Parker and Judith Owen were awarded QSMs in 1989⁸⁶ and 1993 respectively.⁸⁷ Margaret Bryson was awarded the New Zealand Order of Merit in 2000.⁸⁸ This demonstrates that even though much of their work has been carried out overseas beyond the vision and comprehension of most people in New Zealand, in their own communities there is an acknowledgment for the work they have done often in situations of personal danger and considerable sacrifice. Jennifer McMahon was held captive in South Sudan in 1988⁸⁹ and Margaret Bryson was evacuated in a landmine accident in Kosovo.⁹⁰ Sheryl Thayer paid the ultimate price for her commitment to humanity on December 17, 1996.⁹¹ She was awarded the Florence Nightingale Medal posthumously in 1997, as well as and the Henry Dunant Medal.⁹²

⁸² ‘Visiting Inter. President meets 71st PM’, *Red Cross News*, Vol. 77, No. 5, (November 1993), p.2.

⁸³ Note, the date was unable to be verified, but it was referred to in ‘Red Cross People’, *Red Cross News*, (March 1997), p.12.

⁸⁴ ‘Right...to the point’, *New Zealand Red Cross News*, (July 1993), p. 2.

⁸⁵ ‘Nurses honoured’, *New Zealand Nursing Journal*, Vol. 85, No. 6, (July 1992), p.8.

⁸⁶ Referred to in *The Year in Review, 1989-90*, p.14.

⁸⁷ ‘Florence Nightingale for Judith Owen’, *New Zealand Red Cross News*, (September 1995), p.11.

⁸⁸ ‘Nurse receives double honour’, *Dominion*, Wellington, 24 February, 2000.

⁸⁹ ‘Dunedin nurse gets international award’, *New Zealand Nursing Journal*, (September 1992), p.7.

⁹⁰ ‘Nurse receives double honour’ *Dominion*, 24 February 2000.

⁹¹ ‘Lets get serious, doctor’!, *Red Cross News*, (March 1997), p.11.

⁹² ICRC list of National Society Funds and Medals, New Zealand Red Cross, ICRC, Geneva.

As stated previously, until 1999, all the New Zealand Florence Nightingale Medal recipients had been women. As a woman, working in different countries and cultures was not always easy. Cultural and gender differences were alluded to in one of the applicant's submission, where it was commented that there were challenging tensions about being a woman in Afghanistan where there were few expatriates.⁹³ More explicit comments about gender issues and traditional doctor-nurse relationships were made in an interview with the 1993 recipient, the usually taciturn, but on occasions forthright, Philippa Parker. An interview suggested she was less than tolerant of some doctors, "I mean I've been doing war surgery for six years when in walks some 'bimbo' who did three months four years ago and he is not willing to listen to experienced nurses' advice."⁹⁴ In the same article, surgeon David Morris referred to Philippa as "Captain of the ship"⁹⁵ with reference to her role as head nurse but with respect for her expertise and competence. Several years on he commented that the nurses' stories needed to be told.⁹⁶

As Rodgers noted, history takes a long time. There must be time to gather sufficient data so that it talks to you. Time is needed to reflect, and see patterns. Like Rodgers (who said this of the nurses in the New Zealand Army Service), I felt there was more to learn about these nurses and their practice than written in the articles, and I wanted them to be able to tell their own stories.⁹⁷

Therefore the use of oral history was justified as a method to gather quality primary material and elicit these details, and to find out more about the Florence Nightingale recipients "tangible contribution to humanity."⁹⁸

⁹³ Application for 36th Florence Nightingale Medal.

⁹⁴ S. McTagget, 'A vital role', *The Year in Review 1989-90*, The New Zealand Red Cross Society, 1990, p.15

⁹⁵ S. McTagget, 'A vital role', p.14

⁹⁶ Personal communication with me on 29 September, 2001.

⁹⁷ J. Rodgers, cited in Kathy Stodart, 'Proving themselves at War', *Kai Tiaki*, April 1995, p.30

⁹⁸ 'Our hands reach out to need', *Red Cross News*, issue 2, 1988, p.9.

This chapter has outlined the documentary findings from primary and secondary sources of literature of the New Zealand Florence Nightingale Medallists. Particular focus was placed on the 1969-1999 recipients. The following chapter presents the results of the oral history interview with the five participants from this latter group.

CHAPTER 6

STORIES FROM THE FIELD: INTERVIEWS WITH FIVE FLORENCE NIGHTINGALE MEDAL RECIPIENTS

This chapter contains profiles of each of the five participants using narratives derived from the interviews, and subsequent conversations to document their nursing over the years. In chronological order it describes their nursing practice with particular emphasis on overseas nursing and a brief background into the relevant socio-political environment in which it occurred. In addition, motivation for working for the Red Cross, relevance of humanitarian principles and reactions to receiving the award are described.

Reference is also made to the information contained in the documentary primary sources, the formal candidate applications for the Florence Nightingale Medal submitted by the New Zealand Red Cross to the ICRC, and secondary sources as appropriate.

Ngaire Simpson

We weren't there to put our ways, they had their own culture, they did things their way and it was not for us to go and change their ways, we could help by example and advising, you can't transpose your methods unless they want you to.¹

Ngaire went to live in Papamoa after finishing boarding school. She wanted to do physical education but as her mother and two sisters trained to be nurses, she thought, "I suppose I'd better be a nurse". She trained at Waikato Hospital and registered as a general nurse in 1954. She then undertook her maternity training at Whakatane Hospital the following year.

¹ Oral history interview with Ngaire Simpson, 1 October, 2001. Unless otherwise stipulated, all information relating to Ngaire Simpson comes from this interview.

In 1956 Ngaire moved to the Cook Hospital in Gisborne for a year staff nursing. It presented her with the opportunity for a variety of experiences and learning new skills. As she said “in those days you didn’t say you hadn’t done it before, you just got on and did it”. During that time she stood in for the district nurse at Matawai for six weeks. The role was a combination of district nursing, and public health nursing and clinic work, with a doctor only visiting once a week. This exposed her to nursing challenges and the need to carry out unfamiliar nursing tasks and travel around on “hairy” and isolated roads.

Ngaire then returned to Tauranga Hospital and the position of afternoon supervisor for a year. She decided to move on and applied to go to Timaru. At the time, nurses did not apply for specific positions, they were told where to go. She found herself in Dunedin in the psychiatric ward for which she had had no specialised training. She worked there for three years and a further three years in a medical ward which she regarded as good experience.

In 1965, Ngaire decided to work in a bush nursing hospital “out in the sticks” in Yackadandah, Victoria, Australia for a year. This also included six months in the surgical ward at the Repatriation Hospital for returned soldiers at Heidelberg, just out of Melbourne. On return to Dunedin, she spent a year on as supervisor on a surgical ward which she describes as being busy as they were always short of staff.

In 1966, Ngaire returned to Tauranga to be with her parents. She assumed the role of afternoon supervisor at the Tauranga hospital. She heard about working in Vietnam from a colleague who led the previous New Zealand team.

We had several staff members from Tauranga hospital who had been members of the surgical team that’s how I got interested.

Vietnam had been at war against the French since 1946 until the Geneva Agreements of 1954 terminated hostilities. This also removed restrictions on Vietnamese independence south of the 17th Parallel, establishing the Republic of Vietnam, with the hand over of services formerly operated by the French.² The United States supported the new

² K. St Cartmail, *Exodus Indochina*, Heinemann, Auckland, 1983, p.17.

republic with aid, but it struggled with the enormous task of social and economic reconstruction and the added economic burden of the arrival of large numbers of refugees from the Communist north, communist and guerrilla insurgency and infiltration into the south along the Ho Chi Minh Trail.³ In 1963 a military coup overthrew the Diem regime of South Vietnam in an attempt to reunify the north with the south. The United States retaliated with bombing raids on North Vietnam and so began the United States military involvement in Vietnam which continued until 1975 when the Communists claimed victory and the process of reunification began.⁴

The New Zealand government had first become involved in the Binh Dinh Provincial Hospital in 1964 in response to pressure from the United States to support the war effort in Vietnam, and remained there until 1975.⁵ This New Zealand Government initiative was under the auspices of the Colombo Plan. Teams of New Zealand surgeons and nurses were sent to treat civilian casualties by working alongside Vietnamese doctors and nurses.

Ngaire was interviewed in Wellington in 1967 and accepted to be part of the New Zealand surgical team to go to Qhi Nhon. The hospital in Qhi Nhon was run by the Vietnam Ministry of Health with the New Zealand government providing extra personnel to support the work of local health professionals. She worked with Vietnamese staff in the 300 bed hospital. Because of the war, the hospital was always short of medical resources and relied on the New Zealand government to send supplies, she was also impressed with the way the Americans helped with extra blood and food, especially during the Tet Offensive. She recalls her first impressions on arrival there.

There was plenty to do, you were struck with overcrowding in the wards, two to a bed, nothing clean. You soon got over it, the main thing was to get people fed. They were looked after by relatives...but some wouldn't have relatives, so we became their carers.

³ K. St Cartmail, *Exodus Indochina*, p.17.

⁴ K. St Cartmail, *Exodus*, p.19.

⁵ 'History of a hospital', *Te Manu Rere*, the international magazine of VSA, December 2001, p.8.

We were there to slot in and help. Most of the local nurses had a more technical training, they put up drips, did some dressings. We looked after paraplegics who had no one to do that.

She spoke of patients who had received burns because they had tapped into the American military fuel supplies, but she did not see evidence of napalm. Mine injuries were common.

They had these three-wheeled Lambrettas and they would pile on maybe sixteen and go over a mine, and you can imagine how it would be, lots of amputees...abdominal wounds, gunshots, a lot of mines.

In January 1968, following the general elections in South Vietnam, the Vietcong waged its Tet Offensive, so named because it took place during the Tet festival.⁶ The offensive affected Ngaire's routine of work for several days.

When the Tet Offensive was on, the physician hadn't put in a drip for years ...and all these people needed resuscitation so I very quickly learned how to put in a drip...in those days nurses didn't. In those situations, you just did.

The bad bit was three or four days, but there were so many casualties from it, that we were busy all the time...one night it wasn't safe to go home... we worked long hours there was so much to do...it was a team effort, everyone worked together....Triage, not called that in those days. They'd see them in casualty, just before they went into pre-op where we would resuscitate, then into theatre.... Did as well as we could with sterility, people did go in and out of theatre...you had to because there was only one fridge.

She had coped with the security issues and increase in workload, but three of her colleagues were sent away.

I felt really quite safe until the Tet Offensive, that really was quite scary....
Three of the nurses, they sent them away out of Qui Nhon after it was all

⁶ K. St Cartmail, *Exodus Indochina*, p.18.

over....One of them was a Chinese nurse....I think it was quite hard for her working in that area, almost harder. She was scared, as people thought she was Vietnamese or Vietcong, so it was hard for her.

Ngaire had respect for local Vietnamese nurses and their culture, she was clear about her purpose for being there which was to help by advising and example.

I hope that we showed them some things about ward care. - that was really my thing, it was something I was interested in...totally different to the routine in a New Zealand hospital, you had to use your own initiative.

Following her return to New Zealand, Ngaire went back to Tauranga hospital as afternoon night supervisor. She was persuaded to do the post-graduate Diploma in Nursing Studies at the School of Advanced Nursing Studies in Wellington in 1970, after which she was bonded to her sponsoring hospital for two years.

At a class reunion in Wellington in 1973 she heard that the New Zealand Red Cross was looking for nurses to send to Pleiku in Vietnam. Their programme had commenced in 1967 and was backed by Red Cross branches. She wanted to return as she had been impressed by the work of the Red Cross she had witnessed on her first assignment, and felt she had “unfinished business.” While in Vietnam, she had contact with Red Cross personnel and was impressed with the way they worked.

I thought I’d like to go back to Vietnam especially having seen what a good job that first Red Cross team did.

Working with Red Cross was much more satisfactory because Red Cross headquarters [New Zealand] left it to us to decide what kind of a programme to set up. Go, see what there is to do and do it to the best of your ability. That’s really commendable.

I got much more [out of my second trip], it was much more satisfying. I felt as though we were able to leave things behind, I think that is an aim of Red Cross.

Vietnam had already experienced the mass movement of people in the 1950s when approximately 890,000 North Vietnamese, the majority of whom were Catholics, fled to the non-communist south.⁷ By the late 1960s, South Vietnam had its own population of displaced people who required care and protection. The New Zealand Red Cross Society launched a fund to support the government surgical team in Qhi Nhon but it decided to send its own independent team to work in the refugee camps of Binh Dinh Province.⁸ Its programme was established in 1967 and four teams had already been dispatched. In 1973, following the Paris Ceasefire Agreement, the New Zealand Red Cross sent a fifth welfare team to care for the public health needs of the Montagnard hill tribes people who were in resettlement villages, having been driven from the mountains by the war.⁹ The aim was to encourage self sufficient communities and villages.

It was a totally different experience from the hospital. We went as a team, an agriculturalist, a sanitation officer, a doctor and two nurses. We were to help the Montagnards...we were there to help resettle them in villages the government was providing. We went to the resettlement villages, there were two to three of those, some well established, but again we had to feel our way. There were a few days of settling in and see what they wanted us to do. You have to look for somewhere to start.

We went to some of the villages it was obvious they were going to need the sanitation officer to help to sort out the water problems. They all came to the clinic, malaria was rife, and Tb and worms, malnourishment.

We would go into the villages on a regular basis. We had our land rovers, we had our interpreters and we discovered there were in fact health workers in the village and they were able to come to the clinics and carry on.

The Montagnards, (mountain people) in approximately thirty distinct tribal groups, were the indigenous peoples of the Vietnamese Central Highlands. Numbering approximately

⁷ K. St Cartmail, *Exodus Indochina*, p.17.

⁸ M. Lowrie, *The Geneva Connection*, New Zealand Red Cross Society, 1981, p.118.

⁹ 'Vietnam a profound experience', *New Zealand Red Cross News*, Vol. 79, No. 3, (July 1995), p.5.

one million prior to the Tet Offensive, they were subsistence dry rice farmers, nomadic, and culturally different from the South Vietnamese.¹⁰ They also practised animism in contrast to the predominately Buddhist South Vietnamese. During the war, Montagnards were recruited by both sides, and they suffered devastating losses. Approximately one-fifth of the Montagnard population was killed.¹¹ Their traditional lands were expropriated to resettle Vietnamese in new highland economic zones, and they themselves were resettled to integrate them into the government programmes. Today they continue to struggle for their cultural survival.

Working with a team meant there was always ready support even if it was not always from professional medical sources. One weekend when the other New Zealand doctors were not around she cared for a pregnant woman in a local hospital who had been shot in the abdomen. The patient later died, but she recalled with appreciation the support she received from a fellow New Zealand team member.

The thing that shone out that day for me was Mac Riding who later was killed - a good person - he had no medical knowledge, but he supported me at that hospital all day. If I asked him to get anything he would off and find it, and he stuck by me, that's the thing about a team, isn't it.

Mac Riding was the first New Zealand Red Cross person to die in the field. He was shot down in the plane he was flying in between Vientiane in Laos and Saigon in 1975.¹² Dangers were always present and local knowledge was essential for safety and appreciated by Ngairé.

There was one day we went out to a village [by] myself...we turned down a by-way we usually turn down and we noticed some Vietnamese military jeeps and other vehicles waiting on the main road. So we got off on our way and we get to Mekuk and the locals were so surprised to see us. The road was mined and that's why the Vietnamese military were waiting for us to go over to see if it was safe.

¹⁰ *Encyclopaedia of the Vietnam War*, A political, social and military history, Vol. 1, ed. Spencer C. Tucker, ABC-CLIO, Santa Barbara, 1998, p.450.

¹¹ *Encyclopaedia of the Vietnam War*, p.452.

¹² 'Vietnam a profound experience', p.5.

So then the dilemma was, it will still be mined when we go back, we'll have to go back, so we did. We have very good interpreters. There was a Montagnard fellow, Mir, who was really like one of us...I knew I was safe with Mir. Afterwards when I got home I didn't feel so good about it, but there was no one there, they were all out.

Assisting other members of the team in their programme, by responding to the unpredictable and being resourceful was a way of life. At times responsibilities extended beyond routine nursing.

The power went off that night and we had 200 ducklings in a bunker because the agricultural fellow ...was going to distribute them to the villages and set up a population of ducks. But of course there was no heat for them, so here was me with the ducklings. There were some missionaries, they came around and we did the best we could and I had some of them in the oven. It was a gas oven. We didn't quite have roast duck but we were able to dry some of them out.

In addition, adapting both practice and behaviour to local practices was essential. Knowing how to assist and advise in a sensitive way and not to impose outside methods unless they were wanted was a constant theme. However, Ngaire found some differences difficult to understand at first.

We were there at Christmas time. The Americans and New Zealanders had sent a lot of presents for the Vietnamese children. We all went one evening and took them to the children's ward and initially we were a bit horrified about the way the relatives all went and grabbed, we were not happy about it. But when we had time to think it through, they had very little, it's the survival thing. They might have gone and 'on sold' at the market to get some money and you have to come to terms with that things aren't like that in New Zealand. For example, we had this little boy, 'Sparrow', who was a real favourite of the New Zealanders. He had raggedy clothes and one of the nurses would fit him out when a new lot of stuff came over and he would be very proud of himself, but he would come back that afternoon in his old clothes because someone had bought them, made a bit of money.

Furthermore she recognised that survival was manifested in a number of other ways and it was not something to make a judgment about.

That was the thing about the girls in the bars [prostitutes], they were earning money so their families could live, that's how you had to view it.

While Ngaire was sensitive to local customs and needs, she raised concerns about approaches adopted by the numerous different aid workers relating to the issue of sustainability in care and treatment of common diseases.

We decided we'd go back to chloroquine for the basics for all the malaria and we decided as a team. You had to something that could be carried on by the health workers. Red Cross allows you to do that.

Some of these concerns were expressed in a letter written to the New Zealand Red Cross in February 1975 by members of the Sixth Rehabilitation team. They praised the way the Red Cross operated, but criticized that billions of aid dollars were wasted because they went into a void, the black market or inappropriate projects. They commented on the need for aid to be action based and felt the way in which their teams worked at the 'paddy field level' and 'people to people' meant that the impetus for aid came from the individual effort which said "I care – I will do something, no matter how small".¹³ Ngaire said that the letter expressed her views as well and denoted a way of working by the Red Cross that continues today. 1975 marked the end of New Zealand Red Cross's seven-year commitment to the welfare of many thousands of Vietnamese through the work of approximately twenty-five of its welfare personnel.¹⁴

On completion of the year's mission, in 1974, Ngaire went to England for six weeks. The New Zealand Red Cross offered her the opportunity to go to on to Cyprus en route, however she elected to return to New Zealand for family reasons. She then took up "another challenge" which she felt was an appropriate move after her time in Vietnam,

¹³ Letter to the New Zealand Red Cross, dated February 1975, by W. F. Grant, L. T. Bowden, M. A. Garner, J. J. Pemberton, M. Riding, in M. Lowrie, *The Geneva Connection*, 1981, pp.4-5.

¹⁴ 'Vietnam a profound experience', p.5.

to work in the community as Charge District Nurse. She felt her experiences in Vietnam gave her an appreciation of feeling her way into the community, assessing what people wanted rather than imposing on them. She also understood the fact that like a guest in Vietnam, she was a guest in people's homes in New Zealand. There was an emphasis on care in the community at the time and she felt it was an opportunity to get in at an early stage and build up the service.

Ngaire remained in this position until 1995 when she retired, because she felt that restructuring would introduce changes which meant collaborative work was not going to be possible in the way it had previously. Over the years she also became involved in the establishment of the Waipuna Hospice service and still continues working as a volunteer today. In 1992 Ngaire was awarded the OBE for services to nursing in New Zealand and overseas. She said in a local newspaper interview, "I am really a very ordinary person, I'm a nurse more than anything else. I've just been lucky I've had good people to work with and have been able to keep a team together".¹⁵ Ngaire was persuaded by her cousin to accept the OBE; "the people who put you forward, do you really want to disappoint them...[so] I did say I'd have it".

Ngaire appreciated her experiences over the years ("one of the lucky ones I consider myself"), and continues to be involved with the Tauranga Red Cross.

I always remain interested and I'm available if a driver is needed to take someone to an appointment. I've got the greatest admiration for Red Cross and always will.

I really believe in their principles and you do go with that feeling that it doesn't matter who you're looking after. I can't speak highly enough of Red Cross, New Zealand Red Cross in particular, they gave us the opportunity to go and see what was to be done and get on with it. I thought that was something that I really learned.

¹⁵ N. Simpson quoted in S. Simpson, 'Vietnam, a tough training ground', Bay of Plenty Times, 3 May, 1995.

Ngaire Simpson was awarded the Florence Nightingale Medal in 1975. The citation noted that during both her tours of duty she had accomplishing her tasks with complete disregard for her personal safety and impressed all concerned with her exceptional courage, energy and devotion to duty. On hearing the news her reaction was typically selfless.

I felt not good at all, partly because it was not long after Mac [Riding] had been shot down...he was a really good mate ...he was a really nice man. It was shocking. Then this came and I thought, oh I don't know about this. I don't think I knew what it meant....I was hoping they [colleagues] wouldn't know but I think the telegram came to work...or someone rang....When I eventually was awarded it....I took one of my sisters to Wellington, a cousin and a sister-in-law and I wouldn't let them come into the Red Cross meeting....I'm not a public personI don't like being in the public eye.

In the absence of the Governor General Ngaire was presented the award at the Red Cross annual general meeting by the Chief Justice, Sir Richard Wild.

My inclination was, really, there are so many other nurses in New Zealand who really do great things in nursing, I see myself as a nurse but I don't think that I have done a lot for the nursing profession, if you see what I mean....I'm not a career person.

Megan Crisp

Nursing principles and Red Cross principles are very much the same.¹⁶

Megan Crisp was born in Wales in 1927, and commenced her nursing training at the Royal Surrey County hospital until she was old enough to go to the Royal Infirmary in Edinburgh, aged 17 years in 1946. Although she had two aunts who were nurses, her immediate family did not expect her to go nursing as the family thought she was too

¹⁶ Oral history interview with Megan Crisp, 21 September, 2001. Unless otherwise stipulated, all information relating to Megan Crisp comes from this interview.

much of a “tomboy” and would not be able to adhere to the discipline. However, in the post war years, she was expected “to do one’s bit.” Megan completed her training in 1948 and became a State Registered Nurse, and then a Midwife in 1949 after undertaking midwifery training at the Simpson Memorial Hospital, part of the Royal Infirmary. Megan stayed for a year staff nursing in the labour ward and then went to work in the Channel Islands to gain further experience, with the intention of going overseas.

A sense of adventure and desire to travel led Megan to apply to join the Queen Elizabeth Colonial Nursing Service which was active in Britain’s colonies in preparation for their transfer to independence. In the post World War II years the Colonial Service offered the chance to work and travel.

As a child I was given a book called ‘Seeing the Empire’ which I suppose in these days would not be ‘p.c.’ [politically correct], and I was very much intrigued by the various stories in the book. It made me feel that when I grew up I would like to travel. It was just post war so there were no opportunities for travel as there are now. So the only way one could travel was with one’s work. I thought besides wanting to be a nurse that would be a good way of combining the two.

The Leeward Islands of the Caribbean, Hong Kong, or Malaya were the options. She decided on Malaya because she had nursed men who had come back from the Japanese war camps and had learnt about the country from them.

When interviewed at the Colonial Nursing Service Office in 1951 in London, Megan was subjected to questioning about her social behaviour in an intimidating way, which reflected a difference in attitude between the 1950s and today.

I was asked to remove my hat - I was rather displeased, as it had taken a whole month’s salary....I was asked all sorts of questions, did I embroider? I think they were wondering if I was a flirtatious soul by the nature of their questioning and I was told, if I was accepted, I was told not to make any unseemly relationships on the ship going out to where I was being posted.

After a three-week course in tropical diseases at the London School of Tropical Medicine, Megan was ready to leave for Malaya (Malaysia) in 1951. She travelled on the *Willem Ruys* cruise ship via Ceylon (Sri Lanka) to Singapore where she was then told to go to Malacca, Malaya. In 1951 Malaya was recovering from the Japanese occupation. The British had helped establish the Federation of Malaya in 1948, but almost immediately there was armed insurrection and 'the Emergency' which lasted until 1960.¹⁷ In 1957, Malaya gained independence and enlarged the Federation to include Sabah, Sarawak and Singapore and became known as Malaysia.¹⁸

The British-administered Malacca General Hospital had approximately 850 beds and catered for maternity, general medical and surgical, paediatric and tuberculosis patients. It was described by Megan as basic, with chickens perching on window ledges, cows peeping through windows, aisles with windows to allow the fresh air to flow through to the ward in the centre. Cooking was done on the floor of the hospital. The stoicism of women was noted, especially in childbirth. Her first maternal death from severe anaemia early in her first month "appalled" her. She was also moved to see the husband take the body of his wife and new baby away in a trishaw. "Shaken" by the experience, she did not feel inclined to discuss it with others because they were senior to her.

The purpose of the presence of British nurses was to reinstate health services, raise standards and prepare for Malaysians take over after independence. There was a strong teaching requirement. As Megan had her midwifery certificate, her first job was to stand in for the midwife while she took leave. She assumed responsibility for training the Malay midwives, or Bidans. Her first lecture notes translated by the guru who being male, omitted to interpret the various parts of the female anatomy, so with gaps in her lecture notes she asked a Chinese nurse to give her the Malay names. She did not realise, but she was given the crude versions of Malay and so she offended the Bidans. However, after this initial indiscretion she established good relationships with her students and her other colleagues. Once they finished their course the Bidans were given a maternity bag.

¹⁷ J. Gullick, B. Gale., *Malaysia, its political and economic development*, Pelunduk Publications, Petaling Jaya, 1986, p.85.

¹⁸ J. Gullick, B. Gale, *Malaysia, its political and economic development*, p.99.

They had to hand in their bamboo knives which they had used to sever the umbilical cord. When we went around to the various villages to check on what they were doing, there was the maternity bag nicely covered in a floral cover sitting on the table to be admired, but not to be used....I think it comes with time and experience [to change practices]. I was very inexperienced at the time. In those days a 23 year old was much younger than a 23 year old is now and I found some of those things rather difficult.

Not all traditional practices were safe. Megan helped set up the rural midwifery service which was run in conjunction with a training programme in the hospital in Malacca. She would visit the midwives in the villages to see how they were doing.

[It] was quite frightening at first because if they had a woman in prolonged labour they'd tie rattan around the waist and one woman would take one end and the other would take the other end and they would try and squeeze the baby out. For bleeding, they would stuff the vagina with leaves from one of the trees or tobacco leaves or something to stop the haemorrhage. That of course would bring about infection. These were the things we would try and stop them from doing.

Being resourceful meant Megan was able to cope with a diphtheria epidemic.

There was an outbreak of diphtheria and I had nine children on the ward with diphtheria and I had the children in the kampongs, that is the villages, running around plucking out the tails of cockerels so that we could clear the tubes...we only had only one machine that could clear the tracheostomy tubes. I remember from some old nursing book that you could clear them with feathers, wet, damp feathers. I would give them ten cents for a bunch of cockerel feathers.

Her inexperience and developing cultural awareness meant, however, that she "got into strife over meals" and she learnt the hard way.

I came to a Malay and he was up in arms and I said 'what on earth's wrong'... 'You should have dealt with him first because you have dealt with pork for the

Chinese, now everything is dirty'. We had to have the Iman [Muslim cleric] in to clean everything up... and somebody else had to come from another area with his food for him....I didn't realise not being p.c, but you don't know these things always, but you just learnt the hard way....The whole place was in an uproar, the other Malays didn't want the food. We did cope....Next time I served the Malays first.

She was also challenged to accept some practices which ran counter to her values.

On the ground floor of the Tb blocks, there were patients for whom nothing more could be done, they were just there to see their last days out. On night duty I thought there was this rather peculiar smell in the men's ward and I happened to say to the nurse in charge, 'what is that' and he said 'chandu,' yes, opium. Apparently they used to let those who nothing further could be done smoke their opium quite happily, and that presented a problem for me. I did not think it was right but what else could I do. But apparently that's what used to happen, so I had to go with the flow as they say. Poor old chaps, all skin and bone lying on their beds smoking these rather odd looking pipes which I had never seen before....Of course it was strictly illegal.

The prevailing political situation in Malaya, the 'Emergency', and the communist terrorist activities had not been fully explained to Megan prior to departure from England. She became aware of the dangers soon after arrival and it was always an issue during her ten years working in Malaya.

We had terrorists brought in. There would be a constable to sit in with them, but often on night duty you'd find the constable and terrorist were top to tail and there was a gun sitting in the corner. One night I collected up the guns and rang the officer in charge of the Police station and I got a rocket for that. I shouldn't have touched the guns, but I said what happens if the terrorist wakes up before the policeman? They then came themselves to check each night after that, to see whether these fellows were awake or asleep.

Other evidence of the 'Emergency' were planters and national service men being brought in for treatment of gunshot wounds, the result of ambushes. As it was guerrilla warfare, it was difficult to know who were fighters and she found the experience "interesting and exciting at times." A year as a matron in a small hospital at Port Dixon also gave her other interesting experiences. Here she cared for French Foreign Legion officers who had jumped ship in the Malacca Straits. She looked after them until they were transferred to the French Embassy in Singapore.

Later, when she was living on a rubber plantation estate, having married a New Zealander in 1953, she worked in the Anglican mission clinic at Yong Peng near Johore. Round worms were a problem because they caused anaemia, rashes were caused from allergies to the sodium arsenic used in weed killers on the estates and were treated with mist. gentian. She and others tried to set up a family planning clinic but it was difficult as the men were against it. It was only later that they were instituted. Sundays were spent working while her children attended church on the estate.

I was the only one that could read the pharmacopeia, so I used to be making up the mist. gentians, and all these odd lotions, not too terrible lotions, but I often used to wonder if I'd poisoned the village, but I hoped I hadn't. But I'd make up the syrups...and codeine mixtures and linctus that we had, very basic medicines. Sunday was the only day we had time to refurbish the things within the clinic....We had to ask them to wash bandages and sterilise as best we could. If they had medicines we would ask them to bring a bottle and we would keep that bottle having sterilised it, a lemonade bottle or beer bottle and we gave them their medicine in that. They would pay five cents because they had this feeling that if they didn't pay for it wasn't any good.

She felt she coped with the unexpected, and with limited materials and knowledge, but wondered if much more could have been done had the circumstances been different. The constraints of the curfew and restricted travel were experienced at first hand. She would be called to assist the workers on the estate because she was a nurse, often with limited resources.

My husband would often come and get me because of a woman who had been in labour and she was not delivering in the due time, and he'd come and say 'there's a foot' and I'd say, what do you mean there's a foot, 'oh I don't know, but there's a foot, I'd have to go and of course it was a breech delivery, and we'd have to deal with that as there was no way to get to major hospital in time....There were lots of things one might have been able to deal with had one had the circumstance of not having a curfew and not the distance to travel, one could have coped a bit better.

She herself had three pregnancies during this time and had to be transported to Kuala Lumpur for caesarian sections for each birth.

Megan and her husband decided to return to Wellington, New Zealand in 1961, as they had three young children to educate. In 1971 she applied for a position with the New Zealand Red Cross Headquarters as the Deputy Director of the Voluntary Aid Detachments (VADs).

The VADs had been active in hospitals during the war years fulfilling a valuable role, but from the 1960s they were no longer allowed to continue this type of work. They were channelled into Red Cross activities such as beauty care and emergency welfare, which they were not keen to embrace as they felt that their skills were unable to be fully utilised. They wanted to do what they had done previously. Megan had the challenging task of making substantial changes within New Zealand Red Cross's welfare programme in line with edicts from Geneva. These were more in touch with contemporary needs for disaster preparedness and relief, as well as health issues. This was the 1970s and over thirty years since the war had ended, and the VADs were now in their fifties and sixties and less suited to the demands of disaster relief and first aid activities.

She was commended for disbanding the New Zealand Red Cross VADS in 1974 with "tactful guidance and considerable diplomacy and foresight in the development of a new programme much more appropriate to contemporary needs".¹⁹

¹⁹ Application for the Florence Nightingale Medal (28th award, May 12, 1981).

We had to change the thinking....It [VADs] was sort of paramilitary in some respects, they are marching here and marching there and all this attention to buttons, and gloves and shoes, and hats... \$500 spent on a uniform that was only being worn perhaps once or twice a month wasn't really necessary as they could do just the same thing with an overall.

Then we had to get rid of the marching because that really wasn't something people wanted to do, neither the cadets, which were the young ones, wanted to march anymore, and the idea of knitting Peggy squares... and they collected clothing, those battered old hats with feathers and roses, old shoes, somebody else's shoes at the best of times don't look so good, ...and if there had been a famine or a problem some where, an earthquake we'd get corsets and things of this sort being sent into HQ and not always too clean. And all these sort of things had to be ratified or cleared up somehow, so this is what I had to do and being made very unpopular in the process.

In 1974 Megan became Director, Health and Welfare for the New Zealand Red Cross and was instrumental in developing the disaster relief units which attracted young people into the organisation. She emphasised the need for first aid training to create self reliance, especially for emergency or disaster situations, a concept which is strongly promoted today within the Red Cross Movement everywhere.

We taught people first aid in order that they could help themselves...to be able to look after themselves should the situation arise. We had courses...first aid, emergency welfare....I instituted instructional technique course, proved quite useful and helped those who were going into schools or public arena, and they could present themselves better than they had done previously.

Her contribution to the setting of standards for cardio-pulmonary resuscitation has had a lasting legacy at a national level. From 1978 until 1981, Megan continued as a lecturer and examiner for first aid and home nursing on a voluntary basis for the New Zealand Red Cross and extended first aid course to non-traditional groups such as the seamen and local industries.²⁰ In her time at New Zealand Red Cross in the 1970s, she saw the

²⁰ 'New Zealand woman earns international award', *Red Cross News*, issue 3 (1981), p.4.

development of support to the Pacific Red Cross Societies, largely through the work of fellow recipient, Moya McTamney and had considerable respect for her Red Cross Colleagues and the organisation itself.

I admire the work that the Red Cross do all over the world, not necessarily in health but in every other way. I don't know that I have thought much about it [Red Cross principles], it's something that is inborn within nursing principles that you can follow through, but it's very difficult in the present day to adhere to those things.

In her retirement, Megan has continued to retain an interest and involvement in New Zealand Red Cross and first aid. She has recently retired from being a supervisor of 5th year medical student examinations for Otago University.

In 1981 Megan Crisp was awarded the Florence Nightingale Medal in recognition for her work in Malaya although it was not with the Red Cross, her work with New Zealand Red Cross as Director of the VADs, Director of Health and Welfare and first aid lecturer and Red Cross volunteer. Her reaction on receiving the award was self effacing.

For me it was one of extreme humility because when I think of some of those other nurses who have received this, I hold in very high regard, I don't know that I have done anything more, and I certainly feel I've done less than many of them, and from that point of view, this is probably the wrong thing to say, but I was rather distressed at receiving it....And of course the medal is there, it's not like a gong you received from the Queen where you are asked if you want it...there is no choice. I was rather surprised and rather horrified that I should be held in the same regard as some of the women who have gone before and those since who have received it.

The medal was presented by the President of the ICRC, Alexandre Hay in a special ceremony at the James Cook Hotel in Wellington.

Rather nerve racking having one's family there, I was honoured by the occasion, especially to having it from someone like Alexandre HayOf course when

you are given such an honour...something you don't do alone, there are several people with whom you work who are behind you, who have done more than enough to assist you to get to that honour....Its not you alone and what you have done, but it's what you have done collectively with others... individually, I am not so sure.

I remember I was at the Blenheim Returned Servicemen's Association, this is way back...and one of the men said to me, 'do you see that woman up there', and there was this nurse, with this picture of this hospital ship. He said 'she's got one of the highest wards' and I said, 'has she', 'she got the Florence Nightingale Medal,'²¹ and he was so thrilled that here in Blenheim they had such a person, and she took pride of place in the RSA there. Yes, [I kept quiet] but I was so thrilled he was thrilled that this person from Blenheim...and she was one of the first recipients.

Glenys Checchi

The only thing you can leave behind in any assignment is knowledge...for me that's the most fundamental thing you can do, transfer of skills, transfer of knowledge.²²

Glenys wanted to be a school teacher but did not have the subjects in School Certificate and went nurse aiding straight from school. She loved this and it had "a big impact" on her. She was advised by an aunt to do her general rather than enrolled nursing and trained at Wanganui Hospital, registering in 1970. She became a staff nurse in the operating theatre where she worked for a year and then went overseas as most nurses did at the time. She worked for nursing agencies in England in a variety of jobs.

²¹ Note, it is thought to be Edith Rudd, recipient in 1961 as her award was presented at the RSA in Blenheim and she had been a member since World War II. Source, 'Highest Red Cross Award presented at Blenheim', *Red Cross News*, (October 1961), p.1.

²² Oral history interview with Glenys Checchi, 8 September, 2001. Unless otherwise stipulated, all information relating to Glenys Checchi comes from this interview. Note also that Glenys is now referred to as Glenys Checchi, not Rodger-Checchi.

On return to New Zealand in 1974, Glenys worked as a theatre nurse at Calvary Hospital in Wellington, and then took some time out to work as a barmaid “to work where there were no sick people.” On return to nursing, she worked as a staff nurse in the cardio thoracic ward and charge nurse in cardiac theatre ward at Wellington Hospital.

Glenys went to live in a community in the Coromandel where she was elected to be the midwife in the group. This led her to undertake her midwifery training at St Helens Hospital in Auckland in 1979. On completion of the course she heard that the New Zealand Red Cross wanted nurses to go to the Thai/Cambodia border.

It was at that time that the New Zealand Red Cross advertised for nurses to go to Thailand to work with Cambodian refugees and they were particularly looking for midwives and one of my other classmates said she was going....I thought I might as well be over there helping someone as sitting around here wandering what to do with myself. I had only just finished midwifery and I went straight off to Thailand/Cambodia as the midwife of the team.

....The biggest motivation....I've got everything here that I need, it filled a philosophical need, it was probably to satisfy my needs, but six months out of my life...I knew there were people here who needed help I thought they did not need it as much as they needed help over there.

In 1979 hundreds of thousands of Cambodians fled the Vietnamese occupation of Cambodia in the wake of the Khmer Rouge ‘killing fields’ and crossed into Thailand. It was estimated that there were about 600,000 or 750,000 on the border at the time.²³ The Cambodians were considered by the Thai authorities to be ‘illegal immigrants’ and moved them into holding centres dotted along the border, confined by barbed wire fences and guarded by Thai paramilitary. A joint emergency operation by UNICEF²⁴ and the ICRC on the border reported that the number of children under five years was low and that 80-90% of them were severely malnourished. Malaria, dysentery, intestinal

²³ W. Shawcross, *The Quality of Mercy*, D.D. Books, Bangkok, 1985, p.227.

²⁴ United Nations Children’s Fund.

parasites and respiratory illnesses were of epidemic proportion. Those weakened by hunger were affected most.²⁵ It was estimated that there were only about fifty doctors remaining for a population of approximately four million people, such had been the decimation by the Khmer Rouge.²⁶ This was the backdrop for several of the nurses who went to Thailand in the early 1980s to assist the ICRC operation.

The New Zealand team were accommodated with other International Red Cross workers at Barnes village at Wattana Nakon, named after New Zealander Seth Barnes who built the autonomous community, approximately twenty-five kilometres from the border near Aranyaprathet.²⁷ The situation in the field was described by Glenys.

It was unbelievable....We were in a team of five....It was like an adventure...Then we had to travel quite a long way over dusty roads on the back of a pick-up to go out to the camps. We were allocated to go and set up an outpatients or feeding station, 'OPD No. 3 Mak Mun', one of the biggest camps. Huge numbers of people, no facilities, flies everywhere. The first week we had to spend building a bomb shelter, a bunker, working with a Japanese team. We were literally filling sandbags for a whole week. If there was any shelling, it was very volatile, we would be able to go in there for shelter. We often had to leave the camp at 1 or 2 [pm] because the situation was so dangerous. We worked really hard, interspersed with leaving the camps because of security reasons.

The people were quite traumatised. So for common coughs and cold they wanted medicine because they thought it would make them feel better and they were severely traumatised. They had fled under terrible situations, they had walked for days, they were tired, hungry and thirsty, and even when they had got to the shelter and safety, there was still shelling and there was a lot of power politics going on in the camp as well. It was just back to basics, not having to rely on any Western sophistication but to try and balance out what you had and what they didn't have, and try and bring together.

²⁵ 'Kampuchea', *Red Cross News Special*, April 1980. p.4.

²⁶ Refugee Appeal, *Red Cross News*, issue 6, (December 1979), p.2.

²⁷ 'Kampuchea' *Red Cross News Special*, p.8.

Glenys learnt to adapt quickly to local resources when a woman was brought into the Out Patients Clinic to deliver her baby.

I said to the doctor, can you get me the kidney dish for the placenta? He said, 'what are you talking about, don't be ridiculous, use this plastic bag'. It was a big huge culture shock as suddenly you didn't have any of your own resources. We had a stethoscope, medicines, a basic list of medicines to treat basic diseases.

Glenys was adamant from the beginning, that of all the things that they could leave behind, skills and knowledge were the most important. This was evident from her experience in Thailand.

At Nong Chan right on the border, once again it was teaching the Khmers as much as we could, they did have some medics we could teach. We quickly realised that was all that was going to be left behind...knowledge. We worked with them, ran training courses, looked after people in hospital, treated diseases we'd never seen before.

As Glenys mentioned, the Cambodians were severely traumatised by their experiences. They had endured four years of persecution and execution under the Khmer Rouge led by Pol Pot and their final escape across the border was far from safe.

The Red Cross recognised the value of traditional medicine even in an emergency situation to help psychological as well as physical healing. This was included in the ICRC medical policy and Khrou Khmer healers were encouraged and promoted in the refugee holding centres.²⁸

Once the camps had got established they did have Khrou Khmer, traditional medicine healers, that was established as well. People realised there was a place for that kind of medicine especially for psychological trauma for them.

²⁸ W. Shawcross, *The Quality of Mercy*, p.243.

After this experience, Glenys decided to carry on with this type of work.

I decided I wanted to carry on. I liked the work, I loved the people, the challenge of work, going back to basics. I liked that way of life, I found myself feeling peaceful because it combined what I thought about people, my skills, travel, working in a different country, many things.

She went on to London to do a course in tropical disease at the London School of Tropical Medicine and then explored with the British Red Cross the possibility of returning to Thailand. She went back as Medical Administrator for five months and did another type of job within the Red Cross. The job required ordering supplies to replenish the warehouse, and organising staff.

When Glenys returned to New Zealand in 1981 she worked as a theatre nurse until the opportunity arose for her to join the first surgical team as theatre nurse to Peshawar in Pakistan in 1982.

The Russians had invaded Afghanistan in 1979 and installed a Communist government there. Many Afghans had fled to the safety of Pakistan or Iran. As they were fellow Muslims and many were Pashtun tribes people, some settled in tribal territory and were able to live in tented open camps on the Pakistan side of the Hindu Kush mountains. At the time, there were approximately three million refugees in Pakistan's two poorest provinces. This presented a major financial, social and political burden to Pakistan.²⁹ The ICRC in 1981 set up mobile first aid teams, to service the camps and treat the war wounded soon after their arrival in Pakistan. In 1982 it established a 106 bed surgical hospital in Peshawar.³⁰

The 1982 team sent to Peshawar in Pakistan included Glenys, a surgeon and anaesthetist, and was supported by contributions from the New Zealand Government of \$25,000 towards the cost of \$56,000 to maintain the team for six months.³¹

²⁹ J. Fullerton, *The Soviet Occupation of Afghanistan*, Methuen, London, 1984, p.173.

³⁰ 'Red Cross in Pakistan', *Red Cross News*, issue No.4, (1982), p.1.

³¹ 'Red Cross in Pakistan', *Red Cross News*, p 2.

The ICRC operated two surgical hospitals in Pakistan [Peshawar and Quetta] to treat Afghan war wounded, as it had not been able to negotiate access into Afghanistan at the time. In Peshawar an old post office was converted and had two operating theatres and several wards, including an intensive care or post operative ward for more critical cases. The approximately 100 bed hospital was staffed by two teams of expatriate theatre staff, a head nurse, laboratory technician and a majority of both Afghan and Pakistani nurses. The staff comprised approximately eight expatriates and over 100 local staff including gardeners, laundry staff and cooks. There was also a large ICRC infrastructure to support the full range of ICRC activities over and above the medical activities.

On the first of these missions, Glenys worked as a theatre nurse with the New Zealand surgical team alongside the Swiss Red Cross team. Initially the ICRC operated from a house.

A bedroom was turned into an operating theatre. We had a steam sterilizer, nothing pre-packed. Gauze squares were all made up from a big roll of gauze and so were the dressings, put into a drum and steam sterilized, but they were only surgically clean, given that the wounds were pretty dirty and infected, that was the best we could do at that stage. We had enough equipment, but it was basic and here the surgeons might be used to fifty different sutures, we had a suture list of about twenty and that hasn't changed for the last three years. We drew up a standard list of sutures and standard list of equipment, because the surgical teams were changing every three to six months, and that was to avoid people coming in and wanting sophisticated equipment when it was felt we could provide basic equipment to do the job but we just couldn't have every sort of equipment that different nationalities wanted.

Glenys returned to Peshawar in 1984, 1985 and 1986 for six, four and one month periods respectively, the latter missions as head nurse. The return to Peshawar in 1986 was for the explicit purpose of establishing a field hospital to take care of the anticipated influx of war wounded patients from Afghanistan. Glenys and four other

New Zealand nurses were ready at 24 hours notice to respond to the need. The hospital was provided by the Norwegian Red Cross;

On arrival, they were taken to the site on the outskirts of Peshawar.

It was a big, big area of dirt at Hayatabad. The field hospital was arriving the next day in containers. We got out there the next day and there were all these boxes...where do you start?... We had some wonderful other New Zealand nurses and we just made lists, and we just ticked them off as we did them....people putting up tents, we got the operating theatre going, someone else was building latrines. It worked, it was great. We made plans along with the Swiss, we need 100 beds, this is where that tent will go, we need an operating theatre, this is where that will go. We had to undo boxes to get everything out ready for us to work. We had a MASH tent. It was truly a field hospital.... then we needed a place for nurses to sleep overnight and there was another tent there. We just got on and did it. The casualties were there in two to three days. We just had to get on and do the best we could with what we had...that was very good, it was back to basics, setting up from scratch again.... It was an extraordinary experience, I felt it was setting up a MASH field hospital, I felt we were in the middle of a TV series...all the funny things that happened, the working conditions, the camaraderie-ship with the other nurses and lots of international people we had worked with before. They are all highly skilled and just get on and do the job. I think it was for about two months, then it got packed up into containers and kept on stand by in case of further influx.

Some things didn't work, in 40 degrees heat we didn't need feather duvets, but that hospital was ready to go anywhere. So we had to sift through the stuff to see what we could use, things like mobile IV stands don't work on rough terrain. You don't want plastic. I can remember I had a fight with a French engineer about what we were having on the ground. We just wanted shingle and pebbles, because the Afghanis have a habit of spitting and just covering up the spit with a scuff of shingle. I got my own way, I got shingle! All the time we were trying to adapt to what was appropriate for them.

Working alongside country nationals to support, teach and exchange skills, helped to nurture a relationship with local staff and patients based on mutual respect and trust. This developed in particular when nurses returned to the same country and area on several occasions. For Glenys, “every time I arrive in Pakistan feels like going home.”

Some teams came in and thought they knew everything, and that the local staff did not know anything, so there was that kind of conflict about how do you get them to recognise that these people were their equals and must be treated with respect. It's not the West coming in and being superior and thinking they know everything. By this stage the Afghan doctors and Pakistani nurses were very skilled at working with Afghani war wounded.

In theatre where I was the first time, we had an Afghani doctor who came across the border working with us. The whole idea was to train them up so they got experience to manage without us. The theatre nurses were Pakistanis and the Red Cross employed both Afghanis and Pakistanis....For the Afghani doctors having the western doctors, I think that was invaluable for them, they learnt quite a lot, and they became very skilled. In the latter years, they were more skilled at treating war wounds than a lot of the western doctors coming in.

Tact, diplomacy, leadership and negotiating skills, along with a sense of humour, were valuable assets. As head nurse at the ICRC hospital in Peshawar, Glenys commented she had applied the skills learnt overseas, in her current job.

That was a great experience learning how to negotiate and deal with different types of workers, and different nationalities. ...If I look back now and if I had my 'HR' experience I have now, it might be a lot easier. They have actually taught me a lot of things I apply here in my current job. Like just trying to negotiate with everyone to get their needs sorted but keeping in mind the overall objective of the whole thing. The administrative staff I that I'm working with - when I find it difficult to deal with them now and their problems, I think back on how did I deal with Abdul there [in Peshawar]!

The family demands on those nurses Afghani and Pakistani were quite a lot and they used to send me some great letters, I wish I'd kept them now. For example.

Dear madam, I won't be coming in to work today because I'm suffering from giddiness, blindness and deafness....Mr John won't be at work today, he had a heart attack last night and died....Abdul won't be at work today because his grandmother has died, and when Abdul came back to work – Abdul, it's funny your grandmother has died three times this week hasn't she - and we would just laugh and laugh, it was great.

From this structured and team situation, in 1986 Glenys accepted the offer by New Zealand Red Cross of the challenge of a complete change and went into a totally different environment requiring different professional skills and a different way of working. Famine had been evident in Ethiopia since 1983, but it was not until late 1984 with a BBC television broadcast, that the reality of the “closest thing on earth to hell”³² was exposed to the world and action ensued.

The ICRC requested a nurse in Ethiopia to do nutritional surveys in the post famine phase. Glenys arrived in Addis Ababa, and within three days was flown to a small village to do surveys. The work involved measuring the local population to assess their nutritional status, distributing sacks of rice and to teach the Ethiopian workers.

Within three days I was off to do nutritional surveys and distribution of food. I had some kind of briefing in Geneva, I had the methodology of how to measure kids, I had also two to three good text books. I suppose I was a bit green. My mission was not to document it but to physically do it and get an idea of their nutritional state.

Glenys found herself “dumped in this tiny little place called Sekata” in Ethiopia, with one other ICRC expatriate. She found the living conditions wanting.

³² A Report of the Independent Commission on International Humanitarian Issues, *Famine, a man made disaster?*, Pan Books, London, 1985, p.23.

I don't think I unpacked. I had a bag, I never unpacked. I always slept in my clothes and had things on the top of the bag ready to go. There were shells every second night and I was under the bed more often than not sleeping.

I realised pretty soon I'm not going to survive this mission. There's going to have to be two ways out, either I have to give it up and say I can't cope with it or I'm going to have to work my way through it. This place is not going to change. If I'm going to survive this, I'm going to have to do the changing, adapting, so....One of the things there was no water for a basic wash, no shower, toilet, just a hole in the ground, latrine, basic as.....If I can get some water and heat it up on the little gas ring, then I might be able to survive.

They worked for several weeks and then had four days off when she would return to the ICRC office in Desi, Wollo province. The daily work involved

distributing food, sacks of rice, and then I said how are we going to fill in the rest of the day, because that was over by lunch time. So we thought we would teach them. We had the books and would teach the Ethiopian workers what we could. So that's what we did for weeks on end and then we would go back to the house in Desi which is where our base was in Wallo.

Glenys also travelled vast distances to do other nutritional surveys, assist in clinics and first aid posts, and at times had to resort to using donkeys to traverse the remote and difficult terrain. She described the local people as "fantastic". She ate local food and adapted to the basic conditions.

We drove about fifteen hours over these roads I'd never seen before....The next day we went by donkey right up into the highlands. Arrived there at 7 [pm] after riding donkeys all day, slept in one of those African little huts where they bring the animals in. We woke up in the morning, mosquito bites, everything, fleas, we woke up to the sound of the farmer chopping off the goat's horn and blood spurting everywhere all over us, we just had a piece of dried corn for breakfast and on we went.

Although people were curious about her as a pale red-haired woman, she blended in by dressing discreetly, and did not find the situation frightening.

I could see how people went troppo. In Lalibela it was a very spiritual place, had those beautiful churches underground, we were the only foreigners, amazing. Once we heard the plane circling overhead for us to go down to the strip, that's our civilisation stress, we got quite used to it in a way. The Ethiopian ladies used to braid my hair and put butter on it. You'd adapt and survive, we would walk around the place...you just adapt.

The departure from Ethiopia after four months was under hurried conditions as the whole ICRC operation was threatened because of the perception of what was trying to be achieved in negotiations to visit prisoners of war. The delegation Glenys left Ethiopia with the other ICRC delegates and returned to Geneva for debriefing.

While she had been in Ethiopia she was asked by New Zealand Red Cross if she would be interested in spending a year in Geneva with the aim of training for her to return to New Zealand and the position of overseas recruitment officer. This offer was accepted and Glenys spent a year in Geneva in 1987. Friends had advised her to continue working in the field, but the temptation to work for the ICRC and, eventually, New Zealand Red Cross was too strong.

The job in Geneva was primarily an administrative one and Glenys felt that her broad range of skills were under-utilised and she was unable to contribute to the medical area of operational work in a bureaucratic system. However, her knowledge of what it was like in the field and the type of person needed was invaluable. She enjoyed the work and contact with other Red Cross National Societies. Glenys spent a year in Geneva working for the ICRC and learning about recruitment for her return to New Zealand.

A wonderful year in terms of living, learning, and working with the organisation, pretty frustrating in terms of basic recruitment, administration. I felt my skills were wasted there. I can remember being in tears many times in Geneva...I can do more than this. I think they found it quite difficult that people were multi-skilled and could do more than one thing...We can cross many

boundaries, and with my experience in the field I was able to cross many boundaries, but it wasn't allowed in that bureaucratic system.

In 1988, Glenys returned to New Zealand and the position of recruiting overseas personnel with the New Zealand Red Cross. It combined the field work experience from Asia and Africa, the knowledge gained from her time with the ICRC in Geneva, and she was able to keep up to date with international developments. The key responsibilities were responding to requests from both the ICRC and the Federation for field personnel often at short notice; to provide comprehensive briefings for the delegates, and maintain contact with them in the field; to keep in touch with delegates' families while overseas; and to debrief the delegates on return to New Zealand.

Professional competency and five years' clinical experience are requirements the New Zealand Red Cross has for nurses to work overseas.

The biggest thing was the personal side, how would they adjust to the field? How would they get on with this person if they are going as a team? Will those personalities get on? Will they observe the Red Cross rules in terms of principles, the security rules? Are they a risk? Are they cow-boyish? Do they want to go off on their own? It was taking into account all of that personal stuff that was really important. So the delegates seminar gave us an opportunity to give them knowledge about what the Red Cross stood for and how they operated in those countries.

Since 1985 the New Red Cross has run annual delegates' training seminars. The Red Cross principles and humanitarian law have been taught at these seminars and attendance is a prerequisite for overseas work. Glenys ensured the continuation of these when she took over the position.

Those delegates seminars were an initial introduction. Some people didn't fit in. We treated them very seriously....Most of those people [who attended] have gone away. It was a basically an introduction to a Red Cross course.

She was interested in exploring the social behaviour of nurses as a part of assessing their suitability to go overseas, and was firm about the expectations of behaviour. While she did not have to withdraw anyone for bad behaviour, she did for health reasons. She had heard of others who had been withdrawn for breaking security rules.

Dealing with war wounded and refugees, situations where there is a huge demand on your own personal resources, when you have to cope physically, you have to cope mentally, on a personal level in terms of environment, cope on a professional level...I don't think it's the place for a young person, but, maybe I'm wrong, maybe they are the ones to go where they don't have those kinds of fears or observations, but I think there is a certain level of maturity needed for you to deal with those sort of things.

Self knowledge and awareness about coping capacity under stress and ways of alleviating stress are important. In this sense, the ability of the nurses to be self reliant and independent is fundamental to their survival, as Glenys herself discovered in Ethiopia.

On their return to New Zealand, the health and wellbeing of the delegates continued to be of concern and the debriefing process provided the opportunity for the delegates and the New Zealand Red Cross to listen, to assess the mission, and to detect any deleterious effects.

At that stage we didn't recognise there was such a condition as post-traumatic stress syndrome, and probably for some of us, we also could have done with some counselling, and debriefing. And I think, now looking back, a lot of those delegates were quite traumatised. There were some significant changes that had happened for them while they were on mission, big huge shifts for people in personal thinking and big huge experiences in what they'd seen.

We helped with the debriefing process in that we spent the time with them, and made them feel important, and recognised their worth and what they had done....A lot of people had given up a lot of stuff...you had to be able to take the risk of not having a secure job at home, so there wasn't the security, if you

like. They had stepped outside that normal pattern. They had made a decision to have that experience but they had also made the decision to leave behind some of that other stuff like a regular job and what will I do if I don't have a job when I get home....A lot of people had made a lot of personal sacrifices, so it's up to us to recognise that.

At the time, there was little problem with Hospital Boards keeping nurses' positions for their return, the Wellington Hospital Board had a particularly generous record. With the State Sector reforms in 1989, it became less easy for nurses to come and go and individual recruitment was affected to some extent. However, there would be no likelihood recruiting five nurses from the same hospital in the 1990s as was possible in the 1980s.

From her frequent and wide range of Red Cross experiences in the field and in head offices, Glenys was able to reflect on concerns about delegates' behaviour and found her values sometimes came into conflict with some of the other expatriates because of her sensitivities about the imbalance of power and the potential for exploitation by outsiders.

I had difficulty with people thinking just anything would do. I was always astounded the way people came into the field and left behind their values at the airport, both professionally and personally. I found that attitude of anything could do really difficult to accept. I found the way some people treated local staff was appalling...that superiority thing. I found the social values of the delegates difficult...men and women working together, foreign country, Muslim women, untouchable....There were serious consequences in a number of cases, found it hard not to judge that situation. I asked myself, would you behave like that in your own countries? When I asked myself that question, in a lot of cases, I don't think they would...it was let loose. I know they thought I was too rigid in my thinking....I thought it was exploitation and I certainly didn't want to be part of that.

Working in areas at war, or close to it, exposes humanitarian workers to considerable risk. The changing nature of war and the environment has increased the risks.

The observation of the different parties of the Red Cross...once before people used to say you are always safe because you are working for the Red Cross but you can forget that now. Its huge personal risk, huge personal safety issues...it's changed.

Glenys also recognised that it was a privilege going to another country, and at the same time appreciated that outsiders are a risk to country nationals.

We are privileged we can go into another person's country and work there....ICRC protects you from a lot of stuff going on, they get a house organised...you can work the whole time because everything else is taken care of....That's why a lot of people find it difficult to let it go....Its great if you want to work....from a professional point of view.

We are a risk in their country, they are really scared that something is going to happen to us and so they want to protect us, and it doesn't matter what you think, but everyone knew what you were doing because you are a foreigner...you are on show the whole time. People forgot that, they thought they could do anything. It's a big risk for these countries to have us there and while they accept the help and they want the aid and money, it is a risk and they are frightened that something's going to happen and they'll get the blame.

Maintenance of professional and personal standards was important and one way to achieve this was to ensure a gap of some months between missions. It was one of the New Zealand Red Cross policies that people would need to come back to New Zealand for six months before they went back out again.

Looking back...we didn't want them to become victims of that work, to a certain degree people who were out for a long period of time did....Whilst they took it, they didn't ever understand where we are coming from...but I've seen people who have become victims. One of the underlying reasons was we felt we should be able to offer the people with whom we are going to help or give aid to, the best possible wisdom and knowledge available at that time. I think if you stay

out in the field a long time you become professionally isolated. There's no way you can keep up to date with the different medical trends here, medical practice and what's happening...so I think that by coming back into your own profession here you keep current, and up to date. I always felt that that was really important because I think it's like a lone practitioner operating in New Zealand society, that there's a real big risk that you cannot keep current as you haven't got that stimulus...or the possibilities of learning new things.

She was sensitive to the effects of the rapid turnover of staff for local staff, so the adherence to standard practices was important. It was usually the nurses who had to keep reminding the doctors of this.

Glenys held this position until 1992 when restructuring at the New Zealand Red Cross meant the dissolution of her position and the termination of what she regarded as, "if I could have the perfect job, this was it". This change also represented a considerable loss of expertise and institutional memory to the organisation and the delegates themselves.

During this period with New Zealand Red Cross, in 1991, Glenys returned once more to Peshawar for a month. This mission was different from previous experiences when she looked after prisoners of war who required hospitalisation prior to repatriation to Afghanistan.

That was a totally different kettle of fish, looking after the people from the other side, just as good, but when I went the people I had worked with in the previous mission asked me why I was enclosed there, we got out once. There was a house in the grounds where our three bedrooms were, a place to cook and eat. You stepped outdoors and there were these two tents with all these Afghani prisoners of war in, so we were eating, sleeping and drinking there.... We had to ask one of the delegates to stay there so we could a day off. They were repatriated back [to Afghanistan] under the ICRC.

Glenys's time with the Red Cross spanned more than a twelve year period. She experienced the Red Cross from range of perspectives and her considerable experiences led her to reflect about the Red Cross.

There are always things about the Red Cross that you question...People criticise [the Red Cross] and say they don't take a stand, and that's frustrating for the people who are independent thinkers and often have a political point of view one way or another, but in the end it's the only way they can work. They have to get the trust of the government of the country they go into. If they are seen to be siding, they wouldn't get as much access...there are times when you can't always understand, but there's always a reason.

You as a professional in those organisations, you have to be able to accept the organisation and principles that you are working with to be effective. If you are always fighting the organisation you can't be effective as it blocks you.

If there was something abhorrent to me and I couldn't possibly do it, like it was against any principle I had, then I wouldn't have done it.

She was also sensitive about local women's issues and her own treatment as a woman.

In Thailand, I never felt I had to be very careful, whilst I was careful and observant about what we wore, you don't see the Khmer women in shorts, I think the different one was Pakistan. It was a Muslim society, fundamentalist, very few Western women living in Peshawar at the time. I had to be very careful what I did and what I wore and when I went out. I can remember riding a bike through the University ground with a couple of doctors and being spat on because I was on a bike. It changes your thinking too because we think we have the power. The Afghani women too had the power at home. Different roles. In Ethiopia people were often saying to me women have to walk miles to get water everyday, down hills and up valleys with urns on their heads. If we brought it closer, what would it do, that was their socialisation. There are lots of issues to think about in terms of to women, power, and different cultures. We used to have a lot of female nurses in Peshawar, there were often things they couldn't do. The Afghani men didn't mind there were Western nurses looking after them.

Glenys was awarded the New Zealand Red Cross award for Outstanding International Service in 1986.³³ Today she works in health administration in Wellington.

She was awarded the Florence Nightingale Medal in 1987. When asked about her reaction to being a recipient of the medal, Glenys could not reconcile the fact that she was benefiting from the misfortune of others.

I felt extremely humble, and extremely embarrassed, because I thought for me, why would we get a medal – the reason you get a medal is because you have been overseas helping people who are in desperate need. I was extremely embarrassed....I still feel like it. It's like writing a book and making million out of somebody else's bad experience. I remember thinking, oh God, if those people hadn't been in that situation, I wouldn't have been there. So this medal...while it's a privilege and an honour ...I still feel like that, I still feel embarrassed. I don't ever like to talk about that. I've got it, people say it must have been the pinnacle of your career, it wasn't, of course. It was a great thrill for my family, I think they got a great thrill out of it, and it was a wonderful honour, but somehow I couldn't get over that...what could I give back to them after receiving that award....I don't feel great about it, I have to say.

I'd never heard about it, no, I never knew that, what it was for. I never knew that that other New Zealanders had it. I didn't have a clue about it actually....For the posthumous awards, I think there needs to be some recognition for the families of those people, but I'm not so sure about those people who are still living.

Do you work because you want to be recognised or honoured? It was something I chose to do, it wasn't as if I was asked, I volunteered.... So do you get something like that medal for volunteering? There was a choice for me, nobody made me do it.

It was great, really...it was a great day. it was a really good day, it was hot...and I made an off the cuff speech, that I think everybody was in tears, they wanted

³³ Application for the Florence Nightingale Medal, (31st Award, 12 May 1987), ICRC Circular 537, Geneva 12 August 1986.

me to repeat it, which I couldn't do because it just came out. In that respect the ceremony was very, very moving, in that respect it was a very nice thing for Red Cross to do, I think, and that part I think is fine. Why you get it is a different issue. Of course I love going to other people who get it...and I absolutely think, isn't that wonderful, they really deserve it and I love going to their ceremonies.

Wendy Smith

The main theme about being a delegate in any place...it's about standards, you set the standards and you say this is how it will be and you don't accept second best.³⁴

Wendy went nursing for no clear reasons. University was not discussed, but she was encouraged by a friend and trained at Wellington Hospital from 1966-1969.

She loved the first three months and has been nursing ever since.

As a student nurse and president of the New Zealand Student Nurses Association, Wendy had her first taste of international nursing through her attendance at the International Council of Nurses Congress in Montreal in 1969. She worked as a staff nurse for a year post registration, and in 1970 travelled overseas as most nurses did at the time, working as a nurse and nanny in England. On her return in 1972 she was employed at Calvary Hospital in Wellington, at Wellington Hospital for a year, and then became a nurse tutor from 1974-1975 at Wellington Hospital.

Wendy undertook the midwifery training at St Helens Hospital in Wellington in 1975 and continued working at St Helens for several years. She then became an obstetric tutor at the Hutt Hospital in 1978 and a charge nurse at Kenepuru maternity hospital. In 1977, Wendy gained the Diploma in Nursing at the School of Advanced Nursing Studies in Wellington.

³⁴ Oral history interview with Wendy Smith, 24 September 2001. Unless otherwise stipulated, all information relating to Wendy Smith comes from this interview. Note, Wendy was known as Wendy Woodward until she married in 1991.

In 1979, Wendy responded to an advertisement for nurses and midwives to go to Thailand. She was selected to go with the first medical team to the Thai/Cambodia border.

I was home alone one morning and listening to the radio. New Zealand Red Cross was looking for nurses and midwives, that was me, they had to be between 26-44 years - I was then, they had to be physically fit and well, - heavens that's me, and then they said they had to be prepared to live and work in rough conditions and I thought I couldn't do that....But this advertisement was so well made that I rang them up....She...made it sound tantalising and suggested I go in and talk to them. About three weeks I went away in the first medical team that went to the Thai/Cambodia border.

This means of advertising for nurses was only used for the early 1980s in response to a refugee crisis on the Thai/Cambodia border. After that time, the New Zealand Red Cross maintained a cadre of nurses who were to go out on a number of successive overseas missions, some at short notice, and who became highly skilled and experienced in nursing in a variety of capacities.

Wendy attended a weekend preparation course, in which issues of security and rules were discussed as well. Wendy particularly remembered the advice of a doctor:

'Until now you have been working with fat well people, now it will be too hungry, too thin', and it was all true.

Wendy arrived in Thailand in a "big muddly wave of excitement". The tasks were to survey the camps, assist in the pharmacy and rotate around the four outpatients in the border camp of Nong Mak Mun.³⁵ After three months in the field her "blood was humming" with her experiences. On her return she was able to secure a full time position as Pacific Island Project Officer with the New Zealand Red Cross in the Pacific Island countries. This position required extensive travel in the Pacific Region to evaluate New Zealand Red Cross projects and provide advice on programmes with the aim of strengthening Pacific Red Cross Societies so they could determine their own priorities and activities.³⁶ She was also available to assist with disasters. On one of her

³⁵ 'Kampuchea', *Red Cross News Special*, April 1980, p.9.

³⁶ 'New Zealand Red Cross in the Pacific', *Red Cross News*, issue No. 1, (1984), p.2.

routine visits to Samoa in 1982 Wendy's visit was interrupted with the news she was to be the League delegate in Tonga to manage the disaster relief programme in the wake of Cyclone Isaac.

I wasn't a relief expert but what we did was to respond to demands. An enormous amount of aid was coming into Tonga....I worked hand in hand with the Tonga Red Cross....The highlight of the period was that we visited the middle group of islands, which is called the Ha'apai group and consists of thirteen, very small islands, quite widespread. We chartered a boat, an octopus boat, unfortunately, the smell made me very sick. With a hold full of supplies and Tonga Red Cross colleagues we visited eleven of the thirteen Ha'apai islands and we distributed relief to everyone of those islands; fishing nets, soap, bowls, lanterns, axes, pandanus leaves for thatching, plastic tarpaulins. It was a marvellous relief operation, beautifully planned and well carried out, and of course with hymn singing before and after distribution and these wonderful little far flung islands which all had to be reached by canoe from the octopus boat, very dicey business. It was just fascinating....It was the second week after the storm so they were impressed with the promptness of our response.

The Vietnam War which began in 1963 culminated in the fall of Saigon and departure of the Americans on 30th April 1975. This triggered the exodus of several hundred thousand Vietnamese. It is uncertain when the first boat people left Vietnam, but it is thought to be at that time.³⁷ This was to continue for a number of years and became a highly organised profit making racket involving considerable suffering and abuse.³⁸ By the beginning of 1979, more than 100,000 Vietnamese had fled to other parts of Southeast Asia. In a six week period, 40,000 people arrived on Pulau Bidong off the east coast of Malaysia.³⁹ This was Wendy's destination on two occasions, in 1983 and 1984, for four and six months respectively.

³⁷ K. St Cartmail, *Exodus Indochina*, p 87.

³⁸ K. St Cartmail, *Exodus*, p.98.

³⁹ W. Shawcross, *The Quality of Mercy*, p.83.

Pulau Bidong was established as a refugee camp for 5,000 Vietnamese in 1978 to accommodate refugees awaiting resettlement in permanent asylum countries.⁴⁰ The Vietnamese boat people were held on Bidong in an enforced containment by the sea, approximately fifty miles off the east coast of Malaysia near Kuala Trenganuu. The island, a one kilometre square volcanic island, with a steep tree covered hill in the middle, a few acres of flat ground on one side and a small beach on the other. This island accommodated approximately 54,000 people at the height of the crisis who were crammed in and living in their own excrement in shelters made from plastic sheets or rice bags stretched over frames made from jungle saplings.⁴¹

The camp was run by the Malaysian authorities with the Malaysian Red Crescent Society dispatching rations provided by United Nations High Commissioner for Refugees (UNHCR), who also processed the refugees. The Vietnamese organised themselves as a community with a black market activity, a Camp committee and radio station, but life was spartan, as fishing or growing vegetables was prohibited by the Malaysian authorities.

In 1983, when Wendy arrived, the lack of adequate sanitation and hygiene facilities, and a poor diet, were preconditions for the risk of epidemics. As head nurse, Wendy had to ensure that basic public health conditions were maintained, such as clean water supplies and working latrines to prevent an such an outbreak.

We worked all day and most of the evening. We were a small group, there was a doctor, dentist, a nurse and lab technician We lived upstairs above the hospital we had a small room each. Shared it with several hundred rats which were a great challenge, and about 12-14,000 Vietnamese people at that time, and the constant presence and pressure of rather thuggish team of guards, called the Task Force.

Refugee arrivals would be processed within several days and provided with a basic comfort kit, weekly rations and cooking utensils.

⁴⁰ K. St Cartmail, *Exodus Indochina*, p.118.

⁴¹ K. St Cartmail, p.118.

The most important work we did was with the new arrivals. When a new boat would come the people had been at sea for anything from a few days to several weeks. They were dehydrated, hungry and tired, some of them were sun burnt, and very badly burnt. Some had petrol burns, and some had flame burns from actions vented upon them by the local population. Burns were a problem, and many of the women had been raped. Many of the people had been beaten. Many lost relatives overboard, either they were pushed over or jumped overboard in order not to face the coming horrors. So a lot of it was dealing with brutalised people, people who had suffered enormously, not to mention whatever it was they were fleeing. Pulau Bidong in some ways was a safe haven between the horrors of their old life and the very extreme challenges of the new life.

This protection provided by the UNHCR under its mandate, along with the presence of the Red Cross personnel, was helpful in reducing levels of violence and abuse, but was not able to eliminate it entirely. Wendy found she had to advocate in the best interests of refugees' health and to prevent violence. In doing so ran into trouble on occasions.

The level of malnutrition and anaemia was appalling. The refugees had rations that were inadequate. Unfortunately I couldn't change them. I remember having a huge row with a horrible guard on Pulau Bidong and I said to him with icy fury, beating people is wrong....We had a head to head row. I thought he was cruel, unnecessarily. I thought he was out of line. He left the island. He was withdrawn.

She resorted to careful, but firm negotiations with the Malaysian Red Crescent Society to obtain antibiotics, a new antibiotic for penicillin resistant gonorrhoea for rape victims on Pulau Bidong.

It wasn't sent, because they said that antibiotic's new and you don't need it, Gunter [doctor] had prescribed it. And I went down to KL [Kuala Lumpur], caught the next boat, challenged the pharmacy, wrote letters to UNHCR signed them, sent them, and said this is the medicine that's ordered, if you have a doctor who can prescribe something else I'd be happy to know about it, but this is what

the doctor's prescribed. I went back the next day with the medicine in my hand. So I think you have to challenge people to the hilt. Yes, there are always ethical dilemmas and you don't make friends by challenging it. I challenged the Malaysian Red Crescent and UNHCR as often as I could. If you write a letter, it's astonishing how people come into line. I never lost my temper, I never shouted, but I could be very firm and I don't mind writing letters. You have to say 'I don't accept this'.

Wendy's next mission in 1985 was to Darfur in Sudan where she worked as a nurse doing nutritional surveys for a year, again with the League. In the 1980s, internal warfare was being waged by Muslim fundamentalists in the north against the Christian and animist people in the south, and famine was one of the consequences.⁴² Darfur is the western most province of Sudan. There are only about 200 miles of paved road in Sudan, in a country bigger than France, and desertification is occurring at the rate of six kilometres a year. Wendy and a Finnish nurse volunteered to go to Darfur in West Sudan to assess the rates of malnutrition, to set up a feeding centre, and to care for people severely affected by a long standing famine.

We went and we were put down from a helicopter into a place and there were three tents, one was the feeding centre, one was the hospital - treatment station, the other, our little tent, and we stayed there for four months. Nobody ever went into our tent, nobody ever stole anything out of our tent, and the helicopter came every day and dropped off medical supplies and food – thousands of people came into that place and were fed and taken care of.

These are mukhet berries, famine food, and that's what people eat in a famine. They are like stones, and probably have a similar flavour and are probably about as good for you as eating stones, and that's what people live on in Darfur in the lean time. They have a lean time every year between one harvest and the next, between the last rain and the first rain but on this occasion it went on for eight months and no-one can survive that, even the adult men were lean. It was an appalling situation. I had never seen famine on a grand scale before. People died every day. At that stage the League had a rule of thumb, if 20% of the

⁴² W. Shawcross, *Deliver us from Evil, warlords and peacekeepers in a world of endless conflict*, p.253.

population are starving, that is, they have moderate to severe malnutrition measured on a weight to height scale (or in a hurry you can do it on an arm circumference but you should verify it later). If the amount of children under five years is more than 20% who show that degree of malnutrition, you should distribute food. In parts of Darfur I went to, without exception it was more than 70%, there were hardly any babies to measure.

The scale of it was so great it was hard to know where to start. It was just a nightmare. It's a country that's extremely poor, racked by civil war in the south...the poverty and malnutrition in Sudan is just ghastly. We stayed [in Darfur] for 4 months. I learnt quickly, and Sudanese women came in and helped us right from the beginning and worked with us...we just got along. You had to cook a big bowl of porridge every morning and serve it up before 7 o'clock. And people were standing in line before you got there. If you are in a community where people want to do things, its very easy.

Prior to her departure for Sudan, Wendy had been briefed by New Zealand Red Cross, and en route, spent a day in Geneva where she was given information by the League's nutritionist as famine relief is specialised and beyond the experience of most nurses. On arrival in Khartoum the briefing became more specific to the mission and localities.⁴³ Wendy's mission in Darfur was in part funded by the 'Live Aid for Africa' donations. In 1985, for the first time in New Zealand Red Cross's history it became involved in a major cooperative fundraising effort with six other overseas relief organisations and run in conjunction with Bob Geldof's Live Aid concerts in London and Philadelphia which were televised to New Zealand.⁴⁴

The following year, 1987, Wendy worked closer to home in Papua New Guinea. Irian Jaya, or West Papua (Indonesia) and Papua New Guinea (PNG) share a border of 750 kilometres cutting across thick jungle, inhospitable mountains in the north and swampy savannah land in the south.⁴⁵ The indigenous people of Irian Jaya are Melanesian,

⁴³ 'Into Africa', *Red Cross News* (May 1986), p.5.

⁴⁴ 'Red Cross Goes Live', *Red Cross News*, issue No. 4 (1985), pp.6-7.

⁴⁵ S. Dorney, *Papua New Guinea, People, Politics and history since 1975*, ABC Books, Sydney, 2000, p.201.

ethnically and socially the same as Papua New Guineans. Those who lived near the border were permitted, through an agreement between the two countries, to cross the border for social for economic reasons.⁴⁶ However, Indonesia's transmigration policy had increased the population of Javanese and other Indonesian racial groups in Irian Jaya and PNG felt threatened by the internal and fighting and secessionist movements within Irian Jaya.⁴⁷ In 1984, 10,000 Melanesians fled into Papua New Guinea, and sixteen years later, several thousand remained in refugee camps in PNG.⁴⁸ UNHCR became involved, initially only playing a minor role as the Papua New Guinea government regarded the Irianese as border crossers, to be repatriated, and not refugees.⁴⁹ In 1986, the government acceded to the United Nations Refugee Convention, involved the UNHCR, purchased land in the East Awin area of the Fly River for camps and granted the border crossers refugee status.⁵⁰

As a health delegate for the League, Wendy worked closely with the Papua New Guinea Red Cross and had the task of developing Red Cross branches out of Port Moresby, the capital, and to assist the Red Cross develop programme to look after the border crossers from Irian Jaya, who at the time were numbered approximately ten thousand. She worked with United Nations High Commissioner for Refugees in the East Awin camp designed to draw the refugees to safety and discourage temporary camps being used by Irianese rebels.

I felt really positive about being there in contrast to the despair of a place like Sudan. I was the only League delegate, my desk was within the PNG Red Cross....I had to do accounts every month, things I hadn't done before. I worked closely with UNHCR. We did set up encampments, not camps, and at the time UNHCR was building a large centre well inland to draw people who wanted to stay on the Papua New Guinea side. Because they are the same people around the border zones, Melanesian, same language groups, same tribal groups and to

⁴⁶ M. Alford, 'Influx in Papua New Guinea', *Refugees*, No. 7 (July 1984), p.11.

⁴⁷ S. Dorney, *Papua New Guinea*, p.202.

⁴⁸ S.Dorney, *Papua New Guinea*, p.202.

⁴⁹ S. Dorney, p.227.

⁵⁰ S. Dorney, p.229.

draw them into a place at East Awin where they could farm and be safe and not subject to the whims of the military posts run by Indonesian soldiers.

For some people that was a good solution, but for those whose traditional lands were in those high mountains around that border area...moving those people away from that area isn't the answer. So we had to look at things like, they were from the high mountains where you don't get malaria, they came down to river banks and into the Baptist mission settlements along the rivers and of course they got malaria so badly. They died of malnutrition after the long walk. They had all the health problems that people of Papua New Guinea had plus, plus. They had lost their land, some their wives, their farms had been burnt, their children had not been able to run fast enough to keep up. Terribly sad stories.

It was a wonderful year, I flew and flew and flew, there are no roads, there are only aeroplanes. I stayed in Catholic and Baptist mission stations with unbelievable people, and had wonderful adventures, travelled in the plane with crocodiles...with cassowaries...with a lot of dead people who were flown home back to their wantoks and I lived in Port Moresby and worked with the Papua New Guinea Red Cross, it was a wonderful year. My best mission.

In 1989, Wendy went to Sri Lanka as a League development delegate to work with the Sri Lanka Red Cross Society and implement a national plan to develop thirty-three primary health care centres. The conflict was between the Sinhalese who were Buddhist and represented 70% of the population, and the Hindu Tamils from the north and east of Sri Lanka, and 22% of the population. The latter were seeking to establish a Tamil state and conflict had been rife since the early 1980s.⁵¹ During a very demanding and frustrating year she managed to write a first aid manual, establish first aid training and visited branches of the Sri Lanka Red Cross. Because of the prevailing situation, the primary health care centres were slow to develop. One of her main achievements was to help facilitate the re-establishment of the ICRC programme in Sri Lanka after many years.

⁵¹ 'Regaining Paradise', *New Zealand Red Cross News*, Vol. 79, No. 2 (May 1995), p.6.

Perhaps one of the most important things I did was that a delegation came from the ICRC, they visited the Sri Lanka Red Cross....We told them all the stories we'd heard about murders, missing people, about bodies we'd seen in the river. I lived beside the canal and I could see bodies in the canal some days, our driver's family had been murdered, shocking things that had been happening there. As a result of that interview with the ICRC...the ICRC re-entered Sri Lanka after an absence of many years. They had four delegates the first week, twelve after two weeks, and something like forty by the end of the month and they were all dealing with tracing, missing persons, people imprisoned and the scale of the horror of the civil war became evident very quickly after that. It was very good to see the ICRC becoming re-established and so quickly grasping the mettle and dealing with the awful problems that were occurring at that time. They are still there to this day and running a huge hospital on the Jaffna peninsula.

The turning point for Wendy was 1991. She had been married in 1990 and was accepted for a position with the League to go to Namibia on a contract basis. She then worked for ten years full time for the League which became known as the International Federation in 1991.

When Wendy and her husband went to Namibia, the apartheid regime in South Africa had just ended, and Namibia became independent from South Africa in 1990. The Namibia Red Cross had been a branch of the South Africa Red Cross until then. Wendy's responsibilities as the only development delegate were to assist in the development of the Namibia Red Cross Society, in particular to assist in the nationalisation of the Namibian Red Cross and to establish branches throughout the country.

The Red Cross was also involved in the country's primary health care programme and Wendy had to oversee its involvement. She was made Head of Delegation during this time. The country also experienced an ongoing drought and she helped develop and maintain a successful drought relief programme which still operates well to this day.

Finncross [Finnish Red Cross] sent three doctors to work in the north. They worked in old mission hospitals which were now going to become national

hospitals....They needed to integrate them into the national health service. They had a huge campaign on primary health care which the Red Cross took the leading role in....I was made head of delegation and that gave me a new status....It was a little bit tricky as I'm a registered nurse and there were three doctors....one wasn't that keen, but he did agree to a few things. I remained as head of delegation which gave me a better status vis a vis the other organisations because I did become more than a development delegate, as we were working on all fronts.

There is more or less an ongoing drought. It is a desert country, the Namib desert and the Kalahari desert. It's as dry as...we had a drought programme which was interesting...we ran it well and some aspects of it are still running to this day. In all of those three fronts things went along quite well and it was with some regret that I left after three years. But three years is long enough for any delegate and it was time for the Namibia Red Cross to take more responsibility and for the League to step down and take a bit less responsibility, and that's what happened.

On leaving Namibia, in 1994, Wendy spent a year in Mongolia where she worked closely with the Mongolia Red Cross Society as head of delegation. Her major task was to build the capacity of the Mongolian Red Cross to cope with disasters, and to build a social protection mechanism for vulnerable people. The backdrop to this was the political emergence of Mongolia from sixty-nine years of Communism after the end of the Cold War. It was at a time of hope and opportunity but economic decline. Self sufficiency was the goal in developing Red Cross branches and community based first aid.⁵²

This was followed in 1995 by three years in Geneva as a health advisor for the Federation. This was a new position created especially to look after the health and wellbeing of the delegates. (The ICRC estimates that one delegate in four experiences

⁵² 'Out of the frying pan into the fridge' *New Zealand Red Cross News*, Vol. 79, No. 1, (March 1995), p. 7.

stress related health problems during their mission and 5% suffers from post traumatic stress.)⁵³

For a long time people had said, the delegates need someone they can phone on health issues....The job evolved very quickly, I saw the delegates before, during and after missions and if they came back to Geneva for any training course I saw them during. So I developed a rapport with most of the delegates...it got down to stress management, clearly the most important problem, and lifestyle diseases such as alcoholism, HIV or anxiety that one might be HIV positive, smoking cigarettes which inevitably increases on mission, and behavioural problems, people who can't control their anger....I was also dealing with other things, people needed medicines, vaccinations. I also had several campaigns where I tilted at windmills, they had a Swiss insurance system which I drove to the limit. I succeeded in getting people paid stress leave and sick leave when they had HIV and were sick. This was probably my greatest achievement in the job. I succeeded in lowering the premiums and increasing the amount the Federation was reimbursed by about 180%. We set up a programme of psychological support....With a doctor and two lady psychologists whom most delegates saw as a matter of routine....It was a psychological evaluation and assistance....Just having a person that delegates could refer to, they could phone, who handled deaths in the field, hospital admissions, was very helpful. The other campaign I followed closely was hepatitis A, B and C. I hope by insisting people had those vaccinations we have saved a lot of people liver cancer and some longer term bad effects.

As health advisor for the Federation in Geneva in 1995, Wendy was affected by the death of colleagues in the field.

A fascinating job and I loved it, but I worked to the hilt, in the end my mind had so much sewerage in it that I had to stop. We had the murders of the three ICRC delegates in Burundi and the murders of our six colleagues in Chechnya....It was a very, very enjoyable job, but in the end it became a little unbearable and I needed to change, and I went back into the field.

⁵³ I. Jaquemet, 'Psychological Support: luxury or necessity?' *Red Cross Red Crescent*, issue 3 (2001), p.8.

The most recent overseas mission undertaken by Wendy, in 1998, was in the Republic of Laos in a society undergoing change but which was still staunchly Communist. Her responsibilities were to assist in the development of the Laos Red Cross Society and its programmes. This mission was curtailed after fifteen months into her two-year contract due to lack of funding.

As she had worked for the International Federation rather than the ICRC for the majority of her missions, her exposure to potential danger, in her view, was limited and she felt she had been lucky. However, she did work in Sri Lanka at a time when there was considerable “turmoil”.

I’ve been very lucky, every check point has the potential for danger, there was a lot of danger in Sri Lanka. I was stoned in Papua New Guinea which was ghastly and I was very upset, very frightened then for a day or so, too frightened to confront the man that attacked me. Compared to working in a war zone, on the Thai border, we were at a safe distance every evening, although we could hear gunfire and knew it was happening to the people we’d worked with.

Wendy like several of the other Florence Nightingale Medallists has worked with the Red Cross in a number of capacities, as a nurse and health and development delegate. Wendy felt that being a nurse and head of delegation may have been unusual, at the time (1993) the Federation had 63 delegations abroad with three headed by women.

I think the important thing for a delegate who is going to be a development delegate is that they are a generalist....I learnt so much in Namibia, it was an excellent mission for me. Yes, it is good to be a nurse and I think it would be good to be a relief delegate as you will always have relief operations. To excuse myself from that, the Federation has good experience in relief and they can always assist you.

The concern for upholding professional standards of practice and behaviour was a responsibility of those involved in recruitment, of the organisation and of the individual. Wendy took this aspect of her work seriously.

One is about being organised and the other is setting standards...nurses have to be organised because they work so hard. The main theme about being a delegate in any place...it's about standards. You just set the standard and you say this is how it will be, and we have the twenty essential medicines....There are standards and you stick by them. There are standards of behaviour and practice, the discipline of working, the discipline of running an office. I have to work on Sunday to be ready for Monday and that's what I came here to do. If I don't work on Sunday, I won't be organised for Monday and will be a laughing stock.

Wendy returned to New Zealand in 2001 from Laos. She is currently working as a staff nurse in a retirement home. When she heard she had been awarded the Florence Nightingale medal in 1993, she was very surprised to receive it.

I had thought the Florence Nightingale Medal was related to a specific mission that was difficult and I thought it related more in the context of war. Initially I had a sense of disbelief about it. I was very honoured to receive it, very honoured indeed....The citation which was written at the time is quite brief and it just says a graduate nurse, a member of the New Zealand Red Cross Society, head of delegation for the Federation, numerous missions on behalf of the International Federation particularly for the development of nursing care in the field. So it's perhaps that variety of missions....I felt very humble, very surprised and after I settled down, very proud.

Mr Sommaruga [President of the ICRC] was coming to New Zealand and it was fitting that both Philippa [Parker] and I should have our medals presented by him at that time. She was also overseas....He in fact presented it and my mother was invited to a cup of tea, so that was lovely.

Louisa Akavi

It gets into your blood...it doesn't matter which side you were working on, Serb, Croat or Bosnian.⁵⁴

Louisa went nursing with her classmates from college. She had wanted to go to university but it was not economically possible for her family. She completed her nursing training at Wellington Hospital in 1977 and worked as a staff nurse in neurology, neurosurgery, cardiology and renal nursing for two years. In 1978 she moved to Rotorua and worked in the accident and emergency department where she gained comprehensive experiences, caring for people with major injuries from the forestry industry, and accidents to tourists, including people with burns from the hot pools.

From here Louisa went to Scotland to do midwifery training which she did not enjoy but it later proved to be a useful background for Red Cross nursing. She then moved to London and worked at the Whittington Hospital accident and emergency department for two years.

[Midwifery was] an excellent training, it has helped me so much with my Red Cross work. An incredible amount of knowledge that I've gained from, which I have been able to incorporate with everything else I do. You need to have a good grounding in midwifery because a lot of what you do is with family groups. Large numbers of displaced people, 25% will be mothers, pregnant women, children. It's no good going with a general nurses background, you are not going to be really useful to 25% of that population if you don't understand what their needs are.

When Louisa returned to New Zealand in 1983 she worked in the accident and emergency department at Wellington Hospital until 1988 when she went on her first overseas mission. Louisa was introduced to the idea of Red Cross by a nursing colleague who had worked in Pakistan.

⁵⁴ Interview with Louisa Akavi, 17 October, 2001. Unless otherwise stipulated, all information relating to Louisa Akavi comes from this interview.

I cringe when I think about it, but I was working in accident and emergency at Wellington, and I met...she had just returned from Quetta, her specialty was theatre nursing. We got talking....She was talking about her experiences with the Red Cross and how much she enjoyed it, the travelling she did....This sounds interesting, so I contacted Gwen Pragnell [New Zealand Red Cross]. She was very pleased I had my midwifery background as it got me my first job with the Federation...and I was sent to Malaysia to Pulau Bidong for the Vietnamese boat people programme.

On arrival on Bidong, as midwife and head nurse, she had responsibility for antenatal care, deliveries, and gynaecology, and running the forty-bed hospital. She said she had “never had to work so hard, almost to a standstill”. At the time, there were approximately 10,000 people on Bidong and there was continuous movement of the population to third countries, processed by the United Nations High Commissioner for Refugees.

I had to do all the administration type things to make sure we had sufficient medical supplies, the drugs, the fluids. Also I was in charge of the general public health of the island...I was overall in charge, my colleague, the second midwife was in charge of the teaching of the community health workers. We also liaised with the education system, it was a whole community set up, a miniature town. So we had schools, someone in charge of public health generally, you know keeping the rat population to an acceptable degree, no way could you eradicate it, then we had maintenance type people. We were inside the compound, then we had the prison, people from the Malaysian government side so they had their own barracks. There was a security system on the island, everybody had to go through the security system, us included. Making sure those who were there didn't escape, and also to maintain law and order. There was a curfew at 10 pm so nobody was allowed to move except for medical emergencies.

Health problems were typical of a group of this size and population.

We had malaria, the usual worms, skin problems, a small group with leprosy treated, so kept in remission. Tb was typical in this population, so nothing significant. Everyone who was accepted for third countries had to be screened and treated....Amazingly, no epidemics, but every so often head lice, no more diarrhoea than you would expect.

We had some violence, little domestic type things, just before my end of mission. One of my colleagues inadvertently killed himself and a day after there was a riot on the island. There was a small group of Khmer-Cambodians who had arrived in the last three months on the island. They had been relocated from Malaysia. They had all renounced their religion and become Muslims. On talking to them they had only done that so they could leave from where they had been relocated from. They were on the island, but there was a lot of conflict which I didn't realise was so bad until after I'd left, when I medivaced my colleague out. Twenty-four hours later there was a riot on the island, knives came out and several people were killed. Then they were segregated.

In addition, Louisa delivered 100 babies in her ten months on the island. At the time the fertility rate was high as many women had lost children in the war. Within the Vietnamese community as in any population affected by war, there is a natural biological desire to compensate for those killed or lost in the war. She also talked about prostitution on Bidong, "lots of shenanigans going on as in any town".

It was a bit controversial because Malaysia is Muslim....We had family planning and my colleague did that side of the work, and I helped her a few times and statistically when I looked at it, it didn't work, not there because you don't have the men agreeing with it. A lot of the older women had lost their children, a lot of the Khmer women definitely, very few of them had children with them, they had all been killed, a high proportion of pregnancies were in this small group. The 18,19 year olds, the family constraints they would normally be under were no longer there. A lot of the older members of the families were dead and so promiscuity was pretty high. Prostitution was there although they kept a low profile...I knew it was happening, it had a lot to do with the prison officers who were on the island. It happens.

The mission on Pulau Bidong was for Louisa her most satisfying from a nursing perspective.

That was nursing in every aspect. I was running the hospital, my midwifery skills were being used everyday, my clinical skills were being used everyday, I was working with colleagues who respected my opinion, and we were running a primary health care programme as well, and that I was overseeing. That was the most satisfying, although the ending was really sad. The experience that I had there was the most challenging and the most satisfying of all my missions.

Louisa also commented on the need for health workers in such situations to change from sophisticated technology to no technology and the need to be honest about it.

You know that very quickly if you can't make that transition, because you feel inadequate and totally demoralised and you will hopefully make the right decision and asked to be transferred out...A few had difficulties, few nurses had problems with the transitions....doctors did have trouble if they came from large university hospitals. There were certain things that they could not have and they had to make decisions on what they clinically knew and what their hands told them.

Louisa returned to Wellington from Pulau Bidong in 1988 and went back to the accident and emergency department at Wellington Hospital. She started a university degree as she felt she was not being 'stretched'.

Vietnamese boat people were also arriving in Hong Kong, at the end of July 1979. There were 67,790 boat people in a country whose population density of 4,712 people per square kilometre was the highest in the world.⁵⁵ In 1990 the British Red Cross asked New Zealand Red Cross for a nurse to work in the High Island Detention Centre. Louisa joined the British team as a community health nurse for six months. She was not allowed to practise as a midwife because she did not have the appropriate registration, but worked as a general nurse in clinics, and primary health care in the detention centre.

⁵⁵ K. St Cartmail, *Exodus Indochina*, p.178.

The population in the centre was approximately 10,000 and divided into the two main factional groups, North Vietnamese, and South Vietnamese.

It was definitely a prison. We had the watch towers, the armed guards, the corridors cordoned off, huge great wire fences separating the North Vietnamese from the South Vietnamese. Other NGOs were in there providing other services.... It was the same as Bidong except I was in a small team, three or four nurses, we did primary health care, and one doctor. It was clinics, dressings, follow up of patients seen by specialists at the local hospital, making sure medications were being taken by those following the Tb programme that had been set up by the local doctors.

The conditions for some refugees in Hong Kong were described as “wretched”⁵⁶ as they were held in dormitories of up to 250 people, crowded into metallic cages stacked on top of one another with no heating in winter or ventilation in summer. The policy was meant to discourage further arrivals.

Louisa became ill with pneumonia and returned to New Zealand early. She went to the operating theatre at Wellington Hospital from 1991-1993 and did the certificate in operating theatre nursing as she felt that if she were to continue with Red Cross she would need some surgical experience.

The next mission overseas was to Somalia in 1992 as a field nurse in Marika about 100 kilometres south of Mogadishu, the capital. Somalia is a country created in 1960 out of former British and Italian colonies in the Horn of Africa. The people are culturally, linguistically and religiously similar, and divided into six distinct clans with which they strongly identify, rather than the state.⁵⁷ Initially a Muslim republic, a coup established Somalia as a client state of the Soviet Union. In 1991, the clans took over. Government, civil society and basic services collapsed. Law and order disintegrated leading to anarchy.⁵⁸ Somalia by 1992 was described as “more of a geographical expression than a

⁵⁶ W. Shawcross, *The Quality of Mercy*, p.406.

⁵⁷ W. Shawcross, *Deliver us from evil*, p.67.

⁵⁸ W. Shawcross, p.67.

country”⁵⁹ and was experiencing a famine. As in Biafra in the late 1960s, Cambodia in 1979 and Ethiopia in the mid 1980s, the press played a role in drawing the world’s attention to the suffering and the United Nations decided to act. Efforts to monitor a ceasefire in Mogadishu and provide a secure environment to enable humanitarian assistance to get through to the starving were thwarted and most of the aid went to warring clans who created protection rackets. A United States force initially established itself under the United Nations, and then UN multinational peacekeeping forces took over in 1993. A succession of deaths of peacekeepers in the pursuit of clan leader Mohammed Aideed, culminating in the death of eighteen Americans, led to the withdrawal of American troops in May 1994, and a reluctance of the United States to become involved in future multilateral UN actions.⁶⁰

Louisa’s position involved daily travel to health centres to deliver supplies and to teach health workers. However, the latter proved to be difficult as there were restrictions on evening movements and she could not stay out in the field. She spent a month in Mogadishu when all non-essential non-government agencies pulled out because the United Nations had been attacked. She assisted another New Zealand Red Cross nurse who was working with people on the other side of the conflict to provide supplies to keep the hospitals operating. On one occasion one of these hospitals was attacked.

A rocket went into the top floor of the hospital....We had to find somewhere safe and just stay down. There was glass and bullets everywhere....We contacted the head of delegation [ICRC] and they had to negotiate with the Americans to allow our car to leave the compound. We had to wait until those negotiations had been confirmed then we could leave. And we got a helicopter escort out of the compound to our compound, a gunship.... Wrong place at the wrong time.

It was in Somalia that for the first time in the history of the Red Cross, the ICRC had to employ armed escorts to protect its delegates, convoys and warehouses, to enable it to deliver supplies and medical assistance to people.⁶¹

⁵⁹ W. Shawcross, p.67.

⁶⁰ W. Shawcross, p.101.

⁶¹ C. Moorehead, *Dunant’s Dream*, p.685.

Louisa returned to Wellington and operating theatre work. She found she was “restless as” and was unable to settle down, she wanted to go away again. She went to Bosnia as a field nurse, then health delegate in 1993, and was there for two different missions over a period of two years. For her first mission she was based in Tuzla. Her responsibilities were similar to those in Somalia, delivering supplies to nine hospitals and some public health work. She also undertook three visits to prisons in and around Tuzla.⁶²

The conflict in the early 1990s, was manifested in a wave of hatred and violence, Yugoslavia was disintegrating, lives were lost, villages were being razed and more than half a million people had fled the fighting.⁶³ Croatia and Slovenia seceded from the Yugoslav federation in June 1991 and the Serbian army moved into areas to build a new Serbian state.⁶⁴ The resulting war, which was characterised by ‘ethnic cleansing’, led to a humanitarian catastrophe which was covered in detail on international television and the press. Bosnia declared independence in March 1992. Fighting spread with further ‘ethnic cleansing’.⁶⁵ The ICRC had been involved since June 1991 in helping the victims of the conflict. The first mission in Bosnia was difficult for Louisa.

First trip for me was really hard, because it was being bombarded the hell out of. Sarajevo was the focus, but Tuzla was being hammered because it was the biggest Muslim enclave, and we were being hammered left right and centre, that first year I was there, and I got really depressed. The thing is I didn’t recognise it then, I do recognise it now, I got really depressed by the end of that mission I was glad to go home. I was home for something like six months then of course Tuzla got bombarded by that huge shell that killed 200 young people and I was in tears. I was thinking about all the people I had met, all the people I knew and thinking about all the medical people that I had actually worked, met, spoken, laughed with. Half of them are dead, so that really comes in on you, that the people you know are not going to be there anymore....In the end that was

⁶² ‘Tuzla: it will never be the same again’, *New Zealand Red Cross News*, Vol. 79, No. 2 (May 1995), p.12.

⁶³ *ICRC Bulletin*, Special Edition Conflict in Yugoslavia, May 1992, p.2.

⁶⁴ W. Shawcross, *Deliver us from evil*, p.43.

⁶⁵ W. Shawcross, p.50.

probably one of the reasons I wanted to go back and resolve what was making me so unhappy.

She did return to Bosnia and was “able to close the chapter”. On her second mission, which occurred after the signing of the Dayton Peace Accords on 21 November, 1995⁶⁶ when the war was effectively over, she was asked by the ICRC to close down the operation in Tuzla and discontinue the provision of supplies to the hospitals within a month. Her negotiating skills were fully extended in this process, and at the same time she was able to secure project funding for the blood bank programme in the hospital, much to her delight and pride.

It was not easy. I did the project proposal as well with a lot of help from the head of the department of the Tuzla General Hospital. She was rapt, and I was too because there was a need for a well equipped... not sophisticated....so the blood could be handled properly. The project proposal was passed on to the Swiss Red Cross who accepted it in full with no changes. I was really happy. Then I had to push to get it started before I left because once you leave, you’ve lost the momentum.

It helped being a nurse, [because of the politics going on]...we had to be careful about how we did it...the constraints and the frame we were working in was always kept in mind...After that they would be able to continue themselves...I was facilitating, strengthening and rehabilitating an existing service which just needed a bit more. When I left I was really happy because I had done something that was sustainable and would continue on and improve over time.

This was very satisfying from Louisa’s perspective because she had facilitated a process to acquire funding for a service to be rehabilitated and sustained long term. This is the main aim of the reconstruction and rehabilitation process in the post war phase, as it moves out of the disaster phase.

Bosnia in the early 1990s taught the Red Cross and other organisations about the need to care for the psychological health of the delegates.

⁶⁶ W. Shawcross, p.164.

So many of my colleagues were burnt out after six months but they kept coming back. Bosnia, or the former Yugoslavia as it was then known, was the time Geneva recognised debriefing was absolutely necessary. Well, not so much debriefing, but counselling for delegates in the field was so important. My second trip back, we got the Geneva counselling department type thing, and Bartold [ICRC psychologist] came to the field and they went to every delegation.

I was really pleased that somebody finally recognised it. Me myself I didn't recognise it, I'd almost totally burnt out, until I spoke to...a wonderful woman came and spoke to every body.

In 1996, after three months back in New Zealand, Louisa was offered the position of surgical ward nurse at a hospital in Novi Atagi, in Chechnya. She thought she "might as well try something else". Here Louisa returned to 'hands on' nursing care.

It was really stressful, getting back to the routine of three shifts.... It was fine, I got into the swing fairly quickly....You had to be there and did all the shift work, a lot of it was showing local nurses how to do things in a certain way, a lot of dressings, a lot of the injuries were old, majority war wounds, all very old, a few domestic violence things...settling domestic violence with a gun was pretty 'normal'.

The Northern Caucasus has been one of Russia's most troubled regions. Since independence was declared in Chechnya in 1991, an economic embargo was announced by Moscow and by 1994, the simmering tensions erupted into open warfare with the Russian army moving into Chechnya. By 1995, the Russians had gained control of the capital Grozny.⁶⁷ Delegates who had worked in the both the Former Yugoslavia and Chechnya considered the latter to be worse, a particularly vicious conflict, with an estimated 70,000 killed by the end of 1995.⁶⁸

⁶⁷ 'A man for all Chechens', *Red Cross News*, Vol. 80, No. 1, (March 1996), p.7.

⁶⁸ 'A man for all Chechens', p.7.

This was the situation into which Louisa entered in 1996. The ICRC had decided to open a field hospital in Chechnya because the main hospitals in Grozny had been damaged. Novi Atagi was twenty kilometres south of Grozny, and as a former boarding school within a compound, was easily converted into a hospital.⁶⁹ As in most ICRC hospital operations where the health services had totally broken down, a small number of expatriates assisted in running a hospital in conjunction with local staff until they were in a position to take over.

The experience of working with people of a particular religious group in one country is not necessarily transferable to another situation. Louisa had worked with Muslims in Bosnia and Somalia but was challenged by the cultural differences she experienced working with the young Muslim men in her care in Chechnya.

I found it stressful as you were forever repeating yourself....It was a Muslim country and the women were dressed in scarves. The majority of the nurses were women...it may have to do with the society itself, the men were fighters and not going to do any menial jobs.

Young men, who were fighters, had the Mujahadeen mentality. I found it difficult not to lose my temper. The majority were respectful to the expats....A small group were ruling the roost. I had to keep my mouth shut, difficult to shut up, this is what happens in this society and you have to respect it, but I don't have that personality. A lot of times I had to zip up and walk away, it was too difficult for me to shut up. I found my niche in the intensive care room where they were not awake!

Louisa also recounted an incident where she had a frightening clash with the relatives of a patient in Novi Atagi, Chechnya. She managed to retrieve the situation, but her time there ended in tragedy.

⁶⁹ F. Buignon, 17 December 1996, Six ICRC delegates assassinated in Chechnya, *International Review of the Red Cross*, No. 317 (March-April 1997), p.140.

I had a stand up fight with the brother of one of the patients, a paraplegic.... He had an ulcer that once was healed, they could take him away....They were telling us what we had to do for him, fly him here and there...one day I just lost it. I knew I shouldn't have....It was no good because they couldn't speak any English and the nurses were going to translate anything I said. I broke a cup, it was accidental, it was theirs. 'I'm dead'... The men were so mad at me, I had three of them in my face....I am now dead. I said I'm really sorry, your brother can't stay here any longer, we can't do anything for your brother.... Our expat translator was an absolute darling, he went through the reasons... That was one day I thought I was going to be killed....In the end when a bit more reasonable in my behaviour, we apologised to each other. 'Louisa you know you can't be here', I can't bend enough for that society, then four weeks later we had everyone being killed.

Louisa experienced one of the most traumatic experiences any humanitarian worker could endure. She survived the murder of six colleagues in Novi Atagi, Chechnya in 1996. One of those murdered was Sheryl Thayer, a fellow New Zealand Nurse.

I have no longer any sort of animosities towards what happened there. We are never going to prove who did it, never. It's a waste of energy and emotion to think about what happened that day, and just be glad I was one of the ones that did survive, survived. I know for sure I can't go back to that sort of society, where I can't control myself. My self control was not good then. Over the years I learnt to be a bit more controlled.

Louisa brought Sheryl's body home to be with her own family. She had some counselling which was effective.

When I look at it now, it was really just to verbalise, that yes I know what happened, yes, but its going to be with me for a long, long time, but no, it's not going to affect who I am, I am not going to let it. The fact that I had already - how many years down the track- I had had to medivac a colleague who had died, and I really did miss the counselling then because it didn't surface until two

years later. So I think I was more than prepared to cope with what happened, more so than other colleagues.

A few of my friends, they were plagued with nightmares, playbacks, flashbacks, for at least a year, a year and a half afterwards. I have never had that. I go to sleep, I have dreams, but they were not nightmares, I was not frightened by them. So I've been lucky. The fact that a lot of what has happened has made me as a person a lot stronger....The risks are there and this I accept, but the work that I do is what I want to do and it comes with it, so I don't think about it anymore.

In 1998 she honoured her commitment to continuing Red Cross work by accepting a mission to Batticaloa on the east coast of Sri Lanka. She was there for fifteen months as a field nurse. Her responsibilities included supervising a well building programme for safe water, and being part of a mobile health team providing health care for approximately 30,000 people in the northern and eastern provinces. The ICRC had returned to Sri Lanka at the time of Wendy Smith's mission with the Federation (then the League) and since then New Zealand has sent six delegates to work there.⁷⁰

Since 1999 with short sojourns back in New Zealand, Louisa became involved in assisting victims of conflicts closer to home, in particular in the Solomon Islands. The Solomon Islands internal disruptions started in 1999 with increasing tensions between the Malaitans and the indigenous Gwales of the main island of Guadalcanal. At the heart of the dispute was tension over land and access to economic and employment opportunities. Two fighting factions had emerged, the Guadalcanal Revolutionary Army later to become the Isatabu Freedom Movement and the Malaitan Eagle Force, each controlling parts of the island of Guadalcanal.⁷¹ With the renewal of fighting in 2000 came the collapse of the government, businesses, and the economy, and the displacement of thousands of people, especially 20,000 Malaitans who returned their island. It was ill equipped to absorb such numbers. The ICRC assumed its traditional activities in a conflict situation, and sought to protect civilians and provide shelter and

⁷⁰ 'Sri Lanka Bomb Blast', *Red Cross News*, Vol. 82, No. 2, (May 1998), p.12.

⁷¹ 'A Pacific patchwork', *Red Cross News*, Vol. 89, No. 4, (November 2001), p.14.

assistance to those driven from their homes, and in remote settlements. Medical supplies for clinics and the hospital were provided and detainees visited.

Louisa first went to the Solomon Islands as a health delegate for the ICRC in May 1999 for four months. She was tasked to carry out a health assessment. She ensured the continuation of medical supplies to the hospital and to people on Guadalcanal who were stranded in villages and unable to get past road blocks to reach the market. She also visited the hospital regularly and experienced the fear of the staff at first hand.

They were really jittery [the staff], they were all talking about leaving....They wanted the Red Cross emblem on the hospital and I couldn't get permission, at the time it was probably the right decision. In 1999 the problem was that the medical and nursing staff were so frightened, 50% ran away. The fact that I had met with some of them prior to this happening, - 'I will come every day if that will make you feel safer' - so I was there everyday. Then we managed to get it down to the weekend, they were frightened in the weekends because the big guys weren't there, it was just the nurses, Saturdays and Sundays I was there. I offered transport home for the staff. I couldn't leave [to come home to receive the medal]. If I left, they would have gone and the system would have broken down.

She resorted to using radio broadcasts to try and calm things down for the hospital staff.

'Don't harass or intimidate the medical staff, you need them'. I think I got a bit carried away on the radio but the message got through. That's the first time I've used the radio for that reason. They put me on national radio to deliver that message because it was getting so bad.

She also worked with the Solomon Islands Red Cross Society to assess its capacity to cope and function if the conflict worsened. The situation did deteriorate and between 10-20,000 Malaitans left Guadalcanal for their home island. The majority were assisted by the Solomon Islands Red Cross.

In November 2000, Louisa returned to Honiara, and worked with the Red Cross society to develop a programme in conflict preparedness which involved first aid training and planning for setting up first aid posts to care for the wounded.

Louisa worked in the Solomon Islands as a health delegate in 2000 and 2001.

The health delegate's job is to sort out what is actually working and what isn't, to strengthen what is working, and what you stay away from....So my job was to identify the ones that would still be there six months down the track and try and make their lives a little easier if possible from a health point of view. And a lot of that was strengthening, the 'PR', the media exposure, checking on what supplies they had in the country. So a lot of what I did was to find out what was still there, and still working, system wise, and the Solomons is not just Honiara, it's the other islands as well.

Louisa became acting head of the Solomons Islands delegation for the ICRC and her scope of responsibilities increased beyond the health arena. She became involved in active dissemination of the Red Cross principles and promoting the work of the ICRC, with political leaders and the police in particular. When she left in August 2001, she believed that the profile and mandate of ICRC had been raised, an understanding of the protective nature of the Red Cross emblem had been accepted.

Because she was working with politicians, police and militant groups as a representative of the ICRC, she had to be watchful about what and how she communicated so as not to compromise her own or the organisation's neutrality.

She expanded further on the challenges of Pacific Island National Red Cross Societies working within the principles. Those of neutrality and impartiality presented particular problems because of people's traditions and culture. Family or 'wantok' obligations transcended those of the individual, employer, or organisations such as Red Cross. This became apparent during the internal tension between people of Guadalcanal and Malaita over the past years and tested the Solomon Islands Red Cross in ways not previously experienced.

They withdrew into their own little society. They didn't really reach out too much. One of the constricting factors was that the majority of them were

Malaitans and they were the target. More than 70% of the national society members at that time were Malaitans so they were having to struggle with their own problems of identifying with the numbers of people being targeted, Malaitans from the Guadalcanal province. They were moving something like 10,000 people over a period of about four months. In total something like 20,000 is being broadcast as the number that went back to Malaita and the majority of that number were assisted by the Red Cross, funded by us [ICRC].

We had to find where they were setting up first aid posts...because they could not come into Honiara because they were being targeted. So that's what was worked on for 2000, conflict preparedness for the national society. But nothing happened until the conflict had settled down sufficiently so people could move.

You need the basic foundation [first aid] because you can bring in your principles with conflict preparedness....The principles are a challenge. They say they understand but when you have to make them actual do it, they can't. The concept behind it is foreign, but if they can see it working in their own society in some form, then the transition to the global picture is easier. You have to find that commonality.

Nurses who held other positions, such as head of delegation were required to have a high level of understanding of the political situation as well. Louisa found that her experiences in the Solomon Islands in particular, when acting head of the ICRC delegation made her more aware of political situations, which in turn was reflected in her relationships and interactions with people.

I have had to watch what I say, to whom I say it. I had a lot of dealings with the members of parliament in the Solomon Islands, politicians, police at management level, and also with various militant groups, and also with the expat community. I have had to be more circumspect, what I say and how I say it. My conversation with a politician is very circumspect. We are a neutral organisation, what I'm saying comes under the mandate signed that we have that has been signed by your government. With that in mind, my recommendations are...these, because.

It's made me more aware politically, so when I'm following a political event, I try to work out what really is going on here. If I know some background - if this continues along this road then the possibility of this occurring increases much higher....With conflict preparedness you have got to develop it, you've got to understand the political, what's going on in that country, understand the ins and outs of who is in charge. I've learnt this really well this last year. If you can identify the major players, in any event, political or otherwise, and follow what they are up to, you can usually work out what might flow on from their consequences. It's been a mind expanding experience from that point of view. I never took any interest politically in countries I was in except what was affecting my general area. It also makes you question the consequences of your decisions and what will follow. It tempers what you say in reporting. You have to justify it, you have to speculate a little bit on what you know. I have been making judgement calls in the last six months, it is scary. So far, I've not been wrong in my assessments.

As a Cook Islander, born on Rarotonga and brought up in New Zealand, Louisa has a strong sense of her own and pakeha culture. Her insights and understanding into the cultural influences on people's understanding and perception of the Red Cross principles of neutrality and impartiality were highlighted during her time in the Solomon Islands.

You can do all the teaching in the world, all the courses, unless they have some exposure to something that interacts within their normal life, their past experience that they can anchor it to, then they can expand on that, your teaching is fine, but you are going to have it parrot fashion....And when you come back ten years down the track, and you ask what do you feel it means, they will just give you the text book answer.

Further to this, she was able to consider the understanding or lack of understanding of humanitarian law by nurses.

Not at all, because as a nurse you know what your job is, it's health regardless of what type of health you are talking about...[ethical standards] those are standards that you know where as international humanitarian law, this has taken me a long time to come to grasp, but I know the basics, so when I have to explain to a group of people who have no understanding I say, what do you need to live; food, shelter, clothing and safety, and those are your primary things, those are the building blocks for international humanitarian law. There are other things, but that's the basic reasons.

With experience in conflicts in both Africa and more recently the Pacific, Louisa reflected on the risks, especially after her experience in Chechnya.

[The 1990s have been] very very dangerous, and I don't understand anymore, why it is so dangerous now, well maybe I do. A lot of where it's been the worst is in Africa....This is my own opinion, when you look at Africa and you look at the Pacific, we are looking at post colonialism and twenty years after independence these countries have got to make a decision about which way they go, if they haven't found a way yet, you are going to have the power struggles, and when I look at the Solomons this is exactly what I see as well, they haven't found their own path yet.

Having returned to New Zealand for several months, Louisa is now back in the field as a detention delegate in Ethiopia. She is also currently working towards completion of a Diploma of Occupational Health and safety.

Louisa Akavi was awarded the Florence Nightingale Medal in 1999. She was in the Solomon Islands at the time.

I was flattered, I was honoured, what happened...it came at a time when I was preoccupied My father's health was up and down at that time....I was honoured, why am I getting it. I knew of it but I thought it only went to nurses who had died in the line of duty....It's an international medal, you have to do something really brave....stupendous.

I was in the field at the time....I would have been back in time and I informed the New Zealand Red Cross I wasn't coming back because the needs in the Solomons were such and they wouldn't have been able to continue without a health delegate on the site, so I was very apologetic....It's impossible, we were in the height of the conflict and there were a lot of small gun battles between the two sides, just before that ceremony was to take place, I couldn't leave. I talked to my mother, she was really upset, it was all organised, a really big deal.

My mother was really unhappy, 'you have to come home'. It was a big thing, for me it was just wonderful, I said you and Dad, you go and I called my brother in Auckland to go with them to make sure they were alright....My mother had a photograph with the Governor General in a side room, they were happy, both my parents were extremely happy. For me that was wonderful. That medal gave my parents one of the best days of their lives. So I thought, this medal I am happy to get just for that.

My mother has it in her big glory box and takes it out every so often when the aunts come to visit and she shows them it. She has Florence Nightingale in our living room.

The stories of these Florence Nightingale Medallists cover over three decades of nursing experiences overseas from Malaya prior to independence in the 1950s, to conflicts in Vietnam, Cambodia, Afghanistan, Sri Lanka, and Chechnya. Famines in Sudan and Ethiopia, disasters in the Pacific and the current conflict in the Solomon Islands in the South Pacific have also been described. Nursing positions with the Federation, the ICRC in Geneva, and the New Zealand Red Cross in Wellington have added to the wealth and depth of the participants' experiences and their humanitarian nursing practice. These stories were set against brief historical outlines of the socio-political contexts to give a sense of environment, the nature of the disasters, and the constraints and issues for nursing.

CHAPTER 7

DISCUSSION

This chapter considers the information explicated from the participant interviews and discusses it in relation to three main research interests: the nurse, their practice, and nursing and Red Cross principles. It discusses the themes identified in the five participants' interviews: cultural awareness and sensitivity, professionalism and standards, teaching and learning, and nursing and Red Cross philosophy. Discussion of these themes is organised under the three main research interests. Secondary themes such as motivation, voluntary service, safety and security and socio-political knowing are interwoven into the discussion. This chapter also draws on both primary and secondary sources of evidence to expand and elaborate upon the discussion. Additional quotations from the participant interviews are used to illustrate points in this chapter.

The nurse

Since it first started sending New Zealand nurses overseas in the 1960s, the New Zealand Red Cross has been consistent in its commitment to overseas work being undertaken by experienced and professional nurses with at least five years post registration experience.¹ This section discusses the nursing backgrounds and personal qualities of the five Florence Nightingale Medallists interviewed.

All participants in this study, with one exception had ten years nursing experience prior to their first overseas mission with the Red Cross. Ngaire Simpson worked as a medical and surgical staff nurse, rural public health nurse, in a psychiatric ward and as a hospital afternoon supervisor. She had also completed her separate maternity training, as obstetrics nursing was not integrated into general nursing at the time. She undertook her Post-Graduate Diploma in Nursing at the School of Advanced Nursing Studies in Wellington. Ngaire also worked in the outback of Australia for a year.

¹ G Pragnell quoted in 'The Right Stuff', *Red Cross News*, (July 1986), p.5.

Glenys Checchi specialised in operating theatre nursing and cardio-thoracic nursing. She was a charge nurse in this area, and undertook her midwifery training prior to working for the Red Cross. She had travelled and worked in England before going on her first Red Cross mission.

With a background in general nursing, midwifery practice and tutoring, as well as experiences as a charge nurse and nursing in England, Wendy Smith had undertaken her Post-Graduate Diploma in Nursing at the School of Advanced Nursing Studies before she went overseas with Red Cross.

Louisa Akavi pursued an interest in accident and emergency nursing for a number of years after experiences as a staff nurse in neurological, neurosurgical, cardiology and renal nursing. She also worked in the operating theatre in a large teaching hospital. She did her midwifery training in Scotland and subsequently worked in England.

Megan Crisp did not go overseas with the Red Cross, but as an English nurse, she volunteered to work with the Queen Elizabeth Colonial Nursing Service and was assigned to work in Malaya (Malaysia). When she went overseas in 1951, it was two years after qualifying as a State Registered Nurse and Midwife, and a year as a staff nurse in the labour ward at the Royal Infirmary and staff nursing in the Channel Islands.

The ages of the participants when they went on their first Red Cross mission were 31 (Glenys), 32 (Louisa), 33 (Wendy), 36 (Ngairé), and 24 (Megan). All except Megan had travelled and worked overseas prior to Red Cross work.

The type of nursing practice and experience deemed appropriate for overseas nursing, according to New Zealand Red Cross criteria are accident and emergency nursing, public health, surgical nursing, and, in particular, operating theatre nursing and midwifery.² Sound selection and training are the basis for a successful mission both from the perspective of both the individual and the Red Cross. Delegates are usually able to cope professionally, but it is in the area of personal values and behaviour that some people have difficulty. This was commented on by one nurse when she said “I

² Note, criteria are not documented in written form. The Red Cross has broad criteria and is guided by the requirements of the ICRC or Federation for individual positions.

never was worried about peoples' professional skills...the biggest thing was the personal side".³ It is also the experience of New Zealand's development organisation Volunteer Service Abroad⁴ and was emphasised at a seminar held at Wellington Polytechnic in 1991 for nurses interested in working in international disaster relief and community development.⁵

The core competencies required both professionally and personally are that the individual is strongly motivated by humanitarian work, able to cope with stress, prepared to work under pressure in a dangerous environment, well organised and analytical, and able to work in a team.⁶ These were the qualities the New Zealand Red Cross assessed in its recruitment process. Potential delegates were interviewed and questioned about their interests and experiences beyond nursing, where they had travelled and how they coped in unforeseen emergencies.⁷ This is consistent with the notion that past behaviour is a good indicator of future behaviour.⁸

Documented evidence about the motivation for nurses wanting to work overseas was discussed in Chapter 1 and that nurses had wanted to use their professional skills. This had been the evidence since the South African ('Boer') War as discussed by Rodgers.⁹ American nurses were also influenced by Kennedy's patriotic invocation of what they could do for their country,¹⁰ and in the early 1990s, the Gulf War again inspired enthusiasm to serve and use skills. The motivation for military nurses thus involved a

³ G. Checchi, oral history interview.

⁴ Personal communication with Carolyn Mark, Recruitment and Training Manager, VSA, 18 February 2002, and my personal experiences while working in the VSA Pacific programme.

⁵ A. Bramwell-Huntington and J. Gilmour, 'Third World work rewarding', *New Zealand Nursing Journal*, Vol. 84, No. 2, (March 1991), p.17.

⁶ ICRC, Job opportunities at the ICRC, Profession: health delegate, dated 5 September 2000, <http://www.icrc.org/icrceng.nsf/4dc394db5b54f3fa41256...28/10/01>.

⁷ N. Sherwood, 'A long time field-worker returns...and Miss Pragnell take leave of us', *Red Cross News*, Issue 1, (1988), p.13.

⁸ Personal communication with Carolyn Mark, Recruitment and Training Manager, VSA, 18 February 2002.

⁹ J. Rodgers, 'Potential for Professional Profit: the making of the New Zealand Army Nursing Service, 1914-1915', *Nursing Praxis in New Zealand* (1996), p.4.

¹⁰ D-M.Boulay, 'A Vietnam tour of duty', *Nursing Outlook*, Vol. 37, No. 5, (November/December 1989), p.271

sense of nationalism and duty of service. They were also going to care for their military colleagues, as distinct from humanitarian nurses who care for anyone who needs it, irrespective of nationality or political partiality.

When the Red Cross was established, motivation to work for the organisation was based on acts of benevolence by people with economic means and social standing.¹¹ At the beginning of the 1900s and until the 1930s, recruitment of nurses in Europe was said to be for four motives: patriotic and humanitarian, religious, scientific (relating to medical advances and technology), and ideological (which related to feminism).¹² The boost of the war years to nursing had been strong, but it was able to be sustained for other reasons as nursing came to represent the opportunity to acquire knowledge and opportunities for women.

Over the past decades, service in times of conflict or emergency, travel and education have been motivators for international nursing, according to Burgess.¹³ In the participant interviews, motivation was explained in terms of “it was a challenge, something totally different from what I’d been doing, I felt I could give it a go,”¹⁴ and “why not go and help somebody for six months...it filled a philosophical need, it was probably to satisfy my needs”,¹⁵ or for travel. British nurses were said to be motivated to do good in another country for religious reasons. Others could remember a single moment when they felt they wanted to do something after seeing a news item which changed their lives and compelled them to act.¹⁶ New Zealand Red Cross has also noted an influx of inquiries arising out of media publicity, as occurred in the 1980s in relation to Cambodia. It was a catalyst for me in 1968.

¹¹ C. Moorehead, ‘The new humanitarian worker’, *Red Cross Red Crescent*, issue 4, (2001), p.4.

¹² J. Guillermand, ‘Historical background’, *Profession: Nurse, (Images 1900-1933)*, Museum of the International Red Cross, Red Crescent, Geneva, 1995, pp.89-92.

¹³ M. Burgess, *Nursing in New Zealand Society*, Longman Paul, Wellington 1984, p.163.

¹⁴ N. Simpson, oral history interview.

¹⁵ G. Checchi, oral history interview.

¹⁶ A. Whyte, ‘Mercy Mission’, *Nursing Times*, Vol. 94, No. 50, (December 16, 1998 - January 5, 1999), p.24.

Today, according to the International Red Cross, humanitarian work attracts idealists who care about people and want to improve an imperfect world, but who are more professional and sophisticated in approach, demonstrating a mixture of humility and efficiency.¹⁷

The main way in which New Zealand nurses hear about Red Cross nursing is through the stories directly from a nurse who has worked overseas. This often results in a “flood of letters from willing recruits”.¹⁸ This was the situation for Louisa and Ngaire. Others such as Glenys and Wendy responded to a radio advertisement. Humanitarian nursing is not presented as an option for new nursing graduates as they do not have enough experience at that stage to be of value to an organisation overseas. Information about the nature and scope of nursing practice of Red Cross nurses available to nurses in general is largely limited to what little is printed in the *New Zealand Nursing Journal* and the *New Zealand Red Cross News*.

Potential delegates are required to attend the New Zealand Red Cross delegates’ seminar which has been in existence since 1985.¹⁹ Now referred to the Basic Training Course, its purpose is to provide comprehensive information about the Red Cross and its principles as well as allow Red Cross staff to observe the interactions and behaviours of those interested in overseas work and assess their potential to work in a team. “It gave us a chance to observe their interaction...You didn’t want people who were running away from problems here and not coping in the field”.²⁰

Most of the participants attended this course, not necessarily prior to their field experience, but at some stage during their Red Cross work. The exceptions were Ngaire who went overseas prior to the course’s inception. She had attended a group interview at the Red Cross during which she knew was being observed to see how they would get on. Megan was not part of the Red Cross system when she went to Malaysia and was interviewed by the Queen’s Colonial Nursing Service in London. The importance and

¹⁷ C. Moorehead, ‘The new humanitarian worker’, *Red Cross Red Crescent*, issue 4, (2001), p.6.

¹⁸ ‘The Right Stuff’, *Red Cross News*, (July, 1986), p.6.

¹⁹ N. Sherwood, ‘A long time field worker returns’ ...p.13.

²⁰ G. Checchi, oral history interview.

time dedicated to selection and pre-departure briefing has reaped considerable benefits over the years, and very few delegates have had to be withdrawn for other than health reasons.

Several of the participants also attended other courses related to health work in developing countries during their time in the field, Glenys did a Diploma in Tropical Medicine in London, Louisa was funded by New Zealand Red Cross to participate in the Health Emergencies in Large Populations (HELP) Red Cross course in Hong Kong in 1998. Wendy attended a League Delegate's Training course in Jakarta in 1981 and an ICRC Seminar for Emergency Medical Action in Geneva in 1981. Several participants recognised the value of exposing themselves to new experiences and attaining new skills. "I was anxious to get back into the field and get more skills."²¹ Louisa did a certificate in operating theatre nursing to gain surgical experience she thought would be useful for Red Cross missions.

One of the fundamental principles of the Red Cross is voluntary service. The Red Cross has been able to mobilise many thousands of volunteers for a range of activities in preparation for, and during, disasters. This is based on the original vision of its founder Henry Dunant, initially to supplement army medical services in time of war, and today, as a world wide network of Red Cross and Red Crescent Societies whose activities transcend the original concept.

Volunteering is at the heart of everything the Red Cross exemplifies as a principle and the means to put principles into action.²² The traditional perception of a volunteer as an unpaid and in some cases, untrained person, who works freely for the benefit of others is changing, as work patterns change - especially for women. The VADs were an expression of this in World War I, and more particularly in World War II, and became involved in welfare activities within the Red Cross system from the 1960s onwards.

But today there is less free time, a greater range of leisure possibilities, and there are competing causes all seeking volunteers. For example in 1909 there were 176

²¹ G. Checchi, oral history interview.

²² R. Allen, 'Where have all the volunteers gone'? p.22.

international non-governmental organisations, by 1993 there were 28,900.²³ The range of activities available for today's volunteers, especially in the health and social services, in a complex social and political environment requires a higher level of professionalism and training. While the Red Cross places a strong emphasis on training and recognising the value of volunteers, it is facing a diminution in their number. The decrease from an estimated 250 million in the 1980s to approximately 105 million today, represents the most dramatic decrease in the Red Cross Movement's history.²⁴ The year 2001 was designated the United Nations International Year of Volunteers and many organisations have used it to reflect on how to make the most effective use of their most valuable resource, the volunteer.

At an international level, the notion of professionalism persists. Humanitarian assistance requires professionals who have specialised training, such as nurses or doctors. This does not diminish the volunteer spirit, but today's professional volunteers are a blend of idealists, activists and technicians²⁵ and are paid to undertake the work for the ICRC or the Federation. Many volunteers come to Red Cross willing to work overseas without pay not knowing they receive a salary.²⁶ In essence, all the participants volunteered to work overseas, either with the Red Cross or another organisation. They also volunteered in New Zealand on their return. "They give generously of their time to share their experiences with the New Zealand public who support the Red Cross and make their missions possible. They willingly take part in school and public education programmes".²⁷ Megan dedicated time to working voluntarily as a first aid instructor for three years and continued with other Red Cross activities for many years.

The qualities needed by nurses for overseas missions were referred to in a *Red Cross News* article. "They must be professionally capable, flexible, adaptable, independent but able to work in a team, with leadership ability to assess situations."²⁸ Further to this,

²³ R. Allen, 'Where have all the volunteers gone?', p.23.

²⁴ R. Allen, p.22.

²⁵ C. Moorehead, 'The new humanitarian worker', p.4.

²⁶ N. Sherwood, 'A long-time field worker returns' ...p.12.

²⁷ 'The Right Stuff', *Red Cross News*, (July 1986), p.6.

²⁸ G. [Rodger]-Checchi quoted in 'A long time field worker returns' ...p.12.

they must have knowledge of the country in which they will be working and a sensitivity towards cultural customs, able to work in teams or in total isolation, be physically fit and able to put up with 'primitive' living conditions.²⁹ In today's disasters, the former is particularly important because of the increasing complexity of the environment in which they work, in many cases the result of historical enmities which have been simmering away for decades and are the context or socio-political "where-in"³⁰ of nursing practice which is discussed later in this chapter.

Most nurses in developed countries like New Zealand practise in well scripted environments with access to technology, peer support and a raft of social and paramedical referral options. The standards of practice and health policies are clear and well documented so the parameters are not blurred. Health workers involved in providing humanitarian assistance in disasters have to work in chaotic and unpredictable situations with limited and in some cases no technology. As Louisa remarked, "they must be able to use their hands, eyes, and of course ears, that's all you need, if they can't do the transition from high technology to nothing – they won't be able to cope in the field".³¹ This requires an expert nurse who can draw from their experience and apply intuition to each situation,³² and use their creativity where "back to basics"³³ was the rule rather than the exception. Several nurses commented on just getting on and doing it and gave examples of resourcefulness.

Professional support was limited, especially for nurses such as Glenys and Wendy when they were involved in nutritional programmes operating in near total isolation in Africa. In a team situation other members were able to offer both professional and moral support but it was still within the limits of available and appropriate technology, resources and security constraints. Camaraderie in the field was noted and friendships that were made endured. "It was good to live with others and you never lose the links

²⁹ G. Pragnell quoted in 'The Right Stuff', *Red Cross News*, (1986), p.5.

³⁰ J. White, 'Patterns of Knowing: critique and update', *Advances in Nursing Science*, Vol. 17, No. 4, (1995), p.83.

³¹ L. Akavi, oral history interview.

³² P. Benner, *From Novice to Expert, excellence and power in clinical nursing practice*, Addison-Wesley Publishing Co., Menlo Park, California, 1984, p.32.

³³ G. Checchi, oral history interview.

with people who've been in that sort of situation with you".³⁴ This is also important as an ongoing support mechanism as there are so few nurses who have worked overseas in these kinds of situations that it can be lonely and professionally isolating for those who return into a New Zealand void. Retaining links with the Red Cross and having informal links with other delegates is vitally important, otherwise there can be a sense of marginalisation in relation to mainstream nursing.

Examples of adaptation to local conditions, both living and work, were provided by the nurses. Further to this and importantly was an awareness of "trying to adapt to what was appropriate for them, to work with what was there",³⁵ and to "work with the people that are there".³⁶ These sensitivities are a consequence of years of documented evidence of aid organisations bringing in inappropriate technology or assistance which cannot be maintained, sustained, locally sourced, or is culturally inappropriate, or as Shawcross described regarding efforts on the Thai-Cambodia border in the early 1980s, "ghoulish, incompetent or otherwise outlandish".³⁷ Thus, Red Cross policy endeavours to ensure that it does not provide services in excess of what local people are accustomed to, have access to or can afford, because of the above reasons. This was an issue on the Thai-Cambodia border at one stage where the Cambodian refugees were receiving a level of care higher than that available to the local Thais and it created considerable resentment.³⁸

An extreme example of inappropriate assistance was the plan by the American La Leche League to send a jumbo jet filled with lactating mothers to suckle abandoned Cambodian babies.³⁹ It is perhaps understandable that in the 1980s, the enthusiasm to assist refugees in Cambodia may have provoked such inappropriate responses, but it is difficult to understand in the year 2001 that such things continue. For example, the air-

³⁴ N. Simpson quoted in 'Vietnam tough training ground', by S. Simpson, *Bay of Plenty Times*, 3 May, 1995.

³⁵ G. Checchi, oral history interview.

³⁶ N. Simpson, oral history interview.

³⁷ W. Shawcross, *The Quality of Mercy*, p.240.

³⁸ W. Shawcross, *The Quality of Mercy*, p.245.

³⁹ W. Shawcross, *The Quality of Mercy*, p.240.

drop into Afghanistan of bombs and food parcels wrapped in the same indistinguishable yellow coloured plastic covering.

Inappropriate or unsolicited aid is also a problem in natural disasters. Wendy mentioned the problem in Tonga following the cyclone in 1982 of “the entire country being swamped by a second devastation which was the aid programme”.⁴⁰ Megan talked about the flood of clothes, some not particularly clean, sent to the New Zealand Red Cross when people heard of a disaster. In Vietnam, Ngaire noted the dangers of malaria becoming resistant because “a lot of different aid groups came in...they would put a lot of medication in and then they would go.”⁴¹ Because of the speed of media communications, the public may act on the basis of one snapshot before a professional assessment has been completed. This can result in “costing money by clogging warehouses with inappropriate items like toys”⁴² and do nothing to help those in need. It can also destroy an already precarious economy. An initial needs assessment should be carried out followed by the securement of specific materials, services, or personnel from within the country, or if absolutely necessary from international sources.

Over the past two decades the Red Cross has developed expertise in appropriate and equitable technology and seeks to disrupt local patterns of life and work as little as possible when it establishes its field operations. It also endeavours to work through its network of National Red Cross or Red Crescent Societies. It is particularly conscious of not raising expectations, creating unsustainable services or ignoring local expertise. In Bosnia, Louisa was able to secure project funding in collaboration with local staff for the continuation of safe blood to a hospital she had been delivering medical supplies to. She was mindful of the local constraints and the Red Cross framework. “They were not going to get the most advanced equipment in the world but what they required and what they could live with as they were going to have to find their own suppliers....It had to be sustainable.”⁴³

⁴⁰ W. Smith, oral history interview.

⁴¹ N. Simpson, oral history interview.

⁴² M. McTamney, quoted in ‘Red Cross People’, *Red Cross News*, (March 1997), p.13.

⁴³ L. Akavi, oral history interview.

The Red Cross has standard lists, for example for operating theatre equipment, and Glenys was involved in compiling the original list in the 1980s. Since then, a small group of Red Cross nurses have produced a book now published by the ICRC on how to establish hospitals.⁴⁴ New Zealand Red Cross nurse, Sue Jeffery was one of the authors. For nutritional and public health related programmes, as Wendy mentioned “we have a hundred and one things to guide us, hand book, texts, ready reckoners”.⁴⁵ There are also manuals, and in many cases, collaboration with organisations such as UNHCR for recruitment policies have been fruitful. However, lists and handbooks can only offer guidance, individual situations require responses which cannot be predicted or prepared for. In many situations the nurses “just got on and did what there was to be done”.⁴⁶ Or, they were “left to get on with the job”.⁴⁷ They therefore had to be self reliant, professionally confident and competent.

Negotiating skills were used by all participants in different ways and also reflect the changing role of the nurse in the field, for example by negotiating their way through check points or road-blocks, dealing with established hospitals for which they were providing supplies, and maintaining a dialogue with politicians, police and military officials. This is discussed under the following heading on nursing practice.

Living conditions for the nurses were spartan and basic in most cases, or “devastatingly uncomfortable”.⁴⁸ As one said, “you could not live there, there were bats flying around...absolutely disgusting, worse than any refugee hut I’d seen on the Thai-Cambodia border”.⁴⁹ Where they may have been more comfortable, there were other constraints such as being confined to an island where there were security guards to “make sure those who were there didn’t escape”.⁵⁰ It also meant living above the hospital with the small number of expatriate staff and a rat population.

⁴⁴ J. Hayward-Karlsson, S. Jeffery, A. Kerr, H. Schmidt, *Hospitals for War-Wounded*, ICRC, 1998.

⁴⁵ W. Smith, oral history interview.

⁴⁶ N. Simpson, oral history interview.

⁴⁷ W. Smith, oral history interview.

⁴⁸ G. Pragnell, quoted in N. Sherwood, ‘A long time field worker returns’...p.13.

⁴⁹ G. Checchi, oral history interview.

⁵⁰ L. Akavi, oral history interview.

Examples were given of simple but effective coping strategies to enable day to day survival. Glenys arrived in Sekata in Ethiopia with one other expatriate and no water, shower or toilet. She found water and if she could “heat a little water, wash my face, essentials,...I actually feel a bit better about being there.”⁵¹

One of the key issues for the nurses was safety and security, or risk to their health and wellbeing. Physical health suffered at times. Wendy had hepatitis in Namibia, Glenys was sick in Ethiopia, Louisa had to return early to New Zealand from Hong Kong with pneumonia, but it can be discerned from the interviews that some degree of personal trauma may be suffered by any delegate who serves overseas. It is inevitably a life changing experience. Ngaire explained in an interview with a local newspaper on return from her second mission in Vietnam, that it had a profound effect on her life.⁵²

All participants recounted ‘horrific’ stories and times when they were deeply affected by what they saw. Details of these have deliberately not been covered in this discussion being mindful of what Biedermann called the “bloody and gory”⁵³ stories which were the public perception of Australian nurses’ experiences in Vietnam. In her study, Biedermann’s participants apologised for not having these stories to recount because they considered their work to be mundane, but also because some were not prepared to relive them again. While the Florence Nightingale Medallists did tell these stories and were prepared to do so, there were other aspects of their life and work that demanded attention and scrutiny. This does not deny the existence of or diminish the profound impact of the experiences on the individual.

Glenys felt that although some of the delegates had been traumatised counselling was not available for delegates in her time and “some of us could have done with some counselling.”⁵⁴ Louisa admitted to becoming depressed on her first mission in Bosnia

⁵¹ G. Checchi, oral history interview.

⁵² S. Simpson, ‘Vietnam tough training ground’, Interview with Ngaire Simpson, *Bay of Plenty Times*, 3 May 1995.

⁵³ N. Biedermann, *The Study Conduct*, Chapter 3, ‘The wartime experiences of Australian Army nurses in Vietnam 1967-1971’, PhD Dissertation, James Cook University, Townsville, Australia, 2001, p.73.

⁵⁴ G. Checchi, oral history interview.

which was exacerbated on her return to New Zealand when she heard news that people had been killed by a rocket near Tuszla. She also thought that counselling would have helped on her return from Pulau Bidong in 1988 after evacuating a dying colleague. Ngairé also mentioned that several nurses were sent on leave after the Tet Offensive in Vietnam because it was felt they needed time out, it had been “rather trying”.⁵⁵ Megan’s nursing colleague who accompanied her to Malaysia on the ship committed suicide after she had returned to England from Malaysia. Scannell-Desch in her study of women military nurses in Vietnam commented that the emotional sequelae of catastrophic events such as serving in a war zone should be emphasized in nursing education programmes prior to deployment. She also added that caring for the emotional needs of caregivers was as important as taking care of victims during the event.⁵⁶

The other psychological phenomenon also well documented amongst nurses was burnout. It is not only confined to nurses but to any worker, particularly those in the helping professions, where the additional burden of working in emotionally charged situations that involve feelings of anxiety, fear, embarrassment and hostility occur for unrelenting or prolonged periods of time.⁵⁷ One of its impacts is to render the worker less effective as well as experiencing feelings of tiredness, depression, exhaustion (physical, mental, spiritual), and disillusionment, amongst other sensations.⁵⁸ It can also lead to low levels of job satisfaction, high absenteeism, alcohol and drug abuse.⁵⁹ This has become more of an issue for the Red Cross since the 1980s when a small number of delegates, in particular the nurses, have had a succession of overseas missions within a tight time frame. Burnout was specifically discussed by Louisa and implied by Wendy. Glenys was particularly concerned about this aspect when working at New Zealand Red Cross. She enforced a policy of delegates having a six month break in between missions “to maintain a perspective on the world...not only to readjust to your own country, but

⁵⁵ N. Simpson, oral history interview.

⁵⁶ E. Scannell-Desch, ‘The Lived Experience of Women Military Nurses in Vietnam During the Vietnam War, *Image: Journal of Nursing Scholarship*, Vol. 28, No. 2, Summer 1996, p. 124.

⁵⁷ E. Sarafino, ed., *Health Psychology*, 3rd edition, John Wiley and Sons Inc., New York, 1998, p. 307.

⁵⁸ B. Blattner, *Holistic Nursing*, Prentice-Hall, Englewood Cliffs, New Jersey, 1981, p.424.

⁵⁹ E. Sarafino, *Health Psychology*, p. 307.

to readjust to your professional standards...and because life on mission is hard on you, you become so involved and committed".⁶⁰

Two of the participants experienced the deaths of colleagues in the field, one survived the assassination of colleagues, another had to deal with deaths from the distance of the head office. Another lost a team member after her return home, and all were affected by the most recent loss of Sheryl Thayer in Chechnya.

The New Zealand Red Cross has lost three delegates in the field over the past thirty years. Mac Riding was killed in Vietnam in 1975,⁶¹ Dr Jock Sutherland in Pakistan in 1993,⁶² and Sheryl Thayer in Chechnya in 1996. Both Jock and Sheryl were awarded the highest award of the International Red Cross and Red Crescent, the Henry Dunant Medal, posthumously. These losses had a profound effect on families, colleagues and the Red Cross. The latest tragedy provoked the ICRC into making a public statement in which it used uncharacteristically strong language such as "assassinated in a brutal attack by gunmen",⁶³ "a new barbarity is emerging",⁶⁴ the "ICRC unreservedly condemns the attack which struck at the very core of humanitarian action".⁶⁵ While it saw it as an aberration, it commented that should the world not commit itself to defending and promoting policies and acts inspired by the humanitarian ideal, humanity was condemned to further acts of barbarity.

The nature of conflicts particularly in the post cold war era triggered "unexpected and savage conflicts and economic rivalries"⁶⁶ with new and more numerous belligerents coming from the disenfranchised and poverty stricken. The concomitant increase in risks to safety were discussed in Chapter 2. Where once the Red Cross emblem was

⁶⁰ G. Checchi, quoted in N. Sherwood, 'A long time field worker returns', p.12.

⁶¹ 'In Memory of Mac', *New Zealand Red Cross News*, Vol 79, No.3, (July 1995), p.5.

⁶² 'Medal Tribute to Jock', *New Zealand Red Cross News*, Vol. 78, No. 2, (July 1994), p.7.

⁶³ F. Bugnion, 17 December 1996, Six ICRC delegates assassinated in Chechnya, *International Review of the Red Cross*, No. 317, (March April, 1997), p.140

⁶⁴ J. de Courten, 'A swath of barbarism spreads across the world', *Red Cross News*, Vol. 81, No.1, (March 1997), p.10.

⁶⁵ F. Bugnion, 17 December, p.142.

⁶⁶ C. Moorehead, 'The new humanitarian worker', p.6.

universally respected and the best-known brand in the world, it has dropped to third place behind Coca Cola and Nike and has now become a target of violence. Ten years ago only 3% of incidents from the field were the result of direct targeting of the emblem, in 2000 it was 40%.⁶⁷

The nurses recognised the risks to themselves and their local colleagues, especially in more recent times and were prepared to work within these dangers, and the constraints imposed by them. “The risk has intensified in the last few years especially, the wars changed, the nature of the conflicts changed”.⁶⁸ Danger was a part of daily life, “every check point has the potential for danger, there was a lot of danger in Sri Lanka”.⁶⁹ As one noted, “the risks are there, this I accept, the work I do is what I want to do, I don’t think about it anymore”.⁷⁰ This sentiment was implied by the other participants, and noted in the New Zealand Red Cross medal applications but as professionals, the work was what they were overseas to do, work that they loved doing and were committed to, and they were prepared to take the risk.

In contrast to the Second World War when ovaltine was offered to patients to relieve nervous tension⁷¹ or those with ‘shell shock’ were offered reassurance and occupational therapy,⁷² psychological suffering of disaster victims and refugees drew a different response in the 1980s. Traditional healers amongst others were used in a complementary and holistic way.⁷³ However, it was not until the 1990s that psychological support began to be included in disaster relief training through work

⁶⁷ C. Moorehead, p.8.

⁶⁸ G. Checchi, oral history interview.

⁶⁹ W. Smith, oral history interview.

⁷⁰ L. Akavi, oral history interview.

⁷¹ Advertisement in *Kai Tiaki*, Vol. XXXIII, No.3, (March 15, 1940), p.95.

⁷² ‘The Increasing scope of war nursing, occupational therapy’, *Kai Tiaki*, Vol. XXXIII, No.11, (November 15), p.354.

⁷³ G. Jackson, ‘Psychological effects of disaster’, *Tropical Doctor*, 21, supplement 1, (1991), p.62.

initiated by the Danish Red Cross.⁷⁴ Psychological support is a concurrent concern with the provision of basic needs such as water, sanitation, food and shelter.⁷⁵

In the late 1960s, the psychological disorders reported by veterans in the aftermath of the Vietnam War were recognised as 'post-Vietnam syndrome' and psychological assistance was provided.⁷⁶ Further attention was given to this relationship between trauma and traumatic neuroses and shifted the onus for symptoms from inner conflict to events in the environment, and it became known as post traumatic stress disorder. The syndrome first appeared in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders in 1980.⁷⁷ Although post traumatic stress disorder had been recognised in military personnel, it was not until the 1990s with increased exposure of humanitarian workers to large-scale atrocities in Somalia, the former Yugoslavia, and Rwanda that the Federation and ICRC were forced to acknowledge the emotional needs of staff and have concern for their psychological health.⁷⁸ Where previously it was thought indecent to express emotion in view of victims' suffering, the high turnover of staff and increase in ill-health and dependencies, such as alcohol (noted by Wendy), changed the approach to staff needs. The evolution of the delegate from idealist to 'humanitarian professional' and acknowledgement that stress can lead to security incidents because it disrupts an individual's healthy capacity for analysis, were also factors in the ICRC establishing a Stress Unit and 'emotional debriefings' of all delegates.⁷⁹ This reinforces the importance of selecting people for overseas missions on the basis of their maturity, emotional stability, experiences and sensitivity to cultural differences,⁸⁰ a policy Glenys adhered to at the New Zealand Red Cross.

⁷⁴ 'Guidelines for the Development of a psychological support programme for victims of disaster and other stressful life events', *International Federation of Red Cross and Red Crescent Societies*, (1993), p.1.

⁷⁵ M. Sonniks, Editorial, *Red Cross Red Crescent*, issue 3, (2001), p.3.

⁷⁶ B. Shephard, *A War of Nerves, Soldiers and Psychiatrists 1914-1994*, Pimlico, London, 2002, p. 357.

⁷⁷ R. Lazarus, *Stress and Emotion, A new synthesis*, Springer Publishing Company, New York, 1999, p.155.

⁷⁸ I. Jaquemet, 'Psychological support: luxury or necessity?' *Red Cross Red Crescent*, issue 3, (2001), p.7.

⁷⁹ I. Jaquemet, 'Psychological support:' p.8.

⁸⁰ G. Jackson, p.62.

The reactions of the participants to being awarded the medal said much about their professional and understated approach to their work, and were notable for the modesty they portrayed about their achievements overseas. Without exception, they downplayed their contribution to humanitarian nursing and the sacrifices involved. “Humility”⁸¹, feeling “humble”⁸² and “honoured”⁸³ were some of the reactions. One nurse had particular difficulty in reconciling her award with the suffering of others. “I wouldn’t even be getting that medal if those people weren’t in need, so I couldn’t reconcile the two”.⁸⁴ Another expressed distress and horror that she should be held in the same esteem as others she regarded so highly.⁸⁵

From these reactions, the characteristics of devotion, service, and selflessness inherent in the Nightingale legacy, and the criteria for the medal’s award can be discerned. However, when questioned about distinguishing themselves by ‘exceptional devotion’, it was difficult for them to describe and give examples from their own experiences. For example, “I don’t know how to explain it, I view it as a job option”.⁸⁶ Another said that most nurses are committed to what they were doing and did it to the best of their ability, or that nurses have a high degree of commitment and desire to mentor and encourage others. “It is a very innate nursing [characteristic] something to do with the spirit of what really is at the core of being a nurse”.⁸⁷ As this terminology in the medal criteria has not changed since the original concept, it is not surprising it is difficult to explain in relation to today’s nursing vocabulary when ‘exceptional devotion’ is not necessarily considered a positive attribute.

The terminology is also interesting in relation to histories of nursing and nurses being confined by two persistent and interrelated social processes, those of “invisibility and

⁸¹ M. Crisp, oral history interview.

⁸² W. Smith, oral history interview.

⁸³ L. Akavi, oral history interview, G. Checchi, oral history interview, W. Smith, oral history interview.

⁸⁴ G. Checchi, oral history interview.

⁸⁵ M. Crisp, oral history interview.

⁸⁶ L. Akavi, oral history interview.

⁸⁷ W. Smith, oral history interview.

stereotyping”.⁸⁸ For the latter, Chinn said that the stereotypes of nurses were often of “exceptional women in exceptional circumstances”⁸⁹ and because the context was often missing and little was known of the nurses themselves, these images created a distorted view of the past and obscured historical patterns that continue in the present. This is always a problem of the past being reinterpreted or reconstructed through different lenses, some deifying or making heroines out of past figures, or equally, discrediting them. As pointed out in Chapter 4, Edith Cavell’s life was constructed to serve the politics of the day and a range of interests.⁹⁰ This is of interest in relation to this study because whilst an historical study, it draws on the contemporary experiences of nurses who are still living and who have the opportunity to explain themselves and their nursing practice within its context. What the nurses think of themselves is relayed through their own voices. Terminology such as ‘exceptional women in exceptional circumstances’ in this respect remains in the language of the Florence Nightingale Medal criteria for its recipients, and ascribed to these nurses who may be reluctant to be burdened with it. However, inevitably, the interpretation of the history makers may distort this reality in the future. Chinn’s comment about invisibility of nurses is apt in relation to these nurses and the Florence Nightingale Medal, and one of the key reasons for undertaking this study.

It is interesting to note the reaction of New Zealand nurse, Andrew Jull to this terminology. Upon reading about Judith Owen’s award in 1995, he questioned rewarding “the outstanding” and “the exceptional”⁹¹ because “very few nurses provide care in war zones or major disaster zones”.⁹² He felt that she was just doing her job. All nurses – ‘the small poppies’ - working in everyday situations deserved recognition in their daily struggles to do the best for their patients. He wrote this editorial in the Auckland Healthcare Services journal at a time when nursing morale was at a low ebb

⁸⁸ P. Chinn, editorial, ‘Liberating nursing history’, *Advances in Nursing Science*, Vol. 12, No.4, (July 1990), p.viii.

⁸⁹ P. Chinn, editorial, ‘Liberating nursing history’, p.viii.

⁹⁰ K. Pickles, ‘Edith Cavell-Heroine no hatred or bitterness for anyone?’, *History Now*, Vol. 3, No. 2, (October 1997), p.4.

⁹¹ A. Jull, ‘In amongst the small poppies’, editorial, *The Professional Leader, Journal of Nursing and Midwifery Auckland Health Services Ltd*, Vol. 2, No. 2, (September 1995), p.3

⁹² A. Jull, ‘In amongst the small poppies’, p.3.

because “nursing has to live in an ethos of fear, a culture of negativity...punishment was common and rewards miserly”⁹³ and his own feelings about this may have provoked his criticism. While he may object to the terms used to describe the recipients of the award (which are those of the ICRC, not the nurses), his comments suggest that he might not have understood the nurses themselves, the context of their work, and their reactions to receiving the award – reinforcing Chinn’s argument about the need to understand the context to get the correct perspective on the historical depiction of nurses.

In their interviews, the nurses articulated that they were indeed just doing their job and would probably regard themselves as Jull’s ‘small poppies’. However, it would be interesting to know if Jull’s nurses would be prepared to make the sacrifices these nurses have made, which is what makes them ‘exceptional and devoted’ in Red Cross terms, respected for their professionalism, humility and uncontroversial approach. They have a sense of their place in the global scheme of things, recognising they are part of a bigger picture and belong to a complex organisation which has as its central tenet the alleviation of human suffering, and a unique mandate to operate within an internationally recognised and accepted legal framework.

Ultimately it is desirable for all nurses to be honoured and valued for their work wherever it takes place, but that should not preclude the contribution of some nurses being recognised by the organisation to which they have made a tangible contribution in dangerous and difficult contexts. *Kai Tiaki/New Zealand Nursing Journal* has been consistent in honouring these nurses over the years in its journal.

The participants also acknowledged that others had contributed to the individual’s honour and there was unanimous satisfaction and pleasure derived for their families rather than themselves. One said it was given to her to recognise the team of which she had been the most senior member.⁹⁴ In a sense the sentiments were also articulated by Hester Maclean on receiving the award in 1920, when she said that it was “made in my

⁹³ A. Jull, ‘In amongst’, p.3.

⁹⁴ S. Simpson, ‘Vietnam tough training ground’, interview with Ngaire Simpson, *Bay of Plenty Times*, 3 May, 1995.

person to the New Zealand nurses who had done so well in the War”.⁹⁵ Similarly Iris Crooke, in a letter in 1959 said that, “it is to the nursing profession of this country that the tribute has been paid and I feel most humble in accepting it on your behalf”.⁹⁶

The participants were honest about their lack of knowledge about the medal and the criteria for its award. It is therefore not surprising that beyond Red Cross circles, understanding about the Florence Nightingale Medal and humanitarian nursing is practically non-existent. It would be a loss for nursing if the nurses were relegated to an historical stereotype. It is the richness of their experiences and contribution which should be remembered.

Humanitarian nursing practice

The goal of the International Red Cross and Red Crescent Movement, as outlined in Chapter 2, is to prevent and alleviate human suffering without discrimination. This is done through the Federation providing humanitarian assistance to improve the lives of vulnerable people in natural and technological disasters, to refugees, and in health emergencies; and through the ICRC protecting the lives and dignity of victims of war and internal violence.

In relation to the ICRC, and working in conflict situations, the rights and duties of medical personnel are outlined in the Geneva Conventions and Additional Protocols and were discussed in Chapter 2. The duties of nurses are related to the rights of the wounded and sick under their care, civilian or military. These rights and the nurses’ duties are respect, protection, and humane treatment. These rights are inalienable and care should be given to protect people irrespective of race, religion or any other category, that is, without discrimination, medical reasons being the only criteria for priority treatment and care.⁹⁷ This is the international legal framework under which most of the nurses in this study worked for the majority of their overseas missions. A range of ways in which nursing practice has contributed to humanitarian assistance is

⁹⁵ H. Maclean, *Nursing in New Zealand*, p.236.

⁹⁶ Letter from Flora Cameron to the Nurses Association, ‘Award to the Director, Division of Nursing’, *New Zealand Nursing Journal*, Vol. LII, No. 3, (June 1959), p.99.

⁹⁷ Y. Sandoz, ‘Protection and Nurses’, *International Review of the Red Cross*, (June 1977), p.299.

outlined in the following section and drawn from the experiences of the five participants.

Since the 1960s New Zealand Red Cross sent nurses to work with the International Red Cross, but also organised and sent nurses as part of welfare and support teams of New Zealand Red Cross personnel. From 1968, nurses have worked with refugees in camps or hospitals in South Vietnam, Kampuchea (Cambodia), Thailand and Pakistan.⁹⁸

One member of the first refugee welfare team to go to South Vietnam in 1968 was 1969 medal recipient, Moya McTamney. The team, which comprised a nurse, vocational guidance officer, sanitation advisor and an agricultural/animal husbandry advisor, was sent to resettle and rehabilitate refugees and provide them with the opportunity to make a new life for themselves in economically viable units.⁹⁹ Moya McTamney received her medal after two years in the field. Participant, Ngaire Simpson was in the fifth rehabilitation team in 1973 and was sent to Pleiku, west of Qui Nhon.¹⁰⁰ Prior to this, her first mission to Vietnam in 1967 was with a New Zealand government team.

In the 1980s, the composition of New Zealand Red Cross teams sent to work with the International Committee of the Red Cross changed to comprise a surgeon, anaesthetist and theatre nurse. The 1982 team sent to Peshawar in Pakistan included 1987 medal recipient Glenys Checchi.¹⁰¹ The ICRC operated two surgical hospitals in Pakistan as it had not been able to negotiate access into Afghanistan at the time.

Where the ICRC operated independent hospitals such as that in Peshawar and in Quetta, it had no onward referral and the patients would stay until their surgical treatment had been completed. The ICRC then had to establish its own services to care for people who required the fitting of prosthetic limbs. In 1984 the ICRC also established the Hayabad Paraplegic Centre for the rehabilitation of paraplegic and tetraplegic war wounded from

⁹⁸ M. Burgess *Nursing in New Zealand Society*, p 177.

⁹⁹ 'Refugee Welfare in South Vietnam a programme completed', *New Zealand Nursing Journal*, Vol. LXIII, No. 1, (January 1970), p.13

¹⁰⁰ 'Vietnam a profound experience', *New Zealand Red Cross News*, (July 1995), p 5.

¹⁰¹ 'Red Cross in Pakistan', *New Zealand Red Cross News*, issue 4, (1982), p 2.

Afghanistan.¹⁰² This centre was handed over to the Pakistani Red Crescent Society in 1996 and is the only facility in Pakistan today.¹⁰³ Local management and operation is the ultimate aim when staff have been trained and sustainability ensured, as in the example above.

The provision of surgical care for victims of war has been an important part of ICRC activities over the past fifteen years and the need for surgical nurses has continued. Large independent ICRC hospitals such as in Cambodia, Pakistan, Afghanistan, Somalia, Sudan and Chechnya were established over the years.¹⁰⁴ In addition, hundreds of existing hospitals have received protection and supplies through the ICRC. Louisa was involved in this on two missions. She worked in Tuszla, in Bosnia, in 1994 and 1995 on separate missions. Local doctors and nurses were still available to the health services in the countries of the former Yugoslavia, even if they did not receive any payment for their work. Because of the breakdown of the infrastructure and services during the war and the lack of supplies, the nature of Red Cross nursing practice was adapted to suit the local needs. "It was not nursing...I delivered medical supplies, but I had a lot of interaction with the major hospital in that region".¹⁰⁵ She may not have regarded it as nursing, but for the ICRC, this was an important role for a nurse to play in this situation and is becoming more common today.

The International Red Cross is able to respond rapidly to changing situations and mobilise staff, especially those from National Red Cross Societies at short notice to assist in its operations. This was the case in Peshawar in 1986 when the New Zealand Red Cross was asked and able to send five nurses at 24 hours notice to help set up as field hospital. Glenys was one of the nurses to go. "They asked New Zealand Red Cross as they knew they had quite a few people who had been to Peshawar....Our job was to set up a field hospital from the Norwegian Red Cross".¹⁰⁶

¹⁰² Khyber Gul, 'Orphan and mascot', *Red Cross Red Crescent*, (January 1987), p.28.

¹⁰³ J. Ibrohim, 'Fell from a roof,' *Asia Pacific Focus*, International Federation of the Red Cross and Red Crescent Societies, issue 26, (September 2001), p.5.

¹⁰⁴ P. Perrin, forward in, *Hospitals for War Wounded*, ICRC, 1998, p.xi.

¹⁰⁵ L. Akavi, oral history interview.

¹⁰⁶ G. Checchi, oral history interview.

A decade later in the 1990s in Chechnya, the ICRC established a hospital using existing staff supplemented by a small number of expatriate staff to support the continuation of these services and to provide medical supplies, “the health services had totally broken down, hospitals were selling supplies...there was no money...patients were being charged...it needed outsiders...society totally breaking down”.¹⁰⁷ Here Louisa returned to ‘hands on’ nursing care at the hospital in Novi Atagi. As has been discussed previously, this mission ended in tragedy.

In addition to providing surgical care for the war wounded, the International Red Cross has a history of caring for and protecting refugees since the First World War when millions of people found themselves stranded beyond their own borders. In 1946, after the Second World War there were approximately 1,675,000 refugees from Europe, Asia and the Middle East who required new homes. Some 320,000 were placed under the ICRC’s responsibility until the International Refugee Organisation was established in 1947.¹⁰⁸

The next large scale refugee operation undertaken by the ICRC was on behalf of the Palestinian refugees in 1948. The United Nations Relief for Palestine Refugees worked in cooperation with the ICRC, the League, and the American Friends Service Committee (AFSC, or Quakers). An estimated 395,00 refugees were cared for by the ICRC, 300,000 by the League and 245,000 by the APSC until 1950 when the operation was entrusted to the United Nations Relief and Works Agency.¹⁰⁹

The Vietnam War from the mid 1960s to 1975 led to the exodus of over a million Indochinese who by 1983 had been resettled abroad.¹¹⁰ But many were held in refugee camps in other parts of Southeast Asia awaiting resettlement or repatriation. Caring for large numbers of refugee populations or displaced people requires public health nursing skills and midwifery. Both Wendy and Louisa worked on Pulau Bidong caring for the

¹⁰⁷ L. Akavi, oral history interview.

¹⁰⁸ F. Krill, ‘The ICRC’s policy on refugees and internally displaced civilians’, *International Review of the Red Cross*, Vol. 83, No. 843, (September 2001), p.608.

¹⁰⁹ F. Krill, ‘The ICRC’s policy’, p.609.

¹¹⁰ W. Shawcross, *The Quality of Mercy*, p.405

obstetric and general health needs of the Vietnamese refugees. They also protected and advocated on behalf of the refugees who were in a position of vulnerability because of their refugee status, what they suffered prior to their exodus, and had endured getting to Bidong. Horrific stories of boat people have been well documented by Shawcross, St Cartmail and Pilger.¹¹¹ Today, the issues have arisen again with Afghan asylum seekers aboard the ship *Tampa*. This time governments such as Australia have been less sympathetic than previously, signifying perhaps fear rather than compassion, reflective of today's international politics.

Once on Pulau Bidong, violence was still being perpetrated as Wendy found when she challenged a guard, "but we beat people in our country so why shouldn't we beat the refugees".¹¹² Louisa also observed some degree of violence, in particular of a domestic nature, and after she had left the island there was a riot and fighting between ethnic groups, Cambodians and Vietnamese, which resulted in several deaths.

The marginalisation of populations such as refugees and the concept of vulnerability in relation to it has been the interest of writers such as Hall, Stevens and Meleis.¹¹³ They stated that "the future of nursing depends on the ability of the discipline to reach out to diverse communities and to meet the health needs of those most vulnerable".¹¹⁴ While this was made in the context of nursing in the United States, it is consistent with the goals of the Federation and its work with for example, refugees, displaced people and those with diseases such as HIV/AIDS.¹¹⁵ With identifying vulnerabilities goes the assessing and building of coping capacities, which Hall et al refer to as resilience, but it has the same goal as building capacities.¹¹⁶ Protection of vulnerable people, advocacy on their behalf and developing their capacities or resilience were all roles the Red Cross

¹¹¹ W. Shawcross, *The Quality of Mercy*. K. St Cartmail, *Exodus Indochina*. J. Pilger, *Heroes*, Vintage, 1986.

¹¹² W. Smith, quoting a guard on Pulau Bidong, oral history interview.

¹¹³ J. Hall, P. Stevens, A. Meleis, 'Marginalisation: A guiding concept for valuing diversity in nursing knowledge development', *Advances in Nursing Sciences*, Vol. 16, No. 4, (1994), p.25.

¹¹⁴ J. Hall et al, 'Marginalisation', p.23.

¹¹⁵ *Annual Review 2000*, International Federation of Red Cross and Red Crescent Societies, 2000, p.15.

¹¹⁶ J. Hall et al, p.33.

nurses were familiar with, as demonstrated in their stories. This is at the core of all Red Cross work.

Another reason for large migrations of people is famine. Famine occurs when a group's normal access to food completely collapses so that mass starvation occurs.¹¹⁷ It is characterised by widespread disruption as people migrate. As well as people dying from starvation, there is an acute breakdown of society. Many people in Africa have an inadequate diet at the best of times and in the early 1970s it was thought that eighty million Africans were living in a permanent state of chronic hunger and malnutrition. In the mid 1980s, that number was one hundred million.¹¹⁸ Today, chronic hunger has become a global problem with an estimated 790 million people who do not have enough to eat. There are around 34 million undernourished in developed countries, more than three-quarters of whom are in countries in transition in Eastern Europe and the former Soviet Union.¹¹⁹ But famine is the tip of a much larger problem, and not just the result of adverse climatic conditions. The people most affected by famine are the poor and powerless, those who are always worse affected by disasters, their vulnerability exposes them to the full impact of a disaster. Famine is usually localised and even in famines if there is some food available, it is a question of who has access to it. The rich, military officers and politicians do not starve.¹²⁰ Demands on the environment for food production, with a pernicious combination of three years of drought and over twenty of conflict, the current situation in Afghanistan, has left four million people reliant on food aid,¹²¹ and while fighting continues the distribution of food supplies is interrupted. It is too dangerous to continue and winter is closing in compounding the problem.

The ICRC approach to famine has changed over the years. In the 1980s they distributed food, in the early 1990s they distributed seed and tools in order to encourage economic

¹¹⁷ A Report for the International Committee on Humanitarian Issues, *Famine, a man made disaster?*, Pan Books, London, 1985, p.25

¹¹⁸ *Famine, a man made disaster?* p.26.

¹¹⁹ Putting a face on world hunger: New FAO report assesses food insecurity, <http://www.fao.org/NEWS/1999/991004>, p.1.

¹²⁰ *Famine*, p.63.

¹²¹ N. Danziger, 'Inside Afghanistan', *New Zealand Red Cross News*, Vol. 89, No. 4, (November, 2001), p.6.

activity, now they utilise the expertise of agronomists, economists, veterinarians and water experts. Even during a crisis time is taken to plan and prepare services for when an operation is over or contained.¹²² The 1980s was the context for Wendy's work in Sudan in 1985, and Gleny's in Ethiopia in 1986, when nutritional assessment and food distribution were the practice.

For both of them it was a new experience and required skills they absorbed in briefings with others or learnt from handbooks. It was also a situation where they worked with only one other Red Cross delegate in an environment isolated from the rest of the Red Cross infrastructure. This required integration within the local community and adaptation to the local conditions.

To do this, cultural awareness and competence was essential and an important part of the spectrum of characteristics required by nurses working overseas. Many of the countries in which the nurses worked were former colonies, and sensitivity and understanding of this was also essential. It has been noted by writers that Western nurses represent, through their practice, a set of values and beliefs which are part of their Western heritage.¹²³ If they are not sensitive to this there is a danger of a perpetuation of neo-colonialism from which most developing countries have unshackled themselves.

At an interpersonal level, it was difficult to fully assess the participants' bicultural or multicultural interactions, and their impact on the health of the patients. As language was a barrier in most situations, the nurses had to rely on translators or non-verbal communication to gain an appreciation of reactions to their presence. As a number admitted, they had to learn by their mistakes. Through participants' comments and descriptions of their cultural understanding and relationships, insights were gained, but only on a superficial and general level.

¹²² C. Moorehead, 'The new humanitarian worker', p.6.

¹²³ B. Parfitt, 'Working across cultures: a model for practice in developing countries', *International Journal of Nursing Studies*, No. 36, (1999) p.371.

Participants recounted how they interacted with people and their attitudes to the different cultures, “they had their own culture, it was not for us to change”,¹²⁴ and how they were treated as women in the cultures in which they lived and worked, how they adapted, were sensitive to and respectful of the local culture. Glenys was particularly conscious of this as a field worker, but also in her role as recruitment officer as she had to brief delegates prior to their departure. She felt that one of the most important things was to be observant about how the local women were dressing as “it’s an insult to expect to go there and wear shorts and T shirts and show all your skin”.¹²⁵ She found that when she returned to New Zealand she reacted to what had once been a familiar and accepted dress code prior to her overseas experiences. She now found this offensive, an understandable and recognised reaction, a kind of ‘reverse culture shock’.

The constraints on where delegates could go alone or in groups were for both security and cultural reasons. “Inside the hospital I think that patients didn’t have any difficulty....I never went out by myself. I rarely visited local staff’s homes. There were certain areas we weren’t allowed into, I always went out with others”.¹²⁶

Awareness of the gender roles meant that “we used to have a lot of female nurses in Peshawar, there were often things they couldn’t do. The Afghani men didn’t mind there were Western nurses looking after them”.¹²⁷ This was also noted by Louisa about procedures taken for granted by New Zealand nurses.

I couldn’t see the local women doing [it] because it meant touching the men, washing men, and stripping them....The ones that needed this type of close care we did ourselves, because you could not expect the nurses to do because society objects to that if [done by] women not related to these men.¹²⁸

¹²⁴ N. Simpson, oral history interview.

¹²⁵ G. Checchi, oral history interview.

¹²⁶ G. Checchi, oral history interview.

¹²⁷ G. Checchi, oral history interview.

¹²⁸ L. Akavi, oral history interview.

It was noted by others that patients' families usually took care of their relatives in hospital and the nurses were only required for basic nursing care when relatives were absent.

The impact of culture on health and practices was noted by several participants and the use of traditional medicine in relation to Cambodian refugees was discussed previously. By using the best in modern medicine with the best in traditional healing, in combination rather than one or other on its own, it was "adding to the refugees culture, not taking something away".¹²⁹ Participants were challenged by some traditional practices. The practice of tying rattan around the waist of Malaysian women in labour was one of the examples of practice which was "the worst I ever saw, it was frightening. In time those things did improve with education and support".¹³⁰

Fertility and family planning were controversial on a number of levels. "Malaysia is Muslim....It didn't work because you don't have the men agreeing with it",¹³¹ but there was a tension because of the biological imperative to procreate due to the loss of family members in war, especially amongst the Vietnamese and Cambodians. However, it was needed because of rape, and the loss of family constraints normally provided by older members who had been killed. "So promiscuity was pretty high, prostitution was there".¹³²

These examples illustrate the dichotomy between the developed and developing worlds and across cultures, encountered by the nurses. Ethical and moral concern about exporting Western ideas and cultural imposition was expressed by Leininger whose theory of transcultural nursing is useful as a knowledge base. However, her unyielding position that transcultural nursing is an overarching framework, a phenomenon¹³³ which she claims is a broader and more comprehensive perspective than international nursing

¹²⁹ G. Pragnell quoted in 'Red Cross people', *Red Cross News*, (March 1997), p.13.

¹³⁰ M. Crisp, oral history interview.

¹³¹ L. Akavi, oral history interview.

¹³² L. Akavi, oral history interview.

¹³³ M. Leininger, 'Transcultural nursing: a world wide necessity to advancing nursing knowledge and practice', in *Current Issues in Nursing*, eds, J.C. McClosky, H.K. Grace 3rd Ed, C.V Mosby Company, St Louis, Missouri, 1990, p.535.

needs to be contested. It is beyond the scope of this study to discuss this fully but my position is that transcultural nursing, like humanitarian nursing, is an element of international nursing, and there are points of divergence and similarity. Of the latter, it is essential that any nurse working overseas is culturally competent and safe and one cannot argue with the sentiments espoused by Leininger to have nurses “give culturally specific or culturally congruent care to individuals, families, and groups for beneficial outcomes”¹³⁴ and to develop an awareness of their own ethnocentrism, especially to ensure culturally safe behaviour. However, her means of achieving it, by expecting all nurses to undertake formal study in transcultural nursing according to her prescription in order to be competent nurses, implies that those who do not are not competent. In relation to this study, it is questionable how much of an impact transcultural nursing knowledge would have had on the competence of the participants’ practice. Their relationships with people of other cultures was on a human-to-human, or humanitarian level congruent with Watson’s human care values,¹³⁵ respectful for the culture within a socio-political context and consistent with the Red Cross principles. This view was also stated by Vance who said that while transcultural nursing was a useful foundation in global interactions, it was through relationships that transcultural awareness developed.¹³⁶

Whilst some nurses spoke with honesty about their early insensitivities or misunderstandings when confronted with cultural variances (for example, one had an initial encounter over food in Malaysia, another was concerned about her reactions to Muslims in Chechnya), they demonstrated they had learnt from the experiences and showed their sensitivities in a number of other ways. One participant observed reactions to her as an outsider, regarded as exotic by local people, much in the way in which the patient may regard the nurse in a bicultural encounter, a key component in concept of cultural safety.¹³⁷

¹³⁴ M. Leininger, ‘Transcultural nursing’ p.537.

¹³⁵ J. Watson, *Nursing: human science and human care*, National League for Nursing Press, New York, 1988, p.31.

¹³⁶ C. Vance, ‘Global Health Awareness and Transcultural Relationships’, *Journal of Transcultural Nursing*, Vol. 10, No. 1, January 1999, p.13.

¹³⁷ L. Ellison-Loschmann, ‘Giving voice to health consumers’, *Kai Tiaki*, Vol. 7, No. 1, (February 2001), p.13. Note, the concept of ‘cultural safety’ has been explored in numerous writings by Irihapeti Ramsden.

One of the ways in which respect for other people was observed was through individual interactions and in upholding professionalism and standards, evident in the nurses' interviews and an important part of their practice. "We felt we should be able to offer the people with whom we are going to help or give aid to, the best possible wisdom and knowledge available at that time".¹³⁸

Understanding the impact of Western presence was also expressed. "For them we are a risk in their country, they are really scared that something is going to happen to us and so they want to protect us".¹³⁹ This was also one of the reasons for strict adherence to security protocols. Several commented that the Western way of doing things was not appropriate or desirable.

Skills and knowledge exchange were thought to be the most valuable contribution made in the relationship between country nationals and the nurses who worked with them. In this respect, both people share and exchange skills, with benefits being derived by all those involved. All the participants mentioned this aspect in their interviews whether it was from a clinical or another perspective. Reciprocal learning was expressed by one as, "we learnt from them, we were not there to change their ways, we were there to help".¹⁴⁰ It was also implied by the other participants in their expressions of sensitivity and knowledge gained working alongside local people.

I think training is the only thing you can leave behind...knowledge. You can leave your resources...a hospital shell, and operating theatre equipment and beds...but in the end...that could go with one bomb or one missile. So the only thing you can leave behind is knowledge. For me that is the most fundamental thing you can do, transfer of knowledge, transfer of skills.¹⁴¹

¹³⁸ G. Checchi, oral history interview.

¹³⁹ G. Checchi, oral history interview

¹⁴⁰ N. Simpson, oral history interview.

¹⁴¹ G. Checchi, oral history interview.

Some thought that most local workers learnt from those experiences, that it had helped them get a job elsewhere. Glenys was also fulsome in her praise of the skills of Afghan and Pakistani nurses, “those theatre nurses, you could put them anywhere, they were stunning, their skill levels were as good as mine, there was no difference”.¹⁴² This view was also expressed in a British article which acknowledged that there was already much expertise, that local counterparts were often more knowledgeable than expatriates, and that helping to train local doctors and nurses within local health services was most beneficial.¹⁴³ Speakers at the international nursing seminar at Wellington Polytechnic in 1991 endorsed this view and stressed the importance of teaching to ensure practices could be maintained after the expatriate left.¹⁴⁴

Importance was placed on organisation and standards. “Nurses have to be organised because they work so hard. The main theme about being a delegate in any place...its about standards. You just set the standard and you say this is how it will be and we don’t accept second best....The standards of behaviour and practice and the discipline of working, the discipline of running an office”.¹⁴⁵ Standards were also maintained by policies of the New Zealand Red Cross to ensure a period of time back in New Zealand to refresh and be re-energized, personally and professionally. In the New Zealand context, raising first aid and training standards within the Red Cross was undertaken by Megan. She introduced instructional training courses and set standards of cardio-pulmonary resuscitation techniques which had a lasting legacy.

At an organisational level, skills exchange was expressed in building the capacity or institutional strengthening within national Red Cross Societies in relation to operational management, resources (both human and material) and performance, as Louisa did when she went to the Solomon Islands in 2000 to assess its capacity to cope and function should the already tense situation deteriorate.

¹⁴² G. Checchi, oral history interview.

¹⁴³ A. Whyte, ‘Mercy Mission’, *Nursing Times*, (December 16, 1998 - January 5, 1999), p.25.

¹⁴⁴ A. Bramwell-Huntington, J. Gilmour, ‘Third World work rewarding’, *New Zealand Nursing Journal*, p.1991.

¹⁴⁵ W. Smith, oral history interview.

Wendy has been involved in capacity building with Red Cross Societies for most of her missions. Her first opportunity to do this was as the New Zealand Red Cross Pacific Project officer when she worked alongside Pacific Red Cross Societies in their gaining full autonomy, and the development of programmes. This is a particular function of the Federation's own development programme and it has a methodology for assessing the needs of a Red Cross Society. As a League and then Federation delegate, Wendy worked with the Namibia Red Cross to assist in its transition from a branch of the South African Red Cross to a fully independent Red Cross Society. The country must sign the Geneva Conventions to enable this to occur. She also worked with the Sri Lankan, Papua New Guinean, Mongolian, and Laos Red Cross Societies.

It could be argued that issues of standards and professionalism might be based on Western values and interpretations and therefore be not necessarily appropriate or relevant to developing countries. The way it is implied here was succinctly stated by Glenys when she said that they wanted to offer the best available care, knowledge and wisdom to the people they were working with. In this sense it is an acknowledgement of equality and respect. It was also articulated by Wendy. "We don't accept second best. We don't accept that everyone should be on penicillin or die, we don't accept that yellow mucky eyes are ok for babies in the third world".¹⁴⁶

It is also implicit in the respect for the dignity of people by not imposing inappropriate aid or disaster relief on them without asking what they want and have a right to receive. The Code of Conduct for the Federation and non-governmental organisations in Disaster Relief, as mentioned in Chapter 2, is a useful framework in this respect.¹⁴⁷

Leadership responsibilities were assumed by Glenys, Wendy, and Louisa as the head nurse working with multinational teams. "The head nurse had to hold it all together, and still keep that hospital running."¹⁴⁸ In addition, Wendy and Louisa had experiences as health and development delegates and were head of delegation and acting head of delegation respectively. These positions required a range of field operational and

¹⁴⁶ W. Smith oral history interview.

¹⁴⁷ Code of Conduct for the International Federation of Red Cross and Red Crescent Movement and Non-Governmental Organisations in Disaster Relief, 1997.

¹⁴⁸ G. Checchi, oral history interview.

management skills. For conflict situations the need was to, "sort out what is actually working, what isn't, and to strengthen what is working."¹⁴⁹ For institutional development, "it is really important to be a generalist and know what makes a Red Cross society work because you have the same dilemmas in every country"¹⁵⁰ when supporting a National Red Cross Society. This was implemented concurrently with programmes such as primary health care and drought relief.

Glenys and Wendy worked in Geneva recruiting delegates, Wendy for the Federation in 1996 for three years, and Glenys with the ICRC in 1987. The challenges for them were very different, and related to the times and the organisations. Glenys's comprehensive skills were under-utilised in the Swiss bureaucracy, but they became invaluable on her return to New Zealand where she worked with New Zealand Red Cross. Wendy's position was new and she had the freedom to develop it and make considerable changes within the system. However, the murders of several delegates in the field over that time meant that she was "worked to the hilt, in the end my mind had so much sewerage in it that I had to stop"¹⁵¹ and she returned to field work.

Both Glenys and Louisa briefly mentioned their work with prisoners of war or detainees. This traditional ICRC work had formerly been confined to the Swiss delegates, but in the 1990s nurses from National Red Cross Societies, especially the experienced nurses, assumed some of the responsibilities previously undertaken by the Swiss ICRC delegates. This expanded role of the nurse has evolved in particular in the 1990s because of the changes within the Red Cross itself since the 1980s, as well as the health problems arising out of armed conflict and the Red Cross response to them. While today's nurses perpetuate the spirit of Florence Nightingale and her work with the war wounded in the Crimea, the role and duties of the Red Cross nurse are "infinitely more varied."¹⁵²

¹⁴⁹ L. Akavi, oral history interview.

¹⁵⁰ W. Smith, oral history interview.

¹⁵¹ W. Smith, oral history interview.

¹⁵² R. Russbach, 'A final word, nurses in wartime', *Profession: Nurse, (Images 1900-1930)*, International Museum of the Red Cross and Red Crescent, 1995, p,153.

Most of the New Zealand nurses commenced their Red Cross experience working in field hospitals or clinics set up especially to treat refugees and war wounded. They usually went overseas in teams with other New Zealand medical personnel or to work with other teams in the 1970s and 1980s. In these situations they would carry out the nursing care themselves. Later experience especially during the 1990s, was as individuals rather than as part of a New Zealand team and was undertaken in European or developed countries: the Balkans; Bosnia, and Kosovo in contrast with earlier experiences. Because these countries already had medical personnel such as skilled doctors and nurses available, the main need was for supplies to be delivered to sites where the wounded and sick were being treated. Nurses such as Louisa, working under the humanitarian mandate of the Red Cross were involved in ordering the supplies and ensuring they were delivered to where they were most needed, even if it meant crossing the front lines and putting her life at risk.¹⁵³

With the change in the conflict environment was a change in the terminology describing the nurses' positions and their role and nursing practice. In the 1960s-1970s, welfare teams of multi-disciplinary workers were used. Descriptions in the earlier part of the period in the 1980s, tended to refer to surgical nurses, head nurses and nurse-nutritionists. In the 1990s, new terms such as field nurse, medical coordinator, relief or health delegates were used. The language of disasters changed in the 1990s too, and the use of the term 'humanitarian' crisis or emergency was applied to disasters of all types.

The role and tasks of the International Committee of the Red Cross nurse today are not well documented in general literature, but nursing can be described according to the categories of victims affected, for example, wounded combatants, prisoners of war and political detainees, civilians affected by war (displaced or otherwise) and the war disabled and amputees.¹⁵⁴ This approach puts the person in need first and is consistent with the humanitarian imperative of the Red Cross.

Within each of these categories there are different roles for nurses. For example, post operative care would require a surgical ward nurse, a description applied to several of

¹⁵³ 'Tuzla: it will never be the same again', *New Zealand Red Cross News*, Vol. 79, No.2, (May 1995), p12.

¹⁵⁴ R. Russbach, *Profession: Nurse*, p.153.

the Nightingale Medal recipients from 1987 to 1999.¹⁵⁵ Care for civilians affected by war, including refugees, involves the broadest responsibilities, such as public health, in particular, nutrition, hygiene and sanitation and was undertaken by the five of the recipients.¹⁵⁶ But in reality these roles are more complex and profound and defy simple descriptions or definitions.

For example, the care of the health and well-being of prisoners and detainees was the responsibility of recipient Judith Owen when she was in the former Yugoslavia in 1994.¹⁵⁷ Louisa also undertook this work in Tuzla on the Bosnian border. She visited detainees in the Solomon Islands in 2001.¹⁵⁸ Glenys returned to Peshawar, Pakistan in 1991 to care for prisoners. "They were prisoners of war so they couldn't go outside those walls. We were looking after them as nurses, three of us, 50-100 prisoners."¹⁵⁹ This sensitive work has traditionally been the responsibility of the Swiss delegates of the International Committee of the Red Cross because of their neutral status, but in the former Yugoslavia it was felt it was better to use non-Europeans.¹⁶⁰ It is interesting that New Zealanders were seen as not coming from Europe. Experienced nurse delegates are increasingly asked to undertake this role.

The importance of overseas experience as a prerequisite for undertaking Red Cross missions¹⁶¹ cannot be overemphasised, but the opportunity for new nurses to obtain that experience has continued to challenge Red Cross recruiters over the years. Previously some missions were seen as training grounds for neophyte humanitarian nurses, for example Khao-I-Dang refugee camp on the Thai-Cambodia border in the 1980s, Lokiochokio in Kenya, and the ICRC surgical hospital in Peshawar. Because the environment has changed, so have the Red Cross's operational strategies, and with fewer ICRC independent hospitals for training purposes, there has been a tendency for

¹⁵⁵ Applications for medal recipients in 1987, 1993, 1995, 1997, 1999.

¹⁵⁶ Medal recipients in 1987, 1991, 1993, 1995 and 1999(2).

¹⁵⁷ Application for 35th medal, ICRC circular 578, 1994.

¹⁵⁸ 'A Pacific patchwork', *Red Cross News*, Vol. 89, No. 4. (November 2001), p.15.

¹⁵⁹ G. Checchi, oral history interview.

¹⁶⁰ 'Tuzla: it will never be the same again', *New Zealand Red Cross News*, (May 1995), p.12

¹⁶¹ 'The Right Stuff', *Red Cross News*, (July 1986), p.5.

the more experienced nurses to continue to take on missions in close succession. Many have also been requested by name by the Red Cross in Geneva.

For a new nurse to gain practical knowledge to practise in a Red Cross mission, there is little written for them to draw on apart from general manuals and guidelines and discussion with former nurse delegates. As this study confirms, and is evident in the literature, the clinical practice of expert humanitarian nurses has not been described or documented in enough specific detail to enable new practitioners to learn from. This is of interest in relation to Benner's descriptions of nursing practice given by expert nurses.¹⁶² As Benner noted, the expert nurse with an enormous background of experience has an intuitive grasp of situations. Capturing the descriptions of expert performance is difficult because they operate with this intuition and a profound understanding of the total situation and may only express it in simple terms such as "you just got on and did what there was to be done"¹⁶³ without detail or explanation. Or matter of factly, "the helicopter came in every day and dropped off medical supplies and food, thousands of people came into the place and were fed and taken care of."¹⁶⁴ As most of these nurses had had years of field experience in a range of situations, relating specific examples of clinical expertise, which could be regarded as examples of what Benner refers to as perceptual acuity or recognitional ability¹⁶⁵ were not immediately identifiable. The issue about whether nursing intervention made a difference was explained in terms of what could be observed, "with war surgery you can see it,"¹⁶⁶ and in general social and survival terms. "We brought more food into the area, we would distribute food and outside there would be a market place with those people wheeling and dealing with our food."¹⁶⁷ But it was also stated in simple terms:

¹⁶² P. Benner, *From Novice to Expert, Excellence and power in clinical nursing practice*, Addison-Wesley Publishing Company, Menlo Park, California, 1984, p.21.

¹⁶³ N. Simpson, oral history interview.

¹⁶⁴ W. Smith, oral history interview.

¹⁶⁵ P. Benner, *From Novice to Expert*, p.33.

¹⁶⁶ G. Checchi, oral history interview.

¹⁶⁷ G. Checchi, oral history interview.

When I looked at some of the kids and we were able to tell the mothers what to do about crusty eyes, then maybe those kinds of things helped. We would say what would you give a baby if it's got diarrhoea and they would have their own local concoction of milk and what ever. Some of those old traditional things we would try to bring back in because those are the things that are left behind. We left an enormous amount of knowledge behind.¹⁶⁸

However, as this study is exploratory and concerned with the overall experience, more specific questioning was not undertaken and may have yielded more specific examples of expert practice and would be a valuable study in the future.

Furthermore, the neophyte Red Cross nurse may be an expert nurse in their field in New Zealand, but will initially be operating at a different level when they first go overseas. However, after time they become experts in that field of nursing too.

This lack of written information about expert practice is also problematic for New Zealand nurses' understanding of overseas work today. Earlier nursing practice, for example surgical nursing, theatre nursing, and public health, was within their ambit of experience, but today's situation is incomprehensible to most New Zealand nurses and is perhaps of little interest given the preoccupation with survival in the 1990s when health services restructuring absorbed much energy and concern. There is also the 'compassion fatigue' element engendered by constant television images of people suffering. However, with the increasing devastating impact of disasters, (for example, each year from 1991 to 2000 an average of 211 million people were affected by disasters, in 2000 this increased to 256 million people),¹⁶⁹ and an increasingly unstable international environment since 11 September, 2001, there is even more justification and importance to understand humanitarian nursing practice as it may be needed more than ever.

¹⁶⁸ G. Checchi, oral history interview.

¹⁶⁹ *World Disasters Report 2001*, International Federation of Red Cross and Red Crescent Societies, Geneva, 2001, p.6.

Nursing and Red Cross principles

The Red Cross had seven fundamental principles which underscore all its actions and way of operating. These principles were discussed in Chapter 2. Humanitarian law is the legal embodiment of the principles of humanity, impartiality and independence in particular. As most of the participants, and indeed many Red Cross nurses work for the ICRC which has a mandate under humanitarian law (Geneva Conventions and Additional Protocols) their practice and ethical comportment is guided by these principles in the field.

In Chapter 2 the Geneva Conventions and their relevance to nursing was discussed. It was also stated that humanitarian workers such as nurses were guided by their national professional ethical codes, such as the New Zealand Nurses Organisation Code of Ethics and international codes such as the International Council Nurses Code of Ethics for Nurses.¹⁷⁰ As the nursing context becomes more complex, the International Council of Nurses acknowledges that nurses are increasingly finding themselves in complex situations with no clear-cut solutions, whether it is conflict or political upheaval, strife or international war.¹⁷¹ These are the situations Johnstone refers to as moral crises and dilemmas, both in everyday and special circumstances, where an individual's morals, their professional ethics are challenged, and where an overriding legal framework is essential to make sense of the situation and how to act.¹⁷² As codes can be overridden by other and stronger moral considerations¹⁷³ and their legal status can be uncertain, the understanding and practice of humanitarian law is essential in such situations as an overarching legal framework. The Red Cross principle of humanity is particularly powerful in this respect.

The relationship between the Red Cross principles and nursing was made by one participant who said, "Nursing principles and Red Cross principles are very much the

¹⁷⁰ ICN Code of Ethics for Nurses, International Council of Nurses, Geneva, 2000.

¹⁷¹ 'Nurses, Caring and Torture' ICN Position Statement presented to the Commission on Human Rights, 54th Session, ICN, Geneva 1998, p.14.

¹⁷² M-J. Johnstone, *Bioethics: A nursing perspective*, 2nd ed. chapter 2, W. B. Saunders, Sydney, (1994), p.59.

¹⁷³ M-J. Johnstone, *Bioethics: A nursing perspective*, p.48.

same....We work along the same lines, impartiality, it doesn't matter if it's the enemy or not, you do the same for both."¹⁷⁴ The nurses articulated their practical experiences and understanding of the principles. For example, "in the end what it comes down to is the whole principle of neutrality, impartiality, independence and being able to work in a country and treating both sides. Giving aid to both sides is really important and they could not be as effective if they were not neutral".¹⁷⁵ Glenys was able to demonstrate this humanitarian principle when she returned to Pakistan to care for prisoners of war on the other side to those she had previously cared for. Louisa also reflected this sentiment, "it doesn't matter which side you were working on, Serb, Croat or Bosnian".¹⁷⁶ The late Sheryl Thayer was reputed to have said in 1994, "what mankind does to each other isn't pretty. It's my job to treat people who are wounded and I don't develop opinions about which side is right or wrong."¹⁷⁷ It is ironic that someone who articulated this principle so eloquently was herself the victim of such violence. This impartiality is also reflected in the ICN code of Ethics for Nurses when it states that "nursing care is unrestricted by considerations of age, colour, creed, culture, disability or illness gender, nationality, politics, race or social status".¹⁷⁸

At its essence, it is providing care in an environment promoted by the nurse in which 'human rights, values, customs and spiritual beliefs of the individual family and community are respected'.¹⁷⁹ These caring values are a public statement of moral standards that patients can expect and nurses uphold. However, in some situations, these values may have variable interpretations, even though the ICN is trying to give guidance to nurses in all countries but not to conflict with an individual's cultural beliefs.¹⁸⁰ The New Zealand Nurses' Organisation also reflects these caring values in its Code of

¹⁷⁴ M. Crisp, oral history interview.

¹⁷⁵ G. Checchi, oral history interview.

¹⁷⁶ L. Akavi, oral history interview.

¹⁷⁷ S. Thayer, quoted in, 'Lets get serious, doctor', *Red Cross News*, Vol.81, No.1, (March 1997), p.11.

¹⁷⁸ ICN Code of Ethics for Nurses, 2000, p.2.

¹⁷⁹ ICN, Code of Ethics, p.2.

¹⁸⁰ C. Holleran, 'Nursing beyond National Boundaries: the 21st century', *Nursing Outlook*, Vol. 36, No. 2, (1988), p.74.

Ethics as a philosophical base for practice.¹⁸¹ However, Johnstone sounded a word of caution about codes of ethics being ‘worshipped’ at the expense of nurses being ethical.¹⁸² The codes are not ends in themselves but guides or a statement of *prima facie* rules that guide moral decisions in nursing care.

In considering the values underlying caring from Watson’s perspective, human caring involves a higher sense of the spirit of the self, and caring “calls for a philosophy of moral commitment toward protecting human dignity and preserving humanity,”¹⁸³ notions inherent in humanitarianism and the practice of humanitarian nursing. This was implicit in the nurses’ actions in different ways. Several participants gave accounts of individual patients for whom they had cared. After periods of over thirty years, these were still vivid memories and one admitted, “I got attached to patients”.¹⁸⁴ It is interesting to note that the other nurses who had worked in the field longer and whose role had changed over this time had less specific recollection of patients, their caring was connected with the local staff they had worked alongside, and so in terms of patient care, it was indirect. All were expressing Watson’s abstract characteristics of caring in that they were responsive to the person as unique, they perceived the other’s feelings, and could set apart one person from another.¹⁸⁵

While the participants had had an introduction to humanitarian law through the Red Cross Principles, and this provided an ethical framework for humanitarian nursing, a deeper level of understanding developed only later after a number of Red Cross overseas missions. So initially they would have drawn on their individual values and nursing code of ethics because, as one said, she did not feel nurses in general had much of a grasp or understanding of humanitarian law, “not at all, because as a nurse you know what your job is...those are [ethical standards] standards that you know, whereas international humanitarian law, this has taken me a long time to grasp”.¹⁸⁶ It was only

¹⁸¹ Code of Ethics New Zealand Nurses Organisation, 1995, p.10.

¹⁸² M-J. Johnstone, *Bioethics: A Nursing perspective* p.46.

¹⁸³ J. Watson, *Nursing: human science and human caring*, National League for Nursing Press, New York, 1988, p.31

¹⁸⁴ N. Simpson, oral history interview.

¹⁸⁵ J. Watson, *Nursing: human science and human caring*, p.34.

¹⁸⁶ L. Akavi, oral history interview.

when she had to make ethical decisions in a leadership position that she examined decisions on the basis of whether they complied with the principles, "professionally they've made quite an impact now that I understand them because for the first five years I didn't have a clue....I was acting head of mission for some months. I had to make a lot of decisions and work with a national society whose understanding is pretty shaky".¹⁸⁷ It is the Red Cross principles and humanitarian law afforded by Red Cross nursing that distinguish humanitarian nursing from other forms of nursing. While most nurses practise according to professional codes of ethics, few work within the Red Cross principles and humanitarian law, extra dimensions to practice and the philosophical framework.

The principles have assumed greater importance in the day to day work in the 1990s as the nurses assumed more traditional ICRC delegates roles such as visiting detainees, providing protection to civilians and crossing road-blocks. This is an important issue for future humanitarian nursing. The rights and duties in relation to conflicts should be learnt during times of peace. In the chaos and turmoil of a conflict situation, nurses are still accountable for their actions.¹⁸⁸ If Red Cross principles and nursing principles are synonymous, then accountability should not present a problem. However, it can and does. The ICN recognises that historically nurses have been used by totalitarian governments to carry out crimes, nurses have been both perpetrators as well as victims.¹⁸⁹ This was evident during the Nazi regime when from 1933 to 1937 nurses, aids and orderlies forcibly sterilized 200,000 young people, some without their knowledge as part of the eugenic cleansing.¹⁹⁰ While it is easy for most nurses in a caring environment to uphold their ethical code to safeguard human rights and provide care for people irrespective of race, colour or politics, the ICN has a particular concern for nurses and how to support those who find themselves, for example, pressured to restrain or revive people during torture sessions.¹⁹¹ Furthermore there is concern for

¹⁸⁷ L. Akavi, oral history interview.

¹⁸⁸ 'The Nurse, Geneva Conventions and Human Rights', *International Nursing Review*, No. 39, (1992), p.61.

¹⁸⁹ 'ICN takes a stand on Child Abuse, Cloning, Practice of nurse-midwives, Cooperation with Doctors and other issues', *International Nursing Review*, Vol.44, No.5, (1997), p.138.

¹⁹⁰ M. Snodgrass, *Historical Encyclopaedia of Nursing*, ABC-CLIO, Santa Barbara, 1999, p.193.

¹⁹¹ C. Holleran, 'Beyond national boundaries', p.74.

those who do give care in accordance with ethical principles only to find themselves imprisoned, detained or tortured for doing so. As the current executive officer of the ICN said after the brutal murders of the six ICRC workers in the Congo in 2001, “health professionals are desperately needed in areas of conflict and have an ethical duty to serve humanity”.¹⁹² She added that protection for them must be strengthened as increasingly the Red Cross symbol was becoming a target, rather than a protection.

Part of that protection comes out of an understanding of humanitarian law. Dissemination is an important role of Red Cross and Red Crescent Societies and the ICRC, so that people know there are minimum standards enshrined in that law to lessen the impact of conflict or disturbances. These are standards that have been accepted by most governments on ratifying international treaties such as the Geneva Conventions, and “are compatible with the private moralities of most people”.¹⁹³ However, what governments sign up to and how this information is passed down to people in communities and villages especially in isolated localities is of concern. Furthermore, the concept of a sovereign state is not tenable in some anarchic societies, and some people identify more readily with their nationality or ethnicity rather than their government. The situation is further muddled by globalisation and multinational corporatisation. This is an enormous challenge to Red Cross everywhere today, when the ability to be truly neutral and impartial is increasingly difficult because of religious, cultural and ethnic demands, as well as the move to individualism rather than community responsibility. It would be interesting to see how different groups in New Zealand would find upholding the principles if confronted by internal tension and conflict. New Zealand nurses would be also tested in this situation, which is why an understanding of humanitarian law is vitally important and should be part of their nursing education. The polarisation of New Zealand society during the Springboks tour in 1981 suggests that this may be difficult, although it may not be a fair example.

As Louisa admitted, understanding humanitarian law is not simple, even for Red Cross people. Examples about the degree of understanding by Red Cross organisations and their members of the meaning of the principles and how they are translated into daily

¹⁹² J. Oulton quoted in Slaying of Red Cross Workers Condemned by World Health Professions Alliance, Press release, 9 May 2001, http://www.icn.ch/PR10_01.htm, p.1.

¹⁹³ T. Gurtner, quoted in “Working with the law”, *Red Cross News*, Vol 89, No.4, (November 2001), p.10.

life were given. Wendy experienced this in Sri Lanka when she found that the turmoil of the country was mirrored in the Red Cross Society she worked with, fragmenting it. It was also experienced in the Solomon Islands by Louisa and exemplified in the work she did with the Solomon Islands Red Cross recently. She said of the Society, “they withdrew into their own little society....One of the constricting factors was the majority of them [70%] were Malaitans and they were the target”.¹⁹⁴ In time and with support from the ICRC in a conflict preparedness programme, she felt that progress had been made especially about raising awareness about what the Red Cross’s role in conflict was and how it could provide assistance to people.

From these examples, it is interesting to reflect on whether it is easier for nurses (or other workers) to work in another country and remain neutral and impartial in carrying out humanitarian nursing care than in their own country, despite inculcation with nursings’ non-discriminatory values. As Glenys commented, the value of using an outside agency and outsiders can be helpful.

It’s of benefit to get an aid agency in because those people don’t have those links or those agenda. We don’t know what it’s like and how we would react in those situations if we had a war in our country...We don’t know how we would react if we were suddenly forced to leave our homes and live on a border of another country in a bamboo shack...if we had a whole lot of refugees flooding into our country and taking away our medical services and we saw another nation coming in and pouring a lot of money in for example, you can’t blame the Pakistanis for getting a bit titchy at 5 million Afghans for getting money for getting health services. We don’t know how we would react.¹⁹⁵

Several of the nurses spoke about how the local people they worked with understood the Red Cross principles and what might happen when perception was different. “In the end we had to leave [Ethiopia] because of their perception of what we had done. I think the delegates were negotiating to see some prisoners of war and I don’t think the local

¹⁹⁴ L. Akavi, oral history interview.

¹⁹⁵ G. Checchi, oral history interview.

authorities liked it and we were out of there in a couple of hours. We were threatened. I wasn't personally threatened...we had to leave very rapidly".¹⁹⁶

One of the paradoxes of working for the Red Cross is the need for the individual to remain apolitical in the midst of complex political and social upheaval which they must understand from a humanitarian operational perspective, but remain uninvolved in so as not to compromise their neutrality, and the impartiality and independence of the organisation. It is not an easy position to be in especially as greater understanding can lead to greater politicisation. As Louisa explained, "It's made me aware more politically so when I'm following a political event, I try and work out what really is going on here".¹⁹⁷ She added that she had to identify the major players, to follow what they were doing and speculate on the likely consequences, so that she could make decisions to provide the best humanitarian assistance. Her interactions with the major players were of necessity circumspect to make sure she did not breach neutrality. As another nurse said reflecting the views of the others, "Red Cross, it politicised me even more...increases your political awareness. Its not to say I don't have one side or another, but in my professional role, I am mature enough to put that aside".¹⁹⁸ In essence, "political awareness but not political involvement".¹⁹⁹ Or as one Red Cross delegate explained, neutrality means not political naivety, but political 'savoir faire', and by having political savvy, one can be neutral.²⁰⁰ In this sense, neutrality can be liberating. One of the participants said that she could not do anything that was abhorrent to her or against principles she had and that she might have difficulty working in Chechnya now after the murder of her good friend Sheryl Thayer.

The Red Cross in recent years has had to clarify its position in relation to the tensions between theory and practice, especially in relation to its principle of neutrality. It avoids political controversy that would undermine its work but aggressively defends the

¹⁹⁶ G. Checchi, oral history interview.

¹⁹⁷ L. Akavi, oral history interview.

¹⁹⁸ G. Checchi, oral history interview.

¹⁹⁹ N. Sherwood, 'A long time field-worker returns...and Miss Pragnell takes her leave', *Red Cross News*, issue 1, (1988), p.12.

²⁰⁰ L. Minear, 'The theory and practice of neutrality: Some thoughts on the tensions', *International Review of the Red Cross*, Vol. 81, No. 833, (March, 1999).p.68.

victims in private and in public if necessary. It is suggested that one way around the tension between the apolitical stance and the highly political issues facing the ICRC is by telling two moral stories, one in public which preserves neutrality and independence, the other in private which is more political.²⁰¹

Red Cross nurses from the earliest days of working in conflict zones, or in supporting the development of Red Cross Societies, have required a level of political awareness. Florence Nightingale's perception of the environment was one in which to help the patient recover health or prevent disease. She also understood the political environment in which she lived and worked and utilised it to her own and nursing's advantage. For Red Cross nurses to be effective and safe in the 1990s environment, they must have an even deeper understanding of the socio-political context in which they are working. White's description of a fifth pattern of knowing, "socio-political knowing", addresses the "wherein"²⁰² or broader context in which nursing and health occur. While White had in mind the need for socio-political knowing as a framework for nursing in an "increasingly economically driven world,"²⁰³ being the developed world, she also had cognisance of Chopoorian's²⁰⁴ concern with underlying determinants of disease arising out of social, political and economic structure, also relevant to the developing world. This is the context in which Red Cross nurses usually work. Both writers called for nurses to have more of an activist role to enable those concerned to have a voice, to develop processes to share governance and for transformations to occur. Chopoorian contended that nurses have concentrated on the psychosocial and developmental aspects of health and illness rather than on the socio-political, and economic conditions that cause them. She calls for a reconceptualisation of the environment to "develop a consciousness of environment as social, economic and political structures; of environment as human, social relationships; of environment as everyday life"²⁰⁵ to enable a better understanding of what supports or works against health.

²⁰¹ L. Minear, 'The theory and practice of neutrality: Some thoughts on the tensions', p.70.

²⁰² J. White, 'Patterns of Knowing; review, critique and update', *Advances in Nursing Science*, 17 (4), 1995, p.83.

²⁰³ J. White, 'Patterns of Knowing', p.85.

²⁰⁴ T. Chopoorian, *Reconceptualising the Environment, New Approaches to Theory development*, ed., Patricia Moccia, National League for Nursing, New York, 1986.pp.39-54.

²⁰⁵ T. Chopoorian, p.47.

In terms of humanitarian nursing and the socio-political environment in which it takes place, Chopoorian's reconceptualized environment is appropriate, and the nurses participating in this study could relate to her vision. However, it becomes problematic for Red Cross workers to move from an understanding to an activist involvement, because of the possibility of compromising neutrality. At the global level, for example, it would suggest the need for strong antiwar activism. This is not the way Red Cross works. However, today it has allowed itself to become involved in other ways such as deepening people's understanding of the health and social impacts of war. For example, it has supported a convention banning the production of land mines and championed the advent of a new international criminal court. Through its SIrUS project²⁰⁶ the ICRC has developed a database, and analysed and quantified the effects, of different conventional weapons on humans. In doing so it has raised awareness about the injury and suffering caused by conventional weapons as a health issue, in turn advocating limiting means of warfare and thus human suffering. Increasingly, the Federation is advocating for the rights of migrants, especially economic and environmental migrants who are currently discriminated against in favour of refugees arising from political persecution.²⁰⁷ At a nursing practice level, nurses advocate on behalf of refugees for their right to receive appropriate treatment and denunciate of violence, as explained by one nurse working on Pulau Bidong.²⁰⁸ Involving people in reducing their vulnerabilities and working with them to improve their capacities to cope in everyday life or disasters, and conflict preparedness, are examples of empowering action.

In the New Zealand context, as noted in the applications to the ICRC, many of the Florence Nightingale Medallists also became involved in dissemination of Red Cross principles and humanitarian nursing on return to New Zealand. This demonstrated their ongoing commitment to the organisation and the nursing work. Some also worked in New Zealand as well. Wendy, Glenys and Megan were staff members of the New Zealand Red Cross. The public awareness raised through dissemination of Red Cross principles and humanitarian law might prove to be the most effective way of

²⁰⁶ The SIrUS Project, towards a determination of which weapons cause 'superfluous injury or unnecessary suffering', ICRC, Geneva, 1997.

²⁰⁷ C. Moorehead, 'The new humanitarian worker', *Red Cross Red Crescent*, issue 4, (2001), p.7.

²⁰⁸ W. Smith, oral history interview.

contributing to one aspect of socio-political knowing by Red Cross nurses within New Zealand. Every opportunity to talk or write about their experiences puts nurses into an international context, the reasons for their work and the socio-political environment in which the nursing is taking place, and could be a powerful educational tool if emphasised in this way.

Cornelio Sommaruga, International Red Cross President in 1996, in writing about the post Cold War confusion exhorted that politics should be humanised. He warned, however, not to “politicise humanitarianism”²⁰⁹ and argued for protection of the humanitarian imperative, to be kept separate from political consideration. He said this only three months before the murder of the six Red Cross workers in Chechnya. It is even more imperative in today’s international climate to protect victims and humanitarian workers alike.

This chapter has discussed the three main research interests: the nurses, their practice, and nursing and Red Cross principles drawing on information from the oral history interviews with the participants. It has teased out the characteristics and attributes of the nurses, their professionalism and humanity, the depth and range of their nursing experience, and their ethical practice which was seen to be compatible with nursing codes of ethics and humanitarian principles. The themes which had been identified in the interviews were discussed within the main research interests along with secondary themes, which were also interwoven into the discussion. Further summarisation of this discussion follows in the conclusion.

²⁰⁹ C. Sommaruga quoted in J-P. Horeau, ‘Humanise politics: don’t politicise humanitarianism’! *New Zealand Red Cross News*, Vol. 80, No. 4, (September 1996) p 7.

CHAPTER 8

CONCLUSION

This study was undertaken to explore and describe the history of the Florence Nightingale Medal and its New Zealand recipients from 1969 to 1999. Historical details about the institution of the medal, its evolution of the regulations governing the award of the medal, and its recipients over the years have been described. The historical development of the Red Cross, humanitarian law, the development of public health nursing, international nursing, and links with Florence Nightingale have been provided as background information to the study. The oral history interviews of five participants covered historical as well as contemporary nursing practice and highlighted issues relevant to nursing in other countries and cultures, in situations of conflict and natural disasters. Historical and contemporary evidence provided the socio-political context for humanitarian nursing were used to document the changes in nursing practice over time.

The Florence Nightingale Medal was introduced in 1920 to honour the legacy of Florence Nightingale's work in the Crimean war and her subsequent contribution to the professionalisation of nursing. The medal was instituted by the International Committee of the Red Cross, an organisation that grew out of the suffering of war, with the aim of alleviating that suffering without discrimination, through the work of trained volunteers and nurses. The award was initiated to honour nurses who had distinguished themselves by exceptional devotion and services to the sick and wounded in war and was at first open only to registered nurses.

Florence Nightingale, the Red Cross and nursing in wartime are inextricably linked. The Florence Nightingale Medal was a reflection of this relationship, it grew out of it, and continues today. While the essence of the original criteria for the award still persist and the award is as prestigious as it was then, it is not well known in contemporary nursing. Nor has the nursing practice of the nurses been explicated in this way before. The regulations governing its award have changed over time to provide for the considerable changes in the nature of disasters, the context in which they occur, the Red Cross and the changes in nursing itself over time.

Twenty-two New Zealand nurses have been recipients of the medal since its inception up until the most recent award was given in 2001. Historically it can be seen that there were three eras in relation to the award of the medal and its New Zealand recipients. The first era was from 1920 until 1965 when the medal was awarded primarily for nursing linked to the two World wars. These were wars fought by regular military forces, and between nations. New Zealanders were intimately involved in the wars through military and nursing contributions. The Florence Nightingale Medal recipients of this era numbered ten and were either registered nurses or VADs. Some worked overseas with New Zealand military forces, on hospital ships or hospitals in England or elsewhere, caring for wounded and sick soldiers. Several of the medal recipients did not work overseas, but were involved in training VADs or had an involvement with another aspect of the war effort in New Zealand such as transporting returned soldiers or working in convalescent homes. They were also active in disaster relief work in New Zealand.

Early in the 1900s, as a consequence of World War I and industrialisation, the need for public health nursing became evident. Its development was in part promoted and realised through the establishment of international nursing courses by the League of Red Cross Societies at Bedford College in London in 1920. These were later to become the responsibility of the ICN in 1933. Public health nursing has continued to be an important part of humanitarian nursing practice over the decades, especially as the number of civilians population affected by disasters has increased.

Since its introduction in 1920, amendments have been made to the Florence Nightingale Medal Regulations. In 1921, an amendment allowed for nurses who had died on active service to be included. This was changed in 1926 to include those who died in the event of an epidemic as well as a disaster, reflecting the influenza epidemic and public health problems of the time. The number of medals was increased from six to eighteen in 1928. Further amendments were added, in 1934 to expand the scope of possible recipients and significantly, included voluntary aids as well as registered nurses. The distribution of the medal occurred biennially to emphasise its significance, and thirty-six medals were available for distribution.

Humanitarian law also developed during this era. The First Geneva Convention for the Amelioration of the Condition of the Wounded in Armies in the Field had been signed in 1864 at the inception of the Red Cross and codified and strengthened fragmentary laws protecting the wounded and those who cared for them. The Second Geneva Convention was signed in 1906 and covered wounded and shipwrecked sailors. The Third Geneva Convention of 1929 gave protection to prisoners of war and the rules governing their humane treatment. Revision of the three Conventions and the adoption of the Fourth Geneva Convention in 1949 sought to address the shortcomings of the original Conventions obvious after World War II, and resulted in the development of Four Geneva Conventions of 1949. Article 3, common to all the Conventions extended their scope to civil wars and other non-international conflicts and gave the ICRC the right of initiative to offer its service to all parties to as conflict.

The second era relating to the Florence Nightingale Medal and New Zealand recipients covered 1969 until the late 1980s, and included four recipients, three of whom were participants in this study. This era saw a change in the nature of warfare in countries such as Korea, Vietnam, and Cambodia. This was characterised by internal conflicts of an ideological nature fought by guerrilla armies and irregular forces whose strategies led to an increasing number of civilian casualties. This environment provided the catalyst for the revision of humanitarian law to include the Protocols Additional to the Geneva Conventions in 1977. The Protocols extended and enhanced the provisions of the Conventions in particular to cover care for civilians in the change in the environment of warfare.

The New Zealand Florence Nightingale Medal recipients within this timeframe worked overseas as part of a New Zealand Red Cross team or for the ICRC or the League/Federation, rather than as part of the New Zealand war effort as in the previous era. The first teams were referred to as welfare teams, and were multidisciplinary, including agricultural, sanitation, and rehabilitation officers, as well nurses and doctors. They treated and cared for displaced people, refugees and civilians arising out of the Vietnam War and drew on public health nursing principles. These teams were transformed into surgical units in the 1980s consisting of a surgeon, anaesthetist, and theatre or surgical nurse, to care for the surgical needs of an increasing number of war wounded. They were not necessarily located in the country at war but could be in a

neighbouring country, for example, Thailand for Cambodians, or Pakistan for Afghans. The ICRC established a number of independent hospitals and related facilities to support their medical actions in this respect.

The effects of war and climatic conditions resulted in famine in several African countries during this time and saw nurses working as nurse nutritionists involved in nutritional surveys and mass feeding programmes. The need for public health nurses to care for large numbers of displaced people or refugees continued. It was also a time when the New Zealand Red Cross sent the greatest number of people overseas. Co-operation was gained from the nurses' employers to enable deployment at short notice and to guarantee employment on return in a sense of shared pride in the nurses and their overseas work.

The Florence Nightingale Medal Regulations were amended in 1981 to reflect the increase in the scope of nursing activities of the time, in particular relating to the primary health care strategy of 'Health for All.' The number of medals available also increased to fifty, as National Red Cross and Red Crescent Societies had also increased.

The 1990s represented the third era when the socio-political context had changed again, and with it the nature of conflicts. The fall of the Berlin Wall and the dissolution of the Soviet Union and its proxy states, led to the hope and expectation of a more peaceful world. However, this was soon dispelled by internal conflicts of a more barbarous and anarchic nature. The wars moved back to Europe in the Balkans, and Russian Independent States, while others still continued to fester away in countries in Africa and Afghanistan. In this new environment came new challenges and a deepening of the security risks to humanitarian workers as they moved closer to the field of action. The death of Red Cross workers in Burundi, and Chechnya, including New Zealand nurse Sheryl Thayer, and more recently in Congo, highlighted in a tragic way the increased dangers. The international response to this, in part demanded by the media and the global community, resulted in humanitarian assistance being merged with military and political strategies and interventions, resulting in a blending of traditional humanitarianism with military and political agenda. The resulting confusion created an operational climate which was unprecedented in its danger.

In this complex situation were further assaults against humanity with 'ethnic cleansing', genocide, and systematic rape. The role of the nurse evolved from the more recognisable nursing nomenclature of surgical nurse, public health nurse, and nurse nutritionist into field nurse, medical coordinator, and health delegate. The teams were replaced by individual nurses, more likely to be attached to a Red Cross delegation, with a change in role and responsibilities to resemble those more traditionally undertaken by the Swiss delegates. This involved visiting detainees or prisoners of war, providing medical supplies to existing hospitals, dissemination of humanitarian law and management of delegations. Several nurses were involved in strengthening the capacities of Red Cross Societies, and in their development programmes.

To some extent this change also represented the accrued experiences and professionalism of the New Zealand nurses as they took on a succession of missions and made a career out of their Red Cross work, some for several decades. During this era (1991-1999), eight New Zealand nurses were awarded the Florence Nightingale Medal, two of whom were participants in this study. Amendments to the Florence Nightingale Medal occurred in 1991 and removed the discrimination against male nurses. The criteria were broadened to take account of the new scope of nursing resulting from epidemics such as HIV/AIDS, and other humanitarian needs and emergencies.

The Florence Nightingale Medallists from 1969 onwards represented the New Zealand Red Cross's commitment to sending registered nurses overseas, noted for their professionalism, experience and mature qualities. The nurses or VADs prior to this time were not less experienced or professional, but rather, the need of registered nurses reflected the needs of a different time in the changing national and global environments.

While the nurses during the 1969-1999 timeframe, and the participants in this study in particular, were not always explicit in their initial reasons for working for the Red Cross, their lengthy involvement both in New Zealand and overseas attests to their commitment to the Red Cross principles and humanitarian ideals. This was also expressed through their reflections on the importance of neutrality and impartiality of the organisation and their own understanding of what this meant in practice. As was evident from this research, these are complex concepts to understand, especially within different cultural and socio-political contexts. However, a deeper understanding of them

and the socio-political environments was necessary as an enhancement of and adjunct to their practice. As a consequence it raised their own political awareness and enabled advocacy on behalf of people affected by conflicts and disasters without compromising the principle of neutrality.

The participants' honesty and humility in exposing their own vulnerabilities, and their reaction to receiving the award said much about them as people who regarded themselves as any other nurse doing their job rather than being exceptional. However, the fact that they have received an international award given only to a small number of nurses every two years, and that several have been honoured in New Zealand, does suggest they have exceeded usual expectations. There is a place in nursing (and history) to celebrate and honour such nurses.

Their examples of nursing practice, awareness of their outsider status, and concern about Western imposition of values and culture, were common threads in the participants' narratives. An emphasis on the importance of teaching, exchanging skills to mutual benefit or reciprocal learning, was discerned and thought to be the most valuable contribution the nurses could leave behind for local staff, as well as upholding standards of care and practice. The diversity and essence of nursing practice were described, at times on what might at first seem to be a superficial level perhaps because of the difficulties in explicating expert practice.

Backgrounds in public health, midwifery, surgical and operating theatre nursing and emergency nursing were core backgrounds for the nurses. New skills were developed in caring for large numbers of displaced people and refugees in conflict situations or famine requiring additional skills in nutritional expertise which was learnt by several of the participants. Visiting detainees to ensure basic health needs were being met was also a new area of nursing involvement in the 1990s and confirmed the role of the nurse expanded in the 1990s in particular.

Humanitarian nursing was defined by the context, for example conflict or natural disaster, by the people affected and cared for, such as wounded combatants, prisoners of war, civilians (displaced or refugees) and war disabled and amputees. Nursing practice was guided by nursing codes of ethics, in particular the Red Cross principles which

provided the philosophical framework, and humanitarian law which gave the legal framework, and more specifically, the rights and duties of medical personnel in situations of conflict. Humanitarian principles are the key to determining humanitarian nursing practice, through the ability of the individual and the organisation to be neutral, impartial and independent. Anything less than this cannot be regarded as fulfilling the definition of humanitarian nursing practice. It should be noted that as this study had focussed primarily on Red Cross nursing, there would be examples of humanitarian nursing practice carried out by nurses working for other international non-governmental organisations. Humanitarian nursing is an element or aspect of international nursing.

The commitment by the New Zealand Red Cross over the years in responding to international humanitarian emergencies by the provision of nurses was also evident. Despite the organisation's size and limited resources compared with its sister organisations, its nurses were eagerly sought and respected for their professionalism and competence by the Federation and ICRC. With an average of about ten nurse missions a year, New Zealand Red Cross has demonstrated a consistent and generous involvement spanning in some cases over twenty years in countries such as Sudan, Ethiopia, Afghanistan, Cambodia, and the Pacific region. This was also evidenced at an international level by the awarding of the number of New Zealand Florence Nightingale Medallists over the period under study. In the 1990s, every biennial award has had a New Zealand recipient, and on two occasions (1993 and 1999), two recipients.

The Florence Nightingale Medal is an award of the past, but it is also of the present and future, as are wars and disasters. These continuities were able to be explored through this study. The oral history interviews brought history alive in a way that the formal documents did not, and were able to record the vivid and human nursing accounts of five participants over more than three decades.

This study has been exploratory and descriptive in nature and the first time a study of the New Zealand Florence Nightingale Medallists has been undertaken in New Zealand. Future work on this topic and comparisons with medallists from other countries would be an interesting research study in the future. The documentation of humanitarian nursing as an aspect of international nursing has also been an outcome of this study. An attempt to provide a simple definition, framework and description of its evolution over

time was of necessity superficial, but could be a valuable study topic for exploration in the future.

Furthermore, nursing in New Zealand has yet to respond to the ICN's call for all nurses to understand humanitarian law. The framework exists already through the work done to produce the ICN, and the Federation's (League) resource, 'The Nurse, the Geneva Conventions and Human Rights'¹. It could be modified and integrated into existing programmes, and placed within the parts of the curriculum related to legal and ethical components of practice.

Within the overall concept of international nursing, it was not possible to quantify the numbers of New Zealand nurses working overseas, where and what kind of nursing they were involved in, or the kind of educational preparation they had been given prior to working overseas, except for Red Cross nurses. The numbers of people affected by disasters are increasing annually, the emergency situations are becoming more complex, and the South Pacific is less politically stable than in previous decades. As environmental degradation continues to place vulnerable people at greater risk from the impacts of disasters, and poverty is recognised as an underlying determinant of poor health status, the need for international nursing is likely to increase.

While the health needs in New Zealand continue to present huge challenges against a background of poor morale, dwindling resources and nurse shortages, globalisation presents an opportunity for a shared sense of responsibility for nursing at an international level. It can be the catalyst for creating opportunities for nurses to work together for practical, moral, and humanitarian reasons to improve the health status and alleviate the suffering of populations.

The New Zealand Florence Nightingale Medal recipients represent the past, present, and the future. As they continue to respond to humanitarian needs in the spirit of Florence Nightingale and Henry Dunant, they will continue to make a valuable contribution to humanitarian nursing practice. They deserve to be honoured and celebrated for their humility and humanity.

¹ 'The Nurse, the Geneva Conventions and Human Rights', The League of Red Cross and Red Crescent Societies, International Council of Nurses, Geneva, 1984.

APPENDIX 1

New Zealand Florence Nightingale Medal Recipients 1920-2001¹

YEAR	NAME
1920	Miss Hester Maclean
1947	Mrs Irene Flora Campbell
1949	Miss Helen Iris Crooke, M.B.E.
1951	Miss Edith Jean House
1957	Mrs Catherine Lynette Wells
1959	Miss Flora Jean Cameron, O.B.E.
1961	Mrs Edith Mary Rudd, R.R.C.
1961	Miss Doris Ogilvy Ramsay
1963	Mrs Mary Ann Gidall
1965	Miss Muriel Jessie Jackson
1969	Miss Moya Clare McTamney, M.B.E
1975	Miss Ngaire Kirkpatrick Simpson, O.B.E
1981	Mrs Megan Margareth Crisp
1987	Ms Glenys Lorraine Rodger-Checchi
1991	Ms Jennifer McMahon, M.B.E.
1993	Ms Philippa Parker, Q.S.M.
1993	Mrs Wendy Dimpna Smith
1995	Ms Judith Christine Owen, Q.S.M.
1997	Ms Sheryl Lindsay Thayer (posthumous)
1999	Ms Louisa Ngatokoivia Akavi
1999	Ms Margaret Anne Bryson, Order of Merit
2001	Mr Geraldo Cruz Pires-Ribeiro

¹ ICRC list of National Society Funds and Medals, New Zealand Red Cross, ICRC, 21.08.01. New Zealand National Awards added for nurses within study timeframe.

APPENDIX 2

FLORENCE NIGHTINGAL MEDAL RECIPIENTS 1969-1999¹

Name	Medal	Qualification	Location	Nursing position	Date	Time in field
Moya McTamney	1969	RN	Sth Vietnam	Refugee welfare	1968-1969	1yr
Ngaire Simpson	1975	RN Dip Nursing	Sth Vietnam	NZ Surgical team Refugee welfare	1967-1968 1973-1974	1yr 1yr
Megan Crisp	1981	SRN SRM	Malaya	Queen Elizabeth colonial nursing service	1951-1956	5yrs
			Malaya	Mission clinic	1958-1961	3yrs
			NZ	Assistant director VAD's	1970-1972	2yrs
			NZ	Director VAD's	1972-1974	2yrs
			NZ	NZRC health and welfare advisor	1974-1978	4yrs
				Volunteer lecturer first aid, home nursing	1978-1981	3yrs
Glenys Rodger-Checchi	1987	RN RM	Thailand	Nurse	1980	5mths
			Thailand	Medical Admin	1981	4mths
			Pakistan	Theatre nurse	1982-1983	6mths
			Pakistan	Theatre nurse/ Head nurse	1984-1985	6mths/ 4mths
			Pakistan	Field Hospital	1985-1986	1mth
			Ethiopia	Nurse Nutritionist	1986	4mths
			Geneva	ICRC Recruitment	1987	1yr
			NZ	NZRC Recruitment	1988-1992	5yrs
			Pakistan	Nurse	1991	1mth
Jennifer McMahon	1991	RN RM MA	Thailand	Surgical nurse	1983-1984	6mths
			Ethiopia	Public health nurse/ nutritionist	1984-1985	10mths
			Sth Sudan	Nurse nutritionist	1986-1987	5mths
			Mozambique	Nurse nutritionist	1987	6mths
			Eritrea	Nurse nutritionist	1988	1mth
			Sth Sudan	Nurse nutritionist	1988	4mths
Philippa Parker	1993	RN	Thailand	Surgical/head nurse	1984-1985	8mths
			Pakistan	Head nurse: field hospital	1985-1986	2mths
			Thailand	Head nurse	1986-1988	2yrs
			Pakistan	Head nurse	1988	2mths
			Afghanistan	Head nurse	1989-1990	1yr
			Somalia	Head nurse	1991	1mth
			Sri Lanka	Medical admin	1991	1mth
			Geneva	ICRC Recruitment	1991-1993	3yrs
			Former Yugoslavia	Field nurse	1993-present	6yrs+

¹ Information from primary documentary sources or oral history interviews. Note the latter have been updated. Primary documentary information not available for M. McTamney or N. Simpson

Wendy (Woodward) Smith	1993	RN RM Dip nursing BA	Thailand NZ/Pacific Tonga Malaysia Darfur Sudan PNG Sri Lanka Namibia Mongolia Geneva Laos	Nurse/Midwife Project officer NZRC Cyclone relief Nurse, refugees Pulau Bidong Nurse/nutritionist Health delegate Development delegate Development delegate/Head of delegation Head of delegation Health advisor Head of delegation	1979-1980 1980-1991 1982 1983-1984 1985-1986 1987 1989-1990 1991-1993 1994-1995 1996-1998 1998-2001	3mths 11 yrs 2mths 4mths/ 6mths 1yr 1yr 10mths 2yrs 2yrs 2yrs 15mths
Judith Owen	1995	RN ADN MA Tropical Health	Thailand Pakistan Ethiopia Somalia Afghanistan Ethiopia Ethiopia Former Yugoslavia	Surgical nurse Nurse field hospital Public health nurse Surgical ward nurse Surgical ward nurse Head nurse surgical Field nurse Field nurse	1980 1985 1985-1986 1988 1988-1989 1990 1991 1994	3mths 1mth 6mths 2mths 4mths 6mths 3mths 6mths
Sheryl Thayer ²	1997	RN	Thailand Afghanistan Thailand Afghanistan Chechnya	Surgical ward nurse Surgical ward nurse Surgical ward nurse Surgical ward nurse Surgical ward nurse	1989 1990-1991 1991-1992 1994-1995 1996	6mths 10mths 1yr 6mths 2wks
Louisa Akavi	1999	RN RM	Malaysia Hong Kong Somalia Bosnia Bosnia Chechnya Sri Lanka Solomon Is Solomon Is	Head nurse refugees Pulau Bidong BRC community health nurse/refugees Field nurse Field nurse Field nurse Surgical ward nurse Health delegate Health delegate Health delegate/Act head of mission	1987-1988 1990 1992-1993 1993-1994 1995-1996 1996-1996 1998 1999 2000-2001	10mths 4mths 8mths 1yr 13mths 2mths 15mths 4mths 10mths
Margaret Bryson ³	1999	RN RM ADN	Malaysia Afghanistan Iraq Somalia Yemen Former Yugoslavia Tanzania Kosovo	Head nurse Pulau Bidong Surgical nurse Head nurse Medical coordinator Surgical coordinator Field nurses Clinical supervisor Health delegate	1988 1990-1991 1991-1992 1993-1994 1994 1994-1995 1996-1997 1998	9mths 4mths 15mths 10mths 2mths 9mths 6mths 5mths

² Posthumous award. Murdered while serving at Novi Atagi field hospital in Chechnya, 1996.

³ Margaret was evacuated from Kosovo after the car in which she was travelling hit a land mine. She has since recovered and returned to Red Cross field work.

APPENDIX 3

Victoria University of Wellington
Graduate School of Nursing and Midwifery

THE NEW ZEALAND FLORENCE NIGHTINGALE MEDAL RECIPIENTS

1969 - 1999

INFORMATION SHEET

Research Student

Jill Caughley, Student, MA (Applied) in Nursing at the Graduate School of Nursing and Midwifery, Victoria University of Wellington

Explanation

I am a registered nurse in the Master of Arts (Applied) in Nursing at Victoria University of Wellington. For my thesis I have chosen to write a history of the Florence Nightingale Medal and some of the New Zealand nurses who have been recipients. I will use oral history interviews as my prime method of data collection.

I would like to interview four to six recipients of the Florence Nightingale Medal between 1969 and 1999, in particular, to find out their background, motivation for nursing overseas and their nursing practice. As you were a Florence Nightingale Medal recipient, I am inviting you to participate in this study.

If you are interested in being a participant in this project, I would interview you at a time and place agreeable to you. The interview might last about an hour and half. I would audiotape the interview. The audiotape would be kept securely stored during the project. My supervisor, Dr Pamela Wood, might also listen to the audiotape. It will be stored securely for five years and then electronically wiped.

I would be interested in viewing photographs, your medal and the accompanying citation, news clips or other information which will add background information about you and your Red Cross work. With your permission, I would request that some of this information can be copied for addition to the study.

In my thesis, I would describe your involvement in Red Cross nursing and include quotations from the interview. You can choose whether you want to be identified by your own name or by a pseudonym, however, as only eleven nurses in New Zealand received medals between 1969-1999, and their names are on public record, it may not be possible to protect your identity.

Your participation in this project is entirely voluntary. If you decide to participate, I will ask you to sign a written consent form. You can stop the interview at any time, or withdraw from the project at any time until I have completed the thesis and the tapes will be electronically wiped.

A copy of the transcript or section of the thesis relating to your contribution will be given to you for checking prior to completion and submission of the thesis.

A soft copy of the completed thesis will be provided to you on request.

If you would like to discuss this with my supervisor, you can contact Dr Pamela Wood at the Graduate School of Nursing and Midwifery, Victoria University of Wellington, P.O. Box 600, Wellington, New Zealand, or by phoning (04) 463-6650.

Ethical consent

This research study has gained ethical approval from the Human Ethics Committee of Victoria University of Wellington.

Your informed consent will be requested in a written consent form.

The interview

The interview is likely to cover the following areas:

- Reasons for becoming a nurse
- Family influences on your decision
- Clinical experiences prior to Red Cross
- Reasons for working with the Red Cross (for example, philosophical, political, ideological, adventure, save the world)
- Significance of the humanitarian principles of the Red Cross for you
- Nature of your nursing practice in your various missions and the conditions
- Changes in practice over time and in different situations, and factors contributing to the change
- Nursing experiences in New Zealand that best prepared you for your work
- The most satisfying mission in terms of nursing practice
- The most difficult mission in terms of nursing practice
- Treatment as a woman in different cultures by patients and other workers
- The contribution of your experiences to nursing in New Zealand
- The personal and professional feelings of being a recipient of the Florence Nightingale Medal

Jill Caughley, Student, MA (Applied) Nursing
September 2001

APPENDIX 4

**Victoria University of Wellington
Graduate School of Nursing and Midwifery**

CONSENT FORM

NEW ZEALAND FLORENCE NIGHTINGALE MEDAL RECIPIENTS

1969 -1999

I have been given an explanation of this oral history project for Jill Caughley's thesis for the Master of Arts (Applied) in Nursing at Victoria University of Wellington. I have understood this explanation and have had the opportunity to ask questions and have them answered to my satisfaction. I understand that my participation in an interview is voluntary, and that I may withdraw my involvement (or any information I have provided) before the project is completed, without having to give reasons.

I understand that I will be offered a copy of the transcript and section of the thesis which pertains to me to check whether I am comfortable with what has been said prior to completion and submission.

I understand that the information I provide, and the audiotape of the interview, will be kept confidential to the interviewer and supervisor. I also understand that any written information related to this project is likely to identify me but that I can use either my own name or a pseudonym. At the end of the project, I understand that the audiotape will be stored for five years, then electronically wiped.

I agree to be interviewed for this oral history project.

Signed.....

I wish to have my own name used in this project.

Signed.....

I wish to have a pseudonym used.

Signed.....

I wish to be given a copy of the completed thesis.

YES/NO

Name of participant Date.....

APPENDIX 5

New Zealand Florence Nightingale Medal Recipients 1920 - 1965¹

Year	Name	Position/experiences
1920	Hester MacLean, Royal Red Cross	1893 Trained nurse, Sydney 1906 Assistant Inspector of hospitals 1913-1923 Matron in chief NZANS Editor, owner, Kai Tiaki
1947	Irene Flora Campbell (nee Stollery)	1941-46 Commandant Hawkes Bay Red Cross, Organised VAD classes
1949	Helen Iris Crooke MBE	1920 Registered nurse Director of Red Cross VADs
1951	Edna Jean House	Registered Red Cross VAD Service to NZ Red Cross conveying sick, aged, infirm to hospitals from remote places. Distinguished herself after cyclone devastated Waikato district.
1957	Catherine Lynette Wells	1916, Trained Wellington. Served NZANS, World War I Centre Advisory Director, Wellington VADS WWII Member of organising committee NZ VADS, WWII Outstanding service to Red Cross, including assistance in reception of Hungarian refugees
1959	Flora Jean Cameron, OBE	1929, Trained Christchurch, Canada. Director of Department of Health Govt representative Red Cross Society Maori Women's Welfare League 1960 Officer, Order of St John
1961	Doris Ogilvy Ramsay	VAD at Montecillo House for disabled servicemen in Dunedin 1944 appointed Centre Commandant of VADs in Otago WWII, in charge of POW records & interviewed next-of-kin, Otago & Southland. Organised transport to meet returning sick & wounded. Represented NZ at Solferino Conference, 1959
1961	Edith Mary Rudd Royal Red Cross	1904, Trained Wanganui Served on Hospital Ship Marama, WWI Nursed, military hospital Trentham 1941-46 Matron Hospital Ship Maunganui, WWII.
1963	Mary Ann Gidall	1904, Trained Paddington, London, registered NZ, Served QAIMNS WWI, Malta & France Transport ship Zealandie Noted for service after Napier earthquake. Lady Superintendent of Wellington VADS, WWII
1965	Muriel Jessie Jackson Associate Royal Red Cross	1929 Trained Auckland WWII personal assistant to Matron-in-Chief Outstanding service with NZ mobile Casualty Clearing Station, Italy Matron 5NZGH Middle East Active interest in training activities of VADs

¹ Source; S. Kendall, D. Corbett, *New Zealand Military Nursing, A History of the RNZNC, Boer War to present day*, Published by Kendall & Corbett, 1990, p.228-229.



Figure 1: The Florence Nightingale Medal

Photograph reproduced with permission of New Zealand Red Cross

(Red Cross News, Issue 1, 1988, p.14.)



Florence Nightingale

Figure 2: Florence Nightingale

Presented to each Florence Nightingale Medallist by the ICRC

Reproduced with permission from Megan Crisp.



THE INTERNATIONAL COMMITTEE OF THE RED CROSS



awards to

Mrs. Megan Margaret Crisp

THE FLORENCE NIGHTINGALE MEDAL

founded and governed by regulations issued by the International Conferences of the Red Cross held in 1912, 1934 and 1952, for presentation to female nurses and voluntary aids of the Red Cross who have distinguished themselves exceptionally by their devotion to the sick or wounded.

For the International Committee of the Red Cross

Geneva, 12 May 1981

The President:

Figure 3: The Florence Nightingale Medal Award

Reproduced with permission from Megan Crisp.



Figure 4: Ngair Simpson at the opening of the New Zealand Red Cross Western Bay Service Centre

Reproduced with permission from the Bay of Plenty Times. 'Te Puke's Ngair Simpson received the Florence Nightingale Medal for her work in Vietnam', *Bay News*, 17 December, 1999, p.3.



Figure 5: Florence Nightingale Medallists, from left to right, Megan Crisp, Wendy Smith, Margaret Bryson, Glenys Checchi and Louisa Akavi.

Photographed at the Marquette Service by Andrew Palmer, 28 October 2001.
Reproduced with permission from the Graduate School of Nursing and Midwifery,
Victoria University, Wellington.



Figure 6: Glenys Checchi with Sir Paul Reeves, Governor General of New Zealand receiving her Florence Nightingale Medal, 1987.

Reproduced with permission from New Zealand Red Cross.
(*Red Cross News*, Issue 1, 1988, p.14)



Figure 7: Wendy Smith, Health Delegate in Sri Lanka, joins Sri Lankan women making handicrafts from palmyrah fibre.

Reproduced with permission from New Zealand Red Cross.
(*The Year in Review 1989-90*, front cover)

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