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DISEASE, HEALTH AND HEALING:

**aspects of indigenous health in Western Australia and Queensland,
1900-1940**

Gordon Briscoe

A thesis submitted to
History Program, Research School of Social Sciences
The Australian National University
for the degree of
Doctor of Philosophy

September 1996



**This thesis is all my own work
except where otherwise acknowledged**

Gordon Briscoe

Dedication

This thesis is dedicated to my late mother, Eileen Briscoe, who gave me my Aboriginal identity, to my wife Norma who kept body and soul together while the thesis was created, developed and nurtured and, finally, to the late Professor Fred Hollows who gave me the inspiration to believe in myself and to accept that self-doubt was the road to scholarship.

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For assistance in research carried out by me in Western Australia, I thank the History Program RSSS for funds to travel and to the Battye and Public Records (including the Archives and photographic collections) Library in Perth, and their staff who helped me enormously, both to gain access to historic records and to find, and provide me with, a large number of primary source materials. While in Perth I stayed with Drs Mary and David Dale, and two of their four sons, Dr Nick and John Dale, and I owe them all a great debt of gratitude which I hope some day to be able to repay. Also while in Perth I had the pleasure of meeting with Dr Peggy Brock and her partner Professor Norman Etherington who both gave me great encouragement to develop my perspective and my chosen topic. Peggy Brock kindly provided me with an opportunity to inform her students on the scope and shape of my thesis research in Western Australia. Other members of the academic community who gave me their time included Mary Anne Jebb, Anna Haebich and Dr Tom Stannage, all of whom met and talked with me about my topic as well as the location of possible source materials. The staff at the Aboriginal Planning Authority include the Librarian Robin South who both helped me to locate the files — Medical, Health and Aborigines Department files — I needed in the massive indexes, and to gain quick and official approval for access to those extremely important files which date from the 1890s to the 1940s. Dr Christine Fletcher of the Research School of Social Sciences gave me valuable advice about Western Australian sources which proved crucial.

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Synopsis

In this thesis I examine aspects of disease, health and healing among the indigenous people in Western Australia and Queensland from 1900 to 1940. I argue that diseases have helped to shape and influence the interaction between the indigenous people and the various members of the settler community most concerned with them — government protectors, missionaries, pastoralists and health workers.

In developing this argument I draw on the distinction made by Stephen J. Kunitz between the universalistic and particularistic approaches to historical epidemiology. Kunitz argues that the development of physiology and bacteriology transformed the practice of medicine by revealing universalistic 'natural histories' of diseases and their causative agents, but that this approach should be tempered by attention to the particular individual, cultural and institutional circumstances of disease occurrence. Diseases have a past, a present and a future of their own, and when considered within the context of human social history, are seen to be a powerful motivate force in human affairs. My approach involves examining the history of diseases, health and healing among the indigenous peoples using models of causation, some of which are biomedical, some are anthropological and others are demographic and epidemiological. There are differences between such models. The biomedical model is 'universalistic' and 'scientific', based on general principles subject to proof or denial through empirical research. In the same way, the demographic and epidemiological models are also universalistic. The anthropological model, however, is 'particularistic' in that each situation is unique and is explained by its history and internal dynamics, not by reference to general principles. The combination of the biomedical, demographic and epidemiological methods with those of social history allows an otherwise silent indigenous population to be brought into the historical narrative from which they would otherwise have been excluded.

In Western Australia, contrary to previous thinking, the total number of Aborigines increased during the study period. In particular, the number of females and older males increased under the influence of protection laws. The increases contradict the popular belief that the indigenous populations were still in decline. However, the spread of disease and the

growing population worsened the already poor personal and public hygiene practices, creating the mistaken impression that the indigenous populations were declining. Indeed, diseases such as leprosy, respiratory and sexually transmitted diseases had by the 1930s reached epidemic proportions, which suggested that the indigenous people were a dying race.

The indigenous populations already contained some pathogenic infections prior to contact with Europeans. The Aborigines had developed a means, however rudimentary, of predicting how sick people reacted to an illness and of determining what the disease might be that healers treated. But following European contact, other diseases came from contact not only with Europeans but also with Asians, who introduced leprosy into mining camps and Kanakas, who introduced leprosy into the cane plantations and tuberculosis into the Cape York regions.

Protection policies intensified the effects of the diseases. In Queensland, the government applied its protection policies with increasing vigour over the period, resulting in most Aborigines living on government relief depots, missions and reserves by the 1930s. Demographic analysis reveals that Queensland consistently overestimated its indigenous populations. Death, disease, health and healing among indigenous groups, therefore, came to have social and political dimensions which few, if any, people recognised at the time. In hindsight, however, we can appreciate that the assumption behind health programs was that the indigenous populations should be the passive, but grateful, recipients of welfare rather than historic actors in their own right. The consequences in terms of disease dynamics were profound. The associated practice of gathering together sick, infirm and infected people in 'disease compounds' created reservoirs of exotic diseases to infect newcomers with low immunity. The social consequences of weakened populations meant, in turn, higher numbers of inmates who succumbed to virulent infections.

Even in the absence of 'disease compounds', overcrowding of depots and inadequate health services based mostly on religious compassion (on both mission and government compounds) were instruments in promoting increased infection. After 1920 professional services supervised by government protectors and health officials became the norm, but in general, Aborigines were not allowed access to normal hospital facilities. During epidemics, overcrowding of depots and settlements meant a greater susceptibility to respiratory and sexually transmitted diseases, which became endemic, as well as to other infections such as hookworm and leprosy.

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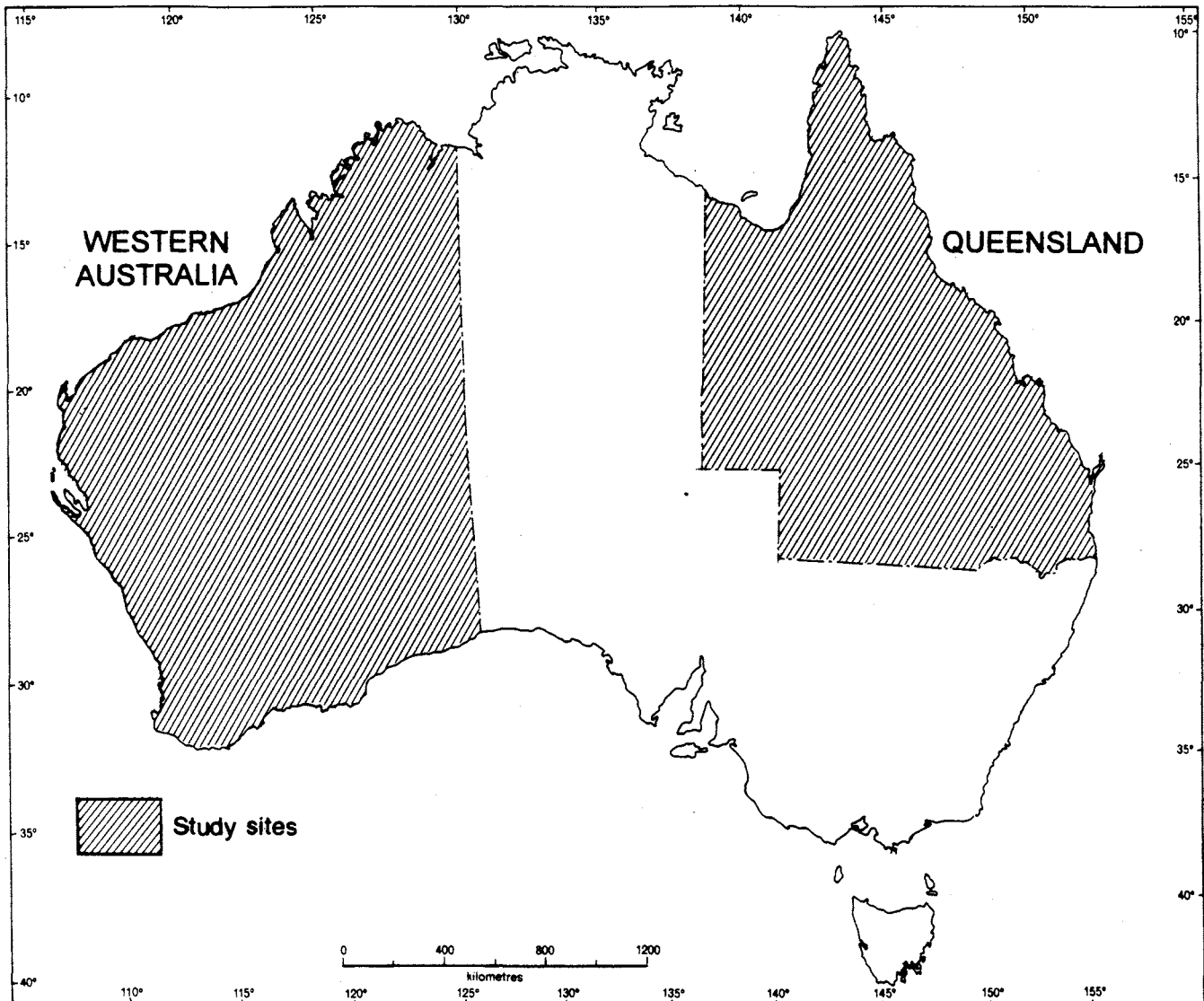
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Map 1

A map of the region of study



A map of Australia which locates Western Australia and Queensland.

Introduction

This thesis deals with aspects of disease and the development of health and medical care services for indigenous people¹ in Western Australia and Queensland from 1900 to 1940. Most observers intimately interested in the impact of settlement on indigenous groups in 1900 believed that the Aborigines would soon disappear. This sentiment was most famously expressed in Daisy Bates's book *The Passing Of The Aborigines*.² The notion of a disappearing indigenous people persisted throughout the period of study and in all regions. The reality however was rather different, as I will demonstrate. In part the issue was clouded by the size and nature of a widely and sparsely scattered indigenous population. In part also, the problem was exacerbated by the staggered pace at which both colonies developed — slow in the southern and coastal strips during the nineteenth century, and faster in the northern regions later in the period.

Some observers believed that the disappearance of indigenous groups originated with the violent confrontations between them and white settlers.³ Others believed that Aborigines were dying out because of the effect of disease contracted from white settlers and Asian seamen. Still others believed the cause was the loss of customary living environments that contained sources of food and water.⁴ Both the colonies of Western

¹ In this thesis I use the term 'indigenous' as a synonym for 'Aborigine' and 'Aboriginal', and I use them interchangeably. I do not attempt in any way to reconstruct the Torres Strait Islander's past, which would involve a separate thesis.

² Daisy Bates, *The Passing Of The Aborigines*, John Murray, London, 1938, pp.1-2.

³ C.D. Rowley, *The Destruction of Aboriginal Society: Aboriginal Policy And Practice*, Vols I-III, ANU Press, Canberra, 1970-71, Vol. I, pp.213-214, and pp.290-292.

⁴ A. Grenfell Price, *White Settlers and Native Peoples*, Georgian House, Melb., 1949; Diane Barwick 'A little more than kin: regional affinity and group identity among Aboriginal migrants in Melbourne', Ph.D. thesis, ANU, 1963, see also, Diane Barwick

Australia and Queensland had enacted legislation in an attempt to protect Aborigines from exploitation, violence, disease and starvation. Studies have been carried out of both the exploitation of Aboriginal labour⁵ and violence under colonial settlement.⁶ No studies have been carried out, however, of disease, health and healing or of the provision of health care services to indigenous people during the period considered here.

This thesis investigates aspects of the biomedical and social consequences of disease, health and healing and their shaping of the indigenous and settler past. Diseases and social action do not always act independently of the social milieu in which they are found.⁷ In his recent publication, *Disease and Social Diversity*,⁸ Stephen Kunitz noted that developments in the physiological and biological sciences transformed medical practices in that they laid bare the idea that germs and bacterial life have a 'natural history' of their own. As a result, Kunitz argued that the knowledge gained in the study of these sciences should also be applied to the human condition by rekindling an attention to individual, cultural and institutional circumstances.⁹ The way this ought to be done, Kunitz argued, was through a 'cross-fertilisation between biomedical

'Changes in the Aboriginal population of Victoria 1863-1966', in D.J. Mulvaney and J. Golson (eds), *Aboriginal Man and Environment in Australia*, ANU Press, Canberra, 1971; see Daisy Bates, *The Passing*, p.65.

⁵ Dawn May, *Aboriginal Labour And The Cattle Industry: Queensland From White Settlement To The Present*, Cambridge University Press, Melbourne, 1994, pp.45-46, and see pp.155-156; Frank Stevens, *The Politics of Prejudice*, APCOL, Sydney, 1971, p.47; see also, Rowley, *The Destruction*, pp.64-73, and pp.157-186.

⁶ Henry Reynolds and Noel A. Loos, 'Aboriginal resistance in Queensland', in *Australian Journal of Politics and History*, Vol. 22, No. 2, 1976; Henry Reynolds, 'Violence, the Aborigines and Australian History', in *Meanjin*, 1972; see also, for an alternative viewpoint, Beverley Nance, 'The level of violence: Europeans and Aborigines in Port Phillip, 1835-1850', in *Historical Studies*, Vol. 19, No. 37, 1981, pp.532-552.

⁷ Stephen J. Kunitz, *Disease and Social Diversity: the European Impact on the Health of Non-Europeans*, Oxford University Press, London, 1994, p.5.

⁸ *Ibid.*, pp.5-6.

⁹ Donald Denoon, 'Book Review', in *Health Transition: The cultural, social and behavioural determinants of health*, Vol. 4, No. 2, October 1994, pp.231-232.

(universalistic) and anthropological (particularistic) models of causation'.¹⁰

In writing a history of disease, health and healing among indigenous people in Western Australia and Queensland, I follow Kunitz's approach, and argue that account must be taken of the natural history of disease as an element in the shaping of the interaction of the indigenous peoples' social relations in history.¹¹ A number of elements have shaped the historical account presented. One was the diseases which cannot be divorced from history, either natural or social. Another was the indigenous people both as patients and clients. Yet another was the Aboriginal administrative system comprising government protectors, magistrates and police, along with doctors, hospital health workers, pastoralists and missionaries. These groupings were crucial in shaping both indigenous and non-indigenous responses to disease and health.

How historians and other writers have brought the indigenous people into their narratives is an important point of focus of this thesis. Until D.J. Mulvaney's¹² and F.G.G. Rose's¹³ ground-breaking work in the 1950s, almost no historians had included accounts of Aborigines in their historical narrative. In the late 1960s and early 1970s C.D. Rowley drew heavily on the ethnographic sources of W.E.H. Stanner, A.P. Elkin, and R.M. and C.H. Berndt,¹⁴ and drew also on government documentation.¹⁵

¹⁰ *Ibid.*, p.231.

¹¹ In the use of the term 'social relations', I follow F.B. Smith when he says, that 'medical history ...[is] the history of social relations', in F.B. Smith, *The People's Health 1830-1910*, Weinfeld and Nicolson, London, 1990, p.11.

¹² D.J. Mulvaney, 'The Australian Aborigines, 1606-1929', in J.J. Eastwood and F.B. Smith (eds), *Historical Studies, Australia and New Zealand: Selected Articles First Series*, Parts 1 and 2, Melbourne University Press, Melbourne, 1964, pp.1-56.

¹³ F.G.G. Rose, *The Winds Of Change in Central Australia*, Akademie Verlag, Berlin, 1965; and also see, Rose, 'The Pastoral Industry in the Northern Territory during the period of Commonwealth Administration, 1911-53', in *Historical Studies*, Vol. 6, No. 22, 1954, pp.150-172.

¹⁴ W.E.H. Stanner, 'Durmungan, A Naggiomeri', in Joseph B. Casagrande (ed.), *In the Company of Man*, Harper, New York, 1960; see also, Stanner, 'On Aboriginal Religion',

Since Rowley completed his trilogy in 1972 other writers reconstructing the Australian past have made efforts to include indigenous people. They fall into two groups. The first includes historians and social anthropologists; the second bring other disciplines to the study of the Aboriginal past. Of the first group, Mulvaney and Rose influenced other historians Manning Clark and Russel Ward, who did include aspects of the Aboriginal past, but only in a limited way. Clark mentioned Aborigines as being dispossessed and disease-ridden. Referring to Sturt's expedition to South Australia he wrote that in January 1830 Sturt thought that he saw Aborigines bearing the effects of syphilis.¹⁶ Ward wrote about Aborigines in a subservient role teaching bush skills to escaped convicts and pastoralists, who then thrived 'up country'.¹⁷

In contrast to the passivity which Clark and Ward ascribed to indigenous people, later historians and social anthropologists have been at the forefront of reconstructing a colonial history that does feature Aborigines. Such an approach was obvious in the first part of the trilogy, *The Destruction of Aboriginal Society: Aboriginal Policy And Practice*.¹⁸ Rowley's main purpose was to identify Aboriginal Australians, and to highlight for Australians the way they had oppressed the indigenous Australians by first dispossessing them and then denying them access to

Oceania Monograph no. 11, reprinted from *Oceania*, Vol. XXXIII, No. 4, 1963; see also, 'Religion, Totemism, and Symbolism', in R.M. & C.H. Berndt (eds), *Aboriginal Man In Australia: Essays In Honour of A.P. Elkin*, Angus and Robertson, Sydney, 1965; see also, Stanner, *White Man Got No Dreaming: Essays 1938-1973*, ANU Press, Canberra, 1979.

¹⁵ K. Windschuttle, *The Killing Of History: How A Discipline Is Being Murdered By Literary Critics and Social Theorists*, Macleay Press, Sydney, 1994, p.117.

¹⁶ Manning Clark, *A Short History Of Australia*, 2nd edn, Macmillan, Sth Melb., 1981, p.64.

¹⁷ Russel Ward, *The Australian Legend*, OUP, Melbourne, 1958; see also, J.R. Beckett, 'A study of a mixed-blood Aboriginal minority in the pastoral west of New South Wales', MA thesis, ANU, 1958. In the thesis Beckett matched the mores of Aboriginal pastoral workers with those of early rural workers.

¹⁸ Rowley, *The Destruction*, Vol. I.

citizenship, democracy and a heritage. Rowley reconstructed his account of the Aboriginal past from a combination of economic, political and anthropological sources, drawing together historical and ethnographic texts to include Aborigines into the narrative. He described and defined Aborigines for Australian society of the 1960s from mostly colonial and other source material from the colonial period and from post Second World War records.

Rowley's contribution to a better understanding of Aborigines' place in Australian history is evident as indicated in a recent critique of Australian historiography. Keith Windschuttle has said that before Rowley,

the great dramas of nineteenth century Australian history were all assumed to have taken place within the realm of the new arrivals: convicts versus jailers, gold diggers versus troopers, selectors versus squatters, labour versus capital. Without commenting at all on the existing picture, Rowley cut it down to size overnight.¹⁹

Rowley also described Aborigines from a national point of view. He defined them in national demographic, political and economic terms.²⁰ As Windschuttle has pointed out, Rowley's perspective was not an Aboriginal perspective,²¹ which arose largely from the paucity of Aboriginal documentary and biographical sources. As a result Aborigines remain shadowy figures, even in the events in which they participated, and consequently suffer from the inability of the historian to give them authenticity and life. Rowley made every attempt to use diverse sources and methods,²² to bring the Aboriginal point of view into the narrative.

¹⁹ Windschuttle, *Killing of History*, p.117.

²⁰ C.D. Rowley, 'Who Is An Aborigine?', in Rowley, *The Destruction*, Appendix A, pp.341-364; see also, Appendix B, pp.365-398. The first paper in Appendix A, discusses defining 'Who is an Aborigine?', a subject I discuss in chapters two and three below; and Appendix B discusses aspects of the national characteristics of the Aboriginal population.

²¹ Windschuttle, *Killing of History*, pp.117-118.

²² J.R.W. Smail, 'On the possibility of an autonomous history of modern Southeast Asia', in *Journal of Southeast Asian History*, No. 2, 1961, pp.71-102; see also, E.J. Hobsbawm,

He employed the American historian Frederick Jackson Turner's²³ metaphor of a concrete frontier moving over time as the division between pre-contact indigenous people, and where the legal limits of the colonial state ebbed and flowed, combining this with an analysis of the politico-economic effects on Aborigines of the settler society. Turner was reacting against abstract depersonalised political history,²⁴ but, writing much later, Rowley's intention was to highlight the dispossession, political and economical dependence of indigenous groups by colonial oppression. He saw that some reparation could be won if Aborigines embarked on a political strategy based on their own self-interest within the Australian political structure. At the same time, other writers were attempting to write on both the epidemiologic and demographic aspects of the Aboriginal past.

A writer who emphasised the importance of epidemiology and demography was Peter M. Moodie, a researcher at the School of Public Health and Tropical Medicine at Sydney University. In outlining the social nature of indigenous health Moodie explained that the epidemiology of indigenous health could not be appreciated unless the nature and structure of the Aboriginal population of the regions of study was first discussed. Moodie wrote about Aboriginal health from data collected after the Second World War.²⁵ He completed his work a year after Rowley's political and economic history,²⁶ and three years after the

'From Social History to the History of Society', in *Daedalus*, Winter 1971, "Historical Studies Today", Vol. 100, No. 1, pp.20-45.

²³ Peter Bourke, *Sociology And History*, Allen & Unwin, London, 1980, p.24. Frederick Jackson Turner was the American historian who launched a criticism in the 1890s on the dominance of political history at the turn of the nineteenth and twentieth centuries.

²⁴ *Ibid.*, pf; see also, A.L. Rowse, *The Use of History*, Penguin Books, 1963, p.153; see also, Jacques Le Goff, 'Is Politics Still the Backbone of History', in *Daedalus*, Vol. 100, No. 1, Winter 1971, pp.1-19.

²⁵ Peter M. Moodie, *Aboriginal Health*, ANU Press, 1973, pp.1-25.

²⁶ Rowley, *The Destruction*, Vols I-III, 1970-72.

publication by J.P.M. Long, *Aboriginal Settlement*, which was published as a part of the same series of studies by Rowley.²⁷ Two other works covered detailed analyses of the national Aboriginal population in this period. These writers were Leonard Broom²⁸ and F. Lancaster Jones,²⁹ who wrote mainly about broad post-contact and post-Second World War national population trends, and questions of identity. These writers did not give any detailed localised analyses, nor did they explain what had happened to the Aboriginal populations at a regional level as their focus was the broad demographic trends arising from population dynamics.

Among the other writers on Aboriginal depopulation from the 1820s to the 1930s two themes are most prominent. On the one hand, one group of writers, including Edmund Foxcroft,³⁰ Paul Hasluck,³¹ and more recently Noel Butlin,³² emphasised the impact of exotic disease on the level of mortality of Aborigines. On the other hand, another group of writers that included Grenfell-Price,³³ Charles Rowley,³⁴ Fay Gale,³⁵ Noel Loos³⁶ and Diane Barwick,³⁷ emphasised the dominant role of violent

²⁷ J.P.M. Long, *Aboriginal Settlement: A Survey of Institutional Communities in Eastern Australia*, ANU Press, Canberra, 1970.

²⁸ Leonard Broom and F. Lancaster Jones, *A Blanket A Year*, ANU Press, Canberra, 1973.

²⁹ F. Lancaster Jones, *The Structure And Growth Of Australia's Aboriginal Population*, ANU Press, Canberra, 1970.

³⁰ E.J.B. Foxcroft, *Australian Native Policy: Its history especially in Victoria*, MUP, Melbourne, 1941.

³¹ P.M.C. Hasluck, *Black Australians: A survey of native policy in Western Australia, 1829-1897*, MUP, Melbourne, 1942.

³² N.G. Butlin, *Our Original Aggression*, George Allen & Unwin, Sydney, 1983.

³³ A. Grenfell Price, *White Settlers and Native Peoples*.

³⁴ Rowley, *The Destruction*, Vols I-III, see in particular, pp.36-38, 115-115, 145-159, 205-214.

³⁵ Fay Gale, *A Study of Assimilation*, SA Library Publication, of Ph.D. thesis, Adelaide University, 1964.

³⁶ N. Loos, *Invasion and Resistance: Aboriginal European Relations on the North Queensland Frontier 1861-1897*, ANU Press, Canberra, 1982, see in particular, pp.22-71, 103-106, 131-132.

³⁷ Diane Barwick, 'A little more than kin: regional affinity and group identity among Aboriginal migrants in Melbourne', Ph.D. thesis, ANU, 1963.

massacres and colonial politics, as well as disease. All of these writers on the Aboriginal past belong to the group of earlier historians and social anthropologists who succeeded in writing Aborigines firmly into the mainstream of Australian historiography. There is, however, a second, later group, whose work I will now discuss.

This second group brought a new discipline to the study of Aboriginal history. There are three contemporary scholars who bring not only new epidemiological and demographic methodologies but also a level of fine detail to the study of the past.³⁸ The first of these scholars, Leonard R. Smith,³⁹ wrote a monumental work on the national Aboriginal population. Smith, a demographer and epidemiologist, followed Rowley's historic model by showing how the modern Aboriginal population was constructed, and how a people without writing could speak through a larger process of demographic historical narrative. Aboriginal people of full descent and mixed descent, Smith revealed, represented a mixing of the races both in the colonial times and the period following that distorted the Aboriginal past. Employing national census material, and other historical primary and secondary sources, Smith described how the Aboriginal population had grown from a colonial phenomenon where each colony dealt with the issue in a different way, into a national one with the beginnings of a common approach. Smith elected to focus on broad national demographic circumstances in reconstructing the Aboriginal past. Gray and Kunitz have emphasised the importance of local perspectives. Gray's work focused on Aboriginal fertility and the determinants of Aboriginal

³⁸ Hobsbawm, 'Social History to History of Society', pp.32-34.

³⁹ L.R. Smith, 'The Aboriginal population of Australia', Ph.D. thesis, University of New South Wales, 1975. This Ph.D. was published as L.R. Smith, *The Aboriginal Population of Australia*, ANU Press, Canberra, 1985.

population and health in a region of New South Wales.⁴⁰ This study is significant because it presents an alternative to all-embracing historic models, and allows us to see Aborigines as actors in their own right. Gray attacked popular ideas about disease as a factor in Aboriginal history, and also those ideas about massacres as a factor in the depopulation of Aboriginal groupings wherever white settlement occurred.⁴¹

An interest in disease patterns prompted Gray to focus on a number of aspects of history and 'the occurrence in the Aboriginal population of disease syndromes interpreted as characteristics of a hunter-gatherer population...or in some cases of the disruptive effects of introduced diseases on a hunter-gatherer population.'⁴² Gray attacked anthropologists of the period from the late-1930s to the 1950s, who dwelt on disease and massacres when assessing the Aborigines of mixed descent, claiming this prescription amounted to a form of 'social Darwinism'.⁴³ Recently the pendulum had swung back, however, to place greater emphasis on the local cultural effects that European expansion had on indigenous peoples.

The other writer in the second group is Stephen Kunitz, an international scholar who writes widely on European settlement and its effects on indigenous health. He included a chapter on Queensland Aborigines and their epidemiological past in his most recent book, *Disease and Social Diversity*.⁴⁴ He called for a revisionist approach to the

⁴⁰ Alan Gray, 'Discovering Determinants of Australian Aboriginal population health' in J. Cleland and A.G. Hill (eds), in *The Health Transition: Methods and Measures*, ANUTECH, Canberra, 1991, pp. 355-379; see also, A. Gray, 'Some myths in the demography of Aboriginal Australians', in *Journal of Australian Population Association*, Vol. 2, No. 2, 1985, pp.136-149.

⁴¹ Gray, 'Discovering Determinants', p.357; see also, Gray, 'Some myths', pp.140-147.

⁴² Gray, 'Discovering Determinants', p.355.

⁴³ *Ibid.*, p.355; see also, N.B. Tindale, 'Survey of the half-caste problem in South Australia', in *Proceedings of the Royal Geographic Society of South Australia*, Vol. 64, pp.140-231.

⁴⁴ Kunitz, *Disease and Social Diversity*.

study of disease and the role it has played in European dominance over indigenous groups. The Queensland study briefly described aspects of Aboriginal health, as Aborigines became affected by 'settler capitalism'⁴⁵ and the advance of the state in Australia during the nineteenth and twentieth centuries.⁴⁶ Kunitz exposed the way all-embracing generalisations obscure the real underlying mosaic of the struggles that indigenous populations maintained in the face of other peoples expanding into their environments, and intruding on their ways of life.⁴⁷

If all these local encounters are indiscriminately lumped together, Kunitz indicates, the histories of indigenous groups becomes obscured. This can happen if diseases are assumed to have wiped indigenous groups out, or seriously weakened their cultural resistance, then their underlying actions to escape such influences remain hidden. Their reactions are therefore omitted from the history that other non-Aboriginal writers produce. In addition, Kunitz believes that different kinds of federalism have produced different kinds of health outcomes for indigenous peoples.⁴⁸ The models developed by the second group of writers are particularly relevant to this study because they represent a historiographical shift towards the inclusion, in historical narrative, of peoples without historical writing of their own.⁴⁹

With the foregoing historiography of the Aborigines in mind, I will now briefly discuss the content of the thesis, but it needs to be stressed

⁴⁵ *Ibid.*, p.49, the use of the term of which he acknowledges, followed, Donald Denoon, *Settler Capitalism*, Oxford University Press, Oxford, 1983, pp.221-224.

⁴⁶ *Ibid.*, pp.82-120.

⁴⁷ *Ibid.*, pp.121-148.

⁴⁸ *Ibid.*, pp.4-6.

⁴⁹ R. MacLeod and D. Denoon, *Health and Healing in Tropical Australia and Papua New Guinea*, JCU Press, Townsville, 1991; and see also, Donald Denoon, 'Temperate medicine and settler capitalism: on the reception of western medical ideas', in Roy MacLeod and Milton Lewis (eds), *Disease, Medicine and Empire, Perspectives on Western Medicine and the Experience of European Expansion*, Routledge, London, 1988, pp.121-139; also see, Denoon, *Settler Capitalism*, pp.217-224.

that while I mention the pre-contact, pre-federation (or colonial) periods I do so for descriptive and not for theoretical purposes and I intend to analyse and evaluate only the period from 1900 to 1940. Similarly, when I discuss the State I do so as a synonym in the transitional processes as they change from independent colonies to federal members of the Commonwealth. In addition, although I use State and Commonwealth census data as well as material compiled from archival records relating to Aboriginal disease patterns I do with the knowledge that collection and collation problems are always present when dealing with very small populations, as in the indigenous population case. Finally, Tables have been included, where the data could be compiled, on total numbers in Western Australia (see Table 6.1 in Appendix 6), and one which makes a simple comparison between Queensland and Western Australia for the period 1900 to 1925 (Table 10.2 in Appendix 10). Other data related to leprosy in Queensland discusses selected populations only, due mostly to the limited data collected by authorities at the time and the limited number of surveys done by the Protectors and health officials in Queensland.

Chapters one and two are descriptive demographic studies. My purpose in these chapters is to define who the people called Aborigines are in Western Australia and Queensland. I use the language as used by the official 'protection' agencies of these two States. There was a rhetoric of 'protection' which pervaded the administration of 'native' peoples and the rhetoric must be understood. For example, indigenous people were known either as 'natives' or they were referred to as 'full-bloods' and 'half-castes' by both administrators and settlers. In both colonies administrative exigencies and population dynamics together changed the population components of these groups. That is, the notion of what 'an

Aborigine' was and who 'the Aborigines' were changed over time, the focus shifting from biological to social determinants. I investigate these changes through time series studies. Both chapters investigate the Aboriginal population age structure, the contributions to total increase made by the various racial and cultural groups of the indigenous population, the sex ratios of males to females and finally expose the differences and similarities of the Aboriginal population over time.

I should point out that the discussion of sex ratios is not to challenge the notion that until the 1940s there was virtually no population in the world in which women outnumbered men.⁵⁰ This is a true statement; but my purpose is simply to graphically show, notwithstanding the demographic collection problems, that a demographic dynamic was at work which helps to explain why the population did not grow as much as it might otherwise have done, under the cover of administrative deception.

The purpose of Chapters three to six is to investigate the development of health and medical service provision to indigenous people in Western Australia from 1900 to 1940. Chapter three also investigates the transitions that saw the instigation of protective legislation — and subsequent employment of protectors — which remained in force from the 1890s to 1936. In the same chapter I describe the way the Chief Protectorate changed under Prinsep and Gale between 1898 and 1910, a period that included an epidemic of venereal disease and a Royal Commission on the Condition of the Aborigines. Following Prinsep's departure as Chief Protector Gale reduced the importance and

⁵⁰ Alan D. Lopez and Lado Ruzicka (eds), *Sex differentials in mortality: Trends, determinants and consequences*, Miscellaneous Series No., 4, Department of Demography, ANU, Canberra, 1983, pp.477-478., see also, United Nations, *Population of Australia*, Country Monograph Series No., 9, UN, New York, 1982, pp.34-36, see Table 8, on p.35, which shows clearly that from 1901 to 1976, the female population was always less than males.

scope of the position. The contraction occurred, for example, in the reporting mechanism for bringing together data on Aboriginal groups. Where information on the condition of the 'natives' consisted of statistical data, Gale disposed of some strategies for reporting to Parliament and personally carried out field trips to investigate Aborigines across the State.

Chapter four looks at the period 1910 to 1920, Chapter five the period 1920 to 1930 and Chapter six from 1930 to 1940. Chapter four explains the transition period when the government handed the responsibilities from Protector Gale to O.A. Neville. By 1919 the venereal disease epidemic began to subside which in turn allowed the two lock-up hospitals to be closed. New hospitals on the mainland opened and soon began to fill with leprosy patients.

Throughout the period 1920 to 1930 leprosy increased slowly and moved north from the Gascoyne, the Pilbarra and into the Kimberley indigenous populations. Other health problems including access to health services continued into the 1930s, and leprosy increased in alarming proportions striking fear in the clients, the carers and the protection agents. Neville ushered in a process of movement by Aborigines into country towns demanding hospital and general practitioner care. Separate 'native' hospitals were built but this reduced rather than increased the prospects of Aborigines gaining a hospital bed when they or their relatives became unwell. I investigate Aboriginal epidemiological patterns and the administrative health structure as it affected missions, reserves, institutions servicing Aborigines, fringe-camp and bush Aborigines through to 1940.

Queensland history differs from that of Western Australia because of the higher degree of institutionalisation of Aborigines in that State

from as early as the 1880s. Chapters seven to ten deal with Queensland and are structured in a similar way to the Western Australian Chapters. My purpose is the same: to investigate the development of the provision of health services to indigenous people in Queensland, from 1900 to 1940. This thesis makes no attempt to discuss theoretical notion of either colonialism or the modern State, but, for descriptive purposes only I discuss briefly the transitional phase of the Western Australian and Queensland colonies to their new status as member states of the Commonwealth. In a similar way I investigate the transition processes, from employment of the Protectors to the instigation of special protective legislation and the relocation of Aborigines to missions and reserve populations into settlements with both primary health and public health services.

Although comparisons between the two States are made throughout I look at each separately because even though they were similar they were separate, and any further comparisons would have made this study unmanageable. In addition, I look at each decade between 1900 and 1940 and pursue a study of the patterns of health and administrative health structures in Western Australia and Queensland as they affected mission, reserve, institution, fringe-camp and bush populations. A short Chapter concludes and recapitulates the findings and points to the differences and similarities between the experiences of Western Australia and Queensland. It is an experience which provides the thesis with its theme and demonstrates my contention that the identity of Aborigines is a socio-political construct resulting in part from settler attitudes towards disease, health and healing, and the bringing to bear on Aborigines of such attitudes.

There appears to be a paradox here, in that Aboriginality is a condition defined not by the Aborigines themselves but by the settler societies. In the period of study, however, questions of identity were not the primary concern of indigenous groups, in contrast to the situation in the modern postwar era. Coping with the onslaught of the settler State as represented by an army of missionaries, protectors, police and townsfolk was the major preoccupation of Aborigines in Western Australia and Queensland for the whole period from 1900 to 1940. This thesis demonstrates that if we look closer at history, Aborigines emerge from the past as authentic actors in their own right rather than as either resisters on the one hand or passive recipients of welfare on the other. That is, they were active participants in Australian history and not some aberrant element which the colonial state had to accommodate.

CHAPTER 1

Disappearance or Resurgence: the Aboriginal population of Western Australia: 1900 to 1940

The aim of this chapter is to examine the size and composition of the Aboriginal population in Western Australia in its historic setting. For descriptive purposes I mention colonial censuses but make no attempt to analyse them. The chapter also includes an analysis of the censuses from 1901 to 1933, and the special Aboriginal censuses from 1919 to 1940, the age-sex composition in the study period and considers the relevance of aspects of demographic change to expose the positive role indigenous people played in the Australian historic past. No other event symbolises the dilemma of studying the Aboriginal population more than when Daisy Bates buried an old man named Joobaitch in 1907.

Bates wrote that when Captain Stirling sailed up the Swan River in 1829, Joobaitch made up part of the group of indigenous observers standing on the shore.¹ By the time Joobaitch died he was in his early eighties and was the last of his family group, according to Bates. It was a family that numbered about 1,500 people in 1829, living in the area now occupied by Perth.² Populations of people of full descent existed in most regions of Western Australia in 1900. As Daisy Bates revealed, in areas where white settlers congregated, the numbers of indigenous people appeared to fall drastically. As I reveal below, the assumptions about a

¹ Daisy Bates, *The Passing*, pp.61-62.

² *Ibid.*, pp, xvii-xviii, and pp.67-72.

'disappearing population' proved to be a distortion. In addition, the beneficiaries of the Government's protection policies were Aboriginal women even though this was not easy to see or appreciate during the period of study. I argue that despite claims about a disappearing indigenous population the number of Aboriginal people of Western Australia — peoples of full and mixed descent — grew throughout the whole period, and this was due both to the Aboriginal people's own internal dynamics and the Government's relief and protection policies.

Other studies of the Aboriginal population have focused on national questions and omitted analyses at the local level. My approach is to separate the demographic from the epidemiological and social questions, and then reintegrate them later. Such a method simplifies the complex nature of the changes through which the indigenous population of Western Australia and Queensland passed. Each State and each region placed different meanings on who and what an Aborigine was. To appreciate the epidemiological analyses of later chapters, it is essential to grasp the differences and the similarities of the varying interpretations.

The use of demography is now widespread in Aboriginal historic reconstruction to support other disciplines but before Rowley it was almost unknown outside a few isolated anthropological studies. After Rowley wrote his trilogy³ in the 1970s a number of studies of aspects of the Aboriginal population soon emerged. The most comprehensive was by L.R. Smith.⁴ His study took account of the way the national Aboriginal population moved from colonial decline to demographic recovery. Other

³ Rowley, *The Destruction*, Vol. I, ANU Press, Canberra, 1970; Rowley, *Outcasts in White Society*, Vol. II, ANU Press, Canberra, 1971; Rowley, *The Remote Aborigines*, Vol. III, ANU Press, Canberra, 1971.

⁴ L.R. Smith, 'The Aboriginal population of Australia', Ph.D. thesis, University of New South Wales, 1975; Smith, *The Aboriginal Population of Australia*, ANU Press, Canberra, 1980.

writers have covered the demographic studies⁵ but Noel Butlin wrote a speculative account of the Aboriginal populations from the particular aspects of Aboriginal pre-contact demography and of the effects of epidemics such as smallpox.⁶ Apart from L.R. Smith none of the other writers previously mentioned contain substantial demographic data on the Western Australian indigenous population. A study of the Aboriginal populations of both Western Australia and Queensland is necessary before any serious discussion occurs of indigenous epidemiological patterns in those States.

Some explanation of the use of terms is necessary before continuing. It is not possible to consult the historic records or secondary studies, for example, without understanding how terms such as 'natives', 'Aborigine', 'full-blood' and 'half-caste' were used.⁷ Other terms used frequently include 'people of mixed and full descent', and 'camp-' and 'bush-dwelling' peoples. In some cases these groups contained members from a number of different racial groupings with different cultural backgrounds. Changing the terms to reflect modern usage not only makes primary source records difficult to interpret and understand, but also distorts the intentions of the people involved in past events. In the text of this thesis the terms Aborigine and the adjectival form Aboriginal have been given capitals. In quoted sources, however, the noun 'aborigine' and

⁵ F. Lancaster Jones, *The Structure And Growth Of Australia's Aboriginal Population*, ANU Press, Canberra, 1970, see also, L. Broom and F. Lancaster Jones, *A Blanket A Year*, ANU Press, Canberra, 1973; see also J.P.M. Long, *Aboriginal Settlements: Survey of Institutional Communities in Eastern Australia*, ANU Press, Canberra, 1970; see also P. Biskup, *not slaves not citizens: The Aboriginal Problem in Western Australia 1898-1954*, University of Queensland Press, St Lucia, 1973; see also M.C. Howard, *Aboriginal Politics In Southwestern Australia*, University of Western Australia Press, Perth, 1981; see also A. Gray, 'Australian Aboriginal Fertility In Decline', unpublished Ph.D. thesis, ANU, 1983.

⁶ Butlin, *Our Original Aggression*, pp.64-67.

⁷ For an excellent example of the uses of these terms in a sensitive manner, see Rowley, *The Destruction*, Vol. I, Appendix A/B, 'Who is an Aborigine', and Smith, *Aboriginal Population*, pp.341-398.

the adjective 'aboriginal' sometimes appear without capitals because the terms were used as either a noun or an adjective. Where this occurs in the sources I leave the term unchanged. In other places the adjectival form appears in lower case and the proper noun in upper case.⁸

This chapter uses rare government documents and archival materials, together with primary sources created by earlier scholars studying the Aborigines of Western Australia.⁹ The census processes set up by the Commonwealth Bureau of Census and Statistics¹⁰ in 1911 were modified in 1921, when a system of annual returns — produced by police who were Aboriginal protectors — was produced in order to obtain better figures for people in remote areas. The system of counting the State's general population was less complex than that for Aborigines. The Western Australian collection system was based on three zones, each subdivided into statistical divisions made up of several Local Government Areas. For the special Aboriginal census from 1921, the basic collection area was police districts.¹¹

⁸ Wherever possible I follow the *Australian Government Style Manual: For Authors Editors And Printers*, Fifth edition, AGPS, Canberra, 1994, pp.137-144.

⁹ From recent studies, and from the administrative records of Western Australia, these sources come mainly from working documents from scholars compiled for other purposes, Commonwealth Government statistical records, Commonwealth Year Books, state and Commonwealth census record. Also, I make use of forms used for the Aboriginal census after 1921 (although I use only total figures in this chapter) by Aborigines Department protectors. In addition use is made of Chief Protector's Annual Reports from the late 1890s to 1940. The following study is made as comprehensive as possible, by including the use of selected social indicators from 1901 and 1930s. All figures are clearly marked near the texts and attachments are included as an Appendix.

¹⁰ Hereafter referred to as the Commonwealth Bureau.

¹¹ Commonwealth Bureau of Census and Statistics, WA, *Population Dwellings: Census, 1911 to 1966, Statistical Divisions and Local Government Areas*, 1968, ABS Library Series No. C.S. 312.09941, AUS. WA. These administrative units received funds directly from State contributions. Subsequent chapters describe how bodies such as the Road Boards controlled matters like hospital fees for Aborigines. Some local government districts became municipalities and some Road Board districts changed to shires. Changes in these intricate structures made it difficult for those involved closely with Aborigines to understand the complexities of the relationships that state and local authorities possessed when either dealing with indigenous people or choosing not to do so.

Arrangements for the census changed when statistical divisions came into use in 1928. The new structure was suggested to the Western Australian Government by the Federal Health Council of Australia and was finally adopted by the Commonwealth statisticians to delineate areas of tabulation. For our purposes they remained reasonably stable units of collection.¹² The national census of 1901 conducted by the Western Australian Government in cooperation with the Commonwealth had included the enumeration of Aborigines and half-castes. The second, third and fourth censuses took place in 1911, 1921 and 1933, again with cooperation and consultation between the federal and state governments. The Deputy Commonwealth statistician worked simultaneously for the State and Federal Government, acting as State as well as Commonwealth statistician.¹³

Demography is 'concerned with the...size and characteristics of the...[Aboriginal] population, how they were attained and...'¹⁴ have changed. In accordance with this definition I compile a population profile of Aborigines from 1900 to 1933, and analyses of the age-sex distributions over time. There are scant data on Aboriginal births, deaths and migration, all of which present difficulties. These and other difficulties are explained at length in the chapters dealing with Aboriginal health patterns.¹⁵ Demographic analyses of such data helps explain the impact of

¹² *Ibid.*, pp.2-3.

¹³ Census, 1911, *Statistician's Report*, 1911, CBCS, Melbourne, 1912.

¹⁴ A.H. Pollard, Farhat Yusuf and G.N. Pollard, *Demographic Techniques*, (3rd edn), Pergamon Press, Sydney, 1991, p.1; see also, G. Hugo, *Australia's Changing Population: Trends and Implications*, Oxford University Press, Melbourne, 1986, pp.1-41; see also, David Coleman and Roger Schofield (eds), *The State Of Population Theory*, Blackwell, 1986, pp.1-14; see also, D. Lucas, P. McDonald, E. Young, C. Young, *Beginning population studies*, ANU Press, Canberra, 1980; see also, D. Lucas and Penny Kane, *Asking Demographic Questions*, ANU Press, Canberra, 1985.

¹⁵ P.M. Moodie, *Aboriginal Health*, ANU Press, Canberra, pp.27-42.

the urban, pastoral and industrial expansion into the indigenous peoples' living places.

The size of the Aboriginal and half-caste populations presented difficulties for two main reasons. First, government administrators dealt with those who needed relief and they primarily saw Aborigines as being people of full descent. Second, property owners used stock workers who were mainly people of mixed descent who often brought full-blood dependants with them. These two circumstances tended to confuse people in the general public who had no clear understanding of whom they referred to when talking about Aborigines.

In 1898 the Premier, John Forrest, wrote a circular for distribution to all staff by Henry C. Prinsep, Chief Protector of Aborigines. The circular indicated that, in addition to care of the aged, sick and infirm, it was 'desirable that monthly lists...be furnished to the Aborigines Department...[with] as far as possible, information as to the names, sex, ages, and condition of the natives to whom relief has to be given'.¹⁶ Prinsep wrote to tell the Premier, however, that he intended conducting an Aboriginal census, which he planned to complete by 1899; though as things turned out the task remained unfinished until the census 1901.¹⁷ When the seventh census of Western Australia took place in 1901 the Chief Protector's data became the basis for estimating the number of Aborigines living in contact with white settlers. All persons of mixed descent — mainly children — were counted.¹⁸ The count totalled 5,261

¹⁶ John Forrest, 'Copies of Circulars issued by Aborigines Department', 1.5.98, *Colonial Records*, in Battye Library, Perth.

¹⁷ Annual Report, *Aborigines Department*, WAGP, Perth, 1900, p.1.

¹⁸ These children were not regarded as Aborigines and were, in general, referred to as 'wards', as they were in the Northern Territory or New South Wales. See J. McCorquodale, *Aborigines And The Law: A Digest*, ASP, Canberra, 1987, p.23, and see pp.23-37; for a more descriptive analysis see, F. Stevens, *The Politics Of Prejudice*, APCOL, Sydney, 1980, pp.66-75.

people of full and mixed descent. The full-bloods were made up of 2,933 males and 2,328 females (see Table 1.1 in Appendix 1). The half-caste population of 951 was made up of 492 males and 459 females (see Table 1.2 in Appendix 1). The combined population of people of full- and half-descent totalled 6,212, and was composed of 3,425 males and 2,787 females.¹⁹ Despite these figures Prinsep's report to Parliament on 30 June 1901 indicated to the Premier that 'the aboriginal population in all parts of the State...settled in any way by whites must remain the same as that...[given] on the [30]...June 1899 [of] about 12,000.'²⁰ Although Neville's draft annual report of 1932 acknowledged the over-estimation of the Aboriginal population it was never made public.²¹ Most probably the larger figure helped to satisfy Colonial Office inquiries about relations between settlers and Aborigines.²²

The great problem of interpreting the Western Australian data was that the nineteenth century Aboriginal population remained undocumented, most probably because of the extent and rate of settlement as well as the costs of conducting regional censuses. The effect was the inclusion of an estimated 10,000 additional Aborigines living beyond areas not occupied by white settlers. The figures for censuses in 1881 and 1919 were over-estimations, and which the authorities wrongly guessed were 'probably too high.'²³

Those who attended the Sydney conference to plan the 1901 census of State and Commonwealth statisticians must have decided on a strategy for conducting the census. They must also have decided what the

¹⁹ B. Doyle, 'Ethnicity', in Lucas and Kane, *Asking demographic questions*, pp.209-220.

²⁰ Chief Protector of Aborigines, *Annual Report*, 1899, p.1, and *Ibid.*, *Annual Report*, 1901, p.1.

²¹ Battye Library Native Affairs Indexes, AN 1-6, Acc. 1393, file entitled 'Chief Protector of Aborigines Draft Annual Report', p.1.

²² Biskup, *not slaves*, pp.1-44.

²³ L.R. Smith, *Aboriginal Population*, p.156.

Australian Constitution meant in its reference to Aborigines. Fraser, the Western Australian Statistician, attended for his Government. The statisticians there decided to tabulate Chinese, Pacific Islanders, and Aborigines (including half-castes) by placing them in separate tables.²⁴ This allowed for the compilation of data on each group, though in the end the figures for half-castes went into the general population totals.²⁵ The collectors had an 'aboriginal' stamp for stamping cards created for 'natives', whether full-blood or half-caste. It was generally intended to first separate each group from the whole and then reintegrate them later.²⁶ The cards, Fraser explained, had to be made out in duplicate. One copy was stamped 'aboriginal' and was to be included in the general population numbers; the other was set aside in a separate 'full-blood' Aboriginal collection.²⁷

The Western Australian Statistician received advice from the Federal Attorney General that:

consequent upon a decision having been expressed by the Federal Attorney General...full-blooded aboriginals alone were to be excluded from, and not deemed to form part of the legally recognised populations of the different States of the Commonwealth.²⁸

Western Australian statisticians nevertheless continued using a separate card system to prevent collectors including half-caste records in returns for the total Aboriginal population. This enabled people of full Aboriginal descent to be distinguished from half-castes when tabulation took place. Although the 1901 census enumerated full-blood and half-caste people it was a state-based census and the Commonwealth figures as

²⁴ Conference of Statisticians of Australia, *Report*, Part 1, 'Historical', Hobart, 1902, p.5.

²⁵ *Ibid.*, Chapter VI, p.43.

²⁶ *Ibid.*, Part IV, 'Records of Resolutions', see resolution No. 12, from Sydney conference, pp.45-47.

²⁷ *Ibid.*, Part VIII, 'Collection and Compilation', p.80.

²⁸ *Ibid.*, pf.

published in the *Commonwealth Year Book* excluded the full-blood population. Commonwealth figures have always included people defined as half-caste or less. This confusion arose not only from the advice from the Commonwealth but also from the way in which the federal and state administrators interpreted the references to Aborigines in Sections 51(xxvi) and 127 of the Constitution.²⁹ Although analysis of the censuses proceeds with rigour care and caution is therefore required, as in any small population, with the interpretation of the census data on Aborigines, a point raised continually.

Section 127 had a lasting impact on relations between white Australians and Aborigines. It specified that 'in reckoning the number of the people of the Commonwealth, or of a State or other part of the Commonwealth, aboriginal natives shall not be counted'. The derivation of this section, according to one constitutional historian, came from the belief of the constitutional drafters that

the reckoning of 'the numbers of the people' lay in the requirements of the finance clauses, including the cancelled clause concerning federal direct taxation. Not until a late stage of drafting was it decided to place this exclusion in the 'Miscellaneous' chapter, so that it would apply not only to the financial clauses but to 'numbers' on which each State's membership in the House of Representatives would be based.³⁰

²⁹ *Commonwealth of Australia Constitution Act 1900*, (63 and 64 Victoria, c12), in John McCorquodale, *Aborigines and the Law*, p.3, and see p.9, and see also, reference p.201, to Geoffrey Sawyer, 'The Australian Constitution and the Australian Aborigines', in the *Federal Law Review*, Vol. 2, 1966, pp.17-36.

³⁰ J.A. La Nauze, *The Making Of The Australian Constitution*, Melbourne University Press, 1972, pp.67-68; La Nauze agrees with both Smith, *Aboriginal Population*, pp.20-21, and Sawyer, 'The Australian Constitution', 1966, pp.17-36, [and I presume McCorquodale even though he does not consult La Nauze] when he says that, 'Although the origin of the section was a good deal more complicated than is implied by Geoffrey Sawyer in his article...[quoted above] he is completely justified in holding that it had no relevance at all to the taking of the census'. La Nauze is right in his argument about the cause of why the section came to be located where it was in the Constitution. I am addressing the effects. In doing so I am arguing that the interpretive error had a devastating impact on Aboriginal/white relations. I do not take issue with any of the above writers on the cause.

Smith, La Nauze and Sawyer agree on the causes of this historic legal anomaly. The point I make here, however, is that the effects were wide ranging. The full-blood Aborigines were omitted from census publications after 1901, and this affected their long term economic, political, cultural and social status. In turn, their omission allowed government and institutions to omit them from sharing in any new accumulation of the State's resources. The lack of public knowledge about their numbers helped to create the myth of a disappearing race that became all the more difficult to reverse at the end of the period of study.³¹

This omission from census publications created further administrative problems because, as time passed, the issue of 'who was an Aborigine?' became more difficult to resolve. Race did emerge as an issue in some of the debates on the Constitution but was not a dominant issue.³² La Nauze asserts that 'The exclusion...was not based on the impossibility of counting nomads, nor on views about their inferiority'.³³ In addition, the omission appeared to be administrative rather than legal. Administrators such as Prinsep sought funding for their relief and protection program based on the population in need of relief. Winning economic support from Government remained their major problem.³⁴ Similarly, the statisticians cooperated in 1901 because according to the published report, they felt more comfortable once they knew that the census count was to include everyone.³⁵

³¹ Smith, *Aboriginal Population*, p.21; for a political argument on the growth of the full-blood population, see Charles Duguid, *No Dying Race*, Angus and Robertson, Adelaide, 1963.

³² La Nauze, *Making of Australian Constitution*, p.68.

³³ Australian Federation Conventions Conference, *Official Records and Proceedings*, Melbourne, 1890; see also, Convention Conference, *Debates*, Sydney, 1891; Convention Conference, *Debates*, Adelaide, 1897; see also, Federal Convention, *Official Records*, Sydney, 1897; see also, Federal Conference, *Official Records*, Melbourne, 1899.

³⁴ Aborigines Department, *Annual Report*, WAGP, Perth, 1901, pp.1-8.

³⁵ Conference of Statisticians of Australia, *Report*, Part 1, 'Historical', Hobart, 1902, p.5.

Fraser, the Chief Statistician of Western Australia, indicated in his Report of 1904 that the settler population of Western Australia had more than trebled, rising from 29,708 in 1881, to 184,124 in 1901, while the Aboriginal population was small but increasing. The number of Aborigines employed by white settlers in 1881, for example, totalled 2,346 males and females. By 1901 the number increased to 5,261, including the emerging group of half-castes,³⁶ whose total reached 951. The new full-blood total reached 5,261, including 2,933 males and 2,328 females (see Table 1.1 in Appendix 1 and Figure 1.1 below). As I argue below, the females of the two different groups of full-blood and half-caste people suffered the most under colonial rule as revealed by the low numbers of females.³⁷

The conference of statisticians reported that the original intention of state censuses was to include all Aborigines, whether full-blood or half-caste, in the returns of the general population. They sought advice from the Commonwealth most probably because of cost factors associated with census collections. In the same report Fraser indicated that the Federal Attorney General wrote that:

in reckoning the population of the Commonwealth, half-castes are not aboriginal natives within the meaning of section 127 of the Commonwealth of Australia Constitution Act, and should therefore be included.³⁸

In Western Australia, therefore, statisticians adopted two strategies for enumerating Aborigines in 1901. The first involved counting half-caste Aborigines with the general population. The second related to full-blood Aborigines who were to be excluded from the national census. Fraser, got

³⁶ This group was later to be described as half-castes deemed to be Aborigines, and half-castes deemed not to be Aborigines.

³⁷ Fraser, 'WA Statistician's Report, 1901', Chapter XIX, 'Aborigines', pp.203-207.

³⁸ *Ibid.*, 'Aborigines', p.203.

around the problem by including presumed 'full-bloods' under the heading of 'Aboriginals and Chinese'.³⁹

Early in his report on the Aboriginal population, Fraser indicated that at no census prior to 1891 had the term half-caste Aborigines been mentioned as a population category. One explanation for this may have been that the term half-caste formed no part of the official language of Western Australia in censuses between 1848 to 1901. The term came into statistical usage at the time of the Western Australian census of 1891.⁴⁰ As a result, the term did not enter the statistical rhetoric until then even though it had entered the lexicon of Aboriginal protection.⁴¹ Many of the camps, according to visiting protectors who collected the figures, included:

in almost every case, half-caste aboriginals...[who were] brought up and subsequently continue to live with those of full-blood, it appears likely that each census of this State previous to that of 1891 the term 'aboriginal' was used to include both 'full-blooded' and 'half-caste' natives.⁴²

As a result, it was impossible to say how many half-castes lived cheek by jowl with full-bloods before 1901.

At the 1901 census, 110 half-castes lived in the metropolitan region of Perth. Approximately 1,419 persons of mixed descent lived in the south western region of the State. In other parts of the areas settled by whites, the northern areas contained the largest populations of Aborigines — a total of 3,857. The full-bloods among this group numbered 3,618, or 69 per cent of the State total of 5,261. In this census the collectors found difficulty in distinguishing the various racial characteristics of each of the regional groups. The 787 enumerated in the south-west and the 767 in the central-

³⁹ *Ibid.*, pf.

⁴⁰ *Ibid.*, pf.

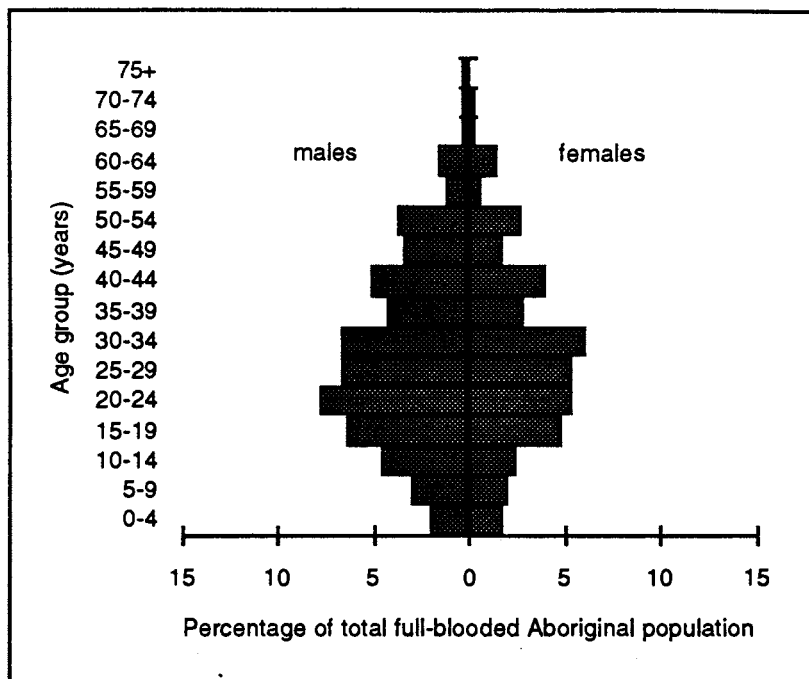
⁴¹ Aborigines Department, *Annual Report*, 1899, pp.1-6; 1900, pp.3-4; 1901, pp.1-8.

⁴² Fraser, 'Report 1901', pp.203-204.

eastern area presented the most difficulty for the collectors, but because of difficulties of identification and classification we cannot really be certain whether these totals included only people of full descent or whether those deemed 'half-castes' were in fact 'full-blood' or indeed 'quarter-caste' or 'eighth-caste' or less. The national census could only locate a total of 89 people of full-descent in the metropolitan area. Of the half-castes counted in the south-west, 632 out of a total of 951 (66 per cent) considered themselves as permanent residents of the region. A further 239 urban residents identified themselves as Aborigines in the north and north-western region. At the same time a further 59 half-castes lived in the central-eastern region, with a further 21 residing in the Perth metropolitan area. Again, self-identification and classification difficulties render the numbers suspect.

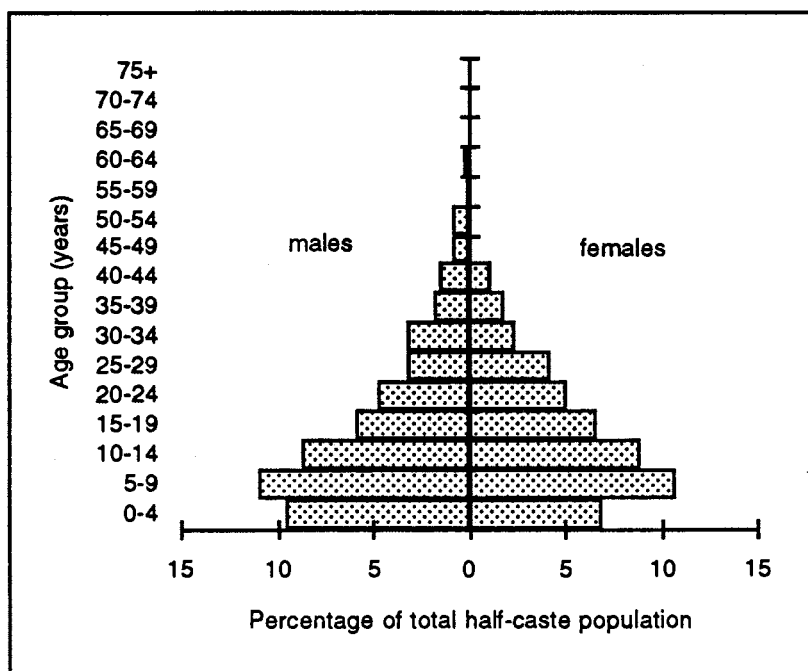
The 1901 census may be analysed further by looking at the age distribution of the Western Australia Aboriginal population (see Figures 1.1 to 1.4). The first thing to notice is that the age-sex pyramid of the full-blood population reveals a rapidly declining population, highlighted by the undercutting of the pyramid in the 0-14 age groups among both males and females. There is also an imbalance of the sexes, with more males than females in all age groups. This may indicate that under colonial conditions females suffered more than males. Colonial contact impacted more heavily on the reproductive capacities of the females who may have merged more readily with European society than males did. This may have caused higher maternal mortality, infertility or even death because of changed lifestyles, diet, health practices, sexual activities and infertility and new patterns of work. Many Aboriginal women moved

Figure 1.1: Full-blood Aborigines by age and sex in WA, 1901



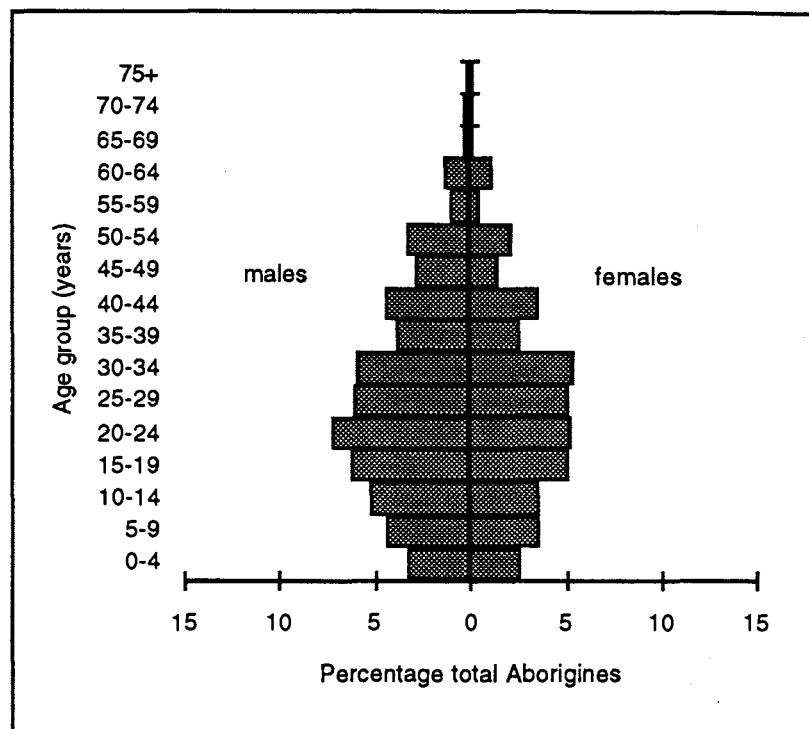
Source: Compiled from Table 1.1.

Figure 1.2: Half-caste Aborigines by age and sex in WA, 1901



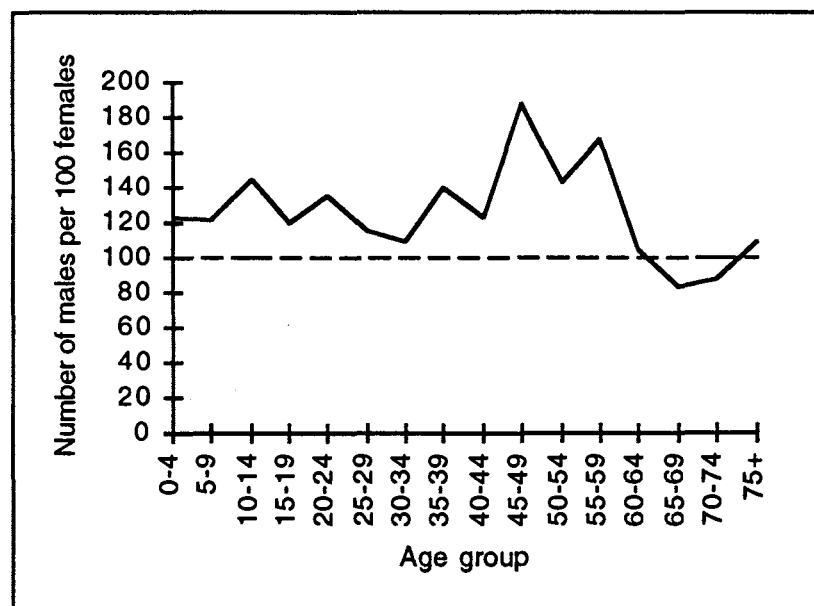
Source: Compiled from Table 1.1.

Figure 1.3: Total full-blood and half-caste Aborigines by age and sex in WA, 1901



Source: Compiled from Table 1.1.

Figure 1.4: Age-specific sex ratio of full-blood and half-caste Aborigines in WA, 1901



Source: Compiled from Table 1.2.

from the bush to domestic life and would have experienced some or all of such changes.⁴³

The pyramid also graphically illustrates the problem of 'age heaping', mainly around the twenty, forty, fifty and sixty age groups. Age heaping tended to occur when either the collector or persons being questioned were unsure how old they were, and a guess by either party was usually rounded to the nearest decadal point. Uncertainty about age by either party also results in a high 'age not stated' category, in this instance 879 full-bloods and 26 half-castes Aborigines of both sexes did not state their age. The 1901 half-caste age-sex pyramid (see Table 1.1, and see Figure 1.2 above) is typical of a young population, even though there is a slight under cutting of the base in the 0-4 age group for both males and females, probably a result of undercounting of young children. Bearing in mind the problems of collecting data on Aborigines, as the graph reflects there were very few half-castes at that time.

The explanation for these phenomena lie in the timing and the pattern of colonisation in Western Australia. Colonisation took place slowly in the period from 1829 to the 1880s. The slow rate at which the settlement expanded in the early decades meant a containment of miscegenation. Following the spread of pearling, gold discoveries and expansion of pastoralism linked by the camel transport systems,⁴⁴ relationships between Aborigines and settlers, who included both Asians

⁴³ A. Grenfell Price, 'The increase in white-Aboriginal mixed bloods', in *Medical Journal of Australia* (MJA), No.2, 1946, pp.557-558.

⁴⁴ Archives Perth WA, see CRS 394/21/7/1858; SSR, 6233/84. These notes are on early development of transportation system and relations with Aborigines and sourced by T.L. McKnight, *The Camel In Australia*, Melbourne University Press, Melbourne, 1969, p.27, and see, pp.90-91.

(Afghans as well as Chinese, Japanese, Filipinos, Malays and others) and Europeans, increased rapidly.⁴⁵

To digress briefly, until the 1940s there is virtually no population in the world in which women have outnumbered men. It is not unusual that Aborigines world reflect human history in that there have always been less Aboriginal females than males. I am not disputing this fact. My purpose in use of sex ratios is to present a descriptive demographic proposal, over the period from 1900 to 1940, that the female component of the Aboriginal population gradually increased over the study period to play a larger part in the latter stages than they did at the beginning. Supplementary to this is the fact that other scholars, as I indicate make the point that Aboriginal females suffered the brunt of colonial settlement, a factor which I also do not dispute.

In the discussion here, therefore, the sex ratio graphs compiled from each census, therefore, indicates a paucity of females. In 1901, for example, males far out-numbered females (see Figure 1.4). Figure 1.4 combines females of both full- and mixed descent and clearly shows a dominant male presence throughout the whole age structure except in the older age groups.

The problem of identification intensified after 1901. Normally the issue only involved males of full-descent who cohabited with females of mixed race descent. That is, a female of mixed descent could be declared a full-blood if at any time she chose to marry a male of full-descent and the female was considered of half- or lesser caste of Aboriginal descent. The

⁴⁵ Aborigines Department, *Annual Report*, 30th June 1901, WAGP, Perth, 1901, p.3; but see also, J.S. Battye, *Western Australia: a History from its Discovery to the Inauguration*, WAGP, Perth, 1925; see also, J.S. Battye, *Encyclopaedia of Western Australia*, WAGP, Perth 1913; J.S. Battye, *The History of the North-West of Australia*, WAGP, 1915; see also, G.C. Bolton and D. Hutchinson, 'European man in south-western Australia', in *Journal and Proceedings of the Royal Society of Western Australia*, 1(2), pp.50-59; see also, J.C. Caldwell, 'Population', Chapter 2, in Wray Vamplew (ed.), *Australians Historical Statistics*, Fairfax, Symes and Weldon, Sydney, 1987, pp.23-26.

1905 Aboriginal protection legislation delegated powers to the protectors for determining who were full-bloods or half-castes, or those definable at all as an Aborigine.⁴⁶ With the power to identify married couples thus residing with the protectors, the individual's racial status became subject to official whim. For instance, if a half-caste married another person of less than half-caste descent individual protectors could change his or her status as Aboriginal by subjective administrative decision based on an 'educated guess' at best, or on the caprice of personal prejudice.⁴⁷ This factor may have contributed not only to the fluctuating numbers of Aboriginal women (see Tables 1.1 and 1.2 in Appendix 1), but also to the huge peaks and troughs in the ratios of males to females (see Figure 1.4). The excess of males in the 40-60 age groups highlights the point made about the impact of colonialism on Aboriginal women.

Based on the collected data (see Table 1.1), it appears that the chaotic demographic aspects of the Aboriginal population during the period reflect a range of complex changes in the geographic, economic, political, cultural and historic circumstances of both Aborigines and settlers, and needs cautious interpretation. First, the colonial governments, their protectors of Aborigines and individual settlers found difficulty in knowing how to assess people of mixed-decent.⁴⁸ Second, in the Murchison, Pilbara and Kimberley regions, in particular, the burgeoning

⁴⁶ For an important discussion on this phenomenon, see, Rowley, *The Destruction*, Vol. I, pp.365-368, and see also, F. Lancaster Jones, *Structure of Aboriginal Population*, pp.6-13, for Western Australia see *Aborigines Act, 1905* (no. 14, of 1905). This legislation, among other things, defined persons deemed to be Aborigines which included an Aboriginal inhabitant of Australia and half-castes or their children.

⁴⁷ Fraser, 'Report 1901', see Chapters XIX under headings on 'Population and Habitation', p.100, and p.131, and 'Aboriginals', pp.203-207.

⁴⁸ Lancaster Jones, *Structure of Aboriginal Population*, pp.6-13.

mixed race populations⁴⁹ could not readily understand their fluctuating official status.⁵⁰

Soon after the 1901 census the Commonwealth Government began preparing itself for its first national federal census in 1911. Section 127 of the *Commonwealth Constitution Act 1900*, influenced administration of the *Census and Statistics Act 1905*.⁵¹ The Commonwealth Attorney General advised the States on how to interpret Sections 51(xxvi) and 127 regarding Aborigines. As indicated above, bureaucratic interpretation rather than legal intention meant that full-blood Aborigines were omitted. The 1911 census provided the Commonwealth with the opportunity of clarifying its own view on who could be defined as an Aborigine.⁵² In Western Australia the Aborigines Department continued to conduct its own count of full-bloods and half-castes, at least among people living within what it called the civilised areas. In this sense the Western Australian Government positioned itself well to participate in the 1911 census.⁵³ But, how individual collectors would act in gathering and how the statisticians would interpret the Aboriginal data remained a problem despite attempts to make corrections to refine the process.

The 1911 census was the first census conducted under the auspices of federal census legislation. It revealed that the Aboriginal population in settled areas of Western Australia appeared to increase to 7,844. The total

⁴⁹ Appendix 1, see Table 1.2; this table reveals a growing half-caste population. Figure 1.2, shows clearly the age structure increases relative to contact with white settlers.

⁵⁰ The 'Travelling Inspector's' reports and Police Protectors' collected from sheep properties make clear distinctions between the numbers of 'natives' and 'half-castes' either on ration relief or resident on the properties visited.

⁵¹ British Parliament, *The Commonwealth Constitution Act 1900*, (63 and 64 Vic. c.12), in McCorquodale, *Aborigines And The Law*, p.3, and when seen in the context of S51 it is possible to appreciate that S127 clarifies the financial clause which became a matter of misplaced interpretation.

⁵² Statistician's Report, *Census of the Commonwealth of Australia, 1911*, Bulletin No. 1, 'Population of States and Territories Report'.

⁵³ For an example of annual accounts, see *Protector's Reports, 1905-1910*.

included 6,369 full-bloods and 1,475 half-castes. The former included 3,433 males and 2,936 females and showed a smaller rate of increase over the 1901 figures. The half-castes, on the other hand, had nearly doubled. This trend appears to continue throughout the whole period from 1901 to 1933, as the half-caste growth rate appeared to out-strip the reported marginal increases experienced by the full-blood population. The population of full-bloods in 1911 showed an increase of males by nearly 500, rising from 2,936 in 1901 to 3,433 in 1911. At the same time female numbers grew from 2,328 in 1901 to 2,936 in 1911, an increase of 608. The rate of growth for males and females was thus 17 per cent and 26 per cent respectively. Of note also was the growth of the half-caste population, which appeared to increase markedly: half caste males increased by 54 per cent and females by 56 per cent during 1901-1911. The faster growth of the half-castes should not have been unexpected for several reasons. First, a younger population has lower mortality than an older one. Second, the parents of mixed descent children were from both the full-blood and half-caste groups, or were people of full or mixed descent cohabiting with whites. Third, full-bloods (normally females) gave birth to children of mixed descent when cohabiting with settlers (normally European males but also often Asian).

The Royal Commissioner in reporting on 'The Condition Of The Native' in 1905, extensively discussed the burgeoning half-caste problem.⁵⁴ In doing so, the underlying assumption prevailed that people of full-descent, and of mixtures of other races and Aborigines, were certainly suffering similar difficulties, as they lived and worked together either on properties as pastoral labourers or in bush camps as 'nomads'. The sharing of half-caste women had become customary among both

⁵⁴ Western Australia Parliament, *Report By The Royal Commission on The Condition of The Natives*, WAGP, Perth 1905.

white and half-caste adult males by this time. This custom resulted in the birth of many children of mixed descent. As I show in later chapters, travelling protectors reported 'abandoned' children in camps and removed them to missions for care by missionaries. Abandoned children concerned the Royal Commissioners of 1904-5 and 1934-35. Those witnesses supplying evidence about abandoned children spoke at length of this problem to inquiries held in the 1920s and 1930s.⁵⁵ The poor living conditions forced the Royal Commissioner of 1905 to recommend common treatment and a common policy of government services. It was this redirection of approach which resulted in full-bloods and half-castes being treated either as equal to each other or as one and the same race. As I discuss later, the economic benefits available to people of full descent were denied to half-castes. Half-castes had been prevented from gaining subsidised access to hospitals, receiving treatment by medical practitioners at government expense or receiving rations at some (mostly northern) depots.⁵⁶

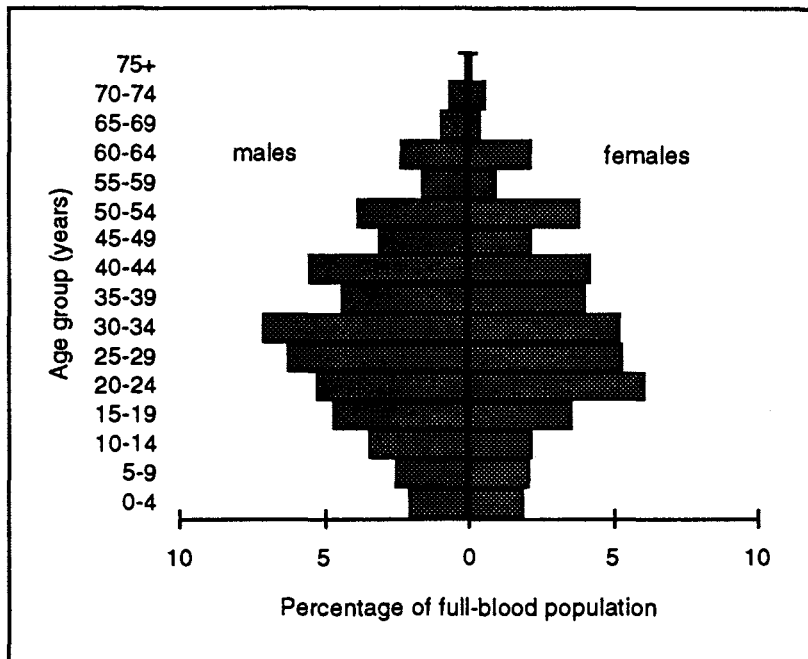
Although federal and state bureaucrats interpreted the Commonwealth Constitution as requiring the omission of people of full descent from census publications, the Western Australian Government still collected its own data as a means of estimating the numbers of people living within its borders. The Commonwealth meanwhile continued to include people of half-caste or less descent in the census reports but people considered to be full-bloods were omitted.⁵⁷

In conducting the census of 1911 authorities employed the same strategies in counting Aborigines, and incorporating the same anomalies,

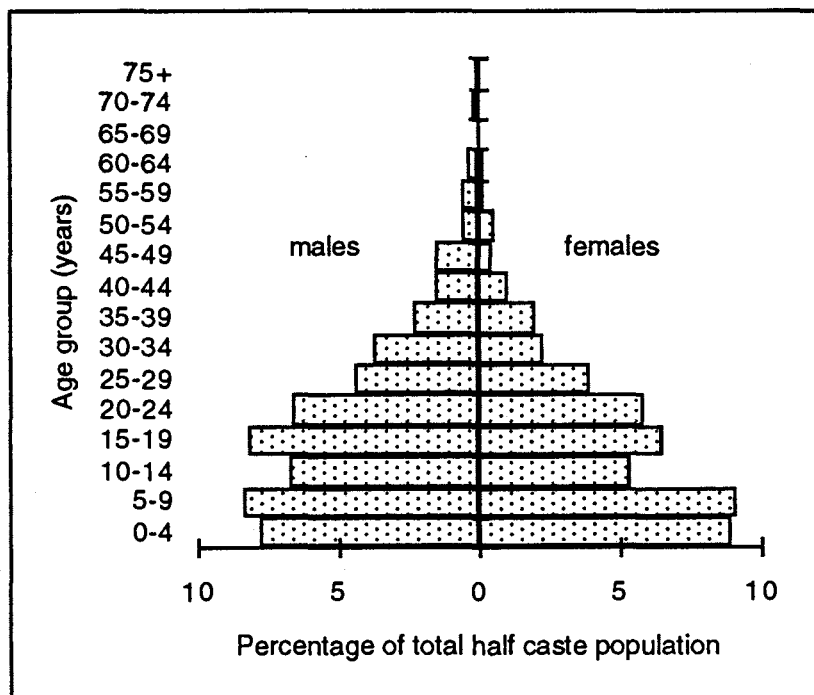
⁵⁵ *Ibid.*, pp.25-32; see transcripts of evidence, 'Appendix B', pp.34-121; see also, Biskup, *not slaves*, pp.45-95, for cause and effects and other detail of Royal Commissions.

⁵⁶ *Ibid.*, pp.1-32; see also, Biskup, *not slaves*, pp. 67-75.

⁵⁷ ABS, 'Population and Dwellings: Census, 1911 to 1966', p.3.

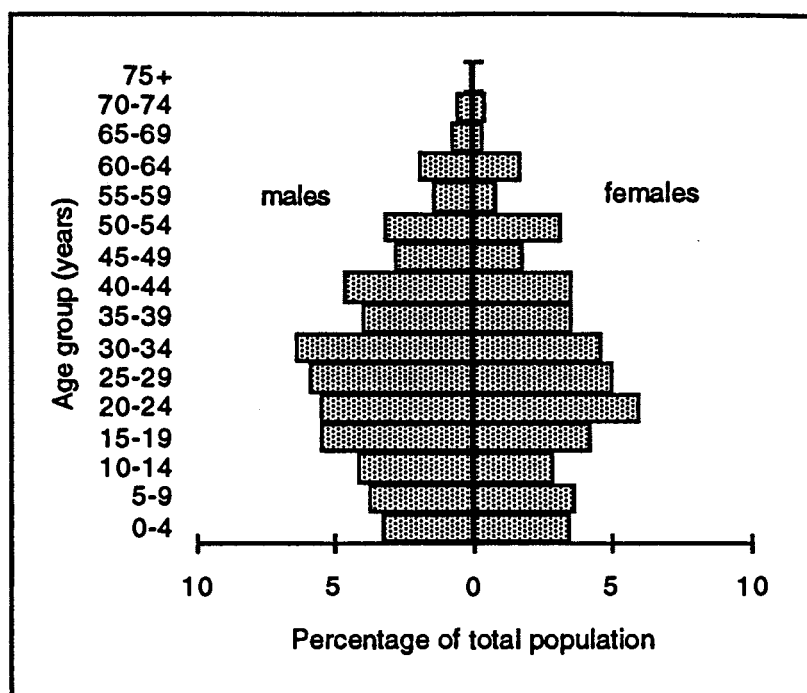
Figure 1.5: Full-blood Aborigines by age and sex in WA, 1911

Source: Compiled from Table 1.3.

Figure 1.6: Half-caste Aborigines by age and sex in WA, 1911

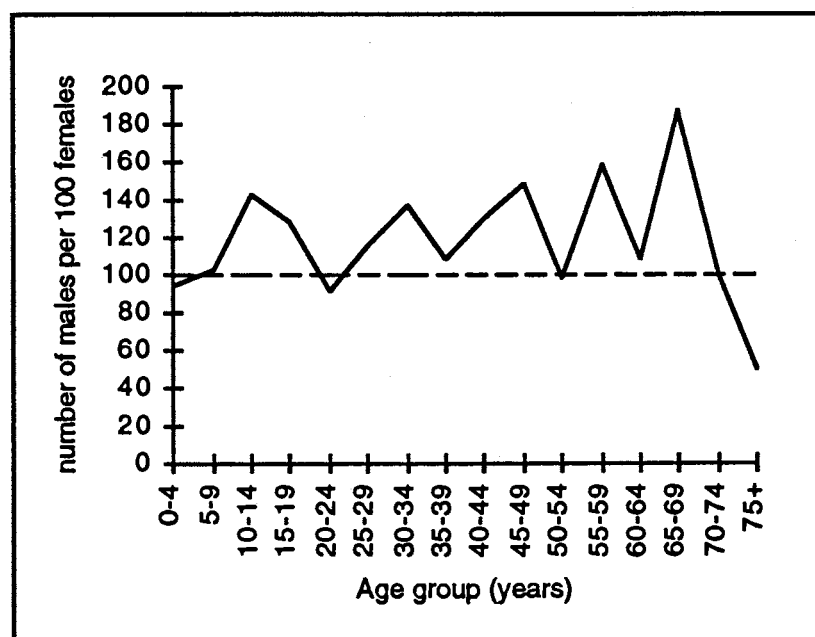
Source: Compiled from Table 1.3.

Figure 1.7: Total full-blood and half-caste Aborigines by age and sex in WA, 1911



Source: Compiled from Table 1.3.

Figure 1.8: Age-specific sex ratio of full-blood and half-caste Aborigines in WA, 1911



Source: Compiled from Table 1.3.

to that for 1901. The census tabulations show the total Western Australian full-blood population as 6,369 persons: i.e., 3,433 males and 2,936 females. As in 1901, the age distribution shows the numbers of full-blood females fluctuating. For example, in the age groups 30-65, numbers rose and fell rapidly. This could have meant either age heaping as described above or a continuing high mortality among full-blood females. Similarly, it could have meant that half-caste females moved between the groups for a number of decades, or from the mid-nineteenth century (see Figure 1.5 below, and Table 1.3 in Appendix 1).

At the same time, there were 1,475 half-castes, consisting of 760 males and 715 females (see Figure 1.6, Tables 1.3 and 1.3 in Appendix 1). In contrast to the full-blood population, the half-caste population presented a young age structure, with a continuing increase in the 0-4 age groups (see Figure 1.6). As in 1901, full-bloods continued to show a declining population in the 0-14 age groups, with the deficit in female children (see also, Figure 1.1). At ages 50 to 75 and above there were still more full-bloods than half-castes for the same reason as in 1901 (see Table 1.3). Both census results highlight the problem of age heaping around the ten year age groupings (see Figures 1.5 and 1.6).

The combined population of full-bloods and half-castes shows a trend towards a more normal population structure (see Figure 1.7), although the sex ratio of the total population shows a continuing preponderance of males. While still heavily weighted towards males in the older 50 to 69 age groups, signs existed then that the imbalance of Aboriginal males to females had disappeared in the younger age groups (see Figure 1.8).

It is noteworthy that the new Chief Protector, C.F. Gale, made no mention of these trends in reporting the census results.⁵⁸ In his 1912 report, however, Gale included a summary of the police district collection reports. These reports gave a brief statement of the physical health and condition of Aborigines of both full-blood and half-caste descent. Similarly they provided information on their total numbers including data on the numbers employed on pastoral properties.⁵⁹ O.A. Neville mentioned a comprehensive census conducted in 1919 of all Aborigines in Western Australia in his 1920 report as Chief Protector of Aborigines, but records of the special Aboriginal censuses from the 1919 to 1923 were either disposed of or lost.⁶⁰

When the 1921 census took place the full-bloods were still omitted from the final Statistician's report. The blame rested with both the Western Australian Government and the Commonwealth, who had failed to cooperate in the period proceeding the census.⁶¹ As usual, all those persons classified as half-caste made the count as part of the general population. The difference between the two earlier censuses and 1921 was that data on the full-blood population was neither processed or published. Half-castes males, at the same time, increase by 341, from 1911 to 1921, when the total rose from 760 to 1,101 (see Table 1.3 and Table 1.5 in Appendix 1). Half-caste females rose from 459 in 1901 to 859 in 1921, an increase of 400 (see Table 1.1 and 1.5). The half-caste male population grew by 45 per cent and the female population had risen by only 20 per cent during the 10 year inter-censal period. This difference in increase from one period to the next was most probably due to the movement of

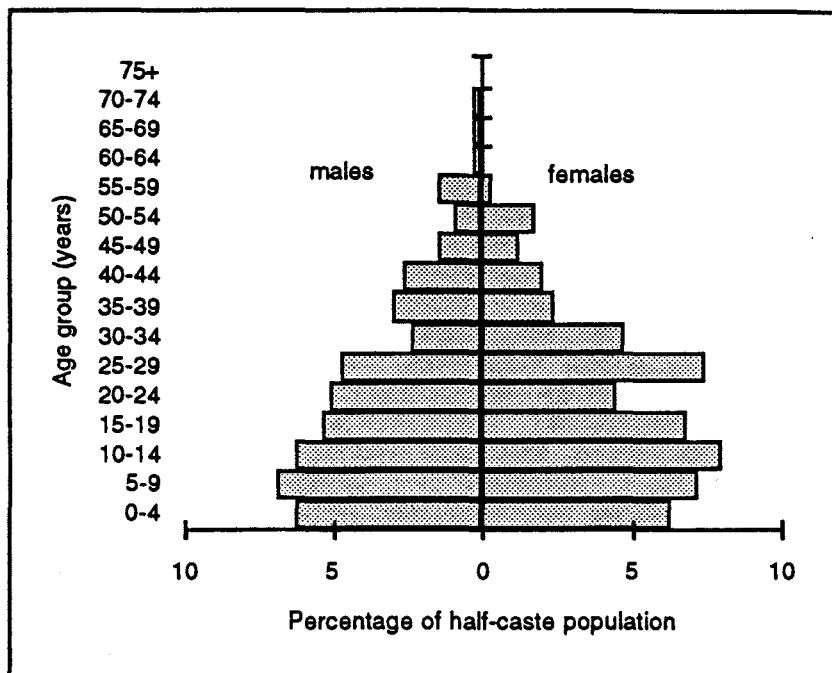
⁵⁸ Chief Protector, *Annual Report* 1911, WAGP, 1912.

⁵⁹ *Ibid.*, 'Annual Report', 1912, pp.2-3.

⁶⁰ Chief Protector, *Annual Report*, 1920, p.11-12.

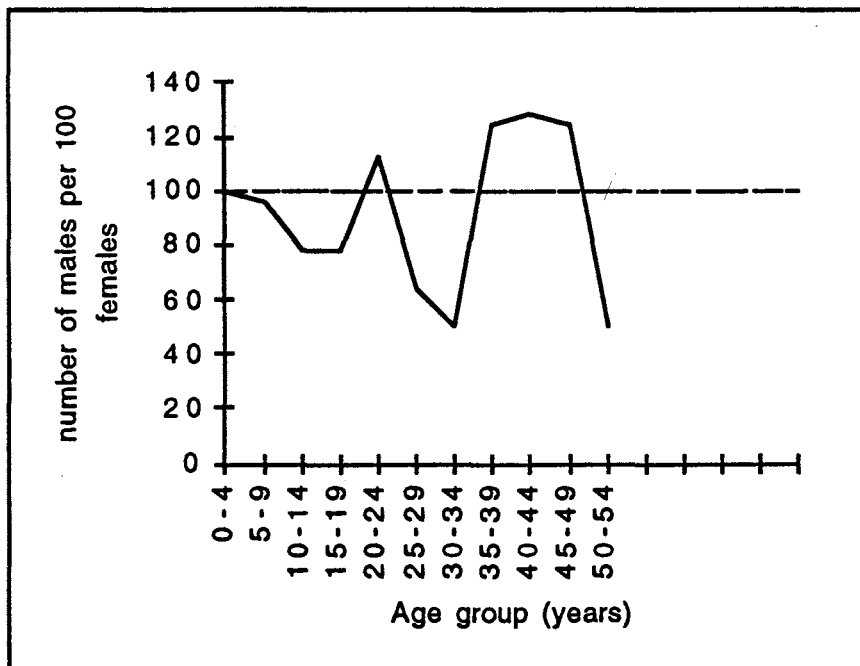
⁶¹ According to the Bureau of Census and Statistics Library these records no longer exist.

Figure 1.9: Half-caste Aborigines by age and sex in WA, 1921



Source: Compiled from Table 1.5.

Figure 1.10: Age specific sex ratio of half-caste Aborigines in WA, 1921



Source: Compiled from Table 1.6.

* No figures for full-blood Aborigines available.

Aborigines between the internal Aboriginal component groups. The half-caste females, for example, may have been moving from one racial and cultural group to others in search of, or leaving, marriage partners. Some females took male partners who were either white or nearly white and then experienced the difficulties of identification because of their choice of marriage partner. Where some people took their partner's racial and social identity they experienced a change in their racial status.

Of the two component groups — full-blood and half-caste⁶² — the half-caste males and females increased in all stages at a faster rate than the full-bloods. The reason could have been the blurring of the racial divisions between full-bloods, those deemed to be half-caste and those half-castes deemed not to be Aborigines. The population pyramid for 1921 (see Figure 1.9) for the half-caste population was typically young. Moreover the pyramid suggested that half-castes reflected their historic demographic relations with white settlers. For instance, during the period 1921 to 1933, the half-caste population pyramid of 1933, for the first time since about the 1840s began to accumulate older people in the 50 to 75 plus age ranges (see Figure 1.13, see Table 1.13).

Additionally, the full-blood population posed the greatest problem for observers because, by 1933, their population pyramid showed characteristics of a stationary population but prompts the notion that they were under great social stress. On the one hand, the total full-blood population appeared to display a long term trend of decrease. On the other hand, after 1933 the full-blood female population appeared to be trending downwards, but in fact in the period from 1901 to 1933, full-blood females had grown by nearly 100 per cent (see Figure 1.15, and Table 1.17). In spite of this real increase, the full-blood female age sex pyramid

⁶² Lancaster Jones, *Structure of Aboriginal Population*, p.8. Jones suggests about eight ethnic arrangements were possible.

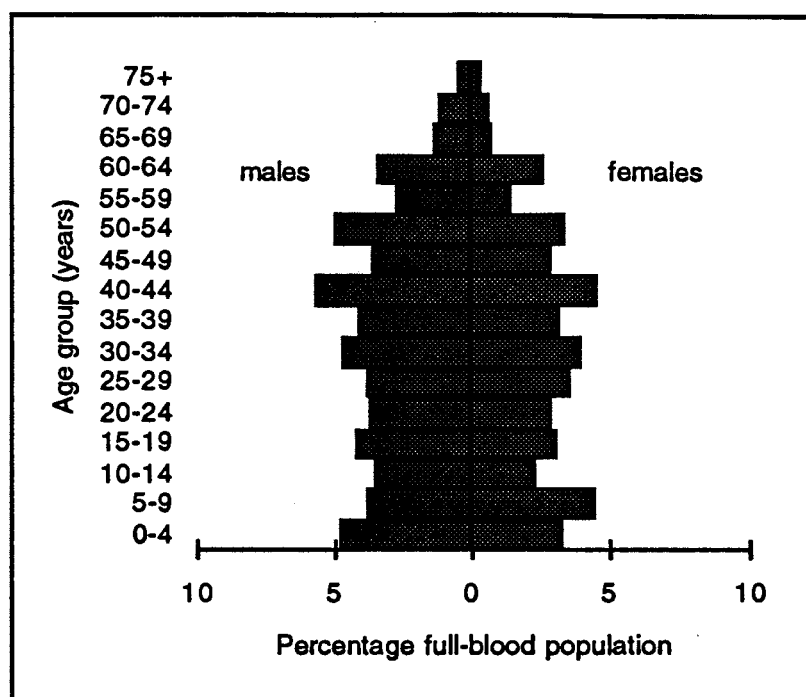
showed characteristics of a population that had been declining over a number of years (see Figure 1.11). The general beliefs was that full-bloods were disappearing while half-castes were on the increase. However, by the 1933 census, the full-blood population pyramid was beginning to take a normal shape. Put another way, what emerged was a mature age-sex distribution. In addition, the whole of the state, except the extreme eastern sections, had been fully settled by the 1930s. Rumours and reports of death by disease and violence persisted.⁶³ Equally, large groups began living in supervised camps, missions and work-camps on pastoral properties that restricted their mobility and kept them away from rural and pastoral towns and service centres thereby restricting them from the view of settlers. Even so, the increased mobility in the 1930s applied mostly to males rather than females. As such males moved around from one employer to the next and in proximity to settler pastoralists, mining company operations and emerging or established missions. Because of the changes in the mode of subsistence and dwelling places the lines dividing traditional practice and the ethno-racial differences became either increasingly more difficult to maintain, or for the younger females to understand.⁶⁴

In the years from 1933 to 1940 camp groups supervised either by travelling protectors or by missionaries and pastoralists became more numerous. Populations of male and female half-castes, despite their small numbers, emerged as the more politically dominant grouping of

⁶³ See Chief Protector, Battye Library Native Affairs Indexes, AN 1-6, Acc. 1393, file entitled, 'Chief Protector of Aborigines Draft Annual Report', pp.1-50; see also, Western Australian Government, *Royal Commission of Inquiry into Alleged Killing and Burning of Bodies in Eastern Kimberley and into Police Methods when effecting Arrests*, WAVP, WAGP, Perth, 1927, Vol. I, p.xv; see also, R.D. Moseley (Royal Commissioner), *Report of the Royal Commission appointed to Investigate, Report and Advise upon Matters in Relation to the Condition and Treatment of Aborigines*, WALAV&P, WAGP, Perth, 1935, pp. 5-6; see also, Rowley, *The Destruction*, pp.300-304.

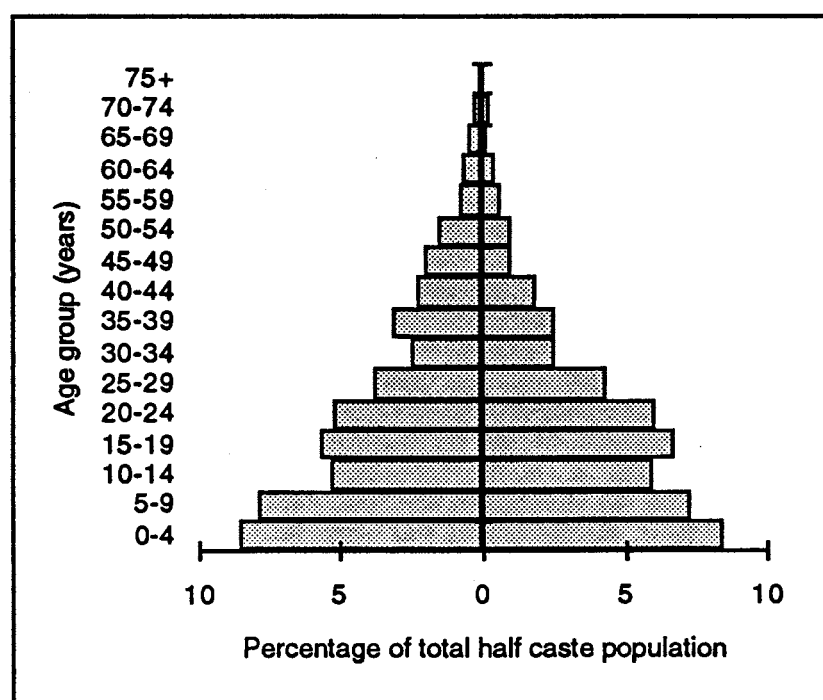
⁶⁴ Mosley, 'Royal Commission Report 1934-35', pp.5-6, and pp.16-17.

Figure 1.11: Full-blood Aborigines by age and sex in WA, 1933



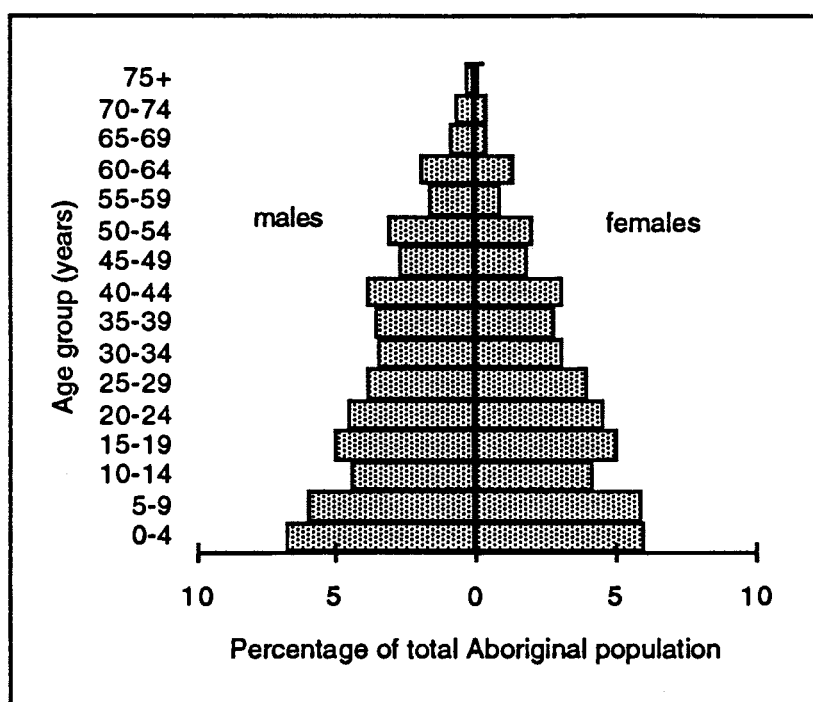
Source: Compiled from Table 1.8.

Figure 1.12: Half-caste Aborigines by age and sex in WA, 1933



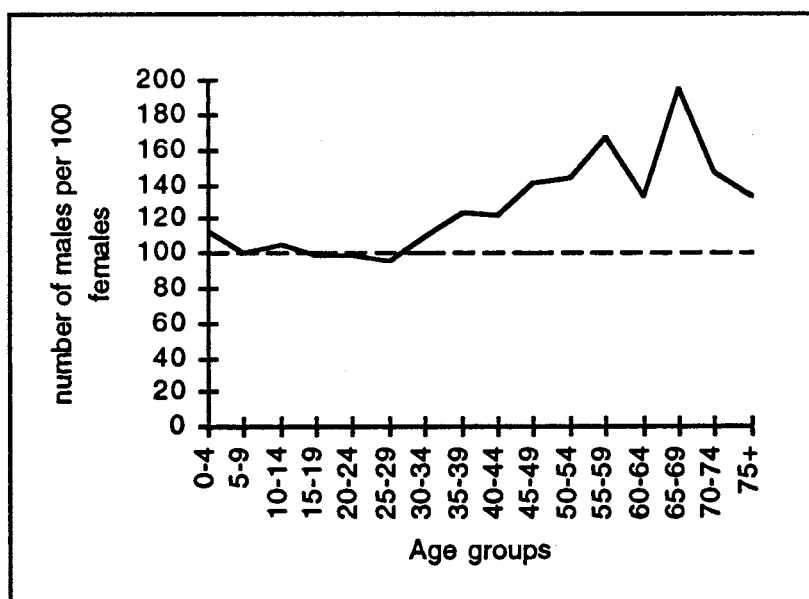
Source: Compiled from Table 1.8.

Figure 1.13: Total full-blood and half-caste Aborigines by age and sex in WA, 1933

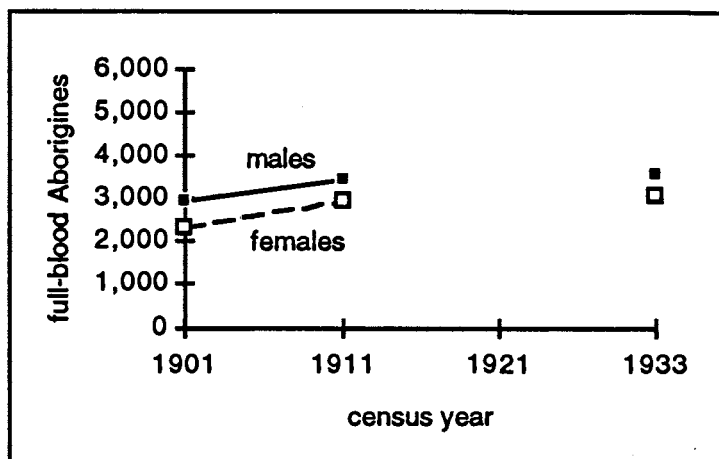
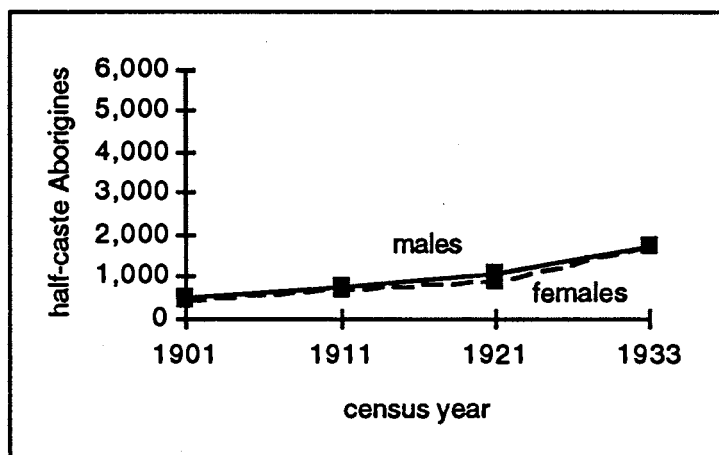
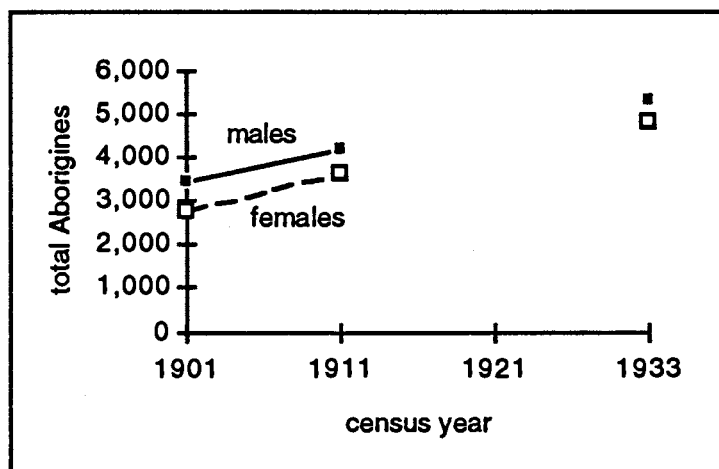


Source: Compiled from Table 1.8.

Figure 1.14: Age-specific sex ratio of Aboriginal and half-caste population in WA, 1933



Source: Compiled from Table 1.9.

Figure 1.15: Full-blood Aborigines in WA, 1901-1933**Figure 1.16: Half-caste Aborigines in WA, 1901-1933****Figure 1.17: Total Aboriginal and half-caste population in WA, 1901-1933**

Source: Compiled from Table 7.1, 'Time Series of population' for 1901-1933.

the components of the Aboriginal population. The females of this new group had a wider choice of partners than in 1901. For example, half-caste males could gain sexual partners from full-blood groupings, either by taking a female of full- or half-caste descent. It became possible for half-caste females to move from one group to another sometimes without changing their racial definition. A feature of the census reports from 1901 to 1933, was references to the dominance of half-caste women as both bread-winners and marriage partners because of their increasing cohabitation with a number of other racial (such as Afghans, Asian and full-blood) male groups.

Similarly, as a further explanation for the increasing maturity of the 1933 age-sex pyramid, fewer numbers were registered in both the 0-14 age groups. The older males and females in the 50 to 54 age groups began to show that government protection policies appeared to be helping them prolong their own and their childrens' lives (see Figure 1.11, and Table 1.15 in Appendix 1). From 1901 to 1933 full-blood males increased by 27 per cent from 2,933 to 3,570. The number of full-blood females rose from 2,328 in 1901 to 3,093, an increase of more than 33 per cent that showed up starkly in the 1933 census enumeration. Added to this is the evidence in the age-sex pyramid of 1933 that equal numbers of male and female babies made up the 0-4 age group. In the 5-9 age group, and the 25-29 age group there are similar male and female numbers. But there are many more males than females in the 35-40 age group. The underlying cause of the latter imbalance is difficult to answer. This is so because it appears that the identification problem and group swapping strategies adopted by Aboriginal females generally lead to a better quality of life under the Government's protection policies. Taking account of the general position that, throughout human history, all society have experienced a lower

population of females, nevertheless, during the period prior to federation, Aboriginal females most certainly suffered more diverse suffering than their male counterparts.⁶⁵

Other developments relevant to the demography of Aborigines in Western Australia included action by the Commonwealth Bureau of Census and Statistics in the census of 1933, which acted to improve their systems for estimating Aboriginal populations. In addition, Aboriginal censuses were conducted each year from 1921 to 1944, and the 1934-35 Royal Commission into the condition and treatment of Aborigines heightened people's awareness about Aborigines in the north of the State.

The census authorities made no attempt to develop a special collection methodology. For instance, the methods of counting people in bush camps did not improve although authorities knew about many of the difficulties.⁶⁶ The accuracy of the count was often impaired because collectors waited for bush groups to come to them rather than for collectors to go out searching for bush people.⁶⁷ Nevertheless, some attempt to count Aborigines did occur but the dangers of bush travel have to be borne in mind when assessing the value of their actions. Collectors such as police magistrates, missionaries, travelling protectors and pastoralists knew the dangers of the bush and most certainly appreciated that bush travel could be unsafe in some areas. Many collectors were police or court officials who knew where the isolated campsites were located. Those people involved in collecting the numbers of Aborigines

⁶⁵ A. Grenfell Price, *White Settlers and Native Peoples*; see also, Fay Gale, 'A Study of Assimilation', unpublished Ph.D. thesis, Adelaide University, 1964; see also, Rowley, *The Destruction*, Vol. 1; see also, Dianne Barwick, 'Changes in the Aboriginal population of Victoria 1863-1966', in D.J. Mulvaney and J. Golson (eds), *Aboriginal man and environment in Australia*, ANU Press, Canberra, 1971, pp.288-315.

⁶⁶ Smith, *Aboriginal Population*, pf.

⁶⁷ Smith, *Aboriginal Population*, pf.

in outlying regions must have been aware of the high level of mobility of bush people.

The Western Australian Government had conducted a comprehensive Aboriginal census each year beginning in 1919 and then each year until 1944. The data collected in the years 1919 and 1921 have never been located.⁶⁸ We do know, however, that wide cooperation occurred between governments after 1921. The figures must, nevertheless, be approached with caution. For example, although the number of Aborigines increased, in Western Australia the figures fluctuated wildly.⁶⁹

During the period 1921-1940, minor fluctuations in the total populations occurred from one Aboriginal census to the next (see Figures 1.15 to 1.17, and Tables 1.10 and 1.11, on the Aboriginal Census data 1921-1940 attachment). During the same period the total half-caste population continued to increase rapidly. In part, the answer to why some of these fluctuations occurred lay with the mobility of rural populations, which presented huge enumeration problems for the collectors. In part also, collectors had problems defining the individuals they were sent to count. They were not so much problems but difficulties experienced after Aborigines themselves made the choice about with whom they wanted to live. If collectors lacked bush experience they came upon differences with every Aboriginal group they faced, especially as they went eastwards into the outback.

Despite the demographic problems mentioned above, at least an effort was made by the State and federal authorities to collect data on Aborigines even though problems remained. The age sex distribution

⁶⁸ Smith, *Aboriginal Population*, p.35.

⁶⁹ See *Western Australian Year Book*, where results are published.

compiled from the 1921 census reflects the kinds of collection problems already mentioned. Even though the numbers and increases were still small, half-caste age structures showed a greater trend towards normality, as revealed in the 1911 age structure pyramid (see Figure 1.7). In addition, although there was a rise in the total numbers of males and females, the proportion of infants fell. Similarly, changes in the Western Australian ratios of Aboriginal males to females appear to strengthen in favour of females in both years 1911-1933 in the 15 to 24 and 50 to 54 age groups in particular (see Figures 1.3 to 1.17 above, and Tables 1.1 to 1.19). Finally, the Aboriginal census counted only those people defined as either half-caste or as full-blood, and this development proved a significant move.⁷⁰

The *Australian Year Book*, stated that:

although still incomplete, [the Aboriginal census] probably represents a much closer estimate than has been available previously....The most serious defect...is an estimate of 10,000 Aboriginals which the Chief Protector of Western Australia regards as out of touch with his Department and consequently not included in figures supplied by him.⁷¹

Even when the 10,000 Aborigines out of contact are deducted the figures appear much higher than earlier counts of the 1901, 1911 and 1921 official census enumerations. The figures tabulated by Smith⁷² and reproduced in Table 1.10, show the way in which census estimates of 'full-bloods' were adjusted upwards to correspond with the total population estimated by the State at all censuses to 1961. The 'half-caste' figures (see Tables 1.10 and Table 1.11 under 'Other') are reasonably consistent.⁷³

⁷⁰ *Australian Year Book*, No. 14, 1921: p.1128. Referred to in Smith, *Aboriginal Population*, pp.58-60.

⁷¹ *Ibid.*, pf. For other sources see *Australian Board of Missions Review*, 'Aboriginal Census', March 1933; see also, *American Journal of Physical Anthropology*, 'Aboriginal Census of Australia', 1927, No. 10, pp.486-489.

⁷² *Ibid.*, p.166. See also, a reproduction of these figures in Table 1.6. Figures in Table 1.7 are compiled by me from ABS publications.

⁷³ *Ibid.*, p.156.

The Aboriginal Censuses from 1921 to 1940 are presented in two differing tabular forms. Table 1.10 gives the total counts for persons of full descent and others, and includes a figure of an additional '10,000' people of full-descent (the figure causing the over-estimation just discussed). Table 1.11 does not include the 'additional 10,000' (see Figures 1.18 and 1.19 and 1.21 to 1.23 below). This Aboriginal census showed the total number of Aborigines decreasing from 27,671, in 1921, to 24,028, in 1924, while the return excluding the estimated 10,000 persons declined from 17,671 to 14,028. Both sets of figures reveal inconsistencies. The totals rose sharply from 26,507 in 1931 to 29,298 in 1933, followed by a sharp decline to 26,515 in 1934. The only group with any consistency were the half-caste groupings (see the heading "Other", in Figures 1.18 and 1.19). When the figures are combined they show the effects of the slight bulge in male and female counts (see Figure 1.20).

In 1932 the Chief Protector felt it was time to question or explain the missing 10,000 that had been such a problem since the mid-nineteenth century.⁷⁴ Under the heading "Population",⁷⁵ Neville indicated that Aboriginal numbers had grown from 26,727 to 28,481 in the past year. The latter figures comprised 14,766 full-bloods, 3,715 half-castes and the additional figure of 10,000. There had thus been an effective increase of 1,754. He observed that it could

be assumed that many natives hitherto regarded as being outside the confines of civilisation have...now been included amongst the known population, pointing to the necessity for revision of the figures given as 10,000 supposed to be still living beyond the fringes of settlement throughout the State.⁷⁶

⁷⁴ Battye Library Native Affairs Indexes, AN 1-6, Acc. 1393, 'Neville's Draft Annual Report', pp.1-50.

⁷⁵ Neville, 'Draft Annual Report', p.1.

⁷⁶ *Ibid.*, p.1.

The increase of 1,754 was real enough but as Neville pointed out, the 10,000 Aborigines supposed to be living beyond civilisation distorted the picture. The bulk of the Aboriginal population was not, as it has been historically suggested, in the Kimberley region but elsewhere.⁷⁷ There were 9,893 people in the Kimberley, which takes account of the 'bush natives'. Elsewhere in the State there were 3,447 natives from Perth to the Pilbara and a further 5,141 in the region south of Perth and eastwards towards the eastern goldfields and the South Australian border.⁷⁸

The Chief Protector's reversal of attitude towards the elusive 10,000 had its own underlying rationale. In continuing his report Neville conceded that the efforts of the State Government to provide long term relief and protection had failed. He wrote that it 'cannot be contended that the condition of the natives improved during the year.'⁷⁹ The obligation of providing relief had increased considerably. This he argued showed that the southern natives had 'never before...sunk to such a condition of penury.'⁸⁰ At the same time, both Neville and H.D. Moseley, the Royal Commissioner who wrote the report of the 1934-35 inquiry into the condition of West Australian Aborigines, believed that people of full-descent were disappearing. As Moseley's report observed,

while it appears beyond doubt...that the full-blooded aborigines are decreasing in number, it is...certain that the half-castes are multiplying rapidly....As to the numbers of natives in the State, it has been impossible for me to estimate this in any way, but, taking the Departmental figures as being as accurate..., there appear to be 29,021 natives throughout the State. Of these, 10,000 are included as "bush natives".⁸¹

⁷⁷ *Ibid.*, p.2.

⁷⁸ *Ibid.*, p.f.

⁷⁹ *Ibid.*, pf.

⁸⁰ *Ibid.*, pp.2-3.

⁸¹ Moseley, 'Royal Commission Report 1934-35', p.3.

Moseley went on to indicate how many Aborigines lived in various regions of the State. The Kimberley had 10,015; the north-west near Carnarvon area there were 2,497; the Murchison district south of Carnarvon had 1,497; and, finally, around Geraldton there were 5,012. The total came to 19,021, and the missing 10,000 were added to this figure. The figures came from the Aborigines Department, and helped it argue for greater resources. Neville had already admitted in 1932 that the 10,000 extra was a myth but in 1935 Neville provided the Royal Commission with the old figures. No doubt he thought that if the Commissioner accepted them they would add weight to his case for increased funding.⁸²

Moseley accepted Neville's spurious estimates of people in the Bush. As a result Moseley was wrong on various points when discussing the Aboriginal population in his final Report to Parliament.⁸³ The total number of people of full-descent was increasing. The first figures available in 1924 from the Aboriginal census had revealed that the total full-blood population numbered 6,557 males and 5,703 females, making a grand total of 12,260. In 1940, the total Aboriginal population was given as only 7,152 males and 4,669 females, a total of 11,827. The apparent reduction is explained by looking at Aboriginal women as represented in the age pyramids for the 1933 census. For example, the Figures 1.12, 1.13 and 1.14 suggest that an increase in the total population was occurring even though the full-blood female population is not showing a revival in the 1930s. The figures of the female population pyramid of 1911 totalled 2,936 (see Table 1.5 in Appendix 1) but in 1933 totalled 3,093 (see

⁸² Transcripts, *Royal Commission appointed to Investigate, Report and Advise upon matters in relation to the Condition and Treatment of Aborigines*, WAGP, 1935, in Battye Library Perth Western Australia, Series No. 2922/V.1-2. Paragraphs are marked chronologically and references refer to those paragraphs. See A.O. Neville's evidence in paras 1-109.

⁸³ Moseley, 'Royal Commission Report 1934-35', p.4.

Table 1.12 in Appendix 1). While this Table shows an increase of only 157 the increase in females was greater than the Aboriginal census revealed (see Table 1.11 below).

Later in his report Moseley describes the conditions of life of the people he deemed Aboriginal or of Aboriginal origin.⁸⁴ In the northern Kimberley they were either in the bush 'in their natural state', or in camps or pastoral stations.⁸⁵ In speaking of cattle workers, Moseley commented that these workers located themselves 'in the country to which they belonged — an important consideration from the point of view of the native.'⁸⁶ These groups made their shelters out of four gallon petrol cans, bags and bush material, but Moseley said they wanted for nothing and displayed no sign of unhappiness. He even imagined it was a virtue that 'the children...[were] trained at an early age to make [such improvised materials] useful.'⁸⁷ But in response to Neville's proposal for the purchase for more land to provide work, Moseley could not bring himself to believe that 'a native of the Kimberley...[could settle] and remain on the property where they were born: of what other use would money be to him?'.⁸⁸

Having mentioned bush and station people in the north, Moseley went on to consider 'miscegenation', an eventuality which, given the prevailing notions about racial mixing, he assumed to be wholly undesirable. He observed that

⁸⁴ *Ibid.*, p.5.

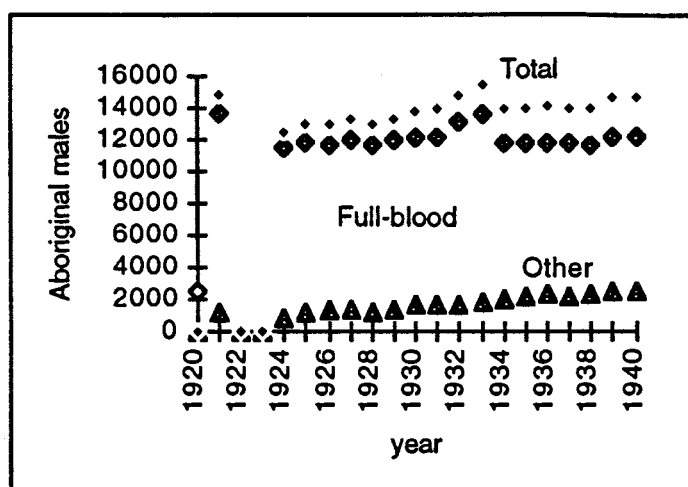
⁸⁵ *Ibid.*, p.4.

⁸⁶ *Ibid.*, pf.

⁸⁷ *Ibid.*, pf.

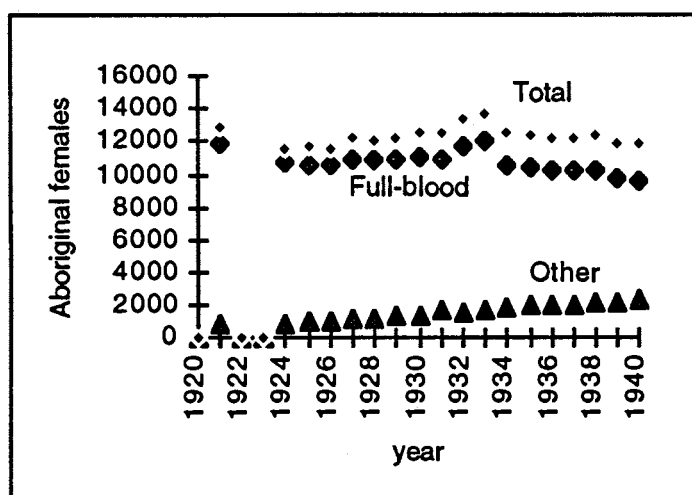
⁸⁸ *Ibid.*, pf.

Figure 1.18: 'Estimated' Aboriginal males, full-blood, other and total in WA, 1921-1940



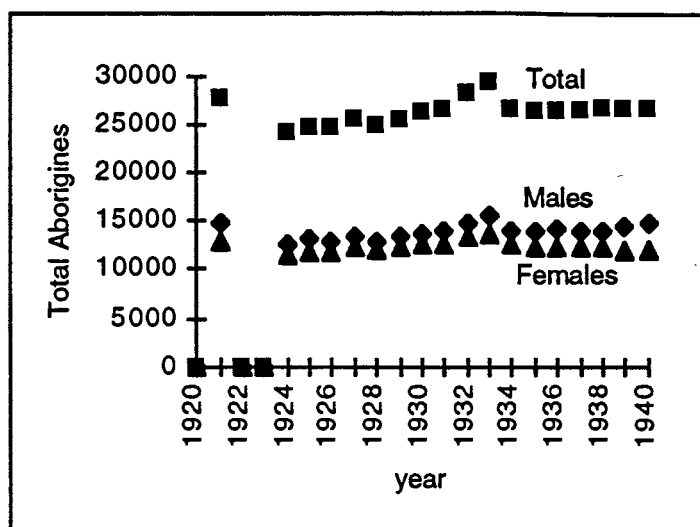
Source: Compiled from Table 1.10.

Figure 1.19: 'Estimated' Aboriginal females, full-blood, other and total in WA, 1921-1940



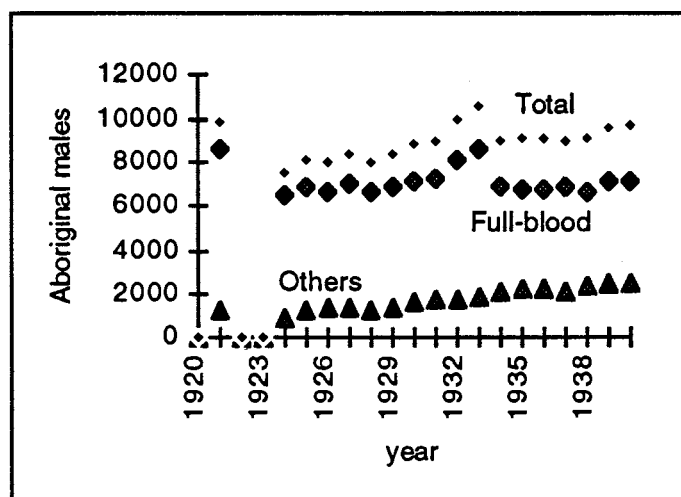
Source: Compiled from Table 1.10.

Figure 1.20: 'Estimated' Aboriginal persons, males, females and total in WA, 1921-1940



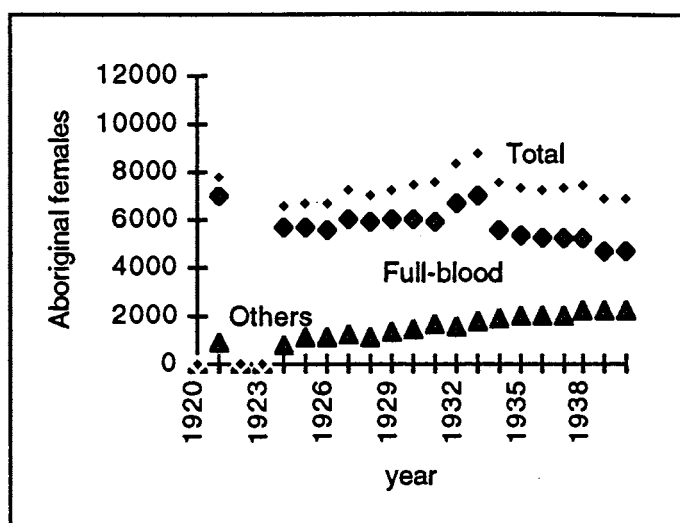
Source: Compiled from Table 1.10.

Figure 1.21: 'Returned' Aboriginal males, full-blood, other and total in WA, 1921-1940



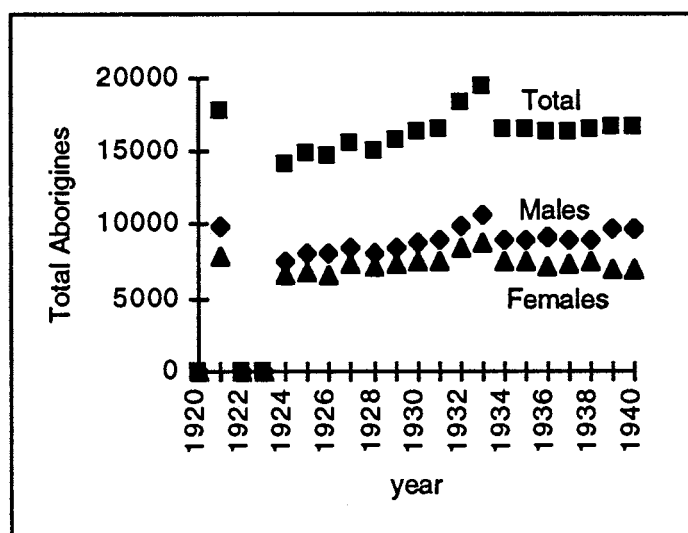
Source: Compiled from Table 1.11.

Figure 1.22: 'Returned' Aboriginal females, full-blood, other and total in WA, 1921-1940



Source: Compiled from Table 1.11.

Figure 1.23: 'Returned' Aboriginal persons, males, females and total in WA, 1921-1940



Source: Compiled from Table 1.11.

in the north few half-castes are to be found on the stations. That is a gratifying fact but one difficult to explain: for it is regrettable that my investigations have satisfied me that in certain parts of the north intercourse between the white man and aboriginal women exists to a degree which is as amazing as it is undesirable.⁸⁹

Moseley's prudery notwithstanding, he had identified the cause of the rapidly increasing half-caste population. His comments about the sexual relations between white men and Aboriginal women may also explain low numbers of births by bush people because, as Moseley reported, many bush females were having children from white men and remaining in town fringe-camps. The other part of the dynamic came from the liaisons between males of mixed descent and full-blood females.

Only one other change to Aboriginal identity influenced the enumeration of the Aboriginal population, and that was the inclusion of people who had any portion at all of Aboriginal descent. In the remaining period between the Moseley Report in 1935 to 1940, the Aboriginal population increased but it did so in a different way than previously. Moseley suggested a new approach:

The definition of an Aborigine [should] be broadened to include 'persons of [Aboriginal] origin in a remote degree'; the Minister (not the Chief Protector!) [should] become the legal guardian of all part-Aboriginal children up to the age of sixteen.⁹⁰

He might not have realised that, ironically, the liberal definition he was recommending — the most inclusive devised up till then — would soon become an instrument of oppression. In the hands of over-zealous officials, it legitimated the removal of light-skinned children from their families, setting in train events the results of which are still apparent 60 years later. The State Government showed great haste in implementing many of Moseley's recommendations due, as I explain in chapter five, to

⁸⁹ *Ibid.*, p.5.

⁹⁰ Biskup, *not slaves*, pp.167-169.

the growth of an Aboriginal political welfare lobby (which included both Aborigines and Christian mission bodies) and the increasing interest in matters of poverty by the daily press. The significant thing to note here is that Aboriginal identity was changed, and at the stroke of Moseley's pen. Western Australian protection policy had a 'knock-on' effect in other places, leading to complex and unforeseen outcomes. How this occurred becomes clear in the next chapter, which considers Queensland's Aboriginal population.

APPENDIX 1

Table 1.1: Aborigines by age and sex in WA, 1901

Age group	Full-bloods			Half-castes			Total		
	Males	Females	Persons	Males	Females	Persons	Males	Females	Persons
0-4	88	80	168	89	64	153	177	144	321
5-9	132	93	225	102	99	201	234	192	426
10-14	199	112	311	80	82	162	279	194	473
15-19	278	216	494	54	62	116	332	278	610
20-24	342	238	580	44	47	91	386	285	671
25-29	291	240	531	30	39	69	321	279	600
30-34	289	269	558	29	22	51	318	291	609
35-39	184	126	310	17	18	35	201	144	345
40-44	220	180	400	14	11	25	234	191	425
45-49	146	80	226	7	2	9	153	82	235
50-54	164	120	284	8	1	9	172	121	293
55-59	49	30	79	1	0	1	50	30	80
60-64	67	65	132	2	1	3	69	66	135
65-69	14	17	31	0	0	0	14	17	31
70-74	14	20	34	0	0	0	14	20	34
75+	12	7	19	0	0	0	12	7	19
Sub total	2,489	1,893	4,382	477	448	925	2,966	2,341	5,307
N/S	444	435	879	15	11	26	459	446	905
TOTAL	2,933	2,328	5,261	492	459	951	3,425	2,787	6,212

Source: Fraser, 'Chapter XIX, Aborigines', pp.203-207.

Table 1.2: Age-specific sex ratio (a) of full-blood and half-caste Aborigines in WA, 1901

Age group	
0-4	123
5-9	122
10-14	144
15-19	119
20-24	135
25-29	115
30-34	109
35-39	140
40-44	123
45-49	187
50-54	142
55-59	167
60-64	105
65-69	82
70-74	70
75+	171

N/S: Not Stated

Source: Compiled from Table 1.1 (above).

(a) the number of males per 100 females.

Table 1.3: Aborigines by age and sex in WA, 1911

Age group	Full-bloods			Half-castes			Total		
	Males	Females	Persons	Males	Females	Persons	Males	Females	Persons
0-4	95	92	187	100	116	216	195	208	403
5-9	116	99	215	108	119	227	224	218	442
10-14	160	104	264	87	70	157	247	174	421
15-19	219	167	386	105	85	190	324	252	576
20-24	241	284	525	86	76	162	327	360	687
25-29	290	251	541	57	51	108	347	302	649
30-34	329	247	576	48	30	78	377	277	654
35-39	204	189	393	30	27	57	234	216	450
40-44	255	199	454	20	14	34	275	213	488
45-49	143	102	245	19	7	26	162	109	271
50-54	180	182	362	7	8	15	187	190	377
55-59	75	49	124	7	3	10	82	52	134
60-64	109	102	211	5	3	8	114	105	219
65-69	43	21	64	0	2	2	43	23	66
70-74	29	30	59	2	1	3	31	31	62
75+	5	9	14	0	1	1	5	10	15
sub total	2,493	2,127	4,620	681	613	1,294	3,174	2,740	5,914
N/S	940	809	1,749	79	102	181	1,019	911	1,930
TOTAL	3,433	2,936	6,369	760	715	1,475	4,193	3,651	7,844

Source: Bureau of Census and Statistics, Census of the Commonwealth of Australia, 1911, Bulletin No., 1, 'Population of States and Territories'.

Table 1.4: Age specific sex ratio (a) of full-blood and half-caste Aborigines in WA, 1911

Age group	
0-4	94
5-9	103
10-14	142
15-19	129
20-24	91
25-29	115
30-34	136
35-39	108
40-44	129
45-49	149
50-54	98
55-59	158
60-64	109
65-69	187
70-74	100
75+	50

N/S: Not Stated.

Source: Compiled from Table 1.3 above.

(a) the number of males per 100 females

Table 1.5: Aborigines by age and sex in WA, 1921

age group	Full-bloods*			Half-castes			Total*		
	males	females	persons	males	females	persons	males	females	persons
0-4				21	21	42			
5-9				23	24	47			
10-14				21	27	48			
15-19				18	23	41			
20-24				17	15	32			
25-29				16	25	41			
30-34				8	16	24			
35-39				10	8	18			
40-44				9	7	16			
45-49				5	4	9			
50-54				3	6	9			
55-59				5	1	6			
60-64				1	0	1			
65-69				1	0	1			
70-74				1	0	1			
75+				0	0	0			
Sub total				159	177	336			
N/S				942	682	1,624			
TOTAL				1,101	859	1,960			

Source: Bureau of Census and Statistics, Census of the Commonwealth 1921, 'Statisticians Report', AGPS, Melbourne; Commonwealth of Australia, Australian Year Book, AGPS, Melbourne, No 14, 1921, p.1128.

Table 1.6: Age-specific sex ratio (a) of half-caste Aborigines, 1921

Age group	
0-4	100
5-9	96
10-14	78
15-19	78
20-24	113
25-29	64
30-34	50
35-39	125
40-44	129
45-49	125
50-54	50
55-59	(b)
60-64	(b)
65-69	(b)
70-74	(b)
75+	(b)

N/S: Not Stated

(a) the number of males per 100 females. (b) the numbers in these cells are too small to calculate a ratio.

Sources: Compiled from figures for 1921 in Table 1.5 above.

* Full-blood Aborigines, and therefore total figures, were not published.

Table 1.7: Aborigines in WA, 1901-1933

Year	Full-bloods			Half-castes			Total		
	Males	Females	Total	Males	Females	Total	Males	Females	Total
1901	2,933	2,328	5,261	492	459	951	3,425	2,787	6,212
1911	3,433	2,936	6,369	760	715	1,475	4,193	3,651	7,844
1921(a)				1,101	859	1,960	1,101	859	1,960
1933	3,570	3,093	6,663	1,735	1,709	3,444	5,305	4,802	10,107

(a) full-blood Aborigines were not counted in 1921 but estimated (not included here)

Sources: Fraser, '7th Census of WA, 1901', pp.203-207. Also, see Statistician's Report, Bureau of Census and Statistics, Census of the Commonwealth of Australia, 1911 Bulletin No. 1, Reports of States and Territories', AGPS, Melbourne, 1913; Statistician's Report, Bureau of Census and Statistics, Census of the Commonwealth of Australia, 1921.

Table 1.8: Aborigines by age and sex in WA, 1933

Age group	Full-bloods			Half-castes			Total		
	Males	Females	Persons	Males	Females	Persons	Males	Females	Persons
0-4	137	95	232	280	276	556	417	371	788
5-9	109	126	235	256	238	494	365	364	729
10-14	100	65	165	175	196	371	275	261	536
15-19	120	89	209	187	221	408	307	310	617
20-24	107	82	189	172	199	371	279	281	560
25-29	110	103	213	125	143	268	235	246	481
30-34	134	112	246	81	84	165	215	196	411
35-39	116	91	207	102	85	187	218	176	394
40-44	161	131	292	75	63	138	236	194	430
45-49	102	83	185	64	35	99	166	118	284
50-54	141	97	238	49	35	84	190	132	322
55-59	77	41	118	25	20	45	102	61	163
60-64	99	75	174	21	15	36	120	90	210
65-69	38	22	60	15	5	20	53	27	80
70-74	35	20	55	9	10	19	44	30	74
75+	15	10	25	1	2	3	16	12	28
Sub total	1601	1242	2,843	1637	1627	3264	3,238	2,869	6,107
N/S	1969	1851	3,820	98	82	26	2067	1933	4000
TOTAL	3570	3093	6,663	1735	1709	3290	5,305	4,802	10,107

Source: Census of the Commonwealth of Australia, 1933. Bulletin No. 24. 'Summaries relating to Full-blood Aborigines'; mixed descent people included in general census.

Table 1.9: Age-specific sex ratio (a) of full-blood and half-caste Aborigines in WA, 1933

Age group	
0-4	112
5-9	100
10-14	105
15-19	99
20-24	99
25-29	96
30-34	110
35-39	124
40-44	122
45-49	141
50-54	144
55-59	167
60-64	133
65-69	196
70-74	147
75+	133

N/S: Not Stated.

(a) the number of males per 100 females.

Source: Compiled from figures for 1933 in Table 1.8 above.

Table 1.10: Annual Aboriginal census in WA, 1921-1940
(includes the estimated 10,000 persons)

	Full-blood		Others		Total (a)		
	Males	Females	Males	Females	Males	Females	Persons
1921	13,611	11,976	1,199	885	14,810	12,861	27,671
1922	N/A	N/A	N/A	N/A	N/A	N/A	N/A
1923	N/A	N/A	N/A	N/A	N/A	N/A	N/A
1924	11,557	10,703	934	834	12,491	11,537	24,028
1925	11,830	10,641	1,238	1,085	13,068	11,726	24,794
1926	11,662	10,560	1,341	1,079	13,003	11,639	24,642
1927	12,027	10,968	1,332	1,255	13,359	12,223	25,582
1928	11,689	10,908	1,288	1,149	12,977	12,057	25,034
1929	11,941	10,975	1,416	1,295	13,357	12,270	25,627
1930	12,112	11,062	1,679	1,447	13,791	12,509	26,300
1931	12,207	10,903	1,738	1,659	13,945	12,562	26,507
1932	13,147	11,736	1,745	1,606	14,892	13,342	28,234
1933	13,608	12,015	1,927	1,748	15,535	13,763	29,298
1934	11,916	10,587	2,071	1,941	13,987	12,528	26,515
1935	11,780	10,408	2,258	1,996	14,038	12,404	26,442
1936	11,820	10,227	2,297	1,969	14,117	12,196	26,313
1937	11,850	10,268	2,172	2,037	14,022	12,305	26,327
1938	11,657	10,225	2,382	2,220	14,039	12,445	26,484
1939	12,166	9,712	2,473	2,215	14,639	11,927	26,566
1940	12,152	9,669	2,507	2,274	14,659	11,943	26,602

(a) includes the estimated 10,000 persons.

Source: Smith, 'Aboriginal Population', p.166.

Table 1.11: Annual Aboriginal census in WA, 1921-1940
(excludes the estimated 10,000 persons)

	Full-blood		Others		Total (b)		
	Males	Females	Males	Females	Males	Females	Persons
1921	8,611	6,976	1,199	885	9,810	7,861	17,671
1922	N/A	N/A	N/A	N/A	N/A	N/A	N/A
1923	N/A	N/A	N/A	N/A	N/A	N/A	N/A
1924	6,557	5,703	934	834	7,491	6,537	14,028
1925	6,830	5,641	1,238	1,085	8,068	6,726	14,794
1926	6,662	5,560	1,341	1,079	8,003	6,639	14,642
1927	7,027	5,968	1,332	1,255	8,359	7,223	15,582
1928	6,689	5,908	1,288	1,149	7,977	7,057	15,034
1929	6,941	5,975	1,416	1,295	8,357	7,270	15,627
1930	7,112	6,062	1,679	1,447	8,791	7,509	16,300
1931	7,207	5,903	1,738	1,659	8,945	7,562	16,507
1932	8,147	6,736	1,745	1,606	9,892	8,342	18,234
1933	8,608	7,015	1,927	1,748	10,535	8,763	19,298
1934	6,916	5,587	2,071	1,941	8,987	7,528	16,515
1935	6,780	5,408	2,258	1,996	9,038	7,404	16,442
1936	6,820	5,227	2,297	1,969	9,117	7,196	16,313
1937	6,850	5,268	2,172	2,037	9,022	7,305	16,327
1938	6,657	5,225	2,382	2,220	9,039	7,445	16,484
1939	7,166	4,712	2,473	2,215	9,639	6,927	16,566
1940	7,152	4,669	2,507	2,274	9,659	6,943	16,602

(b) excludes the 10,000

N/A=Not available

Source: Smith, 'Aboriginal Population', p.166.

CHAPTER 2

'To leave them alone':¹

An analysis of the indigenous population Queensland, 1900 to 1940

The purpose of this chapter is to describe the indigenous population of Queensland as it changed between 1900 and 1940.² As previously stated use of pre- and post federation census data on Aborigines is not definitive but a use of descriptive demography. This chapter like the last is a precursor to the study of the historic epidemiology of an Aboriginal population. The thesis makes no attempt, however, to analyse either pre-contact or colonial demographic questions except for descriptive purposes, but focuses on the study period only. But I concentrate on the Gulf region because this was the area where most writers and commentators expected the missing populations would be located. The argument in this chapter, therefore, is that the Aboriginal populations in the Gulf and Cape York region were largely known by 1900. Despite that the numbers of Aborigines counted in the censuses were grossly over-estimated both in the nineteenth century and in the period of study. The total Aboriginal population continued growing after 1900, and this was mostly due to Aboriginal females of mixed-descent. Aboriginal females of full descent suffered under colonialism, but it was they and the males of

¹ Archibald Meston, *Report on the Aborigines of Queensland*, Queensland Legislative Assembly, Votes and Proceedings (QLAV&P), 1896, Vol. iv, pp.723-740.

² As indicated earlier, Torres Strait Islanders are omitted from any analysis because of the paucity of source material.

full descent who became the beneficiaries of Queensland protection and welfare relief policies.

The last phase of white settlement in Queensland commenced around 1900 and lasted until just after World War I. The only land then left to settle were sections of the Gulf of Carpentaria and Cape York hinterland, and various pastoral areas along the New South Wales border west from Roma to Cloncurry and the Northern Territory. White settlement in these regions left a small Aboriginal population, whose numbers could only be estimated by protectors and missionaries working there.

By way of description, the area west of the Great Dividing Range is examined to determine how land settlement impacted on the Aboriginal population. Writers from Rowley,³ Long⁴ and most recently Dawn May⁵ have all assumed that large numbers of Aborigines lived in the bush beyond white settlement. Those best qualified to determine accurately the size of the Aboriginal population were the early government protectors and missionaries⁶ working in the Gulf and Cape regions. No

³ Rowley, *The Destruction*, pp.368-398.

⁴ Long, *Aboriginal Settlement*, pp.4-5, and see also, pp.91-98.

⁵ Dawn May, *Aboriginal Labour*, in pre-contact p.13, and in post-contract p.94, where May believed that 'depopulation' among Aborigines in the 1930s was still proceeding. No definition is posited and no analysis is offered even though the use of recent studies could have helped her be less dependent on abstractions.

⁶ S.E. Stephens, 'Meston, Archibald', in Nairn, Searle and Ward (eds), *Australian Dictionary of Biography (ADB)*, Vol. 5, 1815-1890, MUP, Melbourne, 1974, pp.243-244 (this entry contains a corrigendum published in ADB Index, Vols 1-2, p.313, referred to 'Archibald Meston' file, ADB, RSSS, ANU, 1994); see also, Archibald Meston, 'Report on the Government Scientific Expedition to Bellenden Ker Range, 1889', in *Annual Report of the Department of Agriculture, Queensland, 1889-1890*; see also, Queensland Parliament, *Report on the Aborigines of Queensland (by Special Commissioner, Archibald Meston)*, QL1896 QLAV&P, 1896, Vol. IV, pp.723-170; see also, F.A. Hagenauer, 'Notes of a Missionary Journey to North Queensland 1885', published with *Report of the Aboriginal Mission at Ramahyuck, Victoria, 1885*, this report was located Victorian Public Records Series (PRS) 1856-1873, among items classified as Registered Inward Correspondence to Surveyor-General, Board of Land and Works, located in Public Records Office of Victoria, see index *Australian Archives and the Public Records Office Victoria*, 'My heart if breaking', A Joint Guide to Records about Aboriginal People in the Public Records Office of

comprehensive research, covering the whole of Queensland, was ever carried out until Broom, Jones⁷, Long and Rowley produced their studies in the early 1970s, but the observations of the protectors and missionaries were ignored and scholars have continued to assume that Aborigines existed in large numbers in the Gulf and Cape regions.

By the first decade of the twentieth century the Queensland Government's dispersal⁸ and protection policies had brought only about 1,500 people into the Aboriginal relief depots. Most such depots were located near coastal service towns within a few days journey of Brisbane.⁹ Not until World War I did Aborigines prove useful in the pastoral industry in Queensland. It was in the 1920s that small Aboriginal populations living on cattle and sheep stations began to reproduce a labour force of size. This pastoral labour force was isolated and had little contact with either mission or government depot populations, except when the pastoral properties were located near missions, from which they drew surplus labour until the economic depression of 1929 to 1932.

White settlement did not begin in the Gulf region until about 1864. This region was huge, extending from the Mitchell River to the source of the Flinders River and north-west to the present Northern Territory.¹⁰ In 1867 the Moorehead and Young stock company drove livestock for agistment as far west as the Albert River. Between then and the 1880s settlements such as Burketown, Normanton, the port at Sweers Island and the mining railhead at Croydon became the service centres for the

Victoria and the Australian Archives, Victorian Regional Office, AGPS, Canberra, 1993, see p.15 and p.19.

⁷ Leonard Broom and F. Lancaster Jones, *A Blanket A Year*, ANU Press, Canberra, 1973, and see F. Lancaster Jones, *The Structure And Growth of Australia's Aboriginal Population*, ANU Press, Canberra, 1970.

⁸ Noel Loos, *Invasion and Resistance: Aboriginal-European Relations on the North Queensland Frontier 1861-1897*, ANU Press, Canberra, 1982, pp.160-182.

⁹ Long, *Aboriginal Settlement*, pp.91-101.

¹⁰ *Port Denison Times*, 30 December, 1865.

settler communities of the region.¹¹ Settler life was subject to the vagaries of life at the limits of settlement. Residents of Burketown were struck by a mysterious fever that routed both the whites and what remained of the indigenous populations.¹² Only a few residents were left. The epidemic closed Burketown, and allowed Normanton to become the main service centre in the Gulf region. The native police were never active in this area and few, if any, major confrontations between Aborigines and settlers took place. The white population never rose above 1,000 in the period before 1903. The main contact with the outside world was the fortnightly postal service which continued, weather permitting, from 1870 to 1900 and beyond.¹³ Two other factors impinge on the link between white settlement and the size of the Aboriginal population in the period from 1900 to 1930. One was the failure of closer settlement and the other was subsidised Aboriginal pastoral labour.

In relation to attempts at closer settlement, the *Land Act 1910*, became 'the most important land legislation since 1884'.¹⁴ Apart from dividing up the land into smaller lots it provided opportunities for later exploitation of the post-World War I land selection program. Selection policies designed for soldiers returning home after World War I generally failed, however. This meant that, particularly in the Gulf and far western regions, selectors came and went quickly.¹⁵ The two regions suffered economically, not only because of the heat, tropical weather and human and animal diseases present in that environment but also through the

¹¹ *Australasian*, 13 July, 1867, p.134.

¹² William Lansborough, 'Extracts from report of W. Landsborough, in command of the Queensland Burke Relief Expedition, to Captain Norman with reference to the Albert River', in *Journal of The Royal Society of London*, Volume 33, 1863, pp.79-132.

¹³ F.H. Bauer, *Historical Geographic Survey Of Part Of Northern Australia*, Part 1, CSIRO, Canberra, 1959, pp.35-37.

¹⁴ Bauer, *Historical Geographic Survey*, p.53.

¹⁵ *Ibid.*, pp.66-67.

failure of the pastoral system to attract greater settlement. The consequent slow development of the western districts beyond the Great Dividing range lessened the impact of pastoral settlement on a sparse indigenous population.

In relation to subsidised labour, good water and grass for stock were necessary for small pastoral holdings, a factor which constrained the numbers of pastoralists who could settle in the region. Only those selectors who could get access to water stayed. The failure of the region to attract new pastoralists was a major reason why this pastoral area stagnated economically between 1900 and 1914. When the European War erupted in 1914 it boosted the prospects of the beef and wool industries. The war had an enormous effect on the coastal areas of Queensland because it increased labour shortages, drove up wages and costs of machinery, fencing and transport, and depleted supplies of materials used by pastoralists. The Western districts, however, were partly protected from labour shortages because of the presence of Aboriginal labour. A benefit of Aboriginal labour was its cheapness because of the subsidies in the employment available under the *Aborigines Protection and Restriction of Opium Act of 1897*.¹⁶ Some people legally exempted from this legislation entered active service but Aborigines were generally excluded from military service under the federal *Defence Act, 1910*.¹⁷ Two droughts reduced labour needs but the white population remained stable between the 1890s and 1920s.

What made it easier for pastoralists to remain was that the pastoral properties in the western Queensland Gulf and in districts further south,

¹⁶ QLAV&P, (61 Vic., No. 17), and assented on 15th December, 1897.

¹⁷ The Defence Act, 1910, No. 37 of 1910, quoted in McCorquodale, *Aborigines And The Law*, p.5.

were free of disaster.¹⁸ The disasters which elsewhere affected black-white relations most severely were massacres of both mining and pastoral settlers on the one hand and Aborigines on the other. A persistent assumption is that all areas experienced massacres during the earlier colonial periods. Such assumptions cannot be made in the Gulf and Cape hinterland, however, for no massacres of Aborigines, or of settlers, occurred in the region. In Queensland massacres were a nineteenth century phenomenon. Even then, the depredations of the Native Police were confined to central and southern coastal regions and did not reach the Gulf or Cape areas.¹⁹ Relations were not always amicable between Aboriginal pastoral labour and pastoralists in the Gulf and Cape, but this represented an on-going structural conflict between land owners or managers and local labour rather than racial strife.²⁰ One problem which did persist was the small size of the Aboriginal population from the 1880s to 1940 and beyond. Throughout this whole period differences between the enumerated and estimated Aboriginal population figures (see Figures 2.1, 2.2 and 2.3 below) remained a conundrum.

The 1901 census data on Aborigines in Queensland indicated that there were 6,670 persons of Aboriginal origin, and of these 5,137 were full-bloods and 1,533 were half-castes.²¹ It was also estimated that a further 20,000 full blood Aborigines were living 'out bush'. The practice of estimating Aborigines went back to the 1881 colonial census when

¹⁸ Bauer, *Historical Geographic Survey*, pp.51-69.

¹⁹ L.E. Skinner, *Police of the Pastoral Frontier: Native Police 1849-59*, St Lucia, Queensland University Press, 1975; see later episodes, also, in Rowley, *The Destruction*, pp.179-181, where Meston mentions continuing brutality and lawlessness of the 'Native Police' on northern coastal Aborigines.

²⁰ Jan Walker, *Jondaryan: Relationships between Pastoral Capital And Pastoral Labour*, University of Queensland Press, St Lucia, Brisbane, 1988.

²¹ L.R. Smith, 'Queensland Census 1901, Aborigines and Half-Castes, 5yr Age Distribution Worksheet, 1970-71, for Ph.D. thesis'; also, Smith, 'Queensland Census 1901, Aborigines and Half-Castes, Single year Age Distribution Worksheet, 1970-71, for Ph.D. thesis', unused and unpublished documents kindly provided by Dr L.R. Smith for my use.

20,585 Aborigines were counted as living in collectors' districts. A further 50,000 Aborigines were 'estimated' to be in the north and north-west.²² By 1901 these estimates had been revised downwards to 20,000 persons, and still further revised in 1933. At that time, only an estimated 2,291 persons were assessed as living in remote areas. These estimates are significant in that they give the overall impression of a large number of Aborigines disappearing during the study period. The problem was that the estimated number of Aborigines living 'in the bush' was grossly over-stated, and that the number of Aborigines actually known to exist — those enumerated — were increasing (see Figures 2.1 to 2.3).

Further in relation to problems of collection, above age 50 it was obviously difficult for collectors to accurately assess the age of an older person. Collectors almost always made their own judgements.

At the first Commonwealth census in 1911 persons of Aboriginal descent in Queensland were categorised as both half-castes and full-bloods. A total of 11,195 persons were enumerated at this census, consisting of 6,506 males and 4,689 females. This figure represented an increase of nearly 70 per cent over the 1901 Queensland census. Of these, 1,361 males and 1,147 females were classified as half-castes and 5,145 males and 3,542 females as full-bloods. The following analysis reveals the very different evolving patterns of growth of the two groups. The 1911 census showed an emerging young population as reflected by the age population pyramid for half-castes (see Figure 2.7 below).²³ The sex ratio appears to be fairly balanced in most age groups, although there are overall more males than females in all groups (see Figure 2.9 below, and

²² L.R. Smith, *The Aboriginal Population of Australia*, ANU Press, Canberra, 1985, p.122.

²³ L.R. Smith, 'Census, 1911, Aboriginal age distribution, worksheets 1971-72, for Ph.D. thesis', pp.1-3, and are unused and unpublished documents kindly provided by Dr L.R. Smith for my use (hereafter referred to as, author's '1911 worksheets').

Table 2.5 in Appendix 2). As would be expected at this time, the peoples classified as half-castes did not by 1901 include many older men or women (those in the over 60 age groups). One reason for this may have been the long term results of liaisons between Aboriginal females and male settlers of other races. In Queensland, the relationships between Aboriginal women and men of other races resembled those in the southern and northern coastal areas of Western Australia.²⁴

The most significant difference between Aborigines in the 1901 and 1911 censuses in Queensland (see Table 2.1) is the downward revision of the 'estimated' Aborigines of full descent from 20,000 in 1901 to an 'enumerated' total of 11,313 in 1911. The result was that the number of persons of Aboriginal descent declined. The 'decline', however, occurred only on paper, due to the revised number of estimated persons. As Figures 2.1 to 2.3) show, those enumerated rose from 6,670 to 11,195 in the period.

At the 1921 national census full-blood groups were again enumerated and estimated. In Queensland the 1921 total figure of 17,104

²⁴ George Grey, *Journal of Two Expeditions of Discovery in North-West and Western Australia During the Years 1837, 38 and 39*, Vols I-II, T. & W. Boone, 29 Bond St London, 1841, p.240, where Grey explains how almost no racial mixing took place because there were no convicts to begin with; see also, J.S. Battye, *Western Australia: a history from its Discovery to the Inauguration of the Commonwealth*, (Oxford 1924); see also, A. Forrest, 'North-West Exploration: Journal of Expedition from De Grey to Port Darwin, 1880', p.40, in F.K. Crowley, *A Documentary History*, Vol. 3, 'Kimberley District Explored', October 1879, pp.67-68; see also, Pall Mall Gazette, quoted in *New York Times*, 13 February, 1882, in Crowley, *A Documentary History*, pp.80-81, where mention is made of half-castes beginning to be seen in the workforce more frequently; see also, H. Colebatch (ed.), *A Story of a Hundred Years: Western Australia 1829-1929*, F.W. Simpson, Perth, 1929; see also, C.T. Stannage, *A New History of Western Australia*, University of Western Australia Press, Nedlands, Perth, 1981; but, for a better exposition of the growth of the half-caste population, Rowley, *The Destruction*, pp.145-156, and see, pp.384-385; see also, N.B. Tindale, 'Distribution of Australian Aboriginal Tribes: a field survey', in *Transactions of the Royal Society of South Australia*, Vol. 64, pp.140-231; see also, Tindale, 'Survey Of The Half-Caste Problem In South Australia', in *The Royal Geographic Society of Australia*, Vol. XLII, 1940-41 Session, pp.67-161; finally, see L.R. Smith, *Aboriginal Population*, pp.6-9.

Figure 2.1: Full-blood Aborigines in Qld, 1901-1933*

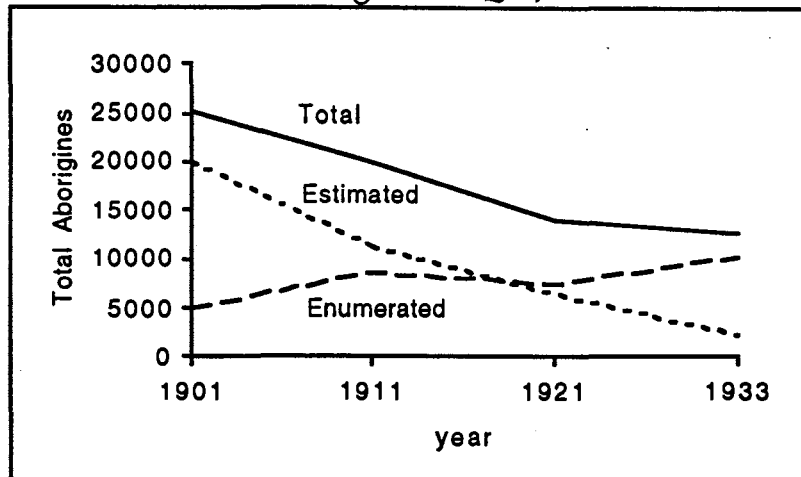


Figure 2.2: Half-caste Aborigines in Queensland, 1901-1933*

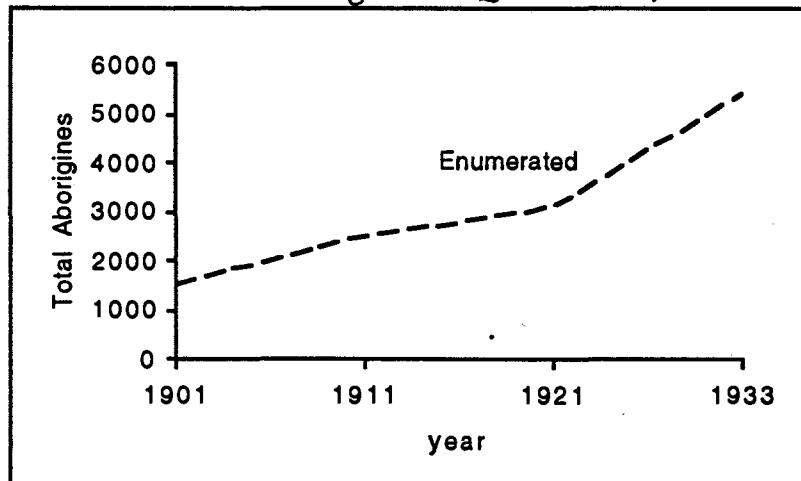
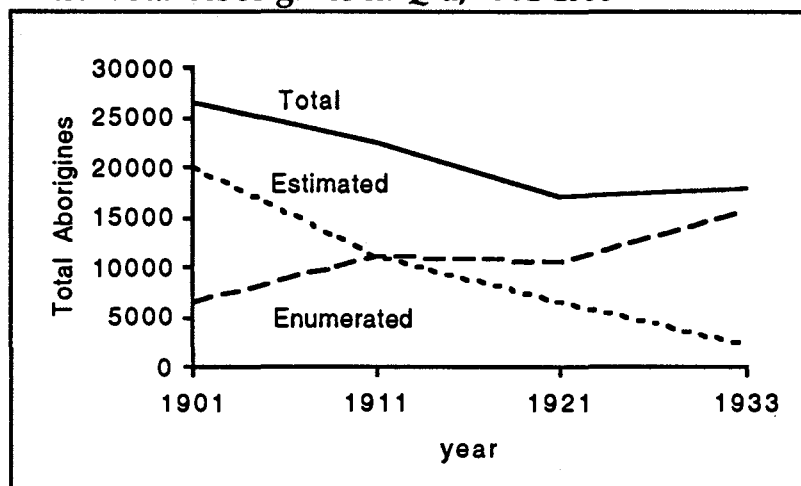


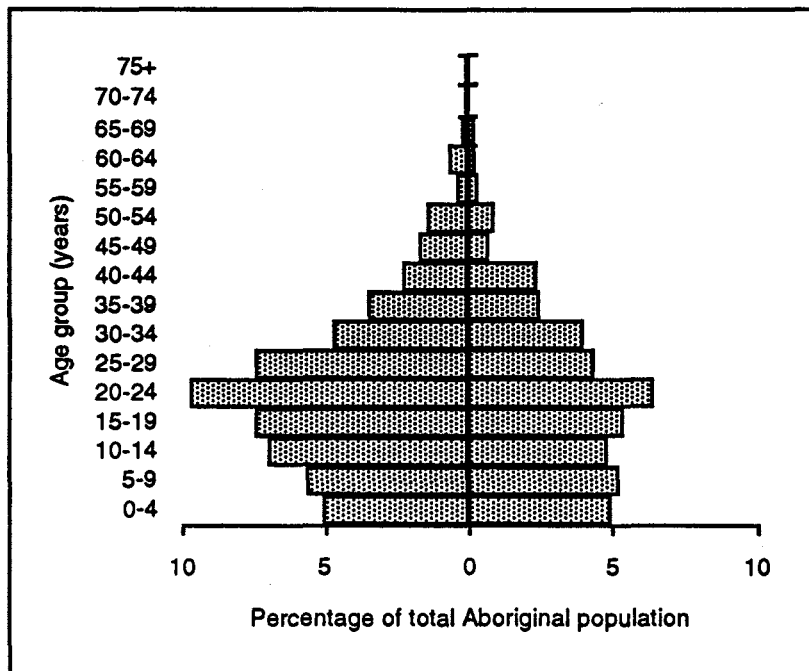
Figure 2.3: Total Aborigines in Qld, 1901-1933*



Source: Compiled from Table 2.1.

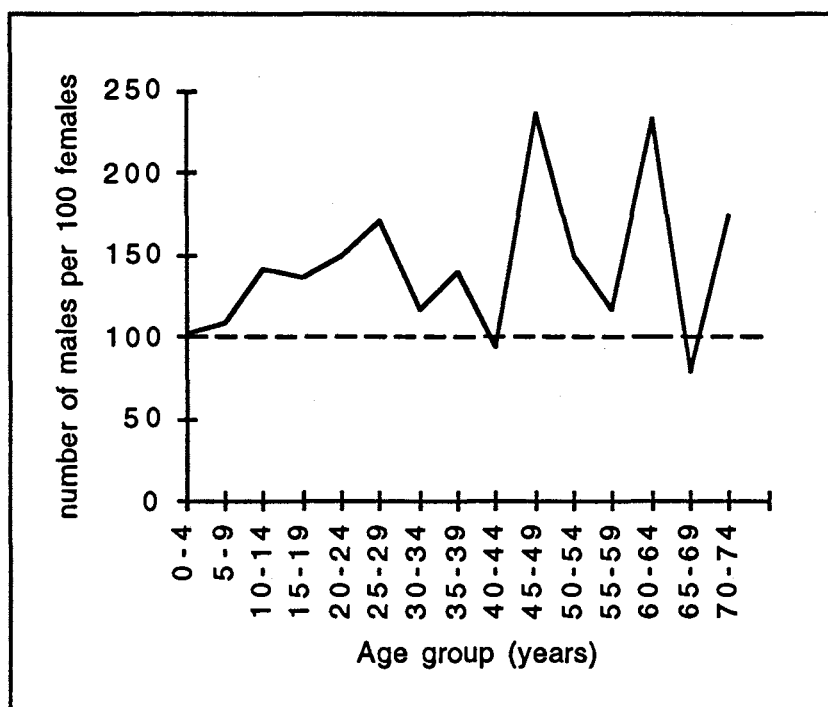
* These Graphs compare the way in which the different modes of counting and estimating Aborigines of both full- and mixed-descent during the period from 1901 to 1933. The real benefit is to show how, on the one hand, the administration and census processes showed the total Aboriginal populations as decreasing, while on the other hand, the Graphs reveal that both component groups were always increasing, from 1901 to 1933.

Figure 2.4: Total full-blood and half-caste Aborigines by age and sex in Qld, 1901



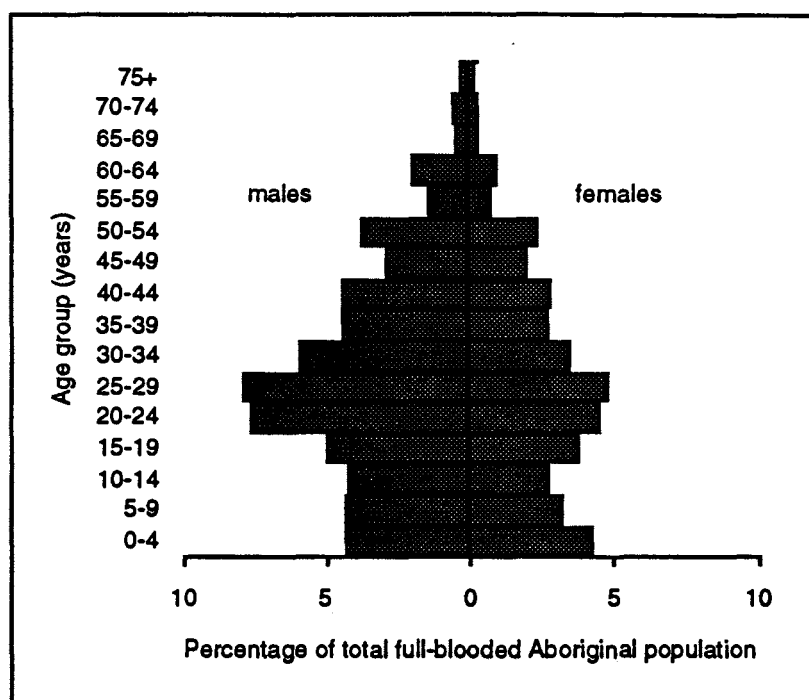
Source: Compiled from Table 2.2 (only half-caste data available).

Figure 2.5: Age-specific sex ratio of full-blood and half-caste Aborigines in Qld, 1901



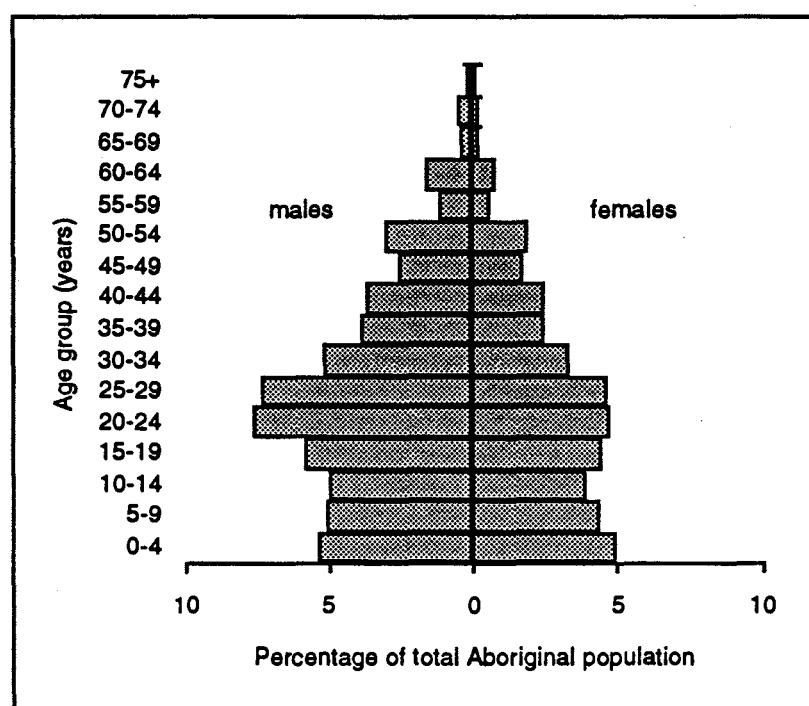
Sources: Compiled from Table 2.3.

Figure 2.6: Full-blood Aborigines by age and sex in Qld, 1911



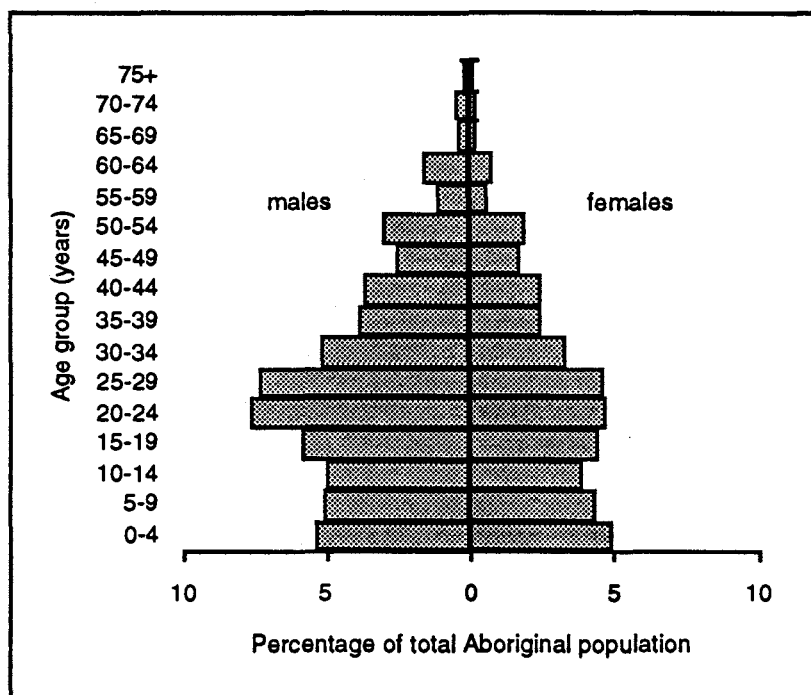
Source: Compiled from Table 2.4.

Figure 2.7: Half-caste Aborigines by age and sex in Qld, 1911



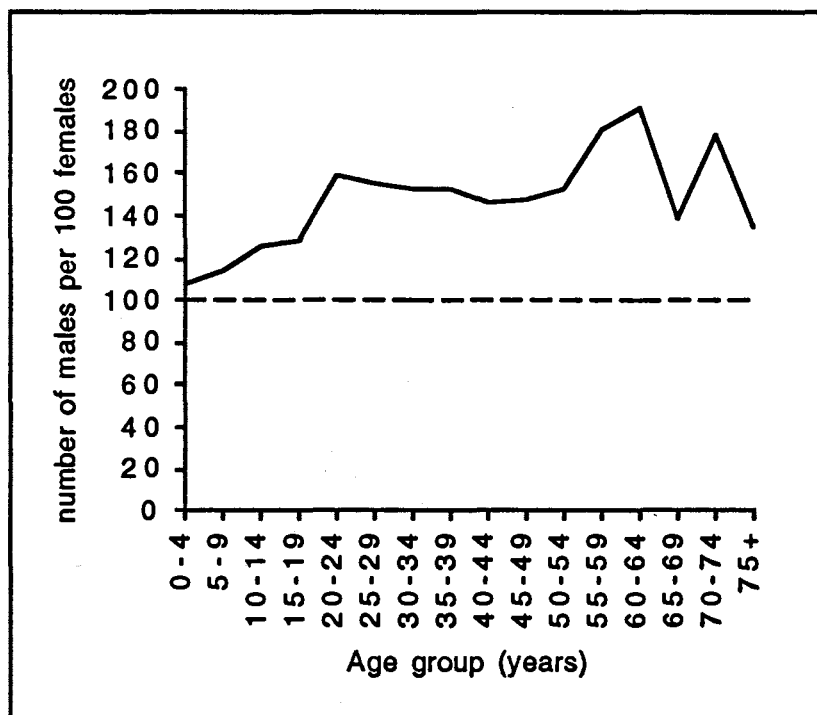
Source: Compiled from Table 2.4.

Figure 2.8: Total full-blood and half-caste Aborigines by age in Qld, 1911



Source: Compiled from Table 2.4.

Figure 2.9: Age-specific sex ratio of full-blood and half-caste Aborigines in Qld, 1911



Source: Compiled from Table 2.4.

is considered the most reliable since the counting of Aborigines began.²⁵ This figure was made up of 3,090 half-castes and 14,014 full-bloods, of whom 7,527 were enumerated and 6,487 were estimated, based on the result of annual Aboriginal censuses.²⁶ Between 1901 and 1921 the half-caste population had increased rapidly, both numerically and also relatively as a proportion of the total Aboriginal population. In 1901, 1,533 half-castes were enumerated, comprising 23 per cent of the total Aboriginal population. By 1921 the total had increased to 3,090, a doubling of their numbers to 30 per cent of the enumerated total (see Figure 2.3, and Table 2.1).

Figure 2.3 indicates the paradox of the full-blood population's estimated numbers appeared to be declining while their enumerated one was increasing at the 1921 census. In that year the total number of full-bloods declined to 14,014, mainly because of the drastic downward revision from the 20,000 estimated in 1901 to 6,487 in 1921. The enumerated full-blood Aborigines actually increased from 5,137 to 7,527 (see Table 2.1), giving the lie to suggestions that the full-bloods were vanishing.

Doubts about the size of the Aboriginal population affected the work of the Queensland officials most intimately involved with the Aborigines — administrators, protectors, police, missionaries and health workers. In the period from 1824 to 1892 the colonial authorities persisted in the belief that about 100,000 indigenous people existed in Queensland. Then from 1892 to about 1930 the estimated figures gradually became realistic, falling by 20,000 between the State census of 1901 and the Commonwealth

²⁵ Smith, *Aboriginal Population*, p.128.

²⁶ Smith, *Aboriginal Population*, see Table 7.3.1, p.131.

census of 1911.²⁷ The figure fell further to 10,000 during the period from 1911 to 1930 when an assessment was carried out for the *Commonwealth Year Book 1932*.²⁸ The adoption of more realistic estimates was appropriate because, as a number of commentators have since observed, the pre-1901 estimates for Queensland had been far too high.²⁹

Radcliffe Brown's 1930 estimate of the size of the Queensland Aboriginal population remained the accepted view until the 1960s.³⁰ Radcliffe-Brown,³¹ Professor of Anthropology at the Sydney University, produced an estimate of possible Aboriginal numbers occupying the continent at the time of the European settlement in 1788.³² This work did nothing to dispel the myth that large numbers of Aborigines still existed in outback areas in the early years of this century. Because no studies were undertaken these assumed 'large populations' of Aborigines reinforced the myth of a disappearing population when they failed to materialise. Further confusion arose because Aborigines in northern and eastern regions of the State remained free of missions and governments until the period from 1910 to the 1920s. In northern Queensland Aborigines had a background of greater concentration on church missions. In the late 1890s in north Queensland missions existed from the Mitchell River in the far north of the Cape York region down to Cairns. In the south greater institutional concentration on government depots and reservations had

²⁷ Lancaster Jones, *Structure of Aboriginal Population*, pp.3-4; this reference is also quoted in Bauer, *Historical Geographic Survey*, p.29.

²⁸ *Australia, Official Year Book No. 23, (1930)*, pp.687-696.

²⁹ Lancaster Jones, *Structure of Aboriginal Population*, pp.3-4; see also, Rowley, *The Destruction*, pp. 2-3.

³⁰ L.R. Smith, 'The Aboriginal population of Australia', Ph.D. thesis, University of New South Wales, 1975, (this work was published as, L.R. Smith, *The Aboriginal Population of Australia*, ANU Press, Canberra, 1985).

³¹ Tigger Wise, *The Self-Made Anthropologist: A Life of A.P. Elkin*, George Allen and Unwin, Sydney, 1985.

³² A.R. Radcliffe-Brown, 'Former Numbers and Distribution of the Australian Aborigines', in *Australia, Official Year Book No. 23, (1930)*, pp.687-696.

occurred. Relief depots existed between the Gold Coast and Brisbane, west to Cloncurry and from Ipswich north to Mona Mona near Mackay. Archibald Meston opened the first ration and relief depot at Deebling Creek, near Ipswich west of Brisbane.³³ Others opened soon after at Barambah and Taroom near Murgon.³⁴ More *ad hoc* relief depots existed in western areas like Charleville, Roma, Winton and Cloncurry. Until 1897 no special government agency existed to administer native policy. The Protector's Office, with Meston and later Walter Roth as Protectors, came under the responsibility of the Police Commissioner.³⁵

Although the State was not fully settled until the 1920s, most Aboriginal mainland groups were in contact with Europeans in the west and along the coast. The proposition that there were large numbers of people out of reach of settlers has never been supported by proper research. In addition, given the climate and the landforms in the west, it is doubtful whether the region ever held anything but small indigenous populations. According to the historian Rusden, in the Hull and Forest River areas, indigenous groupings began coming together under Christian influences which centralised them on mission and depot reserves from about 1870. In general, it may be argued that 'concentration' of the indigenous population rather than 'dispersal', appears to be a better metaphorical description of what happened.³⁶ Methodists and Lutheran missionaries began gathering people as early as

³³ J.W. Bleakley, *The Aborigines of Australia*, Jacaranda Press, Brisbane, 1961, p.115.

³⁴ Long, *Aboriginal Settlement*, pp.91-175.

³⁵ *Ibid.*, p.95.

³⁶ G.W. Rusden, *History of Australia*, (first printed 1887), Reissue of 2nd ed., Melbourne, 1908. Rusden's account seems more authentic than R. Evans, Kay Saunders and Kathryn Cronin, *Exclusion, Exploitation and Extermination: Race Relations in Colonial Queensland*, ANZ Book Co., Sydney, 1975, pp.64-66; see also, from similar secondary sources, R. Fitzgerald, *From Dreaming to 1915: A history of Queensland*, Queensland University Press, St Lucia, 1982, pp.138-143.

the 1870s and even into the first decade of the twentieth century.³⁷ Archibald Meston, the first Queensland Government Chief Protector for Aborigines, recommended in an 1896 report that the policy should be that white settlers, Asian fishermen and Chinese traders should cease interfering with Aboriginal women.³⁸ Earlier in the 1890s Meston and Roth³⁹ had reported to the Queensland Government on the location of the bush people. They indicated that the only places where such people lived out of contact with white settlement were in the far south western and north western areas and in the areas north of Croydon station on Cape York. The populations in desert regions probably always remained sparse because of the low yield of desert food sources which in turn affected female ovulation due to low body weight.⁴⁰ On top of that, loss of living place and disease and the social and environmental consequences, subsequently played a part in keeping the population at low levels.⁴¹

Regular contact between Aborigines and settlers occurred along the trade routes west to Cloncurry and north along the telegraph route from Charters Towers to Normanton. Populations here and along the New South Wales border regions had already been systematically moved east, or had congregated on pastoral leases as stock labour.⁴² For our purposes,

³⁷ AA/VPRS, 2896, see, F.A. Hagenauer, 'Notes of a Missionary Journey to North Queensland 1885'.

³⁸ A. Meston, Special Commissioner for Queensland Government, *Report on the Aboriginal of Queensland, 1896*, in QLAV&P, Vol. IV, pp.723-740.

³⁹ Barry Reynolds, 'Roth, Walter Edmund (1861-1933)', in Nairn and Searle (eds), *ADB*, Vol. 10, pp.463-464.

⁴⁰ J.A. Eden (MD), *Womens' Hormone Problems*, Royal Hospital for Women, Paddington NSW, 1996, pp.1-11.

⁴¹ Smith, *Aboriginal Population*, pp.93-95; see also, Alfred W. Crosby, *The Forgotten Pandemic*, Cambridge University Press, London, 1989, pp.10-11, and see A.W. Crosby, *Germs, Seeds and Animals, Studies in Ecological History*, M.E. Sharp, London, 1994, pp.82-108; see Kunitz, *Disease and Social Diversity*, pp.3-43, see for Australian Aborigines, Chapters 71-120; see also, Denoon, *Settler Capitalism*, p.231-232.

⁴² QLAV&P, 1860, pp.529-783 and to 1873, pp.1173-85; see also, Dawn May, *Aboriginal Labour*, pp.85-98.

however, the western region from along the southern and western border to the Gulf of Carpentaria was fully (though sparsely) settled by 1904. The known Aboriginal populations were mainly distributed along a thin inland corridor stretching from Brisbane to Cloncurry and north around the Gulf to Normanton. The first reliable figures from Protectors' reports indicated that approximately 20,585 Aborigines were living in areas serviced by collectors during the 1891 Colonial census. A further 50,000, some writers claimed, lived in the bush, but from 1900 the validity of such estimates was increasingly doubted.⁴³

No census data on Aborigines exists before 1881, and the earliest colonial estimate available is for 1898.⁴⁴ No figures, before 1901, can be accepted as reliable, and 'the period of the [assumed] Aboriginal population decline, is almost entirely undocumented.'⁴⁵ There was the usual confusion with turn-of-the-century points of view about who an Aborigine was.⁴⁶ Smith has explained that before the first Commonwealth census in 1911 information on race was simply noted by collectors under 'place of birth' and whether those being enumerated were Chinese, Pacific Islander or Aboriginal. In the report of the 1901 census these groups were separated from the main figures, but no record exists about whether or not they were included before 1881,⁴⁷ the Colonial Office data does not consequently specify what racial groups the people counted belonged to, or if some people were excluded altogether. The 1901 Chief Protector's Annual Report indicated that

⁴³ Smith, *Aboriginal Population*, pp.10-12, and p.122.

⁴⁴ *Ibid.*, see Table 7.3.1, p.131, and 122-131.

⁴⁵ *Ibid.*, p.122.

⁴⁶ Queensland Statisticians Ninth Census Report, 1902, in QLAV&P, 1902, QGP, Brisbane, 1902, p.vii.

⁴⁷ Smith, *Aboriginal Population*, p.10.

whilst 5,137 full-blooded Aborigines, as well 1,533 half-castes,...who became integral parts of the industrial population [were included in the census]...all those whether full-blooded or half-caste, living in camps and leading the lives usual to Aborigines were excluded.⁴⁸

What the statistician called 'civilised half-castes' became incorporated in the general Queensland colonial population from 1891 and then in the general Australian population till well after 1940.

A common assumption of historical accounts based mainly on secondary source materials⁴⁹ is that from the initial operations of the *Protection Act 1897*, a systematic removal of Aborigines from western hinterland properties occurred. Myths persist of large numbers of Aborigines who were never counted and large groups being removed from their dwelling places. Many people certainly left 'native' living sites for various reasons, including caring for sick adults and children at government depots and missions. The protection legislation in place from 1897 made life difficult for Aborigines because adults offending against the legislation were often removed by the courts. The Chief Protectors recorded most of the removals in their annual reports, but no comprehensive studies have been undertaken of this movement of people. When considered in relation to the limited number of depots in the south and the annual tally of about 1,500 people accounted for at the depots, the exodus was comparatively small. This is confirmed by the fact that, to cater for the population movement, the creation of only three new reserves was necessary in the south. One was located at Barambah near Murgon, another at Taroom further north and the other was at Duaringa near Hull River.⁵⁰ Palm Island was first opened in 1918 as a

⁴⁸ Chief Protector, *Annual Report*, 1902, QLAV&P, QGP, Brisbane, 1903, p.1.

⁴⁹ Bleakley, *Aborigines of Australia*, pp.11-100; Long, *Aboriginal Settlement*, pp.94-95; see also, Dawn May, *Aboriginal Labour*, pp.40-101; Rowley, *The Destruction*.

⁵⁰ Bleakley, *Aborigines of Australia*, p.115.

leprosarium and converted into a small Aboriginal settlement at the end of the 1920s. It is often held up as the example of oppression.

From the 1911 census onwards the Commonwealth began to show an increasing interest in the Aboriginal data question. When the Commonwealth began discussing the possibility of special Aboriginal censuses with the states in 1918, those involved hoped that by using special collection methods a clearer demographic picture of the total Aboriginal population would emerge.⁵¹ But a number of problems in deciding on appropriate criteria for defining Aborigines had emerged. Sometimes it was purity of race and at other times it was social habit and custom. Sometimes people of half-caste or less than half Aboriginal descent were counted, and at other times they were not. In yet another category were those people of mixed descent leading a bush-dwelling way of life, who were sometimes omitted but were now meant to be included in the 1911 national census. In Queensland, as in other states, the major problem appeared to be the inability of collectors to distinguish people of mixed Aboriginal decent from 'natives'. Collectors relied on local protectors (that is mostly the local police), pastoralists and property owners and managers to identify who could be regarded as Aborigines as distinct from people of mixed race.⁵² As for full-bloods, state and federal statisticians have always gathered data, and although excluded from published final reports of the general population those most affected by Aboriginal administration had a good idea about their actual numbers.⁵³

Such problems of identification notwithstanding, it is possible to draw certain conclusions from the data gathered during successive censuses. Thus, the age structure pyramid of the combined total full-

⁵¹ Smith, *Aboriginal Population*, pp.34-66.

⁵² *Ibid.*, pp.34-66.

⁵³ *Ibid.*, pp.29-34.

blood and half-caste population for 1901 reveals a population with deepseated demographic problems. It strongly suggests a population in decline (see Figure 2.4 above). In each age group under 20 years of age the numbers of males decline; females too seem to be missing in large numbers; there are abnormally more males and females in the 20-24 year age group than in any other. The percentages of persons aged 60 or more decline sharply, the social factors of which are discussed in later chapters. As with colonial data there is an excess of males over females at all ages.

The imbalance in the sex ratio of 1901 (see Figure 2.5 above) continues in most age groups until well after Federation, and is particularly noticeable in the young adult and older age groups. The fluctuations in the sex ratio in the older age groups may, in part, be explained by age heaping — that is rounding a person's age to the nearest ten-year group. This may not be the only explanation but no data exists to elaborate on the underlying reasons. It may equally be explained in terms of the custom of white and Asian settlers and South Pacific seamen cohabiting at will with Aboriginal women of full and mixed descent. The sudden upsurge in the white population in the 1890s and early twentieth century plus an increased presence of Asian pearlers could have been a factor.

Aboriginal males did not have the choice of cohabiting with white women, and as such different racial groups cohabited with the same relatively small number of Aboriginal females. White women did not go into the outlying regions of settlement until after the 1920s, and generally they went to isolated properties. In these instances Aboriginal males were kept on outstations some distance from the homestead.⁵⁴ The health and

⁵⁴ Dawn May, *Aboriginal Labour*, pp.44-74; Rowley, *The Destruction*, pp.157-186, see also, Rowley, *Outcastes in White Australia*, pp.227-240.

social consequences of this phenomenon are discussed in other chapters, but these factors relate directly to collection problems.

At the 1911 census, there were 8,687 Aborigines of full descent, comprising 5,145 males and 3,542 females.⁵⁵ Their age distribution graphically tells another story. Both the full-blood and half-caste populations appear to be on the way to demographic recovery. It is almost certain that the cohabitation of full-blood males and females with half-caste and other white, Asian and Pacific Island male populations resulted in substantial increases in the numbers of 'half-caste' children, as reflected in Figure 2.7 above. This clearly demonstrates that males exceeded females in each age group in the full-blood population distribution (see Figures 2.6 and 2.9 above). What the figures do not indicate is the great variety of racial mixing that was encompassed under the all-embracing term 'half-caste'.

It is difficult to establish the exact dynamics of what was happening to the full-blood Aboriginal population because of the paucity of recorded information. There is, however, sketchy information about individual missions that gives some indication of the process. Jeremy Long estimated that at Aurukun Mission, deaths increased from 12 in the period 1904-05 to 30 in 1911-15, resulting in a negative growth rate of nearly two per cent for the latter period. As Long acknowledges, these records are of limited value because it is unlikely that all births and deaths were recorded.⁵⁶ In addition, the resident population of the Aboriginal camps increased and decreased unpredictably, making any accurate record keeping difficult if not impossible. Most of the adult population lived at some distance from the mission and when children

⁵⁵ L.R. Smith, '1911 worksheet', pp.1-2.

⁵⁶ Long, *Aboriginal Settlement*, p.144; for an appreciation of infant mortality from 1933-47 see Kunitz, *Disease and Diversity*, pp.89-93.

became sick they were brought in by missionaries from the larger bush camps. According to Roth, the population sometimes reached 200 to 400 bush people.⁵⁷

The southern populations were made up mostly of government and mission depot people who came to these institutions either for a health complaint or because they were destitute. The concentration of populations had a marked effect on the deterioration of people's physical condition. Once remote station and mission people became ill or injured they were moved to new, and usually, infectious surroundings. Even if people came to the depots free of any health complaint they soon became vulnerable to infection. In addition such problems increased as the population of the ration and relief depots, and hospital fringe-camps increased.

Figure 2.8 shows the combined Aboriginal population in 1911, and the pyramid clearly contrasts with the earlier one for full-bloods, which displayed a population under great stress. The combined pyramid of the 1911 population looks like a population just sustaining itself

The sex ratio shown in Figure 2.9 clearly displays the heavy imbalance of males to females, with a ratio of 1.4 males to every female overall. The ratio comes close to normal in the younger age groups, which is a further aspect of a strengthening population. The half-caste age structure (see Figure 2.7) reflects the past sexual relations between indigenous groups and white settlers. In addition the half-caste groups were beginning to show substantial numbers at older ages. By 1911, Queensland government policies were beginning to restrict the previously chaotic relations between white settlers and the bush, station and depot populations. At the same time the older full descent

⁵⁷ Long, *Aboriginal Settlement*, p.144; see also, Chief Protector, *Reports*, 1905, p.19 (in QGP, 1906, Vol. II, p.931).

population began stabilising under the combined influence of both protection policies and relief programs.

The imbalance of the sex ratios defies simple explanation. The change which occurred between 1901 and 1911 involved an increasingly pronounced skewing of the overall sex ratio in favour of males. Figure 2.9 suggests an increase in 1911 in the capacity for survival of females at younger ages. In the younger age groups there were only marginally more males than females. The ratio was 108 males to every 100 females in the 0-4 age group, a figure only a little higher than that in the non-Aboriginal population.⁵⁸ But the sex ratio increased substantially in the middle age groups, averaging 153 males to every 100 females, which reflected the earlier constricted body of females moving through the age structure. In the older age groups the ratio fluctuates considerably, reflecting probable age heaping as described above in the 1901 analysis.

The age pyramid structure of the 1921 census revealed further changes, though the national census in 1921 did not record the age structure of the full-bloods. It is only the half-caste population which provides data with which to construct an age pyramid (see Figure 2.10). The 1921 census counted 3,090 half-castes, embodying 1,604 males and 1,486 females. The pyramid reflects a young and rapidly growing population (see Table 2.6). In the 0-4 age group the number of males exceeded females while the opposite occurred in the 5 to 9 age group. In the middle age groups there is a trend towards equal numbers of males and females. Overall the sex ratios below age 50 look quite reasonable.

As we move to the 1933 full-blood Aboriginal population the male figures are much higher than those for females. This group, according to some writers, was still recovering from

⁵⁸ Smith, 'Census, 1911, Aboriginal age distribution, worksheets', p.1.

the nineteenth century depopulation [that] resulted in...a gross excess of males in the population in settled areas....In this century, remote Aboriginal groups brought under control were not subject to the same drastic assault and destruction so their progressive inclusion in the censuses since 1901 may have even reduced the overall masculinity of the enumerated population throughout the age ranges.⁵⁹

The total number of Aborigines enumerated at the 1933 census was 15,676, which included 8,465 males and 7,211 females (see Table 2.8, and see Figure 2.14 below). The group contained 5,709 males and 4,532 females of full-blood descent and 2,756 males and 2,679 females of half-caste descent. It was estimated that an additional 2,291 persons existed in remote areas, making a total Aboriginal population of 17,967 (see Table 2.1).⁶⁰

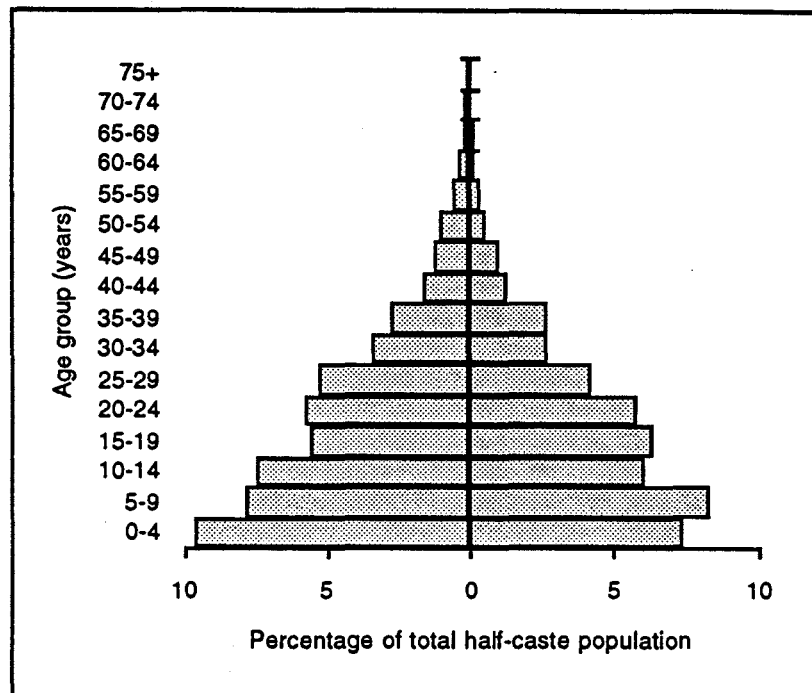
The following discussion is based on the enumerated figure 15,676. The age distribution is the key component of this analysis.⁶¹ The enumerated population of full-bloods totalled 10,241, and the age distribution provides some insight into what was happening during this period. The 1933 age structure reflects a mature profile characteristic of a population that is just replacing itself. The structure of the full-blood population suggests that there were probably just sufficient numbers in the younger age groups to sustain population growth greater than the numbers of people who died. Although mortality data from disease was collected the Queensland Government did not collect general mortality information on Aborigines of either full- or half-descent. It was impossible, therefore, to match only the mortality data by causes and by sex. Although the males outnumbered the females at all ages, the differential is greatest in the older age groups (see Figure 2.12 below). By

⁵⁹ Smith, *Aboriginal population*, pp.128-129.

⁶⁰ *Ibid.*, see Table 7.3.1, p.131.

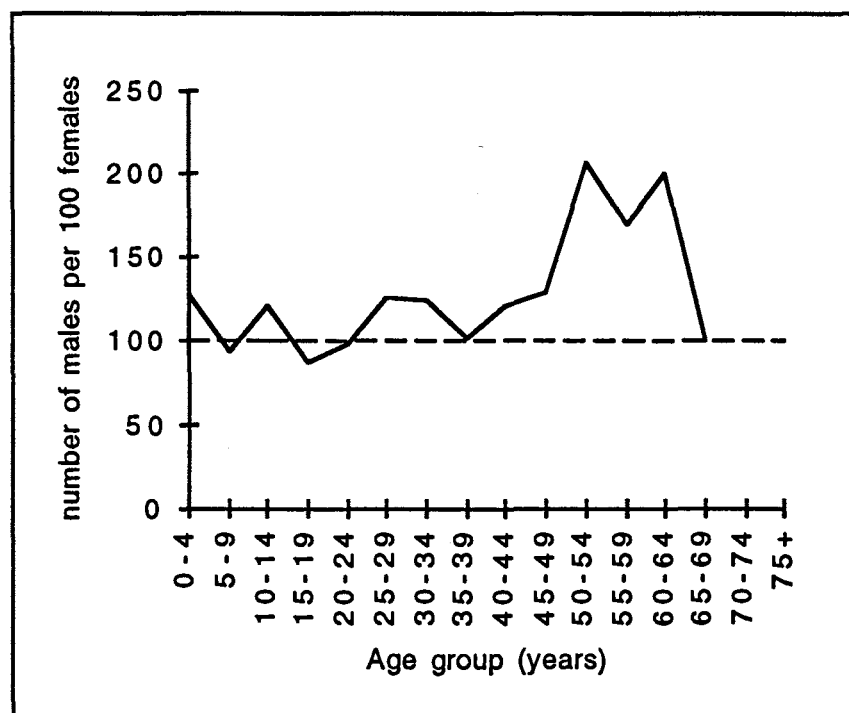
⁶¹ Smith, '1933 worksheet', p.1.

Figure 2.10: Half-caste Aborigines by age and sex in Qld, 1921



Source: Compiled from Table 2.6.

Figure 2.11: Age-specific sex ratio of half-caste Aborigines in Qld, 1921



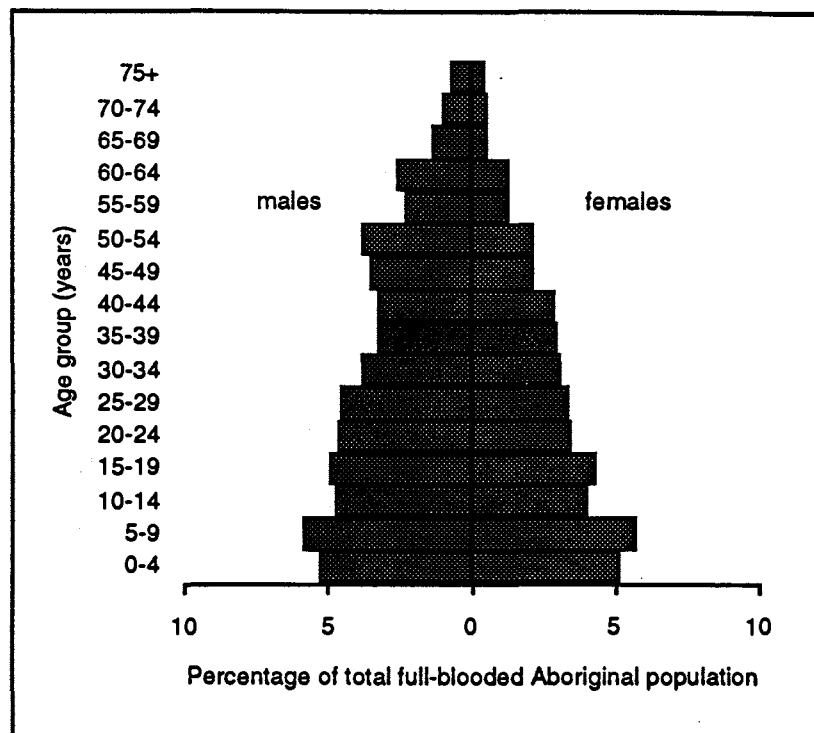
Source: Constructed from Table 2.7.

contrast, the age structure of the half-castes displayed the characteristics of a young population with the potential for rapid growth (see Figure 2.13).

By 1933 then, the total Aboriginal age structure was assuming the characteristics of a population already entering a period of growth. The younger age groups displayed greater resilience, and a larger proportion of Aborigines were surviving in the older age groups. In 1901, by contrast, only 97 full-blood and half-caste persons had survived to aged 60, whereas in 1933 the numbers in the latter age group increased to 985. The 1933 figures consisted of 619 males and 366 females compared with only 42 males and 18 females in 1901. Presumably the government policies of earlier decades had begun making an impression on the older as well as the younger age groups.

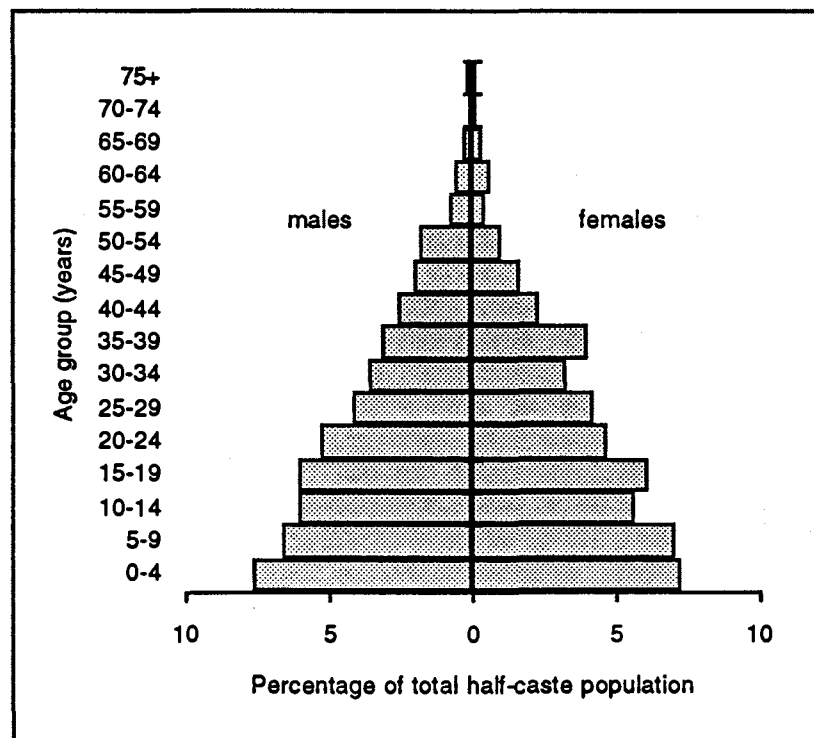
The overall trend of a converging sex ratio appears to have continued in the 1933 census. In 1901 no full-blood figures were separated out from the total Aboriginal population so no comparison is possible. For 1911 a comparison of the data reveals that although the total Aboriginal population is on the increase it is the half-castes that give the population the strength displayed in the pyramid shown Figure 2.8. This is a reflection of the historic potential (that is, in hindsight the then undetected increases which were actually taking place) for positive growth. Although there was government dissatisfaction with the management philosophies of depots and health facilities operated by the Christian missions that spans the period from 1919 to the late 1930s, two factors were evident. The first was that the Queensland Government was driven by a broader political concern for Aboriginal welfare. The second was that the population reversals were beginning to show that protection and relief programs did succeed. The advances became more evident after 1921 due to the State's increasing awareness of its role in public health,

Figure 2.12: Full-blood Aborigines by age and sex in Qld, 1933

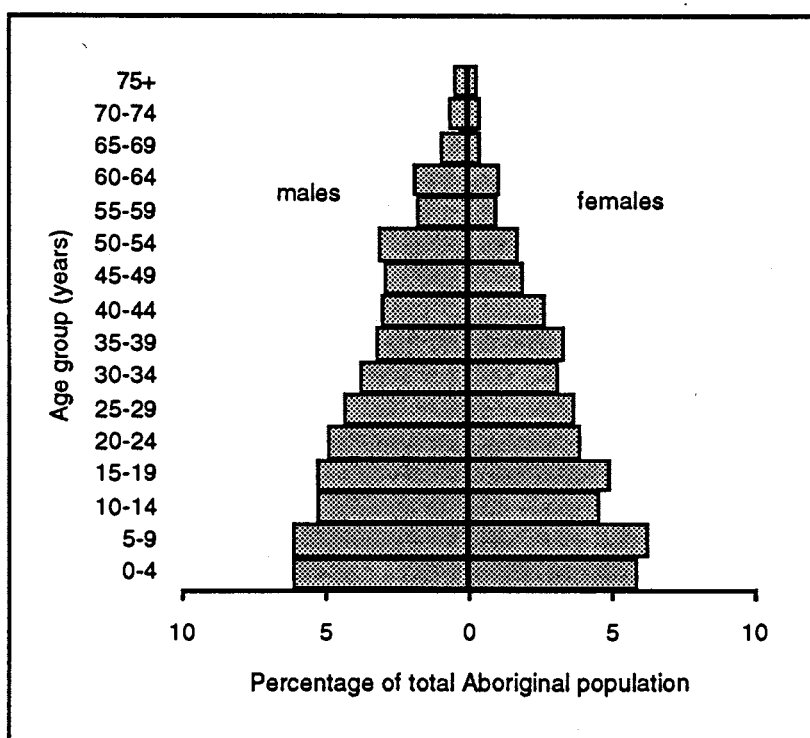


Source: Compiled from Table 2.8.

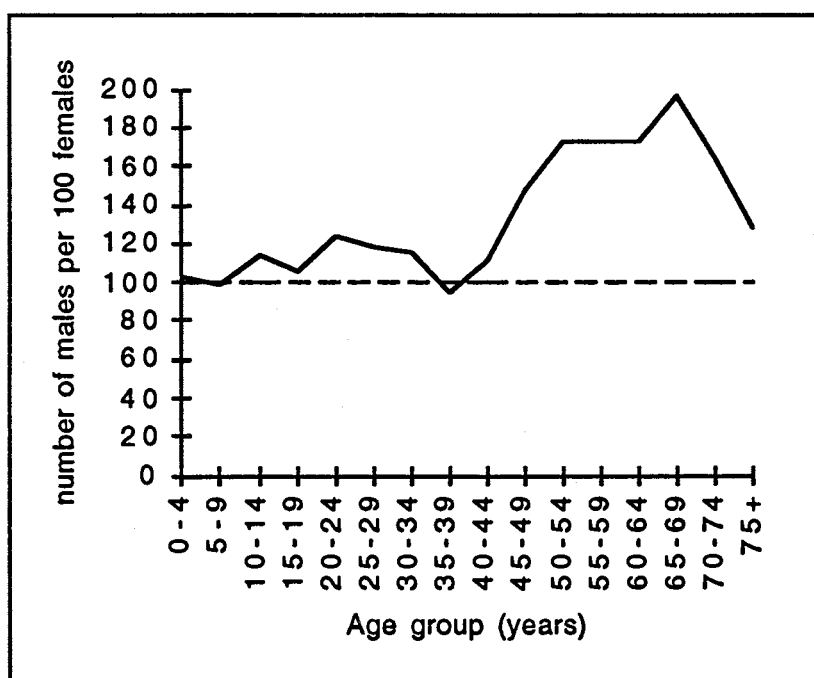
Figure 2.13: Half-caste Aborigines by age and sex in Qld, 1933



Source: Compiled from Table 2.8.

Figure 2.14: Total Aborigines by age and sex in Qld 1933

Source: Compiled from Table 2.8.

Figure 2.15: Age-specific sex ratio of full-blood and half-caste Aborigines in Qld, 1933

Source: Compiled from Table 2.9.

and particularly the health of Aborigines. Thus, as I examine in more detail below, the government attempted to keep track of infectious diseases such as the respiratory ailments which killed the aged and infirm in considerable numbers. Furthermore, other lethal diseases captured public concern and from the turn of the century child mortality became a wider Australian public health issue that also affected Aboriginal depots. As the 'baby health' movement began influencing Aborigines in the 1920s, better pre-natal care for younger pregnant women was one outcome which helped to strengthen the Aboriginal population growth potential.⁶² Finally, the introduction of easier access to professional medical care presented itself as an option for both government protectors and missionary services to Aboriginal groups. From 1921 Aboriginal females began thriving under protection, a phenomenon that became more marked in the two decades that followed. In this period the Queensland government began taking greater responsibility for disease, health and healing in Aboriginal depots, on missions, in work-camps on pastoral properties, and in town and hospital fringe-camps.

White settlement continued from 1901 to 1940. Such settlement was less traumatic to Aborigines in the western and northern hinterland because of the strengthening of legal protection in 1897. Once the protection process began operating more effectively there was greater possibility for the Aboriginal population to increase. The full-blood groups grew slowly because of the demographic problems resulting from their nineteenth century experiences. The mixed descent groups grew more quickly, and as governments incorporated them into the State's health and relief programs they thrived, in at least a demographic sense,

⁶² Phillippa Mein Smith, 'Reformers, Mothers and Babies: Aspects of Infant Survival Australia 1890-1945', Ph.D. thesis, Australian National University, January 1990, pp.106-188.

under the protection policies. The difficulty in knowing whether the Aboriginal population was either increasing or disappearing arose from the constantly shifting interaction between the enumerated and estimated Aboriginal populations in Queensland. One further complication was a changing understanding of what Aboriginal identity meant among people of full, half and other mixed-descent peoples. Yet another complication was the imperative of estimating the number of Aborigines of full-descent who lived beyond census collection districts. These estimates became subject to constant revision throughout the period from federation until well after 1940. The figures fluctuated from a high of 20,000 in 1901 to a low of 2,291 in 1933 (see Figures 2.1 to 2.3 and Tables 2.1 and 2.3). The earlier gross over-estimation led to false assumptions that the population was declining dramatically (Figures 2.1 to 2.3), and that large numbers of bush people lived in locations away from white pastoral settlers.

As a result of the distorted perspective adopted by the State, federal and mission administrations the total population appeared to decline from 26,670 to 17,967 during the study period. On further analysis, however, the total enumerated Aboriginal population increased substantially, from 6,670 in 1901 to 15,676 in 1933 (Table 2.1). People of full-descent increased by 100 per cent, and the half-castes by over 250 per cent. Figure 2.1 above (and Tables 2.1 to 2.3) summarises what the true demographic trends were. I now discuss each State in turn, between the period 1900 to 1940, beginning with Western Australia and later focusing on Queensland.

Table 2.1: Aborigines in Queensland (Qld), 1901-1933

		Full-descent			Others			Total		
		males	females	persons	males	females	persons	males	females	persons
1901	Enumerated	3,089	2,048	5,137	773	760	1,533	3,862	2,808	6,670
	Estimated	9,911	10,089	20,000				9,911	10,089	20,000
	Total	13,000	12,137	25,137	773	760	1,533	13,773	12,897	26,670
1911	Enumerated	5,145	3,542	8,687	1,361	1,147	2,508	6,506	4,689	11,195
	Estimated			11,313						11,313
	Total			20,000	1,361	1,147	2,508			22,508
1921	Enumerated	4,501	3,026	7,527	1,604	1,486	3,090	6,105	4,512	10,617
	Estimated	3,536	2,951	6,487				3,536	2,951	6,487
	Total	8,037	5,977	14,014	1,604	1,486	3,090	9,641	7,463	17,104
1933	Enumerated	5,709	4,532	10,241	2,756	2,679	5,435	8,465	7,211	15,676
	Estimated	1,364	927	2,291				1,364	1,927	2,291
	Total	7,073	5,459	12,532	2,756	2,679	5,435	9,829	8,138	17,967

Source: Smith, The Aboriginal Population of Australia, page 131.

Table 2.2: Aborigines by age and sex in Queensland (Qld), 1901

Age group	Full-bloods*			Half-castes*			Total		
	Males	Females	Persons	Males	Females	Persons	Males	Females	Persons
0-4							319	313	632
5-9							356	326	682
10-14							434	306	740
15-19							464	339	803
20-24							607	404	1,011
25-29							468	275	743
30-34							296	255	551
35-39							220	158	378
40-44							143	151	294
45-49							109	46	155
50-54							87	58	145
55-59							27	23	50
60-64							42	18	60
65-69							11	14	25
70-74							7	4	11
75+							1	0	1
Sub total							3,591	2,690	6,281
N/S							271	118	389
TOTAL							3,862	2,808	6,670

Source: Queensland Parliamentary Papers CA, 74, 1901, Ninth Census of Queensland, QGP, Brisbane, 1902, Table L1, p.115.

Table 2.3: Age-specific sex ratio of Aborigines and half-caste population in Qld, 1901

Age group	
0-4	102
5-9	109
10-14	142
15-19	137
20-24	150
25-29	170
30-34	116
35-39	139
40-44	95
45-49	237
50-54	150
55-59	117
60-64	233
65-69	79
70-74	175
75+	

N/S: Not stated

Compiled from Table 2.2. (a) the number of males per 100 females.

* Separate figures for full-bloods and half-castes are not available.

Table 2.4: Aborigines by age and sex in Queensland (Qld), 1911

Age group	Full-bloods			Half-castes			Total		
	Males	Females	Persons	Males	Females	Persons	Males	Females	Persons
0-4	304	304	608	195	158	353	499	462	961
5-9	300	226	526	171	187	358	471	413	884
10-14	296	199	495	168	171	339	464	370	834
15-19	347	265	612	194	155	349	541	420	961
20-24	530	323	853	177	119	296	707	442	1,149
25-29	555	339	894	125	97	222	680	436	1,116
30-34	415	247	662	65	66	131	480	313	793
35-39	311	193	504	46	40	86	357	233	590
40-44	309	201	510	37	36	73	346	237	583
45-49	207	141	348	30	20	50	237	161	398
50-54	263	170	433	17	13	30	280	183	463
55-59	102	57	159	7	3	10	109	60	169
60-64	140	74	214	9	4	13	149	78	227
65-69	35	25	60	4	3	7	39	28	67
70-74	41	24	65	2	0	2	43	24	67
75+	23	17	40	0	0	0	23	17	40
Sub total	4178	2805	6,983	1247	1072	2319	5,425	3,877	9,302
N/S	967	737	1,704	114	75	26	1,081	812	1,893
TOTAL	5145	3542	8,687	1361	1147	2345	6,506	4,689	11,195

Source: Smith, '1911 Worksheet on full-bloods as enumerated', p.4.

Table 2.5: Age-specific sex ratio of Aborigines and half-caste population in Queensland, 1911

Age group	
0-4	108
5-9	114
10-14	125
15-19	129
20-24	160
25-29	156
30-34	153
35-39	153
40-44	146
45-49	147
50-54	153
55-59	182
60-64	191
65-69	139
70-74	179
75+	135

N/S: Not stated.

Source: Compiled from Table 2.4. (a) the number of males per 100 females.

Table 2.6: Aborigines by age and sex in Queensland (Qld), 1921

Age group	Full-bloods*			Half-castes			Total*		
	Males	Females	Persons	Males	Females	Persons	Males	Females	Persons
0-4				275	214	489			
5-9				225	240	465			
10-14				214	176	390			
15-19				159	183	342			
20-24				165	167	332			
25-29				151	120	271			
30-34				97	78	175			
35-39				79	77	156			
40-44				45	37	82			
45-49				36	28	64			
50-54				31	15	46			
55-59				17	10	27			
60-64				12	6	18			
65-69				5	5	10			
70-74				5	1	6			
75+				1	2	3			
Sub total				1,517	1,359	2,876			
N/S				87	127	214			
TOTAL				1,604	1,486	3,090			

Source: Smith, '1921 Worksheet on Census for 1921, 'half-castes', p.2.

Table 2.7: Age-specific sex ratio (a) of Aborigines in Qld, 1921*

Age group	
0-4	129
5-9	94
10-14	122
15-19	87
20-24	99
25-29	126
30-34	124
35-39	103
40-44	122
45-49	129
50-54	207
55-59	170
60-64	200
65-69	100
70-74	500
75+	50

N/S: Not Stated

Source: Compiled from Table 2.6. (a) the number of males per 100 females.

* Full-blood figures not available for 1921.

Table 2.8: Aborigines by age and sex in Queensland (Qld), 1933

Age group	Full-bloods			Half-castes			Total		
	Males	Females	Persons	Males	Females	Persons	Males	Females	Persons
0-4	522	510	1,032	411	391	802	933	901	1,834
5-9	578	569	1,147	356	381	737	934	950	1,884
10-14	470	395	865	327	306	633	797	701	1,498
15-19	481	426	907	324	331	655	805	757	1,562
20-24	457	344	801	283	255	538	740	599	1,339
25-29	443	337	780	223	228	451	666	565	1,231
30-34	376	311	687	192	179	371	568	490	1,058
35-39	316	299	615	169	215	384	485	514	999
40-44	317	286	603	138	124	262	455	410	865
45-49	347	216	563	105	89	194	452	305	757
50-54	372	216	588	96	54	150	468	270	738
55-59	229	134	363	43	23	66	272	157	429
60-64	257	133	390	29	33	62	286	166	452
65-69	132	58	190	18	18	36	150	76	226
70-74	99	55	154	8	10	18	107	65	172
75+	66	50	116	10	9	19	76	59	135
Sub total	5,462	4,339	9,801	2,732	2,646	5,378	8,194	6,985	15,179
N/S	247	193	440	24	33	26	271	226	497
TOTAL	5,709	4,532	10,241	2,756	2,679	5,404	8,465	7,211	15,676

Source: Smith, '1933 Worksheet on Age Distribution File Enumerated for full-bloods', p.1.

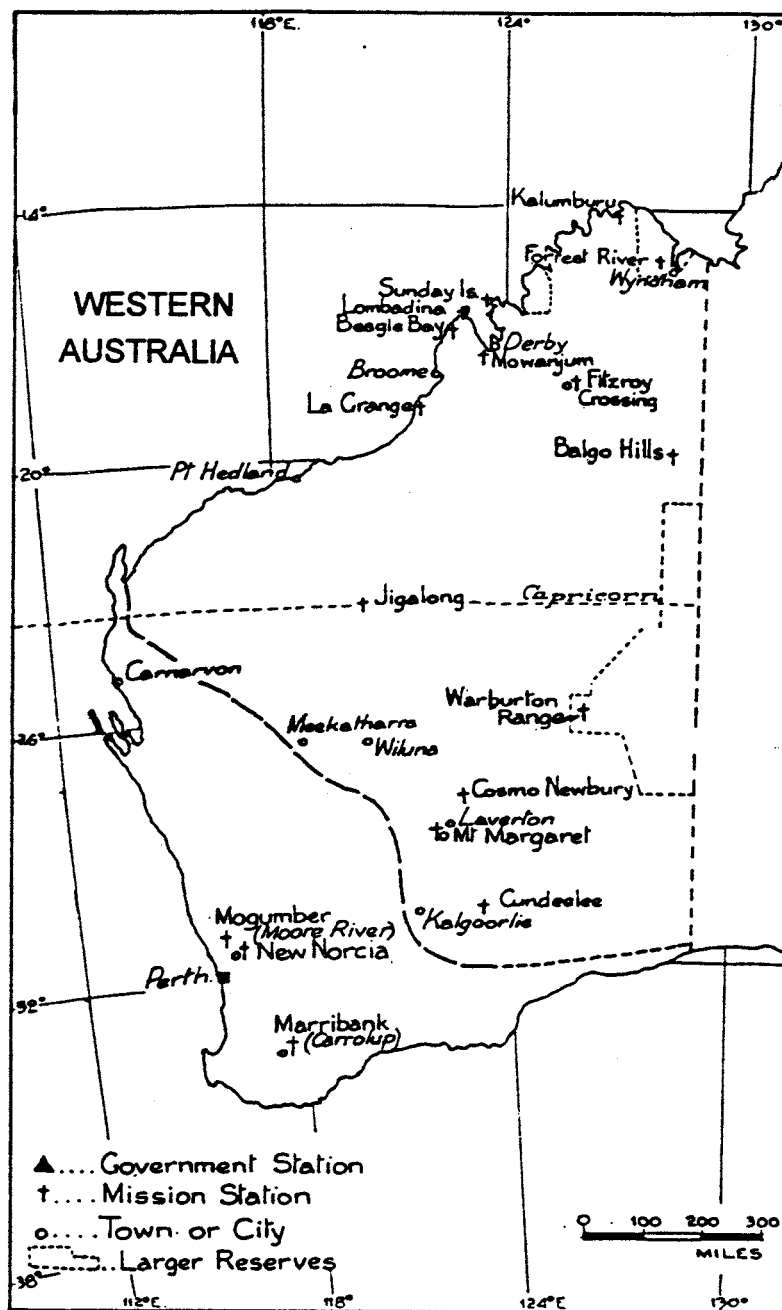
Table 2.9: Age-specific sex ratio(a) of Aborigines and half-caste population in Qld, 1933

Age group	
0-4	104
5-9	98
10-14	114
15-19	106
20-24	124
25-29	118
30-34	116
35-39	94
40-44	111
45-49	148
50-54	173
55-59	173
60-64	172
65-69	197
70-74	165
75+	129

N/S: Not Stated.

Source: Compiled from Table 2.8. (a) the number of males per 100 females.

Map 2



A map of Western Australia locating government and mission stations, reserves and some country towns and cities mentioned in the text.

Source: adapted from J.P.M. Long, *Aboriginal Settlement*, p.191.

CHAPTER 3

Protection as Health: indigenous health in Western Australia, 1900 to 1910

By 1900 the settler population of the Swan River colony were aware that their Government's long established policy towards the indigenous inhabitants was in need of change. British policy gave the Aboriginal inhabitants full legal and civil liberties as British subjects. In addition they were to be embraced by British civilisation through the agency of Christianity. They were also to receive protection which included safeguards of their well-being.¹ These ideals underlay the views on Aboriginal administration formulated by the Colonial Office. The policy was eventually enshrined in the *Aborigines Act 1886*. This legislation conferred wide powers on the Perth-based Aborigines Protection Board to oversee both Aboriginal labour and the land owners employing them.²

By the 1890s relations between settlers and indigenous groups had deteriorated, however, and change was demanded. Settlers wanted self-government and less control by the Colonial Office in Britain. Those settlers interested in protecting the Aborigines wanted a new and stronger legislative protection structure. At this time the policy embodied in the 1886 legislation had become unworkable. This left those Aborigines still coming into first contact with settlers without the protection they needed. The pastoral

¹ P.M.C. Hasluck, *Black Australians: A survey of native policy in Western Australia 1829-1897*, MUP, Melbourne, 1942; see also, Rowley, *The Destruction*, pp.64-73; Keith Cole, *The Aborigines Of Western Australia*, Keith Cole Pub., Bendigo, 1985, p.19.

² John McCorquodale, *Aborigines And The Law: A Digest*, Aboriginal Studies Press, Canberra, 1987, p.92.

settlements continued to expand into environments occupied by Aborigines, and although there was hardship for the settlers the Aborigines suffered in the ensuing economic and political exchanges.

On top of the changes in the old social relationships came the catastrophic impact on Aboriginal customs and manners of new diseases. Indigenous women and older males were affected most.³ One reason was that although many people of full descent lived in the bush, many also lived in the areas newly settled by colonists. Another reason was that people living in the southwestern corner of the State were mostly people of mixed descent, and they lived closer to, or in, white settlement and, although it was not guaranteed, they could be given medical treatment. In the north, however, most Aborigines had only recently begun to move from bush life onto newly established missions.⁴ In the transition from the 1890s to 1900, the care of indigenous people and their descendants now relied on the newly created Aborigines Department which was established by the colonial government under the *Aborigines Protection Act 1897*.⁵

The Christian churches, scholars and journalists were interested along with government protectors and some sympathetic land owners in protecting indigenous groups, and in learning as much about their customs, habits and practices as the Aborigines were able to impart. Early in the twentieth century Daisy Bates,⁶ the writer and ethnographer, travelled widely around the south of Western Australia and into the Kimberley region as the wife of a property manager, and also as a researcher with the

³ A. Grenfell Price, *White settlers and native peoples*, Georgian House, Melbourne, 1950, see in particular Chapter VI, on the decline of Aborigines due to disease; see also, L.R. Smith, *Aboriginal Population*, pp.260-261.

⁴ Hasluck, *Black Australians*, pp.122-161; see also, Rowley, *The Destruction*, pp.86-107 and pp.187-191; Daisy Bates, *The Passing*, pp. 1-29.

⁵ McCorquodale, *Aborigines and the Law*, p.92.

⁶ Isobel White (ed.), *Daisy Bates, The Native Tribes Of Western Australia*, National Library of Australia, Canberra, 1985, pp.1-35; see also, Daisy Bates, *The Passing*.

anthropologist, Radcliffe-Brown.⁷ Bates worked among and wrote about Aborigines, contributing to the development of ethnographic methodology. She recorded Aboriginal customs, manners and languages, witnessed and recorded Aboriginal ceremonial practices and wrote about the attitudes of Aborigines toward diseases and the way they treated their maladies.⁸

Notions of what indigenous people understood as disease and sickness were intrinsically bound up in other complex ideas about the relationships that Aborigines had with each other, and in belief systems about the animal world and the locations of their birth. Magic played an important role in Aboriginal thinking about disease because magic was understood to be at the root, causing people to become sick, die or be cured.⁹ Bates wrote variously on the magic of the Murchison peoples as well as some groups in the Kimberley. Bates accepted that what she observed were forms of superstition which she regarded as part of a general Aboriginal religion.¹⁰ Isobel White points out that Bates concluded in her ethnography that Aborigines thought there was no such thing as death from disease of any kind. People she interviewed had no notion of death from disease because disease could not be translated as a unified concept. She added that if an Aboriginal person died because they ate rancid meat from either whale, or fish, they believed that it was magic that killed the victim rather than the bad food. Further, if a person choked with a bone from an animal or fish, it was because they were bewitched. If they died from gluttony, the food consumed must have been tampered with by sorcerers, or the food preparation custom was in some way broken.¹¹ If an animal was caught, cooked and eaten and stomach pains

⁷ Isobel White, *Daisy Bates*, pp.1-35.

⁸ *Ibid.*, pp.18-20.

⁹ *Ibid.*, pp.226-238.

¹⁰ *Ibid.*, p.216, in the notes to Chapter 6 Isobel White explains how Daisy Bates arrived at this view in her unpublished manuscripts; see notes 1-2, p.238, see ANL Series, 365/33/5-6, quoted in *Ibid.*, p.290.

¹¹ *Ibid.*, p.230.

occurred, the victim would become suspicious of magical intervention, and look for the nearest sorcerer.

Ideas of the causes of disease and their cures appeared to Bates to be part of the sorcerer's retinue. Normally, sorcerers had names that reflected natural phenomena such as thunder or sparks from a fire.¹² Sorcerers and their practices appeared to be ubiquitous, and Bates noticed that the 'magic stick' was in common use — mainly in concert with other things sorcerers carried such as plants with which magic was worked — by the southern, central and northern groups. Bates indicated that she believed that 'their greatest power...came from their metaphysical strength, and magic...[which] was secreted...from within themselves, and their apparent control ...over the elements.'¹³ Other signs of impending doom or illness such as unusual and strange animal actions or sounds which mimicked the call of a crow or the screech of a cockatoo after dusk, or at night, might serve to explain something that would come to injure the sick or diseased person.¹⁴

Bates noticed how fearful of sorcerers many people were and how that fear gripped people to whom she spoke. People believed that sorcerers could do them harm even from great distances. If storms occurred the sorcerer would be blamed, and sick or dying people believed this meant that sorcerers were trying to communicate with them.¹⁵ Other natural phenomena such as eclipses of the sun or moon could frighten people into believing that a sorcerer was attempting to communicate with them personally. Unknown events also played on people's fears, giving the sorcerer actual physical power. The 'mulgarguttuk' as she wrote, might tell of a distant illness, or death, or suggest that a person had suddenly

¹² *Ibid.*, pf.

¹³ *Ibid.*, p.231.

¹⁴ *Ibid.*, pf.

¹⁵ *Ibid.*, p.232.

developed powers of sorcery or that a sorcerer was about to die. Sorcerers also were thought to afflict the healthy and strong by their magical powers, an additional factor that made them powerful in the minds of those who held such beliefs.¹⁶ The gradation of any sorcerer's powers appeared endless and one sorcerer could easily die or be affected by another more powerful. Males tended to dominate the skills and practices of sorcery, but, in some groups, women could be found practising magic.¹⁷

Of particular importance to Bates were the traditional cures for sickness, pains and injuries. Some ideas recorded by Bates appeared to contradict notions of cures of sicknesses. She recorded ideas which were considered by her informants not to be illnesses but natural events, especially if the illness was unfamiliar to the sorcerer. Indigenous sorcerers used herbal potions for some complaints offered by victims along with the use of 'topical bleeding' — bleeding in a common place such as the arms — as well as body hair from their own armpits, or pubic area, to rub or leave on the sick person and, finally, many used urine, either their own or produced as a preparation from older females. Some of the diseases brought by Europeans were not part of the knowledge or experiences of the sorcerers to whom she talked. Bates found that there were many illnesses with which Aborigines were acquainted, and had a customary mode of use.¹⁸ According to Bates, most of the sickness which they contracted related directly to 'the result of over-indulgence in food, over-excitement in dancing, or...ceremonies.'¹⁹ As Bates travelled among the informants she did notice the presence of what was popularly called 'ophthalmia'. Ophthalmia (trachoma) was regularly present, 'particularly amongst the north west natives, and was

¹⁶ *Ibid.*, pp.232-233.

¹⁷ *Ibid.*, pp.234-235.

¹⁸ *Ibid.*, p.288.

¹⁹ *Ibid.*, pf.

due mainly to great plagues of flies which infest the district during two-thirds of the year'.²⁰ Bates noticed that the action of wind and sun on the dry dust and sand had an effect on the eyes of settlers and Aborigines. Once the eyes became sore infection could follow to become ophthalmia, popularly called 'sandy blight'.²¹

Other illnesses known by Aborigines, prior to European settlement, included dysentery, diarrhoea, pneumonia, colds, headache, liver troubles, biliousness, sores, rheumatism, inflammation, and various skin complaints such as erysipelas inflammation.²² Mental illness, or what Bates describes as idiocy and temporary madness, were known to Aborigines up and down the coastline of Western Australia, as were deformities, but most of the deformed babies either died at birth or were killed.

Bates clearly stated that, except for those diseases which were introduced from outside such as gonorrhoea,²³ the native had apparently no infectious diseases among them. Because she had a limited knowledge of bacteriology, she did not elaborate on some of the body wasting and deforming diseases she came across. She most certainly believed that infectious diseases such as some sexually transmitted diseases and diseases caused by poor hygiene such as yaws (a disease I discuss below), leprosy (a chronic bacterial disease of the skin, peripheral nerves and the upper airways, also known as Hansen's Disease)²⁴ and tuberculosis (a mycobacterial disease, which also includes phythis, or pulmonary tuberculosis and discussed further below), came with either season visitors or settlers. Later researchers, however, throw a different light on this very

²⁰ *Ibid.*, pf.

²¹ *Ibid.*, pf.

²² *Ibid.*, p.289.

²³ Abrams S. Benenson (ed.), *Control of Communicable Diseases in Man*, Fifteenth Edition, APHA, Washington DC, 1990, p.185. See also *Concise Oxford Medical Dictionary*, Third Edition, Oxford University Press, New York, 1990, p.294.

²⁴ Benenson, *Communicable Diseases*, p.243.

complex question. In trying to dispel the earlier harsher viewpoint of a decrepit and blinded race, Daisy Bates put forward her own view that Aborigines were not as diseased as the English navigator Dampier had suggested.²⁵

Acceptance of Daisy Bates' romanticised view failed to erase the doubt that still existed about the possibility that infectious diseases existed in groups of Aborigines before European settlement.²⁶ Did bacterial and viral infections affect Aborigines prior to European settlement? Is it probable that forms of venereal diseases (to western medicine venereal disease means diseases which are sexually transmitted, not all of which are discussed in this thesis)²⁷ existed in the populations of the mainland? If such infectious diseases did exist before 1788 who or what brought them, and in particular, was their passage made possible by the Asian and Pacific navigators known to have contacted mainlanders since the commencement of the holocene?²⁸ Bates contradicts her unpublished material in which she implies that the evidence provided by an informant showed that sexually transmitted diseases did exist and formed part of a system of knowledge used by Aborigines, and their name for it was 'called koo-ar-oo...common to coastal...[groups]'.²⁹ They knew also that the disease affected 'newborns as

²⁵ William Dampier: *A New Voyage Around The World*, 3rd ed. (London 1698) Vol. (i) pp.350-351, in C.M.H. Clark, *A History of Australia: From The Earliest Times To The Age Of Macquarie*, Melbourne University Press, 1962, pp.39-41.

²⁶ Butlin, *Our Original Aggression*, p.8; see also, A. Gray, 'Some Myths In The Demography Of Aboriginal Australians', in *Journal of the Australian Population Association*, Vol. 2, No. 2, November 1985, pp.136-149.

²⁷ *Concise Medical Dictionary*, p.631. Of the diseases which are discussed in this thesis, the definition includes Syphilis and gonorrhoea.

²⁸ R.L. Kirk, *Aboriginal Man Adapting*, Oxford University Press, Melb., 1979, pp.18-38; see also, C.C. Macknight, 'Macassans And Aborigines', in *Oceania*, Vol. XLII, No. 4, June 1972, pp.283-321.

²⁹ Goldsmid, *Deadly Legacy*, p.15. See also Daisy Bates, *The Passing*, pp.4-6; see also Kirk, *Aboriginal Man Adapting*, p.170.

well, [and] could have been related...to the occurrence of yaws³⁰ or endemic syphilis³¹ in the pre-European era.³²

By contrast, Herbert Basedow said he believed that both syphilis and gonorrhoea came with Europeans.³³ But based on recent physical and biological anthropological research, treponemal diseases such as syphilis and yaws may have existed well before European settlement.³⁴ Similarly, missionaries on the Kimberley coast revealed that forms of venereal diseases and skin complaints were already present when they arrived to live with Aboriginal groups just after 1910.³⁵ They support published evidence gathered directly from Aborigines by Daisy Bates that conditions showing symptoms similar to endemic and congenital syphilis and yaws had existed prior to white settlement, possibly after contact with seasonal Macassan visitors.

At this point it is useful to review what is known now about the likely presence of bacterial and viral infections in hunter gatherer groups similar to Australian Aborigines before and following outside contact. Yaws (which is not sexually transmitted) and syphilis are closely related. Moreover, *Treponema pertenue*, which causes yaws, provides immunity to syphilis by conferring cross-immunity against *Treponema pallidum*, which causes syphilis.³⁶ Yaws is found in areas of tropical rain forests and was first named

³⁰ Benenson, *Communicable Diseases*, p.483.

³¹ *Ibid.*, p.420. This disease comes in two forms (sexually transmitted disease (STD) and non-STD) and is discussed further on in the text.

³² *Ibid.*, pf.

³³ H. Basedow, 'Diseases of the Aborigines', in *Journal of Tropical Medicine and Hygiene*, 1932, Vol. 35, pp.193-277.

³⁴ M. Prokopec, 'Demographic and Morphological aspects of the Ronka population', in *Archaeology and Physical Anthropology in Oceania*, 1979, Vol. 14, pp.11-26.

³⁵ Maisie McKenzie, *The Road to Mowanjumb*, Angus and Robertson, Sydney, 1969.

³⁶ A. Castellani, 'On the presence of spirochaetes in two cases of ulcerated parangi (yaws)', in *British Medical Journal*, 1905, 2, 1280; see also, A. Gray, 'Some Myths', pp.136-149.

by Castellani in 1905.³⁷ Mostly a disease of childhood, yaws spreads by direct contact with other human hosts. Also hosts may pass the infection on through direct skin contact by exposing broken skin directly to infectious lesions either on the mouth or sores on limbs, where the infection can expand and contains numerous bacteria. The disease can then spread to the hands and feet, infecting the bones as well. This form of yaws is morphologically identical to sexually-transmitted syphilis.³⁸ Since the turn of the century these diseases have been particularly difficult for trained and untrained health workers to detect. Syphilis has been described as 'a democratic disease for it does not discriminate between people of different social classes, races, sexes, religions, ages, or countries.'³⁹

As hunters and gathers moved from Africa to other parts of the globe they took parasites with them.⁴⁰ Although there is no absolute means of knowing, one plausible writer, W.H. McNeill, has speculated that parasites probably were passed from one host to another by direct contact and passing body fluids either by sexual intercourse or between mothers and babies before, during and after birth. It is equally probable that yaws, could survive in temperate climates within small populations of migratory hunters.⁴¹ The process could well have last for some time 'as long as the infection acted

³⁷ G.D. Wasley and H.H.Y. Wong, *Syphilis Serology: Principles and Practice*, Oxford Medical Publications, OUP, Oxford, 1988, p.5 and also, pp. 53-67; see also, Benenson, *Communicable Diseases*, pp.438-439.

³⁸ Wasley and Wong, *Syphilis*, p.9; see also, John P. Fox, Carrie E. Hall, Lila R. Elverback, *Epidemiology Man and Disease*, Macmillan, London, 1970, pp.61-67; see also, M. Prokopec, 'Demographical and morphological aspects of the Rookna population', in *Archaeology and Physical Anthropology in Oceania*, Vol. 14, 1979, pp.11-26.

³⁹ D.J. Mulvaney, *Prehistory of Australia*, pp.128-171; see also, A.G. Thorne, 'Morphological contrasts in Pleistocene Australians', in R.L. Kirk and A.G. Thorne, *The Origins of the Australians*, AIAS, Canberra, 1976, pp.95-112; see also, J.M. Bowler, 'Recent developments in reconstructing late Quaternary environments in Australia', in Kirk and Thorne, *Origins*, pp.55-77; see also, Kirk, *Aboriginal Man Adapting*, pp.18-38, p.170; see also, Goldsmid, *Deadly Legacy*, p.15; see also, Isobel White, 'Tribes of WA', pp.288-297; see also Daisy Bates, *The Passing*, pp.4-6.

⁴⁰ W.H. McNeill, *Plagues and Peoples*, Penguin, New York, 1976, pp.38-39.

⁴¹ *Ibid.*, p.39.

slowly and did not incapacitate the human host too severely'.⁴² These parasites most probably travelled with hunting gatherers 'from humanity's tropical cradle lands throughout the earth'.⁴³ In indigenous Australians research conducted by Cleland⁴⁴ (a trained research biologist) and Basedow⁴⁵ (a general practitioner) demonstrated the presence of forms of venereal diseases. In 1908, Cleland wrote about his study of *granuloma pudenda*, which he found among Aborigines in north Queensland,⁴⁶ and even more commonly among Aborigines of Western Australia.⁴⁷

The presence of yaws has been a contradictory saga, as recent research indicates. Noel Butlin, for example, believed that yaws existed in Victoria, but Gray doubted this proposition. Gray claimed that these two forms — *Treponema pertenue* and *Treponema pallidum* — occurred on the mainland as a disease mostly affecting childhood.⁴⁸ The important point to be made here, as Goldsmid emphasised, is that yaws most probably existed in many Aboriginal communities when Europeans first arrived. Researchers have

⁴² *Ibid.*, pf.

⁴³ *Ibid.*, pf.

⁴⁴ J.B. Cleland, 'Contributions to the History of Diseases of Man in Australia', 3rd Report Government Bureau of Microbiology, 1914, pp.226-232; see also, J.B. Cleland, 'Diseases amongst Australian Aborigines', in *Journal of Tropical Medicine and Hygiene*, Vol. 31, pp.157-160, pp.173-177, pp.216-220, and pp.232-235.

⁴⁵ Herbert Basedow, 'Diseases of Aborigines', in *Journal of Tropical Medicine and Hygiene*, 1932, Vol. 35, pp.177-185, pp.193-198, pp.209-213, pp.229-233, pp.247-250, pp.273-277.

⁴⁶ M.J. Lewis (ed), J.H.L. Cumpston, *Health and Disease in Australia*, AGPS Press, Canberra, 1989, p.271; see also, J.B. Cleland, 'Pathology of infective granuloma of the pudenda', in *Australian Medical Congress*, 1908 (2), pp.266-269; Cleland, 'On the aetiology of ulcerative granuloma of the pudenda', *Australian Medical Congress*, 1909 (2), pp.143-151.

⁴⁷ Basedow, 'Diseases of the Aborigines', pp.193-277; see also, D. Kaus, 'Basedow, H.', in D. Horton (gen. ed.), *The Encyclopaedia of Aboriginal Australia*, Vol. 1, A-L, Aboriginal Studies Press, AIATSIS, Canberra, 1994, pp.106-107.

⁴⁸ McNeill, *Plagues and Peoples*, pp.38-39; see also, Wasley and Wong, *Syphilis*, pp.5-12; see also, Butlin, *Our Original Aggression*, pp.8-9, see where, Butlin argues that anthropological descriptions of indigenous groups could not be described as in a stable relationship with their environment. But, see Gray in a paper above, Gray, 'Some Myths', pp.136-138, and in this paper, Gray disputes Butlin's point by saying that the way he argues constructs new myths out of old ones and in doing so restricts sound analyses; see also, Macknight, 'Macassans And Aborigines', pp.283-321. The quotation used from Macknight is taken from p.317.

found that yaws has been endemic for a long time among the Aranda tribe of central Australia, and discovered yaws lesions in Aboriginal skeletal remains from southern and eastern Australia.⁴⁹ Others argue that such treponemal infections became endemic in Aboriginal populations long before Asian and white contact.⁵⁰

Gray also wrote about *Lymphogranuloma venereum* which is caused by strains of trachoma or Chlamydial disease. Trachoma affected Aborigines in Western Australia and Queensland.⁵¹ Although trachoma surveys began in Queensland as early as 1907, as I explain later, there were no research projects in Western Australia until Ida Mann's in the 1950s. She commented on how white settlers had coped as trachoma had appeared in epidemic proportions in Victoria in the nineteenth century.⁵² It disappeared from settler communities after the adoption of hygiene controls which ultimately curbed the infection.⁵³

In Western Australia Ida Mann, in contradicting Daisy Bates, doubted that trachoma did affect Aborigines prior to settlement and infection. She argued that it occurred only after close bodily contact with the white population. This raised the question of the origin of trachoma in Australia. According to Mann the disease had become endemic in New Guinea and adjacent islands by the seventeenth century. The islanders had had contact with Aborigines even earlier, making possible its early passage onto the mainland.⁵⁴ Some forms of blindness from trachoma are transmitted during

⁴⁹ C.J. Hackett, 'A Critical Survey of Some References to Syphilis and Yaws among Australian Aborigines', in *MJA*, Vol. 1, 1936, p.735.

⁵⁰ Kirk, *Aboriginal Man Adapting*, pp.170-184, on syphilis, see also, p.170 and p.183, on yaws; see A.T. Sandison, 'pre-European skeletal remains', pp.45-48.

⁵¹ Gray, 'Some Myths', p.136-137.

⁵² Ida Mann, *Culture, Race, Climate and Eye Diseases: An Introduction To The Study Of Geographical Ophthalmology*, Charles Thomas, Springfield, Ill., USA, 1961.

⁵³ *Ibid.*, pp.454-458.

⁵⁴ *Ibid.*, p.459.

birth in both bacterial and viral forms from mother to child, and may also be contracted through sexual intercourse.

The diseases suffered by Aborigines partly explains why the Western Australian Government passed the *Aborigines Protection Act 1897*.⁵⁵ As discussed earlier, this legislation established the Aborigines Department, and following the passage of the Act the Premier John Forrest appointed Henry C. Prinsep as Chief Protector of Aborigines, in 1898. The rush of prosperity caused by the mining boom of the 1890s profoundly impacted on the well being of Aborigines in parts of the State occupied by settlers.⁵⁶ It was possibly the impact of disease on sedentary groups that forced the appointment of a travelling inspector with medical training. The first tasks Prinsep gave to the travelling inspector, Dr G.S. Olivey from the London Hospital,⁵⁷ focused on the taking of a census of Aborigines. Another immediate task was to assess the physical condition of Aborigines and the conditions under which they lived.

The inspector's reports told of the widespread effects of venereal diseases among Aborigines.⁵⁸ Prinsep wrote immediately to Forrest to tell him that venereal disease among Aborigines was serious and appeared to be spreading. In some places, he reported to the Premier, Government efforts should be backed by 'legislation with the object of preventing the Aborigines, in their own interest...from affecting...both the black and white population.'⁵⁹ From his own experiences gained during his exploration treks

⁵⁵ McCorquodale, *Aborigines And The Law*, p.94.

⁵⁶ Hasluck, *Black Australians*, pp18-41.

⁵⁷ *Annual Report*, Aborigines Department, 1899, WAGP, Perth, p.1, in *Western Australian Parliamentary Votes and Proceedings*, (WALAV&P) 1898-1900, WAGP, Perth, 1900.

⁵⁸ *Ibid.*, pp.1-8.

⁵⁹ 'H.C. Prinsep to John Forrest, 17.10.1898-99, private letter', quoted in Mary Anne Jebb, 'The Lock Hospitals Experiment: Europeans, Aborigines and Venereal Disease', in Bob Reece and Tom Stannage, *European-Aboriginal Relations in Western Australian History: Studies in Western Australian History*, The University of Western Australia Press, Perth, 1984, pp.68-88.

around Western Australia, Forrest had some knowledge of Aborigines, and would consequently have been receptive to Prinsep's proposal.⁶⁰ The public, too, would have been similarly attentive, for not only were there general fears about a disease which whites might contract from Aborigines but there was the added fear about 'miscegenation' between the races producing an increasing half-caste population.⁶¹

During the period 1900 to 1910, the commonest sexually transmitted diseases in Western Australia included gonorrhoea, non-specific urethritis and syphilis. Gonorrhoea, at the time, was a new type of sexually transmitted infection to Aborigines. It is a highly contagious bacterial infection that attacked the mucous membranes of the male and female genitalia, the anus, mouth and eyes. The symptoms were a discharge from the urethra and pain when urinating. The most important long term health problem was sterility in women, but the disease also affected other internal organs, and could cause kidney failure. Aborigines occasionally suffered from symptoms closely resembling gonorrhoea, but sometimes the diagnosis failed to trace the cause to gonococci. This form of disorder became known as non-gonococcal, or non-specific urethritis. By the 1930s most health service people knew something about bacteriological processes, and could apply some forms of preventive treatments and cures. At the turn of the century, however, Aboriginal groups did not know that bacteriological and viral infectious agents were at work, nor were they able to take preventive measures to ensure immunity against disease and general illness. Moreover,

⁶⁰ Elizabeth Goddard and Tom Stannage, 'John Forrest And The Aborigines', in Reece and Stannage (eds), *European-Aboriginal Relations*, pp.52-58.

⁶¹ Aborigines Department, *Annual Report of Chief Protector*, 1899, p.1; see also, P. Biskup, *not slaves*, pp.27-44.

the size of the pre- and post-contact Aboriginal groupings affected physiological and biological defences against viral and bacterial diseases.⁶²

Aborigines were most certainly affected by the lengthy time of their separation from other groups and which in turn must have affected the possibilities for them to develop immunity to forms of bacterial and viral infection. Biological limitations, therefore, were placed on indigenous groups because of the small size of family groups and their mobility.⁶³ Where syphilis occurred, after some time resistance could have built up in some Aboriginal populations. It is probable that the nature of the contact between seamen from Asia and some Pacific Islands with small groups of Aborigines involved seasonal encounters. This intermittent contact would have made it difficult for local indigenous groups to build up resistance.

Two anthropologists, researching in some Aboriginal populations in the 1950s, Ronald Berndt and Peter Worsley, studied groups in the far north of Western Australian and the Northern Territory. They investigated what indigenous groups had to say about their contacts with Asian sailors in their remembered past. Their accounts indicated a less gruesome contact than occurred post-settlement. Macknight, however, has questioned their views on the grounds that the work was flawed by the absence of any satisfactory independent account from the Macassans' perspective.⁶⁴ While it may not be possible to adjudicate these arguments, it is true that the records compiled by government, missionaries, and earlier ethnographic writers revealed a society which was under great stress by 1900.⁶⁵

⁶² A.W. Crosby, *Germs, Seeds and Animals, Studies in Ecological History*, M.E. Sharp, London, 1994, pp. 82-108; see also, A.W. Crosby, *America's Forgotten Pandemic: The Influenza of 1918*, Cambridge University Press, New York, 1989, pp.227-263, this chapter discusses the impact of the pandemic of 1918-1919 on indigenous people of Alaska and Samoa.

⁶³ Butlin, *Our Original Aggression*, pp.8-9. See Gray, 'Some Myths', pp.136-138.

⁶⁴ Macknight, 'Macassans And Aborigines', pp.283-321.

⁶⁵ Rowley, *Outcastes in White Australia*, pp.1-127; see also, Leslie R. Marchant, *Aboriginal Administration in Western Australia, 1886-1905*, AIATSIS, Canberra, 1981.

Fringe-camp living, which tended to pollute the living area, was most probably a post-European contact phenomenon but it could have come earlier. This form of living site became common in southern and eastern areas of the State where some life-style infections became endemic. Aborigines who moved from the bush to sedentary camp life began developing a range of disabilities and health problems. For example, blindness and crippling bone diseases often preceded dementia, especially among the old, frail and infirm. The blind were compelled to become sedentary and this event was a factor in polluting living sites and harbouring infections which camp people were unable to combat. It is entirely possible that, at least in the north of Australia, sedentary lifestyles could have occurred in advance of European settlement through the seasonal visits of Macassan traders. These visitors arrived on a regular seasonal basis for at least 200 years prior to 1829. This seasonal contact continued after white settlement.⁶⁶ Although there is no certain cause of why indigenous groups became so afflicted with disabilities such as blindness, debilitating bone diseases and sexually transmitted infections. In compiling disparate information from protector's reports Table 3.1 gives some idea of the numbers of people who may have been suffering from disabling diseases resulting from changes in lifestyle.

It can only be assumed that such afflictions appeared soon after the emergence of the fringe-camp life-style. Once this occurred, illnesses of this nature became endemic. Generations passed and some infections became congenital, associated with permanent pools of infection. The creation of such pools helped indigenous groups to share the patterns of disease and sickness across Western Australia. In every group of people shown as destitute the females fared worse than the males, except for those older full-

⁶⁶ Macknight, 'Macassans And Aborigines', pp.283-321; for a compact interpretation of the saga see also, Mulvaney, *Prehistory of Australia*, pp.14-41.

blood males suffering the long term effects of venereal diseases. Aboriginal females were generally more disadvantaged because they were forced by circumstances to become sole carers for children and young adults. Certainly from the 1890s through to 1904, the level of disability proved worrisome to property owners, police protectors, hospital medical staff and administrators. It was these members of the settler community in particular who bore the brunt of providing even greater amounts of relief and care for diseased, sick, disabled, indigent and dying Aborigines.

The extent of the burden is evident in a host of incidents. For example, on 25 September 1898 the Resident Medical Officer at Derby reported to the Chief Protector that he had provided medical treatment to six Aborigines between 26 August and 25 September at the rate of 9 pence per day. These people had worked or lived on cattle properties near Derby owned by Adcock Brothers and Company. Most were old and infirm and one was totally blind.⁶⁷ In the same year, William Padbury of Guildford near Perth applied for a refund in a memorandum to the Chief Protector for the supply of a tent. The tent had cost him £1.17.0. The Chief Protector noted that 'the tent was for the use of a sick native and was purchased on the 21 April.'⁶⁸ Similarly, at a camp site at Norseman in the same year, Sergeant Lappin authorised a Dr Harvey to supply medical treatment to a native woman named Kitty.⁶⁹ Sergeant Lappin indicated that he had given permission for the doctor to give treatment to Kitty in her camp because he considered that she was dangerously ill, suffering from a chest complaint.⁷⁰

⁶⁷ Public Records Office (PRO), Battye Library, Perth, AN, 1/3, Acc. No. 255, file 1898/262, file name, and subject, 'Resident Magistrate Derby: Relief of Natives'.

⁶⁸ *Ibid.*, no folio numbers.

⁶⁹ *Ibid.*, see, 'Relief of Natives: Sergeant of Police Norseman April 30th 1889, Sergeant Lappin'.

⁷⁰ *Ibid.*, no folio numbers.

It was not always easy for treatment to be sought or demanded, as indicated in an incident reported in the *Mount Magnet Miner* on 27 October 1898. A number of Aborigines had been camping near a water hole called 'Yowera', near Cue, and were suffering from measles. The local doctor had refused to attend despite a request by the police, who reported the circumstances to the Aborigines Department. The doctor had refused to attend because payment could neither be guaranteed by the Police nor by the department.

Medicines were sent from Cue to Mr W. Watson. Wilson, who had first reported the incident, refused to administer them because he had no idea what the group was suffering from. Further representations were made to the Chief Protector in Perth for the doctor to be offered a moderate fee to treat the group. Watson agreed to provide the vehicle to take the doctor out to the water hole. Chief Protector Prinsep, however, made no response. With heavy sarcasm the report pointed out that the government and pastoralists would act quicker if they found scabby sheep than they had in attending sick Aborigines. The report went on to say that the victims in this case were Aborigines and nothing was done even though a protection board existed to take the public's interest in Aborigines more seriously.⁷¹

Another incident involving the department was criticised by the Town Clerk at Northam, who wrote to the Colonial Secretary about the condition of natives in the colony. The letter said, 'I think I am right in saying that beyond an annual distribution of clothes and food by the Government nothing is done for these poor creatures.'⁷² The Town Clerk continued in another letter asking whether, in the Chief Protector's view, some action

⁷¹ *Mount Magnet Miner*, 27.10.1898, in PRO, AN, 1/3, Acc. 255, file 496/1898, 'Resident Magistrate Murchison, Mount Magnet Miner'.

⁷² PRO, AN, 1/3, Acc. 255, file 577/1898, J. D'Alton, 'Town Clerk Northam: Condition of Natives in the Colony'.

could be taken to establish shelters to act as a school building for Aboriginal children.⁷³

Soon after, Prinsep observed in his travels that syphilis in the Wyndham area was 'prevalent: several deaths had occurred within the last twelve months'.⁷⁴ Most of the camps in or near the towns had visits from either the travelling inspectors or from the District Medical Officer.⁷⁵ The travelling inspector noted that generally Aborigines in the Kimberley appeared to be in good health, apart from venereal disease, which he claimed abounded throughout the whole district. Malcolm Fraser, a Kimberley land owner, expressed the view that the source of the infection was the 'unspeakable dirt of the native women'.⁷⁶

In 1899, the year after the Protection Board was abolished in favour of a department and individual protectors, the manager of a property owned by Nairn and Sons wrote to the Protector on 10 April about his concern for an Aborigine seen crossing his leasehold. The man was crippled, and it became impossible for him to walk. That was on the 14 March and he was fed by the station manager. According to the manager the man had walked a considerable distance but could go no further. The man was old and it appeared to the white manager that he would perish if given no food. The property owner was reluctant to feed the man indefinitely and asked the Chief Protector to pay him for the food which he was willing to issue each day. The owner added that as winter was coming he would be needing food and blankets soon.⁷⁷ Compassion was a part of Aboriginal ideology, but it

⁷³ *Ibid.*, no folio numbers.

⁷⁴ Aborigines Department, Chief Protector's Report, June, 1898, see, 'East Kimberley', WALAV&P, 1889, WAGP, p.5.

⁷⁵ Report Protector Aborigines, *Annual Report*, 1898, WALAV&P, WAGP, p.5.

⁷⁶ *Report of the Aborigines Protection Board*, 1897, WALAV&P, WAGP, 1897, see, 'Appendix I - East Kimberley', pp.5-6.

⁷⁷ AN, 1/3, Acc. 255, file 324/1899, Relief to Cripple "Yallajarra", 'I. Nair and Sons to Chief Protector'.

was not easy to detect by either government agents or property owners and managers. Destitution was general, and worried many settlers, as did the presence of venereal diseases among groups in camps near towns and on private properties.

Just prior to 1900 Malcolm Fraser wrote to the Chief Protector about his concerns for the health of Aborigines who worked for R.H. Habgood Company, in a coastal region of the Kimberley. Fraser indicated that the most common forms of illnesses in the labour fringe-camps were chest, skin and eye infections.⁷⁸ But Fraser was not the only white person able to appreciate what was happening. Similar incidents suggest that many white settlers showed concern for, if not compassion towards, diseased, indigent and sick Aborigines. Some land owners at least were concerned about the condition of those Aborigines who had made permanent camps on their pastoral properties, and the concern seems to have arisen as much from humanitarian motives as from fear that the Aborigines would pass on their diseases to the white community. The Aborigines were not able to adapt as successfully to the changing circumstances as the whites would have wished. Indigenous groups were confronted with dwindling food resources, competition for water from pastoral expansion, and problems associated with their newly adopted sedentary camp life. Even though there were some pastoralists who showed disdain towards the predicament in which Aborigines found themselves, in general the responses of the local magistrates, land owners, contractors, missionaries and protectors to the Aboriginal predicament was more often than not characterised by humanity and compassion.

For all that, however, Aborigines in many locations continued to suffer greatly from a range of medical complaints. Some reports specified bone and

⁷⁸ Malcolm Fraser, 'R.H. Habgood to Chief Protector of Aborigines, 1887-1888', in *Report of the Aborigines Protection Board of Western Australia, 1887-1888*, WAPP, p.4.

joint disorders which observers reported as rheumatics. Other reports indicated the presence of dysentery, asthma, colds and venereal diseases. Some of these sick elderly people sought relief at a telegraph station in the La Grange region where a number of camps had developed. Also, at the remote interior telegraph station at Hall's Creek camps of sick, starving, blind and crippled people worried officials. For example, the telegraph operator at Hall's Creek became so distressed that he sent for medicines which had to be brought in by boat from Broome via Wyndham. This crisis developed mostly because the hospitals at Hall's Creek and Wyndham had both been closed and because a mission was opened in the vicinity. Patients in emergencies were treated by the missionaries.⁷⁹

Various officials recorded their private worries about the poverty and destitution into which the Aborigines were subsiding. On 5 October 1900 a resident magistrate wrote to the Chief Protector about a number of concerns he held for Aborigines on G.I. Brockman's Nimilya station, saying:

1. I have written to Mr. Brockman explaining his accounts for feeding twelve (12) natives for nine months.
2. I do not see how owners of stations could be compelled to feed the old and infirm natives....unless Parliament legislates on the subject.
3. I am afraid that if old and infirm natives had to ...[look after themselves and] their relatives on the various stations for the means of subsistence they would [all] soon die of starvation.
4. I know of several settlers who would feed the old and infirm natives on their stations were they in a position to do so but drought and bad seasons stand in their way.⁸⁰

As the letter suggests, while some settlers went out of their way to give humanitarian assistance, others wanted payment. On top of other complaints, malaria and whooping cough affected people in the camps

⁷⁹ Report Protector Aborigines, *Annual Report*, 1899 WALAV&P, pp.5-6.

⁸⁰ AN, 1/3, Acc. 255, file 8/1900, Aboriginal Natives At Nimilya – Mr G.J. Brockman, re support of old and infirm, 'Resident Magistrate to Chief Protector' October 5 1899.

located near the ration depot at the Fitzroy telegraph station. Many old and crippled people stayed there while the younger members stayed in the bush. White townspeople blamed local illnesses on the contact between 'Mongolian and Asian pearlers' and Aboriginal females. C.J. Annear, the telegraph operator at Fitzroy, reported to the Chief Protector in Perth, that these Asian seamen came during 'the fever months'.⁸¹

In the La Grange and Beagle Bay areas during 1901-02 the protectors' reports included accounts of how Aboriginal physical and health conditions were being degraded as a result of the old men living off the earnings from prostitution of their wives and younger women. In turn this meant that venereal disease had a firm footing by 1903, and was causing a great deal of damage. The telephonist at La Grange reported that gonorrhoea was causing internal problems for Aboriginal women and the disease was rife throughout the district. Also he indicated that syphilis and other skin diseases seemed to be something Aborigines caught from Asian sailors. He thought also that half-caste women appeared to be the most affected because they came into towns. Both he, as well as the local protectors, missionaries and police were concerned enough to report the effects to the Chief Protector. Among those affected were 12 to 13 year old girls.⁸²

In the same year, pastoral station owners in the Eastern Kimberley region became concerned about the health of their Aboriginal labour. Mr Kearney of Argyle station, for example, wrote of a number of natives who were feeble and crippled, some children who were orphaned and one blind boy, and he called for medicines and a doctor from Wyndham to treat them. They had colds, rheumatics and venereal diseases. The manager indicated that this station was a route to the hinterland and many Aborigines passed

⁸¹ *Ibid.*, p.6.

⁸² Chief Protector Aborigines, *Annual Report*, 1903, WAPP, WAGP, 1904, Perth, p.1.

through, travelling both east and west. Similarly, at Halls Creek and Fitzroy ration stations, the police officers reported that an influenza epidemic (a disease I discuss in chapters four and eight) had struck camp people. And in May 1903, at nearby Flora Valley, at least 16 deaths occurred after about 200 Aborigines had been camped nearby. A supply of medicines reached them to alleviate the raging epidemic of influenza and to treat a child suffering from syphilis.⁸³

A year later, in March and April, Constable Cadlow reported a fresh influenza epidemic, and the presence of other diseases. One of the conditions was 'ague' (a form of malaria), that manifested itself with variations of chronic shivering.⁸⁴ Four people died from one or other of these diseases. A disease which the police report was unable to specify was similar to swamp fever, or Beri-Beri, seemed to be present among the Asian mariners who cohabited with Aboriginal women when they arrived in 1904. Asian fishermen seemed to arrive with venereal diseases and sometimes with small-pox. Passenger ships also brought small-pox, but only one case came to light among Aborigines.⁸⁵ Strict quarantine was generally applied and managed by the local general practitioner, which made some difference.⁸⁶ Natives around La Grange, Broome and Beagle Bay were quarantined for six weeks and the Asian sailors prevented from mixing at all with Aboriginal males or females. As many Aborigines as possible were vaccinated by Dr Blick, Dr Thompson and the local policeman at La Grange, Constable Kuhlmann.⁸⁷

⁸³ *Ibid.*, pp.6-18.

⁸⁴ *Concise Medical Dictionary*, pp.405-406.

⁸⁵ Chief Protector Aborigines, *Annual Report*, 1905, WAPP, WAGP, Perth, 1905, pp.11-14.

⁸⁶ Chief Protector Aborigines, *Annual Report*, 1904, WAPP, WAGP, 190, p.8.

⁸⁷ See, 'letter from Tuckett to Prinsep, 6th September 1904', in Chief Protector Aborigines, *Annual Report*, 1905, WAPP, WAGP, Perth, 1905, p.14; see also, 'letter from Constable Kuhlmann to Prinsep', *Ibid.*, p.15, this letter, among another things, describes in detail the quarantine arrangements put in place by those medical quarantine team named in the text.

Providing medical care to Aborigines remained in the hands of either district hospital staff or private general practitioners in country towns. Not all districts had hospitals, however, and if they did the payment of the amount charged by hospitals and doctors proved the only sure way to get access. Even emergency cases sometimes failed. Aborigines under contract to pastoralists sometimes, but not always, had their bills paid by pastoralists.⁸⁸ Destitute Aborigines had their bills sent to the Chief Protector of Aborigines and medical bills of poor white people went to the Medical Department in Perth.

Indigence was no guarantee of access to hospitals or medical care because hospitals decided, one way or another, depending on the general condition of the patient. Most importantly, access depended on the attitudes of hospital staff and general practitioners.⁸⁹ Some health workers simply passed the accounts directly on to the Chief Protector's office, and if funded from Government revenue they sometimes waived the costs. Half-castes were distinguished from what the bureaucracy understood, or accepted, as Aborigines. From the Protector's records, the average stay per patient was approximately 24 days, which was considerable. Furthermore, the average cost per patient of an annual account sent to the Chief Protector's Office from the Health Department amounted to £48.16.0 per patient which also made up a considerable amount. Some patients stayed longer but most stayed for short periods. The records reveal that about 236 Aboriginal patients were received into country hospitals all over the State. This figure in no way indicated the numbers who were sick, but it signifies a considerable number of Aborigines entering hospitals for treatment. Although in many cases access was denied to both white paupers and Aborigines living in

⁸⁸ Biskup, *not slaves*, pp.111-113.

⁸⁹ AN, 120/4, Acc. 1003, file 292/1901-1902, 'Hospital treatment of "Aboriginals"', folio 5.

fringe-camps, it is also true that many hospitals did care for indigent Aboriginal and white patients.⁹⁰

In 1902 the Principal Medical Officer wrote to the Under Secretary concerning the type of payment structure in place and the problems in delivering health care to out-lying 'lockup-hospitals'⁹¹ such as Peak Hill. A doctor managing an isolated lock-up hospital (that is, secured hospitals which patients needed a medical permit to leave), at Peak Hill had been placed in an invidious position because he was appointed by a committee whom he claimed was irresponsible for not allowing Aborigines to enter the hospital as patients when they became sick. The doctor said he tried his best to administer medical care to sick Aborigines but he felt betrayed by higher authorities because they made no effort to force hospitals to accept the diseased Aborigines for therapy. As an example, the Principal Medical Officer said that, in the case of Edward Whitworth, the patient might have been saved with treatment had he been allowed access earlier.⁹² Edward Whitworth died at Peak Hill hospital and the main cause of his early death may well have been the difficulties in admitting the sick man to hospital. The incident began when the local Police Constable of the Murchison district, John McGinley, reported the circumstances by telegram to the Principal Medical Officer. McGinley said that an Aboriginal man named Whitworth arrived in the town about three weeks earlier. Whitworth was suffering from syphilis, and he was admitted to hospital on an order from Mr Bagot, the Warden of the lock-up hospital at Peak Hill. When the hospital authorities

⁹⁰ *Ibid.*, see 'Statement showing amounts due for treatment of natives: for 1901-1902', on same file but with no folio numbers.

⁹¹ The lock-hospital was a British invention used for containing people with contagious diseases. These lockup hospitals were legislated for under the British (1866) and then Tasmanian Contagious Diseases Act, 1879, see F.B. Smith, 'Ethics and Disease in the late Nineteenth Century: The Contagious Diseases Acts', *Historical Studies*, Vol. 15, No. 57, Oct. 1971.

⁹² AN, 120/4, Acc. 1003, file 282/1902, 'Death of Edward Whitworth in Peak Hill'.

discovered that Whitworth had been diagnosed as having syphilis 'they turned him out. He has since been wandering Peak Hill in a dying condition.'⁹³ That was in December 1902, and three weeks later Warden Bagot gave an order that 'Whitworth should be locked up as a vagrant. The spread of the syphilis caused the patient to become critically ill.' Whitworth was so ill that he was 'unable to face the court for the vagrancy charges.' The hospital authorities 'refuse to have anything to do with him as his case [was] very infectious'.⁹⁴

In this southern region the total Aboriginal population stood at approximately 1,216, and of these, 8 out of every hundred were living on the fringes of towns.⁹⁵ Of all the Aborigines in the area, only about 15 were permanently on relief. Work for male and female Aborigines presented no difficulty because the population was so small that it insulated them from the pauperising effects of long periods of unemployment and some relief was given by local settlers and missionaries. As one protector stated, 'they are civilised, and their wants are well attended.'⁹⁶ That year the severe cold produced more deaths among the older people than usual. They died 'from the inevitable cold which their mode of living brings on — among...them was a native named Billy Kickett, who...gave...assistance to... explorers under Mr (later Sir) John Forrest'.⁹⁷ Billy Kickett had received a government pension for his efforts. Another old man at Pinjarra caused some concern because of his blindness. 'He was very much diseased and had given much trouble and expense.'⁹⁸ The Protector added that the man's disease made it

⁹³ Telegram 1, in *Ibid.*, f.2.

⁹⁴ Telegram 2, in *Ibid.*, f.3.

⁹⁵ Anna Haebich, 'A Bunch Of Cast-Offs': Aborigines in the South west of Western Australia, 1900-1936', an unpublished Ph.D. thesis, Murdoch University WA, 1985, pp.39-40.

⁹⁶ Chief Protector, *Annual Report*, WAPP, 1904, pp.10-11.

⁹⁷ *Ibid.*, p.10.

⁹⁸ *Ibid.*, pf.

impossible to move him, and that he had a large shelter built and employed a cottager's wife 'to look after his wants and his warmth — a most unpleasant duty'⁹⁹ for which the Protector had to pay at a higher rate than elsewhere. He was happy to report that, at Katanning and Guildford, it was possible to provide special camping places for fringe-campers, and these proved a success.¹⁰⁰

Along the south coast towards Esperance, kangaroo shooters used Aboriginal hunters, and few travelling inspectors visited the region because it was very lonely country. Even so, the Southern Protector felt that the symbiotic relation enabled the Aborigines to maintain their independence. The Protector highlighted two things — the dwindling numbers of Aborigines and the over-killing of kangaroos. He also wrote that a man called Castilla had been in the area for many months in charge of the water boring party. While Castilla was there he saw Aboriginal males and females with 'awful mutilations of the generative organs of both men and women...[which] militates against the continuance of race....Should the kangaroo-hunters' camps cease to exist, the natives would lose many benefits'.¹⁰¹

What Castilla observed, and what the Southern Protector described, had already been studied and named *Granuloma pudenda*.¹⁰² This condition came as no surprise to either the Chief Protector or medical practitioners in the north, who had already expressed their alarm at the presence of venereal disease. Even so, diagnosis presented great difficulty for protectors with no

⁹⁹ *Ibid.*, pf.

¹⁰⁰ *Ibid.*, pf.

¹⁰¹ *Ibid.*, p.24

¹⁰² J.R. Hickenbotham, 'Ulcerative Granuloma of the Pudenda in the Gascoyne District of West Australia', in *Australian Medical Congress Transactions*, 1908, Vol. II, pp.264-9, also cited in Mary Anne Jebb, 'The Lock Hospitals', in Reece and Stannage, *European-Aboriginal Relations*, pp.68-87.

medical training, and concern about the prevalence of this disease ranged wide.¹⁰³

The Protector's correspondence conveys vividly the kinds of difficulties and occupational stress which the doctors in particular, but also police, local magistrates, hospital personnel and departmental officers, had to cope with in handling infectious diseases at that time.¹⁰⁴ The letters specify that doctors were called upon to travel long distances by horse and buggy to outlying camps to provide medication to sick and dying camp Aborigines. In addition, police officers and magistrates sometimes had to fill in for medical personnel as did local Protectors of Aborigines. At the same time, Aborigines' difficulties in gaining access to hospitals became complicated by staff attitudes and their social status *vis-à-vis* other State institutions. The correspondence also provides some insight into the difficulties which doctors and other State functionaries nearly always faced in providing medical care and meeting patients' welfare needs. Their difficulties became apparent during the course of the Royal Commission on the Condition of the Natives which the Western Australian government appointed in 1905. The Commission's terms of reference required it to investigate venereal disease, health care costs and general matters relating to treatment of Aborigines by the medical system.¹⁰⁵ Further terms of reference related to the general

¹⁰³ J. Sergeant, 'The Lock Hospitals of Western Australia' – a public health measure to control venereal disease in the Aborigines of the northwest of Western Australia. Unpublished assignment paper presented to the School of Public Health University of Sydney, 2.8.1989.

¹⁰⁴ AN, 120/4, Acc 1003, file 175/1901, New Norcia, 'Complaint of Conduct of Doctor for the District'.

¹⁰⁵ *Western Australian Government Gazette*, on 31st August 1904, gave the order from Governor Sir Fredrick G.D. Bedford to Walter Edmund Roth, Esq., to conduct a Royal Commission into the administration of the Aborigines Department, and the employment and treatment of the aborigines and half-caste in habitants of the State; this letter is contained also in, *Report, Western Australia Royal Commission On The Condition Of The Natives*, WAGP, Perth, 1905, p.1.

conditions of life and treatment of Aborigines and half-castes by the settler population.¹⁰⁶

Walter E. Roth, the Chief Protector of Aborigines of Queensland, was appointed to conduct the Commission, and he commenced its duties early in 1905.¹⁰⁷ His general task was to investigate the employment and treatment of Aborigines and half-castes by white and Asian people in Western Australia. The appointment of Roth, a greatly respected ethnographer and administrator, was a measure of the Government's concern. Roth's inquiries revealed a shocking state of affairs. His anger was plain. He bluntly reported that there were no legal protections to stop the 'greatest scoundrel unhung, European or Asiatic, putting under contract any black he pleases.'¹⁰⁸ At the coastal pearling port of Broome 'quite half the children from ten years and upwards are indentured to the pearling industry and taken out in the boats....and the Chief Protector cannot prevent this.'¹⁰⁹ Also, Roth addressed the issue of medical care for sick Aborigines and its provision by medical officers at local hospitals.

Section C of Roth's report considered the medical fees paid by the Aborigines Department which, for the past three years, varied between £92 and £96. The practice was for the Medical Department to annually forward government Medical Officer's accounts for treating contingencies such as Aboriginal maternity cases, epidemics, injuries and long standing ailments, directly to the Aborigines Department. The amounts involved were really paltry: those for 1902-4 were the equivalent of only \$11,000 to \$11,500, converted into 1996 approximate values. The report also revealed that government Medical Officers had obligations to attend pauper Aborigines,

¹⁰⁶ WAPV&P, No. 5, 1905, *Report, Western Australia Royal Commission On The Condition Of The Natives*, WAGP, Perth, 1905, p.(i).

¹⁰⁷ *Ibid.*, pp.1-121.

¹⁰⁸ *Ibid.*, pp.1-26.

¹⁰⁹ *Ibid.*, p.26.

'though the only authority appears to be a circular, dated May 1898, and issued by the Premier'.¹¹⁰ At that time Forrest had said that attending indigenes in their camps was part of the duties of the resident magistrate, the resident medical officer and local police constable. In addition, the Premier thought that property owners had a duty to care for sick Aborigines in their employ, and that this duty extended to assisting the 'aged, infirm and sick'.¹¹¹ Because of the custom of 'employers neglecting...natives working in their service, a certain expense had to...be incurred by the Aborigines Department in attending to the medical relief of such cases'. Employers of sick Aboriginal labour were also supposed to 'cover the costs of service and care', but it was rare that they ever did.¹¹²

In reporting to Roth the Chief Protector had contradicted himself when he gave evidence that the general health of the Aborigines was good. In reporting on the operations of his department to Parliament in 1905-6, Prinsep, perhaps chastened by the Royal Commissioner's findings, wrote more frankly than previously. He indicated that many of the severe illnesses in the area could be attributed to venereal diseases. Medical expenses for treating Aborigines suffering from venereal complaints had almost doubled that of the previous year. Venereal infections among Aborigines became a real concern of Prinsep which he now believed in 1905 had become an epidemic. Prinsep felt extremely uncomfortable about the way Aborigines suffered from the disease.¹¹³ During the proceedings of the Royal Commission, the comments of both Roth and Prinsep had suggested that they held common views on what legislative changes should be made to make Aboriginal health policy more effective. They agreed that health

¹¹⁰ *Ibid.*, p.100.

¹¹¹ *Ibid.*, p.24.

¹¹² *Ibid.*, p.25

¹¹³ Chief Protectors, *Annual Report*, WAPP, 1906, p.5.

responsibilities should be spread between the two authorities most interested, that is the Aborigines and the Medical Departments. Similarly they both thought that half-castes ought to be covered by the legislative changes.

According to Commissioner Roth the condition of people in the north of the State was more desperate in 1905 than when the Western Australian parliament had passed its 1897 Aboriginal protection legislation. Pastoral expansion and pearling had caused greater health, social and economic hardship to the indigenous people of the north. Roth, therefore, provided the option in his recommendations for people of mixed descent to be identified as Aborigines rather than as European, Chinese, Japanese and Afghan descent. Half-castes had no legal status and their liberties had become highly ambiguous. Biskup noted that 'most part-Aborigines of the nineteenth century were true half-castes, the off-spring of white men'. As '[offspring]... of white men, they demanded the rights of the white men'.¹¹⁴ The first law passed to reduce the status of part-Aborigines occurred in 1874. A little more than a decade later the Aborigines Protection Act 1886 focused on only half-castes and their offspring 'who were habitually associating and living with' other Aborigines.¹¹⁵ This was one contradiction confronted by Protectors but other hidden ones also existed.

The confusion over the new identity of half-castes also caused problems for people of full descent, and who would pay their health costs. More particularly, health costs became associated with whether a full-blood person, or their relatives, could pay for services provided by doctors or nurses at country hospitals. Some understanding of the difficulties faced by

¹¹⁴ Biskup, *not slaves*, p.44.

¹¹⁵ *Ibid.*, pf.

those closely associated with giving medical and health services to Aborigines is necessary, which extended beyond only health workers.

The health services in Western Australia at the turn of the century were by no means easy to understand either for Aborigines or health officials. It was even more difficult for Aborigines when their understanding of the health maintenance system, and that of the State's flimsy rural health service, on which they came to rely, had begun to crumble. Indeed, the policy adopted under the 1897 legislation collapsed almost over night, mainly due to the confusion over who had to pay for medical treatment and who was exempt from payment.¹¹⁶ The inquiries initiated by the Western Australian Parliament were supposed to correct the disease, health and healing problem faced by indigenous people in 1904-5 by fixing up the system already in place since 1897.

The 1906 legislation was intended to end the complication over such matters following the 1905 Royal Commission. The *Aborigines Act 1906*, resulted directly from the recommendations proposed by Roth. Biskup blamed Roth for the identity crisis inflicted on Aborigines, which caused such confusion over health questions at the end of the decade. Biskup wrote that Roth had 'failed to face [the health and identity questions] squarely — the impression...from contemporary records is one of optimism, of hope that the half-caste, like the man who wasn't there, would somehow go away': that is people of mixed racial descent would be absorbed without trace into the white community.¹¹⁷ Although Roth saw 'part-aboriginals as a social problem', with a high degree of rectitude, he did recognise their existence, a perspective and humanitarian attitude he brought with him from his profession and his time in Queensland.¹¹⁸ As such the public was to pay for

¹¹⁶ *Ibid.*, pp.111-113.

¹¹⁷ *Ibid.*, p.66.

¹¹⁸ *Ibid.*, pf.

their health fees but the situation was never made sufficiently clear either to the health and medical system or to the indigenous people if and when they became ill.

If the legislation corrected some anomalies, such as providing material support for half-castes who then became entitled to recognition as being 'Aborigines', there remained the question of who had responsibility for the payment of medical fees. This responsibility remained with the Aborigines Department. Public health responsibilities, however, passed to the Medical Department who took on the task of developing facilities for the control of venereal disease, which continued to be one of the most serious health problems. A remedy was soon to come in the building of a segregated lock-up hospital for sufferers of venereal disease. This remedy masked the more serious problem of leprosy which entered the Western Australian indigenous population late in the nineteenth century (see Table 6.1 in Appendix 6).

The manner in which leprosy entered the Gascoyne, Pilbara and Kimberley districts and its impact on indigenous population requires explanation. Because of the leprosy found among Chinese miners brought to the northern Territory in the late nineteenth century, popular wisdom was that these workers brought the disease into the Daly River, a location not previously known to contain the disease.¹¹⁹ The Chinese had been brought to the Northern Territory from Singapore and shipped as mining labourers by the South Australian government to fill labour shortages during the late-nineteenth century. They soon began cohabiting with Aborigines, who

¹¹⁹ Editorial, *The Journal of Tropical Medicine and Hygiene*, Vol. XX, Jan. 1 to Dec. 15, 1917, p.41; see also, (Sir) Leonard Rogers, 'When Will Australia Adopt Modern Prophylactic Measures Against Leprosy?', in *MJA*, Vol. II, No. 16, Sydney, October 18, 1930, pp.524-527; see also, C.E. Cook, 'Leprosy problems', in *MJA*, 11 December 1926; see also, E.H. Molesworth, 'Leprosy', in *MJA*, 12 March 1927; see also, Suzanne Saunders, 'A Suitable Island Site', pp.11-28; see also, Cecil Cook, *The Epidemiology Of Leprosy In Australia*, Commonwealth of Australia, AGPS, Canberra, 1927; see also, Lewis, *Cumpston, Health and Disease*, pp.207-218.

subsequently contracted the disease. Infected Aborigines and Chinese carriers subsequently moved across to northern Western Australia. It is equally possible that the animals used as food sources, such as rodents and mud crabs,¹²⁰ carried the disease, or it was transmitted through contact between Macassan seamen and Aborigines. The Macassans came to obtain *bêche-de-mer*, or sea cucumbers, and to harvest pearls. Leprosy may also have come via the pearlers who came to Roebourne, Broome, Derby and Wyndham.¹²¹ The infection then spread among the Aboriginal groups and across to the Kimberley region where, by 1900 or soon after, the disease began to take hold.¹²²

The first reported case of leprosy in Western Australia was in 1880. The victim was a Chinese male who had worked at Roebourne and Onslow as a cook on pastoral stations.¹²³ In 1902, however, a white male was admitted to Guildford hospital and later moved to Woodman's Point along the Swan River.¹²⁴ There was a dispute over whether the man, who was a pauper from Sydney, was contagious enough to be detained and where he should be kept until he was returned to his home state.¹²⁵ In a letter to the District Medical Officer the Principal Medical Officer in Perth indicated that the man was only mildly infectious and that there was little reason to move him to Sydney. The real problem was that no adequate facility existed for the man to be either treated or hospitalised.¹²⁶ Although no data existed at the time,

¹²⁰ J.M. Dalziel, 'Some Notes On Leprosy: Native beliefs, Heredity', in *The Journal Of Tropical Medicine And Hygiene*, Vol. XV, Jan. 1 to Dec. 16, 1912, pp.70-72; see also, E.C. Long, 'Notes On The Transmission Of Leprosy', in *The Journal Of Tropical Medicine And Hygiene*, Vol. XV, March 1, 1912, p.72.

¹²¹ Macknight, 'Macassans And Aborigines', pp.283-321; see also, Mulvaney, *The Prehistory of Australia*, pp.24-39.

¹²² Cook, *Epidemiology of Leprosy In Australia*, pp.9-71.

¹²³ Davidson, *Havens of Refuge*, pp.4-6.

¹²⁴ AN, 120/4, Acc. 1003, file 235/1902, 'Guildford Hospital - Case of Leprosy'.

¹²⁵ *Ibid.*, see 'Principal Medical Officer's letter dated, 27th August, 1902'.

¹²⁶ *Ibid.*, see 'letter from PMO to DMO, 27th Aug, 1902'.

reports claimed that the numbers of lepers among Aborigines was growing. The system of recognisance introduced by Prinsep proved weaker than expected.

The Chief Protector, in his *Annual Report* for 1907, announced that lock-up hospitals were to be established on Dorré or Bernier Islands. According to the Chief Protector the islands were ideally 'separated from one another so that Aborigines could be treated under lock and key' and detained there until completely cured. In fact no cure existed and sick Aborigines were detained falsely because administrators believed that a temporary halt to the disease was 'of little use'.¹²⁷ The advent of lock hospitals began a long process of isolating people being diagnosed as infected with either venereal infections or suspected of being infectious with leprosy. Mary Anne Jebb¹²⁸ in her study of the lock-up hospitals pointed out that Charles Fartier, the travelling inspector of Aborigines, first suggested the idea of an island hospital as a way of treating the venereal disease epidemic. His view was taken up by the Ashburton district shire. An article appeared in the *West Australian*¹²⁹ in December 1907 saying that a systematic treatment program for Aborigines suffering from forms of venereal disease had commenced. The Medical Department emphasised the need to segregate patients under medical supervision. Aboriginal patients diagnosed as being a leper, prior to 1907, had no prospect of receiving medical care and were refused treatment by hospitals. Inspector Fartier, said his concern was that Aborigines were 'being wiped out' by infectious disease.¹³⁰ In the first medical report from the island the Medical Superintendent Dr Frederick Lovegrove wrote that 'the condition of some of my patients bears eloquent testimony to the urgent

¹²⁷ Aborigines Department *Annual Report*, 1907, p.1.

¹²⁸ Mary Anne Jebb, 'The Lock Hospitals', p.74; see also, Public Records Office, Battye Library, 2425/2, from cutting of article in *West Australian*.

¹²⁹ *Ibid.*, p.74.

¹³⁰ PRO, file 2425 B/L, and cited in *Ibid.*, p.74.

necessity for maintaining these institutions for the segregation and treatment of these unfortunate people'¹³¹ in the most efficient way possible, not only for their own sakes but for the sake of the community at large.¹³² On the completion of hospital buildings and staff quarters native males were despatched by ship across to the hospital on Dorré Island. Venereal disease was the disease that concerned settlers but leprosy was the disease which struck most fear into their hearts.

Leprosy emerged as a serious threat to the indigenous people of northern Western Australia. What caused leprosy and how was it treated in Australia? In the period from 1900 to 1910, 129 patients with active or neutral leprosy notifications were brought in by police from many regions of the State.¹³³ Leprosy has an enigmatic past in Australia as it has in Europe. *Mycobacterium leprae*,¹³⁴ is the organism which causes leprosy and the disease has assumed emotionally loaded nuances in Australia because its visual symptoms, the *stigmata*, acquired close associations with xenophobia and racial prejudice against Chinese, Kanakas and Aborigines. Leprosy can affect the skin, the mucous membranes and the nerves. The incubation period ranges from 1 to 30 years and the symptoms develop slowly, characterised by widely distributed lumps on the skin. The lumps result from a pronounced thickening of the skin and nerves and sometimes come with a loss of feeling in the limbs, muscular weakening followed by paralysis and disfigurement. Tuberculosis — which was also confused by some observers with phthisis — sometimes developed alongside sufferers of leprosy, but whereas leprosy is contagious, *Tuberculoid leprosy* is often benign.¹³⁵ In either

¹³¹ *Ibid.*, pf.

¹³² *Ibid.*, p.6.

¹³³ *Ibid.*, 'Table 1', pp.124-127.

¹³⁴ S.G. Browne, 'Some Aspects of the history of Leprosy: the Leprosy of Yesterday', in *The Journal of The Proceedings of the Royal Society of Medicine*, Vol. 68, August 1975, pp.485-493.

¹³⁵ *Concise Medical Dictionary*, p.385.

form diagnosis was always difficult. In the northern areas of Western Australia, the primitive level of technology and health expertise in both the missions and government medical services meant that health workers found it almost impossible to diagnose these diseases.¹³⁶ Moreover they experienced difficulty in communicating their own helplessness and the lepers' plight.

Dr W.J. Durack, the District Medical Officer at Marble Bar, wrote to the Principal Medical Officer in Perth on 10 August 1904 saying that leprosy had been diagnosed in the Pilbara region. No record of infection appeared in the Kimberley region, however, until 1908. As the advanced leprosy cases were diagnosed along coastal areas to King Sound near Derby, two cases were diagnosed at Cygnet Bay and another at Point Torment. These three people died a short time after diagnosis, and another patient inland at Mount Anderson station meant that bush people would soon be presenting with the disease.¹³⁷ As the disease spread to bush people, segregation of lepers as the favoured form of treatment began to raise the prospects of white settlers being locked away in the same institutions as full-blood Aborigines.¹³⁸ While this form of quarantine was initially successful, it terrified white settlers and soon raised the prospect of having leprosariums close to white towns.¹³⁹

In circumstances where the centralisation of the administration favoured the Government, the medical records of the Aboriginal patients were forwarded to the Chief Protector who published only what he felt was necessary to keep Parliament informed. The Medical Department did

¹³⁶ W.S. Davidson, *Havens Of Refuge: A History Of Leprosy In Western Australia*, University of Western Australia Press, 1978, pp.3-11.

¹³⁷ *Ibid.*, pp.8-9.

¹³⁸ See *Concise Medical Dictionary*, p.568; but see also, Suzanne Saunders, 'Isolation: The Development Of Leprosy Prophylaxis In Australia', in *Aboriginal History*, Vol. 14, No. 2, 1990, pp.170-184.

¹³⁹ Suzanne Saunders, 'Isolation', pp.168-169; see also, Suzanne Saunders, 'A Suitable Island Site': Leprosy in the Northern Territory and the Channel Island Leprosarium 1880-1955', BA Hons Thesis, Murdoch University 1986, pp.14-33.

likewise but combined leprosy figures without reference to race. This complicated the method of reporting the statistics and as a result the data on Aboriginal health generally was unclear. Moodie makes reference to this problem of distortions in Aboriginal data in Western Australia, even after 1960, but it was much worse in the first decade of the twentieth century.¹⁴⁰

Biskup, in his history of the administration of Aborigines makes the point that Roth's Royal Commission Report of 1905 had asked for reforms in reporting a wide range of data on Aborigines. Improved reporting of information to the Chief Protector after 1905 represented an important administrative achievement. When Prinsep resigned, however, and C.F. Gale, the new Chief Protector, took over by 1908,¹⁴¹ and the growing incidence of venereal disease was a real worry. This tension added impetus to the opening of the lock-up hospitals, for which the new *Aborigines Protection Act 1905* made provision.¹⁴² When, in 1908, the new lock-up hospitals finally opened, Aborigines from the various ration depots, bush and fringe-camps, pastoral properties and missions were rounded up and taken there to receive treatment for syphilis and other venereal diseases. In the same year, there was a large increase in all categories of Aboriginal destitution and illness. Gale apparently had less interest in alleviating such conditions than his predecessor, Prinsep, however, for while he reported on his many trips to rural ration depots he made rather less mention of Aboriginal social and health conditions.¹⁴³

The changes in the Chief Protectors' manner of reporting the condition of Aborigines meant that the tabulation of data on blindness and infirmity ceased until 1912. Interest shifted temporarily to the prevalence of leprosy

¹⁴⁰ Moodie, *Aboriginal Health*, pp.146.

¹⁴¹ Biskup, *not slaves*, pp.111-113.

¹⁴² *Ibid.*, p.112.

¹⁴³ Biskup, *not slaves*, pp.111-113.

and to the incidence of venereal diseases, and the associated cost of constructing lock-up hospitals.¹⁴⁴ Under Gale health in general had only secondary importance after cattle killing. Roth's 1905 investigation into Aboriginal and settler relations had a great deal to say about cattle killing by Aborigines.¹⁴⁵ Health for Roth had been a major issue but only in so far as it was a factor in race relations, as when Aboriginal women contracted diseases from pearlers and Asian seamen in the northern areas of the State. Roth largely left the southern region of the State out of his consideration. The southern region took in Perth and stretched south along the western and southern seaboard to Cape Leeuwin and then east to Albany and Esperance. The regional boundary also took in all the inland towns between Norseman and Perth, and included various Aboriginal institutions and missions. This included the Mogumba, Moore River and New Norcia missions northeast of Perth. The complaints affecting the Aboriginal people of the region included blindness, injuries resulting from domestic violence, sexually transmitted diseases, early senility and periodic epidemics as well as general indigence.¹⁴⁶

In his numerous and extensive travels around Western Australia Gale found little illness or disease among the northern coastal natives. The absence of venereal disease surprised him, considering the reports by local protectors and police of the increased level of intercourse between Aboriginal women and lugger crews. Gale could only account for this phenomenon by his own observation that it was the 'cleanly habits of the coloured crews', who were constantly in the salt water. The natives, Gale remarked, also swam a lot during the hot weather. He reported that

¹⁴⁴ Chief Protector, *Annual Report*, WAPP, 1911, p.3.

¹⁴⁵ Chief Protector, *Annual Report*, WAPP, 1912, pp.3-7.

¹⁴⁶ Chief Protector, *Annual Report*, WAPP, 1908, pp.1-5 and 1909, pp.3-4 and, pp.12-13, and 1910, pp.12-15.

'blindness was the most prevalent disease amongst almost every mob of blacks'.¹⁴⁷ He concluded that there were 'sure to be one or two blind women or men, and nearly every station has blind people amongst their old natives'.¹⁴⁸ Gale mistakenly thought that because young natives showed no outward effects from the infection that the affliction had something to do with aging. Many of the older natives were suffering from syphilis sores, which in most instances healed up, but were sure to break out again. Young children were subject to the same trouble, but they would grow out of it. What the Protector observed was a cause unrelated to aging but to hygiene and social habits of camp life.¹⁴⁹

In 1908 a total of 1,200 Aborigines were reported suffering from the following categories: blind aged, decrepit and destitute. In the first category 119 Aborigines (43 males 76 females) were blind and consequently also suffered reduced mobility and independence. Aged and decrepit Aborigines numbered 735 (314 males 421 females). Destitute Aborigines totalled 346 people (144 males and 202 females). The female to male imbalance was heavy in every category.¹⁵⁰ Gale first visited the eastern goldfields centred on Coolgardie and the northwestern central gold fields of the Pilbara as well as pastoral stations of the Kimberley, but his first health report covered conditions across the whole of the state. It focused on the indigent and infirm and the increased number of fringe-camp, station and mission people who had contracted leprosy. He made special mention of the 112 ration stations which were scattered across the State.¹⁵¹ The figures in the three categories rose to 1,504 in 1909 with the largest increases coming in the female aged decrepit and destitute categories. While an overall fall in the three categories

¹⁴⁷ Chief Protector, *Annual Report*, WAPP, 1908, pp.3-5.

¹⁴⁸ *Ibid.*, p.4.

¹⁴⁹ *Ibid.*, pp.4-5.

¹⁵⁰ *Ibid.*, pp.5-7.

¹⁵¹ *Ibid.*, p.4.

occurred in 1910, the fall was among the males while the female numbers increased.¹⁵² Finally, Gale noted that venereal disease and leprosy were being monitored and that those suspected of having these diseases were being taken to a government property called Mount Wangee, about 140 kilometres from Roebourne. From there they were taken to various lock-up hospitals if they tested positive.¹⁵³ The patients were taken from one destination to another by police disease patrols.¹⁵⁴

Under Gale's administration the nakedness of the Aboriginal population became an issue of concern for administrators and protectors. Administrators had to justify the expenditure on clothing as bush and fringe people wore their issue of clothing until it fell from the body. The bush and fringe-camp people were constantly entering mining and service towns during their travels and to obtain food at the town stores. Most came into the stores and depots either naked or scantily dressed. Not only did nakedness offend the sensibilities of the settlers in the towns and mining establishments, it exposed the debilitating deformities the Aborigines suffered in fights and from leprosy, tuberculosis and venereal disease. Clothing, therefore, played a particularly important part in the minds of some protectors because it provided Aborigines with some protection against abuse by settlers, who were highly critical and prejudiced about indigenous nakedness, as well as against the natural cold, wind and rain.

Some district inspectors rejected the idea that clothing could provide warmth even when wet. Some claimed that tunics would engender the idea that clothing should be on permanent issue like rations. Such notions, some protectors argued, should not be encouraged because they believed that camp people would become dependent. Nevertheless, the Chief Protector

¹⁵² *Ibid.*, pp.1-4.

¹⁵³ Chief Protector, *Annual Report*, 1910, p.5.

¹⁵⁴ *Ibid.*, 1910, pf; for a description of what occurred see Daisy Bates, *The Passing*, pp.93-96.

recommended that the supply of cheaply made clothing was an answer to the problem of Aboriginal nudity. By contracting for large quantities of warm tunics with belts, Aborigines would not have to suffer the indignities of nudity when confronting townsfolk. Gale felt that this system was more convenient for natives and far more suitable than expensive trousers, shirts and jackets. The detractors argued that to give natives such good clothing was foolhardy because they would soon turn to rags. In turn, the clothing would soon become too dirty to wear. In addition, when the clothing got wet they would cling to the bodies of people and were more likely to cause colds and chills.¹⁵⁵

The paradoxical position of protectors was evident. The protectors wanted to protect Aborigines from criticisms levelled at them by white townsfolk. For instance white town residents were critical of the way bush people congregated around mining camps for food and money. This was a different way of life than they lived in their traditional customary ways. According to the rural protectors, bush people were, therefore, forced by circumstances to change their patterns of living and their practices of supporting their eating, shelter and habits within their bush customs. Alternatively, protectors laboured to keep people from embarrassment in the face of settler prudery, and at the same time keeping camp people's body and soul in one piece, which proved a difficult task for isolated protectors.

Indigenous people's ideas about health were powerless to treat the diseases prevalent in 1910. Western medicine was used, therefore, to assist in attempting to build good relations between settler and indigenous groups. Whereas in 1900 only the Government's Aborigines Department was involved in protecting Aborigines by 1910 others were beginning to assist indigenous groups from the ravages of an expanding colony. This was

¹⁵⁵ Chief Protector, *Annual Reports*, 1908, p.4.

evident by the way the Western Australian government employed protectors who had a knowledge of western medicine. The program of lock-up institutions created in 1907-8 were specifically designed to cope with the ravages of the venereal diseases epidemic identified by the Roth Royal Commission. To pastoralists the policy of protection meant the holding back of the growth of the colony, but to others it was beginning to mean that the State would ensure that a distance was kept between settlers and indigenous people wherever possible, and this is the subject of Chapter four.

APPENDIX 3

Table 3.1: Disability in Aborigines of WA, 1900-10.

Disability	1900-1	1902-3	1904-5	1907	1908-10	totals
Blindness						
male	78	na	70	30	125	303
females	144	na	181	60	145	530
Aged/Crippled						
males	353	na	561	270	654	1838
females	681	na	702	366	977	2726
Destitute						
males	64	na	175	112	310	661
females	110	na	242	158	533	1043

Sources. ¹⁵⁶ na= data not available

¹⁵⁶ Chief Protector, *Annual Report*, WAPP, 1900-1, pp.7-14; see also, *Annual Report*, WAPP, 1904-5, pp.13-14; see also, Chief Protectors, *Annual Report*, WAPP, 1907, p.17; see also, Chief Protectors, *Annual Report*, WAPP, 1908-10, pp.8-14.

CHAPTER 4

Search For An 'Isolation Area': Indigenous health and treatment in Western Australia, 1910-1920¹

The administration of the health of indigenous groups in Western Australia in the decade 1910 to 1920, was influenced by the setting in train of two administrative changes which also had an impact on the whole study period. In this decade, however, the first change was when the Aborigines Department amalgamated with the Department of Fisheries, and the second change began in 1915 when Immigration was added to form the Department of Aborigines, Fisheries and Immigration.² C.F. Gale remained in charge of the Aborigines Department until April 1915, when A.O. Neville became Chief Protector. In this period venereal disease, the onset of leprosy (which was confined to the northern regions of the State; see Table 6.1 in Appendix attached to chapter 6), hookworm and access by Aborigines to country hospitals for medical treatment preoccupied the departments dealing with Aboriginal protection and primary health.

One of the first tasks carried out by Protector Gale in 1910 was when the Western Australian Governor made Daisy Bates a travelling protector and paid her as a Special Commissioner. At the same time Bates joined

¹ Battye Library, AN, 120, Acc. 1003, File 140/08, 'Derby Leprosy among Natives'; see, 'Letter from DMO, to President, Central Board of Health, Perth, dated 19 July, 1908'.

² Tom Reynolds, 'Records Relating To Aborigines In The Western Australian Government Archives', in Reece and Stannage, *European-Aboriginal Relations*, pp.88-101.

an international party to study Aborigines in the central and northern areas of Western Australia. Part of her duties was to 'conduct inquiries into all native conditions and problems'.³ Another of her tasks was to look at how Aborigines and half-castes were employed on stations, and to act in guardianship and care of Indigents, and this included keeping an eye on the distribution of rations. The half-caste question loomed large in her mind along with the 'morality of native and half-caste women in towns and mining camps', and other matters affecting their welfare from an administrative point of view.⁴ Bates witnessed police rounding up Aborigines suspected of having chronic infections while she was on the expedition in 1910.⁵

From Laverton, in the central eastern part of the State, she travelled to Dorré and Bernier Islands. Decades later the shock of her experiences there remained vivid in her memory. She wrote that the two lock-up hospitals on Dorré and Bernier Islands were no places of refuge for the sick. She described them as places of deplorable suffering, 'misery and horror unalleviated...tombs of the dead'.⁶ Her concern was that the Government had abandoned its previous generally humane protection policy when faced by the potential scourge of venereal disease. In doing so, 'regardless of tribe and custom and country and relationship, they were herded together — the women on Dorré and the men on Bernier. Many had not seen the sea before, and died in terror of it.'⁷

Bates remarked that very little companionship existed and most of the inmates were either unknown to each other or feared contact with

³ Daisy Bates, *The Passing*, p.93; see also, D.J. Mulvaney, *Encounters in Place: Outsiders and Aboriginal Australians 1606-1985*, University of Queensland Press, 1989, Chapter 26, pp.183-194.

⁴ *Ibid.*, pf.

⁵ *Ibid.*, p.94.

⁶ *Ibid.*, pp.96-97.

⁷ *Ibid.*, p.97.

other Aborigines who were regarded as strangers. Similarly, most of the women roamed aimlessly in all weather and at most times of the day. Some women cried of loneliness and others stood for hours in one position peering across the water because they missed their relations, or grieved for their country. Many simply died of grief and many graves littered the islands in evidence.⁸ This painted a true picture because, when patients died on the islands the hospital buried them on the island and the hospital had no responsibility to send the bodies back to the families, or felt no compunction to do so. When the police disease patrols brought the patients in they had no legal responsibility to record where they came from. Similarly, Bates observed the carelessness of police contracted to bring diseased patients in from bush living places. She described one policeman who arrived

with new consignments of unfortunates collected throughout the vast State, and [she] went over to Carnarvon to meet them. [The police]...camped four miles away on the outskirts, with about 133 natives, all stricken with disease....[She wrote] shall I ever forget the surge of emotion that overcame me as they saw me, and they lifted their manacled hands in a faint shout of welcome, for some of them recognised me? There was a half-caste assistant with [the policeman]..., and the natives were chained to prevent them from escaping....In one donkey-wagon were forty-five men, women, and children, unable to walk.⁹

To Bates the attempts by Government to arrest the spread of venereal diseases and treat the effects, appeared inhumane. Any government system for dealing with the epidemic required that the project continue for a very long time before effective means for controlling the disease among Aborigines began producing results. Bates's views on these means clearly diverged from the Government's but she never stated what alternative approach she favoured.

⁸ *Ibid.*, pp.98-99.

⁹ *Ibid.*, p.102.

From the opening of the lock-up hospitals in 1908 to its closure in 1918, Aboriginal males and females were collected by police on behalf of the Medical and Public Health Department. On Dorré and Bernier Islands they were isolated from one another (including from their own relatives) by sex, and from white settlers. Because of the shortages of white woman in mining, fishing and pastoral service towns white men had sexual relations with Aboriginal women. Such activities were the cause of most of Aboriginal female venereal infections. As a result, indigenous women made up the largest number of people admitted for treatment at the lock-up hospitals. For example, in 1910, 72 females and 57 males were transported to the Islands suffering from sexually transmitted diseases.¹⁰ At the same time 10 male and 27 female Aborigines were discharged to their homes as cured. The inmates were drawn from widely dispersed areas somewhere between Wyndham and Carnarvon, and their departure left a total of 119 patients on the two islands. Many of the patients, according to the Chief Protector, were in the older age groups and had been suffering from some form of venereal disease from well before the advent of the lock-up hospital.¹¹

Once on the islands the patients were 'allowed to live their own lives in their natural way.'¹² What this meant was that when bush and camp people came they were allowed to live in the sand hills and erect their own shelters. By 1910, however, the hospital staff were finding it 'impossible to give the very bad cases the necessary attention.'¹³ The Government, 'on the report of the Superintendent Medical Officer,...authorised...the erection of an incurable ward...of 20 beds for

¹⁰ Chief Protector of Aborigines, *Annual Report*, WAGP, Perth, 1911, p.5.

¹¹ *Ibid.*, pf.

¹² *Ibid.*, pf.

¹³ *Ibid.*, pf.

females...and...10...for males.'¹⁴ In addition, an expert pathologist, Dr Steel, took up duties to try and 'discover the aetiology, treatment, and cure of the venereal diseases from which the natives suffered.'¹⁵ That year the Aboriginal male patients gathered the timber to build the new ward, and they collected 500 loads of coral, sand and limestone. With the coral they helped to mix the concrete to build constructions. When that was finished they built the fences and looked after animals that provided the meat for the medical staff.¹⁶ Building and farm-worker jobs were allocated to the able bodied males. For females bread-making, collection of firewood and transport of drinking water by bucket made up their contribution to daily operations. To collect the fresh water the women dug holes in the sand to access the underground water system and then carry the fresh water back to the hospital kitchen. This water supplemented rain water from the hospital roof which drained to concrete storage tanks. Apart from the task of carrying water, bush people were neither familiar with such tasks and were not used to hard labour. As a result, conflict between the nursing staff and inmates arose because of the way Aborigines were expected to perform these duties. This saved the Department money on building but caused problems in other direction. 'The standard of medical care...was undermined by the persistent punishment applied to Aborigines', which meant that patients would be physically whipped by hospital staff if inmates failed to do the tasks allocated.¹⁷

In the following year, a number of fights occurred between Aborigines. A white female employee later reported that the Medical staff

¹⁴ *Ibid.*, pf.

¹⁵ *Ibid.*, pf.

¹⁶ Mary Anne Jebb, 'The Lock Hospitals', in Reece and Stannage, *European-Aboriginal Relations*, p.80.

¹⁷ *Ibid.*, p.80.

'locked up the ringleaders'¹⁸ involved in the troubles. Part of the problem arose from an attempt to keep some Aboriginal men on Dorré island rather than to transfer them back to Bernier Island where they were normally hospitalised. Travel between the mainland and the two islands was always fraught with danger because of the westerly winds and swift flowing tides.¹⁹ When the men were allowed to stay, some of the women objected and fights broke out. Mary Anne Jebb argued that the cause of conflict was the austere management practices adopted by the medical staff on the islands.²⁰ But in Daisy Bates's opinion pre-existing hostilities among the patients appeared to be an underlying cause.²¹ Conditions did improve in 1912 when the extension to the Bernier Island hospital permitted some sufferers to receive surgical treatment they would otherwise not have been able to get.²² Surgical operations involved repair of male and female genital wasting or damage from the long-term neglect of the infected region of the body.²³

During the period from 1911 to 1916, although the numbers of patients with diseases — presumed at the time to be sexually transmitted infections — began to decline, the method of collecting patients became more organised. For example, patients were collected by boat from a number of mid-west-coast ports and taken to the island lock-up hospitals.²⁴ In 1911, 1912 and 1916 special disease patrols were sent into

¹⁸ *Ibid.*, pf.

¹⁹ Fred Lovegrove, Superintendent Medical Officer, 'Annual Report of Lock Hospitals Bernier and Dorré Islands', in *Ibid.*, pp.13-15.

²⁰ Mary Anne Jebb, 'The Lock Hospitals', p.80; for evidence of this view, in Battye Library, Public Records, file 2425/2, Helen Lenihan, see footnote 142, p.87.

²¹ Daisy Bates, *The Passing*, pp.97-98.

²² AN, 1/7, Acc. 2187, file 11/1932, 'Education and Domestic Training', some material on this file related to Bernier Island dated 16.5.12 (no folio numbers).

²³ *Ibid.*, pf.

²⁴ Mary Anne Jebb, 'The Lock Hospitals', p.75; see also, AN, 120/4, Acc. 1003, file 82/1917, 'Health Act 1911-12, Amendments', p.folio 15; see also, the *West Australian*, 8 September 1919, p.5.

the Gascoyne, Ashburton and De Grey districts to bring Aborigines into coastal towns for venereal disease screening prior to their dispatch to the island lock-up hospitals. In 1911 the disease patrol brought 96 men, women and children to Carnarvon. According to the Chief Protector's Annual Reports of 1912 to 1916, which gave no medical treatment details, the disease patrols were headed by travelling inspectors. These inspectors collected smaller numbers of Aborigines in this period because minor cases of infection were treated on the spot while other cases were transported to Marble Bar for dispatch to the island hospitals.²⁵

Though controversial, a research project on venereal disease which commenced in 1911 began to reveal a new perspective on the disease from which indigenous people were suffering.²⁶ According to Biskup, early research proved inconclusive, but 'the break-through came on the eve of the war when the ailment was finally diagnosed as *Granuloma of the pudenda*, an infection which at the time was thought to be venereal disease. In addition, this disease was assumed to be peculiar to the Aboriginal race.'²⁷ Mary Anne Jebb has argued, however, that Biskup's assumption that this complaint was an infectious disease peculiar to Aborigines was unsound. She based her views on the fact that a medical researcher, J.R. Hickenbotham,²⁸ had noticed 'interesting discrepancies in the manifestations of syphilitic lesions present in white stockmen.'²⁹ The disease, Hickenbotham showed, 'was also present in Aboriginal women with whom they cohabited. Furthermore he had treated the patients with

²⁵ Mary Anne Jebb, 'The Lock Hospitals', p.79; see Protector of Aborigines, *Annual Reports*, WAVP, WAGP, Perth, 1911, 1912 and 1916.

²⁶ Lovegrove, 'Lock Hospital Report', in Chief Protector of Aborigines, *Annual Report*, *Ibid.*, pp.13-14.

²⁷ Biskup, *not slaves*, p.113.

²⁸ J.B. Hickenbotham, 'Ulcerative Granuloma of the Pudenda in the Gascoyne District WA', in *Australian Medical Congress Transactions*, 1908, vol. II, pp.264-265, cited in Mary Anne Jebb, 'The Lock Hospitals', p.86.

²⁹ Mary Anne Jebb, 'The Lock Hospitals', pf.

syphilitic treatment measures and only the white stockmen had responded.'³⁰ Hickenbotham speculated that the white male pastoral workers might have had a milder form of the disease than the Aboriginal women, but their malady had little to do with race.³¹ In any event, Aborigines had less chance of getting the treatment they needed in the general hospital and under the medical circumstances of the time.

Throughout the period a total of 635 indigenous people were admitted to the lock-up hospitals created on Dorré and Bernier Islands (white people infected with sexually transmitted diseases were sent to Perth). The total number sent to these hospitals consisted of 426 females and 209 males. There is no evidence available to explain why twice as many females as males were admitted for treatment, but might certainly have been the problems women experienced as a result of the effects to their reproductive cycle and genital wasting. One explanation however, is that the males (mostly white) could always go south to Perth or other Australian capitals for the treatment. Another reason might have been that in the Gascoyne, Pilbara and Kimberley regions females were attracted to white settlement in greater numbers. As with the Asian mariners in the north, older Aboriginal males could indulge in the trading of sexual favours for cash from white settlers. Camps were established throughout the large river systems frequented by white and Asian settlers. Both pastoralists and Aboriginal settlers were attracted to the more productive lands around the mouths of the Fortescue River just south of Roebourne, the De Grey River north of Port Hedland and

³⁰ *Ibid.*, p.77.

³¹ Hickenbotham, 'Ulcerative Granuloma', pp.264-265; see also, AN, 120/4, Acc. 1003, file 259/1905, 'Carnarvon, Dr Hickenbotham - suggests trip through Milinya for purpose of vaccinating natives', see memo to Dr Lovegrove on 1 May 1905, giving reasons for trip, which shows concern about the spread of primary and secondary syphilis among both white and Aboriginal in outlying rural regions.

the Fitzroy and Drysdale Rivers. Here Aborigines could establish their camps in situations offering many advantages including permanent fresh water, bush food sources in the rivers and the sea, permanent dwelling places and easy access to the nearby towns, where store-food could be obtained for cash earned from white settlers.

In 1917 only 18 women and 4 men were admitted to the lock-up hospital near Carnarvon. In the same year 25 females and 7 males were allowed to return home. The numbers of people who died at the institution totalled 116 females and 46 males. According to Mary Anne Jebb's calculations, only 13 people stayed longer than three years, most of whom were females. Many patients stayed for only six months to a year and were then sent home as cured.³² Meanwhile, some local government bodies in the north began constituting themselves as local authorities under the new State health legislation.³³ They began exercising their legal capacity to frustrate projects that would benefit Aborigines suffering from sexually transmitted diseases. They did so by constructing Aboriginal hospitals near the towns within their jurisdiction. The new hospital at Port Hedland, for instance, might have been built further north at either Wyndham, Derby or Broome but for the protests of local Broome townsfolk who calculated — successfully as it turned out — to prevent the Government from doing so.³⁴ Similarly, calls came to bring the Commonwealth into the debates about venereal disease and hospitals for

³² Mary Anne Jebb, 'The Lock Hospitals', p.81.

³³ AN, 120/4, Acc. 1003, file 2044/1918, 'Wyndham Road Board — Constitution of a Local Health Authority', see memos: 'from the District Medical Officer Arthur Adams to the Commissioner of Public Health Department Perth', dated 22 April 1918.

³⁴ AN, 120/4, Acc. 1003, file 1959/1918, 'Darling Range Road Board — Local Board of Health'; see also, AN, 120/4, Acc. 1003, file 97/1919, 'Broome Local Health Board — Constitution of Road Board as Local Health Authority', pp.folios 1-20; see also, article in *The Medical Journal of Australia*, on Cabinet, April 1919, p.303, discussing approval of amalgamations of such bodies, folio 20.

Aborigines in which to treat the epidemic.³⁵ The closure of the lock-up hospitals on both Bernier and Dorré Islands took place in 1918 and a new 'native hospital' was opened at Port Hedland to deal with a range of illnesses and diseases suffered by Aborigines.³⁶ As the incidence of venereal diseases subsided, leprosy acquired greater prominence for health and protection agencies and white settlers in country towns. Although only 22 cases of leprosy (see Table 6.1 in Appendix 6) were reported in Western Australia between 1898 and 1920, reports showed that in the next decade the disease had been steadily spreading from the Gascoyne area into the Fitzroy River region of the Kimberley from about 1908.³⁷

Leprosy was first recorded among Aborigines who came from the mouth of the Fortescue River near Roebourne and around the Fitzroy estuary at King Sound. These two regions provided the largest number of lepers and the first group to be segregated on make-shift lazarets on Barrett and Berzout Islands.³⁸ It was from these locations that leprosy spread, and by 1920 it had spread throughout the Kimberley.³⁹ Some confusion existed over which authority was to deal with questions of primary and public health posed by the epidemics of venereal diseases

³⁵ AN, 120/4, Acc. 1003, file 6/1919, 'Quarantine and other Diseases Coordination of Commonwealth Powers re Quarantine', see letters from J.H.L. Cumpston Chief Quarantine Officer to Everitt H. Atkinson, and from the Premier of Western Australia to the Acting Prime Minister of Australia.

³⁶ AN, 120/4, Acc. 1003, file 888/1925, 'Interview with Dr Cecil Cook with Dr Dale', here Cook and Dale discuss changes to health system for diseased Aborigines including difficulties about building and locating lazarets and the incidence of venereal diseases.

³⁷ AN, 120/4, Acc. 1003, file 630/1925, 'Leprosy in North West', see notes on outbreak of leprosy at Mt Shadforth, on the Fitzroy River, in the Kimberley district in 1918; see Davidson, *Havens of Refuge*, pp.1-17.

³⁸ AN, 120/4, Acc. 1003, file 579/1908, 'Treat Leprosy of Chinese patient raises protest by Derby Progress League, dated 17 June 1908'; see also, AN, 120/4, Acc. 1003, file 140/1908, 'Derby Leprosy Among Natives', this file also mentions infections from tuberculosis in Aborigines at Derby Hospital; but it also contains memos on directing police to assist in providing assistance to attend lepers, take them to island locations and assist doctors by bringing lepers from isolated islands in Kings Sound to Derby.

³⁹ *Ibid.*, pf.

and leprosy. The numbers of diseased Aborigines, Asians and white settlers was becoming an urgent issue. Who should accept the responsibility, however, was not clear, and the overlapping legislation on infectious diseases, quarantine, local government clouded responsibility further. Aboriginal protection and public health led to disputes between the interested agencies.⁴⁰

One missionary's interpretation enables us to appreciate the difficulties which arose from trying to care for Aboriginal and Chinese lepers on isolated tidal sand islands.⁴¹ On 18 February 1908 a Dr Cortis wrote to the Principal Medical Officer in Perth to say that an outbreak of leprosy had occurred on islands located in King Sound.⁴² Cortis reported that he had visited Sunday and Cygnet Islands, where he found that the Catholic missionary, Father Nicholas Maria, had collected most of the sick, blind and infirm Aborigines onto an island.⁴³ There were about 45 men and about 50 women, and also a baby 'with an infected arm hanging from the body as if to drop off.'⁴⁴ Adult Aborigines that Cortis examined appeared to have cancer covering the whole of their faces. Cortis asked for larger subsidies and more medical assistance.⁴⁵ He and other medical practitioners and hospital staff throughout the State, together with protectors, pastoralists, townsfolk in the north and diseased sick and

⁴⁰ AN, 120/4, Acc. 1003, file 82/1917, 'Health Act 1911-12', this file gives some background to the problems faced both by the Medical Department, the Protector of Aborigines, the State and the Commonwealth, and discusses the drafting of the 1911-12 Health Act; see also, AN, 120/4, Acc. 1003, file 1761/1907, 'letter from Acting Regional Medical Officer, Arthur Adams, dated August 28, 1907', this letter sets out the difficulties and frustrations that doctors had in dealing with the health system, the hospitals, the police and the magistrates regarding infectious diseases and calls for drastic action to implement treatment and stem the spread of a number of infectious diseases.

⁴¹ 'Derby Leprosy among Natives', in AN, 120/4, Acc. 1003, file 140/1908, see 'letter from Dr Cortis to PMO, dated 30 January, 1908'.

⁴² *Ibid.*, see letter, 'Dr Cortis to PMO dated 18 February 1908'.

⁴³ *Ibid.*, see, 'letter from Dr Cortis to PMO dated 30 January 1908'.

⁴⁴ *Ibid.*, see reference in same letter 'Cortis to PMO'.

⁴⁵ *Ibid.*, pf.

dying Aborigines, had some time to wait before a reasonable level of order would be brought to the chaotic health situation. The Royal Commission of 1904-5 brought some respite but changes had to be made to the laws relating to public health, disease control and the creation of regional health authorities.

Reform did come on 1 June 1911 when the Western Australian Executive Council passed the *Health Act 1911-12*.⁴⁶ This new legislation changed the infectious disease clauses to take account of rural Aborigines needing attention. The significant changes, however, related mostly to the organisation of public health at the local government level. The legislation, nevertheless, made it possible for government to designate twenty new Road Board districts as health districts. At the same time it enabled existing Road Boards to receive government funding as health districts. A further 47 health districts became subject to direct control from the Board of Health, and a further 29 municipal districts came under the direction of the Health Department, which, with enhanced powers, was able to begin reorganising the public health system. Sufficient legislation existed to tackle the related problems of public health, Aboriginal protection and the treatment of Aborigines with infectious diseases.

The new *Health Act 1911-12*., approved on 1 July 1911, contained important changes.⁴⁷ The most significant change was that the Medical and Public Health Department absorbed two earlier portfolios of the Medical and Health Departments. The new department assumed control of the venereal disease hospitals at Bernier and Dorré Islands established under the *Aborigines Protection Act 1906*.⁴⁸ Although attention to

⁴⁶ 'Health Act 1911-12', in AN, 120/4, Acc. 1003, file 82/1019, folios 10-15.

⁴⁷ On the question of the amalgamation of the Medical and Health Departments, see, 'Health Act 1911-12 Amendments', in AN, 120/4, Acc. No. 1003, file 82/1917.

⁴⁸ Dr Maloney's Report, in 'Leprosy at Roebourne', in AN, 120/4, Acc. 1003, file 1262/1917, folio 43, dated, 1912, pp. folios 18-40.

Aboriginal lepers remained the responsibility of the Chief Protector (and his staff in rural and isolated regions), the Medical Department received additional powers under the *Infectious Diseases Act 1896* to administer treatment to anybody with infectious disease. Unfortunately, the Department did not exercise its new powers.⁴⁹ It lacked both the health infrastructure and the resources to influence what it could do in either the southern or the far northern areas of the State.

In one sense this was a natural development arising from increases in the State's population and advances in its economic development. In another sense it raised the awareness of local settler society about health in the region. That in turn promoted moves among the settlers to reject local measures to aid sufferers of leprosy and venereal disease: no one, it seemed, wished to have leprosaria or venereal disease clinics in their neighbourhoods. Such attitudes both complicated and restricted the task of government agencies responsible for treating patients who suffered from these ailments.⁵⁰

In the period from 1910 to 1915, medical identification of leprosy improved, but diagnosis by health workers and government agents remained difficult.⁵¹ The main complication was that other mutilating diseases such as tuberculosis and venereal diseases — syphilis and gonorrhoea — made diagnosis by hospital staff, doctors, police and protectors sometimes impossible. Although there was some debate about what ought to be done about lepers, the spread of leprosy in the north continued because almost no health authority existed there. Lepers were simply deposited on islands in Cygnet Bay, 300 kilometres north west of

⁴⁹ Davidson, *Havens of Refuge*, pp.98-100.

⁵⁰ Davidson, *Havens of Refuge*, pp.6-9, and pp.15-17.

⁵¹ 'Derby Leprosy among Natives', in AN, 120/4, Acc. 1003, file 140/1908, see note on file regarding building of lazaret at Derby, dated 25.5.1908.

Derby. This served to isolate leprosy cases from the general public, and visits by medical personnel rarely took place. About once in every eight months the police delivered water, bulk food such as flour and tea and firewood.⁵²

Medical services for special diseases such as leprosy developed slowly. In general those infected were isolated from villages, towns and cities. In Western Australia the same practice was adopted and early victims, both Chinese and Aborigines, were taken from remote bush camps by police. If either suspected or diagnosed as a carrier of the infection these patients faced the terror of both isolation and harsh painful treatment regimes. In Australia, early medication meant that leprosy patients received orally, or intravenously, chaulmoogra and hydnocarpus oils, made from vegetable derivatives of the East Indian chaulmoogra tree. These oils greatly improved the option of injection directly into the muscles, but were nauseating and a traumatic substitute for taking the dose by mouth.⁵³ This form of treatment was adopted by Dr Durack of Marble Bar in the Pilbara of northern Western Australia, who treated Manilamen with chaulmoogra oil by mouth. Locally derived treatments were rather more severe: in Roebourne Dr Maunsell added arsenic to the medication while in Derby antimony was considered a suitable addition by Dr Hodge.⁵⁴

Administering chaulmoogra oil orally with a small amount of strychnine was a practice adopted overseas. This caused nausea in some patients. As an alternative treatment Dr Victor Heiser in the Philippines

⁵² 'Treatment of Chinese', in AN, 120/4, Acc. 1003, file 579/1908, see note by Theo H. Lawson, the President of Central Board of Health dated 25.4.1908, regarding lepers from Cygnet Bay, near Derby; see also, AN, 120/4, Acc. 1003, file 140/1908, entitled 'Derby Leprosy Among Native', see telegram note from District Medical Officer (DMO) Lovegrove, dated between 26.2.1908 and 3.3.1908.

⁵³ Suzanne Saunders, 'Isolation', pp.169-170.

⁵⁴ Davidson, *Havens of Refuge*, p.95.

began a course of treatment by 'hypodermic injection with a formula composed of chaulmoogra oil, resorcin, and camphorated olive oil,...in 1 cc doses.'⁵⁵ Dr Heiser began the treatment on 15 February 1911 and, by April of 1911, increased the dosage to 12 cc per day over two months and then reduced back to 1 cc and then back to the maximum dose by October 1911. Before the treatment began the patient tested positive to a bacteriological test. On completion of the trials the researcher found that 'the patient was microscopically [tested] negative for leprosy.'⁵⁶ Although the leprous macules (a spot of discolouration of the skin or thickening and swelling to the skin that forms a distinct area from the normal tissue) developed as ulcers these healed by 1913 and microscopic tests failed to show any presence of the leprosy bacilli.⁵⁷ This was a short term result because no cure had been recognised at the time. Research on leprosy treatment was going on throughout the world and researchers had, by 1914, just begun to locate the similarities of both the leprosy and tuberculosis bacillus.⁵⁸ At the same time in Australia only 'standard' treatments persisted.

In 1911 Chief Protector Gale visited the lazarets on Cygnet Bay islands.⁵⁹ He kept in close contact with Dr Maloney of Roebourne⁶⁰ and Dr I. Maunsell of Broome,⁶¹ both of whom cooperated in keeping the

⁵⁵ V.G. Heiser, 'Leprosy: Treatment Of Two Cases With Apparent Cures', in *The Journal of Tropical Medicine and Hygiene*, Vol. XVII, January 1 to December 15, 1914, pp.53-54.

⁵⁶ *Ibid.*, p.53.

⁵⁷ *Ibid.*, pf.

⁵⁸ A. Johnston, 'Bacteriology of leprosy', in *The Journal of Tropical Medicine and Hygiene*, Vol. XVIII, January 1 to December 15, 1915, p.285.

⁵⁹ AN, 120/4, Acc. 1003, file 1262/1917, 'Leprosy Roebourne', see notes, folios 1-25, dated from 11.7.1908 to 14.11.1911, in particular notes from Gale to Under Secretary of Department of Fisheries, and long 1912 report on folio 43, by Dr Maloney about building of shelters for Aboriginal leprosy patients.

⁶⁰ *Ibid.*, folios 19-24.

⁶¹ Maunsell, in 'Leprosy at Roebourne', AN, 120/4, Acc. 1003, file 1262/1917, dated 15/11/1911, see 'Bezout Island - Visit by Dr Maunsell', on folio 2.

Chief Protector informed about the progress of the disease. Dr Maunsell went to Bezout Island on 15 September 1911 and examined 5 female Aborigines. He reported that two Aborigines, a man named Jimmy and his wife Nangetty, cared for about five adult females. Four of the women, after bacteriological examination, returned positive swabs for leprosy. Maunsell added that there was 'no doubt that Wagar and Cooranung...suffered from leprosy and the disease had become more marked in the last six months.'⁶² In addition, he saw an Aboriginal female called Parley, alias Jemima, whom he diagnosed as 'syphilitic and not suffering from leprosy....The...eruption she had before she went to Bezout [Island in King Sound] has practically cleared away.'⁶³ Many sufferers were understandably modest about close examination by doctors. Many doctors too, like Dr Maunsell, would not have wanted to impose a diagnosis on such isolated groups. Similarly, doctors could only guess at the stage of progress of the disease in such isolated groups because they had no legal capacity to move people to the mainland.⁶⁴

Gale's trip to the region, and particularly Berzout Island was to experience the difficulties his staff were faced with at first hand. On Berzout, Gale saw that 'the natives were at the time of...his visit living principally on turtle meat and eggs, which they much prefer to the food supplied to them'⁶⁵ by government. The size of the island on which patients lived was 'roughly about [two kilometres] in length and 100 to 200 yards wide and well above the sea level, so is in every way...suitable for the purposes of segregation.'⁶⁶ While there he saw the sheds in which stores were kept and those where patients could move to take shelter

⁶² *Ibid.*, folio 2, see 'Bezout Island - Visit by Dr Maunsell', on folio 2.

⁶³ *Ibid.*, pf.

⁶⁴ *Ibid.*, pf.

⁶⁵ *Ibid.*, folio 41.

⁶⁶ *Ibid.*, pf.

from the elements. Large water tanks were located for people to get water for drinking and cooking as needed. Before leaving the island Gale 'made arrangements for all the tanks to be filled in case anything unforeseen happened preventing a regular supply [of timber, and firewood and stores] being delivered.'⁶⁷ The supply was sufficient to last for about eight months.⁶⁸

Gale wrote that when he arrived on the island he 'found 7 bags of flour, 2 bags of sugar,...4 bags of tea, 4 dozen 2 pound tins of meat, and 3 dozen tins of jam in the stores, which the patients have access to any time.'⁶⁹ Dr Maloney, the District Medical Officer at Roebourne complained about the conditions but was criticised by the Health Department as the holder of 'alarmist' views, but it was enough to bring Gale to the area. Once there he satisfied himself that the depot staff under his control were carrying out their tasks as satisfactorily as possible.⁷⁰ He felt also, that, from a medical point of view, 'there was much left wanting in the proper treatment of these leper patients.'⁷¹

There were about eight adult 'natives' on the island whom Gale thought were suffering from leprosy, 2 males and 6 females. Some of the lepers had other relatives with them, and Gale advised the Under-Secretary of the Premier's Department that he thought this was unsatisfactory.⁷² Gale pointed out that the health Department authorised the police to place the lepers on the island. He agreed with the District Medical Officer that this was unacceptable:

⁶⁷ Gale, in 'Leprosy at Roebourne', AN, 120/4, Acc. 1003, file 1262/1917, dated 14.11.1911, see report, from C.F. Gale, Chief Protector of Aborigines to Under Secretary.

⁶⁸ *Ibid.*, folio 40.

⁶⁹ *Ibid.*, pf.

⁷⁰ *Ibid.*, pf.

⁷¹ *Ibid.*, folio 42.

⁷² *Ibid.*, pf.

I admit the difficulty of holding any native suspect until his or her disease is determined, but the opinion of Dr Maloney has been frequently voiced by himself when at Roebourne that an illegal action is taking place with natives which the authorities would dare not do if the subjects were Europeans, and I feel sure this phase of the question will be ventilated by the public sooner or later.⁷³

One of the difficulties was that the island was twenty kilometres from the mainland, which made travel dangerous for the medical staff. In heavy weather the time taken to travel to and from the island was about thirteen hours. The police cutter that ferried the stores, firewood and water, and took the medical officers to and from the island was a poor craft.⁷⁴ In view of such difficulties Gale thought that a place on the mainland had to be found, despite public objections.⁷⁵

In the two years from 1912 to 1914 debate ensued over whether leper patients ought to be taken south to one of the islands off the coast of Carnarvon.⁷⁶ No decision was possible, however, due to the conflicting interests involved. That was until a white female presented at a Perth hospital with signs of leprosy. The head of the Health Department, Everett Atkinson, then pressed the Minister for Health to take action. A tidal island close to Roebourne was located, and the quarantine station at Cossack was designated as an alternative location. A district medical officer, Dr Davidson, put the problem of indecision, over the building and the locating of a lazaret, down to a lack of communication between the interested parties.⁷⁷ At the same time the numbers of leprosy victims

⁷³ *Ibid.*, pf.

⁷⁴ *Ibid.*, pf.

⁷⁵ *Ibid.*, folio 43.

⁷⁶ Davidson, *Havens of Refuge*, p.17.

⁷⁷ Gale, in 'Leprosy at Roebourne', AN, 120/4, Acc. 1003, file 1262/1917, dated 14.11.1911, folio 43.

were growing and bush medication, that is traditional remedies, proved as inappropriate as those of western medicine.⁷⁸

Traditional medications and cures for some illnesses did exist among bush people. In some cases, especially with fevers and the associated pain, treatment had mixed benefits. Sorcerers treated the sick person by ordering that they eat a particular plant or by rubbing the juice and oils of the plants on the body with animal fat. This activity was accompanied by the patient being treated by a traditional magician, or 'clever' healers, who could be male or female. These practitioners sat near the patient, or placed them wholly in water to lower the patient's temperature. Thus the symptoms rather than the disease were treated. As far as the patients were concerned, medical science was as impotent as cultural ideologies in explaining what leprosy was, how people contracted the disease and how it should be treated.⁷⁹

The Western Australian Government began collecting aggregate data on leprosy as early as 1905. The first researcher to use that data was Dr Cecil Cook in his 1922-23 epidemiological study of leprosy.⁸⁰ The health administration for leprosy and its treatment processes have remained relatively unknown until recently, however. This was possibly due to restrictions on both the personal medical and government records

⁷⁸ William H. McNeill, *Plagues And Peoples*, Penguin Books, London 1976, p.50. The same form of treatment offered in the period from 1910 to 1940 continued until after World War II, but by 1950 new drugs offered a better prophylaxis than segregation, see R.G. Cochrane, *Practical Text-book of Leprosy*, Oxford Medical Pub., 1947.

⁷⁹ McNeill, *Plagues and Peoples*, p.164; see also, Suzanne Saunders, 'Isolation: The development of leprosy prophylaxis in Australia', in *Aboriginal History*, Vol. 14, No. 2, 1990, pp.168-169; see also, Suzanne Saunders, "'A Suitable Island Site': Leprosy in the Northern Territory and the Channel Island Leprosarium, 1880-1955", B/A Honours thesis, Murdoch University WA, 1986, pp.1-33; see also, C. Cook, *The Epidemiology of Leprosy in Australia*, AGPS, Melbourne, 1925; see also, J.H.L. Cumpston & F. McCallum, *The History of Plague in Australia, 1900-1925*, AGPS, Melbourne, 1926; see also, M.J. Lewis (ed.), J.H.L. Cumpston, *Health and Disease in Australia: A History*, AGPS, Canberra, 1989, pp.207-218; Davidson, *Havens of Refuge*, pp.94-97; Goldsmid, *Deadly Legacy*, pp.81-89.

⁸⁰ See Chief Protectors, *Annual Reports, 1908-1920*, used in the study by Cecil. E. Cook, 'The Epidemiology of Leprosy'.

on the disease and the nature of the legislation covering the government records.⁸¹

At the end of Gale's term as Chief Protector communicable diseases infecting Aborigines had spread to such an extent that some venereal diseases and leprosy had become endemic. Gale had two major concerns about the issue of bringing health care to Aborigines. The first involved the international hookworm campaign, which in Western Australia largely focused on Aboriginal missions and government settlements. The second was medical care for Aborigines in rural hospitals.

Interest in *Ancylostomiasis*,⁸² or hookworm, was well described in the reports of the Australian Hookworm Campaign,⁸³ which defined it as 'an insidious infectious malady, caused by two species of parasitic intestinal worms (*Necator americanus* and *Ancylostoma duodenale*) which attach themselves to the delicate inner lining (or mucous membrane) of the small intestine, and there give rise to multiple small haemorrhages.'⁸⁴ Both species are 'nematodes', which are parasites of

⁸¹ Davidson, *Havens of Refuge*; see also Mary Anne Jebb, 'The Lock Hospitals', pp.68-87.

⁸² *Concise Medical Dictionary*, p.31; *Ancylostomiasis duodenale*, was first recognised in 1838 by Dubini, an Italian physician, in a post mortem examination. The importance of the disease came to light in 1898 when Looss (accidentally) observed the penetration of the human skin by the hookworm larvae. The second type of hookworm was observed in 1902 by Stiles in the USA and he called this find, *Necator americanus*, and this is an African, Australasian and American species, while the former is located in Egypt, Europe. Australia has both species, see, in AA/1969/10, Item 17 I, 'Hookworm Disease and Control', pp.1-2.

⁸³ *Concise Medical Dictionary*, p.31; see also, AA/1969/10/1, Item 17 K, 'Hookworm Disease', p.1.

⁸⁴ Cumpston, 'Gastro-intestinal Diseases', in Lewis, Cumpston, *Health and Disease*, pp.239-245; see also, AA/1969/10, Item 17 I, 'Hookworm Disease and Control', see, F.F. Longley, 'Some Defects In Country Health Administration, And A Practical Remedy', *Reprinted from the Supplement to The Medical Journal of Australia, (Transcription of Congress)*, May 17, 1924, pp.1-7, this article reflects some of the concerns about rural health in Australia focusing on sanitation; see also, W.A. Sawyer, 'The Sciences Underlying Public Health', in *Reprint from the Supplement of The Medical Journal of Australia, (Transcription of Congress)*, May 17, 1924, pp.1-6; see also, W.C. Sweet, 'The Intestinal Parasites Of Man In Australia And Its Deficiencies As Found By The Australian Hookworm Campaign', *Reprinted from the Supplement to The Medical Journal Of Australia*, April 26, 1924, pp.1-8.

animals as well as plants.⁸⁵ The worm passes through the larval stage in the ground.⁸⁶ The final report of the Australian Hookworm Campaign noted 'a preponderance of the Necator', and commented that

more recent work in the northern coastal districts gives an opposite result. The recent immigration of numbers of Southern Europeans may have changed the ratio of the species....Where the *Ancylostoma* is predominant it is believed to [come] from Chinese and Southern European sources, while the origin of the *Necator* [is] the Melanesian archipelagos.⁸⁷

The hookworm larvae prefer warm, moist, oxygenated habitats.⁸⁸ Such conditions stimulate the hatching of the egg and the larvae cut through the human (or other animal) host's skin to enter the blood stream.⁸⁹ Once in the blood stream the worms travel through the lymphatic and blood vessels to the heart and lungs. They break the thin walls of the alveoli of the lungs, travelling up the trachea, down the oesophagus, and finally attach themselves to the wall of the small intestine.⁹⁰ Groups of people burdened with poor group hygiene are most likely to be affected. This was especially the case where Aboriginal fringe-camp hygiene practices resulted in the creation of reservoirs of hookworm infection.⁹¹

Hookworm, in the decade 1910 to 1920, became more widely reported among Aborigines, but it also infected white Australians.⁹² The

⁸⁵ AA/1969/10/1, Item 17 K, 'Hookworm Disease', p.1.

⁸⁶ *Ibid.*, pf.

⁸⁷ *Ibid.*, pp.2-5, see Figures, 1-4, which give the various stages of the metamorphoses of the hookworm.

⁸⁸ *Ibid.*, pp.6-7.

⁸⁹ *Ibid.*, p.7.

⁹⁰ *Ibid.*, pf.

⁹¹ *Concise Medical Dictionary*, p.324; see also, Benenson, *Control of Communicable Diseases*, pp.219-220.

⁹² James A. Gillespie, *The Price Of Health: Australian Government and Medical Politics 1910-1960*, Cambridge University Press, 1991, pp.37-46; see also, J.A. Gillespie, 'The Rockefeller Foundation and National Health Policy', in MacLeod and Denoon, *Health and Healing*.

first survey in 1918 among Western Australian Aborigines,⁹³ reported rates of infestation ranged between 50 and 90 per cent.⁹⁴ The Chairman of the Road Board at Broome wrote to the District Medical Officer, Dr Atkinson, to notify him that a case of hookworm had been found in Broome.⁹⁵ This prompted the State Government to contribute 33 percent of the total cost of conducting a hookworm survey in the north.⁹⁶ Other contributors were the Commonwealth Government and the International Health Board of the J.D. Rockefeller Foundation.⁹⁷ A sample survey was conducted in 1918 in Western Australia and showed the presence of hookworm.⁹⁸ The continuity of inspections for communicable diseases by District Medical Officers, who visited some missions, was broken only by the commencement of the First World War.

The Medical and Public Health Departments had already been monitoring hookworm infection in the northern parts of the State. Dr Hayes indicated that the mission provided favourable conditions for the spread of hookworm because of the presence of pools of stagnant water at the locations where bare footed children played. At some locations crude sanitation aided its spread rather than helped in its prevention. The

⁹³ D.J.R. Snow, 'Notes on Communicable Disease in Western Australia, North of Capricorn', in *WA Public Health Report of the Commissioner*, WAGP, 1949, pp.68-69; see also, D.J.R. Snow, 'The History of Some Communicable Diseases in Western Australia (1828-1951)', Part I, *WA Public Health Report of the Commissioner*, WAGP, 1953, pp.49-51; see also, 'The History of Communicable Diseases in Western Australia (1828-1951)', Part III, *WA Public Health Report of the Commissioner*, WAGP, 1953, pp.67-75.

⁹⁴ Goldsmid, *The Deadly Legacy*, p.43-44; note that areas in the plantation regions south from Cairns surveyed a number of institutionalised Aboriginal groups and some fringe-camp workers only. In Western Australia, Moore River and Catholic Missions near Broome and Derby offered the other sample group during 1918.

⁹⁵ AN, 120/4, Acc. 1003, file 8297/1921, 'Hookworm Campaign - General Correspondence', see folio 13.

⁹⁶ *Ibid.*, folio 1. These are 1921 facts but Cumpston confirms the program's development in Lewis, *Cumpston, Health and Disease*, p.239.

⁹⁷ 'Hookworm Campaign', AN, 120/4, Acc. 1003, file 8297/1921, folio 1.

⁹⁸ Lewis, *Cumpston, Health and Disease*, pp.10-11, and pp.239-240.

incidence of the disease was not surprising considering 'the number of Malays...Manilamen etc., in north west, spread the disease to Aborigines.'⁹⁹ A later letter from John Dale (Deputy Commissioner of Public Health) advised the Minister about the 'Hookworm Campaigns' that were proceeding in the eastern states. Dale told the Minister that the idea for such a health campaign came from the International Health Bureau, an establishment of the J.D. Rockefeller Foundation of the United States of America.¹⁰⁰ The motivation behind Rockefeller's action in developing a world wide campaign targeting hookworm arose from, among other things, Joseph Bancroft's promotion of the health sciences in Australia.¹⁰¹

After hostilities ceased in Europe in 1918 the Australian Institute of Tropical Medicine re-commenced their efforts in the hookworm campaign in cooperation with the Health Board of the Rockefeller Foundation. The campaign was based on criteria established by Anton Breinl in 1911.¹⁰² Breinl had written that notification of the presence of hookworm was insufficient and that the geographical incidence had to be known, as well as its demographic distribution. Compulsory treatment then had to be imposed on sufferers.¹⁰³ The thrust of the first survey focused on Queensland, where a high prevalence had already been identified. In Western Australia, interest was focused on the north, and appropriate data collected. The initial sample survey commenced in 1918-19 and it was conducted with school children selected as a representative

⁹⁹ 'Hookworm Campaign - General Correspondence', AN, 120/4, Acc. 1003, file 8297/1921, folio 13.

¹⁰⁰ *Ibid.*, pf.

¹⁰¹ Gillespie, *The Price Of Health*, pp.36-42; see also, Fenner, 'Bancroft kindred' in Pearn and Powell, *Bancroft Tradition*.

¹⁰² A. Breinl, 'Ankylostomiasis', in *Transactions of Australian Medical Congress*, 1911, p.536.

¹⁰³ *Ibid.*, pf.

sample of the Aboriginal institutionalised population. This method changed when some mission populations needed a different sampling approach. In those cases adults were taken as a representative group of the population. In areas where hookworm was known or suspected to be endemic a mass screening occurred to obtain samples from everyone at the mission.¹⁰⁴ The results of the Western Australian sample survey were made available to Parliament, but not until 1921.

Concentrating on the operations of the sample survey, the hookworm campaign centred on the Aboriginal community at Beagle Bay near Derby.¹⁰⁵ An agreement was approved by Dr Sawyer of the Western Australian Health Department, with the Director General of the Commonwealth Health Department, Dr Cumpston, on 6 May 1921.¹⁰⁶

While the concerns about hookworm infestations in Aboriginal groups preoccupied Western Australian health circles, the struggle to pay for primary health care for Aborigines continued, as did the struggle to give them access to ordinary country hospitals, medical establishments and private medical practitioners' clinics.¹⁰⁷ From 1900 to the 1920s the

¹⁰⁴ Lewis, *Cumpston, Health and Disease*, p.240.

¹⁰⁵ 'Hookworm Campaign - General Correspondence', in AN, 120/4, Acc. 1003, file 8297/1921, folios 25-27.

¹⁰⁶ *Ibid.*, p.folio 28.

¹⁰⁷ AN, 120/4, Acc. 1003, file 262/1902, 'Official Correspondence between WA and NSW on Health Procedure', this file refers to, among other things, epidemics and plagues and how other states dealt with epidemics among Aborigines; see also, AN, 120/4, Acc. 1003, file 34/1906, 'Kalgoorlie Hospital', see 'letter from Stanley Tratman, Secretary of Government Hospital Kalgoorlie to PMO Perth, dated August 6 1906'; see also, AN, 120/4, Acc. 1003, file 292/1901-1902, 'Hospital treatment of "Aboriginals" Principal Medical Officer Claims', see 'letter from PMO to Chief Protector', dated 8 October 1902, p.folio 5; see also, AN, 120/4, Acc. 1003, file 282/1902, 'Death of Edward Whitworth in Peak Hill Lock-up Hospital', see 'letter from PMO to Under Secretary of Premier's Office re payment of burial, health and medical costs and fees. See also folios 2 and 3, re telegrams from Constable McGinley about treatment of a sick Aboriginal vagrant with infectious disease; see also, AN, 120/4, Acc. 1003, file 354/1904, 'Wyndham Hospital Payment of Fees', see 'memo from Dr Belgrave to PMO, re fees for sick and diseased Aboriginal Women', folio 5; see also, AN, 120/4, Acc. 1003, file 32/1906, 'Geraldton Hospital Fees Collection', see extensive documentation on fee payments and other costs for Aborigines at local rural hospital and sanatoria.

Medical Department in Perth administered country hospitals.¹⁰⁸ This meant that stockworkers and Aboriginal mission populations were denied direct access to health care from doctors. Stockworkers in most regions of the State had to rely heavily on property owners and pastoralists possessing medical chests to deliver their primary health care services because no professional help was available.¹⁰⁹ Aborigines on missions largely had to fend for themselves or rely on priests and missionaries to meet their primary health care needs. This often meant involvement by missionaries in the political and legal battles over the care and costs of treating their mission inmates.¹¹⁰

Father Lyon Weiss wrote to the president of the Medical Board of Western Australia in Perth, as early as 1905 asking for pressure to be brought to bear on the Government to use its influence on hospital administrations and asking them to admit Aborigines, particularly those from the Kimberley region. Weiss told the Board that local hospital establishments at Broome, Derby and Wyndham¹¹¹ would not cooperate to admit Aborigines.¹¹² In the interest of justice and humanity Weiss asked whether hospitals in Western Australia had 'a rule which debarred people from hospitals on the basis of their race.'¹¹³ The Board's reply indicated that Aborigines were admitted and did receive the same

¹⁰⁸ AN, 120/4, Acc. 1003, file 34/1906, 'Kalgoorlie Hospital "Fees Collection"', although there is no mention of Aborigines other files document the struggle to retrieve fee for service from white and Aboriginal paupers and from employees of pastoralists, folios 1-10.

¹⁰⁹ AN, 120/4, Acc. 1003, file 459/1906, 'Re Medicine Chests for outlying Districts', see 'letter to Dr Hicks by PMO Lovegrove, on inquiry by H. Gregory from Edgar Owners and Company', dated 7.3.1906.

¹¹⁰ AN, 120/4, Acc. 1003, file 121/1906, 'Father Lyon Weiss, and Aboriginal treatment in hospitals and etc.', see 'letter from Father Weiss to the President and Medical Board of Western Australia', dated 25 September 1905 and 11 December 1905. The matters cover the right of hospitals, doctors and health staff to refuse treatment to sick Aborigines.

¹¹¹ *Ibid.*, pf.

¹¹² *Ibid.*, pf.

¹¹³ *Ibid.*, pf.

treatment and care as other patients. Hospitals had special wards for Aborigines in many parts of the State, and where provisions were not provided the natives were placed in the general wards and made to lie side by side with other patients.¹¹⁴ Weiss knew that the Board was protecting the medical profession and the status quo, and he was unable to argue about health practices elsewhere. This was a continuing battle between missionaries, protectors and some property owners whose responsibility it was to pay for their sick labour.

As country hospitals increased in number centralised management became unworkable. After 1 July 1911, when the *Heath Act of 1911-12* came into force, municipalities everywhere became health districts and Road Boards whose boundaries joined became a local health authority.¹¹⁵ A dichotomy existed in that, on the one hand, hospital staff and private doctors demanded payment from Aborigines before rendering a service. On the other hand, these same people accepted responsibility for their health. Chief Protector Gale knew this and he indicated that every care and consideration should be given to sick Aborigines because as patients hospital staff were duty bound to 'make them as comfortable as possible.'¹¹⁶ The reality was, as Weiss knew also, that the prejudice of health personnel dominated their actions.

As early as 13 November 1911 the Medical Department began involving itself in the way Aborigines were treated at country hospitals.¹¹⁷ On 25 November 1911 the Principal Medical Officer wrote to the Narrogin hospital that tents were on their way for use by Aboriginal

¹¹⁴ *Ibid.*, pf.

¹¹⁵ 'Health Act 1911-1912 Amendments', in, AN, 120/4, Acc. 1003, file 82/1917, folios 1-15.

¹¹⁶ 'Leprosy at Roebourne', in AN, 120/4, Acc. 1003, file 1262/1917, p.folio 40.

¹¹⁷ AN, 120/4, Acc. 1003, file 1325/1925, 'Narrogin Hospital: treatment of Natives', folio 65, see note on file about concern about the quality of treatment of Aborigines at Narrogin hospital dated 13 November 1911.

patients. In addition the Chief Protector wanted to know why a separate ward was needed for Aborigines. By 1914 the Aborigines Department built the wards and they needed maintenance two years later.¹¹⁸ In 1916 Neville had been the Chief Protector for a year when the problem of maintaining 'native' hospitals emerged. He wrote to Narrogin hospital objecting to paying for repairs on the 'native' ward.¹¹⁹ The District Medical Officer, James. B. Lewis wrote during November 1919, that a large number of natives had been admitted to the hospital and placed in a portable frame tent at the rear of the hospital. According to Lewis, these natives were housed outside the main hospital because they were not clean. He added that their habits made the white patients uncomfortable. 'If materials were approved, the orderly could manage the construction. Otherwise the Police Department have a frame tent that could be used.'¹²⁰ The Medical Department wanted the old ward (which was erected at the Protector's expense) to be maintained by the Chief Protector together with an additional ward because of the increased numbers of Aborigines the hospital was taking. Neville noted on file that two small wards at the back of the hospital were intended for Aboriginal cases.¹²¹ Continuing his reaction, the Chief Protector wanted to know from the Medical Department whether his Department was to understand that because of the increasing number of Aboriginal patients, there was no separate accommodation for them.¹²² The problem of accommodating Aborigines abated when the Carrolup reserve offered a refuge where sick

¹¹⁸ *Ibid.*, p.folio 65, see reference, on 26 August 1916, to building of Narrogin Hospital Aboriginal Ward.

¹¹⁹ *Ibid.*, see, Memo: from 'District Medical Officer to Perth Medical Officer of Medical Department', dated 7 November 1919.

¹²⁰ *Ibid.*, see Memo: 'Medical Department to Chief Protector of Aborigines', dated November 7, 1919.

¹²¹ *Ibid.*, p.folio 70.

¹²² *Ibid.*, p.folio 70.

Aborigines could be cared for if disaster struck (as it did in the 1918-1919 Spanish influenza pandemic).

In 1916 two reserves were created because Chief Protector Neville wanted to remove people who had begun congregating in fringe camps on the outskirts of Perth. One was at Moore River and the other at Carrolup. These camps were populated mainly by unemployed Aborigines moving south from the Roman Catholic mission at New Norcia, which had recently closed. Aborigines had been gathering around the fringes of small towns since the Aborigines Department had been implementing its policy of closing the missions and bringing their inmates more deliberately into the workforce. As people experienced the freedom and ease of movement in the new style of fringe-camp life they tended to live close to where work became available rather than return to the rigours of Government and strictness of mission reserves if at all possible. In addition, the Department aided this change by encouraging private pastoral land ownership to employ Aboriginal labour on local farms in the southern districts of the State.¹²³

As World War I intensified it took white labour from the economy and allowed Aborigines to gain work in both the city and rural areas of the south. Near Perth Aboriginal domestics lived in fringe-camps located in bushland on the outskirts of the suburbs. These camps attracted most attention, and from 1916 a number of complaints were received from nearby white residents about conditions there. The Department also showed concern when reports came in about an epidemic of measles, bronchitis and pneumonia which affected many Aboriginal residents. In 1918 Neville instructed the local police to order Aborigines to shift their

¹²³ Biskup, *not slaves*, p.154.

camps to Moore River, a reserve near the country town of Carrolup.¹²⁴ Once there these camp populations suffered recurring respiratory infections. In part this was due to peoples' inability to adapt to mass social living and poor economic circumstances. In part also these camp dwelling places meant that Aboriginal residents were forced to live partly indoors and partly outside and as a result they were subject to all the elements. In addition, both adults and children were in poor physical condition.¹²⁵ Then, Soldiers began returning from the European War and with them came the Spanish influenza.¹²⁶

In late October 1918 the federal authorities quarantined two ships returning from the European theatre of war via South Africa. The first was the *Charon Bay*, a passenger steamer and mail carrier. The ship entered quarantine on Wednesday 21 October 1918. This vessel arrived at Broome in Western Australia, with many passengers on board seriously ill from Spanish influenza, which was also known as 'pneumonic' and 'swine' influenza.¹²⁷ At the same time, the Director of Commonwealth Quarantine Services assured the nation that this, like diseases such as cholera and other infectious disease threats from Asia, should hold no fear for Australians on the mainland because they were in no immediate danger. The *Charon Bay* contained a large number of Fremantle residents. The second passenger steamer was the *Mataram* from London via South Africa, arriving in Darwin on 22 October 1918 on its way to Sydney. The quarantine officials in Darwin directed the vessel to sail

¹²⁴ Anna Haebich, 'A Bunch Of Cast-Offs', p.323.

¹²⁵ *Ibid.*, pp.324-333.

¹²⁶ Burnet, *Viruses and Man*, pp.103-111; see also (Sir) F. Macfarlane Burnet, and D.O. White, *Natural history of infectious disease*, Cambridge University Press, 1972, pp.202-205; Goldsmid, *The Deadly Legacy*, pp.14-16.

¹²⁷ Lewis, *Cumpston, Health and Disease*, pp.319-320.

immediately to Brisbane due to the larger quarantine facilities developed there.¹²⁸

Undoubtedly the pandemic spread throughout Western Australia. However, there is very little direct evidence of its impact on the Aboriginal population. At this time, Aborigines were not reported as being affected with the disease in Western Australia. But influenza did occupy the mind of the Chief Protector of Aborigines when he wrote his reports for 1918 to 1920 to Parliament. No additional information was given by the Medical and Health Departments which published aggregate data on the Spanish Influenza pandemic. Similarly, these departments made no distinction on the basis of race in handling the pandemic. In any case, a number of characteristics were different in 1918-1919 from earlier epidemics. One difference was its rapid movement across the world, from America, France, England and Spain to places such as South Africa, India and New Zealand to Australia. Reports soon reached Australia that the pandemic was a serious event affecting vast numbers of people in many different countries, especially those people who had little or no immunity.¹²⁹ Strangely, those stricken were generally the younger rather than the older members of society. Mortality figures revealed that, unusually, it was the strong, healthy and young adults who were most severely affected.¹³⁰ By contrast, among Aborigines most deaths were in the older age groups, particularly among those already weakened by other wasting diseases such as tuberculosis, venereal disease and pneumonia.

¹²⁸ *The Brisbane Courier*, Tuesday, October 22, 1918, p.6.

¹²⁹ *Concise Medical Dictionary*, p.505.

¹³⁰ Lewis, *Cumpston, Health and Disease*, pp.313-319.

The influenza death toll in Western Australia soon rose to 538 people of both sexes,¹³¹ out of a total population of 332,732.¹³² There are conflicting estimates of the numbers of Aborigines who perished. Chief Protector Neville maintained that the health of Aborigines in the southern region remained good,¹³³ and in his 1918-1920 reports to Parliament he indicated that a total of only five Aboriginal deaths from influenza occurred in 1918. No adequate health reporting system existed in Western Australia and information on either epidemics among indigenous groups or pandemics such as in 1918-1919, were reported long after the event, or not at all. In 1919, Neville reported that 17 Aborigines had succumbed to influenza. A more recent claim puts the Western Australian mortality figure at 150 Aborigines from both sexes.¹³⁴ The general population suffered most after May 1919, with a peak in July, and a slow fall thereafter.¹³⁵ Commenting on his Department's work for the year ending 1918, Neville wrote that the pandemic affected Aborigines only to the extent that 'a little' influenza appeared 'here and there'.¹³⁶ Unlike the reporting system in Queensland, which had the status of a legal death and disease register, the Western Australian reporting system came from protectors' reports, and only as estimates.

Neville repeated the words of the previous year in his report to Parliament saying, 'the health of the natives throughout the State had been good.'¹³⁷ His firm conclusion was that no epidemic of a serious

¹³¹ *Ibid.*, p.319.

¹³² Wray Vamplew (ed.), *Australians: Historical Statistics*, Fairfax, Syme & Weldon Acc., 1987, pp.26-27.

¹³³ Chief Protector of Aborigines, *Annual Report*, WAPP, 1919, pp.3-6.

¹³⁴ Anna Haebich, 'A Bunch Of Cast-Offs', pp.323-333.

¹³⁵ Lewis, *Cumpston, Health and Disease*, pp.317-318.

¹³⁶ The Chief Protector of Aborigines, *Annual Report*, 1918, WAGP, 1919, p.8.

¹³⁷ The Chief Protector of Aborigines, *Annual Report*, 1919, WAGP, 1920, pp.6-7.

nature had occurred amongst them.¹³⁸ It is entirely possible that deaths from influenza may have been misdiagnosed as pneumonia, given that medical personnel in America, Europe and Queensland had difficulty distinguishing between pneumonia and influenza.¹³⁹ The rise in deaths from influenza was swift, when considered in terms of either the size of the State and the numbers of Aborigines in the whole of the State, but it was not catastrophic. In contrast to Queensland, the number of Aborigines dying from influenza in Western Australia appeared, from reports, to be low. If this was the case it reflected the quarantine efforts of protectors, police, pastoral property owners and missionaries.¹⁴⁰

The influenza pandemic came and went but the big issue in 1919 was the threat to white settlers of the perceived increase of leprosy among Aborigines.¹⁴¹ However, much of the fear was unfounded because only 22 cases of leprosy emerged between 1898 and 1920. But the disease had been spreading from the Gascoyne area into the Fitzroy River region since the earlier decade.¹⁴² As reports of increasing numbers of Aboriginal lepers circulated white townsfolk in the Gascoyne, Pilbara and Kimberley regions feared for their own health. To counteract the prospect of white settlers becoming infected the police confined suspected victims on isolated and remote tidal islands, a practice repeated from earlier outbreaks. Government agents, and police, then had the hazardous task of both keeping the patients in food, water and shelter for the rest of the decade. The first group of lepers from the Kimberley were segregated on

¹³⁸ *Ibid.*, p.7.

¹³⁹ Burnet, *Viruses and Man*, pp.114-115; see also, Alfred W. Crosby, *America's Forgotten Pandemic: The Influenza of 1918*, Cambridge University Press, 1989, pp.10-11.

¹⁴⁰ See reports in, Chief Protector of Aborigines, *Annual Reports*, 1918-1919.

¹⁴¹ Mary Anne Jebb, 'The Lock Hospitals', p.81.

¹⁴² AN, 120/4, Acc. 1003, file 630/1925, 'Leprosy in North West', see notes on outbreak of leprosy at Mt Shadforth, on the Fitzroy River, in the Kimberley district in 1918; see Davidson, *Havens of Refuge*, pp.1-17.

Barretta and Berzout Islands at the beginning of the decade. From then to 1920 time leprosy began spreading throughout that region.¹⁴³

At the beginning of the decade Chief Protector Gale had to cope with an epidemic of venereal disease and although he brought in a style of protection not envisaged by Walter Roth, he did bring protectors, missionaries and pastoralist closer than at any previous time. Gale visited 'native' hospitals, ushered in the lock-up hospitals on Bernier and Dorré Islands and supported the National Hookworm Campaign, and involved the Department in caring, albeit on a rudimentary basis, for lepers segregated on tidal islands in King Sound. One weakness with Gale's administration was that reforms introduced by Commissioner Roth, such as collecting information on Aboriginal health, were allowed to lapse mainly due to Gale's public relations approach to his task.

In 1915 important changes were introduced which influenced the direction, and substance, of Aboriginal welfare in Western Australia for the next decade and a half. Protector Neville presided over the introduction of segregated 'native' wards at country hospitals and the opening of the new 'native' hospital at Port Hedland. When the Spanish flu pandemic occurred in Western Australia it was impossible to know what the overall effect on Aborigines was because proper disease and death records were never kept, as they were in Queensland. Health services in the northern regions of the State began to develop¹⁴⁴ as the flu

¹⁴³ AN, 120/4, Acc. 1003, file 579/1908, 'Treat Leprosy of Chinese patient raises protest by Derby Progress League, dated 17 June 1908'; see also, AN, 120/4, Acc. 1003, file 140/1908, 'Derby Leprosy Among Natives', this file also mentions infections from tuberculosis in Aborigines at Derby Hospital; but it also contains memos on directing police to assist in providing assistance to attend lepers, take them to island locations and assist doctors by bringing lepers from isolated islands in Kings Sound to Derby.

¹⁴⁴ AN, 120/4, Acc. 1003, file 82/1917, 'Health Act 1911-12', this file gives some background to the problems faced both by the Medical Department, the Protector of Aborigines, the State and the Commonwealth, and discusses the drafting of the 1911-12 Health Act; see also, AN, 120/4, Acc. 1003, file 1761/1907, 'letter from Acting Regional Medical Officer, Arthur Adams, dated August 28, 1907', this letter sets out the difficulties

pandemic subsided, at the same time as leprosy began to dominate the minds of the Western Australian politicians and the settlers of the Kimberley and Pilbara regions. Austerity marked the way the State reorganised its protection policies and the way it influenced its approach to reserves, the hookworm campaign (while I do not deal with the international implications of the Rockefeller Foundation, a topic covered by others), leprosy and venereal infection, while at the same time, a greater interest in ethnographic advice emerged, all of which are themes I develop in Chapter five.

and frustrations that doctors had in dealing with the health system, the hospitals, the police and the magistrates regarding infectious diseases and calls for drastic action to implement treatment and stem the spread of a number of infectious diseases.

CHAPTER 5

Servants or Tutors:

Aborigines in Western Australia and the social instability of poor health; 1920 to 1930

In 1920, and again in 1926, the Western Australian government reformed the way they administered Aboriginal affairs by changing its structure and continuing the austerity approach towards protection policies. This influenced the missionaries to become 'surrogate protectors' in the east and south of Western Australia. Additionally, the Australian Hookworm Campaign continued its final surveys in 1920 and the report was made public in 1924. I do not investigate the international ramifications of this controversial program but I do concentrate on what its impact was on Aborigines, and what the presence and significance of the disease was on those populations surveyed. In the southern and eastern regions of the State, the Government's austerity measures helped promote greater movement of Aborigines from government reserves which in turn helped to create a new style of missionary, or surrogate protectors in the fringe-camps. In the north, the Commonwealth began taking an interest in leprosy as international critics attacked the treatment regimes of the disease employed in Australia. New forms of ethnographic advice to the Government based on the administration of Aboriginal affairs began to develop. I discuss aspects of disease health and healing of indigenous groups in the contexts of these themes.

The restructuring of Aboriginal protection agencies affected the lives of Aborigines, government administrators, missionaries, health workers and pastoralists employing Aborigines. The government divided the new protection agency into two separate regions, one for the 'north' and the other for the 'south'. In the north the region extended from the 25th parallel and north along the coast to the Northern Territory border. The areas of the north which concern this chapter are the Gascoyne, the Pilbara and the Kimberley districts. The Chief Protector in that region was A.O. Neville, previously the Chief Protector for the whole State. Moreover, he was appointed Secretary in charge of a new Department of the North West.¹ In the south, Aboriginal administration and protecting became the responsibility of Fred Aldrich. Aldrich learned his craft of growing oysters and breeding fish at Botany Bay and Port Hacking near Sydney New South Wales. He was appointed Inspector of Fisheries for Western Australia in 1911.² His main skill was the development of oyster-bed fisheries and he focused mainly on that occupation until 1920 when the Western Australian Government restructured a number of rural interest departments. Aldrich was appointed Chief Inspector of Fisheries and Protector of Aborigines for the Southern region. The Fishing Industry had a number of interests in the southern area of the State which included whaling and deep ocean fishing, for which Aldrich was responsible. His region of protecting Aborigines extended south from the Gascoyne, taking in all of the wheat belt, the eastern goldfields and the whole area south of Perth to Albany and on to the South Australian

¹ Biskup, *not slaves*, pp.73-74; see also, Tom Reynolds, 'Records Relating to Aborigines', in Reece and Stannage, *European-Aboriginal Relations*, pp.91-92.

² *Western Mail*, 13 May 1911, see photograph on p.27, and see biographical sketch on p.34. Aldrich died on 21 September 1965, see *West Australian*, 23 September 1965, p.34.

border.³ His general unfamiliarity with race questions and particularly Aboriginal health prevented Aborigines from getting to know him and enabled him to implement the government's austerity program with some aloofness.⁴ As such when the administration was changed again in 1926 Aborigines still looked to Neville to correct the anomalies that they experienced.⁵

At the beginning of this period too, a number of follow-up surveys of the hookworm disease were still under way, and by 1924 the results of a combined international, national and state funded survey on hookworm was made public. Although some survey teams focused on Aborigines it was not specifically an Aboriginal program. The results revealed high levels of the incidence of parasites in Aboriginal groups. A pilot survey commenced in 1911 by the Australian Institute of Tropical Health had resulted in a further survey that began in 1919. Following funding from the Rockefeller Foundation a national program began on October 1, 1919 and continued until 30 June, 1924. The Australian Hookworm Campaign, as the program became known, made a number of surveys of parts of the Australian population to discover the locations of the hookworm infestations. The survey examined human faeces of sample populations in each state. Along with the search for the presence of hookworm other parasites were also recorded. In the Australian campaign the result of the

³ Biskup, *not slaves*, pp.73-74. Very little biographical information exists on Fred Aldrich, but as far as can be determined he served as a Protector of Aborigines and was Chief Inspector of Fisheries until 1926 when the government abandoned the separate regions. See also, Reynolds, 'Records Relating to Aborigines', in Reece and Stannage, *European-Aboriginal Relations*, pp.88-91.

⁴ Anna Haebich, 'A Bunch Of Cast-Offs', pp.352-354.

⁵ Biskup, *not slaves*, pp.155-166; see also, M.C. Howard, *Aboriginal Politics in Southwestern Australia*, University of Western Australia, 1981, pp.67-69;

surveys was that of the 248,721 persons examined 48,256 or 19.4 per cent were found to be infected with hookworm.⁶

According to Sweet the highest local infection rates of parasitic infections in Australia were found in Aboriginal camps of the tropics.⁷ In these camps the rate of infection by intestinal parasites was similar to that found in Papua and New Guinea.⁸ Some parasites depended on both the moist temperatures of the tropics and the insanitary habits of the population. Some parasitic worms were found in drier interior regions as well, and such parasites did not rely on the rainfall of moist tropical regions to spread, as was the case of hookworm.⁹ More recent indications show that hookworm was never as serious as some medical administrators suggested. The parasite causes anaemia and can be fatal, but the kinds of parasites found in Aborigines at the time of the survey could be found in many other Australian populations, small or large.

J. Gillespie has recently argued that the hookworm project was a political device presented to the Federal Quarantine Agency as a means of expand itself into a fully fledged 'Public Health' department, a goal it achieved by 1920. Gillespie claims also that most of the parasites found among the Aborigines who were screened proved relatively harmless.¹⁰ The real problem related to the complications arising from prolonged hookworm infection. The worms could travel through to the bloodstream and on to the lungs and other organs. Internal bleeding

⁶ W.C. Sweet, 'The Intestinal Parasites Of Man In Australia And Its Dependencies As Found By the Australian Hookworm Campaign', in *MJA*, April 26, 1924, (see reprint in) Australian Archives Series, AA/1969/120/1, (8B) 'Australian Hookworm Campaign', pp.1-2.

⁷ *Ibid.*, p.4.

⁸ *Ibid.*, pf.

⁹ *Ibid.*, p.5.

¹⁰ J.A. Gillespie, 'The Rockefeller Foundation, the Hookworm Campaign and a National Health Policy', in McLeod and Denoon, *Health and Healing*, pp.64-87; see also, Gillespie, *The Price Of Health*, pp.31-45.

followed and anaemia developed thereby reducing the energy of the infected persons.¹¹ Throughout the world the social stigma of the disease caused it to be labelled as 'the germ of laziness'.¹²

The national hookworm project was enthusiastically supported across Australia. It already operated a number of pilot surveys extending back before the First World War. It commenced once more in Western Australia in April of 1921, when Dr Atkinson, the Principal Medical Officer of Western Australia, was notified by the head of the new Commonwealth Health Department, J.H.L. Cumpston, that 'Hookworm disease existed on the north-west coast of Australia. Several cases were reported from Beagle Bay near Broome.'¹³ Cumpston was not able immediately to say whether these were Aboriginal cases, but Atkinson knew that those surveyed were Aborigines, and hookworm had been located in their mission communities.¹⁴ When the survey report was made public the Western Australian results indicated that 308 people out of a population of 2,846 surveyed had contracted the disease. Western Australia's hookworm rate of infection stood at 19.8 per cent, a figure marginally above the national total infection rate of 19.4 per cent, as indicated by Sweet.¹⁵ This was sufficient for the Western Australian government to approve payment for their involvement in the National Hookworm Campaign to eradicate the disease.¹⁶

The District Medical Officer in Broome, Dr Hayes, asked Atkinson whether the Commonwealth wanted the 'stools' of Aborigines from

¹¹ *Concise Medical Dictionary*, p.324.

¹² John Etting, *The Germ Of Laziness*, Cambridge University Press, London, 1981.

¹³ AN, 120/4, Acc. 1003, file 8297/1921, 'Hookworm Campaign - General Corro.', see, folios 20-27.

¹⁴ *Ibid.*, see 'Report to Minister from John Dale, dated 20 November, 1920', folio 5.

¹⁵ Sweet, 'Australian Hookworm Campaign', pp.4-5.

¹⁶ AN, 120/4, Acc. 1003, file 8297/1921, 'Hookworm Campaign - General Corro', see, 'Funding Sources - Dr Sawyer', folio 1.

Beagle Bay and 'half-caste' camps around Broome sent to Perth for testing, a suggestion that was made by the new Director of the National Hookworm Campaign, Dr Sawyer. At the same time he gave verbal assurance that costs would be recouped from the Commonwealth. Notification of approval of the expenditure came on July 1921, regarding cases at Beagle Bay where specimens of faeces could be received for testing from Broome.¹⁷ Two years later Cumpston wrote asking what action the Western Australian Government was taking about the endemic hookworm at Broome and Beagle Bay.¹⁸

On 24 August 1921 the national coordinator of the Hookworm Campaign, Dr Sawyer, wrote a memo to the Superintendent of Moore River Settlement at Mogumber saying that, following a phone conversation with the Chief Protector of Aborigines, they had arranged for an Aboriginal girl, Ruth Clinch, to return from treatment in Perth by train and that someone from the settlement should meet her at the Mogumber railway station.¹⁹ In a note from the Chief Protector to the Reserve manager at Mogumber, Dr Baldwin was to visit the reserve to investigate hookworm disease on his way to other places in Western Australia. Dr Baldwin was particularly interested in examining the Laverton natives. The note indicates also that treatment was also to occur among Laverton Aborigines but that it would be conducted in a professional way, with concern for patients. The manager in his reply made the point that Aborigines moved across the State when ceremonies were in process and often travelled for long distances.²⁰ In addition to the itinerant worker population from New Norcia, Aborigines had settled at

¹⁷ *Ibid.*, 'Funding Sources - Dr Sawyer', folio 34.

¹⁸ *Ibid.*, Cumpston, 'Memo, to Atkinson', no folio number but dated 3 June, 1924.

¹⁹ *Ibid.*, folio 1.

²⁰ *Ibid.*, folio 1.

Moore River from as far east as Laverton. These people used the settlement as a safe haven when looking for work in the south.²¹ Moore River was 110 kilometres north of Perth and, on the other hand, Laverton about was 750 kilometres north-east of Perth, and 250 kilometres due north of Kalgoorlie. These distances suggest that Aborigines had acquired considerable geographical mobility. It also suggests how infection could travel so quickly from one group to another, across vast distances.

In September 1921 Dr Sawyer wrote to the manager of Carrolup indicating that 7 per cent of the 300 Aboriginal adults and children had become infected with hookworm. He also said that Dr Baldwin had notified him that Aborigines at the reserve were hosts to a number of parasitic worm infections. The people had travelled from northern areas to work near New Norcia. From there they had moved south to Guildford near Perth, and then to other southern fringe and settlement camp locations. Notes on record show that health inspections took place as far east as Eucla in South Australia in the same period.²² About fifty people were named in both the infected and itinerant category and among them were about ten young children. Some of these people, the records showed, had been treated and had moved on only to be re-infected at other camp-sites. This phenomenon, in hindsight, reveals problems in the mass treatment of highly mobile individuals.²³

A newspaper article reported in July 1924 that the Commonwealth's representations to the State Minister for Health, H.B. Jarvis, indicated that health authorities had won the battle, at least for the time being, against

²¹ Howard, *Aboriginal Politics*, pp.1-17.

²² 'Carrolup and Moore River Settlements - Hookworm Treatment', in AN, 1/2, Acc. 1326, file 2552/1921, no folios, see memo dated, 9 September, 1921.

²³ *Ibid.*, no folios, see 'memo dated, 9 September, 1921'.

hookworm infestation.²⁴ The Hookworm Campaign continued the survey to other parts of the State and examined Aborigines living both on government reserves and on government camp-site excisions.²⁵ These excisions created by the Chief Protector were becoming permanent living places for Aboriginal groups.

Although the government continued to expand the supply of rations to newly established missions, the austerity measures placed stress on protection agencies and problems of access by Aborigines to existing services. In turn, this created greater Aboriginal mobility away from established reserves and missions. From this trend came a new style of missionary who began to act as surrogate protectors. The Chief Protector began to supply rations as well as funds to missionaries to manage those bush people who had recently abandoned their bush life-styles. The two most notable regions were in the southwestern region from Perth, Albany and Esperance and central eastern regions such as Leonora, Wiluna and Mount Margaret. In general, Aborigines of mixed descent in the southwestern area lived either on privately leased sheep, wheat and cattle properties as indentured labour,²⁶ on missions and government reserves, or on government owned fringe-camp sites. Health conditions were generally poor. In 1920 residents at Moore River government station, for example, suffered from out-breaks of scabies, pneumonia, influenza and tuberculosis. That year an epidemic of flu caused three deaths and the hospitalisation of 106 people.²⁷

²⁴ *Sunday Times Perth*, 'Commonwealth Representations to Minister on Hookworm', 5th July, 1924.

²⁵ AN, 1/2, Acc. 1326, file 2552/1921, 'Aborigines: Carrolup and Moore River Settlements - Hookworm Treatment', folio 1.

²⁶ Anna Haebich, 'A Bunch of Cast-Offs', p.343.

²⁷ *Ibid.*, p.358.

Nurses delivered primary care while the administration of public health remained with the Fisheries Department. Sixty years later a Moore River resident remembered that Aborigines had to be very sick or nearly dead before a doctor came to see them. The same happened with a dentist. If any person suffered from toothache the Superintendent would take the tooth out.²⁸ At the same time, small family groups in the south who became dissatisfied with institutional life on mission or government settlements, began moving in ever increasing numbers to fringe-camps. These were reserved land set aside for use by fringe-camp dwellers and deliberately provided by government for that purpose. Such camps were in common use during the mid-1920s.²⁹ This migration to the fringe-camps was caused primarily by the implementation of Protector Neville's 'native settlement scheme'.³⁰ One effect of Neville's policy was that in the south unemployment throughout the 1920s increased for people of mixed descent as they chased casual farm work. The Department's policy of encouraging people to move into white society was rigorously pursued. As people were released from the constraints of reserve or mission life they moved in increasing numbers to the fringe-camps. These reserves were mostly occupied by those Aborigines who had either come west from desert areas for work or were migrants from Carrolup Mission. They had moved to the fringes of rural service towns from the missions and more remote government reserves, and then became casual labourers on the soldier settlement and land development schemes after the First World War.³¹

²⁸ *Ibid.*

²⁹ *Ibid.*, pf.

³⁰ *Ibid.*, pf.

³¹ *Ibid.*, pp.343-345.

Once on their camp sites Aboriginal land clearers were left to fend for themselves. It was assumed that they brought with them a natural social order. Also, there was an assumption that hygienic and healthy living practices were a part of the culture brought by camp dwellers to their current fringe dwelling sites. Assumptions such as these proved wrong. Health was affected by peoples' circumstances and certainly by their pursuit of employment. The camp sites of farm workers, according to a recent assessment, were looked on by local white townsfolk as 'unsightly' and a 'menace to health'.³² Although there was doubt about where the evidence came from, local opinion was that social chaos emerged from black farm workers and 'undesirable' whites who camped with the Aboriginal workers and their families. Further, in the camps there was a lack of authority which led to heavy drinking and fighting.³³ In 1924, the local Council at Kellerberrin together with the local Medical Officer told the Commissioner of Health that Aborigines were making the local camping ground 'unhealthy' because they were camping too close to the catchment area of two government dams. The camps were without proper sanitation which, according to the Shire Councils, represented a threat to health.³⁴

Despite government resistance to the missionaries they continued to find new ways of proselytising the newly emergent camp-dwellers. One way was to take on the mantle of advocate for fringe-groups problems by directly intervening between the authorities and campers. Another new approach was for these new missionaries to live in the camps. There they held religious gatherings and performed baptisms, weddings and burials

³² *Ibid.*, pp.349-352.

³³ *Ibid.*, p.351.

³⁴ AN, 240/1, Accession number 1003, file number 202/1927, 'Kellerberrin Road Board – General Corro', no folio numbers, but cited in, Haebich, 'A Bunch of Cast-Offs', pp.351-352.

as needed. Some became spokespersons for the campers in disputes with townspeople. Providing clothing for the destitute and food for the hungry campers, formed one of the services the new missionaries provided. They also commenced child minding and some camps had their own schools. These missionaries also helped to bridge the communication between indigenous families in need of health care and the staff at country hospitals.³⁵ Migration from missions and reserves to fringe-camps in the south swelled the numbers of people living in fringe-camps. In turn the spread of some communicable diseases such as tuberculosis began infecting a few Aborigines. Some children were removed to places like Moore River and the Swan River Mission in Perth to be closer to medical treatment. Other infectious diseases, especially influenza, proved more destructive.³⁶ Although tuberculosis could wipe out whole families, influenza could remove the whole population of a fringe-camp. During the 1918-19 Spanish influenza pandemic, 43 people died in the southern reserve populations of about 1000 people. Neville claimed, as he had done the previous two years, that in the southern region the health of Aborigines remained good, but the health reporting system was done by protectors not trained to do so, possibly due to the frugal nature of his administration.³⁷

Such assurances notwithstanding, virulent pathogenic diseases and resistance by the health services to accept Aborigines as patients typified both the Aboriginal epidemiological patterns and the Aboriginal responses to government austerity measures in the south. At Moore River in 1921-22 about 106 residents contracted influenza with three deaths resulting. In the same period, at Katanning, bureaucratic exigency

³⁵ Anna Haebich, 'A Bunch of Cast Offs', pp.394-395.

³⁶ Aborigines Protector, *Annual Report*, WAPP, 1922, pp.14-15.

³⁷ Aborigines Protector, *Annual Report*, WAPP, 1919, pp.3-6.

and social custom clashed when some Aborigines died after local doctors refused them treatment. During the 1920s, a number of camp dwellers complained to the Chief Protector about being refused treatment by district hospital medical staff. Such prejudice often forced Aboriginal patients to travel long distances before finding a doctor who would treat them. One complaint in 1927 was about Katanning Aborigines who rushed their sick relatives to Gnowangerup where at least three subsequently died.³⁸ Policy on the management of local hospitals was made by the local Road Boards, who held responsibility for running local hospitals. The Commissioner for Public Health had powers under the *Public Health Act, 1911-12* to compel hospitals to admit Aborigines but local interpretation of the legislation always meant that hospital staff usually had the final say. Court magistrates, local police and protectors similarly failed in their duty to require that Aborigines be admitted.³⁹

The austerity measures instigated everywhere by the government in 1922 placed stress on the living accommodation at Moore River. The annual report from the Aborigines Department, in 1923, showed that approximately 400 inmates were living at Moore River. This was nearly double the 1922 figure of 261. A reduction in costs incurred from £7,711 in 1923 to about £5,500 in 1924 was then imposed. The reserve management responded by reducing building maintenance which in turn led to problems with vermin, water supply and a general deterioration in living conditions.⁴⁰ The Department's austerity measures prevented it from

³⁸ Anna Haebich, 'A Bunch of Cast Offs', p.395.

³⁹ Public Health Department, 'Health Act Amendments, 1911-12', in Series AN, 120/4, Acc. 1003, file 82/1917. The legislation reveals that every Municipality was given the power to become a health district and every Road Board whose boundary was coterminous with the respective local health district became a local authority. The Commissioner for Public health held powers of last resort over hospital admissions, and also infectious diseases.

⁴⁰ Department of Native Welfare, *Annual Report, 1923*; these reports are located in Australian Institute of Aboriginal and Torres Strait Islander Studies, Library, Canberra.

tackling the overcrowding of dormitories, in which large numbers of Aborigines were forced to sleep very close together. It was the Department, then, which created the conditions for rapid spread of airborne infections and skin and other diseases that were transferred by close body contact. In adults the diseases most commonly transmitted in this way were venereal diseases, influenza and tuberculosis. In children the diseases were most often scabies and parasitic infections such as hookworm. On top of these cases resulting from overcrowding was the denial of access to hospitals. The reluctance of the hospitals to admit Aborigines was to lead to a twenty-five year struggle between the Aborigines, the State health authorities and the local government bodies before Aborigines gained freedom of access.

Although fringe-camps had their origin round about the turn of the century, their popularity in the twentieth century may be dated from the closure of the government reserve at Carrolup. The closure of Carrolup propelled people in two directions. The strong and healthy gravitated directly to fringe-camps, where the new style of missionary tended them if they became ill. The Chief Protector transferred the sick, elderly and younger residents directly to Moore River, a refuge which lacked proper health facilities. Carrolup had opened as a ration depot and refuge in the 1880s, but in June 1922 the general austerity measures put in place by Deputy Protector Aldrich forced its closure. This action meant that the sick and frail waited for prolonged periods for treatment.⁴¹ At the same time, those Aborigines moving to Moore River believing they would be better off were mistaken.

Many years after his retirement Neville recalled that relations between the Aborigines Department and health authorities had

⁴¹ *Ibid.*, pp. 156; see also, Anna Haebich, 'A Bunch of Cast-Offs', pp.356-360.

deteriorated throughout the 1920s. The clauses of the *Aborigines Act 1905* relating to health could not alone correct insanitary living conditions in the camps in the absence of adequate funding. Payment of medical expenses by the Aborigines Department, still in force in 1920, was the means by which Aborigines anywhere in the State were meant to obtain primary health attention. But that measure did not guarantee access to care, because of the shortage of hospital beds in country hospitals, which remained a continuing problem, and the fact that even when special arrangements for Aborigines were in place, there was no obligation for hospital staff and general practitioners to comply.

Hospitals with special wards for Aborigines often put white patients in them when beds in the general wards became scarce. Almost from the day he commenced Neville struggled unsuccessfully to keep health facilities open for use by Aborigines. The records reveal a long running battle between protectors and hospital administrators to force the latter to admit sick Aborigines. In most cases Aboriginal protection agencies paid for the erection of separate shelters, in some cases tents, at the rear of country hospitals. Neville's failure was a result of his having to deal directly with each offending rural hospital separately, and sometimes even separate sub-professional personnel in each hospital. At the same time, changing economic circumstances in the 1920s forced him to spend less on what, some argued, was a disappearing Aboriginal 'problem'.⁴²

In another town the fringe-camp dwellers wanted the same services as other indigent mission and reserve dwellers. Lance Williams, while relating his story of living on Gnowangerup mission during the 1980s, told Anne Haebich that 'in 1926 a tent was provided for Aboriginal

⁴² Biskup, *not slaves*, pp.72-74.

patients at Gnowangerup hospital.'⁴³ When the reserve at Carrolup opened a clinic the tent was transferred to the reserve. Williams attended the school run by the missionaries at the time, and he recalled how, 'in those days, Aborigines were not allowed into the hospital at Gnowangerup'.⁴⁴ When other missionaries came into the camps they gave us a big sleep-out, a big canvas tent on a camping ground. 'My sister had an abscess on the brain then, just behind the ear, and you know they had to have the operation in this tent. The doctor, he was a German bloke, and matron and two nurses done it'.⁴⁵

Further changes to the administration occurred in 1926 when a new Aborigines Department was formed following the abolition of the Departments of North West and of Fisheries. As part of a general increase in interest in Aboriginal issues, health featured prominently in the five years from 1925 to 1930. This did not mean an automatic acceptance by country hospitals of the need to allow Aborigines to have access to hospital and primary medical care, however. This matter remained unresolved. Neville wrote to the Secretary of the Medical Department about 'the large number of natives at Narrogin...requiring medical attention'.⁴⁶ He reminded the Medical Department that Narrogin, a government funded hospital, had an obligation to treat Aborigines who sometimes needed treatment. He indicated further that it should revert 'to its original purpose, or some other arrangement [should] be made for the treatment at hospital of natives, and thus avoid unnecessary expense.'⁴⁷

⁴³ Anna Haebich, 'A Bunch of Cast Offs', pp.427-428.

⁴⁴ *Ibid.*, p.428.

⁴⁵ *Ibid.*, pf.

⁴⁶ 'The Matron Narrogin Hospital', in AN, 120/4, Acc. 1003, file no. 1325/1925, see, 'letter from, The Chief Protector of Aborigines to The Secretary of Medical Department', dated 30 October 1929, folio 80.

⁴⁷ *Ibid.*, pf.

Two female protestant missionaries (United Aborigines Mission),⁴⁸ Misses Bradshaw and McRidge, became concerned at the poor education Aboriginal children were receiving,⁴⁹ and they started a mission at Gnowangerup, in January 1930. In the beginning the mission developed along similar lines to missions in other places. It started with a small bough shed school and within a few years there were up to forty children attending. Classes were later moved to a small hall which served as a church and a small hospital was erected. The Aboriginal families camped in different places. According to Lance Williams, they formed a 'square but somebody over here and somebody over there. But they got little tin places made out of kerosene tins, used to go to the dump...cut up the tin and make a sort of tin place'.⁵⁰ This was a significant change in living patterns and in personal and group hygiene.⁵¹

A researcher indicated that the mission population grew rapidly and by 1928 there were one hundred Aborigines living at Gnowangerup regularly. At the same time the camp was evolving into a little town with its own store, school, hospital and camp-site. 'The women worked in Gnowangerup washing clothes for the white ladies at about 5 shillings for a whole days washing, hanging it out, fetching it'.⁵² The Aboriginal women from the camps washed white townsfolk's clothing by hand and did a lot of house work for them besides.⁵³ These Aboriginal families were distinctly different from mission and government settlement groupings. They were kangaroo shooters, contract fencing workers, farm-

⁴⁸ Biskup, *not slaves*, pp.155-166.

⁴⁹ Anna Haebich, 'A Bunch of Cast-Offs', pp.431-432.

⁵⁰ *Ibid.*, p.432.

⁵¹ *Ibid.*, footnote on p.432. Anna Haebich acknowledges Eaton as the provider of this data on the family make up of the fringe group.

⁵² *Ibid.*, p.429.

⁵³ *Ibid.*, pf.

work labourers and shearers. Many also earned money by felling trees to supply farmers with fencing posts.⁵⁴

Political organisation by people of Aboriginal descent proved difficult to achieve. Political, economic and social matters surrounding health always presented problems. A group of mainly male Aborigines of mixed descent took a political stand against the state government, when, as a Perth newspaper pointed out, they banded together 'in order to obtain the protection of the same laws that govern the white man'.⁵⁵ The idea was the 'brainchild of a half-caste farmer from Morawa district, called William Harris, and a delegation led by him met with Premier Collier.' The delegation said to Collier that they 'wanted to live up to the standards of the white man but to do so they needed to be exempt from the Aborigines Act, and allowed to live our lives in their own way.'⁵⁶ They owed their confidence to their Christian background. The protestant denominations of the Salvation Army, the United Aborigines Mission and the Anglican Churches had worked hard to convert fringe-camp people to their respective denominations. These bodies were responsible for the emergence of a radical group of Aborigines of mixed descent wanting equality with whites.⁵⁷ However, as a 'ginger' group for change, the Harris group failed to make an impact on either the administration or other Aborigines, who may have hesitated for fear of reprisal. An ethnographer working in the region fifty years later found that this delegation had no impact on white Western Australian or their Aboriginal counterparts. The 'emergence of any autonomous Aboriginal

⁵⁴ *Ibid.*, pf.

⁵⁵ Article in *West Australian*, entitled, 'Cultured Aborigines Call On Big Fella Collier', October 1, 1928.

⁵⁶ *Ibid.*, pf; see the details of the delegation in, Anna Haebich, 'Bunch of Cast-Offs', pp.444-445.

⁵⁷ Biskup, *not slaves*, pp.117-161; see also, Howard, *Aboriginal Politics*, pp.66-68.

political activity in the inter-ethnic field was discouraged by issuing exemption certificates to those deemed sufficiently acculturated.⁵⁸

Throughout the 1920s and 1930s tensions existed between Aborigines Department administrators and the various religious bodies interested in Aborigines. Missionaries tended to institutionalise fringe-camp people by converting them and creating around them new types of religious structures that differed markedly from the type used by earlier missions: the missionaries acted as servants rather than dogmatic tutors. In the southern region, 'all the old style church institutions had closed by 1921',⁵⁹ and this provided Christians with some opportunities for the evangelical proselytization of camp peoples.

Meanwhile, in the northern regions of Western Australia two notable developments occurred in the Kimberley region. One was criticism of the policy of isolating lepers; the other related to a Commonwealth funded leprosy survey of the Kimberley. In this period the Kimberley region produced 28 leprosy patients out of the progressive total of 35 patients (see Table 6.1 in Appendix 6 above) the patients of which came from the northern regions of Western Australia, and most were Aborigines.⁶⁰ The preponderance of Aborigines among these leper populations heightened the fears of white residents in remote northern towns such as Roebourne, Broome, Derby, Wyndham, Fitzroy Crossing and Kununurra. In the 1920s health authorities were forced to abide by the law and provide treatment whereas in earlier decades the white residents, in collusion with the police, health and protection authorities, simply shipped lepers out to isolated islands, as mentioned in the last chapter.

⁵⁸ Howard, *Aboriginal Politics*, p.67.

⁵⁹ Biskup, *not slaves*, p.155.

⁶⁰ Davidson, *Havens of Refuge*, pp.124-127.

The protection legislation had always imposed an obligation on the protectors to provide medicines, medical attendance and shelter for sick, aged and infirm Aborigines.⁶¹ We have already seen that this legislation created tensions between the department and the health agencies. Antagonism between the Aborigines and the Health Departments arose over treatment of Aboriginal lepers. This centred on the responsibility for providing food, shelter and land to erect hospitals and clinics, and on responsibility for the care of Aboriginal patients. Neville always assumed that once Aborigines fell sick they became the responsibility of the health authorities. Neville's inertia in relation to lepers underlay arguments about his failure to provide health care in general. The health system operated in such a way that people paid for services either when receiving treatment or when a service was demanded. Payment, therefore, had to come from the 'natives' themselves, the Chief Protector, employers, the police or the courts. Aboriginal lepers suffered more than most Aborigines because they lost all their liberties as soon as a positive diagnosis of their condition was made. The Chief Protector who had the responsibility of protecting Aborigines was powerless to do so in the face of more powerful Health Department.⁶² The health agencies were able to exercise almost unlimited power to apprehend and segregate Aborigines with an infectious disease. They expected the Chief Protector to pay maintenance costs of Aboriginal lepers while in custody.

Very little change had occurred in screening practices and the collection of suspected leper sufferers for transportation to the nearest hospital or lazaret. Aborigines suspected of harbouring the infection were kept in custody until the pathologist's diagnosis was known. Those who

⁶¹ *Ibid.*, pp.99-100.

⁶² *Ibid.*, pp.100-106.

were suspected of being infected were gathered from their distant bush camps by police disease patrols. Once in custody they travelled long distances (normally chained to each other) and were marched by foot or carried by bullock wagon to a central screening point such as Roebourne, Broome, Derby and Wyndham.

Disputes persisted over the administrative responsibility to feed the lepers while they were travelling. The patients needed food while in custody and this was normally done on route to the lazarets at Wyndham, Broome and Derby. The screening process also took weeks and suspected lepers had to be fed. For instance, the test samples went south by special post from the northern trade centres to Perth. The results were usually sent back by radio directly to the transport dept. All this time patients had to be maintained, and food normally came from either private contractors, who sometimes worked in other government employment, or from hotel kitchens in Roebourne, Broome, Derby and Wyndham. If the tests proved negative, the suspects travelled home by themselves — a highly dangerous exercise. Such arrangements were harsh, and the infectious diseases legislation contained almost no humanitarian provisions.⁶³

One of the Aboriginal Department's employees, F. Luyer, who attended leprosy patients as they came in from the bush in 1927, requested additional salary payments for feeding the members of the contingent. On 17 November 1927 the Chief Protector of Aborigines approved the payment of five shillings for each leprosy patient he fed before their transportation to further destinations. On 27 November Luyer wired the Commissioner for Public Health to request permission to build a shelter at the cost of £10. He also requested urgent action to maintain the security

⁶³ *Ibid.*, pp.106-107.

of the quarantine compound because some patients would be sure to escape.⁶⁴ His correspondence reveals the practical difficulties of operating a disease patrol in which a number of agencies held an interest.

The relevant legislation was the *Public Health Act 1886*, which allowed officials to isolate persons suspected of having the disease. As early as 1889 general statutes on leprosy existed, but leprosy was not a notifiable disease until the enactment of the Commonwealth quarantine legislation in 1908.⁶⁵ On the question of legislating for notifying infectious diseases, Western Australia followed Victoria, where legislation bestowed wide powers for isolating people suspected of having infections.

Federal reluctance in 1920, and the sudden upsurge of leprosy cases, tended to confuse the politicians and bureaucrats of state and federal governments alike.⁶⁶ The confusion intensified because the Western Australian Government took a position that distanced itself from full responsibility for leprosy. The State felt that the Commonwealth held responsibility for controlling exotic diseases. Leprosy, in particular, was a disease that northern townsfolk believed came from mariners and pearlers, who were considered as foreigners. Doctors saw some strains of venereal disease as peculiar to Aborigines, where the body wasting appeared similar to leprosy; so it was that rural townsfolk believed that leprosy was a disease that mainly peoples other than whites contracted.

⁶⁴ *Ibid.*, p.41 and p.53.

⁶⁵ Lewis, *Cumpston, Health and Disease*, pp.7-8, and p.217.

⁶⁶ AN, 120/4, Acc. 1003, file 623/36, 'Leprosy in the North-West', see 'Report from the Hon. J.J. Holmes to the Hon. F.J.S. Wise, Minister for the North-West, 11 June, 1936', pp.1-6; this report also appears in Appendix 4, Davidson, *Havens of Refuge*, pp.156-164.

The disease, many believed, would not spread to white settler populations of the north-west.⁶⁷

Segregation, even on humanitarian grounds, was never an easy choice for either publicly or privately employed doctors. The style of segregated hospitals already existed and had been in use to isolate venereally diseased Aboriginal patients since the late nineteenth century. In defence of the Western Australian medical system, they mistakenly applied models used by Europeans, mainly under conditions of epidemic maladies.⁶⁸ When the problem of leprosy arose in the far northern areas of Western Australia the solution appeared obvious.

Doctors and administrators did not appreciate it at the time, but leprosy was never very contagious. Instead, rumours or news of an increase in the number of lepers struck fear in the hearts of the medical profession and the public. Race prejudice ruled the placement of lepers in treatment programs. Chinese, Manilamen and Aborigines were put in the same location. White patients were kept apart from the bulk of leper suspects and patients. Cook in his 1922-24 study drew the conclusion that the causes of the leprosy epidemics originated in the social conditions adopted by the few white pastoral workers who cohabited with Aborigines in the many fringe-camps of the northern towns.⁶⁹ Throughout the 1920s a number of small outbreaks did occur. These involved all races, but the majority were Aborigines. Even though the numbers of people contracting leprosy were small in the 1920s, the stage was being set for a huge increase in the next decade.

⁶⁷ Annual Report Medical Department, 1913, in *Western Australian Parliamentary Votes And Proceedings*, No. 8; see also Biskup, *not slaves*, p.113; and see also, Mary Anne Jebb, 'The Lock Hospitals', pp.77-78.

⁶⁸ Mary Anne Jebb, 'The Lock Hospitals', pp.68-69.

⁶⁹ Cook, *Leprosy in Australia*, pp.17-20.

Increasing interest in leprosy arose from two sources. The first were the white settlers, who were terrified of the infection and feared that some of them would soon become infected and join the leper ranks. Indeed, leprosy was spread to white society from Aborigines, and leprosy gained a foothold in the white community by 1920.⁷⁰ The upsurge in interest by rural white settlers was partly due to its spread among white townsfolk. The second source of interest was the Commonwealth who expressed their intentions to investigate the causes of diseases, and the method of preventing diseases, by collection of sanitary data, as well as educating the public in matters of public health.⁷¹ To make matters more complex, as early as 1919 the Wyndham Road Board sought and gained approval from the Western Australian Government to act as the local health authority, and the request became law on 7 August 1918.⁷² Parallel to this development, as a government document on quarantining disease⁷³ pointed out, the Western Australia quarantine position was considered by the Federal Cabinet who decided to list the matter of leprosy at the next Federal and State Ministers' conference. The next meeting was scheduled for January 22, 1919 at which the State and Federal

⁷⁰ AN, 120/4, Acc. 1003, file 82/1916, 'Leprosy Case at St Leonards Street, Cottesloe Beach, Mrs I.A. Golden: General Corro', see note dated 1916 to 'Minister for Public Health from Everett Atkinson, Commissioner for Public Health'; see also AN, 120/4, Acc. 1003, file 1262/1917, 'Leprosy At Roebourne', see note dated 14 August 1922, from 'I. Maunsell, the District Medical Officer, Roebourne to the Commissioner for Health Perth'.

⁷¹ AN, 120/4, Acc. 1003, file 6/1919, 'Quarantinable and Other Diseases Coord. of Commonwealth State Power re: Quarantine', see Circular No. 19/989, to Premier's Conference note Melbourne 19th Feb. 1919, where Cumpston proposed and federal government adopted by Acting Prime Minister.

⁷² AN, 120/4, Acc. 1003, file 2044/1918, 'Wyndham Road Board, Constitution of a Local Health Authority', see memo signed by Arthur Adams, District Medical Officer, dated 22 April 1918.

⁷³ AN, 120/4, Acc. 1003, file 6/1919, 'Quarantine and other Diseases Coord. of Commonwealth and State Powers re: Quarantine', see notes dated from 19 February 1919 to 28 August 1920.

Governments discussed the question of the coordinating Commonwealth and State powers in relation to quarantine and disease.⁷⁴

In a memo written in 1920 to the Western Australian Minister for Health, Everitt Atkinson, the Commissioner for Public Health in Western Australia pointed out that the Commonwealth authorities held the responsibility for the isolation and care of quarantinable diseases arriving in Australian ports on board a ship. The State authorities, Atkinson stated, were responsible for diseases arising in the State, whether as a definite extension of overseas or not.⁷⁵ Cumpston, the head of the newly created Commonwealth Public Health authority, wanted to adopt a new system. He proposed that in addition to its Quarantine responsibilities, his agency should research the causes of disease and death, investigate methods of preventing disease, collect sanitation data and, finally, educate the public on issues relating to public health.

Furthermore, Cumpston wanted the Commonwealth to subsidise States with any well-directed effort to eradicate disease and, using a system adopted in the United States of America, inspire and coordinate public health measures without jeopardising State sovereignty. Without exception, by October of 1920 the States saw in such moves an underlying conspiracy to encroach upon their powers. The Commonwealth had been funding Western Australian venereal disease programs with subsidies from as early as 1907. These subsidies went directly to treat mostly Aboriginal sufferers. The Western Australian Government reacted to public fears by pressing the Commonwealth for subsidies to attend to the increasing number of leprosy patients.⁷⁶ But these funds were to be spent on old methods of segregating sufferers from the public and transporting

⁷⁴ *Ibid.*, pf.

⁷⁵ *Ibid.*, see note from Acting Prime Minister.

⁷⁶ Davidson, *Havens of Refuge*, pp.23-24.

them away from Western Australia. While that State's consciousness about health and safety rose a matter of international controversy took public prominence.

In the early 1920s Sir Leonard Rogers, a researcher into leprosy, and his co-worker Ernest Muir wrote a paper critical of the way Australia treated leprosy patients. Both men were leaders in the treatment of leprosy in India and Africa. At a conference of the Pan Pacific Science Congress in Sydney in 1923, Rogers presented his views, as Davidson pointed out,⁷⁷ arguing that a policy of isolating leprosy patients deterred them from coming forward to be treated by trained medical doctors. Once lepers became confined to lazarets the standard of treatment in Australia fell below that available in other countries. Rogers claimed that Australian policy had not been able to reduce the incidence of leprosy and new cases had been recorded each year showing that the disease continued to increase. According to Suzanne Saunders,⁷⁸ Rogers agreed that leprosy was reaching epidemic proportions in the Aboriginal populations of north Australia.⁷⁹ At the time of Rogers' presentation there were four leprosariums across Australia. Western Australia had establishments at Roebourne, Broome and Derby, while the Northern Territory had a facility on Mud Island. Queensland catered for leper patients on islands off the coast of Cairns and New South Wales facilities were located in Sydney. In all instances isolation remained the main form of treatment in 1920.

The Commonwealth's interest in the epidemiology of leprosy manifested itself when Dr Cecil Cook began a research project to study

⁷⁷ *Ibid.*, p.24.

⁷⁸ Suzanne Saunders, 'Isolation', pp.168-181.

⁷⁹ Sir Leonard Rogers, 'When Will Australia Adopt Modern Prophylactic Measures Against Leprosy?', in *MJA*, Saturday October 18, 1930, Vol. II, No. 16, pp.525- 527.

leprosy in Australia. He compiled a major report on the prevalence of leprosy in northern Australia. Cook was born on 23 September 1897 in Bex Hill, Sussex England, at a time when J. Ashburton Thompson was publishing his prize-winning essay on the first Australian epidemiological survey of leprosy.⁸⁰ Cook's father, an English doctor, migrated to Barcaldine in Queensland, where he established a private medical practice. Cecil Cook went south to study medicine at Sydney University. On his graduation in 1922, he claimed the prestigious public health award, the British Wandsworth Research scholarship, taking it up in 1924-25.⁸¹ His research involved an investigation of the prevalence of leprosy in northern Australia,⁸² in conjunction with the Commonwealth School of Public Health and Tropical Medicine in Queensland.⁸³

Cook's report on leprosy was one of the first epidemiological studies done in Australia since the 1890s. Cumpston later remarked that Cook had painstakingly examined the facts and formed definite views. He observed that Cook had characterised leprosy as an infectious disease caused by *Mycobacterium*. The disease was transmitted from one person to another by direct contact, under certain environmental conditions. Due to the problem of not knowing the medical histories of many who had come in contact with the infection it was impossible to know much about the contagion in many Australian cases, largely the result of imperfect observation and incomplete investigation. The disease appeared to infect persons who had experience of long periods during which they harboured infection and possibly were a danger to their associates. Many carriers harboured the disease but showed no outward

⁸⁰ J. Ashburton Thompson, 'A Contribution to the History of Leprosy in Australia', in *Prize Essays on Leprosy*, The New Sydenham Society of London, 1897.

⁸¹ *The Herald, Who's Who*, Melbourne, 1950, pp.176-177.

⁸² Cook, *Leprosy in Australia*, pp.54-71.

⁸³ Cumpston, 'Leprosy', in Lewis, *Cumpston, Health and Disease*, p.207.

sign of disease. Leprosy was found to be successfully diffused, and had become endemic only in humid climates.

The outward signs of the thickening of the skin of the forehead was less noticeable among infected Aborigines than among most Europeans. This folding of the forehead was attributed to the stimulation of resistance by the greater exposure to the ultra-violet rays of the sun. Cook surmised that leprosy was unknown amongst the Aborigines and early European settlers. He thought also that the disease had been introduced from China and islands around the Pacific during the last century through the importation of coloured labour into Australia from those countries. The disease then spread to white males through contact with Aboriginal women.⁸⁴ The infection spread from those whites to others. It was through this process, he argued, that the disease had become endemic.⁸⁵ White females, Cook claimed, did not contract the disease until 1890, but the incidence among them increased rapidly by 1925 when 23 white female cases were reported.⁸⁶ Between 1900 and 1921 the number of white Australian males who contracted leprosy had risen to 22 which tends to support Cook's conclusion that the disease came from Chinese mine workers and passed to Aborigines thence to white people.⁸⁷

Cook made a preliminary investigation in 1922 and began his major project a year later. He travelled to the northern area of Western Australia where he visited the sheep and cattle properties of the Ashburton, Fortescue and the Pilbara regions. He went on to Broome, Derby, inland along the Fitzroy River and north along the border to Wyndham and Forrest River.⁸⁸ He noted that the local leprosarium was

⁸⁴ *Ibid.*, p.215.

⁸⁵ *Ibid.*, pf.

⁸⁶ *Ibid.*, p.216.

⁸⁷ *Ibid.*, pp.207-213.

⁸⁸ Davidson, *Havens of Refuge*, p.23.

housed in the old government buildings. He criticised the use of these dilapidated buildings and the lack of interest shown by the medical profession of the northern regions in improving them as well as the lack of concern shown by the Government.⁸⁹ Cook's report was released in 1924 and published by the Commonwealth in 1925. One of Cook's propositions was for greater federal and state coordination of funding leprosy treatment. At the same time he criticised the isolation of leprosy patients but could see no immediate alternative.⁹⁰

Only a few researchers in Australia worked on leprosy, and those who did so conducted their inquiries mainly in the Pacific and elsewhere. An article appeared in a Western Australian paper, the *North West*, stating that following the experiments which lasted six months the surgeons at the hospital where lepers were received claimed they had cured all cases treated with radium.⁹¹ The article went on to quote an unnamed Collins Street specialist who possessed experience in treating lepers in Nauru. The specialist was quoted as saying the use of radium produced results and was a 'great step forward'. Further, the specialist indicated that the form of treatment adopted up to then consisted mainly of isolation and strict hygienic practices comparable to those used in treating tuberculosis cases. Chaulmoogra oil, with its various compounds, was the drug most used, and was given by injection. Other remedies were tried, but this oil appeared to be the only preparation which brought satisfactory results.⁹² The lack of research in the Kimberley, as reported by Dr Cecil Cook,⁹³ probably heightened local

⁸⁹ *Ibid.*, pf.

⁹⁰ *Ibid.*, pp.23-24.

⁹¹ *North West*, June 23, 1925, in Australian Archives Canberra Series A 659/1, file 34/2154, Darwin Leprosarium.

⁹² *Ibid.*, article 'Science and Disease – Leprosy Cured/Radium Treatment'.

⁹³ Cook, *Leprosy in Australia*, p.38.

residents' anxieties. The effect of Cook's study and recommendations on the Commonwealth Health Department was instantaneous.

In June 1925, Cook reported to the federal government on a specific recommendation arising from his research. This was for the development of a lazaret on the Commonwealth Controlled Channel Island in the Northern Territory.⁹⁴ Cook pointed out that there were already eleven leprosy patients on the island, and that a Chinese man Jimmy Ah Cup from Roper River, together with two Aborigines, Alick and Judy from Pine Creek, and Billy from Maranboy were also living on the island. A Greek café proprietor from Darwin was isolated in his suburban home after diagnosis as a leper. The report argued that while they waited for plans to be finalised for his removal elsewhere there would be no special reason to condemn the man to exile in a lazaret like the one at Darwin.⁹⁵ In the same report Cook explained that in 1916 a lazaret had been created on waste land on Darwin harbour. This miserable locality had been the home of twelve lepers isolated there for some time. The inmates at this deplorable place included a healthy half-caste girl of four. No effort had been made to treat those Aborigines affected by leprosy with a view to its eradication. The diagnoses of many Aborigines were made by white bushmen or the local policemen, sometimes erroneously. Many notifications were free of the disease, and others actually suffering from it were overlooked altogether. Cook went on to indicate that the island was used exclusively to isolate Aborigines, and he scathingly criticised health authorities in Darwin. He urged action

⁹⁴ Cecil E. Cook (MB, Ch.M, (Syd.), DTM&H, Wandsworth Scholar), 'Report: On The Proposed Establishment Of A Joint Lazaret At Darwin: June 1925', in AA 659/1, Item 44/1/657, 'Darwin Leprosy', pp.1-23.

⁹⁵ *Ibid.*, p.23.

immediately because many Europeans were now becoming infected and accommodation had reached crisis point.⁹⁶

Cumpston wrote to the Secretary of the Department of Home and Territories in Melbourne on September 1925 stating that Cook's report had revealed that leprosy among the Aborigines was serious. Cumpston went on to argue that something should be done immediately and he believed that it was clear that three things needed to be done. The first need was a properly equipped leper station at Darwin. A second was for the appointment of a medical officer with proper training and reliable personality to be placed in charge of the hospital. And a third was that Channel Island was the most suitable place and with adjustments to the quarantine regulations would be the best option for a lazaret.⁹⁷ Cumpston tried to move too quickly, however, to get the lazaret going, and, in doing so, distorted Cook's objections to the Darwin site.

The lazaret at Channel Island had two iron buildings. A doctor from the mainland visited once a week when weather permitted. When Aborigines were diagnosed as lepers the health officials shipped them straight to the island and left them to themselves. The condition of the island was regarded as sufficient for Aboriginal patients.⁹⁸ But the Bishop of Carpentaria, Dr Davies, and the Rev. H.E. Warren of the Church Missionary Society had already brought their viewpoints to the notice of the Minister for Home Affairs. The secretary of the Department of Home Affairs wrote to Cumpston and pointed out that temporary improvements were unacceptable. He agreed with Bishop Davies about the unacceptability of forcing Aboriginal and white patients to live under

⁹⁶ *Ibid.*, p.1.

⁹⁷ AA 659/1, Item No. 44/1/657, file 25/ 17415, 'Leprosy: letter from J.H.L. Cumpston to Sec, Home Affairs, September 1925'.

⁹⁸ *Ibid.*, 'Secretary Home and Territories Dept., to Director-General of Health Melbourne, 8.10.1925'.

such poor circumstances. Ironically, despite the Bishop's protest, missions under his control continued to send patients to Darwin and many went straight to Channel Island.

Drs Cook, Jones and Norris of the Commonwealth Department of Health decided on 9 October 1925 that leper patients identified at church missions would be segregated at mission stations as a temporary arrangement. They would then be treated with medicines and medical direction from Darwin supplied by the missionaries on the spot.⁹⁹ Mr Urquhart, the Administrator Northern Territory, wrote to Cumpston earlier in the month about Dr Norris's view,¹⁰⁰ that the lazaret on Channel Island was unfit for any patients not under supervision.¹⁰¹ Despite the problems experienced in Darwin in 1925, Cumpston was planning to send Dr Elkington to report on the situation.¹⁰²

The Western Australian responded immediately to Cook's report by writing to the Prime Minister, who replied to the Premier on 8 August, 1927 about establishing a lazaret at the Commonwealth Quarantine Station on Channel Island, near Darwin.¹⁰³ He requested information from the Premier on what districts, the numbers of lepers to be accommodated at the outset.¹⁰⁴ Without providing answers to these questions the Premier responded immediately that as soon as the lazaret

⁹⁹ *Ibid.*, 'Memo: Urquhart, Administrator Northern Territory, to Secretary Home and Territories, 11.11.1925'.

¹⁰⁰ *Ibid.*, 'Memo from Dr Norris, Secretary Home and Territories to Mr Urquhart, Administrator Northern Territory, 5.10.1925'.

¹⁰¹ *Ibid.*, 'letter from Urquhart, Administrator Northern Territory, to Secretary Home and Territories Dept, Melb.'.

¹⁰² *Ibid.*, 'Leprosy: memo from Cumpston re Elkington to go to Darwin to report on leprosarium', AA, 659/1, Item no. 44/1/659, file 25/17415.

¹⁰³ *Ibid.*, AA, 659/1, Item 44/1/657, file 25/17415, 'Leprosy: Darwin Leprosarium, 15 January 1926'.

¹⁰⁴ *Ibid.*, pf.

was finished he would send the Western Australian lepers there for treatment.

Some years after his criticism of Australia's practice, Sir Leonard Rogers wrote a further critical paper in *The Medical Journal of Australia*. This time he condemned Australia's approach to treating venereal diseases and leprosy patients.¹⁰⁵ Writing in 1930 he was even more 'authoritative and persuasive'.¹⁰⁶ He brought to bear a criticism of Cook's work which was based on a decade of international research together with experience that indicated just how backward Australia's treatment of leprosy was compared to world-wide developments.¹⁰⁷ Further, Rogers doubted Cook's assumptions that leprosy in Australia was as limited in its incidence as he had concluded in 1924.¹⁰⁸

Rogers marshalled convincing data. He presented them in these terms:

In 1924 [Dr Cook] pointed out that, in spite of leprosy having been a notifiable and quarantinable disease for three decades, it is still as prevalent as ever in some of the States, and in his 1927 report he showed that the disease in Queensland, after declining between 1910 to 1919 from 83 to 42 steadily increased again from 1919 to 1927 from 42 to 77, especially among Europeans. He thought that leprosy was under control in New South Wales, but this is not altogether borne out by recent data, for in the seven years up to 1920 the total segregated cases varied between 20 and 24 and the yearly admissions averaged three; and from 1920 to 1927 the admissions numbered 26, an average of 3.25 and the decline in the total remaining to 17 at the end of 1927 was due to five repatriations and 15 deaths during that period.¹⁰⁹

Rogers then attacked the segregation of 'poor lepers', who were compulsorily imprisoned for many years and observed that 'in no other

¹⁰⁵ Rogers, 'Australia Prophylaxis on Leprosy', in *MJA*, 18 October 1930, pp.525-527.

¹⁰⁶ Suzanne Saunders, 'Isolation', p.168.

¹⁰⁷ *Ibid.*, p.181.

¹⁰⁸ Rogers, 'Australia Prophylaxis on Leprosy', pp.526.

¹⁰⁹ Suzanne Saunders, 'Isolation', p.252.

disease was treatment imposed with such penalty'.¹¹⁰ The true volume of infection in Australia was disguised by patients who became fearful of being diagnosed due to the severity of treatment, which implied that it was criminal incarceration. In short, Rogers elaborated on the social consequences of leprosy patients being labelled, and that the cure for this disease in Australia was worse than the disease. Australian approaches were, moreover, racially prejudiced against Asians and Aborigines.¹¹¹

As for curing the disease, Rogers alluded to his experience in Calcutta and Hawaii. They 'demonstrated that in early treatment stages of the disease out-patients could be cleared of all clinical signs of active infection'. These out-patients were 'rendered bacteriologically normal and uninfected by weekly injections of soluble preparations of the active parts of chaulmoogra and hydrocarpus oils'.¹¹² Reverting to statistics, Rogers claimed that he had 486 patients treated over a five year period. Of this number, only 8 per cent of advanced cases had not responded to treatment while 38 per cent of those with moderate infection and 64 per cent of early stage infection had been diagnosed as clinically recovered. Modern methods of treatment, Rogers claimed, consisted of proper surveillance in which the patient's contacts would also be observed over time for signs of early infection and included in an early treatment program. This method could help to clear up the pool of infection within five years, and before the new cases reached high infectivity, thus eliminating the sources of infection.¹¹³ Rogers's methodology was, he argued, supported by his own and pathological research which indicated that 'Hansen's bacillus is not always found in early nerve and skin

¹¹⁰ *Ibid.*, pf.

¹¹¹ *Ibid.*, pf.

¹¹² *Ibid.*, pf.

¹¹³ *Ibid.*, pf.

cases'.¹¹⁴ People in this category were best treated as outpatients. Those with higher infectivity could be isolated but only if skilled treatment was provided.

While these arguments were being propounded another observer of Aborigines' customs, manners and daily lives arrived in the Kimberley. This was A.P. Elkin. Adolphus Peter Elkin (1891-1979),¹¹⁵ Professor of Anthropology at the University of Sydney from 1933 to 1956, was one of the few scholars who spent time in the northern area of Western Australia during the 1920s studying the customs and manners of the Aborigines of the Gascoyne, Pilbara and Kimberley districts. Inevitably Elkin had to confront the problems of Aboriginal health and its administration. The views he developed there were to have profound implications for government policy in a number of States: they underpinned the protectionist and later assimilationist policies which most governments adopted during the last decade of this study. Like Walter Roth in an earlier era, Elkin was a scholar whose influence extended beyond the seminar room, particularly in Western Australia.¹¹⁶

Elkin was born in March 1891 and received tertiary education at both Sydney and London Universities, graduating from the latter with a PhD. in anthropology.¹¹⁷ After arriving back in Australia Elkin did much of

¹¹⁴ *Ibid.*, pf.

¹¹⁵ Ian Howie Willis, 'Elkin, A', in Horton, *Encyclopaedia of Aboriginal Australia*, pp.335-336.

¹¹⁶ *Ibid.*, pf.

¹¹⁷ Tigger Wise, *The Self-Made Anthropologist: A Life of A.P. Elkin*, George Allen and Unwin, Australia, 1985, pp.46-49; see also, Ian Howie Willis, 'Elkin, A', in Horton, *Encyclopaedia of Aboriginal Australia*, pp.335-336; see also, *Australian Dictionary of Biography*; see also, A.P. Elkin, 'The Journal Oceania: 1930-1970', in *Oceania*, Vol. XL, June 1970, pp.245-279; see also, Heather Goodall, 'An Intelligent Parasite: A White Perception of the History of Aboriginal People in New South Wales', unpublished paper delivered to the Australian Historians Association, August 1982; see also, R.M. Berndt and Catherine H. Berndt (eds), *Aboriginal Man In Australia: Essays in Honour of Emeritus Professor A.P. Elkin*, Angus and Robertson, 1965, see 'Foreword', pp.xi-xviii, and Chapter 1, pp.1-26; see also, A.P. Elkin, 'Aboriginal-European relations in Western Australia: An

his early fieldwork in the area between the Gascoyne River and the Anglican mission at Forrest River south of Wyndham, where the head missionary was the Rev. Ernest R.B. Gribble. Privately Elkin was highly critical of Gribble's policy, practices and personality. Gribble's manner was authoritarian but he was a humanitarian and had proved fearless in exposing the massacre of Aborigines by police near Forrest River in 1927, when an unknown number of Aborigines had been killed and burnt.¹¹⁸ Although Gribble had become a legend in religious circles, and to those white settlers in the Kimberley, Elkin learned that he was regarded as a 'reckless tortured tyrant, so oblivious to comfort that he lived on bush rations and expected everyone else so to do.'¹¹⁹ According to Elkin, 'Gribble ran his world with megalomaniacal fanaticism.'¹²⁰ If the blacks stole his cattle, and they did, he went after them, unarmed and into the wildest country to catch them. Gribble dealt summary justice where he was the judge and his sentence was to horsewhip the culprit.¹²¹ Elkin, astonished by what he had heard and seen of Gribble, viewed the missionary as holding utopian ideas, though often gripped by defeatism, and possessing the mean streak of a tyrant.¹²²

Elkin endeavoured to put these views aside while he visited missions in the Kimberley. On his first field trips to the region in late

Historical and Personal Record', in R.M. and C.H. Berndt (eds), *Aborigines of the West: Their Past and Present*, University of Western Australia Press, Nedlands, 1979.

¹¹⁸ *Royal Commission of Inquiry into Alleged Killing and Burning of Bodies of Aborigines in East Kimberley and into Police Methods when Effecting Arrest*, WAV&P, 1927; see also, Battye Library, PR File 5384/1-2; see also, Biskup, *not slaves*, pp.84-86.

¹¹⁹ Tigger Wise, *Life of A.P. Elkin*, p.61.

¹²⁰ *Ibid.*, pf; see also, N. Green, 'In Search of a Priest', an unpublished manuscript, can be located in 'The Elkin Papers'. Green has published widely also on the Forrest River Mission and aspects of the impact of the Gribbles. The paper referred to here may be sighted at the Fisher Library Archives, University of Sydney, see Box 1, Item 1-6. In particular, see 'Kimberley Journal', unpublished record of research field trip to the Kimberley region in 1927-28.

¹²¹ Tigger Wise, *Life of A.P. Elkin*, p.62.

¹²² *Ibid.*, p.62-64.

1927, he travelled to Wyndham from Broome by mission lugger with Gribble.¹²³ Once in the Kimberley, he travelled extensively. In his 1926-8 journal he described his experiences:

Before I went to the Kimberley, my knowledge of individual Aborigines as persons was almost nil. My thoughts had not turned to their condition or the effects of contact on them. I had no humanitarian motive. My task was to record and analyse Aboriginal social organisation, ritual and mythology and to that task I stuck.¹²⁴

He travelled by lugger from Broome to the mission at Port Georges via Cape Leveque, Kings Sound and the mission at Walcott Inlet. On another occasion he travelled by steamer to Forrest River via Wyndham. He made numerous other trips around the Kimberley, either by foot, donkey or horseback. Travelling east along the Margaret River to Mt Frank and north via the government cattle station at Mulla Bulla, he then went to Violet Downs near Turkey Creek and back to Halls Creek along the Ord River. Later, he crossed the Ord from its western side near Carlton Hill travelling west to Wyndham, making diary entries as he passed abandoned sheep and cattle stations to the north.

Elkin noted that Aboriginal labour was cheaper than white labour. Workers' diets consisted of some meat, bread, tea and sugar, some tobacco and occasionally some clothes; they earn all they get on these stations Elkin wrote.¹²⁵ Similarly, he took an interest in sick camp people. After visiting one camp, he wrote:

I rode out with the half-caste boy to this camp and had an interview with the old blacks. On the previous evening, one of them was very ill, and by way of remedy had grass string bound around his legs (thighs) upper arms and chest. This morning, however, it was all discarded except one bit from an arm. On my asking 'how sick-feller', he replied 'me sick-feller'; he was sitting up and having a

¹²³ The Principal source on these journeys are 'The Elkin Papers', Fisher Library, Sydney University.

¹²⁴ *Ibid.*, Box 1, Item 1-6; also cited in Tigger Wise, *Life of A.P. Elkin*, p.72.

¹²⁵ *Ibid.*, Box 1, Item 1-6, 'Kimberley Journal' Broome, WA, 14 December, 1927, p.27.

drink. He took quite an interest and part in the talk about their marriage rules which followed. They take shelter during the day in a shade made from branches....The old sick fellow has since died.¹²⁶

After a visit to the Beagle Bay mission Elkin described the people and buildings there. The people were diverse and on the five hour trip to Beagle Bay he recorded his impressions of his fellow passengers:

The other passengers were a sister from the mission (Irish), a Salesian brother going out on a short visit to Broome (Spanish), a black boy to open the gates and to go for help in case of trouble....Then there were two German mission brothers who said little....The sister was ready to talk and tell me plenty about the blacks and half-castes. She had been out there 21 years, [but the journey ended without further talk].¹²⁷

He found buildings constructed of bricks manufactured on the reserve. According to Elkin they were of poor quality but they lasted longer than wooden buildings, which were attacked by termites. Government health authorities made no visits to monitor the health of the church mission establishments or their populations. District hospitals sometimes experienced overcrowding and tents located at the rear served as accommodation for Aboriginal patients at most of the hospital facilities he visited. Elkin became acutely aware of the number of specially segregated hospitals, something not present in the Hunter Valley of New South Wales, his home region. The number of Aborigines suffering from venereal diseases was also an unfamiliar sight. This, he noted, was a major responsibility of the government which was to subsidise hospitals that treated the sick and frail, and to give medicines to Aborigines affected by yaws, syphilis and gonorrhoea.¹²⁸

Elkin observed an increase in these health problems during his time among the Kimberley Aborigines. The Chief Protector's reports to the

¹²⁶ *Ibid.*, p.29.

¹²⁷ *Ibid.*, p.31.

¹²⁸ Mary Anne Jebb, 'The Lock Hospitals', pp.68-87.

Western Australian Legislative Assembly confirmed this trend but claimed the increase was only a temporary aberration.¹²⁹ The number of patients admitted to the Port Hedland 'native hospital' in 1928 rose to 60 compared with 23 the previous year. A total of 11 patients remained from the previous year making a grand total of 71. The number of cases of venereal disease stood at 25; 58 patients had gone home as cured, and 6 patients had died, leaving 7 under treatment. Of the 71 patients admitted 32 had contracted *Granuloma pudenda*, 17 had gonorrhoea but none had syphilis, and 24 had a variety of non-venereal complaints. Elkin was surprised to confront such an epidemic but thought the treatment that Aborigines were receiving was the most up-to-date available.¹³⁰

Elkin's knowledge of sexually transmitted diseases was limited and extended more to a concern about what he saw. The government health initiatives to arrest and control venereal diseases in Aborigines had been in progress for some years. When Elkin offered the criticism that venereal disease was on the rise he failed to observe that two things were already happening. First, although the drugs used to treat venereal infections in Aboriginal patients had been employed for some time, they were receiving the most up to date medication. Second, the incidence of venereal infection had begun to fall in the late 1920s. The treatment for granuloma normally began with antimony tartrate — tartar emetic — given intravenously at weekly intervals. According to a 1928 report on the operations of the Native hospital, by the Medical Superintendent Dr Davis, a two per cent solution in distilled water made up the standard treatment. The method of application adopted by Dr Davis commenced

¹²⁹ Dr Albert Davis, 'Report on Port Hedland Native Hospital', in 'Chief Protectors Annual Report, 1928', p.3.

¹³⁰ Allan M. Brandt, *No Magic Bullet: A Social History Of Venereal Disease In The United States Since 1880*, Oxford University Press, 1987, p.12, pp.98-131 and 170-171.

with a 1 cc dose to 6 cc of diluted normal saline. The dose had to be increased weekly by 1 cc up to a maximum of 8 cc, which represents 2.5 grams of antimony tartrate, and, according to Dr Davis' report the dosage was never exceeded. As Davis indicated, the patient coughed a lot but did not vomit. Some patients, depending on the degree of infection, would require a second round of medication.¹³¹ Even so, the duration of stay was longest for those suffering from syphilis, the victims of which were few. The forms of the disease presented were congenital syphilis (that is transplacental infection or *Treponema pallidum*),¹³² of which there were several cases; and two cases¹³³ of sexually transmitted syphilis disease.¹³⁴ None of those had recently been infected, but one patient, an older male with cerebral syphilis (*Neurosyphilis*)¹³⁵ died.

At Moore River reserve, as Biskup has demonstrated, the settlement hospital opened later in the decade and was referred to officially as the Midland District Hospital. It consisted of a single ward with accommodation for male and female patients, 'including women in labour and patients with communicable diseases such as syphilis'.¹³⁶ The bathroom doubled as a surgery, and the same room was used occasionally for sick babies from the camps. These babies were often kept in the bath tub to prevent them from wandering back to the camps. According to Biskup, 'the hospital had no resident doctor and relied instead on the services of the doctor at Moora and Mogumber and sometimes even

¹³¹ Dr Albert Davis, 'Report on Native Hospital', in 'Chief Protectors Annual Report, 1928', p.4.

¹³² G.D. Wasley and H.H.Y. Wong, *Syphilis Serology: Principles and Practice*, Oxford Medical Publications, London, 1988, p.8.

¹³³ Dr Davis Report, in 'Chief Protectors Annual Report, 1928', p.4.

¹³⁴ Wasley and Wong, *Syphilis Serology*, p.5.

¹³⁵ *Ibid.*, p.7.

¹³⁶ Report by Ms Stoneman, in *Annual Report, Public Health Department*, WAGPS, 1930.

Perth when epidemics of measles, mumps and influenza struck.’¹³⁷ This depot population in 1930 rose to 150 people when people came in from nearby bush camps infected with influenza, from which five people died. Biskup and others reported that this was a group suffering from a range of health problems, and ‘The State Psychologist, Miss Stoneman, states in her 1929 Annual Report that one hundred...children...were underweight for their age.’¹³⁸ It was possible for missionaries to decide to start a mission and rapidly attract an Aboriginal population. Services in the north were dealing with other more exotic infections and involved a wider public fear and a greater expectation of Commonwealth involvement.

Occupancy levels at the native hospitals — of which there were five between Wyndham and Moore River — always remained high. In 1929, for instance, the total number of patients admitted to Port Hedland totalled 54, compared with 68 the previous year of whom 7 were ‘incurables’ from the previous year, leaving a total of 61 for 1929. Of those treated, 40 had been discharged as cured, four inmates had died and 17 patients were still under treatment. Dr Albert Davis of the Port Hedland Native Hospital wrote that:

the activities for...1929 suggest...that we are slowly...reducing the incidence of venereal disease among the native population....Fifty seven patients were treated compared to 71 the previous year. Of the 57 there were 35 suffering from venereal complaints, the remaining 22 being inflicted with various illnesses....All the venereal complaints were...granuloma.¹³⁹

By 1930 venereal diseases among Aborigines could be described as being under control and although the method of isolation remained the same the means of treating the disease improved.

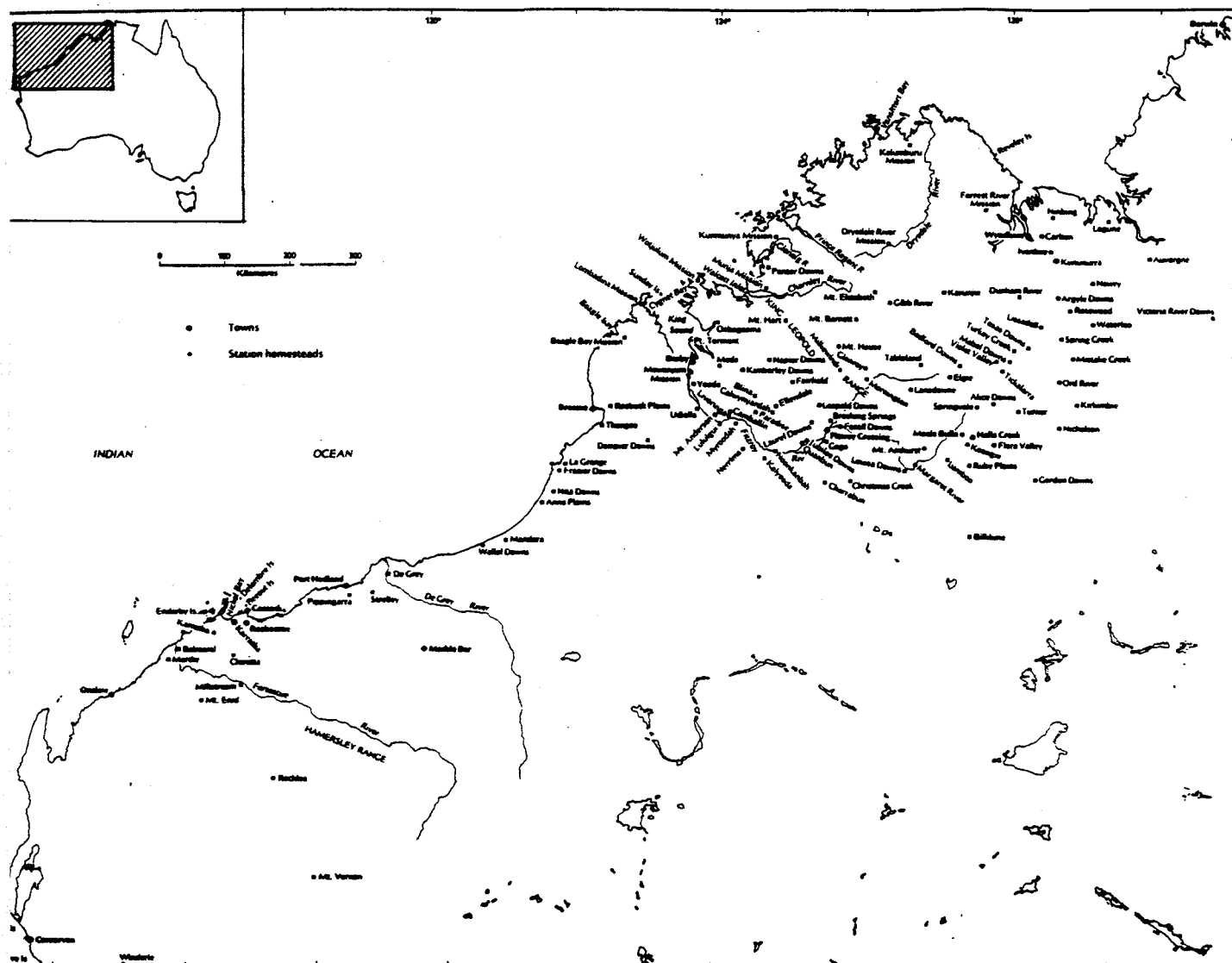
¹³⁷ *Ibid.*, pf.

¹³⁸ *Ibid.*, pf.

¹³⁹ Chief Protector Aborigines, *Annual Report*, 1928, WAPP, p.4.

In 1920, Western Australia restructured its Aboriginal protection administration. This change created a period of austerity that unwittingly fostered an exodus of Aborigines from government reserves and old style church missions. At the same time a new style of missionary emerged in the fringe-camps in the southern areas of the State. In the north, as rumours of an impending leprosy epidemic spread, closer public interest in disease gripped rural settler society. Leprosy featured as a subject of criticism from international experts. The study of Aboriginal customs, manners and social organisation was beginning to occupy the mind of government politicians and administrators, but public opinion would be a new influence on the administration of the health of Aborigines, a subject I now turn to in Chapter six.

Map 3



A map of northwest Western Australia showing the origin of leprosy patients 1889-1975.

Source: Davidson, *Havens of Refuge*, see Table 1, p.124-127, and see maps on, pp.135-147, which were copies of prints in Chief Protector's Reports to Parliament, from 1933 and beyond period of study.

CHAPTER 6

The Grand Fear: Aborigines in Western Australia, Leprosy, the Church and the State; 1930 to 1940

Among other things, the focus in this chapter is on aspects of some sexually transmitted diseases, the austerity approach by Protector Neville, and the problems relating to Aborigines gaining access to health care, in southern populations. Additionally, I draw on the struggles which developed over the care and welfare of Aborigines between the Church missionary bodies and the State Protector's Department. In the north the focus is on leprosy and access to health care for them as the disease spread (for total figures on leprosy see Table 6.1 in Appendix 6). The Royal Commission of 1934-35 investigated much of what the Aboriginal administration did, and this set the stage for reforms, aspects of which are analysed in this chapter.

Fear pervaded relations between those Aborigines who contracted infectious diseases, the white and Asian residents of the northern towns of Western Australia and the institutions responsible for managing the infections. These groups and bodies, however, distrusted each other. Among groups of indigenous people diseases affected them which settlers feared might infect them. In the south white rural populations feared venereal diseases while indigenous groups feared institutionalisation and being denied services white people took for granted. In the north it was leprosy which acted as the motive for settler fears, and indigenous

people feared disease and the prospect of being removed from their environments and incarcerated in institutions, and never be seen again.

Tensions intensified among the increasing numbers of people of Aboriginal descent¹ who began migrating away from government and mission controlled institutions to take up residence on the fringes of white society. The tensions among fringe-camp groups manifested themselves in injuries from fighting, disrupted relations between males and females, and daily disputes between extended family groups. Moreover, destitute children, and couples sometimes with too many children, were forced to live in over-populated camps. Such circumstances also existed in the fringe-camps on the outskirts of Perth. In addition, white townsfolk held deep seated fears about the Aboriginal campers due to the heavy consumption of alcohol and squabbles between camp residents, after dark. In some cases Aboriginal camp groups feared white townsfolk who sometimes asked for the camps to be removed. The fear by campers was particularly acute when sick and dying Aborigines were in the camps.

In 1930 in the southern parts of Western Australia, despite years of concern, disease remained unchecked due to government policies that encouraged unhygienic fringe-camp social and economic groupings. Similar problems of hygiene persisted throughout the 1930s, as Paul Hasluck, the journalist, historian and later federal politician, reported in

¹ I use the term 'people of Aboriginal descent' because not all people who had some mixture of Aboriginal descent were regarded, or regarded themselves, as 'Aborigines' until the gazettal of the *Aborigines Act Amendment Act 1936*; see also, Rowley, *The Destruction*, pp.250-254, and pp.290-315; see also, O.A. Neville, 'Contributory causes of Aboriginal depopulation in Western Australia', in *Mankind*, Vol. 4, No. 7, 1948, pp.3-13, and O.A. Neville, 'The half-caste in Australia', in *Mankind*, Vol. 4, No. 7, pp.274-290; for aspects of legislation, see McCorquodale, *Aborigines And The Law*, pp.95-98.

a series of articles for the *West Australian* newspaper.² Throughout the 1930s, the Health Department had responsibility 'to provide the medical service care of indigent Aborigines.'³ The lack of cooperation aggravated the lines of demarcation on who held the responsibility to guarantee that the diseased, sick and injured received care. Hasluck believed that during the early 1930s the Health Department openly refusing to fulfil its duties towards destitute camp people.⁴ Furthermore, he claimed that these conditions provided the circumstances that proved so critical both to the lot of the southern 'half-caste' and to the health of the northern 'full-blood'.⁵ The Chief Protector of Aborigines, A.O. Neville, and a missionary, Mary M. Bennett, provided a common perspective in support of that viewpoint. Bennett and Neville were antagonistic towards one another but in their criticism of the Health Department they appeared united.⁶

In the north, most medical people felt that venereal disease had come under medical control, except in the bush districts of the Kimberley. Dr Albert Davis showed that the numbers of people affected by

² See Paul Hasluck's articles in, Paul Hasluck, *Our southern Half-caste Natives and their Conditions*, published by the Native Welfare Council, 1939; see also, Paul Hasluck, *Shades of Darkness: Aboriginal Affairs 1925-1965*, Melbourne University Press, Melbourne, 1988, pp.1-65; see also, Paul Hasluck, *Native Welfare In Australia: Speeches and Addresses by the Hon. Paul Hasluck, MP, Minister For Territories*, AGPS, Perth, 1953; see also, Paul Hasluck, *Mucking About, an autobiography*, Melbourne University Press, Melbourne, 1977, Chapter 17, pp.202-227.

³ Anna Haebich, 'A Bunch of Caste-Offs', p.410.

⁴ Hasluck, *Mucking About*, p.220; but see also, Anna Haebich, 'A Bunch of Cast-Offs', p.410.

⁵ Hasluck, *Mucking About*, pp.202-206.

⁶ A.O. Neville, 'Transcription of Evidence', in, *Transcripts of the Royal Commission Appointed to Investigate, Report, And Advise upon matters in relation to the condition and Treatment of Aborigines*, Battey Library, Perth Western Australia, AN, 104/2, Acc. 1003, Series No. 1934/2922, Vols 1-2, (RC 1934), pp.595-651, (this document will here after be cited as 'Transcripts of Royal Commission 1934', in AN, 104/2, Acc. 1003, Series No. 1934/2922, Vols 1-2, (RC 1934)); see also, Mary M. Bennett, 'Transcription of Evidence', in, 'Transcripts of Royal Commission 1934', in AN, 104/2, Acc. 1003, Series No. 1934/2922, Vols 1-2, (RC 1934), pp.246-248, and, pp.255-295.

granuloma had fallen slightly from 32 in 1928 to 27 in 1930. The incidence of other forms of sexually transmitted disease such as gonorrhoea fell also, from 17 in 1928 to 3 in early 1930.⁷ Davis wrote of the work he did in coping with the disease,

the method of treatment...[remained the] same as last year....Some of the cases were recurrences and reinfections; others from remote parts of the district had so neglected themselves that a cure seemed hopeless.⁸

Bad hygiene in the bush and fringe-camps provided the reason given by Davis for why a cure had become so difficult for some people. Hygiene problems, which persisted throughout the 1930s, appeared as the most obvious cause.⁹ Still another cause was resistance to change among the Aborigines of the bush, fringe and pastoral camps. Their inertia was caused by the strength of these bush people clinging to their own customs and a general ignorance of western ideas of hygiene and disease under such conditions of change. Similarly, the cause existed in not only economic change caused by expanding white settlement but also toward political and cultural changes imposed on their customs and manners. Another factor was the parsimonious State and the frugality of missionaries who saw it as their responsibility to care for Aborigines. The Western Australian government, according to the Protector's records,¹⁰ was aware of what was taking place in other States where more deliberate attempts were made to raise the health standards of the Aborigines.

⁷ *Ibid.*, p.4.

⁸ *Ibid.*, p.5.

⁹ Paul Hasluck's articles in, Paul Hasluck, *Our southern Half-caste Natives*; see also, Hasluck, *Mucking About*, pp.215-220.

¹⁰ A.P. Elkin, 'Aboriginal Evidence and Justice in North Australia', in *Oceania*, March 1947, pp.182-203, also quoted in Rowley, *The Destruction*, pp.294-295.

Although fringe-dwellers did live in squalor, this was partly their own preference. Others may certainly have chosen another cleaner environment, but camp people firmly believed that certain conveniences existed in occupying living sites of their own choosing: such as the absence of authoritarian reserve managers; different foods people were compelled to eat, new uncomfortable customs of bathing daily, sleeping on beds and the use of blankets. Similarly, their propensity to spend quickly what they earned through labouring meant that little money remained to pay for health care expenses. Moreover, this was something most fringe-camp people firmly believed was a responsibility that belonged to the government.

The Western Australian government was also influenced by how the Aboriginal agencies in other States and the Northern Territory were taking Aboriginal customs into account. The Churches had begun taking more seriously the ideas about 'culture' that came from anthropology, and endeavoured to adopt such ideas in their management of the Aborigines' transition away from their customary practices. In Queensland a conference in the early 1930s

made representations to the Commonwealth Government on [developing] general policy for Aborigines [in which] 'full justice' required 'full consideration[of] tribal traditions and customs' with field officers to interpret these.¹¹

Meanwhile, in areas south and east of the Gascoyne, Aborigines continued to leave the old style missions in large numbers. The Chief Protector's strategy for preventing Aborigines from moving between government reserves and places of employment worked in one sense but failed in others. He thought this strategy would encourage Aborigines in

¹¹ *Ibid.*, pf.

the south of Western Australian to integrate economically and socially into the surrounding society. These social forces, together with the rising tide of disease among Aborigines in the south and the north, helped to create the conditions under which most fringe-camps remained in squalor.

The reduced level of government care for Aborigines living in temporary camps in the south allowed missionaries with less formal attitudes to fill the gap. As the number of Aborigines living in the camps rose so did the prevalence of diseases caused by poor hygiene and by social arrangements — such as lack of order which promoted heavy drinking, trauma from fighting and break-down of marriage arrangements — which exacerbated poor health practices. In the north, unhygienic living sites created the conditions from which the leprosy epidemic emerged in the 1930s. In 1934 the mounting Aboriginal health crisis played an important part in forcing the Western Australian government to appoint a Royal Commission, discussed later in this chapter.

The growing Aboriginal population made relations between some missionaries and government even more uneasy. The missionaries, who came face to face with camp dwellers, were the first to appreciate the full extent of the Aboriginal health problem. When Frederick James Boxall, the Church of England Rector of Narrogin and a local protector of Aborigines, travelled between Kalgoorlie, Albany and Perth, he noticed that the number of half-castes had increased substantially. South of the goldfields railway line and west to Coolgardie-Esperance track there were 900 half-castes in 1905. By June of 1932, they had increased fourfold to 3,715. Immediately south and east to the South Australian border the number of people in the camp totalled 50 in 1905. This number had increased by 1932 to 1,536 residents, an increase of 1,486 (or an increase by

30 times) in 27 years. In Boxall's district he had observed an Aboriginal family which contained 20 children from the one father. This rise in the number children surviving into adolescence had a domino effect in that there were too many children for camp people to care for adequately. This caused chaos in these small camps because social rules belonging to rural white society had to be practised, such as sending people to schools, and work arrangements established by employers. Other families consisted of 14 members, Boxall wrote and added that there were also at least two families with nine children each.¹² The bulk of this population lived not in houses but shacks, tents and 'Wurlies' (a Western Desert Aboriginal word for wind-breaks made from tree branches).¹³ These structures had little to no furniture and people lived and slept on dirt floors covered only by sacks and old rugs. Some of these temporary dwellings had some utensils, and a bush fire-place for cooking outside the sleeping area.¹⁴

From 1931 to 1932, the great majority in the of Narrogin district existed on rations costing the government, Boxall said, '56 cents per week per adult.'¹⁵ A few received clothing and a blanket and the rest begged for clothing cast off by local white farmers. The State was not at all liberal with its rations, Boxall claimed.¹⁶ At one location called Geeraling he counted between 70 and 100 natives on the roadside camp and the land was never declared as an Aboriginal reserve.¹⁷ On this land no sanitary conveniences existed, and in the summer the water in the well turned

¹² 'Fredrick James Boxall, Rector Narrogin', in, 'Transcripts of Royal Commission 1934', in AN, 104/2, Acc. 1003, Series No. 1934/2922, Vols 1-2, (RC 1934), p.189.

¹³ *Ibid.*, pf, and is a term which Boxall actually uses.

¹⁴ *Ibid.*, pf; see also, Biskup, *not slaves*, pp.91-169; see also, Anna Haebich, 'A Bunch Of Cast-Offs', pp.483-566.

¹⁵ Boxall, 'Transcripts to Royal Commission', p.189.

¹⁶ *Ibid.*, pf.

¹⁷ *Ibid.*, p.190.

brackish. At the Narrogin camps the occupancy levels fluctuated from between 25 and 150, in 1930. The people at this camp lived on a reserve adjoining and overlooking the sanitary depot with no water for bathing and their drinking water came from a tap at the depot. The site here and elsewhere were completely devoid of sanitary arrangements.

At Wagin, Aboriginal casual workers camped on a traveller's resting place alongside the road. In addition, Boxall told the Commissioner that at Katanning Aborigines were living beside the rubbish pit and at Williams only two portable toilets serviced between 70 and 120 people. As at other places no water existed on the reserve and was supplied from a nearby property. Boxall took an officer from the Department in September 1931, when the reserve was completely under water.¹⁸

Boxall angrily described the camp people's predicament arguing that society should not allow these 'half-castes to pig it in wurlies in which father, mother, children and dogs curl in together'.¹⁹ He pointed out that there was no privacy; the children see and know too much. In this regard they were worse off than the bush natives, and the morals of the latter were certainly higher than those who lived in the fringe-camps.²⁰

Dr Keith McGinn, who treated Aborigines in the Quairading district, described their health circumstances. He claimed there was a serious problem, and that it had been that way for many years.²¹ McGinn saw three major difficulties. The first problem was that of hospital accommodation. The local hospitals were supposed to take in sick people

¹⁸ *Ibid.*, pf.

¹⁹ *Ibid.*, pf.

²⁰ *Ibid.*, pf.

²¹ 'Keith Edward McGinn, medical practitioner Quairading, Transcript of evidence to Royal Commission 1934', in, 'Transcripts of Royal Commission 1934', in AN, 104/2, Acc. 1003, Series No. 1934/2922, Vols 1-2, (RC 1934), p.232.

of any colour, creed and station in life, but McGinn added that if Aborigines were taken in 'we would soon have only native patients.'²²

The second problem for McGinn was that

in cases of severe illness, we have to admit them, but our hospital accommodation is limited, and admission of these cases often presents as awkward. We have a small wooden structure, large enough for one bed only, at the rear of the hospital, and where possible a sick native is kept there.²³

Finally, McGinn mentioned that the habits and health of the natives was so bad that people presented with infections such as 'scabies...lice...colds, influenza, bronchitis and pneumonia in winter.'²⁴ Venereal disease, however, was not among the ailments McGinn observed here. The Aborigines he serviced lacked physical exercise and he argued that the camp should be stocked with surgical and medical supplies for dressing wounds, particularly at ration depots. The protectors tried to provide some first aid equipment. In addition, proper sanitary conditions plus water and shower facilities should have been provided to guard against skin and intestinal infection.²⁵ The conditions described by McGinn were fairly typical in the south, but in the north the circumstances were even less under the control of the health and protection agencies.

In the early 1930s Beagle Bay, a Roman Catholic mission north of Broome, had a stable population of 282 people. In this population there were 134 children under the age of 14 years. There were 167 males and females of full descent, and the remaining males and females totalled 115. The staff comprised 2 priests, 5 brothers and 6 nuns. The mission could have been regarded, even then, as a small township with church, cottages

²² *Ibid.*, pf.

²³ *Ibid.*, pf.

²⁴ *Ibid.*, pf.

²⁵ *Ibid.*, p.233.

for the missionaries and a series of maintenance buildings, one of which was a blacksmith shop and another a brick-kiln. Livestock grazed in nearby fields and the beef cattle holdings normally totalled 3,500 head. Tropical fruit trees lined the perimeter of the vegetable gardens which provided fresh food for the whole mission population for most of the year. Many Aborigines worked, and the skilled jobs in the tannery sheds and the boot-maker's shop were held by the 'half-castes'. The children worked in the gardens supervised by six adult Aboriginal women.²⁶

Care for the sick was the responsibility of the Sisters of St John of God, most of whom were trained nurses. The sisters conducted clinics for out-patients from a surgery constructed of locally made brick. There was also a special isolation ward for leprosy patients 'awaiting transportation to Port Darwin.'²⁷ It was this religious order, through the agency of Sister Joseph from the Convent of St John of God in Broome, who wrote to the Prime Minister in November of 1933. This religious community offered the services of their Sisters to work at the proposed leprosarium planned for Channel Island near Darwin. Sister Joseph acknowledged that the hospital was a government institution and that they would have to carry out all the duties for treating lepers as instructed by the Chief Medical Officer.²⁸ In this role they asked only for their 'food, medical treatment, and a yearly allowance for clothing and other little incidentals, also their fares to Darwin, ...[and] a fare south' for those who became sick.²⁹

²⁶ Otto Raible, Chief Supervisor of the Roman Catholic Church in the Kimberley Division, in, 'Transcripts of Royal Commission 1934', in AN, 104/2, Acc. 1003, Series No. 1934/2922, Vols 1-2, (RC 1934), pp.132-141.

²⁷ *Ibid.*, p.133.

²⁸ AA, 659/1, Item 45/1/2887, 'Copy of one page letter from Sister Joseph of Convent of St John of God, Broome, dated 3.11.33'.

²⁹ *Ibid.*, pf.

The offer was for four Sisters to go to the Darwin Leprosarium. One was from Perth and the others from Beagle Bay, and the latter had extensive experience 'nursing the blacks on the Beagle Bay Mission.'³⁰ The Commonwealth replied to Monsignor W.M. Henschke in Broome, who in turn wrote to Sister Joseph, the head of the community. The letter to Sister Joseph relayed the message that 'the Government ...[was] unable at present to accept their offer'.³¹ Cecil Cook, now an adviser to the Commonwealth and directly involved in giving advice about the Sisters, had prepared a report in 1925 on the suitability of establishing a joint lazaret facility in Commonwealth Territory. As Chief Commonwealth Medical Officer in Darwin in 1934, he advised the Northern Territory Administrator that he

wholeheartedly opposed...[the Sisters'] method of staffing however economical it may appear to be unless they accepted full responsibility for the leprosarium including the management, providing medical attention and arranging transportation is undertaken by the Order.³²

Further out in the bush, towards the southern tip of King Sound near Sunday Island, another Catholic mission was operating at Lombardina, and this mission fulfilled similar functions to the one at Beagle Bay. The total population of 82 males and females, contained a larger proportion of 'full-bloods', and there were similar numbers of people above and below the age of 14. The staff at the mission consisted of one priest, one brother and three sisters. The walls of the building were

³⁰ *Ibid.*, pf.

³¹ AA, 659/1, Item 45/1/2887, 'One page letter written by W.M. Henschke to H.G. Brown, dated 2 July 1934'.

³² Confidential (two page) 'Report from Dr Cecil Cook, Chief Medical Officer of the Commonwealth in Darwin, to His Honour The Administrator of the Northern Territory, Darwin, dated 5 March, 1934', in AA, 659/1, Item 45/1/2887.

made of local timbers and the roof consisted of local brush thatching.³³ At Beagle Bay, only the Sisters normally cared for the sick, unless an epidemic occurred, and then everyone helped.³⁴

When working in the clinic at Lombardina the Sisters treated mainly coughs and colds, but sometimes gave out medicines. Other more serious diseases (for example hookworm infestations and eye infections) made up the rest of the illnesses. Even though the mission faced the ocean and sea bathing was a local custom, some communicable diseases persisted. Hookworm became endemic due to the contaminated soil on which the camp and mission people lived.³⁵ Trachoma was usually present in the creche and among the older youth. The boys and girls of school age slept on bunks in huge dormitories with dirt floors, and close body contact was unavoidable.³⁶ Leprosy was a problem at Lombardina and as those patients were identified and diagnosis verified by analysis in Perth they went to the lazaret at Beagle Bay.³⁷

Among northern bush-dwelling Aborigines, leprosy spread from contact with Asian mining labourers from the Northern Territory and

³³ Otto Raible, Chief Supervisor of the Roman Catholic Church in the Kimberley Division, in, 'Transcripts of the Royal Commission 1934', in AN, 104/2, Acc. 1003, Series No. 1934/2922, Vols 1-2, (RC 1934), p.132.

³⁴ *Ibid.*, pp.133-134.

³⁵ AN, 120/4, Acc. 1003, file 8297/1921, 'Hookworm Campaign - General Corro', folios 222-228; see also, AA, 1969/10/1, Australian Hookworm Campaign, see, Lewis, *Cumpston, Health and Disease*, pp.239-245; see also, F.F. Longley, 'Some Defects In Country Health Administration, And A Practical Remedy', in reprint from *MJA (Transactions of Congress)*, May 17 1924, pp.1-7; see also, W.A. Sawyer, 'The Sciences Underlying Public Health', in reprint from *MJA (Transactions of Congress)*, 17 May 1924, pp.1-6; see also, W.C. Sweet, 'The Australian Hookworm Campaign', in reprint from *MJA (Transactions of Congress)*, 17 May 1924, pp.1-13.

³⁶ AA, 16581, Item 807/1/5, Pt 1, 'Ophthalmia Disease Trachoma', see 'Memo dated November 1931, by J.H. Cumpston, Director General of Health, Canberra, to R.W. Cilento, Director of Health of Tropical Hygiene', pp.1-2; see on the same file a pamphlet created from a letter to the Editor, *Brisbane Courier* by a J.B. Hogg, dated 14 June 1928, spelling out the public hygiene code regarding trachoma.

³⁷ Otto Raible, 'Transcript of Evidence to Royal Commission 1934', pp.132-135.

from other Aborigines migrating across the border region for customary contacts.³⁸ Many of these people had almost no contact with the outside world, and consequently knew little about sanitary habits under sedentary living conditions. Although hunter gatherers prevented the propagation of some parasites by low numbers and constant movement, as they began to settle in one location they began to experience new health hazards. Close body contact by bush people resulted from sleeping close to each other and also the group slept close to their hunting dogs to keep warm, which allowed transfer of parasites. The circumstances changed once people became fixed in the one locality. Once leprosy was introduced, it was thought that wearing clothes which became filthy, and bathing in stagnant water, all became possible vectors. In the late 1920s leprosy infection among Aborigines increased sharply. As a result of its spread the transportation of patients to the Northern Territory began in earnest and although it was never an easy procedure, the practice continued well into the mid-1930s.

The treatment of leprosy patients became chaotic as the number of cases increased. In Western Australia the Health and protection agencies developed a number of temporary holding compounds. The transportation of these patients to Darwin was a particular difficulty.³⁹ Moreover, residents in towns such as Roebourne, Broome, Derby, Wyndham and Fitzroy Crossing and local white pastoralists expressed fear and loathing about the way authorities placed diseased Aborigines on

³⁸ Cook, *Leprosy in Australia*, pp.27-45; see also, P. Moodie, *Aboriginal Health*, ANU Press, 1970, p.151.

³⁹ AN, 120/4, Acc. 1003, file 79/1932, 'Leprosy in North West', see letter from Prime Minister to WA Premier dated March 1930, this letter talks about transportation arrangements of leprosy patients to Darwin and where the PM told the WA Premier that his Government would have to make provision for the transport.

the outskirts of 'their' towns. Discussions between the Western Australian and Commonwealth Governments went on incessantly from the mid-1920s until they could both agree on the terms for the transportation and management of lepers arriving at the Commonwealth leper station in Darwin. Eventually, after long bargaining and discussion 14 leprosy cases from Cossack and three Kimberley Aborigines were taken by a coastal lugger to Darwin. Captain Scott contracted his ketch the *Colarmi* to the Commonwealth.⁴⁰ The first 'shipment' of lepers occurred on 18 September 1931 and the 'cargo' arrived in Darwin on 10 October.⁴¹

The Broome Road Board's concerns, as expressed to the Health and the Aborigines departments, suggested that Road Board members believed leprosy was infecting Aborigines in large numbers in their local region. A couple of surges in new cases occurred in the late 1920s and threatened to rise once more in the early 1930s. The Road Board told the Minister for Public Health on 20 July 1932 that five lepers would soon be removed to Darwin.⁴² One year later the Board wrote to the Minister indicating that more cases had been located and that one, a fifteen year old boy, was at a school in the south (possibly Perth).⁴³ The following year the Board protested that dormitory arrangements meant bedding down leprosy patients in the same room regardless of sex. The Minister wrote back highlighting his view over problems of accommodation of lepers in

⁴⁰ Davidson, *Havens of Refuge*, p.32.

⁴¹ *Ibid.*, p.33.

⁴² AN, 120/4, Acc. 1003, file 360/1927, Leprosy in North West, 'Broome Road Board', see memos dating back to July 1927, re labour and leprosy; see also, AN, 120/4, Acc. 1003, file 116/1934, 'Leprosy - Summary of Indicators In North West and Transfer to Darwin', folios 1-21 and folios 26-91.

⁴³ *Ibid.*, folios 33-34.

transit. The problem lay with the Commonwealth, the Mister thought, rather than with his own administration.⁴⁴

The Broome Road Board's fears were largely confirmed as leprosy numbers rose in the Kimberley. This fear was not lessened by a contemporary article entitled 'Australia's Problems in Tropical Areas'.⁴⁵ In 1932, Dr Raphael Cilento, a Queensland medical and public health official, emphasised that tropical and sub-tropical areas were of interest because of their industrial resources. Cilento argued that since successful development was essentially a matter of applied public health, medical services were an important part of all developmental activities. He argued also that the tropical portion of Australia made up the largest tropical possession within the British Empire,⁴⁶ and that both hookworm and leprosy were the aftermath of the use of 'coloured labour' in Queensland. These maladies, he claimed, represented the most serious outbreaks of tropical disease in Australia's medical history. Across the north of Australia the two diseases had become endemic. Leprosy, he claimed 'had been introduced by the Chinese, who when the country was opened poured in' uncontrollably.⁴⁷ (This was not entirely true.) He went on to say that the conditions Australia confronted had occurred within a period of twenty years and that the Australian Institute of Tropical Medicine had been opened at Townsville to deal with the problems incidental to the establishment of a healthy white population in the tropics.⁴⁸

⁴⁴ *Ibid.*, pf.

⁴⁵ Newspaper article in '*Sydney Morning Herald*', entitled, 'Australia's Problem in Tropical Australia: Dr Cilento's Address, Tropical Colonisation', in AA, 1928/1, Item 635/38.

⁴⁶ *Ibid.*, pf.

⁴⁷ *Ibid.*, pf

⁴⁸ *Ibid.*, pf.

Early in January 1933, discussions progressed between the federal Department of Health, the Aborigines Department and the Western Australian Public Health Department regarding the transportation of lepers from the north-west of Western Australia to the Northern Territory. During these discussions a launch was purchased for this purpose, but no action was taken.⁴⁹ Soon after, an offer was submitted to the Minister for Public Health from a Mr F. Redfern of Broome to transfer the lepers from all ports in the north to Darwin for £1,250 per annum. One month later the Broome Road Board wrote to the Minister for Public Health in Perth, drawing to his attention the prevalence of leprosy in the district. They urged the Minister 'to provide periodic inspections by a medical man of the Kimberley area.'⁵⁰ The Board recommended that Dr Hayes, the Broome District Medical Officer, be appointed to undertake the task. Dr Atkinson, the Chief Medical Officer, replied immediately asking him if he would 'accept responsibility to undertake the examination of the natives'.⁵¹

Later that year the Minister wrote to the Broome Road Board saying that his Department had spared no expense in attempting to cleanse the Kimberley, and Western Australia, of lepers. The department's efforts, however, were hampered by Captain Cockrane's early departure from Broome on his way to Darwin. Dr Hayes was notified that the launch could only take eight patients and that Cockrane did not call at Derby. Dr Cecil Cook, now the Director of Commonwealth Health in the Northern Territory, was asked to get an explanation from Cockrane of why he failed

⁴⁹ AN, 120/4, Acc. 1003, file no. 360/1927, 'Leprosy in North-West'.

⁵⁰ AN, 120/4, Acc. 1003, file no. 116/1934, title, 'Leprosy - Summary of incidents in Nth West, and Transfer to Darwin', folios 1 and 21.

⁵¹ *Ibid.*, folios 54 and f90.

to stop at Derby. One reason for the concern was that there was a build-up of leper patients at towns specified as transit points for collecting lepers. The Chief Protector wrote to the Under Secretary for Health on 26 October 1933 advising him that five lepers and a number of suspected lepers had camped outside the native hospital fence at Derby and he feared that others would be attracted to the site.⁵² The boats took months to collect their human cargo, travel to Darwin and return, sometimes with a different cargo altogether. This meant an uncoordinated build-up of patients which in turn exacerbated townspeople's fears. While all this occurred leper suspects and patients had to be managed in the small overcrowded disease compounds.

Other combinations of events made life in the north more complex. The local Aborigines Department employee at Derby, Franz Luyer — who was mentioned in the previous chapter — still attended to the new leper patients as they came in from the bush. His pay and conditions were rather poor and he had made repeated requests for increases in his rates of pay. Once more he had made a request to the Chief Protector for an increase in wages for feeding and generally keeping the lepers under surveillance in the compound awaiting transit to Darwin. He also asked for more money to look after the growing camping population. The Aborigines Department thought it would be better if the Health Department could handle the matter. Dr Hodges of the Health Department was reluctant to move either on the wages or accommodation question, and argued that funds would be wasted if diagnosis did not confirm the infection.⁵³

⁵² *Ibid.*, folios 53-54.

⁵³ *Ibid.*, folio 21.

The job of feeding, sheltering and securing lepers never proved to be easy. Luyer often became the object of derision among local townsfolk for attempting to provide comfort to the compound inmates. They also demanded that he secure the compound to protect town residents. On 27 November 1933 Luyer wired the Commissioner for Public Health for permission to erect a shed at a cost of £10, to shelter prospective leper patients. His request was for urgent action because some patients were sure to escape.⁵⁴ The Chief Protector had already notified the Aboriginal adviser in Derby, a few weeks earlier, that all the camp people would be transferred to an island lazaret near Darwin and this made the Aboriginal suspected lepers uneasy.⁵⁵ One man named Yama was among this group awaiting transportation and Dr Webster of Wyndham reported that Yama had been tested for leprosy earlier in November. Unfortunately, like many anxious Aborigines before him, Yama's tests proved positive. He would soon be transported to Darwin.

No improvement occurred either in the coordination of the screening of leper patients or the quality of their transportation. The two governments hesitated partly due to the costs, but also because of their underlying philosophies. The problem lay partly in the way responsibility was divided among a number of government departments. The transport of patients nevertheless continued and on 26 January 1934 the Department of Public Health received a letter from Mr R.A. Bourne quoting for the transport of 25 lepers to Darwin at a cost of £350 per month. The Department asked Dr Hayes to inspect the lugger for its suitability and seaworthiness. By 30 January another offer came from

⁵⁴ *Ibid.*, folios 41 and 53.

⁵⁵ *Ibid.*, folio 25.

Gregory and Company for the schooner *Eva* at a cost of £30 a month plus insurance on the vessel plus a per voyage cost of £1,500.⁵⁶ While the two governments hesitated about the direction they would follow, other problems persisted.

On 14 March 1934, the Perth newspaper the *West Australian* made an effort to allay the concern of northern townspeople. It published an article which made the point that while people in the towns were naturally concerned about Aborigines contracting the disease, from the outset while it was usual for them to speak 'about leprosy as a "foul... and a most loathsome disease" in actual fact the terms...[were] only applicable when, to the disease itself was added, the dirt and septic processes of uncleanness, and the squalor of the leper's surroundings forced upon the victim.'⁵⁷ The writer went on to say that 'leprosy was no more foul or loathsome than syphilis and a number of other diseases'⁵⁸ and just as science had swept away our fears of syphilis 'so it would do the same for leprosy.'⁵⁹ This article appeared at the same time as the detection of a leprosy case came to light in Perth.

Not all lepers were Aborigines. White patients were confined to Wooroloo infectious diseases hospital near Perth but Aborigines were confined north of the 25th parallel, or what some called the 'leper line'.⁶⁰ A comparison of the living conditions of the two types of patients is instructive.⁶¹ In Wooroloo the small comfortable rooms had fireplaces

⁵⁶ *Ibid.*, folios 90-91.

⁵⁷ Australian Press Cutting, in AA, 659/1, Item 45/1/2887, see *West Australian*, Perth WA, 'Native Lepers, Misconception about Disease', dated 14 March 1934, p.5.

⁵⁸ *Ibid.*, pf.

⁵⁹ *Ibid.*, pf.

⁶⁰ Davidson, *Havens of Refuge*, pp. 104-105.

⁶¹ AN, 120/4, Acc. 1003, file No. 683/1934, 'Leprosy - Case of Mrs Z'; see also, AN, 120/4, Acc. 1003 file no. 1765/1923, 'Leprosy in North-West'; see also, AN, 1/7, Acc. 993, file no.

where the patients could read, sew and entertain friends and family members. The food was described by an elderly woman patient as excellent and staff did most of the cleaning while also providing a wide range of services. The sanatorium was near the sea. Patients were able to do things for themselves such as their washing and ironing and, in 1934, the consensus was that they were contented.⁶²

Aboriginal conditions in the north-west were vastly inferior. Many patients were left stranded in either bush and cattle camps or were not picked up by medical screening. Travelling protectors or disease patrols conducted by police on contract identified cases and were paid by the number of suspected Aboriginal lepers they brought in from the bush. Aborigines would sometimes emerge from the bush to confront horrified pastoralists, protectors, police or local residents of peripheral country towns. In one instance, near Mount Shadforth, there was

a male native with his face eaten away, who looked like a horrible skeleton. There was no flesh on the face and no skin on the forehead and for some inches below the chin, and the ears were...missing. There was only bare bone to be seen. The jaw and teeth were exposed owing to the absence of the lips. The eye lids were exposed, and when the eyes were moved the strings (muscles) could be seen working. There were sores all over the neck, scalp, arms and body.⁶³

When Aborigines did get attention they were normally chained by the neck and, even in the late 1930s, were walked or taken by wagon for long distances before they received treatment.⁶⁴

3/1936, 'Leprosy among natives in the North-West'; see also, Libby Peebles, 'The Role Of Prejudice, Racism and Isolationism In the Treatment Of Leprosy In Western Australia: 1890-1940', in Battye Library, Research Essay submitted for requirements of B/A (Lit. Hist.) Murdoch University, 1992, pp.20-24.

⁶² AN, 120/4, Acc. 1003, file 626/1936, title, 'Woorooloo Lazaret', folio 41.

⁶³ AN, 120/4, Acc. 1003, file 630/1925, see notes from a report by the District Medical Officer Derby, circa, late-1920s.

⁶⁴ James Robert Beattie Love, Minister of Religion of the Presbyterian Church, and Superintendent of the Kunmunya Mission, Port George the VI, in, 'Transcripts of the Royal

In towns patients crammed into very small shelters or compounds which they were not allowed to leave, sometimes for months on end while awaiting transport to Darwin. On 9 January 1935 the Broome Road Board informed the Health Minister that lepers diagnosed near Broome had 'no place to be put'.⁶⁵ The real cause rested with the Broome hospital's refusal to admit leprosy patients, and as a result leprosy patients were kept at a distance from other hospital patients.⁶⁶ The Secretary of the Road Board at Wyndham, a town further north from Broome, and located on the Cambridge Gulf, notified the Health authority that a number of lepers had been seen there.⁶⁷ The Broome Road Board received the information that an Aboriginal woman held at the Wyndham hospital for six months had contracted leprosy and later transferred to Darwin.⁶⁸ Two Aboriginal males from the Wyndham gaol were also diagnosed as having leprosy but they both escaped to the bush.⁶⁹ Such events left white townsfolk uneasy.

The local member for the Kimberley in Legislative Assembly, Aubrey Augustus Michael Coverley, had expressed local peoples' unease. Born in the south-west of the State, Coverley had migrated north some sixteen years earlier. In his evidence to the Commission Coverley stated that

Commission 1934', in AN, 104/2, Acc. 1003, Series No. 1934/2922, Vols 1-2, (RC 1934), pp.592-593.

⁶⁵ AN, 120/4, Acc. 1003, file 116/1934, 'Leprosy - Summary of incidentals in North-West and Transfer to Darwin', folios 91-92.

⁶⁶ *Ibid.*, folio 93.

⁶⁷ *Ibid.*, folio 26.

⁶⁸ AA, 659/1, Item 1944/1/657, 'Lepers in WA: Proposed transfer to Darwin', sundry papers and a copy of letter from Broome Road Board referring to them receiving information about this woman and her transfer to Darwin.

⁶⁹ 'Leprosy - in North-West and Transfer to Darwin', see, AN, 120/4, Acc. 1003, file 116/1934, folio 53.

events have proved that leprosy is gaining ground...in the Kimberley. Six or seven years ago the Road Board members resigned in a body as a protest against the inactivity of the Government towards leprosy....To prove that the disease is increasing, there are about 30 cases awaiting transport to the Darwin leprosarium at the moment.⁷⁰

Coverley observed that one of the difficulties was that no medical practitioners travelled around inspecting Aborigines, and that the medical clinics had to be built to support them.⁷¹ In addition, the 'native hospital' at Derby lacked sufficient room to take lepers. Many diseased natives in the Derby area lived along the coast and did not come in contact with townspeople, and no effort was made to do anything with them. When medical attention was provided, the white town residents wrongly assumed that they were running a risk of infection. Medical authorities informed those who would read or listen that leprosy was not as contagious as people believed. Many townsfolk were less than public minded and believed that the sooner the business was cleared up, the better it would be for the white people.⁷² Aboriginal concerns were dealt with by keeping them out of the town limits. Coverley feared the possible escape of lepers from the disease patrols. He was critical of the Chief Protector's Department on the grounds that suspected lepers were allowed to camp near the town awaiting transport to Darwin, and their control was so lax that many did escape.⁷³

White and Asian town residents held a deep seated fear of Aborigines, particularly of those who escaped from the compounds who were all thought to be diseased. Government neglect stirred resentment

⁷⁰ A.A.M. Coverley (MLA Kimberley), evidence in, 'Transcripts of the Royal Commission 1934', in AN, 104/2, Acc. 1003, Series No. 1934/2922, Vols 1-2, (RC 1934), pp.396-400.

⁷¹ *Ibid.*, p.400.

⁷² *Ibid.*, p.406.

⁷³ *Ibid.*, p.407.

as did the idea of mission development. White residents' fears were intensified by the bottleneck of suspected leprosy patients living in the town compounds. An article, 'Silent Menace Of The North' by the novelist Ion L. Idriess appeared in the *Melbourne Herald*. It captured the townspeople's fear.⁷⁴ What really mattered to the whites was that they might become infected.⁷⁵ White townsfolk also harboured the fear that leprosy could be spread by the bush and house fly, mosquitos and the flea.⁷⁶

Such rumours inflamed townspeople's attitudes towards the missions, which they felt propagated the disease. At Kunmunya, the head missionary, the Reverend Love, a Presbyterian, rejected such beliefs. Love thought that the most serious medical complaint they had was granuloma. Love, like most other commentators about Aborigines, believed this form of venereal disease was peculiar to Aborigines. As far as Love was concerned there were no cases of syphilis or gonorrhoea at the Kunmunya mission.⁷⁷ To Love the existing system of missions was the only way of providing 'philanthropic work' to tackle the health problems faced by the resident and nearby Aboriginal population. The missionaries were appointed by the Church and not paid for their work and their whole object was to benefit Aborigines. The Church, Love said,

⁷⁴ Ion L. Idriess, 'Silent Menace Of The North', *The Herald*, Thursday 22 February, 1934, in AA, 1928/1, Item 635/38; see also, Beverley Eley, *Ion Idriess*, ETT Imprint, Sydney, 1995. One of Idriess's most famous novels was *Lasseter's Last Ride* (1931) a saga about the goldseeker, Lasseter and his search for the mythical reef of gold; see also Idriess, 'Menace Of The North', *The Melbourne Herald*, in AA, 1928/1, Item 635/38, p.4.

⁷⁵ *Ibid.*, pf.

⁷⁶ *Ibid.*, pf.

⁷⁷ A.A.M. Coverley (MLA Kimberley), evidence in, 'Transcripts of the Royal Commission 1934', in AN, 104/2, Acc. 1003, Series No. 1934/2922, Vols 1-2, (RC 1934), p.592.

had a reservoir of qualified and educated men and women on whom they could draw.⁷⁸ The first duty of the mission was to care for the sick.⁷⁹

The Presbyterians serviced several populations in the Kimberley, including Fitzroy Crossing, where they began building a hospital.⁸⁰ The Australian Inland Mission had been planning to introduce its flying doctor services to Western Australia. Although this was a popular idea with isolated missionary bodies such as the United Aborigines' Mission, this body was in conflict with the Chief Protector.⁸¹ As such, local protectors of Aborigines discouraged direct contact with the broader Christian evangelism of Inland Mission.

In spite of the Chief Protector's prejudices against mission expansion, so great was the demand for medical services that in the 1930s the United Aborigines' Mission pushed ahead with the provision of hospital services for the pastoralists. Greater levels of illness certainly arose from the concentrations of indigenous people on the missions. These institutions unwittingly helped spread communicable diseases to both cattle property and town fringe-camp populations. White and Asian settlers already had a public health structure in the towns but the isolation of cattle properties caused a demand for primary care which in turn needed an Aboriginal hospital system. The Mission moved to meet the social as well as the religious need.⁸² Mr F.S. Bray of the Chief Protector's office received a letter from them on 20 July 1934 indicating

⁷⁸ *Ibid.*, p.582.

⁷⁹ *Ibid.*, p.585.

⁸⁰ AN, 120/4, Acc. 1003, file 741/1924, 'Fitzroy Crossing - Establishment of Hospital', see internal memos from Neville to other departments about the hospital.

⁸¹ AN, 120/4, Acc. 1003, file 1932/1055, 'Medical - Organisation of Medical and Hospital Services in North-West', folios 1-24.

⁸² Maisie Mackenzie, *Fred McKay: Successor To Flynn Of The Inland*, Boolarong Publications, Brisbane, 1990.

that the United Aborigines' Mission at Morgans had begun erecting a bush hospital. The mission sought financial help from the Chief Protector, and asked 'whether the Department would assist on a pound for pound basis.'⁸³

In any event, the hospital had already commenced when the Mission Superintendent wrote saying the building consisted of a two ward hospital measuring 40 by 14 feet. The plans included nurses' quarters of three rooms and a maternity labour ward. The Mission itself intended spending £250, and wished to employ only trained nurses. The need existed because of the three hundred natives who now lived within the sphere of the Mission's influence, and 200 of them were already consuming supplies from the Protector's 'indigent rations and medicines.'⁸⁴ The Protector wrote that 'serious cases are sent to Leonora and the Aborigines Department usually meets any transport expenses. He acknowledged that the Mission at Morgans did good work, but relied too heavily on the Aborigines Department's support. His department carried in the bulk indigent food supplies and medicines, and monetary assistance in attending to individual needs. The Mission would be in serious straits if it was not for the work of the Protectors. Missions seldom give credit to government contributions to its success.'⁸⁵

Mr Bray described the Mission in a note on file as 'persistent beggars and the more it gets from the Government the more it wants'.⁸⁶ He cited the case where the Mission received a large consignment of medicines from Neville, which the missionaries had used without any

⁸³ AN, 120/4, Acc. 1003, file no. 627/1934, 'Aborigines - Establishment of a hospital at Morgans by the UAM, Financial Assistance and Advice re', folio 1.

⁸⁴ *Ibid.*, folio 2.

⁸⁵ *Ibid.*, f2.

⁸⁶ *Ibid.*, f2.

acknowledgment of the Department. The Mission, according to Bray, 'unblushingly asked for more medicines and drugs far beyond the generosity of the Department.'⁸⁷ This conflict between the Chief Protector's Office and the missionaries in the field centred on the question of who was to decide the question of what way Aborigines should perceive themselves, and what they believed — the Church or the State?

Bray recorded on file that the Chief Protector's Office was working to solve this problem, and there was little reason for the missionaries to act so defensively.⁸⁸ He intimated that no earlier instance existed where the Government had approached missionaries to fulfil a normal function of the State, and he saw no reason to create a precedent for assistance in this instance. The Aborigines Department had already appealed to the Lotteries Commission of Western Australia for financial assistance for a settlement hospital at Moore River. Bray indicated further that the Lotteries Commission had responded with a cheque for £500. On the question of the hospital development at Morgans he was certain that the local Member for the Legislative Assembly, Mr Nulsen and other friends of the mission, would make favourable recommendations on the mission's behalf. The staff at the mission had already risen to 16 missionaries and there would be pressure to expand further eastwards if more support was given.

Expansion of the mission's sphere of influence over the daily lives of Aborigines proceeded without the slightest encouragement from the Aborigines Department. But their activities were soon to come under the

⁸⁷ *Ibid.*, f2.

⁸⁸ 'Aborigines – Establishment of a hospital at Morgans', in AN, 120/4, Acc. 1003, file no. 627/1934, folio 2.

spotlight when, on Friday 23 February 1934, the terms of reference of the Royal Commission were published. The Western Australian Parliament established the Royal Commission to investigate 'the social and economic conditions of Aborigines and persons of Aboriginal origin in or from native camps.'⁸⁹ The government appointed Henry Doyle Moseley as Commissioner and requested him to report on the social and economic conditions of Aborigines, the laws relating to Aborigines and persons of Aboriginal origin, their administration and, finally, to investigate allegations appearing in the Press since 1 July 1930 about the ill-treatment of Aborigines in Western Australia in general.⁹⁰ The missionaries in the southern areas of the State felt victimised by the Aborigines Department. At least, this was the view they presented to Commissioner Moseley as they tried to convey their attempts to fill the gap left by a receding State in caring for camp-dwellers. That Moseley did pay some attention to their views was apparent in his report in which he wrote:

there is one aspect of the native's life which require[s] attention—the question of medical treatment. Those in charge of pastoral properties and Missions do all they can to care for sick natives: it is obvious, however, that their ability is limited. Each of the stations and missions which I visited carried a supply of medicines suitable for the treatment of ordinary every-day ailments, but serious epidemics occur when something more than household methods are necessary....

One East Kimberley pastoralist of 34 years residence described Moola Bulla as the pulse of the native situation...and urged...that...medical services should be provided at this centre....Coming further south....Although it is not quite clear as to

⁸⁹ J. Willcocks (Atg Premier), *Government Gazette*, Western Australian Govt. Printers (WAGP), Friday, 23 February 1934.

⁹⁰ *Government Gazette*, Western Australia, WAGP, 1934, see 'Royal Commission approved by the Acting Premier WA, Mr J. Willcocks, dated 21 February 1934'.

the meaning of the term "Native Settlement"....I have inspected—the native camps of the Southern Districts...⁹¹

The condition of southern native settlements, he wrote, displayed a level of squalor that had been generally overlooked by Western Australian society.

Moseley observed that government-operated establishments could not be praised. For example, the 'compound' at Moore River consisted of a set of dormitories which had become dilapidated, and so over-crowded that people slept on the verandah. 'Dr Maunsell, of New Norcia, who frequently visits...agreed....that the dormitories are vermin ridden...making disease eradication impossible.'⁹² The hospital, Moseley wrote, 'is a substantial building, but two additional wards are necessary.'⁹³ The nursing sister told him that a labour ward was necessary, there was no isolation ward for children with syphilis, who were allowed to mix freely with other children. In addition, the main ward housed both men and women.⁹⁴ Moseley responded to Neville's suggestion⁹⁵

[that] in order to provide for proper medical, surgical, and hospital treatment for Aborigines and half-castes who become ill or injured or affected by any disease while in the service of employers, it be made a condition of every permit that a fee, to be fixed by regulation, be paid by the employer into a special fund to be controlled by the Minister, and that the proceeds of the funds be utilised to provide the cost of such medical, surgical, and hospital treatment.⁹⁶

⁹¹ *Report of the Royal Commission appointed to Investigate, Report and Advise upon matters in relation to the condition and treatment of Aborigines*, Vol. I, WAV&P, 1935, pp.9-11.

⁹² *Ibid.*, p.12.

⁹³ *Ibid.*, p.13.

⁹⁴ *Ibid.*, pf.

⁹⁵ A.O. Neville, 'Transcription of Evidence', in 'Transcripts of Royal Commission 1934', in AN, 104/2, Acc. 1003, Series No. 1934/2922, Vols 1-2, (RC 1934), pp.595-651.

⁹⁶ Moseley, in, *Report of the Royal Commission 1934-5*, Vol. I, WAV&P, 1935, p.20.

Moseley suggested a permit system to supply rations, clothing and a reform relating to providing medical treatment to sick bush people.⁹⁷

The health of Aborigines featured prominently in Moseley's report. During the inquiry he had questioned the Commissioner of Public Health and the Principal Medical Officer, R.C.E. Atkinson,⁹⁸ about a number of problems outlined by other witnesses during the Royal Commission hearings. Dr Atkinson's evidence spelt out his Department's difficulties in dealing with the problems raised by the local Member of the Legislative Assembly.⁹⁹ Atkinson expressed a commonly held view that many difficulties arose because of the way the bureaucracy managed the business of the Government. This had a direct effect on the way leprosy patients were treated. The transportation of lepers out of the State was conducted by the Chief Protector, his own and the Commonwealth Department of Customs and Shipping: all played a part in transporting lepers to Darwin.

Atkinson tried to convey to Moseley the reality of the lepers' isolation and their transportation in small boats.¹⁰⁰ Similarly, he criticised the missions and protectors for the isolation methods adopted in treating lepers.¹⁰¹ In answering the Commissioner's criticism Atkinson felt his department was humane, but wanted to speak about

⁹⁷ *Ibid.*, p.14.

⁹⁸ Dr R.C.E. Atkinson (Principal Medical and Public Health Officer, WA), evidence in 'Transcripts of Royal Commission 1934', in AN, 104/2, Acc. 1003, Series No. 1934/2922, Vols 1-2, (RC 1934), p.527.

⁹⁹ *Ibid.*, pp.527-535.

¹⁰⁰ Ernest William Hogben, Presbyterian Minister of Religion, transcript of evidence, in, 'Transcripts of Royal Commission 1934', in AN, 104/2, Acc. 1003, Series No. 1934/2922, Vols 1-2, (RC 1934), pp.444-463; see also, James Robert Beattie Love, transcript of evidence in, 'Transcripts of Royal Commission 1934', in AN, 104/2, Acc. 1003, Series No. 1934/2922, Vols 1-2, (RC 1934), p.592.

¹⁰¹ Atkinson, transcript of evidence in, 'Transcripts of Royal Commission 1934', in AN, 104/2, Acc. 1003, Series No. 1934/2922, Vols 1-2, (RC 1934), pp.527-529.

shifting the responsibility from his State to the Commonwealth, as it was a question of the 'national interest'. Atkinson indicated that he had raised the matter at a recent meeting of the Federal Health Council in Canberra, where he argued that the Commonwealth should do something in the national interest to assist.¹⁰² In spite of what Atkinson had attempted it was clear that the Commonwealth was being used as a scapegoat for the State's intractability in caring for Aboriginal leprosy patients.

Chief Protector Neville was in his element in giving evidence on 12 March 1934. He indicated that the health of Aborigines in the south-west of the State had 'deteriorated very much.'¹⁰³ In his view, 'the natives had learned to enjoy certain amenities of life and they wanted to be near the centres of civilisation.'¹⁰⁴ He added that pastoral activities took all the land and no land has been left for Aborigines to camp. In the southern part of the State, despite the fact that the Department had catered for campers by creating 50 camp-sites, many of these camps lacked basic health facilities such as ablutions, fresh water supplies and toilets.¹⁰⁵

The Department, he said, was

not in a position to install such supplies on account of the financial situation. We do our best. In some of the areas we are carting water to camps. Sanitation is another difficulty. We have had certain structures erected, but very often the natives do not use them, and [they] are few and far between.

From the departmental point of view it is...advisable to have natives near town in order to avoid costs of transport of supplies

¹⁰² *Ibid.*, pp.530-531.

¹⁰³ A.O. Neville, Chief Protector of Aborigines', dated, 12.3.34, in, 'Transcripts of Royal Commission 1934', in AN, 104/2, Acc. 1003, Series No. 1934/2922, Vols 1-2, (RC 1934), p.7.

¹⁰⁴ *Ibid.*, pf.

¹⁰⁵ *Ibid.*, pf.

when we have to feed them...to ensure medical attendance to be applied if possible, to arrange for expectant mothers.¹⁰⁶

Neville also explained that the physical fitness of Aborigines in all parts of the State was 'a gloomy picture.'¹⁰⁷ But, he said, 'in the north, except where introduced diseases are evident, the bush natives are a healthy virile people. Their condition varies according to whether the seasons are good or bad.'¹⁰⁸ On cattle stations the condition of Aboriginal workers was generally good. The wives and children of workers are also fed by the majority of stations, and their diet consisted 'of meat, bread, tea and sugar.... At least one medical man in the north [had] informed...[him] that the majority of the natives in his district...[were] suffering from malnutrition...due to the sameness of the diet.'¹⁰⁹ Some stations provided cooked food and others the basic ingredients for workers' families to cook their own meals. One major problem was that while people worked the cattle, they would not hunt for food but happily ate what the station provided. When they moved back to the bush, however, they did eat their customary bush foods.¹¹⁰

In southern areas of the State such as the Goldfields 'we find that most of the Aborigines are reduced to dependence on government rations.'¹¹¹ The people who issued rations to Aborigines are either rural white people trusted by the Department, protectors or police officers. Throughout the State there were 74 government ration depots. On reserves and cattle stations owned by the government the diet was better

¹⁰⁶ *Ibid.*, pf.

¹⁰⁷ *Ibid.*, p.9.

¹⁰⁸ *Ibid.*, pf.

¹⁰⁹ *Ibid.*, p.10.

¹¹⁰ *Ibid.*, pf.

¹¹¹ *Ibid.*, pf.

than elsewhere because stock and gardens provided more balanced nutrition on a continuous basis.¹¹²

Also in southern regions the monthly rations normally amounted to two kilograms of meat, five of flour, two of sugar and 400 grams (about three packets) of tea. The issue included tobacco, mainly to smokers, but, Neville was quick to point out that this was carefully watched because it was a cost to the Department which Aborigines themselves should shoulder. He added that rations were intended as 'a standby and were never meant to develop as a 'hand-out' as well as replace bush foods as the staple food of the people.'¹¹³ Although reliant on advice from outside, Neville had no hesitation in putting the view that the natives throughout the southwest and Goldfields area suffered from malnutrition and weakness brought about through poor diets and their low resistance to powerful diseases.¹¹⁴

Neville told Moseley how, even on reserves operated by the government, airborne transmission of infection proved unavoidable. In his view, the cause was the way Aborigines were forced to live too close together:

The children in the southern areas,...suffer[ed] from the effects of cold and sickness, probably brought about by the lack of clothing....This has the effect of making the whole family huddle together in a small ten feet by six...structure with probably every crevice closed up, their heads under the blanket and in those conditions the whole family are breathing in filth and germs all the time.¹¹⁵

Under the circumstances the medical costs to the Aborigines Department always remained considerable.

¹¹² *Ibid.*, pf.

¹¹³ *Ibid.*, p.11

¹¹⁴ *Ibid.*, pp.11-12.

¹¹⁵ *Ibid.*, p12.

Neville explained what his department had done to restructure primary health care arrangements. Doctors subsidised by the Aborigines Department were expected to attend to indigent natives, and 'where they do we have to pay them for their services.'¹¹⁶ In the past 'native wards' had existed but now these have all been absorbed by hospitals. 'As for hospital accommodation, there is practically none for natives in the south.'¹¹⁷ The Moore River reserve hospital was expected to cater for all the sick Aborigines in the Midland region.¹¹⁸ In the southern and eastern goldfield areas no hospital was available for natives. There were only a few government hospitals left and they were nearly all operated by committees hostile to allowing Aborigines to enter as patients, even though the hospital was subsidised by the Medical Department.¹¹⁹ According to Neville the hospitals run by committees were

loath to accept native cases and it is, in fact, impossible to find accommodation for maternity cases. There are in the country certain good women, matrons and nurses, who are willing to, and who, go out into the native camps and look after those cases. The native today is not the native of 50 years ago, and some of the native women suffer intensely from childbirth. They have lost all the old stamina of the black and they have considerable difficulty in bringing children into the world, possible because of their mixed blood.¹²⁰

Neville never explained this speculation, but he did have considerable experience in observing his clients.

Even worse for the well-being of camp people was the disruption to their lives because 'camp life as it existed was bringing them lower and lower....The old tribal laws have broken down and there is nothing to

¹¹⁶ *Ibid.*, p.13

¹¹⁷ *Ibid.*, pf.

¹¹⁸ *Ibid.*, pf.

¹¹⁹ *Ibid.*, pf.

¹²⁰ *Ibid.*, pf.

check the [actions of] young men and women.'¹²¹ The social erosion was the cause of two problems for the Department's policy, Neville put to the Royal Commission. First he claimed there was a problem in encouraging young Aboriginal bushmen to leave the main group to follow work in other parts of the State, without which Neville implied factionalism and lawlessness would result. Second was the problem of maintaining a level of camp morality as seen through the eyes of the department. Ironically, it was the same morality which had subjected the younger camp members and many women to incest, brutality, fighting, factionalism and a breakdown of social order.¹²²

Neville's opinion about the cause of such dysfunction was aimed partly at Aborigines, but more particularly at the parsimonious State and its institutions. The State institutions displayed prejudice towards the plight of Aborigines both in the past and more recently.¹²³ Neville's main complaint was that he reported to government each year about the problems his department confronted, but lacked funding and support for changes to the legislation. On both counts he was right because his departmental funding had been systematically reduced since 1920 and no changes had been made to the *Aborigines Protection Act*, since 1906¹²⁴ apart from various structural rearrangements to the Department.

The period from 1935 to 1940 represented the aftermath of Moseley's Royal Commission. The period was characterised by the Government's response to Moseley's recommendations, the prevalence of leprosy, and

¹²¹ *Ibid.*, pf.

¹²² *Ibid.*, pp.13-14.

¹²³ *Ibid.*, p.14.

¹²⁴ Biskup, *not slaves*, pp.273-282, Biskup detailed catalogues of funding both from Government to the Aborigines Department, which was nearly stable from 1915 to 1934 and detailed grants from the Chief Protector to Missions, which actually fell from 1915 to 1934; for legislative changes see, McCorquodale, *Aborigines And The Law*, pp.95-98.

the further deterioration of relations between the missionary bodies and the Aborigines Department. One of the government's first responses was to appoint Dr Albert P. Davis, a specialist in public and tropical health, who became the first District Medical Officer assigned exclusively to attend to the health of Aborigines. He had graduated from Melbourne University with medical and science degrees in 1923. In 1934 he had qualified in tropical health from the London School of Hygiene and Tropical Medicine. By 1935, soon after his term as district medical officer at Port Hedland had ended, the Commonwealth appointed him as a travelling medical inspector. His new responsibilities consisted of surveillance and inspection of Aborigines in the Pilbara and Kimberley regions. One of his first tasks involved approving the establishment of the two hospitals at Broome and Wyndham and the construction of the leprosarium near Derby.¹²⁵

Another early task for Davis was to travel through the Kimberley towns, cattle and sheep properties, missions and government reserves to inspect the health of Aboriginal groups. He took with him Reverend Love of Mowanjum, because of his knowledge of Aboriginal customs, habits and language. Davis and Love commenced a leprosy survey of the coastal regions between Derby and Wyndham. When they visited Kunmunya they

found an alarmingly high proportion of venereal disease, as well as leprosy. Love was thankful to learn... that the leprosarium was shortly to be built near Derby and all the natives contracting the

¹²⁵ Davidson, *Havens of Refuge*, p.83; in 1941, Dr L.A. Musso superseded Davis, who moved to Perth to assume control of the Medical Officer Perth City Council. During the period 1941-1946 he served as a medical officer in the Australian Infantry Forces. From 1946 until his retirement, he worked in the Perth Immunisation Clinic in Beaufort Street.

dread disease would be able to be treated and kept until they were free of it.¹²⁶

When Love had given his evidence to Moseley a year earlier, he had been adamant that no leprosy existed at Kunmunya, but he feared it might come. Davis's inspection uncovered large numbers of people with venereal disease at the missions that Love managed. Once leprosy was diagnosed in a mission the local Road Boards together with the country hospitals and district medical officers became involved. As some idea of the incidence of leprosy among Aborigines became known to the public, fears of a leprosy epidemic gripped the white townsfolk in the entire north of the State.

The main reason for this terror about leprosy was that Aboriginal lepers were being brought into the coastal towns in growing numbers from a wide area of the Kimberley hinterland. Large groups were left for long periods in towns. Patients came into the rural outposts and towns and remained there exposed to the gaze of townsfolk. There seemed to be large numbers of lepers concentrated in the transit towns of Broome, Derby and Wyndham but this was largely an illusion driven by fear. For instance, in the four years from 1936-40, the Kimberley region contributed 133 new leprosy patients out of a total of 192 new patients Statewide (see Table 6.1).¹²⁷ So in effect the numbers involved in the epidemic were low but the epidemic appeared to be much greater. Social, economic and cultural arrangements in the northern towns made infection of prospective new cases seem much easier to townspeople than in reality it was. A further reason for the continued unease of the white and Asian

¹²⁶ Maisey McKenzie, *The Road To Mowanjum*, Angus and Robertson, Melbourne, 1969, p.98.

¹²⁷ Davidson, *Havens of Refuge*, pp.124-127.

townspeople was that the situation at the 'native hospital' at Derby as described by Davis was 'chaotic'.¹²⁸ Moreover, Davis's criticism of the Aborigines Department staff was further adding to the alarm. He had pointed out that the hospital operated under Aborigines Department management, and that the manager Luyer and his wife were not medically trained. Their brief appointment at the Cossack quarantine facility was hardly experience enough to manage a lazaret under epidemic conditions. Davis was angered by the staff's lack of experience in managing lepers, but the Department was powerless in such an isolated region to attract trained staff.¹²⁹ The increase in the number of leprosy patients at the time appeared to confirm the urgency of the situation Davis was depicting, but even he could only hope things would improve.¹³⁰

While these northern Western Australian activities were unfolding, an event of international significance for those involved in leprosy treatment occurred in Sydney. A view had developed that the Commonwealth should encourage States to develop segregated centres for treating of Aboriginal lepers, isolating them from the rest of the population.¹³¹ This became part of the Commonwealth's approach when Cumpston, Cilento and Cook addressed the International Pacific Health Conference in Sydney from 3-6 September 1935.¹³² The continuation of such a policy appeared odd, considering Sir Leonard Rogers' long-

¹²⁸ *Ibid.*, p.57.

¹²⁹ *Ibid.*, pf.

¹³⁰ *Ibid.*, p.58.

¹³¹ AN, 120/4, Acc. 1003, file 116/1934, 'Leprosy — Summary of incidents in North West and transportation to Darwin', see report dated 12 October 1932 by R.W. Cilento, on Aboriginal Survey, 'Report to The Director General of Health Canberra', p.7.

¹³² AA, 1/1, Item 35/2301, 'Commonwealth of Australia, Report of the Second International Pacific Health Conference, Sydney, 3-6 September 1935, AGPS, Canberra, 1935, pp.1-88.

standing criticisms,¹³³ and Cecil Cook's own well-known objections.¹³⁴ In Western Australia, meanwhile, the Government continued to expand the number of lazarets in the north as the number of lepers mounted.

Political opportunists who contributed in one way or another to the complexity of the health and politics of the Kimberley region continued to criticise the Chief Protector and the government. On 11 June 1936, a Member for the Legislative Assembly, J.J. Holmes, wrote a report which he sent to the Minister for the North West, Mr F.J.S. Wise. This report referred to the increasing numbers of patients being received at the Broome hospital. Holmes also said that

all governments — National, Country and Labour were equally liable for the alarming spread of leprosy in the Kimberley....The Commissioner of Public Health was charged with the care of the white residents in this State, and the Chief Protector of Aborigines is charged with the care of the Aborigines.¹³⁵

Holmes complained to the Minister about the Broome Road Board, which held responsibility for general health services to the Kimberley region. The Road Board's failure to act resulted from the fact that no common understanding existed between health workers and the Board about what health really meant. Holmes hinted at this when he claimed that

the local health authority...the Broome Road Board, have definitely set their face against persons suffering from leprosy being allowed to remain within the boundaries of the Broome township. The district

¹³³ (Sir) Leonard Rogers, 'Memorandum on the prevalence of a prophylaxis against leprosy in the British Empire', BELRA, no date, circa 1925, quoted in Suzanne Saunders, 'Isolation', p.181.

¹³⁴ Cook, *Leprosy in Australia*, p.270; AA, 1928/1, Item 690/8/106, NH&MRC, Grants - Cilento, see 'Memorandum, from Dr Cecil Cook to The Director School of Health and Tropical Medicine', entitled, *Leprosy Surveys - Dr Cook*, dated 5 September, 1939, folios 1-3.

¹³⁵ J.J. Holmes (Member of the Legislative Assembly WA), Report on Broome Hospital, Leprosy and Treatment of Aborigines', in Davidson, *Havens of Refuge*, pp.156-164, see quote on p.156.

Medical Officer at Broome is opposed to having them in the hospital which is situated at the centre of the town, and where white and coloured patients, and out-door patients, receive medical attention....The departments referred to say that the Broome hospital grounds is the place for leper subjects to be held until moved to Derby or elsewhere.¹³⁶

Leprosy, Holmes mistakenly implied, prevailed only among Aborigines and he expressed his concern that all patients used the same seats and conveniences while waiting for treatment. This, he remarked, would spread infections. Furthermore, maids and cooks were all employed from the Aboriginal compound across the road from the hospital and that, he implied, was a health hazard.¹³⁷

An appreciation of the legislative changes which sprang directly from the Royal Commission are crucial to understanding why the Western Australian government and the mission bodies were unable to agree on the strategy to attend to the health problems faced by indigenous groups and their conditions of life. The first important change, as mentioned above, was the appointment of inspectors.¹³⁸ As we have seen, Dr Davis took the role as the travelling health inspector. The second change came as the State modified its legal understanding of who it now regarded, officially, as an 'Aborigine'.¹³⁹ The new definition created by the revised legislation considered all people of Aboriginal descent as Aborigines except 'quadroons' over twenty one who neither associated with nor lived after the manner of Aborigines. However, any person could lose that 'exempt' status through designation by a court.¹⁴⁰ The

¹³⁶ 'Leprosy in North West', in AN, 120/4, Acc. 1003, file No. 258/1937, folio 10; see also, J.J. Holmes, 'Report on Broome Hospital', in Davidson, *Havens of Refuge*, pp.156-157.

¹³⁷ 'Leprosy in North West', in AN, 120/4, Acc. 1003, file no. 258/1937, folio 33.

¹³⁸ Aborigines Act Amendment Act, 1936, in McCorquodale, *Aborigines And The Law*, pp.97-98, see point (1), on p.97, for comment on the various changes to the legislation.

¹³⁹ *Ibid.*, p.97.

¹⁴⁰ *Ibid.*, pf; see also, Hasluck, *Mucking About*, pp.22-27.

other important section in the legislation was the inclusion of the right of the government to compulsorily detain for an 'examination and treatment' any Aborigine 'afflicted with disease'.¹⁴¹ Neville argued painstakingly before the Royal Commission for all these legal changes, and he explained to the Commissioner why they were needed. Similarly, he explained that he needed wider powers, and that the old Aborigines Department should become a commission administered by commissioners.¹⁴² With the passage of the new legislation Neville gained all the powers he wanted. These enabled him not only to regulate mission development but also to deal with the problems posed by an expanding white rural industry and deteriorating Aboriginal health. Such powers nevertheless proved difficult to exercise.

Without elaborating on the growth and development of the Flying Doctor Service, it is sufficient here to observe that the Australian Inland Mission was a prime mover in its development. The service declared that it had a specific role, which was to provide a health service for rural white farmers and isolated pastoralists.¹⁴³ The antagonism between the smaller mission societies and the Chief Protector may be understood better if it is appreciated that Neville concurred with that role, and resisted mission views that the service should also cater to Aborigines.

¹⁴¹ *Ibid.*, pf.

¹⁴² A.O. Neville, 'Transcription of Evidence', in, A.O. Neville, Chief Protector of Aborigines', dated, 12.3.34, in, 'Transcripts of Royal Commission 1934', in AN, 104/2, Acc. 1003, Series No. 1934/2922, Vols 1-2, (RC 1934), pp.595-686; Neville gave evidence in May 1934, when the Commission began hearings, and then again in December of 1934. The December hearings appear to be special sittings to answer problems for Commissioner Moseley posed by other witnesses. Moseley handed down his report early in 1935.

¹⁴³ Maisie Mackenzie, *Fred McKay: Successor To Flynn Of The Inland*, Boolarong Pub., Brisbane, 1990, pp.17-103; see also, AA, 1658, Item, 614/2/1, Pt 1-4, 'Medical Services General - Flying Doctor Service General, 1947-1961'. These files are not comprehensive but have pamphlets and some memos of interest only; see AA, 1928, Item 715/8, Section 1, 'Northern Territory Medical Services Katherine Darwin'. These files have data on Royal Flying Doctor Service (RFDS), and the Rev. Frank Flynn, the initiator of the RFDS.

The Royal Commission had proposed a special arrangement covering the costs of medical fees for Aborigines and their families working in the pastoral and coastal marine industries.¹⁴⁴ The new *Native Administration Act 1936*, provided powers for the Government of Western Australia to issue periodical 'regulations'. In July of 1937,

the government gazetted further regulations on the Natives' Medical Fund, and requiring employers to contribute £2 annually with respect to every Aborigine permanently employed....At the same time the British Medical Association agreed to lower the doctors' fees ...[for] Aborigines covered by the fund and the Medical Department reduced hospital charges for members of the fund.¹⁴⁵

Neville was generally without criticism by pastoral interests until the scheme came into force when the regulations struck opposition both inside and outside of Parliament.

Finally, the Chief Protector wanted also to licence mission workers, a proposal which antagonised individual missionaries and their entire missionary organisations but it also rallied the support of local political representatives. So great was the reaction to Neville's proposal that, as Biskup commented, 'the missions and the churches must have taken the department by surprise, for it decided not to enforce the regulations.'¹⁴⁶ The conflict between the government and missions persisted. A year later the government through its protection system reasserted itself, with continuing detrimental effects for its relations with both Aborigines and the missions. These were to last well beyond 1940, when the period for this study ends.¹⁴⁷ Western Australia occupied almost half the continent

¹⁴⁴ A.O. Neville, 'Transcription of Evidence', in, 'Transcripts of Royal Commission 1934', in AN, 104/2, Acc. 1003, Series No. 1934/2922, Vols 1-2, (RC 1934), pp.1-7; see also, Report of the Royal Commission appointed to Investigate, Report and Advise upon matters in relation to the condition and treatment of Aborigines, Vol. I, WAV&P, 1935, pp.23-24.

¹⁴⁵ Biskup, *not slaves*, pp.170-178.

¹⁴⁶ *Ibid.*, p.174.

¹⁴⁷ *Ibid.*, pp.174-178.

and although both natural and social history were influenced by infection and human action its size too was a factor. I now turn to a discussion of mainland Aborigines in Queensland and discuss disease health and healing as it affected them in the same periods.

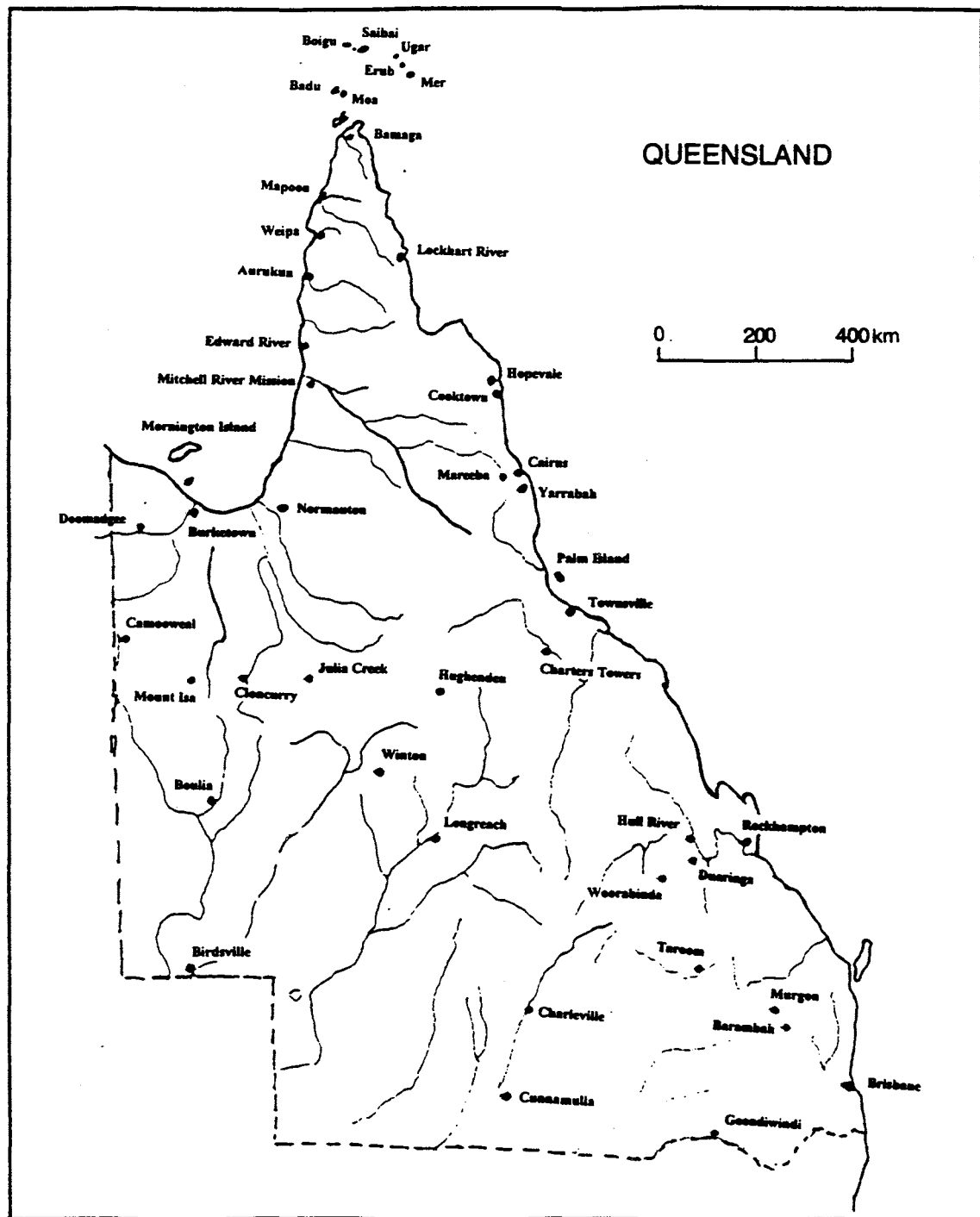
APPENDIX 6

Table 6.1: Leprosy in Western Australia, 1898-1940

Year	Males	Females	Total
1898-1920	16	6	22
1921-1930	25	10	35
1931-1935	111	50	161
1936-1940	105	87	192

Source: , W.S. Davidson, 'Havens of Refuge', pp.124-127.

Map 4



A map of Queensland showing some of the government relief depots, missions, pastoral stations, country towns and cities mentioned in the text.

Source: this map is an adaptation from J.P.M. Long, *Aboriginal Settlements*, p.93 and p.40, and Dawn May, *Aboriginal Labour*, p.12.

CHAPTER 7

Protection: the crucible of disease, health and healing, of Queensland Aborigines, 1900 to 1910

In this chapter I investigate aspects of some of the main diseases affecting Aborigines in Queensland between 1900 and 1910, and the way that care for diseased and infirm indigenous groups acted to assist in the processes of protection. I also look at how the hospital and medical systems coped with epidemics. My focus is on some ethnographic views on indigenous people's belief about healers, the practice of healing, views on sickness and wellness, and how government depots dealt with the sick and the dying, together with aspects of the health of Aborigines on pastoral stations, religious missions, and fringe-camps. In chapter two I examined the Queensland Aboriginal population from 1900 to 1940,¹ and considered how pastoral settlement had influenced Aboriginal demography. Contemporary historians have attempted to sustain the dual notions of 'dispersal' and 'exclusion' as a metaphor depicting the history of relations between white settlers and Aborigines. Apart from Rowley's economic narrative of the history of the reconstruction of Aboriginal identity,² no historian has attempted to consider the Aboriginal population in its complexity when placing this group within Australian history.³

¹ Torres Strait Islanders have been omitted from any analysis because of the paucity of source material, and in the period of study this ethnic group was not identified until 1932. Apart from an inquiry in that year on fishing in TI, primary archival sources are limited.

² Rowley, *The Destruction*, Vols I-III.

³ See the following modern Queensland historians: Ross Fitzgerald, *From the Dreaming to*

The last phase of white settlement in Queensland commenced around 1900 and lasted until just after World War I. All that was left to settle was the hinterland of the Gulf of Carpentaria and Cape York Peninsula. In addition, there were sparsely settled pastoral areas along the New South Wales border west from Roma to Cloncurry and northern South Australia (now the Northern Territory). From 1900 onwards the small Aboriginal population in these regions could only be estimated either by protectors or missionaries working in the region. Land settlement in the years up to 1910 had an effect on the Aboriginal population. Underlying the narratives of Rowley,⁴ Long⁵ and Dawn May⁶ was the common belief that there were huge numbers of Aborigines living in the bush beyond white settlement. In earlier chapters I argued that such an assumption was unsound because early government protectors and missionaries⁷ were the only people capable of saying accurately how many Aborigines they saw in the Gulf and Cape region, but it was impossible for them to do so. The health of Aborigines in 1900 was intrinsically bound up with the collapse of the Aboriginal traditional economic and social organisation. The types of relationships in transition involved beliefs and other customary systems that gave stability to both food supplies and the human relations of daily life.⁸

1915, Queensland University Press, St Lucia, 1982, pp.204-262; see also, R. Evans, K. Saunders, K. Cronin, *Exclusion, Exploitation and Extermination*, ANZ Press, Sydney, 1975; Dawn May, *Aboriginal Labour And The Cattle Industry: Queensland From White Settlement To The Present*, Cambridge University Press, Melbourne, 1994.

⁴ Rowley, *The Destruction*, Vol. II, pp.368-398.

⁵ Long, *Aboriginal Settlements*, pp.4-5, and see also, pp.91-98.

⁶ Dawn May, *Aboriginal Labour*, p.13.

⁷ See also, F.A. Hagenauer, 'Notes of a Missionary Journey to North Queensland 1885', published with 'Report of the Aboriginal Mission at Ramahyuck, Victoria, 1885', this report was located in the Victorian Public Records Series (PRS) 1856-1873, among items classified as Registered Inward Correspondence to Surveyor-General, Board of Land and Works, located in the Public Records Office of Victoria, see index Australian Archives and the Public Records Office Victoria, *My heart is breaking*, Victorian Regional Office, AGPS, Canberra, 1993, see p.15 and p.19.

⁸ Long, *Aboriginal Settlements*, pp.91-136.

One of the most significant people to affect governments and their policy formation and implementation was Archibald Meston. Meston was a journalist, civil servant and an explorer who was born in Scotland and came to Sydney with his parents in 1859. In 1874 he went to the Clarence River region of Queensland to manage a plantation. From 1875 to 1881 he was editor of the Ipswich Observer and represented the Rosewood electorate in the Queensland Legislative Assembly. Early interests in exploration lead him to conduct a survey into the Bellenden Ker Ranges where he found new plant species. In 1894 the colonial secretary commissioned him to 'prepare plans for improving the lot of Aborigines in Queensland.'⁹ The Queensland Legislative Assembly incorporated his research, and the recommendations on Aborigines, into the Aboriginal Protection Act of 1897. When the Act was implemented Meston was made a Protector of the Southern region of Queensland until 1903. More than anyone before Walter Roth, Meston took an interest in the well-being of Aborigines and travelled more extensively than most. Meston's impact on the policies of protection had a lasting effect on the operations of both government and mission protection agencies.¹⁰

Meston obtained information for his report he travelled along the coastal strip around the Cape and south to Normanton. Although he entered Carpentaria, he went no farther west and assumed that there

⁹ S.E. Stephens, 'Meston, Archibald', in Nairn and Serle, *ADB*, Vol. 5, pp.243-244 (this entry contains a corrigenda published in *ADB Index*, Vols 1-2, p.313, referred to 'Archibald Meston' file, *ADB*, RSSS, ANU, 1994); see also, Archibald Meston, 'Report on the Government Scientific Expedition to Bellenden Ker Range, 1889', in *Annual Report of the Department of Agriculture, Queensland, 1889-1890*; see also, Queensland Parliament, 'Report on the Aborigines of Queensland (by Special Commissioner, Archibald Meston), 1896 Queensland Legislative Assembly, Votes and Proceedings (QLAV&P), 1896, Vol. IV, pp.723-170; Archibald Meston, 'Report on the Aborigines of Queensland: Special Commissioner under instructions from the Queensland Government, to The Honourable Horace Tozer, Home Secretary', in *Queensland Legislative Assembly Votes and Proceeding*, 1896, Vol. IV, pp.723-740.

¹⁰ Long, *Aboriginal Settlements*, p.94.

were considerable numbers of Aborigines who had had little or no contact with whites and were still living their traditional lives in the thin wetland strip of the Gulf coastal region.¹¹ Meston's views were not new.

As Long later remarked,

[Meston's] inquiry marked the beginning of consistent government activity in this field and governments in Queensland have ever since followed administrative practices broadly in line with Meston's views....[And what this meant was that] the best thing ...[to do, in their view, was] ...to 'leave them alone'....Whites and others [Asian and South Sea Island mariners] had been disastrous and...[the remaining Aborigines]...should be collected up on to reserves and their total exclusion from towns...[thus ending] their unfettered liberty to roam around and mix with whites.¹²

Protection, in Meston's terms, therefore meant both attending to the health and welfare needs of Aborigines and to keep contact to a minimum by keeping bush people out of towns. But nobody knew how effective this would be because the government protectors had no idea of the size of the total Aboriginal population.

Populations in central and far western Queensland had only been estimated, and by 1900 Aboriginal 'remnants' in the southern areas around Brisbane and west to Blackall who had not been killed off or died from diseases, had taken up permanent residence on pastoral properties, ultimately vacating their traditional living places. They had been replaced as the dominant population, as a result of white settlers migrating south and west. The elimination of some Aborigines by native police played a part, but it must be remembered that this punitive force was both small and restricted to the Great Dividing Ranges and the coastal strip north from Brisbane to the Cairns region.¹³ In any event, the Aboriginal

¹¹ Meston, 'Meston Report', pp.1-14; see also, Walter E. Roth, Northern Protector Of Aborigines Queensland, 'Superstitions, Magic, And Medicine, North Queensland Ethnography', Bulletin No. 5, January 1903, pp.1-42.

¹² Long, *Aboriginal Settlements*, pp.94-95; see also, recommendations by Meston, 'Meston Report', pp.13-14.

¹³ G.W. Rusden, *History Of Australia*, 1897, Reissue of 2nd ed., Melbourne, 1908; see also,

population in 1900 could only be guessed at. As explained earlier, people of mixed descent were included in the census from 1901 and all other national censuses.¹⁴ As a result of the distorted means of estimating the total Aboriginal population census and State officials appeared to accept its decline from 26,670 to 17,967 during the study period.¹⁵

In 1900 the settler population, as estimated by the Registrar General, totalled 502,415 males and females. The Aboriginal population totalled 6,670, consisting of 3,862 males and 2,808 females. These estimates referred only to those people 'engaged in industrial pursuits, or as living in fixed abodes, and who had abandoned the nomadic...[environments] of the ordinary Aboriginal'.¹⁶ Many Aborigines of mixed descent were profoundly affected by the settler economies and acted as the settlers'

N. Loos, *Invasion and Resistance: Aboriginal-European Relations on the North Queensland Frontier 1861-1897*, ANU Press, Canberra, 1982, pp.22-27; see also, J.B. Gribble, *A Plea for the Aborigines of New South Wales*, Jerilderie, 1879; see also, Gribble, *Black but comely, or Glimpse of Aboriginal Life in Australia*, London c1884; see also, 'Report from the Commissioner appointed to Inquire into the Employment and Protection of the Aborigines in the District of Mackay, and Generally to Inquire into what steps can be taken to Ameliorate the Condition of Aborigines of Queensland', in QLAV&P, 1874; see also, 'Report on the North Queensland Aborigines and Native Police', in QLAV&P, no. CA, 10, 1897, this report paralleled the new Queensland Protection legislation of 1897; see also, F.A. Hagenauer, 'Notes of a Missionary Journey to North Queensland 1885', published with other material, 1885; see also, G.C. Bolton, *A Thousand Miles Away: A history of North Queensland to 1920*, 2nd impression, Canberra, 1970; see also, A Laurie, 'The Black War in Queensland', in *Royal Historical Society of Queensland Journal*, Vol. VI, no. 1, September 1959; see also, Rowley, *The Destruction*, Vol. I, pp.157-186; see also, Long, *Aboriginal Settlements*, pp.92-96; see also, Meston, 'Meston Report', pp.1-2.

¹⁴ *Commonwealth of Australia Constitution Act 1900*, (63 and 64 Victoria, c12), in John McCorquodale, *Aborigines And The Law: A Digest*, ASP, Canberra, 1987, p.3 and see p.9, and see also, reference p.201, to Geoffrey Sawer, 'The Australian Constitution and the Australian Aborigines', in the *Federal Law Review*, Vol. 2, 1966, pp.17-36; see also, J.A. La Nauze, *The Making Of The Australian Constitution*, Melbourne University Press, 1972, pp.67-68.; La Nauze agrees with both Smith, *The Aboriginal Population*, pp.20-21, and Geoffrey Sawer, 'The Australian Constitution', pp.17-36 (and I presume McCorquodale even though he does not consult La Nauze) when he says that, 'Although the origin of the section was a good deal more complicated than is implied by Geoffrey Sawer in his article...[quoted above] he is completely justified in holding that it had no relevance at all to the taking of the census'. La Nauze, as I explained in chapter 1, was correct to argue that, the cause of the problem lies in the section's location in the Constitution.

¹⁵ Lancaster Jones, *Structure of Aboriginal Population*, pp.2-13; see also, L.R. Smith, *Aboriginal Population*, pp.122-123; see also, Broom and Lancaster Jones, *A Blanket A Year*, pp.41-43.

¹⁶ J. Hughes, *The Queensland Official Year Book, 1901*, QGP, Brisbane, 1901, p.62.

labour force.

Pastoral settlement extended from Brisbane west to Dalby, Roma and Charleville, then north from Brisbane to Coen, west of Cairns, but remained south of the Cape York region.¹⁷ Attempts to both expand the Queensland colony to Cape York and Christianise Aborigines failed in the 1860s.¹⁸ With the abandonment of the outpost near the tip of Cape York at this time missionaries had to postpone the Christianisation of Aborigines in this region until the 1890s and later.¹⁹ As the Queensland settler economy and population grew, the need grew also for the Government to protect Aborigines rather than leave the State's interests in the hands of missionaries alone. Archibald Meston made himself an advocate for Aborigines, and the Government quickly seized upon his skills by employing him to make recommendations on how protection of Aborigines should proceed.

Meston saw illness experienced by Aborigines as a condition of starvation, ignorance and superstition. In 1900 he reported that

all the minor ailments afflicting European communities are met with among the Aboriginal population, though what with ignorance and superstition, want of proper care and nourishment...their effects are not easily... [removed]. At Cloncurry five deaths took place last October during the epidemic of a disease resembling measles, while at Urindangi, in April... thirteen deaths occurred from influenza and dysentery; in other cases, the rations

¹⁷ R. Fitzgerald, *From the Dreaming To 1915: A history of Queensland*, University of Queensland Press, 1982, pp. 16, 19, 136, 264 and 285; see also, Constable C. Petrie, *Tom Petrie's Reminiscences of Early Queensland Dating from 1837*, Brisbane: Watson Ferguson, 1904), pp.48-49, also quoted in Fitzgerald, *From Dreaming to 1915*, pp.16-19; see also, Marianne Ilbery, 'Pastoral Occupation of Back-Country in South-West Queensland', an unpublished Lit B. thesis, ANU, 1984.

¹⁸ Fitzgerald, *From Dreaming to 1915*, p.207; see also, Loos, *Invasion and Resistance*, pp.19-22; see also, F.J. Byerley, *Narrative of the Overland Expedition of the Messrs. Jardine of Rockhampton to Cape York, Northern Queensland*, Buxton, Brisbane, 1867; see also, Adrian Stevens, 'A Barren Promontory', the Failure of the Colonial Vision at Somerset, Cape York Peninsula, 1864-1877, BA (Hons) thesis, ANU, 1980, pp.73-85.

¹⁹ R. Fitzgerald, *From Dreaming to 1915*, p.190; see also, Colonial Office (CO) file, 234/12, Dispatch no. 41, notes of 5 July, 1865, quoted in A. Stevens, 'A Barren Promontory', p.51.

supplied assisted in saving many lives.²⁰

Wasting from tuberculosis and syphilis existed wherever he travelled. Of some relief to him were the pockets of the population who had escaped venereal complaints. Where it did exist, syphilis was made more infectious because of the lag between copulation and the emergence of the disease.²¹ Native tobacco (pituri)²² was another way Meston thought that syphilis was spread, from mouth to mouth as it was shared between one person and another. Treatment of syphilis was difficult, moreover, because as Meston wrote, 'the semi-civilised blacks take medicine neither constantly nor regularly',²³ and they sometimes drank the whole bottleful. If the sick person saw no cure within a short time Meston said that they regarded both doctor and medicine as 'no good'.²⁴ Local remedies were used by protectors and police, on the one hand, while on the other hand, Aborigines in the camps used sorcery and witchcraft.²⁵ So numerous were the cases of syphilis, and so 'foulsome' were the sufferers who roamed the district that Meston created a lock hospital about eight miles outside of Cooktown, 'where any such really bad cases could be treated'.²⁶

Although contradictory to the attitude he took in his earlier writings, Meston objected to diseased or sick Aborigines being indiscriminately collected up and 'removed to reserves'.²⁷ Meston

²⁰ W.E. Roth, 'Report Of The Northern Protector Of Aborigines For 1899', QLAV&P, Vol. V, Session 1900, pp.581-597.

²¹ *Ibid.*, p.10.

²² D.J. Mulvaney, *The Prehistory of Australia*, Penguin Books, 1975, p.111.

²³ Roth, 'Report, Northern Protector, 1899', p.10.

²⁴ *Ibid.*, pf.

²⁵ *Ibid.*, pf.

²⁶ *Ibid.*, pf; see also, QSA, A/58853, 'Venereal - Aboriginal General', see references to VD Camp at Cooktown in which these camps had by 1925 become institutions.

²⁷ *Ibid.*, pf.

believed this approach was not only objectionable as 'a matter of justice'²⁸ but also physically impossible due to the numbers of Aborigines with infections.²⁹ With those Aborigines infected with diseases and situated too far from medical attention, Meston encouraged police and local protectors to give relief, including rations and tobacco, 'and so help them make their last days on earth a little more bearable'.³⁰ Even in 1900, Government medical officers had the duty of attending to sick Aborigines. These doctors supplied medicines — paid for by the Queensland Government — to police, mission stations and anyone willing to take responsibility.

Meston was basically reacting to the way camps were unwittingly created as an alternative to placing Aborigines into hospitals.³¹ As a measure in part for his own convenience he created the Deebing Creek depot to put sick and diseased people in where he was then able to bring doctors to treat them rather than fight with hospital officials for beds. The problem with this solution was that once a place was created for sick Aborigines it soon became overcrowded. In any event, he was able to follow his own plans because of his diverse background.³² His forcefulness contrasted with his colleague Walter E. Roth, who was still a student in England when Meston was at the peak of his bush exploits.³³

Walter Roth, like Daisy Bates in Western Australia, was the first ethnographer to collect, from Aborigines, a wide range of customary

²⁸ *Ibid.*, pf

²⁹ *Ibid.*, pf.

³⁰ *Ibid.*, pf.

³¹ *Ibid.*, pf.

³² S.E. Stephens, 'Meston, Archibald', Nairn and Serle, *ADB*, Vol. 5, pp.243-244; see corrigenda published in *ADB Index*, Vols 1-2, p.313, referred to 'Archibald Meston' file, *ADB*, RSSS, ANU, 1994.

³³ Ian Howie Willis, 'Roth W.', in Horton, *Encyclopaedia of Aboriginal Australia*, pp.955-956.

beliefs about the pre-contact ideas of diseases and sicknesses. He was the first serious professional ethnographic researcher of ideas held by Aborigines about their notions of beliefs relating to diseases, sicknesses and wellness. He also made observations of these in a number of areas of Queensland. He dismissed the views of other public officials and sought scientific solutions to understand Aborigines. He tried to influence Parliament to adopt his view-point. His perspective was that of the new discipline of ethno-anthropology,³⁴ and in documenting traditional ideas on health, healing and sorcery he added to its body of knowledge.³⁵

Roth had studied at Oxford with Baldwin Spencer, who later became Professor of Biology at Melbourne University. They continued for a time as ethnographic colleagues after Roth came to Australia in the 1890s,³⁶ and Roth was still working on that aspect of Aboriginal life at the turn of the century. He described the belief that sorcerers through disease and accidents produced sickness in an enemy, and this doomed the victim beyond recovery. The person singled out had a fate inflicted from which it became impossible to escape. This superstition accounted for the difficulty in halting the spread of venereal disease, making medical treatment almost impossible because people could not see the linkage between causes and effects.³⁷ Roth took an interest in the terms his informants used in naming things and processes. For instance, some Aborigines in Queensland, Roth noted, believed that if victims healed too quickly the origin of the sorcery might not be revealed, and the

³⁴ D.J. Mulvaney and J.H. Calaby, *'So Much That Is New': Baldwin Spencer 1860-1929, A Biography*, Melbourne University Press, Melbourne, 1985, p.47, and pp.195-209.

³⁵ Walter E. Roth, 'North Queensland Ethnography: Bulletin No. 5, January 1903 entitled, Superstition, Magic, and Medicine', in Queensland Parliamentary Papers, CA 5, 1903, QGP, 1903, pp.1-42.

³⁶ Mulvaney and Calaby, *'So Much That Is New'*, p.182.

³⁷ Walter E. Roth, 'North Queensland Ethnography: Bulletin No. 5, January 1903 entitled, Superstition, Magic, and Medicine', in Queensland Parliamentary Papers, CA 5, 1903, QGP, 1903, p.29 (para 120).

individual doing the 'mischief' would escape. While this cannot be regarded as the fact of the situation, victims did pursue cures associated with sorcery. If they felt themselves getting weaker they would accept their fate, according to Roth.³⁸ Also, they believed that people who became the target of the sorcerer could be identified by their strange behaviour.³⁹

Superstitions played an important part in various strategies in combating malice, or inflicting death on the breaker of any custom.⁴⁰ Enemies doomed others to suffer accidents or illnesses throughout life, which could be inflicted either by living people or by the re-appearance of dead persons. Roth took the opportunity of discussing these matters with customary medicine-men, or doctors, but they were able to teach him only some of the mysteries of their craft.⁴¹

In most areas of Queensland Aborigines believed that these sorcerers held supernatural powers, the source of which came from the objects they carried in a small leather bag tied around their waists. They created a belief in the minds of their patients that they could alleviate nearly all aches and pains. Diseases of all kinds, whether observable or not, had only one name, 'turrwan'.⁴² Sorcerers, or doctors as Roth reluctantly called them, had a powerful position of influence throughout the north and north west no matter what methods they used. The whole group believed that the powers affected everyone, except other more powerful sorcerers. The sorcerer's power played an important role in beliefs about sicknesses and remedies, as did beliefs about the effect of events such as

³⁸ *Ibid.*, p.28 (para 114).

³⁹ *Ibid.*, p.28 (para 114).

⁴⁰ *Ibid.*, p.28 (para 114).

⁴¹ *Ibid.*, p.28 (para 115).

⁴² *Ibid.*, p.30 (para 121).

thunder and other natural outside agencies.⁴³

Roth went on to investigate the effects of types of infection, accidents and disobedience to certain rules or breaking 'tabus'. Breaking the sanctions of sorcery produced illnesses and suffering. Blindness, for example, was believed to result from disobedience to ceremonial practice rather than from infection.⁴⁴ Even children and other relatives could be implicated in another relative's illness if they ate the wrong foods, unwittingly causing some harmful action as an agent of the sorcerer.⁴⁵

Roth's research went some way towards explaining why European medicine could hinder rather than promote curative and preventive health in the face of competing belief systems. Aborigines, according to Roth, were unwilling and unable to reconcile their superstitions with the strange ideas of European medical science. Understanding Aboriginal beliefs was important in a professional sense for Roth and he focused his didactic approach on people like missionaries, protectors and policemen. All such people, he believed, should develop an understanding of Aborigines' view of life and the environment. Ideas of hygiene were even harder for Aborigines to assimilate, most probably because of the time lag between setting up a new dwelling place and the onset of infectious disease. The camps Roth saw everywhere were harbouring potential disasters.

Protectors occupied arbitral positions between Aboriginal labour and the property owners, who saw protectors as agents for Aborigines rather than as serving a public interest in scrutinising agreements drawn up under the 1897 legislation. By 1900, however, the weaknesses of that legislation's provisions for care of destitute, sick and aged people were

⁴³ *Ibid.*, p.30 (para 122).

⁴⁴ *Ibid.*, p.37 (para 150).

⁴⁵ *Ibid.*, p.37 (para 151).

obvious to Roth. He pushed for greater powers to be given to protectors to force land owners to comply with the agreements they made with Aborigines. The private property owners and pastoralists took every opportunity to complain. Roth believed that pastoralists, Chinese traders and foreign mariners were abusing the protection legislation. His main suggestion for amending the legislation was for the creation of a hierarchy of protectors, with a Senior Protector appointed to supervise a number of deputy protectors, all of whom would ultimately be answerable to the Chief Protector.

Roth proposed two means for controlling relationships between the pastoralists and Aborigines. Both involved the creation of registers. One register was to control Aboriginal labour relations, and the other was to record information about Aboriginal disease and mortality. The employment register allowed protectors to keep a record of all people employing Aborigines. It indicated which pastoralists had to renew their agreements with Aborigines each year. New restrictions were imposed on the amount of time land owners and merchants could employ Aborigines or remove them from the protection of the State. Employers had to record in the register all transactions such as wages paid to Aboriginal male and female employees such as payments for special conditions and gifts of rations. Each employer had to fill out forms of all articles such as blankets given to Aboriginal workers and their families. Employers had to account for any new agreements they made with Aboriginal contracted labour on special forms. Police, and protectors, were given wider powers to over-ride the authority of local hospital staff and their managing committees in order to force them to give access to sick and diseased Aborigines. Indentured Aborigines had health accounts covered by graziers. The previous legislation contained only a few clauses

for protecting individuals, and it had lacked real power to redress the harsh treatment applied to Aboriginal workers.

The new Aborigines Protection legislation made a number of health reforms.⁴⁶ The new legislation forced protectors and health officials to record all Aboriginal deaths and all their deaths from infectious diseases in an official register. Nowhere in Australia in 1901 was there a system for keeping track of the number of Aborigines who had died from natural causes, injury at work or infectious diseases such as measles and respiratory infections. Similarly, death from violence in the camps or at the hands of Chinese, Kanaka or white settlers went unrecorded. Protectors were required to file annual returns but had no legislative powers to compel employers, missionaries or mining and market gardeners to report Aboriginal deaths and the causes of deaths. Roth's proposals were put forward as a way to correct that discrepancy.

Legislative powers already existed in the 1897 protection legislation and although Parliament accepted suggestions to tighten employment relations they failed to legislate additional funds to implement Roth's suggestions for monitoring Aboriginal mortality and disease. The amendments which were legislated, did two things. They made administrative changes to centralise the population and gave protection to Aborigines throughout the whole of western and northern Queensland. The additional protectors provided more information on what was occurring at a distance from Brisbane. Protectors reported more fully on the needs facing Aborigines and on what they believed was necessary to remedy the problems. Protector Quilter's annual report of 1900 to Home Secretary Tozer, for example, advised that in his district of Cloncurry there were several camps with a total of seventy-one

⁴⁶ Long, *Aboriginal Settlements*, pp.95-96; see also, Dawn May, *Aboriginal Labour*, pp.67-76.

Aborigines (thirty-nine males and thirty-two females) of whom twenty-one were under agreement.⁴⁷

There were also eleven under agreement at Cork and Brighton Downs.⁴⁸ There were signs of widespread destitution that protectors wanted to treat, and they now had the responsibility. Power to feed and protect starving, sick and destitute Aborigines now existed, even if the attitudes of some isolated protectors remained unchanged. Protector Quilter issued rations and blankets, for example, but he wrote that he refused to issue some Aborigines with such items because he believed 'that they would come to expect it'.⁴⁹ The reforms brought greater relief to Aborigines in the old pastoral regions of the west and the newly settled areas of the Cape and Gulf regions, and also gave support to missions which concentrated on teaching children to read, write and count.⁵⁰

At the same time, the new powers enabled people to be moved from the fringes of western country towns, and in 1901, about 401 males and females were removed from fringe camps to ration depots near Brisbane: the latter were Durundur, 30 kilometres from Caboolture, and Deebing Creek, 10 kilometres north of Ipswich. Camp people were not the only ones to be moved to eastern relief depots. Police sent those Aborigines arrested for petty crimes into the custody of the Southern Protector, Meston. The largest groups of Aborigines forcibly removed numbered between 33 and 63. Some of the people removed suffered from alcoholism, some were lame, crippled or paralysed, blind, old and infirm.

⁴⁷ QSA, A/44681, 'Northern Protectors of Aborigines Miscellaneous Correspondence', dated 20/9/1894, pp.1-2; see also, QSA, A/58986 - 'Register of Act, 1897-1934'. This is a book in which copies of legislation, regulations and amendments are pasted, see folios 1-109, see in particular, folios 77-99.

⁴⁸ *Ibid.*, 'Northern Protectors of Aborigines Miscellaneous Correspondence', in QSA, A/44681, dated 20/9/1894, pp.3-4.

⁴⁹ *Ibid.*, p.2.

⁵⁰ *Ibid.*, pf.

Some people had been fed for some years and needed medical attention.⁵¹

Following the legislative changes, a protector reported to Meston that

medical treatment was arranged and medicines sent for sick Aborigines in various parts of the West. I sent one packet of medicine to the care of Sergeant O'Connor, at Boulia, in the far North West. Blacks whose ailments... [could not be treated were] removed to the coast, where they could be treated properly. These include four blind Aborigines and three permanent cripples.⁵²

The new legislation did little to benefit fringe-camp Aborigines in western parts of the State, particularly dependent sick and ageing individuals. Although many suffered sickness and the effects of aging, police protectors moved people eastward to ration depots simply to force them out of the area rather than because they were disabled.⁵³

Protection thus became an excuse for moving people across the State. The usual justification was that Aborigines had to be protected from the ravages of white settlement and from themselves.⁵⁴ Aboriginal belief, built on traditional customs and attitudes, proved unable to cope with the change. It failed to convey an understanding of the adjustments needed when moving from one form of dwelling place to another, including the need for hygiene when living permanently on one small area of land. Settlers were not able to see what was happening and could not appreciate that crowded and polluted dwelling places created conditions for the rapid transmission of illnesses such as respiratory diseases. It was almost inevitable that, as Roth observed, there would be an increase in the number of

people dying from the disease. The cause, [which] could be put down to the fact that whenever a person has died here from the effects

⁵¹ A. Meston, 'Report Of The Southern Protector, Annual Report, 1902', p.2, in QPV&P, Vol. I, pp.1175-1180, QGP, Brisbane, 1902.

⁵² *Ibid.*, p.3.

⁵³ *Ibid.*, pp.3-4.

⁵⁴ Fitzgerald, *From Dreaming to 1915*, pp.204-262; see also, Rowley, *The Destruction*, pp.246-249; see also, Long, *Aboriginal Settlements*, pp.95-116.

of...disease, [it was] noticed that one or more of the relatives attending to the sick person ...[had] very soon fallen victim themselves.⁵⁵

Roth went on to say that consumption accounted for eleven deaths in 1901, three of the women being wives of the same man. At Yarrabah, four people died from tuberculosis, making an accumulated total of 24 deaths between 1893 and 1901. While representing only about three deaths each year, it was a sign that concentrated living in larger groups aided its spread. Many of these people according to Reverend Gribble, were near death on arrival at the mission.⁵⁶ Tuberculosis killed Aborigines in numbers, and by 1902 appeared to be endemic.⁵⁷

Sedentary living increased the infectious pool for adults, but even more for children. Children suffered in almost all locations in which Aborigines lived, as the Chief Protector reported to his Minister when he advised that many Aboriginal children were suffering from syphilis. The dilemma Roth faced in providing health care was that he lacked the legislative power to act. This remained a difficult issue. For example, Topsy, 'a little girl, twelve years of age, from Magoura Station, suffered with syphilis. The station owner brought her to Normanton where [she was] joined by her sister in the local camp'.⁵⁸ Roth reluctantly sent the children directly to Mapoon mission. His report to the Minister indicated

⁵⁵ 'Report of Northern Protector, 1901', QPV&P, 1901, pp.10-13.

⁵⁶ *Ibid.*, pp.16-18; see also, Walter E. Roth, 'North Queensland Ethnography: Bulletin No. 5, January 1903 entitled, Superstition, Magic, and Medicine', in Queensland Parliamentary Papers, CA 5, 1903, QGP, 1903; see also, QSA, A/19898/9, 1898-1903, W.E. Roth, 'Scientific Report On The Natives of the (lower) Tulley River', and these documents are his field notes, in particular, see notes on superstitions and medicine, in Part 48-56.III, and pp.7-14; see also, 'Northern Protector Aborigines, 1901', QPV&P, 1901, pp.9-10; see also, Queensland Parliamentary Votes and Proceeding, QPV&P, 'Statistics Of Queensland', QGP, 1901, p.397; see also, A. Meston, 'Report of the Southern Protector Of Aborigines', QPV&P, CA, 80, 1902, QGP, Brisbane, 1902, pp.1-3.

⁵⁷ Queensland Parliamentary Papers, *Annual Report Of The Protector Of Aborigines For 1901*, QGP, Brisbane, 1901, CA 61, 1902, pp.1-19.

⁵⁸ W.E. Roth, *Annual Report Of The Northern Protector Of Aborigines For 1902*, QPV&P, CA 6-1903, QGP, Brisbane, 1903, p.13.

that he asked Protector Galbraith to

report as to the ability of the sister to provide Topsy's wants....[Roth explained to the Minister about how he] did not care to trespass too much on the kindness of the Mapoon Mission people, to whom we have already sent diseased half-caste children; and if, ultimately, it may be desirable to send her there, I think it only fair that the Superintendent be consulted beforehand.⁵⁹

At the same time many people from Thursday Island were reported suffering from syphilis. They presented with numerous leg and body ulcers and were taken to the mainland for treatment. On those mainland mission stations seven

cases of ankylostomiasis existed...and a few deaths from phthisis had occurred. In the Gulf missions tubercular and venereal diseases have claimed a few victims.⁶⁰

Tuberculosis, (or sometimes diagnosed as 'phthisis', a pulmonary complaint), was a society-wide concern and Roth tried to broaden the public interest in the disease.

As the Chief Protector Roth wrote to the Society for the Prevention of Consumption to ask for help. He gave a general description of the disease among Aborigines living on missions in the Cape York region.⁶¹ He met with Dr Hirschfield to discuss the large numbers of Aborigines who were contracting the disease on the Bêche-de-mer boats. 'Phthisis', or some similar pulmonary disease, was widespread in the area and Hirschfield sent printed material to the various missions to advise how lay missionaries could diagnose, treat and carry out surveillance of the disease. Tuberculosis sufferers went to the same camps as people with venereal and other infectious diseases. The Cooktown and Cloncurry hospitals refused to treat patients diagnosed as carriers of venereal diseases. As a result, many people suffering from other maladies where

⁵⁹ *Ibid.*, p.13.

⁶⁰ *Ibid.*, p.17.

⁶¹ *Ibid.*, p.14.

wasting was obvious, were also refused entry,⁶² and were forced to remain in camps nearby.

These camps were encouraged by hospital medical officers. Camps like these acted as infectious pools and they retained diseased people of all kinds. Aborigines of full- and mixed- descent came from missions and pastoral properties looking for medical care. They stayed for long periods of time at the depots, or bush camps, waiting for follow-up medical attention. People suffering from sexually transmitted diseases lived crowded together, with pregnant females frequently among them. These circumstances intensified the dangers of these living sites. Protector Galbraith complained that

[from] all parts of the district comes the same tale: venereal and ophthalmia....[The sick are held in] outside places away from civilisation...there is...[no] freedom from disease. There is no way of combating this evil, except by quarantine: to point out my reasons for same would only mean reiterating your arguments to bring forward facts that you are obviously acquainted with.⁶³

There were probably many deaths from disease at stations like Yarrabah (on Cape Grafton near Cairns), Mapoon (on the Batavia River), Weipa (on the Embley River), and Hope Valley (Cape Bedford near Cooktown), but there was no legal requirement to record them.

In 1902, Roth wrote to the Registrar-General's Department seeking information on the prospect of recording Aboriginal deaths. The Registrar-General replied that 'births and deaths of full-blooded aborigines are not registered, whether residents at mission stations or elsewhere.'⁶⁴ Births of half-castes, he added, 'are registered only when

⁶² Chief Protector Of Aborigines, *Annual Report, QV&P, 1901-1904*; see also, QSA, A/58853, 'Venereal - Aboriginal General', see notes under Aboriginal VD Camps, - Cooktown which go back to turn of century; see also, QSA, A/44681, 'Chief Protector's Corro', see Dr Roth's Progress Reports 1904-1906.

⁶³ Roth, 'Northern Protector Aborigines, 1902', p.14.

⁶⁴ *Ibid.*, p.17.

certified to by the white parent, and the matter of civilisation would be considered when deciding whether or not the death of a half-caste should be registered.’⁶⁵ This view of the proper ambit of registration complicated the question of who was responsible for protection and who could be protected. Similarly, it confused people in those bodies operating ration depots, and isolated missionaries engaged in protection. In addition, because protection agents had difficulty sometimes in determining who was regarded as an Aborigine, protection policy became confused about putting it into practice.

Sickness among Aborigines in 1904 did concern the Chief Protector but cost was a constraint. Hospitals needed to cover the costs of servicing the sick but the Chief Protector had to justify expenditure on relief and health care to the Queensland Parliament. Hospitals had the responsibility of treating sick Queenslanders, but only those paying for the service. On this matter, Roth reported to the Minister that ‘a letter had been sent to the Cloncurry and Cooktown Hospitals about the department refusing to pay charges for Aboriginal paupers. Aborigines classified as not in legal employment had the right to claim pauperism.’⁶⁶ Aborigines employed under the Aborigines protection legislation, however, had legal cover through their employers. Those living on protection stations, reserves, camps and missions had no legal health cover. What normally happened during epidemics, such as occurred in 1904, was that ‘the fever-stricken blacks’⁶⁷ at Cape York, relied almost solely on the compassion of Protector Bennett, who ‘sent across rations

⁶⁵ *Ibid.*, pf.

⁶⁶ W.E. Roth, *Annual Report Of The Chief Protector Of Aborigines For 1903*, in QPV&P, CA 45-1904, QGP, Brisbane, 1904, p.15.

⁶⁷ *Ibid.*, pf.

and medicine'⁶⁸ despite which some men died.⁶⁹ Thus, in 1904 missionaries living on remote settlements and caring for sick Aborigines, had to rely on the generosity of protectors whenever epidemics occurred, or whenever they suffered injuries from accidents.

Access and medical costs were a dilemma for health workers. Doctors had discretion in accepting sick Aborigines as patients. When Aborigines came to doctors' surgeries claiming to be paupers, the doctors redirected them to hospitals. They either received immediate attention there or were despatched to government relief depots or bush fringe-camps to await follow-up treatment. Some were refused treatment altogether. In 1904, for example, the Rev. Gribble, the Superintendent of Yarrabah Mission, wrote to the Chief Protector asking if the Cairns hospital 'had the right to refuse entry' to Aborigines.⁷⁰ Gribble was told that 'the matter was entirely in the hands of the various hospital committees.'⁷¹ Gribble's intervention was prompted by Dr Browning of Taroom who charged high fees. Those Aborigines who could not pay the doctor went to the Cairns hospital which might also refuse them treatment. They were then forced either to go back to the doctor or simply miss out on treatment. Although no information exists on the treatment prescribed in this case, Dr Browning treated the patient and sent the bills to Gribble, who forwarded the accounts to the Chief Protector. One bill sent to the Chief Protector was for £20.0.0 for a sick female Aborigine named 'Sissey Queenslander'. Browning later reduced the fee to £10.5.0.⁷²

⁶⁸ *Ibid.*, pf.

⁶⁹ *Ibid.*, pf.

⁷⁰ QSA, series A/44681, 'Chief Protector of Aborigines Corro' file, dated September 1904, (no folio numbers marked).

⁷¹ *Ibid.*, see letter from Gribble relating to complaints about hospital at Cairns; see also, QSA, A/44681, see letter dated September 1904, from Reverend Gribble about Hospital at Cairns.

⁷² *Ibid.*, pf.

Roth had to battle with hospitals to open them up to sick Aborigines and he also had running battles with hospitals who sought payment for servicing Aborigines. The most disturbing of these incidents were those where hospitals staff exercised their discretion to refuse sick Aborigines access to country hospitals. Sometimes sick Aborigines were simply left at hospitals. They might be turned away but if the illness was serious they might be admitted and their accounts forwarded to the Chief Protector. The Chief Protector then had to decide either to dismiss the request to pay the bill. Roth reported to his Minister that he had refused to certify the voucher tendered by a medical officer because 'a pauper native, with a fractured arm'⁷³ had been admitted into the subsidised government hospital at Boulia.⁷⁴ The practice, and expectation, was that government-subsidised hospitals gave sick Aborigines free services. This custom, however, was not always followed, partly because of the difficulty of hospital staff having to decide who was an Aborigine, and partly because many of those people classified as Aborigines by protectors and hospital staff might not accept such categorisation.⁷⁵

The following year Roth returned from conducting a Royal Commission into the conditions of Aborigines in Western Australia. The Member for Cook in the Queensland Legislative Assembly, John H. Hargreaves,⁷⁶ raised complaints about Roth in parliament. He alleged that F.T. Briggs, a local landowner and constituent of Cook electorate, made a statement to him that 'the protector refused to attend a

⁷³ Roth, 'Annual Report of Protector', 1904, p.12; see also, QSA, A/44681, 'Chief Protector's Corro', see memo from Home Department to Chief Protector in July 1904.

⁷⁴ *Ibid.*, QSA, A/44681, 'Chief Protector's Corro', pf.

⁷⁵ C.D. Rowley, 'Who Is An Aborigine?', in Rowley, *The Destruction*, pp.341-364; see also, Lancaster Jones, *Structure of Aboriginal Population*, pp.6-13; see also, Broom and Lancaster Jones, *A Blanket A Year*, pp.1-12; see also, Long, *Aboriginal Settlements*, pp.1-13.

⁷⁶ D.B. Waterson, *A Biographical Register of Queensland Parliament 1860-1929*, Australian National University Press, 1972, p.81.

blackfellow who was seriously ill'.⁷⁷ Briggs further accused Roth of not acting 'when requested to do so by the landlord of Gregory Downs Hotel'.⁷⁸ In the same debate, the member for Carpentaria, James Forsyth,⁷⁹ made other complaints about Roth.⁸⁰ Forsyth, the Member for Carpentaria,

criticised the actions of the Protector in connection with the removal of a half-caste boy named Harry from Lawn Hill Station to Mapoon, and [Forsyth] also stated that the Protector declined to visit a girl at Burketown who was ill.⁸¹

Other politicians complained about Roth in his last years of tenure. The Member for Clermont, for example, accused Roth of removing a number of ethnographic specimens from an Aboriginal camp in his electorate.⁸² Roth was further criticised for selling the material to the Sydney Museum, retaining the proceeds of the sale. Roth denied the charges and indicated that any payment from Sydney went direct to camp people.⁸³ As Protector Roth felt a duty to intervene in these exchange transactions as a way of protecting Aborigines from exploitation, which the legislation he controlled was meant to prevent. Both land and labour interests, therefore, conspired to restrict his power and ultimately remove him from the position of authority.

Nevertheless, Roth survived these political attacks, but had to contend with some administrative problems of his own making. He

⁷⁷ QSA, A/44681, 'Chief Protector's Corro', May 1904.

⁷⁸ See Queensland Legislative Assembly (QLA), *Hansard*, debates in 'Committee on the Estimates', dated 25 October, 1905, pp.1335-1340.

⁷⁹ Watson, 'Biographical Register Queensland', p.62.

⁸⁰ See memo 'Hargreaves to Chief Protector', in Department of Public Lands, QSA, A/44681, 'Chief Protector's Corro', 1905.

⁸¹ *Ibid.*, pf.

⁸² Serle, *ADB*, Vol. 11, pp.463-464; see also, QSA, A/44681, 'Chief Protector's Corro', see memos from the Honourable Member for Clermont about complaints against Roth for removing artifacts and despatching them to the Sydney Museum, dated 2.11.1905.

⁸³ QSA, A/44681, 'Chief Protector's Corro', *Ibid.*, pf.

reported that on a visit to Barambah he had noticed a number of sick natives with skin diseases. Also, one woman suffered from 'a fallen womb, a source of great pain to her.'⁸⁴ Similarly, there was a

man with sores on his neck, face and body and there were some suffering from venereal disease. A number of cases were pitiful and the distress of the parents over the illness of their children was painful to witness.⁸⁵

Roth tried to arrange for a doctor and the Government Medical Officer to visit the relief depots. He said that the present arrangement was to send sick natives to Maryborough hospital — an expensive and unsatisfactory option which was pursued only when cases became critical and other people in the camps became infected.⁸⁶ In September 1906 Roth retired because of illness, but before he did so Samuel Lipscombe, the Superintendent of Barambah relief depot, complained to him that he had not sent the medicines promised a month earlier to service the relief depots under his responsibilities as a protector. Lipscombe, wrote that he needed the medication urgently because 12 patients under his care were suffering from syphilis.⁸⁷

By December 1906 Roth had resigned and his more humanitarian approach was superseded by a less enlightened administration. As indicated Roth tended to leave people with incurable infections close to their homes. The new administration took a different view as the Protector's Office renewed its interest in two aspects of Aboriginal life which became a continuing source of concern — venereal disease and the increased number of hunting dogs in the camps. Richard B. Howard, the

⁸⁴ *Ibid.*, pf.

⁸⁵ QSA, A/58676, 'Sickness - Barambah Complaints, 1906', see 'letter from Roth to Superintendent Samuel Lipscombe of Barambah, reporting a number of illness, 10.10.1906.

⁸⁶ *Ibid.*, pf.

⁸⁷ *Ibid.*, see 'memo from Superintendent at Aboriginal Settlement Barambah, to Chief Protector, dated 26.9.1906.

Acting Chief Protector, wrote to Lipscombe indicating that the 'natives' known to be suffering from venereal disease 'must at once be removed to a camp in one place at a distance from all other natives.'⁸⁸ Howard suggested that a building be erected away from the general depot population and 'enclosed in a fence of several barb wires with a proper gate and lock. A building of say [three metres] by [six metres] would perhaps be sufficient in which to house the incurables.'⁸⁹ A further suggestion was that another hut be built outside this compound for people with other illnesses.⁹⁰ Further, two Aborigines from the depot should be selected to act as supervisors, keeping patients in and other depot residents out. The gates, Howard suggested, would be locked each evening and those people coming and going had to be scrutinised thoroughly.⁹¹ This was the very first of a type of specialised construction which Howard referred to as "The Hospital". Before the construction of disease compounds, these structures were used to segregate diseased Aborigines from other inmates, and were the only specialised buildings constructed for the care of sick Aborigines. Such building could only be found on government and mission relief depots.

When Aborigines were brought to these relief depots they migrated with their own camp dogs. As many dog-owners succumbed to their illnesses the depots became overpopulated with dogs. Roth had allowed inmates to keep their dogs for protection, hunting and for warmth on cold nights, and he had encouraged people to camp behind the shelter of branches, or windbreak, in their traditional way. When Roth retired, officers of the Chief Protector's Office moved to clear all dogs away from

⁸⁸ *Ibid.*, pf, see 'memo from Richard B. Howard, Chief Protector Of Aborigines, dated 8 December, 1906'.

⁸⁹ *Ibid.*, pf.

⁹⁰ *Ibid.*, pf.

⁹¹ *Ibid.*, pf.

government depots. He then wrote to Lipscombe on 8 December 1906 asking him to 'destroy all diseased and useless dogs.'⁹² Such action by protectors was justified on the grounds that domestic dogs harboured parasites which complicated other ailments. It was mostly the children and women who suffered as a result of campsite infestations. Camp dogs also bred out of control but they were important in helping catch kangaroos, a staple bush food for Aborigines. Moreover, campsites in isolated locations, sometimes at long distances from homesteads and towns, were subject to attack either by other blacks or by white settlers, and the dogs offered some protection. They served to warn camp occupants when outsiders approached, and could attack unwelcome visitors. Howard's order for the destruction of the dogs caused deep concern, and disrupted depot peoples' lives for a long time to come. Harsher, and more authoritarian, management was to follow.

The earlier idealism of protecting Aborigines faded. It was replaced by a new utilitarianism: politicians and even Church leaders and protectors thought that the State protection policy would produce large numbers of Aboriginal labourers thereby ensuring that white settlers would support the policy. Aborigines, they hoped, would replace Pacific Island labour. These plans failed miserably.⁹³ Sickness and disease destroyed the dream as large numbers of sick Aborigines created their own pools of infection in the depots of the eastern seaboard.

Diseases such as venereal disease and tuberculosis became common complaints, and thereafter, leprosy (see Table 10.2 in Appendix 10) began to increase among their numbers. Leprosy was not endemic among Aborigines of Queensland in either pre- or post-contact groupings⁹⁴ until

⁹² *Ibid.*, pf, see 'memo: notice of destruction of Black's dogs', dated 8 December, 1906.

⁹³ Loos, *Invasion and Resistance*, pp171-182.

⁹⁴ J.A. Ashburton-Thompson, 'contribution to the history of leprosy in Australia', in *Prize*

the 1930s, and the first Queensland case appeared in 1868 among indentured Kanaka labourers from Melanesia and Fiji.⁹⁵ Reports of infected Aborigines came during the 1890s.⁹⁶ For example, Roth noted the existence of the disease when he wrote in 1899 that, 'during the past twelve months two Aboriginal lepers have been discovered — a male on the Pennefather River, and a female at Georgetown.'⁹⁷ The first record of a medical identification came in the first decade of the twentieth century the source of which was unknown.⁹⁸

Notwithstanding the confusion of the causes and effects of leprosy on the indigenous population during the period from 1895 to 1900, Aborigines in regional districts did become infected with leprosy. For example, two came from Etheridge, five from Cape York Peninsula, and one each from the Ingham, Innisfail and Rockhampton regions. The total fell to seven in the period 1900 to 1905, but rose sharply to 22 in the period 1905 to 1910. In this latter period most lepers came from areas in central and northern Queensland. Leprosy was spreading among Aborigines but the spread was slow due partly to government intervention. In part also, it was due to the relatively small number of Aborigines living on mission and government depots for any length of time. From 1895 to 1900, only one leprosy case came from Cunnamulla; from 1900 to 1905, single leprosy patients came from Mackay, Ayr and Cunnamulla. From 1905 to 1910, only one patient from the southern Queensland region

essays on leprosy, Vol. CLXII, The New Sydenham Society, London, 1897. See also, Basedow, 'Diseases in Aborigines', pp.193-198.

⁹⁵ G.H. Ree, 'Pattern of leprosy in Queensland, Australia, 1855-1990', in *Leprosy Review*, Vol. 62, 1991, pp.420-430. Cited in W.J. Britton and J.C. Hargrave, 'Leprosy in the tropics and Australia', *MJA*, Vol. 159, 6 September 1993, pp.326-330; see also, J.H.L. Cumpston, 'Leprosy', in Lewis, *Cumpston, Health and Disease*, pp.210-211; see also, Deryck Scarr, *Fragments Of Empire: A History Of The Western Pacific High Commission 1877-1914*, p.137, and see, pp.219-249.

⁹⁶ See, 'Leprosy in Queensland', p.420; see also, Cumpston, 'Leprosy', p.211.

⁹⁷ Roth, 'Report, Northern Protector, 1899', p.1-11.

⁹⁸ Britton and Hargrave, 'Leprosy in the tropics and Australia', p.327.

presented and that patient came from Moreton Bay.

In Queensland the health authorities began to deal with leprosy infection in the Kanaka labour force,⁹⁹ from which it spread to Aborigines. As the condition first became obvious among plantation workers and Aborigines, parliament amended the legislation on infectious diseases to make leprosy a notifiable disease, but made the mistake of doing so only in urban areas. The legislation, therefore, failed to halt infestations expanding to and within isolated Aboriginal settlements. In any event, there was no regulatory body to compel the detention of infected people.¹⁰⁰ The records of leprosy infection in Queensland identified people by sex and disease but not by race. It is possible, therefore, to use regional leprosy prevalence figures extracted from Cecil Cook's Queensland study. It should be noted, however, that the data used are only approximations. It is known that by 1895, 82 people were infected in Queensland with one form of leprosy or another. A slight fall occurred in the period to 1905, but because more Aborigines were presenting with leprosy the figure rose to 84 persons by 1910.

The Chief Protector reported a high level of cooperation from other government officials in tackling leprosy. In 1904 the Department of Home Affairs reported that the protectors 'had no legal power to deal with a wife of a suspected leper, Sam Weegeegan.'¹⁰¹ The man was a South Sea Islander from Buderim Mountain, and the Chief Protector suggested that he be dealt with under the *Leprosy Act, 1894*, rather than the Aborigines

⁹⁹ For information on Kanaka and Torres Strait Islander data see, Kay Saunders, *Workers in Bondage: The origins and Bases of Unfree Labour in Queensland 1824-1916*, University of Queensland Press, 1982. See also, Queensland Government Parliamentary Papers, Reports On Protector of Torres Strait Island, in QPP, 1900 to 1910. In these annual reports may be found extensive background on Queensland Government activities in Torres Straits, which had separate legislation from protection legislation for Aborigines.

¹⁰⁰ Lewis, *Cumpston, Health and Disease*, pp.218-219.

¹⁰¹ Roth's Progress Report – 4th July 1904, Chief Protector's Corro' (no folios provided).

protection legislation. 'Subsequently, if necessary a home could be found for the gin and child.'¹⁰² The Goonda Asylum received the man, following his transfer from Georgetown on 4 July 1904. The responsibility for caring for the wives and children of non-white patients, it was almost always assumed, fell on the Queensland Government. In another instance Walter Roth wrote in May 1904 that owing to the death of 'a gin 'Dolly' during her confinement at Oakley Creek, Constable Kenny of eight mile native police camp, Cooktown, had to bring up the twins by bottle.'¹⁰³ Due to the policeman's display of humanity towards these children, Roth expressed his appreciation directly to the Police Commissioner. At the same time, he indicated that rations were allowed to be distributed to sick Hector and his Gin in the Roma camp because of their condition and Mr O'Brien, the local protector, sent medicines to this camp and over to the sick blacks at Red Island.¹⁰⁴ Leprosy and venereal disease infections were on the rise, possibly due to the naivety of protectors and hospital staff who were unable to diagnose the disease. Aborigines who harboured the infection were left in camps near urban country towns, and the mission system was so isolated that they were more or less left to their own devices. In Kanaka and European cane cutting labour camps and in Aboriginal fringe-camps, exotic diseases persisted after they had disappeared in the rest of the community.¹⁰⁵

The institution most responsible for keeping Australian society disease free was the Australian Institute of Tropical Medicine. It must have been easier to keep under control, or to prevent, exotic infections entering Australia, and in particular, the northern regions of

¹⁰² *Ibid.*, pf.

¹⁰³ *Ibid.*, 'Roth's Progress Report', May 1904'.

¹⁰⁴ *Ibid.*, pf.

¹⁰⁵ Goldsmid, *The Deadly Legacy*, 55-74. See also, Evans, Saunders and Cronin, *Exclusion, Exploitation and Extermination*.

Australia.¹⁰⁶ This organisation came under the administrative umbrella of the Sydney University, and quarantine and public health considerations lay behind its creation.¹⁰⁷ Townsville became the site for the Institute and it soon developed an interest in the Northern Territory and Papua New Guinea. The Institute depended on public subscriptions for financial survival and focused on malaria and tropical diseases relating to quarantine rather than on venereal disease and leprosy in the labouring and Aboriginal fringe-camp groups of Queensland. The Institute did little to help sick and diseased Aborigines gain access to hospital, or to focus its research on Aboriginal public health dilemmas.¹⁰⁸

The devastating effects of public health on Aborigines, mostly associated with the adoption of camp living, remained little understood or studied, and were simply observed from a distance. Fear of disease occupied the minds of some people with an interest in northern development and there were those who feared that white settlers could not settle the northern and inland reaches of a vast vacant land.¹⁰⁹ For the most part the Institute did little besides promoting the scientific discipline of public health in Australia.¹¹⁰ The reluctance of health officials to treat people with venereal diseases as sick people or deserving indigents, rather than simply as undeserving Aborigines, was a barrier not only to disease care but also to effective disease control.

¹⁰⁶ Lewis, *Cumpston, Health and Disease*, pp.11-15.

¹⁰⁷ QSA, A/5070, 'Influenza - 1919-1923', see letter from Colonial Office, Lord Crewe to Bishop of Carpentaria, dated 16 December 1908.

¹⁰⁸ Ralph Doherty, 'Australia's contribution to tropic health: past and present', in *MJA*, Vol. 158, 19 April 1993, pp.552-556.

¹⁰⁹ Gillespie, *The Price of Health*, pp.34-35; see also, R.W. Cilento, 'White Settlement in the Tropics', in P.D. Phillips and G.L. Wood, *The Peopling Of Australia*, Melbourne, 1928, pp.230-131, cited in Gillespie, *The Price of Health*, p.35.; see also, R.W. Cilento, *The White Man in the Tropics*, Commonwealth Department of Health Publication (Tropical Division), No. 7, 1925, cited in Gillespie, *The Price of Health*, p.35.

¹¹⁰ Gillespie, *The Price of Health*, pp.41-42; see also, Ralph Doherty, 'Tropical Health: Australia's contribution to tropical health; past and present', *MJA*, Vol. 158, 19 April 1993, pp.552-557.

Except perhaps for the lock-up hospitals the general health system was not able to administer health care to Aborigines.¹¹¹ The regional hospitals, as the records reflect, were operated only with settlers in mind. And it is probable that Aborigines made up the larger number of inmates in the lock hospitals, to which protectors sent Aboriginal women from all over the state.¹¹² The first lock hospital was located in Brisbane in the mid-nineteenth century, but because records of Aborigines sent to it were haphazard, the number treated there is unknown.¹¹³ Many of those who ended up there were probably prostitutes, because police records attest that various Aboriginal women were engaged in prostitution in the period from 1900-10, and even earlier.¹¹⁴

Aboriginal prostitutes who harboured venereal infections were moved first to the southern ration depots such Barambah, Taroom and Duaringa. With a large number of diseased Aboriginal prostitutes congregated at these institutions, the Government was forced to increase the number of depots. Although it was difficult to screen for sexually transmitted diseases in prostitutes, the existence of the disease in their number was a sufficient excuse to move them away from northern towns and into southern depots. At the same time, the growing incidence of

¹¹¹ Kay Saunders, *Workers in Bondage*, pp.90-110. See also, Dawn May, *Aboriginal Labour*, pp.140-141.

¹¹² Meston, Southern Protectors Reports, 1897-1903; see also, QSA, A/19899, 'Report Commissioner Of Police to W.E. Roth, re Condition and Disease' (on microfilm); see also, A/44681, 'Northern Protector, of Aborigines, Miscellaneous Corr'; see also, QSA, A/44764, 'Medical Examination of Patients in Custody'; see also, QSA, A/44832, 'Conveyance of (1) Sick and Indigents (2) Destitute Persons (3) Unemployed: 1893-1959', see also, memos by District police in rural areas and travel vouchers and disputes over same.

¹¹³ Lewis, *Cumpston, Health and Disease*, pp.256-262, leprosy was the only disease, up to 1910, recorded by races, and only on an *ad.hoc.* basis.

¹¹⁴ Kay Saunders, *Workers in Bondage*, pp.99-110; see also, Dr Roth, in his *Annual Report 1900*, hinted that hospital Committees had refused services to Aborigines suffering from diseases; see also, Kay Saunders who cites Police letter books which reveal that police complained to the Chief Protector for Aborigines about hospitals refusing to receive Aboriginal patients suffering from venereal diseases at the following hospitals: Maryborough, Gympie, Nanango, Prosopine, Atherton, and Hughenden hospitals. See also, R. Evans, *Aboriginal-European Relations*, pp.58-59.

tuberculosis, venereal infections and influenza, assisted the growing demand for mission services, and for relief depots. If none existed these people were then sent as patients under police escort, from as far away as Cooktown on Cape York and from Cloncurry in the west by car and train to lazarets and sanatoria near Brisbane. The difficulties for both police escorts and the Aboriginal patients are now hard to imagine.

Police acted as surrogate health workers from 1900 until the early 1930s as they fulfilled their role as escorts. Aborigines suffering from leprosy, tuberculosis, venereal and other medical conditions became a familiar sight around the fringes of Queensland country towns and plantation service depots.¹¹⁵ The lack of facilities for treating such cases and for dealing with Aboriginal prostitutes was directly responsible for the building-up of Aboriginal groups around settlements, and that in turn created the impression that all Aborigines were derelict, diseased or destitute. As white settlement intensified in the first decade of the twentieth century the State government seized every opportunity to continue centralising and civilising Aborigines.

While Roth was away conducting a Royal Commission into the conditions affecting Aborigines in Western Australia, the Queensland Government stopped issuing free rail passes. The police had been using the method of issuing free rail passes as a way of moving Aborigines from rural regions. Police regarded ration and relief depots and mission stations, in their early formation, as holding centres for disparate Aboriginal populations who had become liabilities. As a means of moving Aborigines from one place to another, however, the Acting Chief Protector agreed to cover the costs of Aborigines being escorted by police, putting the practice on an official footing.

¹¹⁵ Kay Saunders, *Workers in Bondage*, pp.86-119.

By 1904 ration and relief depots were operating at Deebing Creek, Barambah, Durundur, Yarrabah, Cape Bedford, Mapoon and Weipa. Of these establishments, the missions were

year by year becoming a greater assistance to the State in dealing with the pauper aboriginal waifs and strays, adults and children, on the most economic lines. Two new missions...opened along the coast, on the Archer and Mitchell Rivers, under the control of the Presbyterian and Church of England respectively.¹¹⁶

Deebing Creek, Durundur and Barambah near Ipswich had one committee to manage these depots. The committee consisted of Church ministers and other public spirited people. The committee employed Mr Tronson as superintendent of both depots.¹¹⁷ The Church of England operated a mission station at Mitchell River on Cape York and a relief and ration depot at Yarrabah near Cairns. As superintendents they employed Reverends Gribble and Chase.¹¹⁸

In addition, Cape Bedford (the name of which was changed to Hope Vale) opened in 1904 and maintained a total population of about 98 males and females. The Lutheran Moravian missionaries could not raise additional funds to admit more Aboriginal inmates so they limited the population to about that figure. Hope Valley was about 20 kilometres from Cooktown by boat, and the Queensland Government covered the cost of a small boat. The Lutheran mission society had its head office in Germany, with the Australian operations headquarters located on York Peninsula, in South Australia. The health of the small population at Hope Valley remained good during 1904. Serious disease and health problems were either not observed or unknown in this coastal location since the German missionaries had arrived in 1901.¹¹⁹ The Lutherans

¹¹⁶ W.E. Roth, 'Annual Report Of The Chief Protector For 1904', p.13.

¹¹⁷ *Ibid.*, p.15.

¹¹⁸ *Ibid.*, p.16.

¹¹⁹ *Ibid.*, p.17.

also had interests at Mapoon and Weipa and they began developing a new settlement on the Archer River. The reconstitution of the reserves of Mapoon, Weipa and Yarrabah took place on 14 July 1904, and they were to be used as 'Reserves for the use of the Aboriginal inhabitants of the State'.¹²⁰

Many of the venereal disease patients were transported to country towns by police from other more distant rural locations. As a result, it was not just a demand for health care which brought Aborigines to congregate in rural hospital centres. Records of the incidence of leprosy were not good, but when the first Aboriginal lepers began to appear for treatment (e.g., it must be remembered that people first infected were only seen by protectors and missionaries and by the time the infection took hold treatment meant exposure to general society and they appeared in the company of police) in the early part of the twentieth century the police had to escort them thousands of kilometres to the southern lazarets. The police had the job of travelling with all Aboriginal patients who had been diagnosed as bearers of contagious disease.¹²¹ In most cases, this meant travelling by train for up to six or seven days. This responsibility became a long running issue between the police department, the Queensland Railways Department and the Chief Protector of Aborigines. Roth's toughness of mind as protector usually paid dividends, especially with police, but sometimes toughness failed.¹²²

¹²⁰ *Ibid.*, p.19.

¹²¹ QSA, series A/4472, 'Conveyancing by Police of Prisoners and Aborigine'; see also, QSA, series A/44746, 'Transporting Aboriginal Prisoners, Police Department, Cairns District'; see also, QSA, series 18515, Northern Sheriffs Office, October 1907-Nov 24, 1919; see also, QSA, series A/18516, 1907-1919, 'Northern Sheriff's Office'.

¹²² QSA, series A/44764, 'Medical examination of Patients in custody', (no dates but c 1900-19); see also, QSA, series A/44832, 'Conveyance of (1) Sick indigents, (2) destitute Persons, (3) Unemployed: 1893-1959', see memos Qld Police: District Inspector's Office Cairns, 1905-1916; see also, QSA, series, A/45332, 'Medical inspection under Health Act, 1900', contains copies of legislative amendments to deal with conveyancing of Sick and diseased people by police; see also, QSA, series A/45253, 'Destitute Persons, 'Free

When this occurred he found difficulty in arranging for sick Aborigines to be transported to hospital towns.

Stradbroke Island lazaret became the first hospital to receive an Aboriginal leprosy patient.¹²³ The patient was escorted there from the north of the state by police using a special rail concession known as a destitute persons' rail pass. In 1905 the Commissioner of Police issued a circular dealing with the transportation of such people. The circular stated that the Home Secretary had directed officers in charge of police stations to authorise the issuing of free rail passes to people urgently in need of hospital treatment, provided that they produced a medical certificate.¹²⁴ This was not a measure designed for Aborigines, but adapted to meet police needs for a short period. In November of 1905, Roth wrote to the Under-Secretary Home Affairs saying that the administrative practice involved protectors contacting the local police constable who would then contact the Chief Protector of Aborigines and the rail passes were issued. The passes could then be charged to the Chief Protector's office.¹²⁵

The Police Department normally issued rail passes to travelling patients. On one occasion they issued a pass to an Aboriginal woman travelling from Narrang — about 100 kilometres south of Brisbane. The woman discharged herself from hospital and subsequently became very sick. She then had to be re-admitted to the Brisbane hospital.¹²⁶ Because

Railway Requisitions to Sick indigents in need of special hospital treatment, see notes by Police Commissioner W.G. Cahill, 1900-1905, where police standing orders were issued on periodic circulars.

¹²³ Queensland Parliamentary Papers, 1904-5, 1st and 2nd Session, pp.69-87, in *Report of the Commissioner of Public Health*, QGP, Brisbane, 1905, pp.1-5.

¹²⁴ 'Destitute Persons', QSA, series A/45253, see, Circular 335 signed by the Commissioner of Police, W.G. Cahill, Brisbane, on 9th May, 1905.

¹²⁵ 'Conveyance of Indigents', QSA, series A/44832, Commissioner of Police – Office of the Commissioner of Police Brisbane', see, Roth to Under Secretary, dated 4th November, 1905.

¹²⁶ *Ibid.*, pf.

of the problem of organising free travel for Aborigines the police refused the woman a second free rail pass once her condition worsened. Police were reluctant to hold sick Aborigines in custody due to the fact that their conditions might deteriorate. When the newspapers heard of the sick woman's predicament they attacked the police for their lack of compassion and apparent negligence. For this criticism the police complained to their commissioner because they feared something might happen to a person if confined in the watch-house while stricken with a highly infectious disease. They were probably also afraid that they themselves might be infected.¹²⁷ The Commissioner of Police re-issued 'circular number 335' on 20 November 1905, saying that the issuing of rail passes to sick indigent persons in need of special hospital treatment 'does not apply...[to] Aborigines.'¹²⁸ Possibly motivated by fear of leaving Aboriginal patients in or near concentrations of white populations, the police skirted around their 'standing orders' by inventing another means of transporting Aborigines away from their districts to southern relief depots and institutions.

The responsibility of getting Aborigines into hospitals and then paying for their treatment, in the years from 1906 to 1910, continued to present problems for the protectors. Roth's final report for 1906 indicated this. He wrote that

various hospitals...assisted in alleviating the suffering of sick natives, whilst the Aboriginal missions and settlements...provided permanent homes....[but] I regret [the] disputes...[about] the cost of treating Aborigines in hospital.¹²⁹

¹²⁷ QSA, series A/45399, 'Transport of Indigents', circa, November 1905.

¹²⁸ 'Conveyance of Indigents', QSA, series A/44832: Commissioner of Police -Office of the Commissioner of Police Brisbane; Circular Memorandum No. 335 "A", 16th November 1905 (this circular superseded circular 335 of 9th May, 1905).

¹²⁹ W.E. Roth, *Annual Report Of The Chief Protector Of Aborigines for 1905*, in QLAV&P, CA 20-1906, QGP, Brisbane, 1906, p.16.

At the remote town of Camooweal, about 160 kilometres northwest of Mount Isa, the hospital administration made a claim for treating an Aboriginal man named Tommy who had a broken leg. The account was forwarded to the Chief Protector for payment. Another case involved the Nanango Hospital, which treated Aboriginal paupers, and sent the account to Roth. In most cases where hospitals were subsidised by government, the Chief Protector refused to pay the costs. Under these circumstances the hospital had to absorb the costs. This approach helped hospitals to adopt a policy to treat only those Aborigines whose bills were paid by employers.¹³⁰

Although there was no specifically identifiable Aboriginal health system outside protection legislation for employees, Roth succeeded in bringing a better administration to the relief of Queensland Aborigines. His greatest disappointment was his failure to gain a better access to hospitals. The hospital committees were to remain in control of rural hospitals beyond the 1940s, and while they retained control, Aborigines had little ability to enter hospitals on request. A further disappointment for Roth was that Aborigines' hygiene problems continued to prevent a general improvement of their health.¹³¹ Hospital staff, in most country towns, refused to accept diseased Aborigines, who were then confined to disease-camps away from townspeople. The hygiene problems generated in these fringe-camps used as temporary accommodation for people awaiting follow-up medical treatment was as if the hospital health workers and Aborigines who made them their homes accept the appalling conditions which these disease-camps offered. Deliberately

¹³⁰ *Ibid.*, pf.

¹³¹ QSA, series A/58676, 'Sickness - Barambah complaints', see notes from Roth to Manager J.M. Costin, of depots regarding hygiene practices and disappointments and also mismanagement of Aboriginal children and some adults of the Aboriginal population, throughout Roth's last year of 1906.

created for the convenience of hospital staff and local doctors, these disease-camps were strategically located outside towns away from public gaze. Aborigines continued to suffer communicable diseases and serious problems that, in the absence of decent hospital access, necessitated the maintenance of the disease-camps.¹³²

In 1909 the Northern Protector of Aborigines observed that venereal disease existed in most districts.¹³³ One case of granuloma came to the notice of a protector at Port Douglas.¹³⁴ In the same year Reverend Brown of the Moravian mission at Weipa reported that a dispensary had been opened in July...to attend to the widespread venereal disease problem which was the worst ailment suffered by Aborigines. The dispensary consisted of a clinic with a room attached where sores and wasting wounds could be dressed, and where sick people could receive attention instead of being treated, as previously, in a building used to keep garden equipment.¹³⁵ Despite the optimistic assumption that venereal disease was declining by 1910, the Brisbane General Hospital had treated six cases of granuloma from Barambah of which two had been returned to their homes near Ipswich as cured. At Taroom the local general practitioner treated 450 Aborigines and of these six presented with venereal disease. Similarly, doctors at Charleville, Hughenden, Normanton, Herberton, Innisfail, Port Douglas and a fringe-camp called Turn-off Lagoon all reported treating cases of venereal disease. Of those living at Barambah two deaths occurred due to venereal infection, and the medical practitioner treated three other cases of the disease. Barambah had become a holding place for sick Aborigines from all over the State and

132 QSA, A/58853, 'Venereal - Aboriginal General', see notes under Aboriginal VD Camps, - Cooktown which go back to turn of century.

133 Chief Protector Aborigines, *Annual Report, 1909, Queensland Parliamentary Papers*, (QPP), QGP, Brisbane, 1910, p.13.

134 *Ibid.*, p.15.

135 *Ibid.*, p.23.

was attracting high numbers of people who only came to die.

Despite the depressing trends in Aboriginal health many people had successfully assimilated into the pastoral and rural economic milieu of the period. Many Aborigines were contracted, and took their families off the government depots and mission stations, to work on properties under the protection legislation. These people worked in a symbiotic relationship with their employers and sent their children to local primary schools. When seasonal diseases such as trachoma struck the whole rural communities often became infected, as did Aborigines. There were no data collected by the health authorities which distinguished Aboriginal victims of trachoma from the white population.¹³⁶

In the early period of the decade from 1900-10, trachoma and hookworm infestation were diseases that ranked with venereal disease, leprosy and tuberculosis in determining people's social acceptability. Trachoma¹³⁷ was treated more seriously in Queensland as a blinding disease than it was in Western Australia. Once trachoma reached epidemic proportions in the general Queensland rural society, government concern turned to medical action.

A series of seasonal outbreaks eventually prompted a major survey. This was conducted jointly by the Queensland Department of Home Affairs and the Commission for Public Health. The screening of the rural population by itinerant teams of trained nurses and an ophthalmologist proceeded, with the intention of locating the infected populations.¹³⁸ As

136 'Report Of The Commissioner Of Public Health', 1905, in QPP, 3rd Session of 15th Parliament, CA 61-1905, Vol. I, pp.681-713.

137 Benenson, *Control of Communicable Diseases*, pp.441-444.

138 Queensland Parliamentary Papers, 'Report of the Commissioner Of Public Health 1904-5', Vol. II, QGP, Brisbane, 1905, pp.69-87; see also, QPP, 'Report of the Commissioner Of Public Health 1905', 1905, Vol. I, QGP, Brisbane, 1905, pp.681-713; see also, QPP, 'Report of the Commissioner Of Public Health 1906', 1906, Vol. I, QGP, Brisbane, 1906, pp.1633-1652; see also, QPP, 'Report of the Commissioner Of Public Health 1907', 1907, Vol. II, QGP, Brisbane, pp.27-53; see also, QPP, 'Report of the Commissioner Of Public Health 1908', 1908, Vol. II., QGP, Brisbane, pp.757-793; see also, QPP, 'Report of the

in a later period in Western Australia, trachoma in Queensland came to Aboriginal communities as settlement spread into their environments, and as they moved into the proximity of white settlers.¹³⁹ Wide-spread reports of trachoma among Aboriginal fringe-camp groups became commonplace, though this epidemic came to light first among the white rural population. In the 1907 survey, no mention of either Aborigines or half-castes appeared because neither group existed as a readily classifiable ethnic (or racial) entity.¹⁴⁰ Many half-castes lived on pastoral properties in and around rural towns. The Commonwealth acknowledged Aborigines as being people with half- and more Aboriginal descent and considered them all as British Subjects, as mentioned in chapter two.¹⁴¹ Alternatively, half-castes and people of less Aboriginal descent were not considered as Aborigines. The number of half-castes attending either the mission or State schools was substantial. It totalled 4,475 males and 4,005 females or a combined total of 8,480.¹⁴²

The report on ophthalmia tabled in the Queensland Parliament on 11 March 1908, gave details of all cases identified since 1907. It paid particular attention to state school children, in Charleville, Tambo, Blackall, Isisford, Longreach, Barcaldine, Aramac, Muttaborra, Winton, Hughenden and Richmond.¹⁴³ Two medical doctors, M.D. and W.F. Taylor, had conducted a survey between October and November 1907. In

Commissioner Of Public Health 1909', 1909, Vol. II, QGP, Brisbane, pp.437-456; see also, QPP, 'Report of the Commissioner Of Public Health 1910', Vol. II, QGP, Brisbane, 1910, pp.851-868.

¹³⁹ Ida Mann, *Culture, race, climate*.

¹⁴⁰ For a lengthy discussions see L.R. Smith, *Aboriginal Population*, pp.10-54; see also, Rowley, *The Destruction*, Vol.I, see Appendix A, pp.341-398; see also, Broom and Lancaster Jones, *A Blanket A Year*, pp.1-12.

¹⁴¹ Queensland, Parliament, 'Ninth Census of Queensland, 31st March 1901', p.(ii); see also, Commonwealth Census, 'Statistician's Report 1911', Vol. 1, pp.227-230.

¹⁴² *Ibid.*, p.230.

¹⁴³ QPP, Report of the Commissioner Of Public Health, A/7, 1908; see also, W.F. Taylor, 'Ophthalmia In The Western Districts Of The State', in 17th Parliament, 1st Session, 1908, A/7 1908, pp.435-445.

Tambo fully 91 per cent of the school population had active trachoma, and in Blackall, Isisford and Muttaborra infection rates were higher than 90 per cent. Barcaldine, Aramac, Winton, Hughenden and Richmond all had rates of infection in the mid- to high- 80 per cent range, due mostly to their proximity to permanent water. The closeness to permanent water normally allowed for hot water to bath and for washing clothes and bedding. Where this facility was absent it was more difficult to maintain hygiene which in turn allowed human hosts to harbour, and flies to spread, the infection. In all towns the total number afflicted with trachoma amounted to 1,740 people.¹⁴⁴

In discussing the causes of the disease, Taylor wrote that the dryness of the air, the periodic rains and the onset of long grass accompanied by the increase in bush flies combined to cause trachoma, or at least to prolong it. The dust storms that followed hot spells caused irritation that in turn left those infected with red eyes followed by conjunctivitis. The infectious pool might begin with only one infection, carried to a healthy eye by means of flies. Aborigines could not escape this mode of infection. As Ida Mann later discovered in her Western Desert studies, there were genetic differences between white settlers and people of full descent, but Aborigines of mixed descent did not inherit the genetic ophthalmic factors of their Aboriginal descendants.¹⁴⁵ Taylor did not report his results along racial lines nor in as technical a way as Ida Mann.¹⁴⁶ He reported that in acute cases of ophthalmia he found discharge of pus from between the lids, flies the active carriers of contagion from the diseased eyes to the healthy ones. Flies settled in swarms on children's discharging and infected eyes from which they went to other children. Once

¹⁴⁴ Taylor, 'Ophthalmia In The Western Districts Of The State', p.9.

¹⁴⁵ Ida Mann, *Culture, race, climate*, p.466.

¹⁴⁶ *Ibid.*, pp.462-470.

disturbed, the flies would infect healthy eyes, and so on until the whole school became the centre of infection along with parents. Normally this was the mother but fathers were also vulnerable.¹⁴⁷ Of the people most affected, all lived and slept in small houses which confined their occupants, both adults and children, to the one sleeping area.

In describing the characteristics of the infection, Taylor, in western Queensland, identified two varieties of trachoma, each different to those occurring in other countries. The differences, as he explained previously, appeared to be 'superficial vascular keratitis pannus' which was lumpy blood vessel tissue,¹⁴⁸ or ulceration of the cornea, a condition not uncommon in Queensland and the other countries.¹⁴⁹ Further, other conditions such as 'papillary hypertrophy', or many small lumps with swelling of the surrounding tissue,¹⁵⁰ was a very common result of the disease in Queensland, varying from mere roughness of the palpebral or eye lid conjunctiva to large exuberant granulations or many lumps similar to lots of grains.¹⁵¹

Taylor thought that after someone had contracted the disease, infection occurred easily 'once the fly season arrives.'¹⁵² Old scarring appeared on eye lids of most people he examined. Unfortunately Aborigines on distant pastoral properties, government reserves, missions and in fringe camps awaiting hospitalisation, missed out on Taylor's survey. As early as 1902, Chief Protector Meston had moved people from the southwest regions of the State close to the Northern Territory border, nearer to the coast where hospital treatment was available for blind bush

¹⁴⁷ Taylor, 'Ophthalmia In The Western Districts Of The State', p.9.

¹⁴⁸ Ida Mann, *Culture, race, climate*, p.5.

¹⁴⁹ *Ibid.*, pf.

¹⁵⁰ Benenson, *Control of Communicable Diseases*, p.441.

¹⁵¹ Taylor, 'Ophthalmia In The Western Districts Of The State', p.9.

¹⁵² *Ibid.*, pf.

people.¹⁵³ Roth's reports made no mention of ophthalmia in the period from 1908 to 1910.¹⁵⁴ This should not be seen as unusual. Many of the government relief depots were situated along the coastal areas where temperatures tended to be lower. In addition, coastal regions had a higher rainfall, and water was plentiful enough for regular bathing which reduced the infection rates. Similarly, people's diet and closeness to medical attention in coastal areas prevented infection occurring at the level of the western rural populations who were subjected to prolonged and regular seasonal drought.¹⁵⁵

As white settlement expanded from Brisbane a depletion of the Aboriginal population most certainly took place. By the time Meston observed their numbers he was only able to conjecture what their estimated size might be. If large numbers of Aborigines had existed, which was unlikely, many had either been killed off, or died from disease and, from 1900 to 1910, their small residual numbers had begun to be moved to government ration depots, mission stations and southern sanatoria. A decade passed before the reforms introduced by Meston and Roth came into effect, but medical practitioners, hospitals and depot management bodies were generally unwilling to grant proper access to sick and diseased Aborigines and the depot structures were managed under a system of compassion and not professionalism. When Bleakley became Chief Protector he constructed a generally compassionate system of caring for Aborigines where none existed previously. The period 1900 to 1910, however, saw a general rise of diseases among Aborigines such as

¹⁵³ Meston, 'Report of Southern Protector, 1902', p.3, in QPV&P, Vol.I, 1902, pp.1175-1180.

¹⁵⁴ QPP, Annual Report of the Chief Protectors Of Aborigines, 1908, Vol. II, QGP, 1909, pp.965-1026; see also, 'Annual Report of the Chief Protector Of Aborigines, 1909', Vol. III, QGP, Brisbane, 1910, pp.957-990; 'Report of the Chief Protector Of Aborigines', 1910, Vol. I, QGP, Brisbane, pp.1297-1329.

¹⁵⁵ Ida Mann, *Culture, race, climate*, pp.480-483.

venereal disease, tuberculosis and leprosy, which were the most common. Reports of Aborigines being infected with diseases were numerous but it must also be remembered that diagnosis was difficult to obtain. Nevertheless, diagnosis persisted because infections ulcerated and remained open. Difficulty of diagnosis existed where bleeding congealed and dead skin existed which was caused by the long period of time people had to wait for proper medical attention. As a result of these open wounds, leprosy, tuberculosis, venereal diseases, yaws and hookworm spread easily. Trachoma surveys most certainly serviced the Aboriginal rural working population by granting them a measure of protection against blindness. By 1910 a greater presence of State and church bodies provided forms of services to Aborigines but new types of infection began to emerge, which is the subject of Chapter eight.

CHAPTER 8

A fading dream: the epidemiology of Aborigines in Queensland, 1910 to 1920

The hopes contained in the policy of 'protection' had almost faded by the beginning of the second decade of the twentieth century, and continuing patterns of infection marked the decade. The pandemic of Spanish Influenza is thought to have been spread by soldiers returning from the European theatre of war in this period. It lasted from early 1918 to late in 1919, killing more than 20 million people worldwide.¹ In Australia some 12,000 people died from influenza. Of these 1,030 were Queenslanders of whom 315 were known to be Aborigines, that is about 30 per cent of the Queensland death toll. Nevertheless, the greater contact between indigenous peoples and white, Asian and Pacific Island peoples brought new health challenges such as the introduction of a wider range of respiratory and parasitic infections during the period from 1910 to 1920.

The belief that reserves could segregate Aborigines from white, Asian and Pacific Islander influences was not working as intended. Protection had been introduced to arrest the effects of opium supplied to Aborigines by Asian mine workers. Settlers and visitors to Australia harboured some infections which spread quickly among indigenous groups. Similarly, starvation forced people onto depots and others into prostitution as a way of earning cash. To cope with police action against

¹ Alfred W. Crosby, *America's Forgotten Pandemic: The Influenza of 1918*, Cambridge University Press, 1989.

the numbers of prostitutes being removed from country towns, hospital workers sent Aboriginal patients to government and mission depots or to fringe-camps outside of town limits. Finally, for people who were starving, the government created three new ration depots as a way of coping with the numbers of Aborigines moved.

The opening of these institutions was due to the initial efforts of the protectors in the last decade of the nineteenth and the first decade of the twentieth centuries. In the second decade, however, it was due to the poor condition of Aborigines as a result of disease and sickness. Archibald Meston's enthusiasm in documenting the Aborigines' physical, social, cultural and economic position said something about everyone's concerns for what was happening to indigenous people in the face of the expansion of white settlement. In addition, Walter Roth created a vigorous administration which attempted to arrest the depressed morale under which indigenous people struggled.² Aboriginal population growth continued and exacerbated poor health conditions.

Once the processes of protection began operating more effectively, they facilitated the growth of populations of people of both full and mixed Aboriginal descent. The former groups grew very slowly due to the demographic problems arising during the nineteenth century. The latter grew more quickly and as governments brought them together on reservations and incorporated them into the State's health and relief programs they thrived demographically under the protection policies. As in Western Australia, some observers had difficulty understanding whether the Aboriginal population was increasing or disappearing. There was continual confusion between enumerated and estimated Aboriginal populations in Queensland. Adding to the confusion, changing

² Long, *Aboriginal Settlements*, pp.91-136 and pp.139-175.

definitions and interpretations of Aboriginal identity clouded understandings of who persons of full-, half-caste and other mixed-descent were.

The enumerated total of Aborigines of full-descent increased from 6,670 in 1901 to 8,687 in the 1911 census. At the same time the people of mixed descent increased from 951 persons to 2,508.³ It is almost certain that cohabitation between full-blood males and females with both half-castes took place. Similarly, miscegenation occurred between Aboriginal females and various white, Asian and Pacific Island male populations. This sexual contact resulted in an increase in the numbers of 'half-caste' children. Moreover the rising number of children taken from camps to institutions came from this population increase.⁴ It is impossible to explain the dynamics of the full-blood Aboriginal population because of the paucity of recorded information, as I argued earlier, but it is possible to say that after the previous imbalance in favour of males, from 1901 a change occurred and the balance was restored somewhat. It was becoming obvious in the early part of this period, that the survival of Aboriginal females of younger ages was improving because in these younger age groups there were now only marginally more males than females. Aborigines were apparently cohabiting more with each other than with peoples of other races. This meant that endemic venereal disease was largely confined to the Aboriginal social groupings, though transfer of infections continued among Asians and Kanakas.

Venereal disease appeared to be one cause of death which could be handled by keeping white people away from Aborigines. The removal of

³ L.R. Smith, '1911 worksheet', pp.1-2.

⁴ Queensland Parliamentary Papers (QPP), *Annual Report Of The Chief Protector of Aborigines For 1910*, 18th Parliament, 2nd Session, 1910, (cited hereafter as Chief Protector of Aborigines 'Annual Report', and year), pp.1297-1329, see p.17.

Aboriginal female prostitutes from service centres where whites settlers, Asians fishermen and Kanak cane plantation labour congregated became a major issue in some locations. One explanation for the spread of venereal disease could be attributed to the health authorities themselves because they sent Aborigines to depots and disease camps where they infected other Aborigines or members of the public with whom they had sexual intercourse. In addition hospitals refused to treat venereal diseases for social status reasons, a choice adopted to avoid offending other patient's sensibilities. Furthermore, health workers experienced difficulty in determining what particular 'wasting disease' contracted by the Aboriginal patient needing medical attention. Few establishments existed at this time where either leprosy or tuberculosis and venereal infections could be managed properly. And while some islands in the Torres Strait were converted into leprosariums, the Pacific Islanders and Asians seamen made up the majority of inmates. If Aborigines suffered from these infections they went back to their bush living places and tended to infect other family members. At the same time, knowledge of Aboriginal health was about to improved because in 1910, the Office of the Chief Protector of Aborigines put into operation a register of recorded Aboriginal deaths by disease and by sex.

In 1907, the first 'Death and Disease Register' was established in accordance with section 2 clauses (xii) to (xv) of the regulations of *The Aboriginal Protection and Restriction of the Sale of Opium Act of 1897*.⁵

⁵ McCorquodale, *Aborigines And The Law*, p.55; see also, A/589526, 'Registrar of Acts, 1897-1934'; this is a book in which all legislation in the period was recorded by the Protector's Office in the Under Secretary's Department, see folios 77-99, and section 2(xii), of the Regulations to the 1897 Act, 'The employer shall provide every reasonable facility in the event of illness of employee or any accident occurring to an employee for such employee to obtain medical attention or medicine, and no charge shall be made against any wage due to the said employee for medical attention or medicine without the approval of the local protector;
(xiii) The employer shall provide all provisions..., and medicines;

These regulations instituted the recording of Aboriginal deaths.⁶ Although the reporting of deaths was clearly incomplete and coverage wavered over time, yet it is still possible to discuss some features of the mortality situation from the incomplete data. Use of the data, therefore, must be applied with caution but their use may occur despite the discrepancies because they remain the only written source. For Aborigines who died from disease, entry of their death into the Death and Disease Register was not necessarily a straight forward exercise. Under normal conditions certification of the death of a white or someone of mixed descent by rural police, a health worker or a medical practitioner, was reasonably simple. Great difficulty existed, however, for someone making a determination of cause of death for a deceased Aboriginal person. In most cases problems existed because of the isolated locations where the Aboriginal person died. Certification had to be made by all sorts of untrained people because medical advice was not available, so it is not surprising that the entries in the medical certificates often gave inappropriate reasons for the death of Aborigines.

The way the registration of notified deaths from a range of diseases operated was that protectors from all around Queensland now sent information to a central register located in the Chief Protector's Office in Brisbane. Thus, when Aborigines died from infectious diseases the particulars were entered into the register. Richard B. Howard was still the Chief Protector of Aborigines when this occurred.⁷ He travelled

(xiv) In the event of illness of an employee under eighteen years of age, or of any accident occurring to any such employee, the employer shall at his own expense provide such employee with the necessary medical attention, medicines, and maintenance during illness or state of infliction to the satisfaction of the local protector;

(xv) The employer shall forthwith report to local protectors in writing, the desertion, illness or death of any employee.'

⁶ *Hansard*, Queensland Parliamentary Proceedings, 1901, debates on amendments to the 1897 Protection Act, quoted in Long, *Aboriginal Settlements*, p.96.

⁷ *Ibid.*, p.34.

extensively throughout the areas in 1910 to all locations where the government and churches operated relief depots and ration stations informing them of the new changes.⁸ The visits made to the north 'showed that the last year was a fairly healthy one for Aborigines.'⁹ For the first time since the protector's office began operating he was able to give some indication of the incidence of chronic diseases among Aborigines and the number of deaths reported from those diseases. He could do so because in 1910 the Queensland government began recording the number and cause of Aboriginal deaths.¹⁰

Howard's report highlighted the venereal disease question which moved Aboriginal people south. In 1910, six female Aborigines went to the Brisbane General Hospital from Barambah near Ipswich. Dr Junk of Wondai, who now visited Barambah once a month, reported to the Chief Protector that two of the women came back to Barambah cured of venereal infection, while four had been pronounced incurable.¹¹ In addition, 27 people had died at Barambah during 1910. This was from a notified State total of 61 deaths from disease.¹² Two of the 27 deaths were caused by the effects of venereal disease. In the whole of Queensland only three other deaths were attributed to venereal disease, though in other parts of the State syphilis was commonly observed and of those identified many suffered from external sores or ulcerated limbs.

Venereal diseases were not a notifiable disease under the *Infectious Diseases Act of 1892*. In 1911 the Queensland Parliament amended *The Health Act 1900-1911*, Sections 124 to 129 of which now included powers

⁸ *Ibid.*, pp.27-33; see also, Long, *Aboriginal Settlements*, pp.139-143.

⁹ *Ibid.*, p.17.

¹⁰ QSA, Series A/58973, file no., 58974, with title, 'Death Registers - Where, Cause', 1910 to 1936.

¹¹ Chief Protector of Aborigines, 'Annual Report', 1910, pp.17.

¹² *Ibid.*, pf.

to remove and detain in hospital people suffering infectious diseases. The sections were primarily designed to deal with people who had no proper accommodation.¹³ There is no reason to believe that the legislation was designed to imprison Aborigines, but it empowered police to detain and remove Aboriginal women to hospital for treatment.¹⁴ Once police had removed prostitutes, other Aborigines could be removed to nearby camps or missions and relief depots. Thus the legislative powers for removal already conferred by the 1897 protection legislation were now reinforced by the health legislation.

In Queensland venereal disease was a general health problem and to on an exclusive Aboriginal health question. In a few Aboriginal groups, particularly in the north, there was no trace of the infection, but for southern women having or wanting children, great problems arose. A number of northern missionaries reported to the Chief Protector that

the health of the mission inmates has been satisfactory, and a great contrast is observable between those who have gone through the mission routine and those who were not so fortunate. The former are healthier and comparatively free from disease, and the women are in consequence more prolific. Six births and...[eight] deaths took place on and near the station during the year. Most of the deaths were the result of tubercular and venereal diseases, and the latter disease is still very prevalent among old blacks.¹⁵

Polygyny was practised mainly by the older generations and, as implied above, Christianity had a great impact on the practice of mission residents who abandoned the practice of having multiple wives and sexual partners.

¹³ QPP, *Annual Report Of The Commissioner Of Public Health, 1911-12*, QGP, 12 August, 1912, Vol, 2, pp.469-496.

¹⁴ QSA, A/5069 (30, A, B, C), 'Health and Home Affairs Department - Correspondence concerning Health Diseases, 1913-1919', see memos for Under Secretary, Home Secretaries Office, and contains details of the changes made to the Health Act 1900-1911.

¹⁵ Rev. N. Hey, Mapoon report, in Chief Protector of Aborigines, 'Annual Report', 1910, pp.29-30.

Interpreting what health authorities, legislators and health workers meant when they spoke about venereal disease is as much a problem in Queensland as it was in Western Australia. Sexually transmitted diseases such as syphilis could be mistaken for other diseases which caused open wounds and pussy lesions.¹⁶ Because these issues were unresolved, the Aboriginal population's capacity to sustain an infectious pool and to develop immunity to either viral or bacterial infections remains a matter of some uncertainty.

In 1912, the Health Commissioner of Queensland hoped that venereal disease could be eradicated by Parliamentary action and that 'the difficulty will, it is hoped, be overcome when Executive authority is obtained for the gazetting of the new Venereal Diseases Regulations.'¹⁷ Syphilis, he pointed out, could be treated if it were identified quickly enough, otherwise treating the long term effects was expensive. Moreover, if left untreated, the cost to society was greater because lunacy might be the long term effect.¹⁸ The issue in Queensland was becoming a matter for concern because, in the metropolitan area alone, 1,477 people between the ages of one and 60 years were infected in just one year.

Among Aborigines the disease had also become a major problem. The results were birth defects, infertility and long term wasting of male and female genitalia.¹⁹ As soon as police suspected Aboriginal women were harbouring sexually transmissible diseases they sent them south to

¹⁶ Basedow, 'Diseases of Aborigines', pp.193-98; Cleland, 'Diseases among Aborigines', pp.157-160; Goldsmid, *The Deadly Legacy*, pp.13-27; see also, T. Sandison, 'Treponemal Infections in Pre-European Contact Exhumed Australian Aboriginal Skeletons', *3rd European Meeting Paleopathology Assoc.*, France, 1980.

¹⁷ QPP, *Annual Report Of The Commissioner Of Public Health, 1911-12*, QGP, 12 August, 1912, Vol. 2, pp.469-496, but see p.6 of Commissioner's Report.

¹⁸ *Ibid.*, pf.

¹⁹ Wasley and Wong, *Syphilis Serology*, pp.5-12; see also, Goldsmid, *The Deadly Legacy*, pp.17-18; see also, Basedow, 'Diseases of Aborigines', pp.209-213; see also, R.W. Cilento, *Tropical Diseases In Australasia*, (2nd edn), Smith and Paterson, Brisbane, 1942.

ration depots or under escort to sanatoria in Brisbane.²⁰ Doctors at Charleville, Hughenden, Normanton, Herberton, Innisfail, Port Douglas and Turn-off Lagoon all reported cases of venereal disease they had treated. Of those living at Barambah two deaths were due to venereal infection, and the medical practitioner there treated three other cases of the disease. This relief depot became a holding place for sick Aborigines from all over the State and held a high number of people sent there only to die. In 1910, the Protectors reported that of 61 Aboriginal deaths throughout the State, 27 took place at Barambah.²¹

In the north of Queensland wasting infections were reported during this period. On Thursday Island, for instance, — a centre to which diseased mainland Aborigines, Japanese, Chinese, Filipino and Pacific Islander mariners were sent — it was reported that a high incidence of venereal disease existed among these groups. Similarly, on the mainland too, various body wasting conditions existed where open sores and peoples' body parts were highly disfigured. Some of these infections were possibly tuberculosis, or yaws, and they were responsible for the majority of Aboriginal deaths reported from coastal regions in 1914. Venereal diseases accounted for 19 of the deaths. As the Chief Protector reported, 'venereal disease, principally gonorrhoea and syphilis, [prevailed] in some districts, particularly the "gulf country", the coastal districts and the far west.'²² Due to the high levels of illness caused by this disease, the government considered opening a lock-up hospital on Fitzroy Island near Cairns, but the First World War forced a postponement.²³ In 1919

²⁰ QSA, see file Nos, A/55853, A/58853 and A/58856, Venereal General; see also, Aboriginal VD Camp — Cooktown 1925-1936.

²¹ Chief Protector of Aborigines, 'Annual Report', 1910, p.17.

²² Chief Protector of Aborigines, 'Annual Report', 1919-1914, in particular, see 1914, p.9.

²³ *Ibid.*, pp. 9-10.

venereal disease was still a concern for protectors and missionaries in some locations. The Chief Protector's official reports observe that

venereal disease was reported in the Gulf country, the Peninsula, the Torres Strait, and far west; and in the last area phthisis was also noticeable....In some communities upwards of 9 people received long term treatment for the effects of venereal diseases, and in some cases low births in some Cape York settlements remained a concern.²⁴

New government reserves had been created to cater for people being moved from the fringes of cattle property homesteads, rural towns and hospital grounds and shifted to reserves controlled by the Chief Protector's office. Bleakley, the newly appointed Chief Protector, reported that between 1914 and 1917, 434 Aborigines had been moved to Hull River, and 256 arrived there in the following year. In March 1918 the new settlement was destroyed by a cyclone and work had already begun on new buildings as new Aboriginal residents were moved there from Greater Palm Island.²⁵ Social problems generated by mining development on the Hull River, together with the problem of Chinese providing opium to Aboriginal men and women as payment for sexual favours, led to the mass migration of Aborigines to the mining camps. In 1919 Bleakley indicated that the existence of venereal infections, endemic in camp people, was a major problem. Many Aborigines worked not for money but for alcohol and opium, and whole families — young men, women and children included — worked for miners in exchange for 'grog' and opium and from this came epidemics of sexually transmitted diseases which plagued them thereafter.²⁶ A common theme of

²⁴ *Ibid.*, p.6 and there mention of 9 people admitted to lock-up hospital, which was a hospital for sufferers of venereal cases; see also p.8, for evidence of native birth control.

²⁵ Long, *Aboriginal Settlements*, pp.91-117; see also, Chief Protector of Aborigines, 'Annual Report', 1914, p.8; see also, Chief Protector of Aborigines, 'Annual Report', 1916, p.6; see also, Chief Protector of Aborigines, 'Annual Report', 1917, p.6; see also, Bleakley, *The Aborigines Of Australia*, p.129.

²⁶ Chief Protector of Aborigines, 'Annual Report', 1919, p.6.

government reports during this period was the prevalence of venereal infections, particularly in the Torres Strait and the far west; and in the last area 'phthisis' was also widely reported.²⁷

Venereal diseases among Aborigines in Queensland caused 116 deaths in the period from 1910 to 1919 (see Table 8.1 in Appendix 8 of this Chapter).²⁸ The data reveals a steady increase in the numbers reported as dying from venereal disease which rose from six in 1910 to 19 in 1914. No administrative system was devised to keep abreast of how many Aborigines contracted the disease during the decade, but the number of deaths does give an idea of the scale of the problem. Health authorities in general were never explicit about the full extent of sexually transmitted diseases during this period.²⁹ Earlier in the decade the Queensland parliament was unable to gain public support for including venereal disease on the list of notifiable diseases. The reason for this was that venereal disease was commonly viewed more as a moral and social problem than as a medical one. Moreover the mobility of Queensland's mining and plantation workers made sexually transmitted diseases among them difficult to control.³⁰

Because of the vague public perceptions of what sexually transmitted disease covered, even as late as 1917 venereal disease remained only a 'reportable' disease (i.e., one generally agreed by doctors) rather than a notifiable disease (one covered by law) under the Queensland Health legislation.³¹ Infected Aborigines living in isolated regions were sent under police escort to either the Brisbane infectious diseases sanatoria or

²⁷ *Ibid.*, p.7.

²⁸ QSA, Series A/58973, file no., 58974, with title, 'Death Registers - Where, Cause', 1910 to 1936, see entries for years 1910 to 1920, (see Appendix 8, see Table 8.1).

²⁹ Allan M. Brandt, *No Magic Bullet*, pp.2-51.

³⁰ QFP, *Annual Report Of The Commissioner For Public Health*, 1917, QGP, Brisbane, 1918, p.3.

³¹ *Ibid.*, pp.5-6.

to the relief depots at Taroom, Barambah and Palm Island. Palm Island had by this time, become a place of detention for people contravening the protection legislation, but it also acted as a screening depot for leprosy, tuberculosis and other 'wasting' diseases (for Queensland leprosy figures from 1900 to 1925 see Table 10.2 in Appendix 10).³²

Health officials in regional centres such as Cairns worried extensively about Aborigines harbouring social diseases such as hookworm and respiratory infections. Hookworm was less important as an infectious disease but assumed prominence as a State, Commonwealth and international political issue, and consequently became a factor in the administration of Aborigines. What began in the latter years of the first decade of the Twentieth Century as a cooperative international disease eradication program continued into the second decade as an international initiative for public health. The program was interrupted due to the restrictions imposed by the First World War. When the fighting had come to an end the program recommenced.

In Queensland, the endemic areas of hookworm infestation in Australia correspond to areas of heavy rainfall, mainly in tropical and sub-tropical regions, where the eggs have sufficient warmth and moisture to hatch. The districts of greatest infestation were Charleville, Longreach, Hughenden, Rockhampton, Ayr, Bowen, Mackay, Ingham, Innisfail and Cairns districts.³³ These were the areas identified by the Australian Hookworm Campaign as those with the 'Aboriginal problem'. The Campaign's report said that there was no doubt that hookworm existed in Aboriginal groups prior to white settlement, but only in a limited way. Papuans and Malays were most likely to have introduced the infection.

³² Chief Protector of Aborigines, 'Annual Report', 1920, p.6.

³³ AA/1969/10/1, Item 17 K, 'Hookworm Disease', p.16.

With white settlement 'the "natives" have been gathered into...fixed localities, such as missionary settlements and cattle stations.'³⁴ These conditions 'were ideal for the spread of hookworm disease. In certain areas the hookworm rate among them on first examination was 90 per cent and after 50 per cent.'³⁵ This meant that if immediate eradication of the infection and the habitat where the eggs hatched, and by treating the Aboriginal hosts with an effective treatment program then serious long term effects would follow.

The report specified that 'the Aboriginal settlements acted as centres for the spread of hookworm disease to Europeans, and...they still present a problem.'³⁶ In 1911 researchers located hookworm in north Queensland.³⁷ Dr Anton Breinl pointed out that the disease occurred in children of the Townsville, Ingham, Innisfail and Cairns areas.³⁸ In the period from April 1918 to September 1919, the International Health Board of the Rockefeller Foundation provided money and personnel to carry out surveys. The coastal area from Cooktown to Townsville was the survey region and 22,844 people were screened. Of this number 4,605 people were infected, representing a total infection rate of 21.1 per cent.³⁹ The number of Aborigines examined was 992 and this group revealed an infection rate of approximately 81 per cent. The differences in the infestation rates between one area and another closely matched 'the amount of rainfall in the several districts, and it reflected the amount of

³⁴ *Ibid.*, p.17.

³⁵ *Ibid.*, pf.

³⁶ *Ibid.*, pf.

³⁷ J.H.L. Cumpston, 'Gastro-intestinal Diseases', in Lewis, *Cumpston, Health and Disease*, pp.239-240; see also, A. Breinl, 'Ankylostomiasis', in *Transactions of Australian Medical Congress*, 1911, p.368, cited in Cumpston, *Ibid.*, p.245.

³⁸ Cumpston, 'Gastro-intestinal Diseases', in Lewis, *Cumpston, Health and Disease*, p.240.

³⁹ *Ibid.*, pf.

soil pollution prevailing in the various communities.'⁴⁰ Following these results the Hookworm Campaign developed into a national program, which is described more fully in the next chapter.⁴¹

Leprosy was a more disturbing hygiene problem than digestive parasites. By 1910 the Commonwealth *Quarantine Act, 1908* had been extended to cover leprosy, but only prevented infected people entering the country. Leprosy by then had already taken hold as an endemic disease in some northern areas of Australia.⁴² Amendments to the *Public Health Act, 1884*, made notification of leprosy mandatory, forcing health workers to report on patients suspected of harbouring leprosy. But the legislation applied only to urban areas, completely leaving the rural population without an authority to care for their interests. These conditions, therefore, failed to halt infections in isolated Aboriginal missions, camps and reserves. The Board of Health had the legislative power to compel the detention of the infected but lacked a regulatory body to control the disease over a geographical area as large as Queensland.⁴³ Reports indicated that leprosy as a consequence had spread quite quickly among isolated Aboriginal groups.

Between 1895 and 1900, there were 13 reported new cases of leprosy among Queensland Aborigines. From available data (see Table 8.2) this number increased to 35 by 1910. Among explanations for the increase were the growing influence of protectors, the vigilance of missionaries, interest in Aboriginal labour by pastoralists and the growing proximity of Aborigines to townships. Such factors increased the likelihood that Aborigines who were reported to be infected with leprosy would be

⁴⁰ *Ibid.*, pf.

⁴¹ *Ibid.*, pf.

⁴² Cumpston, 'Leprosy', in Lewis, *Cumpston, Health and Disease*, p.216.

⁴³ Cumpston, 'Leprosy', in Lewis, *Cumpston, Health and Disease*, pp.218-219.

detected and reported to authorities. In the next decade reports of the incidence of leprosy among Aborigines became proportionally greater than among the general population. Between 1895 and 1925 (see Table 10.1 in Appendix 10), the number of recorded cases of leprosy in the wider population fluctuated, peaking in 1915 at 84 cases. During the six years from 1915 to 1920 the number of Aboriginal cases fell from 84 to 56. All new cases were now coming from northern Queensland. In the southern areas of the State no new cases presented in the 15 years from 1910 to 1925, suggesting that the disease had now become a north Queensland phenomenon (see Table 10.1). Leprosy was a disfiguring disease with social consequences and not one identified as a killer disease.

Respiratory diseases killed Aborigines right across the age and sex range. The first entry made in the 'Aboriginal Disease and Death Register' by the Chief Protector in 1910 was for an Aboriginal man from Barambah by the name of Finigan, who died from pneumonia.⁴⁴ From 1910 to 1920 Aborigines died in Queensland from a range of diseases, including pneumonia, venereal disease, senile dementia, tuberculosis, influenza, kidney disease and a large number of other complaints which were categorised as 'other diseases'. Throughout the period, pneumonia remained a constant problem. In 1910, 18 people died from pneumonia; after that the number declined until 1918 when it began to rise once more.⁴⁵

The epidemics appearing periodically in Australia affected only parts of the population, and this was true for both Aborigines and the rest of the Queensland population.⁴⁶ Many small family groupings living on

⁴⁴ QSA, Series A/58973, file no. 58974, with title, 'Death Registers - Where, Cause', 1910 to 1936, folio 1.

⁴⁵ *Ibid.*, pf.

⁴⁶ (Sir) Macfarlane Burnet, and David O. White, *Natural history of infectious disease*, 4 edn, Cambridge University Press, England, 1972, pp.102-123, and see p.204.

isolated northern and western pastoral and mission lands escaped the influenza epidemics altogether, and as a result may not acquire immunity against later epidemics. Those Aborigines who were born after the influenza epidemic of 1895, or who escaped infection during later outbreaks, failed to acquire immunity.⁴⁷ The reason is that influenza strains appear every three or four years and some indigenous groups were either too young or too isolated to have been infected, and therefore developed no resistance to later strains. This could possibly explain the reports of groups of Aborigines suffering from influenza that continually appear in mostly secondary reports and in Protectors' reports at the turn of the century, and why some were affected as they came closer to white settlement during the various epidemics between 1895 and 1918.⁴⁸ Such reports are problematic because they either lack clarity about the event observed by outsiders at the time who fail to reveal the kinds of information required by present-day investigators to draw accurate conclusions about the causes of particular epidemics.⁴⁹ That was not entirely the case in Queensland when records were kept during the pandemic of Spanish Influenza which spread across the world in 1918-1919.

Close to a million American soldiers reached France from June to the 4th of July (American Independence Day) 1918.⁵⁰ But, between August and mid-September of 1918, a strain of either the Spanish Influenza, or what locals called swine fever, infected and killed 1,500 American troops even before leaving the United States for France. Then, even larger

⁴⁷ Bleakley, *The Aborigines of Australia*, pp.174-175.

⁴⁸ Long, *Aboriginal Settlements*, p.96.

⁴⁹ Peter M. Moodie, *Aboriginal Health*, ANU Press, Canberra, 1973, p.vii, and see also, pp.16-25.

⁵⁰ *The Brisbane Courier (TBC)*, 'American Entry: President Wilson's Address', Friday 5 July 1918, p.7.

numbers of American troops left their homeland still infected with the influenza virus, and they became ill and died on route to France.⁵¹ The consequence was that disease infected soldiers from both sides of the conflict who met in battle. From the front it spread to the civilian population on the continent, spreading to England and Spain, killing large numbers of people in both countries. Not since the Black Death in Fourteenth Century Europe had an epidemic inflicted such catastrophe on the people of Europe.⁵² After World War I hostilities ended the epidemic travelled back to England and America then on to South Africa and New Zealand before entering Australia by October 1918.⁵³ In London and Manchester the pandemic had killed 1,600 people by October 1918.⁵⁴ By that month the disease had also reached New Zealand, spreading rapidly throughout the country.⁵⁵

The number of people who were already suffering respiratory diseases when the pandemic reached the Aboriginal populations in Queensland makes it difficult to assess accurately the extent of the impact of the pandemic among them. Table 8.1 indicates the number of people suffering from pneumonia, tuberculosis and non-Spanish influenza, each of which were killer diseases among Aboriginal people. In Table 8.1, the category 'pneumonia' was a particularly persistent killer of Aborigines, and occurred most seriously among people already located in depots and the hospital camps on town fringes close to where sick white people were being brought to hospitals.

⁵¹ Crosby, *Forgotten Influenza*, p.222; see also, F.M. Burnet, *Viruses and Man*, pp.113-114.

⁵² McNeill, *Plagues and Peoples*, pp.156-159; see also, Crosby, *Forgotten Influenza*, p.222.

⁵³ TBC, Tuesday October 15, 1918, p.6; see also, *Annual Report (AR) Of The Commissioner of Public Health (CPHQ)*, p.148, in QPP, Sessions of 1919-1920, QGP, Brisbane, 1918, pp.147-159.

⁵⁴ TBC, Thursday October 17, 1918, p.6.

⁵⁵ *Ibid.*, Tuesday October 22, 1918, p.7.

In the period 1910-1918, Aborigines recorded as dying from diseases (see Table 8.1) numbered 357 males and 224 females: a total of 581 deaths. Those dying from pneumonia in this period totalled 129, and consisted of 79 males and 50 females. The annual number in 1918 rose to 21 males, but only six females, a trend which probably related directly to Spanish Influenza even though it is difficult to know since only deaths of those people in institution (hospitals, doctor's clinics, and government and mission depots and reserves), and those under work contracts of employment were recorded. Deaths from influenza is similar for both males and females and in this period which never rises above 12 deaths in any one year to 1918. It then jumps to 29 males and 9 females. But, from Table 8.1, these trends follow those of the total number of deaths from respiratory infections.

Deaths from tuberculosis rose in the same way and possibly conditioned the authorities to accept abnormally high mortality, so that in 1918 when the Spanish Influenza pandemic struck, people expected that many Aborigines would die. What complicated the picture was that at that very time, 64 males and 51 females succumbed to tuberculosis, or what was diagnosed as phthisis. In 1910 only two males were diagnosed as dying from tuberculosis while no female deaths were recorded. The number of Aboriginal males deaths increased to 15 in the eight years from 1911 to 1918, while in the same period females only rose to a total of 12 deaths. These figures with the rest of those dying from other respiratory illness set the base line for an even more serious number of deaths from the Spanish Influenza pandemic when it struck.

The spread of the disease onto mainland Australia was contained for two basic reason. First, the wartime quarantine restrictions were kept in place as the disease came closer. Second, as the troop and passenger ships

from Europe arrived they were quarantined immediately. Anyone who was either suspected of harbouring the infection or confirmed as a carrier of influenza was removed to the Commonwealth Quarantine Station located in each major seaport. In this way these people were not regarded as reaching Australia and this somewhat distorted both the time at which it was officially recognised as arriving in Australia and when the first case was reported on Australian soil. In Queensland the State Government amended the Infectious Disease Act 1900-1917 to include pneumonic influenza as a notifiable disease.⁵⁶

It appeared from the beginning that this outbreak would affect Aborigines in the same way as the white population. Influenza was not an alien disease to Aboriginal groups but this new strain was particularly virulent, especially among weak and undernourished people. On 22 October 1918, Inspector Quinn of Rockhampton reported 'the death of a half-caste named Butcher, at Comet, from influenza'.⁵⁷ Apparently Butcher had arrived at Rockhampton several days before his death. According to *The Brisbane Courier*, Butcher came from the Springsure District to attend the local races. He remained at Comet for a few days before catching the disease and dying soon after. Sergeant Quinn stressed that he attempted to send Butcher back to his relations living at Emerald, but death came too swiftly.

At the beginning of May 1919 the number of Queenslanders dying of the disease stood at 49 and by the end of May 1919 about 650 people had been hospitalised. In Queensland the hospital system proved unable to cope with newly infected people. At Charleville *The Brisbane Courier* reported, influenza was still spreading in the district and 'the Parish Hall

⁵⁶ AR/CPHQ, 1919-20, pp.149-150.

⁵⁷ *Ibid.*, p.7.

has been fitted up with many beds.'⁵⁸ Hotels and theatres closed, inoculations took place everywhere, bed linen appeals went inter-state, as did the Queensland Health Minister's requests for assistance from hospital nurses. This was the general situation in early 1919; however, a more dangerous predicament was developing among Aboriginal ration depot, reserve, labouring and fringe-camp populations. When the known deaths rose sharply, pleas for help were soon going out from government depots and church missions. Under normal winter conditions Aboriginal groups living in large depots and missions suffered bouts of respiratory infections. It was expected that Spanish Flu would impact heavily upon them.

The reported Aboriginal deaths from influenza, however, never rose above 11 per year until 1916. In 1918 the number of Aborigines dying from pneumonic influenza throughout Queensland reached 38 (29 males and nine females). The excess of male over female deaths is difficult to explain but it should be remembered that Aboriginal male workers in the cattle industry were closer to normal white society than their families. As a result, as they fell ill with the flu their employers immediately despatched them either to public hospitals or directly to relief depots near the coast. As the depot and mission populations increased, the number of reported deaths rose sharply in early 1919 to 277 (174 males and 103 females). These numbers followed both the Australian and the world-wide trend of deaths from the Spanish flu. The total fell progressively from 28 deaths in 1920-22 to none in 1923. The true numbers of deaths from the pandemic were most probably higher than reported as some of the early deaths were entered in the death registers as 'pneumonia', or as

⁵⁸ *Ibid.*, pf.

'bronchitis related infections'. At the beginning of the pandemic its origins and seriousness mystified everyone.⁵⁹

There has been an extensive debate in the medical literature about the incidence of influenzal infection and the immune responses among Aborigines. The historical and anthropological literature in general accepts that the effects of influenza, including the pandemic of 1918-19, were catastrophic. The truth is that we simply do not know. Only the State of Queensland had a death and disease register from which accurate assessments can be made. In other States some confusion exists about the extent to which Spanish flu affected the Aboriginal populations. Most groups of Aborigines in rural areas and in bush camps had small populations and were isolated at long distances from white settlements. Although few reports exist of its actual effect it is probable that their small numbers made it impossible for them to develop any immunity to new strains of disease. It is also possible that some groups missed contracting the infections altogether due to their isolation. For most Aborigines who were infected with the virus, the probability of infection was heightened by their centralisation on missions, depots and confined living areas which served as reservoirs for infection. The next influenza attack after their arrival at the relief depots ensured that inmates became ready-made targets for infection. Peoples' generally low nutritional level predisposed

⁵⁹ Anthea Hyslop, 'A Plague on Whose House? Ballarat and the Spanish flu', p.203, in H. Attwood and R.W. Home, *Patients Practitioners And Techniques, Second National Conference on Medicine and Health in Australia 1984*, published by the Medical History Unit, University of Melbourne, 1985, pp.195-215. In Queensland, by mid-May 1919, Queensland Health ceased using the term 'pneumonic' in combination with 'influenza', see AR/CPHQ, QPP, 1919, p148. The major reason given was that health professionals had difficulty of distinguishing it from pneumonia (see, Crosby, *Forgotten Influenza*, pp.7-13). The same problem occurred in America in 1918, and proved to be a complicating factor later at Aboriginal depots, in, Chief Protector of Aborigines, 'Annual Report', 1919; see also, Chief Protector Bleakley's thoughts, that the most significant feature of the pandemic was that white people caused the outbreak among Aborigines, in, Chief Protector of Aborigines, 'Annual Report', 1919. On the same point see also, Bleakley, *The Aborigines of Australia*, pp.172-174, and pp.540-553.

them towards infection from flu, as did their polluted and over-populated dwelling places.

At the time the flu broke reports were flooding in from around the State about respiratory infections. At the Mitchell River mission on Cape York a number of adults had been reported as suffering from forms of tuberculosis. Cloncurry people were said to be suffering from bronchial pneumonia combined with influenza. Diseased Aborigines were transported from all over Queensland to relief depots, complicating the general picture of respiratory infections. As Figure 8.1 shows an epidemic of pneumonia was already in progress when the Spanish flu arrived, and Aborigines came to relief depots to be treated for one respiratory infection or another. Some went directly to hospitals at Rockhampton, Mitchell and Burketown suffering from complications of tuberculosis. Some sick people from the pastoral properties were delivered directly to hospital by white property owners. But once there hospital staff moved them to hospital disease camps or directly to government relief depots at Duaringa, Barambah and Taroom.⁶⁰

A general gathering of people with serious respiratory disease already existed at the depots prior to the onset of the influenza pandemic (see Figures 8.1 and 8.2). The number of Aborigines dying from combined respiratory infections had increased at least twelve months in advance of the pandemic reaching Australia. This phenomenon is clearly shown in Figures 8.1 and 8.2. For some time after the pandemic reached Australia it was contained in quarantine stations, principally those at Fremantle, Sydney, Melbourne and Brisbane, and its main impact was delayed until 1919. It became obvious in the south in February 1919, and peaked in

⁶⁰ QSA, A/5070, 'Influenza, 1919-1923 - Infectious diseases deputations'; see also, *The Morning Bulletin*, Rockhampton, (TMB/R), Tuesday, 28 January, 1919, see also, newspaper articles circa 1919, from Cairns; see also, *Brisbane Telegraph*, June 1-4, 1921.

August.⁶¹ The quarantine barriers had proved effective, at least temporarily, in arresting its spread, including to Aboriginal groups in Queensland.

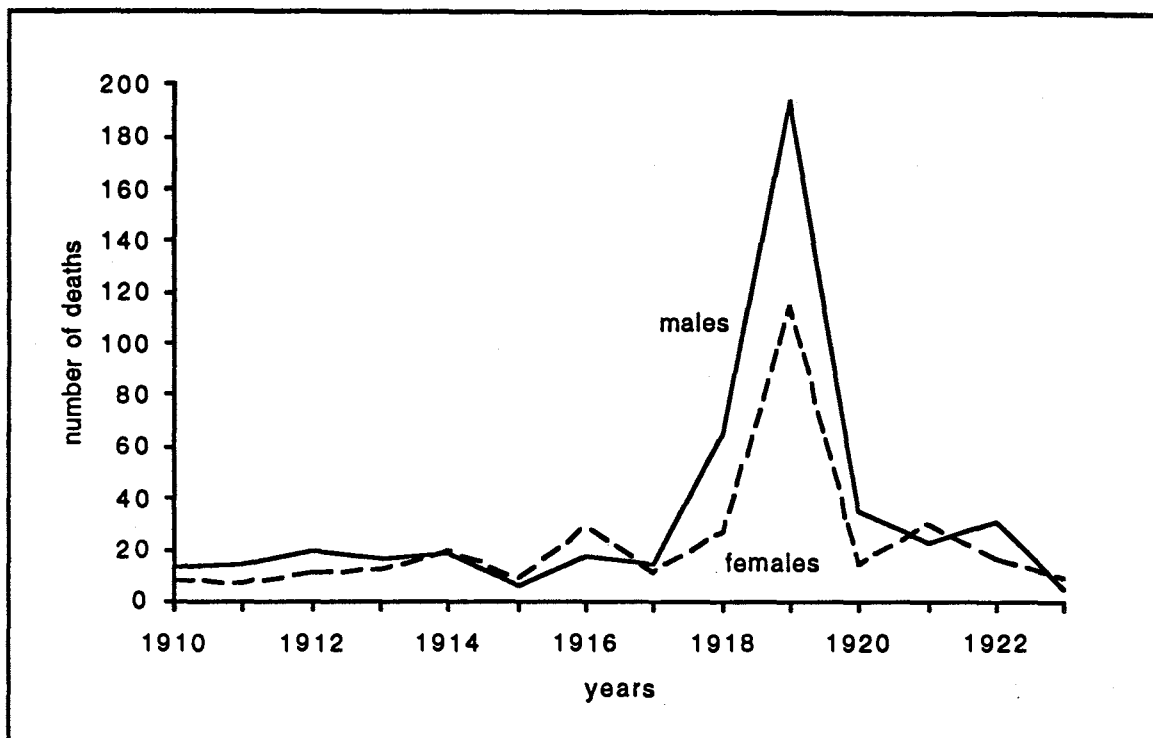
The pandemic came first to the main seaports of middle to southern Queensland and then moved inland to urban and rural regions. It affected white people initially then began affecting Aborigines on top of what has already been described as an epidemic of pneumonia. As the numbers of Aborigines with influenza increased they were taken to disease compounds on the government depots which consisted of fenced areas resembling huge wire cages, built with a ten foot-high cyclone fence and topped by barbed wire to prevent entry and escape. The huts at the relief depots were made of weather-boards with fire-places built outside for cooking meals. The compounds which had been constructed a decade earlier as punishment compounds for people who became infected with venereal disease were now being used to keep people suffering from Spanish Influenza away from the other inmates of the relief depots.

Aborigines who became ill often were influenced by beliefs about death, and as a result when large numbers of inmates died many other inmates reacted by escaping the compounds for the refuge in the bush.⁶² On 8 June 1919, *The Morning Bulletin* of Rockhampton reported that Dr Junk, a general practitioner from the town of Murgon, had attended sick Aborigines at Barambah at the request of the Home Department. He said

⁶¹ See *Melbourne Argus*, "Medicu", January 8, 1919, p.8; see also, *TMB/R*, Tuesday 28 January, 1919, p.7; see also, *TBC*, Wednesday January 22, 1919, see article, 'Pneumonic Influenza', p.8. In Brisbane, the infection began early in May of 1919, in *TMB/R*, '228 cases in Brisbane', Monday May 12, 1919, p.8. A few days earlier, however, a telegram from Cunnamulla on 9 May 1919, reported that as many as 50 per cent of the town had come down with the virus, *TMB/R*, see 'telegram from Cunnamulla', Friday May 9, 1919, p.10; One month later the main impact began infecting Aborigines in numbers, see Bleakley, *The Aborigines of Australia*, p.174.

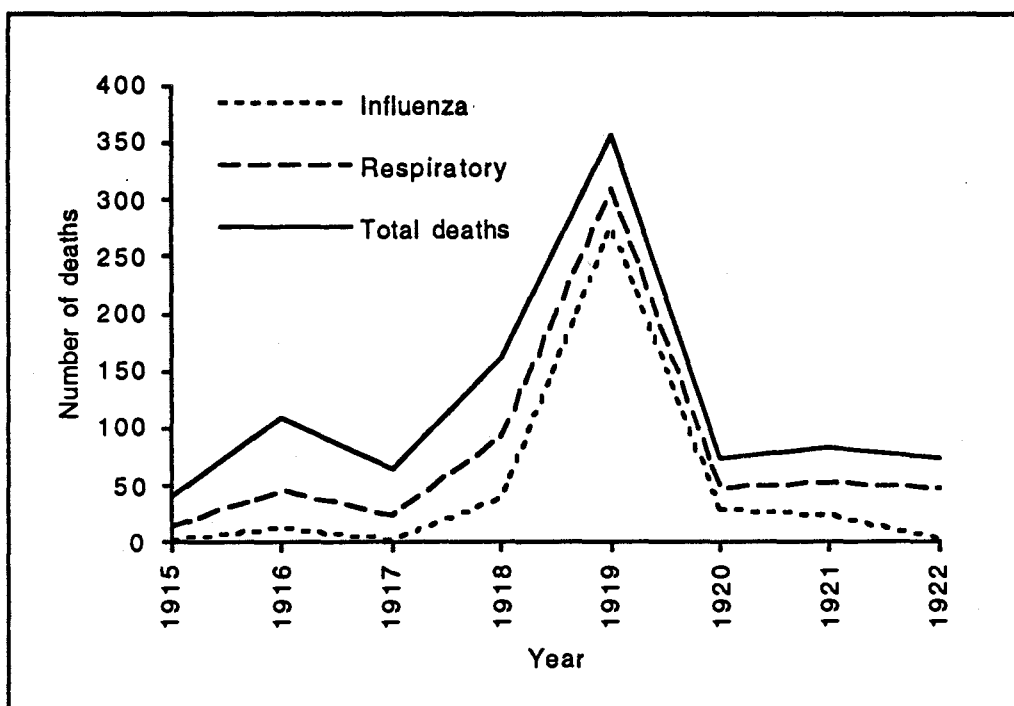
⁶² For a sound approach to and an account of an ethnographic explanation of Aborigines in coastal Queensland and their world-view see, QSA, A/19898, 1898-1903, 'Scientific Report on the natives at Hull River', W.E. Roth, September 1900, pp.3-56.

Figure 8.1: Aboriginal deaths from respiratory diseases in Queensland, 1910-1923



Source: Compiled from Table 8.1.

Figure 8.2: Aboriginal deaths from influenza in relation to total deaths from respiratory diseases in Queensland, 1910-1923



Source: Compiled from Table 8.1.

there was a 'state of panic at the dire effects of the epidemic which influenza caused among the natives at the settlement.'⁶³ Dr Junk also reported that 596 natives had become infected with influenza, of whom 69 Aborigines (24 were males and 45 were female) had died. Most of the dead were aged, infirm or diseased.⁶⁴ Dr Junk said he found old people running about in a panic, and as a result some of the weakest of the older people died immediately. He noted that of those who had died later,

many died of simple "funk", while some through grief and panic, made little resistance and courted death. There can be no doubt as to the result of this fatalistic creed among Australian Aborigines.⁶⁵

He went on to report that two waves of infection had occurred. During the first wave about ten of the white staff suffered infections while caring for sick inmates. During the second wave a similar number of white and Aboriginal staff came down with the disease. He observed that a 'notable feature of this disease was that there had been no deaths among the children.'⁶⁶ It is not possible to say why they were not infected by the adults. Nevertheless, neither Junk nor the Chief Protector's records were able to explain how long the children had been at the depot. Possibly, as at the Palm Island reserve, they escaped the impact of the pandemic because of the distance and isolation from the mainland.

The pandemic caused general chaos. Such large numbers of deaths occurred with each outbreak that disposal of the dead was a major problem. Burials took place immediately. The worst periods were the months from March to October 1919 (see Figure 8.3). At Taroom, for instance, numbers were high from April, and the numbers rose until 10 people died in the last few days of June. Their burial took place in one

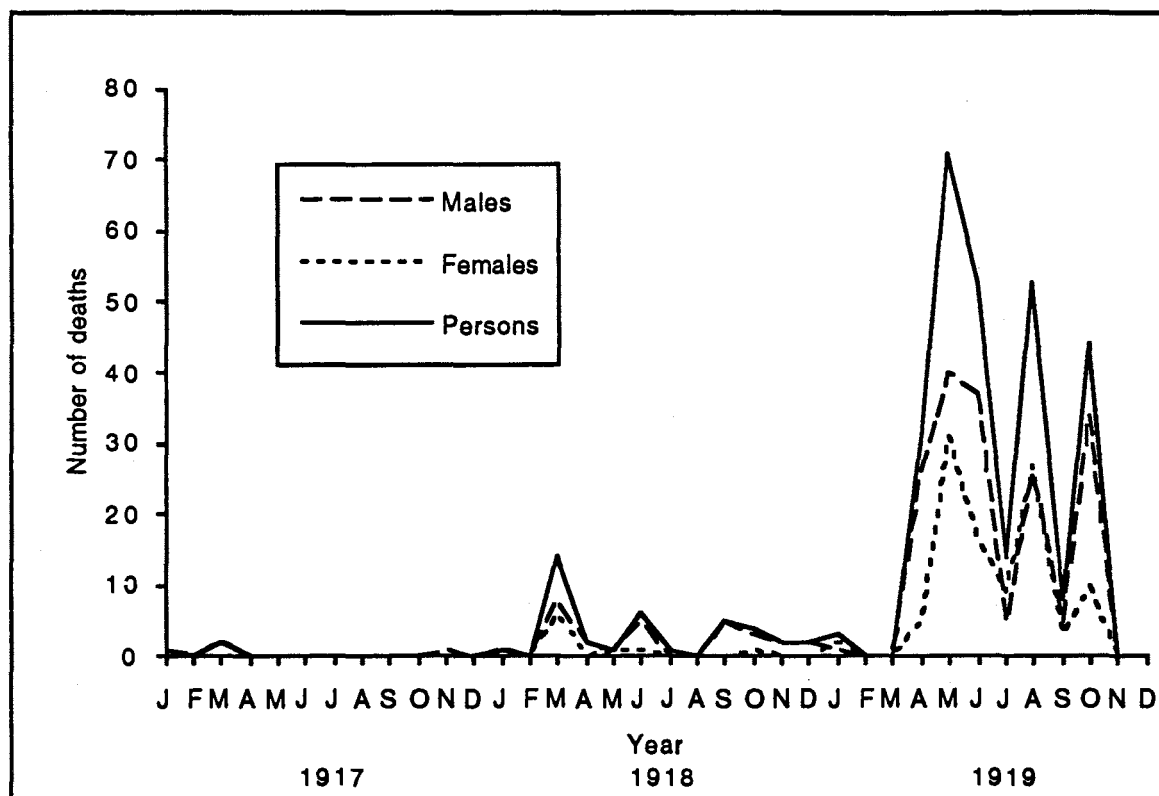
⁶³ *TMB/R*, Monday June 9, 1919, p.8.

⁶⁴ *Ibid.*, pf.

⁶⁵ *Ibid.*, pf.

⁶⁶ *Ibid.*, pf.

Figure 8.3: Aboriginal deaths from influenza per month and by sex in Queensland during the period January 1917 to December 1919



Source: Compiled from QSA, Series No. A/58973-58974, 'Death Register - Where, Cause, 1910-1936'.

session on 29 June. Similarly, on October 10, 1919, approximately 14 deaths occurred and the burials took place in one session at Mareeba, near Cairns.⁶⁷ The dead among Aborigines of full descent at the relief depot went directly to the depot graveyards. At Yarrabah and Purga missions, and the various camps around Cairns, people of full descent went to government relief depots and mission graveyards, while people of mixed descent, including those exempted from the Protection Act 1897, went to public cemeteries.⁶⁸ These high numbers of deaths of Aborigines from influenza were sustained until the end of November 1919.

By late 1919 the influenza pandemic was receding among the general population but in the Aboriginal relief camps the disease appears to have lingered into 1920. Although other respiratory diseases show no major outbreak, this could have been a return to the normally high incidence of pneumonia. It is also possible that the larger pastoral groups and hospital fringe-camps harboured and sustained the infection into the following year. The causes of the continuation of the infection in Aboriginal populations related both to their physiological and social circumstances. These two factors appeared to have acted independently of each other but, as this thesis shows, they also work together. Crosby argued that indigenous populations (similar to those in Queensland under observation in this period) were populations at risk because they had not 'had contact within the lifetime of their oldest members with the disease that...[attacked] them and...[were] therefore immunologically... defenceless.'⁶⁹ This is the 'virgin soils' theory, and the Spanish Influenza pandemic of 1918-1919 supports Crosby's hypothesis.

⁶⁷ QSA, Series A/58973, file no. 58974, 'Death Registers', 1910-1936, September 3, and see October 10, 1919; see also, Chief Protector of Aborigines, 'Annual Report', 1919-1920.

⁶⁸ Chief Protector of Aborigines, 'Annual Report', 1919.

⁶⁹ Crosby, *Germes, Seeds and Animals*, p.222.

The number of Aborigines who perished from the disease (see Table 8.1 and Figure 8.2) remained high for almost a year after it subsided in the white community. Chief Protector Bleakley mentioned in his 1920-21 reports that Aboriginal mortality remained throughout the two years.⁷⁰ Depot and fringe-camp populations in Queensland lived in mostly small isolated groups in the bush. They also lived some distance from urban populations capable of harbouring the infection and becoming immune to that particular strain of the disease. If Aborigines were at a disadvantage by being unable to deal immunologically with new infectious diseases, they were not the first to fail in this way.⁷¹ The difference between the dwelling sites where Aborigines were born and lived for most of their lives, and the new environment was that bush people now lived under totally new hygiene and social conditions. Large numbers of people were gathered in a common or mass living area. These kinds of living conditions were unknown in bush camps or on pastoral properties. When sick Aborigines migrated or travelled away from their homes to seek treatment, their exposure to new pathogens and new social environments led directly to poor health. Their physiological system was unable to cope with the infections confronting them. Under the new circumstances in which the sick found themselves — one in which they faced a range of exotic viral and bacterial infections — good health was almost impossible to maintain.

In contrast to the quarantine and isolation measures implemented everywhere else, the pandemic moved to Queensland and sick indigenous people were brought to government and mission depots.

⁷⁰ Chief Protector of Aborigines, 'Annual Report', 1920-21; see also QSA, Series A/58973, file no., 58974, 'Death Registers', 1910-1936, see figures for, 1919-1920; see also, Table 1, in Appendix 8.

⁷¹ McNeill, *Plagues and Peoples*, pp.23-140; see also, Kunitz, *Disease and Diversity*, pp.72-114.

Once there the pandemic was already established, and they soon became infected, the disease killing mostly the very young babies and the weakened aged. As it did it caused cultural chaos which in turn affected a whole range of Aboriginal peoples' social relationships.⁷² These relations were affected by the pandemic because it led to such rapid social change. It eroded traditional Aboriginal social relations by forcing people to travel long distances for treatment in unfamiliar missions, reserves, relief depots and hospital camps. Older people were commonly despatched to the depots from pastoral properties and from fringe-camps near coastal towns, which could help explain why so many older Aborigines became infected and perished soon after they arrived at their new place of residence. Many of those transported to the large population centres simply lacked the immunity and the strength to fight potent infections such as the Spanish Influenza. At the same time sick and dying Aborigines who were brought to depots were unable to understand the nature of the danger with which they were confronted. As such these sick bush people were unable to adapt quickly to a physiological threat from outside their normal customs, manners and habits. These social relations had been entirely disrupted as the disease uprooted them from bush dwelling places in which they were autonomous and shifted them to a new environment in which they became totally dominated.

In the period 1910 to 1920, the increasing incidence of venereal disease, tuberculosis, leprosy, hookworm infection and the Spanish Influenza pandemic highlighted the need for a change in health delivery services to Aboriginal groups. Authorities searched for answers to such phenomena as more Aborigines were moved to government reserves from cattle properties for care and protection. Government officials,

⁷² Burnet and White, *Natural History of Infectious Disease*, pp.204-209; see also, *TMB/R*, Monday, June 9, 1919.

politicians, church leaders and even the State Governor worried over finding explanations and solutions for the Aboriginal predicament.⁷³ Reform to the health system servicing Aboriginal groups was about to be introduced and, although some of the earlier preoccupations persisted, this is a topic I pursue in the Chapter nine.

⁷³ TBC, NLA series mfm, NX 253, Jan. 1, 1919 - June 30, 1919; but see article in TBC, May 23, 1919, entitled, 'Influenza In France', this article indicates that pneumonic influenza should be considered as life threatening, and was taken from a series of articles by Dr Francis Hackel, published in a French magazine entitled, *Le Illustration*, about how to treat the virus, the important thing is that the disease commenced in Europe and was transferred to Australian by returning soldiers.

APPENDIX 8

Table 8.1: Aboriginal deaths in Queensland, 1910-1919

	1910	1911	1912	1913	1914	1915	1916	1917	1918	1919	Total
Males											
Pneumonia	10	10	12	7	6	2	6	5	21	14	93
Influenza	1	1	1			3	1	4	29	174	214
Consumption, TB, phthisis	2	3	7	9	12	1	10	5	15	6	70
Nephritis		1			2			1	2	11	17
<i>Sub-total respiratory</i>	<i>13</i>	<i>15</i>	<i>20</i>	<i>16</i>	<i>20</i>	<i>6</i>	<i>17</i>	<i>15</i>	<i>67</i>	<i>205</i>	<i>394</i>
Venereal diseases	3	4	8	6	11	7	6	4	7	4	60
Senile decay	5	6	9	16	8	5	14	9	17	2	91
Other diseases	5		3	3	5	5	19	9	18	8	75
<i>Sub-total other diseases</i>	<i>13</i>	<i>10</i>	<i>20</i>	<i>25</i>	<i>24</i>	<i>17</i>	<i>39</i>	<i>22</i>	<i>42</i>	<i>14</i>	<i>226</i>
Total male deaths	26	25	40	41	44	23	56	37	109	219	620
Females											
Pneumonia	8	3	4	9	6	5	10	4	6	9	64
Influenza			4	1	2	1	11		9	103	131
Consumption, TB, phthisis		4	3	2	12	3	8	7	12	3	54
Nephritis									1	5	6
<i>Sub-total respiratory</i>	<i>8</i>	<i>7</i>	<i>11</i>	<i>12</i>	<i>20</i>	<i>9</i>	<i>29</i>	<i>11</i>	<i>28</i>	<i>120</i>	<i>255</i>
Venereal diseases	3	2	8	9	8	8	6	4	5	3	56
Senile decay	2	2		3	7	1	8	8	8	8	47
Other diseases	5	3	1	5	8	1	10	5	12	6	56
<i>Sub-total other diseases</i>	<i>10</i>	<i>7</i>	<i>9</i>	<i>17</i>	<i>23</i>	<i>10</i>	<i>24</i>	<i>17</i>	<i>25</i>	<i>17</i>	<i>159</i>
Total female deaths	18	14	20	29	43	19	53	28	53	137	414

Source: Queensland State Archives, Series No., A/58973 — 58974, 'Death Registers - Where, Cause, 1910-1936'

Table 8.2: Aboriginal deaths in Queensland from influenza during January 1916 to December 1919, by sex and month

	1915	1916	1917	1918	1919	1920	1921	1922
Total influenza	4	12	4	38	277	28	24	3
Total respiratory	15	46	25	92	309	49	53	47
Total deaths	42	109	65	162	356	73	83	74

CHAPTER 9

For their own contentment and comfort:

Aspects of Aboriginal health in Queensland, 1920 to 1930

The period from 1920 to 1930 was important for Aboriginal health. These years saw the publication of the results of the hookworm surveys carried out along the central Queensland coastal districts between 1918 and 1923. In addition, the reforms introduced throughout the 1920s transformed the old style ration and relief depots into settled, permanent and segregated Aboriginal townships. One reason why such townships were created was in an attempt to ensure that Aborigines married and produced children only among themselves. In addition, these townships were developed as separate, segregated institutions so that Aborigines could feel 'contentment and comfort'.¹ In this chapter I examine this shift in policy and its associated developments in Aboriginal health. The latter includes follow-up action on the hookworm survey, the continuing problem of venereal disease among coastal Aborigines, mortality from respiratory infection, the transformation of health compounds into health clinics with the concomitant emergence of new social relations, and finally the growing problem of the reported existence of leprosy among Aborigines (see Queensland and Western Australian leprosy Totals from 1900 to 1925, in Table 10.2 in Appendix 10).

¹ Chief Protector of Aborigines, *Annual Report*, 1913, p.17, in QPP, 1914, Vol. III, pp.1011-1030; see also, Long, *Aboriginal Settlements*, p.97; see also, Bleakley, *The Aborigines of Australia*, pp.166-180.

The post World War I phase of the National Hookworm Campaign which ended in 1924 was entwined with the growth of ideas about public health from which came the 'Betterment' movement² for Aborigines. Aborigines by now were widely perceived as being in need of 'improvement'. This view included a belief that they could productively assist during postwar reconstruction.³ One approach to 'improvement' was to ensure that Aborigines coming into the labour camps were free of infectious diseases which could threaten the rest of the work force. The notion that hookworm was a 'disease of laziness' had to be dispelled immediately. The National Hookworm Campaign therefore targeted Aborigines as the group most vulnerable to hookworm infection and consequently the group among whom the disease had to be treated first. As revealed in previous research among indigenous groups, the rate of infection was high among Aboriginal groups. Practically all indigenous groups of north Queensland were affected by hookworm the report claimed.⁴ Some groups contained extremely high rates of infestation. One researcher found a 100 per cent infection rate among Aborigines at Yarrabah, a mission near Cairns. Three years later, the survey found an infection rate of 75 per cent in the two settlements of Aborigines on Palm Island.

² National Library of Australia (NLA), mfm NX 643, 'Daily Mail', May 22, and 12th June, 1919, see article, 'Justice for our Aborigines', and 15 June 1919; see also, NLA, mfm NX 643, 'Courier Mail', dated 19 June 1919, letter to the editor; and see also, interview with Premier Theodore dated 12 June 1919; see also, NLA, mfm NX 640, 'Standard', dated 12 June 1919; see also, NLA, mfm NX 190, 'Cairns Post', dated 12 June 1919; see also, NLA, mfm NX 190, 'Telegraph', dated 12 June 1919, and also, 'Courier Mail', dated 20 June 1919.

³ Chief Protector of Aborigines, *Annual Report, 1919-1920*, in QPP, 1920; see also, Long, *Aboriginal Settlements*, pp.96-97, (Long talked about the scheme but makes no elaboration); see also, Dawn May, *Aboriginal Labour*, pp.104-123, (Dawn May makes no mention of the Betterment Scheme or the Betterment Movement).

⁴ Chief Protector of Aborigines, *Annual Report, 1919-1920*, p.6, in QPP, 1920, Vol. II, p.233.

By 1924 the data collected by the National Hookworm Campaign was released to the public.⁵ Selective material was presented to show what the incidence of the disease was among only some Aboriginal groups,⁶ but it indicated that

with white settlement the natives were eventually gathered into more or less permanent groups in fixed localities, such as missionary settlements, and cattle stations, and these altered conditions were ideal for the spread of hookworm disease. In certain areas the hookworm rate among them on first examination, was found to be over 90 percent, while 50 percent and over was usual. These Aboriginal settlements have acted as centres for the spread of hookworm disease to the European, and as a matter of fact, they still present a problem.⁷

The problem extended to those Kanaka, Chinese and white populations who failed to construct 'privies' at their place of residence and whose habit was to defecate close to their houses.⁸

Although the campaign lasted well over a decade, its final stages commenced in August 1920 and lasted until 1924.⁹ It followed a preliminary campaign conducted by the Queensland Hookworm Campaign under Dr S.M. Lambert. The final report indicated that the population was a shifting one, which meant that a number of mass treatment visits became the normal eradication strategy.¹⁰ Aboriginal settlements, the report stated, resulted from the inability of Aborigines to

⁵ A/A, 1969/10, Items, 17 I, 17J, and 17K, 'Hookworm Disease and Control', see, W.C. Sweet, 'The Activities Of The Australian Hookworm Campaign', Reprinted from *The Medical Journal Of Australia (Transactions Of Congress)*, May 17, 1924, pp.1-13.

⁶ Cumpston, 'Hookworm', in Lewis, Cumpston, *Health and Disease*, pp.241-245, this is a much shorter version summarising the period of operations and outcomes, but for more detail see the archival material cited above and Sweet, 'Australian Hookworm Campaign', pp.1-13; see also, Gillespie, 'The Rockefeller Foundation', in McLeod and Denoon, *Health And Healing*, pp.64-87.

⁷ A/A, 1969/10/1, Item 17K, 'Final Report of the Australian Hookworm Campaign', pp.17-18.

⁸ *Ibid.*, see copy of letter, 'From A.E. Wilkinson Town Clerk of Cairns to Dr J.H. Waite, of the Australian Institute of Tropical Medicine', dated 27 August, 1918.

⁹ A/A, 1969/10/1, Item 17K, 'Final Report of the Australian Hookworm Campaign', p.55.

¹⁰ *Ibid.*, pf.

live in comfort among the white population, though in some cases the Aborigines had been placed in settlements for misdemeanours under the protection legislation. The report claimed the settlements were like 'a home, a benevolent asylum, and a reformatory.'¹¹ The Aborigines surveyed at the Ingham Aboriginal reserve displayed an infection rate of 70.4 per cent out of a population of 92 people.¹² Although very young children had been infected, throughout the population of Aborigines tested, older children and young adults appeared to have highest rates of infection.¹³

Barambah began as a relief depot and in the space of little over a decade its residents had become an institutionalised population. At this settlement 142 people presented with hookworm infection from a population of 602, or 24 per cent.¹⁴ The Barambah rate was clearly much lower than in the north. The reason for this disparity may have been that Barambah and other southern settlements had already been treated with chemicals. Phenyl was sprayed on the ground surrounding the toilets and urinals. In addition, most houses on depots, and most public facilities including the disease camp areas, were sprayed with the disinfectant by pressure pumps. The presence of the disease among Aborigines destroyed the image of the Aborigines portrayed by the 'betterment movement' to Australian society.

A total of 1,079 Aborigines were living in this district apart from the Barambah population of 602. A further 426 Aborigines lived in fringe-camps near Murgon (a farming service town close to both Barambah and Taroom Aboriginal ration and relief depots). Another 51 Aboriginal

¹¹ *Ibid.*, pf.

¹² *Ibid.*, p.57 (a) on cover sheet, form 133; but see also, p.61.

¹³ *Ibid.*, p.57 (a).

¹⁴ A/A, 1969/10/1, Item 2E, 'Relief and Control Of Hookworm Disease In Queensland, Australia', pp.1-17, see Table 5, p.10.

workers of the district had no specified dwelling place.¹⁵ The incidence of hookworm infection by age and geographical distribution revealed that the highest infection was in the age group between 6 and 18 years, most of whom lived in the fringe camps.¹⁶ At the reserve, however, the figures revealed that 62 people in the 6-18 year age were infected or approximately 10 per cent of the total population. In the camps, out of a total of 417 only 6 were infected. As the researchers stated, the numbers were 'too small for any importance to be attached to these groups.'¹⁷ The national hookworm survey teams tabulated the results, correlating them with the rainfall and climate.¹⁸

Elkington, the new Director at the Institute of Tropical Medicine, indicated in 1923 to Cecil Cook, the Commonwealth Quarantine Officer in Darwin, that hookworm constituted a 'menace to white people' in the Northern Territory and Queensland, and would consequently require all available funds for a considerable time.¹⁹ Cilento, the new Director of the Division of Tropical Hygiene, had a different view of treatment: the public were to be educated. His view was that

the new hookworm campaign was basically educational. Illustrating pamphlets in Maltese, Italian were distributed in the community and lantern light slide lectures were held to demonstrate...[the need] for clean sanitary habits. Hookworm nurses and inspectors visited schools and other public places. There were laboratories in most centres for testing samples of faeces for the presence of hookworm eggs....It was difficult to collect faeces from sugar farmers...among whom domestic sanitation was appalling...[they] had little or no

¹⁵ *Ibid.*, see Table 5, p.10.

¹⁶ *Ibid.*, p.12.

¹⁷ *Ibid.*, pf.

¹⁸ Cumpston, in Lewis, *Cumpston, Health and Disease*, see Table 113, p.242.

¹⁹ Gillespie, 'The Rockefeller Foundation', in McLeod and Denoon, *Health And Healing*, p.86. Gillespie also cites this letter and quotes more extensively from it, see A/A, letter from Elkington to Cook, 18th August, Series No. CRS, A1928/495/21, Canberra.

English, lived in poverty in squalid hovels and kept to themselves.²⁰

Cilento obviously understood workers' habits in the cane cutting districts.²¹

The Health Commissioner of Queensland had a two day follow up survey conducted among the various Aboriginal groups, and this

took in Dunwich, Myora and Amity Point. The survey commenced on 14 August and persisted until 16 August 1924, and the numbers [of people previously infected] examined in Dunwich was 309, and of these only two cases were found positive, and these men were aged 52 and 75 respectively. This showed the previous treatment...[to be] very successful. At Myora 24 cases were examined...[and] 15 harbour[ed] hookworm.²²

The difference between the Dunwich and Myora figures was remarkable. Bleakley, the Chief Protector, believed that if the attempt to eradicate the disease was to succeed in the long term then Aborigines had to stop walking around barefoot and should wear 'some foot-covering.'²³ Cumpston had suggested that the Institute of Tropical Medicine should become a central testing agency of use by medical practitioners of the north. Cilento had changed the research orientation of the Institute from a preoccupation with disease conditions to preventive medicine or, as he put it, 'from sickness to health.'²⁴ He knew that 'by the early twentieth century the aetiology and cure for hookworm infestation had been well understood.'²⁵ The hookworm surveys also found high levels of

²⁰ Fedora G. Fisher, *Raphael Cilento: A Biography*, University of Queensland Press, Brisbane, 1994, pp.45-66.

²¹ *Ibid.*, pp.45-66, and see p.138; and see also, Geoff Burrows and Clive Morton, *The Canecutters*, Melbourne University Press, 1986, pp.78-80; see also, A/A, 1969/10/1, Item 2E, 'Relief and Control Of Hookworm Disease In Queensland, Australia'.

²² Chief Protector of Aborigines, *Annual Report*, 1924, p.16, in QPP, QGP, Brisbane, 1925.

²³ *Ibid.*, p.16. Bleakley stated his scepticism that little support of the hard work already applied would be forthcoming.

²⁴ Fisher, *Raphael Cilento*, p.46.

²⁵ Gillespie, *The Price of Health*, p.66-86; Gillespie also cites this letter and quotes more extensively from it, see A/A, letter from Elkington to Cook, 18th August, Series No. CRS, A1928/495/21, Canberra.

infestation among some migrant groups. In the original investigation in three north Queensland districts, of 1,339 Italians examined, 32 per cent showed infection by hookworm. In a group of 221 Spanish people the rate was 29.1 per cent. In a sample of 12,318 British Australians, however, the rate was only 15.3 per cent, while among 112 Pacific Islanders the rate was 30.3 per cent. By contrast, in a group of 393 Aborigines the rate of infestation was 62.1 per cent.²⁶

Those leading the development of public health tended to overstate the threat of hookworm in Australia. There was a concern that the effects of the disease on Aborigines was to create a permanent pool of infection which would always pose a threat to the broader Australian population. Cilento was one whose views, on this subject, were extreme. In his diary of 17 December 1917, Cilento reveals a perspective of prejudice and a tinge of compassion about Aborigines, when he writes that

my Aboriginal patient was in a meanly built cottage...As the car drove down it was greeted by scores of mongrel dogs...Their furious barking brought natives old, young and middle-aged, black, yellow and almost white to every door and window....The home of the sick women was floored with mud and stamped hard....The living room was crowded with waiting gins....The bedroom was smaller dirtier and similarly floored and roofed with bags that bulged with many a hint of vermin and dirt.²⁷

These comments seemed naive and prejudiced to Yarwood, who wrote about Cilento in the early 1990s.²⁸

Sanitary conditions in the cane plantation regions had been poor and as a result most plantation workers became infected. The same was true for the Aboriginal communities. Sanitary closets were not

²⁶ Douglas Gordon, *Health, Sickness, and Society, Theoretical concepts in social preventive medicine*, Queensland University Press, Brisbane, 1974, p.111.

²⁷ Cited in A.T. Yarwood, 'Sir Raphael Cilento and The White Man In The Tropics', in MacLeod and Denoon, *Health And Healing*, pp.47-48. Quote is on p.48.

²⁸ Yarwood, 'Sir Raphael Cilento', in MacLeod and Denoon, *Health And Healing*, pp.54-60.

extensively provided because of the costs of installation. In the mid-1920s Bleakley had difficulty in showing that the Aboriginal population was increasing on reserves. However, populations were increasing in the fringe camps and information on their size was never properly collected. The demand for toilet facilities was never accepted as a legitimate health need. The final report of the Hookworm Campaign concluded that the main cause of the spread of the hookworm disease was a lack of proper toilets and latrines. Further, it argued that those people not already infected would eventually become victims by coming in contact either with infected material such as polluted soil or through direct contact with other humans and animals.²⁹

Temporary relief depots and places of segregated detention possessed human waste systems described as 'primitive'.³⁰ What this meant was that of all the hundreds campsites and scores of homes occupied by Aborigines in the various depots, settlements, missions and fringe-camps only six had privies.³¹ According to the final report on hookworm, mission, camp and depot populations were observed to simply defecated and urinated where they stood, slept and ate, or in the bush nearby.³² Researchers reported that the ground around Aboriginal living sites soon became polluted. The constant use of the dwelling site as a repository for human excreta ensured this; even where toilets had been constructed they were allowed to overflow and pollute the surrounding areas for some distance.³³ The Queensland Protector was paradoxically placed because they wanted to leave people alone while at the same time

²⁹ A/A, 1969/10/1, Item 2E, 'Preliminary Report, No 73871, on the work for the Relief And Control Of Hookworm Disease In Queensland, Australia, From April 17 to August 28 1918, by J.H. Waite, MD, State Director', p.11.

³⁰ *Ibid.*, p.14.

³¹ *Ibid.*, pf.

³² Sweet, 'Australian Hookworm Campaign', p.9.

³³ *Ibid.*, see Table VI, pf.

expected that they should be able to request public views when needed. But of course this was an optimistic expectation of people who had so recently emerged from bush life and to which no amount of tuition by the State for inmates to use the latrines would solve the problem as it presented itself.

Meanwhile, there were two inspections in the period from 1920 to 1923, and the second revealed a vast improvement over the results of the first. Comparisons of hookworm prevalence in places completely re-surveyed in September 1923 showed, for example, that whereas at Purga Aboriginal mission near Cairns the first inspection had revealed a 70.4 per cent infection rate, by the time the second inspection had occurred the rate had fallen to 45.9 per cent. The figure was still too high, however, because even though there had been a 24.5 per cent improvement, a rate of almost 46 per cent among Aborigines was two or three times higher than the rate among other groups.³⁴ Other Aboriginal settlements showed improvement too, but the incidence of hookworm infection remained unacceptably high. Palm Island, which had an infection rate of 66.2 per cent at the first inspection fell only by 9.3 points to 56.9 per cent. As mentioned earlier, a similar small improvement occurred at Barambah where the initial rate was 25.0 per cent, falling by 4.7 points to 20.3 per cent at the second survey.³⁵ In the places where the sanitation improved, a reduction in infection rates occurred, but even when sanitation improved and treatment was administered other factors such as the continued pollution of the living area ensured high levels of infection. Aboriginal camps had no sanitation whatsoever and so in these locations the rates of infection sometimes increased.³⁶ As at Barambah

³⁴ *Ibid.*, Table VI, pf.

³⁵ *Ibid.*, Table VI, pf.

³⁶ *Ibid.*, p.10.

improvement generally came because government acted deliberately to reduce the risk of infection by providing toilets, cleaning the surrounding polluted soil and disposing of human waste.³⁷

In the whole of the Queensland survey, as reported by Sweet in 1924,³⁸ 167,290 people (blacks and whites) were screened. Of this number, 15,472 (or 9.2 per cent of all surveyed) were infected with hookworm. The Queensland infections amounted to 6.2 per cent of the Australian total screened, which was 248,721. The highest rates in Australia were among the Aboriginal groups of Cape York, where tropical conditions were similar to those in the Pacific Islands.³⁹ Following the screening and treatment program a permanent control plan was devised and put into operation on 1 January 1923. The Australian Hookworm Campaign employed sanitary engineers to inspect sites identified by the surveys as 'hookworm polluted'. Their strategy was to carry out surveillance of infected sites and to make sure that the public was being educated about the complex nature of 'soil pollution'. In addition the engineers had to consult with local government authorities, who then followed up on the engineering advice. The data collected by the engineers of the Australian Hookworm Campaign Office, went to the Queensland Health Department for follow-up treatment and surveillance work.⁴⁰ No mention was made in the final report about what the States ought to do either follow-up or continuing surveillance.

Except for continuing work among Aboriginal camp groupings the Australian Hookworm Campaign completed its work on 30 September

³⁷ *Ibid.*, pf.

³⁸ W.C. Sweet, 'Intestinal Parasites Of Man In Australia And Its Dependencies as Found By The Australian Hookworm Campaign', in Reprint from *MJA*, April 26, 1924, p.1.

³⁹ *Ibid.*, pp.3-4; see following articles cited by Sweet, J.H. Waite, 'Preliminary Report on Ankylostomiasis in Papua', in *MJA*, Sept 15, 1917, p.22; see also, S.M. Lambert, 'Intestinal Parasites in North Queensland', in *MJA*, April 23, 1921, p.332.

⁴⁰ Sweet, 'Intestinal Parasites', pp.11-12.

1924. That body had national responsibility to monitor control measures. Limitations on what its diagnostic laboratories could do were imposed by the funds it received. Although it planned in 1925 to have a number of laboratories located around Australia to continue the survey and treatment program, in practice this proved difficult to achieve. No further action on follow-up treatment of hookworm occurred either in Aboriginal institutions close to rural service towns or in isolated religious missions.⁴¹

Bleakley was still the Chief Protector and his reputation as an authority on Aborigines had grown.⁴² His views on protection favoured segregation, and the allocation of reserved lands for that purpose. Both of these objectives were central to the policies of his administration. But despite his concern to segregate Aborigines from society, outside influences still penetrated the protective net in the form of contact between Japanese mariners and Aborigines. The Japanese maintained fishing communities in the Solomon Islands, and they came south to harvest fish, at which times they lived in various locations along the Queensland coast for extended periods. An unknown number of these mariners set up camps, or lived in cottages built by Australian fishermen on islands off the coast of northern Queensland. They also stayed for long periods in the hundreds of estuarine locations on the Queensland coast itself. They were mainly males, although a number of Japanese females were brought in between 1907 and 1910, and many of these fishermen took Aboriginal women as labourers, concubines and even as 'articles' of exchange. Venereal infections must have been passed between Aboriginal women living close to or with the Japanese and other Asian mariners.

⁴¹ *Ibid.*, p.12.

⁴² Ian Howie-Willis, 'Bleakley, J.', in Horton, *Encyclopaedia of Aboriginal Australia*, pp.134-135; see also, Raymond Evans, 'Bleakley, John William', in Nairn and Serle, *ADB*, Vol. 7, pp.325-326.

No comprehensive record of venereal infections among these fishermen exists, nor were comprehensive records among Aborigines kept either by protectors or medical practitioners. The 'Death and Disease Register'⁴³, however, did record the number of Aboriginal deaths from venereal diseases.

Anxiety by Queensland fishermen and Commonwealth Customs agents about cohabitation between Japanese men and Aboriginal women prompted the Chief Protector to inspect annually the Aboriginal reserves and campsites along the Queensland coast.⁴⁴ The transfer of communicable diseases between Aborigines and the Japanese mariners was a matter for concern to the protectors and government agents. Speculation about the presence of foreign fishermen led to rumours that they were spreading venereal diseases among Aborigines. Articles on Japanese sailors periodically appeared in the newspapers of coastal towns. These articles were placed on record in the files of customs officers. Although no correspondence passed between the customs authority and Bleakley, he probably received information from customs officials in Cairns. Early in 1922 an article appeared in the *Cooktown Independent*, focusing on the prospects of 'the white man being gradually deprived of his hold on the fishing industry along the coast.'⁴⁵ The article went on to say that 'Asiatic fishermen are not only multiplying in numbers, but...are masters of the natives of the land.'⁴⁶

A number of Japanese sailors were under surveillance by the Home and Territories Department in 1920. Skippers of luggers employed by

⁴³ QSA, Series No. A/58973 – 58974, 'Death Registers – Where, Cause, 1910-1936'.

⁴⁴ QSA/58853, 'Venereal – Aborigines General', see also, papers marked 'Aboriginal VD Camps – Cooktown', dated 6 August, 1925.

⁴⁵ *Ibid.*, pf.

⁴⁶ Along Our Coast – 'White Fishermen Out-Rivalled – How Asiatics Coax The Natives', *Cooktown Independent*, June, 1922, in news clippings in Australian Archives Series No. A 1, 1923/14083, Home Territories File No. 23/6432, – 'Japanese Cohabiting'.

Nippon Yushen Kaisha Co., a Japanese fishing Company with bases in Thursday Island, New Guinea and Hong Kong, all employed Japanese contract seamen.⁴⁷ Seamen such as Captain Niro Nagasaku, Wahichi Nakashiba, Hachiro Wooi, Kichizo Goto and Yonematsu Nishakawa all fished along the Australian coast for many years and had long contact with Aboriginal men and women. Mr F.N. Gabriel, a Customs Officer in Cairns, reported that Japanese luggers rested in inlets and were 'in and out of ports after dark without hindrance.'⁴⁸

The Japanese mariners knew well all the coastal inlets and bays from Mackay to Thursday Island. They sheltered regularly in these waters even though between Cape Grafton and Cooktown, 'no attended lighting existed.'⁴⁹ Similarly, no guiding lights existed along the 1,000 kilometres of coastline between Cooktown and Goode Island.⁵⁰ The sailors would leave their luggers, sometimes for weeks, trek inland to Aboriginal missions and live there undetected by either mission or government authorities. An Aboriginal informed Gabriel that on 2 July 1922 plenty of Japanese boats had come to Port Stewart near the Daintree River and had stayed 'a long time.'⁵¹ They had brought 'plenty of food and grog and the Japanese got plenty of gins.'⁵² There were many drunken brawls between the Aborigines and the Japanese, and the Japanese took the drunken Aboriginal men and women away on the boats.⁵³ At Port Stewart temporary thatched huts served as accommodation for six or seven Japanese sailors. In addition the sailors used huts built by white men as a

⁴⁷ Report: to The Chief Clerk, Home And Territories Department, by Inspector F.N. Gabriel, Collector of Customs, Cairns, in Home and Territories file 23/6432, 'Japanese Cohabiting', in AA Series A/1, 1923/14083, pp.1-6.

⁴⁸ *Ibid.*, p.4.

⁴⁹ *Ibid.*, pf.

⁵⁰ *Ibid.*, pp.5-6.

⁵¹ *Ibid.*, pf.

⁵² *Ibid.*, p.2.

⁵³ *Ibid.*, pf.

haven from rough seas. Dr Elliott of Cooktown advised Gabriel that the Japanese had received treatment for both syphilis and other less dangerous forms of venereal disease.⁵⁴

Although the Courts deported him once, Nakashiba disappeared into the bush for over a year. Then Gabriel 'discovering him at Yarrabah mission building boats for the mission.'⁵⁵ Nakashiba received no wages from the mission, which supplied the material for the boats.⁵⁶ Gabriel said that Nakashiba told both Rev. Smith and Captain Brewster (the Harbour Master at Cairns) that he owned a cattle property at Cow Station inland from Cairns.⁵⁷ Another report by Gabriel⁵⁸ indicated that a Japanese named Miyagawa had opened a store at Cooktown to supply food to the boats arriving there. Miyagawa came originally from Cairns as an employee of P.J. Doyle, a merchant, selling wines and spirits to Japanese mariners. According to Gabriel, Miyagawa came under notice for illegally selling alcohol to Aborigines and was fined £100 for doing so. In addition Dr Elliott had him under surveillance because he said that 'men and women suffering from syphilis still continue to arrive at Cooktown from Coen.'⁵⁹

The rising incidence of venereal disease caused an exodus to the Cairns hospital and health camps.⁶⁰ The overcrowding forced staff to use tents to house those who, suffering from venereal disease, had come for treatment. In Cairns, the Customs officials accommodated the sick and diseased Japanese and Aborigines in the 'alien' stockade. This practice

⁵⁴ *Ibid.*, pf.

⁵⁵ *Ibid.*, p.5.

⁵⁶ *Ibid.*, p.6.

⁵⁷ *Ibid.*, pf.

⁵⁸ AA Series A/1, 1923/14083 - 'Japanese Cohabitation', in 'Progress Report relating to suspicious movements of Japanese between Mackay and Port Stewart', dated 19/12/1922 (this is a one page report).

⁵⁹ *Ibid.*, pf.

⁶⁰ *Ibid.*, pf.

was adopted by the medical officers, who held emergency powers under the infectious disease legislation to do so. Such accommodation remained unhygienic, although repairs were gradually undertaken. In Cooktown the alien cells at the hospital were otherwise known as the Aboriginal venereal disease and leprosy stockade, which I mention more about below.⁶¹

Meanwhile, Gabriel received a letter from F.W. Hayes of the Land Office in Cooktown on 21 June 1922, who wrote about

obtaining authentic information [about] the Japanese Bêche-de-mer fishermen along the Queensland coast [who] are cohabiting with the Aboriginal women. I am in a position to state emphatically that they do, and have been indulging in the practice for years.⁶²

Hayes wrote that he planned a trip to northern Cape York soon and would not be back for about three months. He would attempt to get more proof if requested.⁶³

In a memo to Gabriel, N.A. Pollock, the northern district inspector of customs, advised that Hayes was in contact with him about Japanese cohabiting with Aboriginal women and that he expected the police patrol to arrive soon

⁶¹ QSA, Series, No. A/58863, Item No. 36/688, 'Hospital Boards Generally', see 'letter dated 21st April, 1933 from Acting Under Secretary, Dept. Public Works', p.1; see also, 'letter from Cooktown Hospital Board to The Under Secretary Home Secretary's Office, dated Nov. 21st, 1933', p.1; see also, copy 'telegram, From Cooktown Hospital Board to Under Secretary, dated 21/11/1933, re contractors to repair accommodation for aliens'; see also, letter, 'Cooktown Hospital Board to Under Secretary, Home Secretary's Department, re repairs to stockade for Aboriginal VD and leprosy patients, dated 17th October, 1934', p.1; see also, 'letter from Chief Protector O'Leary to Under Secretary Home Department re proposed removal of cells from Cooktown hospital, dated 7th February, 1935', pp.1-2; see also, 'letter from Chief Protector O'Leary to Under Secretary Department of Health and Home Affairs, dated 25th February, 1936', pp.1-2.

⁶² *Ibid.*, AA, Series, A/1, file, 23/6432, see, 'letter from F.W. Hayes to Gabriel, Customs Office Cairns, dated 21 June, 1922', p.1.

⁶³ *Ibid.*, pf.

with seven Aboriginal women afflicted with syphilis contacted allegedly from Japanese. Pollock [said] he thought the Japanese were operating in a region along the coast from Cooktown north to Port Stewart, a distance of about 300 kilometres north of Cooktown.⁶⁴

Although impossible to discern today, these developments may have encouraged Gabriel to urge the chief clerk of the Commonwealth Home and Territories Department to travel to the area and personally investigate.

In the period 1923-29 Bleakley's interest in the condition of hospital facilities concentrated on the quality of health care at depots such as Taroom and Barambah and on the prevalence of leprosy among some Aboriginal groups in Queensland. The development of better quality health care at the depots depended variously on the reserve and local hospitals, the Aboriginal hospital attendants, the nursing staff, the visiting medical officers, and the reserve managers and their wives (known as female protectors). The medical officers had the power, under the *Public Health Act 1911*, to admit Aborigines into local district hospitals or to create emergency holding depots, as happened during the influenza pandemic. Better care of the depots was important because most, but not all, local hospitals refused to accept Aborigines suffering from infectious diseases such as venereal disease, leprosy, tuberculosis and infectious skin complaints.

During the 1920s primary health care for Aborigines consisted largely of the first aid box maintained by untrained depot staff. Emergencies were attended to by medical practitioners, who travelled long distances to attend to sick Aborigines at relief depots such as Barambah. In most cases the bush fringe-camp offered the best

⁶⁴ *Ibid.*, see, 'Memo, N.A. Pollock, Nth Dist Inspector to F.N. Gabriel, Customs to Collector of Customs, Cairns, in 'Re: Japanese cohabiting with Aboriginal Women, dated June 8th', 1922.

compromise for all concerned. For the doctors it provided a way of keeping sick Aborigines near the hospitals for follow-up treatment. For Aborigines it served as a respite from strict hospital matrons, and provided a level of comfort not available in hospitals. For the white townspeople the fringe camps were distant enough to protect their sensibilities and keep the possibility of infection well away from the town. What had begun as an emergency measure gradually gained acceptance as permanent practice. It was therefore most convenient to dispatch Aboriginal patients to bush camps to await treatment, but they sometimes went with aliens — mainly Chinese and Japanese — to police lock-ups.⁶⁵

The alternative destination for Aborigines was relief depots like Barambah and Taroom, to which large numbers of sick people were sent from all around Queensland. In 1924 Bleakley reported that an outbreak of influenza had caused some deaths and left many people sick at Mapoon on the Cape. Severe outbreaks of influenza, followed by pneumonia and pleurisy, occurred at the Barambah and Palm Island settlements.⁶⁶ Similarly, at the Taroom settlement an outbreak of measles in the autumn, unfortunately left many serious cases of pneumonia in its wake.⁶⁷ Venereal disease, too, brought people to central points for treatment and continued to incapacitate people, sometimes beyond a full calendar year.

⁶⁵ *Ibid.*, AA, Series, A/1, file, 23/6432; see also, QSA, A/45263, 'Inquiries for Health and Home Affairs', 1881-1959, see notes dated 1920 to 1926; see also, QSA, A/45275, 'Epidemics', dated 1926; see also, QSA, A/45359, 'Dimantina Hospital 1912 to 1942'; and file, 'marked chronic diseases', 1911 to 1930; and finally, file marked 'Public Health Inquiries', 1900 to 1940'.

⁶⁶ Report upon the Operations of Certain Sub-Departments of the Home Secretary's Department, p.3, in Queensland Parliamentary Papers, 23rd Parliament, 1925, Vol. I, pp.1089-1155.

⁶⁷ *Ibid.*, p.3.

Protector Bleakley made trips north each year to inspect at first hand how protection policies operated. In 1925 he wrote that

venereal disease [was]...most evident in the Gulf and east coast districts, but isolated cases were treated at a number of district hospitals. Four cases were at Normanton Hospital, and a similar number in the Torres Strait Seaman's Hospital, while eighteen cases from Palm Island Settlement, mostly new arrivals from mainland districts [received treatment] in the Townsville Hospital. Venereal cases coming from the Peninsular [and treated] under direction of the government medical officer were kept in the compound of the old Cooktown gaol.⁶⁸

The Church Mission Society owned and operated some of the rural and coastal hospital establishments, but under the *Public Health Act 1911* they were ultimately controlled by the Queensland Health Commission. These arrangements often confused the health issue because responsibility remained divided.

The number of Aborigines treated in district hospitals throughout Queensland in 1925 totalled 406 people of both sexes. According to Bleakley all missions gave direct clinical and in-patient treatment. At Barambah 941 sick inmates received some form of treatment, of which 246 received treatment in the hospital compound. At Taroom 645 patients received treatment from the hospital and of these 70 stayed as in-patients.⁶⁹

Recruitment of hospital trained nurses always came from outside the district, and once employed at the depots they came under the Public Service employment regulations.⁷⁰ The regulations acted for nurses employed under the auspices of the *Public Health Act 1911*, the *Aborigines Protection Act 1897*, and the provisions of the *Public Service*

⁶⁸ *Ibid.*, pf.

⁶⁹ *Ibid.*, pf.

⁷⁰ QSA, Series No. A/58677, 688/1928 – 2030/1929, – 'Sickness', see papers on enquiry by Charles David O'Brien, Police Magistrate, Bundaberg, into administration at Barambah, entitled 'The Public Service Acts, 1922 to 1924'.

*Act 1922.*⁷¹ Medical practitioners, that is visiting medical officers, billed the Chief Protector for their fees. They, however, came under the control of public health and medical legislation. These visiting doctors agreed to make weekly visits to inspect the hospitals and to treat the sick Aborigines at the ration depots (which were now becoming known as Aboriginal settlements). Once on the depots they performed minor surgery, prescribed drugs and gave other treatment and follow-up care for patients. In addition, they could consult on the telephone or, if they wished, have patients brought to their private surgeries. They were able to admit patients either to local hospitals or send them to sanatoriums and hospitals such as the Brisbane General, or the Diamantina Sanatorium. In addition, they advised reserve managers on the supervision of settlement and village health conditions, and carried out the health surveys that formed part of their annual report to the Chief Protector.⁷²

White townspeople dreaded the practice of white men having sexual relations with Aboriginal women. Townspeople believed that Aboriginal women were the original source of venereal diseases and white males would bring the infection into white society. Alternatively, the reason Aborigines did not fear venereal infection was that they could not see the result of the infection and in any case, the disease was largely under control among them along the northern coast. In addition, the number of Aborigines who died from venereal causes was small during the period from 1920 to 1929. In the five year period 1920-24, only 18

⁷¹ *Ibid.*, pf; see also, document entitled 'Duties and Emoluments of Officers On Settlement and Island Reserves, Queensland Aboriginal Department'; see also, document entitled, 'For Information Of Applicants For Position Of Matron, Barambah Aboriginal Hospital'.

⁷² *Ibid.*, see document named, 'Suggested Duties Of Visiting Medical Officer Barambah Settlement'.

Aboriginal men and 10 Aboriginal women died from venereal diseases.⁷³ A possible reason why more Aboriginal males suddenly began dying of these disease than Aboriginal females was that the transmission of infection was partly congenital and partly coming in from outside of Aboriginal social groupings. Protection policies were designed to prevent white and other males from conducting sexual liaisons with Aboriginal females. The government policy, therefore, began to become more effective (leaving aside contact between Asian sailors). White men had generally begun to bring their own women to live on isolated properties and in country towns.

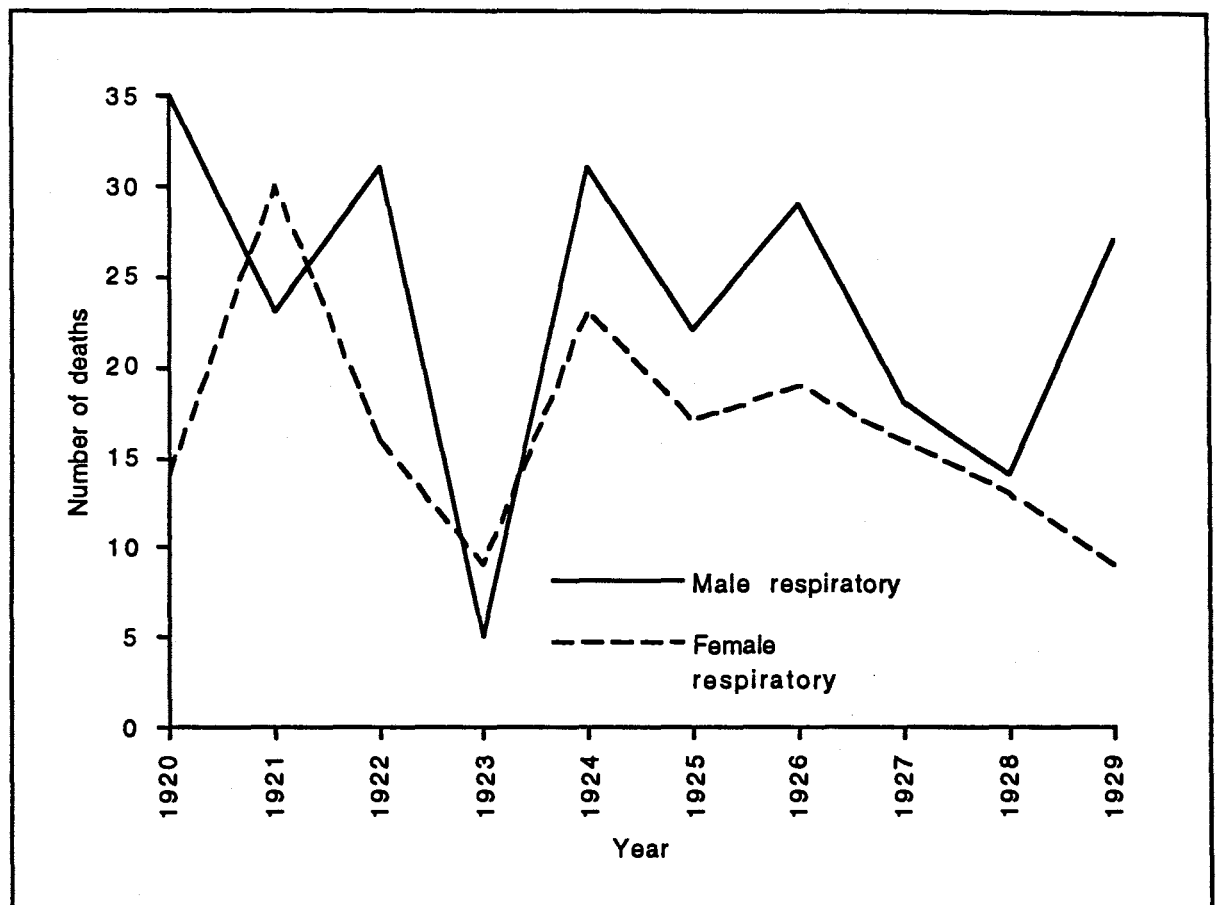
Most settlers, including the Chinese males, had been segregated from contact with people of either full or mixed Aboriginal descent through the protection legislation. Segregation took place under the more forceful policy management of Protector Bleakley, who firmly believed in keeping the races separate. In the next five years, 1925-29, only 12 Aboriginal males and 9 females died from venereal causes.⁷⁴ The decline from the previous five-year period reflects the seriousness with which Bleakley fulfilled his responsibilities. Additionally, protection was reshaping the kinds of other diseases Aborigines contracted.⁷⁵ Protection policies allowed the Chief Protector (and the Courts) to move people from one institution for Aborigines (i.e., reserve or industrial training centre or mission station) to another. This migration (a migration imposed on unemployed Aborigines) meant that if an endemic infection such as tuberculosis entered the pool of infection, then it would remain in the group until either the infected person was removed or immunity to the infection was achieved. For tuberculosis no such immunity existed

⁷³ QSA, Series No. A/58973 – 58974, 'Death Registers – Where, Cause, 1910-1936'; see folios dated 1920 to 1924.

⁷⁴ *Ibid.*, see years from 1920-1930.

⁷⁵ Bleakley, *The Aborigines of Australia*, pp.170-178, and see also, pp.194-200.

Figure 9.1: Aboriginal deaths from respiratory diseases in Queensland by sex, 1920-1929



Source: Compiled from table 9.1.

in Australia. All this time camp residents were vulnerable to infection. Table 9.1 (see Appendix 9, and see also Figure 9.1) shows that respiratory infections — pneumonia, influenza and tuberculosis — were reported to have caused the deaths of 235 Aboriginal men and 166 Aboriginal women during the ten years 1920-29, and almost no cure existed. Of these reported deaths 110 were from pneumonia and 220 were possibly from three different strains of influenza. The first strain was probably a lingering form of Spanish Influenza,⁷⁶ which killed 52 people in the two years 1920-21. Another wave of influenza arrived in 1924-26 with a further epidemic in 1929.⁷⁷ In this period there was still no knowledge of the differences between either the various strains of periodic influenza viral attacks, or between pneumonia and influenza.

Recognition or diagnosis of diseases in general was difficult for health workers. Pneumonia, as in earlier epidemics, became confused with influenza, so reported information about Aboriginal deaths can only act as a guide. In the period from 1920 to 1929, for instance, 77 Aboriginal males and 33 Aboriginal females died from "pneumonia", while 64 men and 46 women were said to have died from influenza. We cannot be sure because the two diseases were often confused. It is interesting to note that while reports of Aboriginal deaths from influenza increased, those deaths recorded from pneumonia declined (see Table 9.1, in Appendix 9).

The increasing number of Aborigines dying from diseases such as tuberculosis was a cause for concern. In the decade 1910-19, the number of Aborigines dying from tuberculosis or similar 'wasting' diseases

⁷⁶ Brown, *et al.*, 'Virus of the 1918 Influenza Pandemic Era: New Evidence about Its Antigenic Character', *Science*, Vol. 166, pp117-119; see also, C.H. Stuart-Harris, 'Biological Sciences: Virus of the 1918 Influenza Pandemic', in *Nature*, Vol. 225, February 28, 1970, pp.850-851; see also, N.R. Grist, 'Pandemic influenza 1918', in *British Medical Journal*, 22-29 December, 1979, pp.163-164; see also, F.B. Rodgers (editorial), 'The Influenza Pandemic of 1918-1919 in perspective of a Half Century', in the *American Journal of Public Health*, Vol. 58, No. 12, December 1968, pp.2192-2194.

⁷⁷ See Table 9.1 in Appendix 9.

increased from two to 27, and from 14 in 1918-20 and to 36 in 1922-24.⁷⁸ After that the number fell to 5 in 1929 (see Table 9.1). Apart from the efforts of the Queensland Tuberculosis Association, a private tuberculosis prevention body (which acted as lobby group for sufferers) no real efforts were made to combat the spread of the disease. The reasons for the increasing numbers of Aboriginal deaths lay in the manner in which the Queensland government managed its protection policies. Centralisation of disparate small bush populations must have been a way of spreading infection rapidly in government reserves, missions and ration depots.

As relief depots took on an image as permanent dwelling places, those who lived there also began developing new forms of social relations as these groups developed into what may be described as communities.⁷⁹ The protection and religious policies allowed more permanent marriage relationships to be created. With these new relationships came a wider range of diseases not experienced under the older social relations. Records show that two types of diseases became important during this period — diseases related to ageing, including illnesses causing deaths by 'natural causes', and diseases resulting from urban living. The first type, mainly leading to deaths from senility and ageing increased from 1920, when six Aborigines died from such causes, rising to a maximum of 28 deaths from ageing in 1926. Thereafter, the numbers fluctuated, falling to 14 in 1928 and rising once more to 19 in 1929 (see Table 9.1 below).

More relevant to this period were deaths recorded from 'other' causes. These rose from 15 to 46 in 1920-24 and then to a record 56 deaths from 'other' causes in 1929. It is not possible to discuss this category in detail because the information is so limited. Many deaths were recorded

⁷⁸ See Table 9.1 in Appendix 9.

⁷⁹ Long, *Aboriginal Settlements*, pp.176-188.

by pastoral employers or by medical, protection and mission staff who were simply unable to specify the actual causes of death. In some cases it was death from a natural cause or a complex of causes such as work related accidents or fighting, snake bite or being trampled by horses.⁸⁰ There are limited data on infant deaths.⁸¹ Epidemics of measles and typhus (that is the parasitic infection from lice and fleas which produce fever) are occasionally recorded together with many entries of dengue and malarial fevers. As happened during previous epidemics, Aborigines were sent to central points for treatment and subsequently suffered more than they needed, despite being under medical supervision.

In the period 1920-29, Chief Protector Bleakley attempted to improve clinical care at the government and missions depots. Bleakley tried new approaches to health services provided to Aborigines in protection institutions which were typified by the system in place at Barambah. The Barambah management, an interdenominational body set up to administer health care to sick and suffering Aborigines, helped to create a new kind of community. The clinic became necessary because of the number of Aborigines dying of disease and starvation following their displacement by early pastoral development. As Bleakley's 'protection with segregation' policy gained acceptance, new forms of communal daily life emerged. The Spanish influenza pandemic demonstrated the weaknesses of the rudimentary health service of the depots. The health clinic at Barambah developed from the segregated compounds staffed by nurses — some of whom were untrained and employed for their

⁸⁰ See column for causes of death in, QSA, Series No. A/58973 – 58974, 'Death Registers – Where, Cause, 1910-1936'.

⁸¹ There are problems in the Register with this category, but, some cover infant mortality data which includes neonatal (data on deaths occurring in the first four weeks of life), postneonatal (or deaths in the first year of life), perinatal material (or data on stillbirths and of first weeks of life). In this register, however, some limitations do exist with the data on infant mortality because sometimes details, such as sex and exact age, are not always mentioned.

religious compassion, while some were trained nurses. The later type of nurses began to be employed by the Chief Protector from hospitals — and were supervised by local general practitioners, or by visiting medical officers. These clinics were also serviced by Aboriginal orderlies who were supervised by both trained and untrained nurses. In turn, these health workers were supervised by medically qualified general practitioners on contract to the Chief Protector. The following events, beginning in the mid-1920s show how these institutions coped, and what some of the problems were that the staff faced daily.

The event began on 21 January 1926 when Bleakley wrote a memo to the under-secretary of the Home Department saying that 'an Aboriginal woman, Maudie King, died suddenly after "taking a bad turn"⁸² from asthma and a heart complaint while on her way to the Barambah hospital'.⁸³ She began feeling ill 70 metres from the clinic. Alex Lander came to the clinic to fetch a stretcher but was prevented from doing so by Matron Little. Maudie's condition deteriorated and she died.⁸⁴ This caused consternation by the Aboriginal inmates of the depot. A large meeting occurred between irate relatives and other inmates at Barambah following the incident.

Statements were collected from all Aboriginal and other witnesses. Most, according to Bleakley, concluded that 'the nurses evidently unaware of Maudie's true condition...treated the request too casually.'⁸⁵ Bleakley saw no wilful callousness in the staffs' actions, and did not think Matron Little had been purposely unkind. 'Natives, too, are difficult to

⁸² This is a colloquialism used to indicate when someone suddenly became ill from mostly an unknown cause.

⁸³ QSA, Series No. A/58677, 688/1928 – 2030/1929, – 'Sickness', see letter from 'Chief Protector Bleakley to under-sec., Home Dept., dated 21st January 1926'.

⁸⁴ *Ibid.*, p.2.

⁸⁵ *Ibid.*, pf.

deal with at times when sick, Bleakley added, [and are] superstitious and mulish, and necessarily discipline is often regarded as harsh.'⁸⁶ Life for inmates was sometimes mundane and even traumatic. Service people sometimes became alienated due to the closeness of the Aboriginal inmates from whom they were unable to escape. The Superintendent at Barambah, W. Porteous Semple, and the Chief Protector realised some of these problems.⁸⁷ In a petition issued from the protest meeting, inmates explained their dissatisfaction, to the Chief Protector, about the services received at the Barambah store and medical clinic.⁸⁸

The issue did not end there. On March 1929 a baby, Maudie Bell, died at the Barambah settlement clinic.⁸⁹ The infant was a female who died at 1 pm on 8 March 1929 from syphilis and heart failure. The infant was

⁸⁶ *Ibid.*, pf.

⁸⁷ *Ibid.*, see draft complaint headed 're: Miss Little - Matron Barambah', attached to draft unsigned Memorandum dated 14th January 1927, from Dr Junk to Chief Protector, re Matron Little. I am unsure whether the two go together, but they revolve around the same issue, and were together on the file, QSA, Series No. A/58677, 688/1928 - 2030/1929, - 'Sickness'. See draft typed letter: 'from Dr Junk to Chief Protector Bleakley, dated 15/1/27'. See draft Memo: 'Chief Protector Bleakley to both W.P. Semple (Super Barambah) Dr Junk (VMO, Barambah), dated 12th January 1926 with attachment of complaints about Matron Little'. See typed (apparently typed copy of original for ease of reading scawly hand writing in Department) 'letter dated 15/1/1927, from Dr Junk addressed to Chief Protector Bleakley, Brisbane'. See hand written letter by Edith M. Lock, dated, 18th August, 1927, in QSA, Series No. A/58677, 688/1928 - 2030/1929, - 'Sickness'. See letter 'From Edith M. Lock to The Superintendent Barambah Murgon, dated 12 November 1927'. See letter 'Edith M. Lock to Superintendent Barambah, dated 28th February, 1928', p.1, in, QSA, Series No. A/58677, 688/1928 - 2030/1929, - 'Sickness'. See 'memo dated 29th February, 1928, from Superintendent Barambah to Chief Protector Brisbane', p.1, regarding further deaths and raising the Barambah residents protest; see two paged Petition dated 16th February, and signed by a number of Barambah residents; see also, 'memo from Superintendent Barambah to Chief Protector Bleakley dated 11th March', doing over events mentioning Aboriginal protest against hospital and store keeper and deaths.

⁸⁸ QSA, Series No. A/58677, 688/1928 - 2030/1929, - 'Sickness', see 'memo from Chief Protector to Superintendent Barambah, dated 6th March 1928'; see also, letter from Chief Protector Bleakley to under-sec., Home Department, dated 28 Jan 1928', in QSA, Series No. A/58677, 688/1928 - 2030/1929, - 'Sickness'. See, 'letter dated 20th January, from Chief Protector Bleakley to under-sec., Home Department', p.1. See also 'Letter from Chief Protector Bleakley to under-sec., Home Affairs, dated 21st May, 1928', QSA, Series No. A/58677, 688/1928 - 2030/1929, - 'Sickness'.

⁸⁹ *Ibid.*, see 'Medical Certificate of Cause of Death', which states primary cause of death as Cardiac failure, and gave as a secondary cause of death 'pneumonia'.

seven months old.⁹⁰ Earlier that month another child died which heightened Aboriginal and settlement management's sensitivity to the problem. But the outside world was also sensitive to Aboriginal infant deaths. Matron Little was charged with 'alleged neglect by refusing to admit a baby to the hospital.'⁹¹ Dr Junk examined the baby on Wednesday 6 May, recording that the baby was only teething and its illness was consistent with that condition.

Another medical opinion was obtained and the baby was sent to hospital immediately because of 'the advanced stage of pneumonia gripping the child.'⁹² The baby died that afternoon and Dr Junk maintained that nothing incompatible existed between his earlier diagnosis and the subsequent development of pneumonia. Bleakley asked for Matron Little's resignation.⁹³ The resignation of the Matron brought the events to a close, and other kinds of health problems began to take priority. These examples, however, give some idea of the health difficulties faced by everyone were managed on a daily basis — inmates and administrators.

Notified deaths among Aborigines from respiratory infections made up a large part of some of the problems which depot, reserve and missions staff had to cope with and I now briefly consider these patterns in more detail. In general, the types of administrative problems exposed above did contribute to some deaths but the problem was much larger. Recorded deaths from respiratory infection among Aborigines in the

⁹⁰ *Ibid.*, see hand written 'memo from Matron Little to Superintendent Barambah, dated 8.3.1929'.

⁹¹ *Ibid.*, see 'Extract from letter of Visiting Justice to Barambah Aboriginal Settlement on 13th and 14th May 1929', see note by Chief Protector at bottom explaining the circumstances to the Secretary of the Home Department.

⁹² *Ibid.*, pf.

⁹³ *Ibid.*, see notes below by Protector Bleakley dated 11.6.1929, and notes above the text of the charge sheet by the Secretary of the Home Department dated 2/7/1929.

period 1920-29, compiled from the Aboriginal Death and Disease Register⁹⁴ revealed that pneumonia, influenza and tuberculosis caused the most concern to the health professionals and the protectors. Aboriginal males died in greater numbers from pneumonia and influenza (see Table 9.1 below), but generally, more people died from 'pneumonia' than 'influenza' mostly because of confusion over the diagnosis. Deaths notified of Aborigines infected with tuberculosis increased slowly and developed almost to epidemic proportions if judged from deaths alone. Tuberculosis exacerbated other respiratory infections (see Figure 9.1 and Table 9.1).⁹⁵

Two waves of influenza struck during the period 1924-26 with a further epidemic in 1929 and drove recorded deaths upwards from respiratory infections.⁹⁶ The reasons for the increasing numbers of Aborigines dying from tuberculosis lay in the manner in which Aborigines began living in larger sedentary groups and using houses with limited space and ventilation, which were provided by mission and government authorities. Protection policies established by the Queensland government, and the way it managed them, were also part of the problem. As Aborigines went south for reasons of protection, illness or offences against the protection legislation they spread the diseases among people not previously in contact with such infections. This was especially true of people who came from Cape York to work in the south,

⁹⁴ See column for causes of death in, QSA, Series No. A/58973 – 58974, 'Death Registers – Where, Cause, 1910-1936'.

⁹⁵ Brown, *et.al.*, 'Virus of the 1918 Influenza Pandemic Era: New Evidence about Its Antigenic Character', *Science*, Vol. 166, pp117-119; see also, C.H. Stuart-Harris, 'Biological Sciences: Virus of the 1918 Influenza Pandemic', in *Nature*, Vol. 225, February 28, 1970, pp.850-851; see also, N.R. Grist, 'Pandemic influenza 1918', in *British Medical Journal*, 22-29 December, 1979, pp.163-164; see also, F.B. Rodgers (editorial), 'The Influenza Pandemic of 1918-1919 in perspective of a Half Century', in the *American Journal of Public Health*, Vol.58, No.12, December, 1968, pp.2192-2194.

⁹⁶ See Table 9.1 in Appendix 9; see also, The Chief Protector, *Annual Report*, 1930, p.1.

and who lived for the first time in centralised settlements, and who brought with them infections related to hygiene, such as leprosy

Although records show that leprosy had been eradicated from the southern groups it could be transported by itinerant Aboriginal labourers working in the pastoral and domestic industries. In Queensland in 1920 there were 31 lepers in Queensland and they were mostly Aborigines, though their numbers also included Torres Strait Islanders, Kanakas, Europeans and Asians. This figure represents a decline in the number of Aborigines contracting the disease of whom there had been 35 in 1910. The number of infected Aborigines rose to 36 in 1925, so it was obvious that leprosy was not about to disappear (see Table 10.1 in Appendix 10).⁹⁷ The regions from which the new cases came were all in the north. A number of towns in the north such as Bundaberg, Innisfail and Ingham provided one leper each and two came from Cardwell. Leprosy had therefore become a disease of the north: no further new cases were reported from the southern areas of the State after 1925 (leprosy data beyond 1925 relates only to selected populations of Queensland).⁹⁸ By that year two leprosaria, one at Fantome Island and another at Peel Island, had been established to house lepers. The numbers of people admitted to Peel Island fluctuated during the mid 1920s and rose to 47 new cases in 1928.⁹⁹ Although no new cases were reported in 1929 the reason might have been the secrecy with which this whole issue was managed by the Queensland Health authorities and the inability of the health regime to locate and track down the source of infection. This was not a simple problem and it persisted well into the next decade.

⁹⁷ Cook, *Leprosy in Australia*, pp.76-185; Cumpston, 'Leprosy', in Lewis, *Cumpston, Health and Disease*, pp.208-212 and see Table 100, p.213, pp.420-430.

⁹⁸ Lewis, *Cumpston, Health and Disease*, p.208.

⁹⁹ A/A 1928/1, Item 690/8/106, 'NH&MRC Grants - Cilento', see graph attached to 'memo: Report from Cecil Cook of School of Public Health and Tropical Medicine', dated 19 June, 1940, pp.1-7; see also, Lewis, *Cumpston, Health and Disease*, Table 99, pf.

Dr Raphael Cilento endeavoured to describe the problem in one of his reports. He wrote that when Kuranda (Mona Mona) reserve started in 1914, the majority of the Aborigines brought there belonged to the Mareeba tribe, a closely knit group.¹⁰⁰ There were a few others from as far north as the Gulf region and some from Mossman, and a large number had been born in fringe-camps and had grown up close to white settlement knowing no other life.¹⁰¹ The first case of leprosy reported among Aborigines in the region 'was an old woman, Nellie, who died in 1916.'¹⁰² According to

native accounts this woman's toes 'looked as if they would drop off', she 'was covered with sores', and she was avoided by other natives. Her principal contacts and relatives [were] known and she [had] no known descendants at the settlement.¹⁰³

Other cases cited by Cilento showed clearly the need for greater awareness of maintaining control of the infected patients as well as the likelihood of the disease spreading to other Aborigines. In a comprehensive report to the National Health and Medical Research Council, in 1925, Cecil Cook outlined some of the complications of the problem. He referred to the problem of 'surveillance and contacts' in a most comprehensive way by focusing on the context of the treatment of lepers in Queensland,¹⁰⁴ and indicated further, that it should be possible through efficient 'prophylaxis' to eradicate the disease in spite of the problems presented by the heat and humidity of the climatic.¹⁰⁵ The problems were inadequate surveillance of suspects, inadequate

¹⁰⁰ (Sir) R.W. Cilento, Director-General of Health and Medical Services, and Professor of Social and Tropical Medicine, Queensland, 'Preliminary Progress Report on Leprosy In North Queensland', in, A/A1928/1, Item 690/8/106, 'NH&MRC Grants - Cilento', pp.1-4.

¹⁰¹ *Ibid.*, p.1.

¹⁰² *Ibid.*, pf.

¹⁰³ *Ibid.*, pf.

¹⁰⁴ *Ibid.*, see 'memo: Leprosy in Queensland, Section 11', p.8.

¹⁰⁵ *Ibid.*, p.1.

investigation of patient contacts, and poor control of lepers discharged after treatment.¹⁰⁶ Tracing contacts meant searching for Aboriginal families, which was an arduous task and sometimes impossible, even under the coercive protection institutions.¹⁰⁷ It meant full investigations into clinical histories of other members of families. Aborigines did not have such things as 'households'. Nor did they have simple 'family connections' as either doctors or society understood them. It sometimes involved upwards of fifteen small extended families spread over a twenty to fifty mile radius. When lepers were located they were sent from their place of residence by missionaries or protectors. Many had no knowledge either then or later of the size of their family. The lepers were travelling hundreds of miles under police custody by train or motor vehicle to the coastal island leprosaria.¹⁰⁸ These difficulties made it impossible for doctors to contemplate releasing Aborigines, on the basis that they would not return for follow-up treatment.¹⁰⁹

Another complication in constructing a treatment regime for Aborigines was that doctors believed there was a hereditary link among patients who became infected with leprosy.¹¹⁰ If there was a 'hereditary factor' or even a suspicion of this then a large number of Aborigines needed to be involved in tracing the causes. Cost factors already plagued attempts to provide primary and secondary health care to Aborigines, and

¹⁰⁶ *Ibid.*, p.5.

¹⁰⁷ *Ibid.*, pf.

¹⁰⁸ QSA, A/44722, 'Conveyancing of Police and Prisoner and Aborigines', this file deals with matters from 1921; see also, QSA, A/44746, 'Transporting Aboriginal Prisoners: 1926-1951', this file has some detail on the transporting of sick Aborigines from 1926-1951; see also, QSA, A/44832, 'Conveyancing of (1) sick indigents (2) destitute Persons (3) unemployed: 1893-1959'; see also, QSA, A/45399, '(1) Sickness of, and Accidents Happening to, Persons Confined in Watch House, (2) Persons Suffering from effects of meeting with Accidents when taken into custody'; see also, QSA, 45253, 'Destitute Persons: Free Rail Passes to Sick Indigents in need of special treatment'.

¹⁰⁹ A/A1928/1, Item 690/8/106, 'Leprosy in Queensland, Section 11', pp.5-6.

¹¹⁰ *Ibid.*, p.6.

this made it even less likely that stringent leprosy follow-up systems could be implemented. Family members lived cheek by jowl with one another, so large numbers from one collection of living site could readily be infected by a single carrier.¹¹¹

By 1925, Cook had produced a major epidemiological study of leprosy in northern Australia.¹¹² In a later document¹¹³ he revealed that no new discoveries had been made since the mid-1920s.¹¹⁴ Segregation, Cook admitted, was the most successful means of treating and limiting the spread of leprosy among Aborigines. While discussing the problems researchers and medical practitioners had in treating Aborigines infected with leprosy, he wrote that 'leprosy amongst...[them] was more easily controlled by segregation than was the case amongst whites, probably because the precautionary measure was more effectively applied.'¹¹⁵ The blame for the break-down of the leprosy treatment in the early 1920s could not simply be laid at the doorsteps of Aborigines and the difficulty of treating them because of their unpredictable social and cultural habits. Cook felt that the medical profession were to be blamed because they lacked the necessary training. He wrote that 'the medical question revolved around the idea that untrained medical practitioners could not detect the symptoms of leprosy, and medical officers failed to understand

¹¹¹ Cilento, 'Preliminary Progress Report on Leprosy In North Queensland', in, A/A1928/1, Item 690/8/106, 'NH&MRC Grants - Cilento', p.1.

¹¹² Cook, *Leprosy in Australia*; this was the results of an investigation in northern Australia during 1924-25, as a Wandsworth Research Scholar from the London School of Tropical Medicine; see also, Lewis, *Cumpston, Health and Disease*, pp.207-219; for other biographical information see, John Pearn and Mervyn Cobcroft (eds), *Fevers and Frontiers*, Amphion Press, Brisbane, pp.87-100.

¹¹³ Australian Archives, AA Series A1/1, Item 1935/2301, 'International Conference', pp.1-88', in Commonwealth Department of Health (CDH) file 35/2301, see also letter from Cumpston, dated 12 March 1936, pp.1-2.

¹¹⁴ *Ibid.*, pp.22-31.

¹¹⁵ AA, Series A659/1, 44/1/657 - 'Leprosy', see Cecil Cook, (Wandsworth Scholar), Report On The Establishment Of A Joint Lazaret At Darwin', dated June 1925, p.2; then see his statement in, 'International Conference', 1935', in 'CDH file 35/2301', p.31.

the level of infectivity of leprosy.¹¹⁶ Individuals, Cook added, 'suffered from the prospects of losing a livelihood if detected, particularly if they had to provide for a family, and fear of separation from...[their family] members.'¹¹⁷ In 1927 Cook thought it reasonable to assume that an improvement in the pattern on the spread, and treatment, of leprosy was occurring,¹¹⁸ but he was mistaken.¹¹⁹ In the following year the numbers of lepers among Aborigines began to increase dramatically.¹²⁰ Some of the new lepers were at the Mona Mona reserve at Kuranda.¹²¹ One person, a man named Tommy, died when his feet became infected. Tommy was thought to be about forty years of age. According to Cilento, the feature of this case was that Tommy had a contagious disease but was never isolated from fit inmates. Cilento wrote that Cyril and Roy, two of his sons, had been taken by Ministerial Order to Peel Island Lazaret, but his only grandchild was still at the settlement, and in danger of infection.¹²² Other relatives were later diagnosed as lepers and removed to Peel Island.¹²³ Reports of hookworm, venereal disease, respiratory infection and leprosy continued to specify them as the greatest health risks to Aborigines. Reform of the health clinics following the Spanish Influenza pandemic began but failed to progress in the period whereas leprosy deepened into the Aboriginal population in the period 1930-40, and is taken up in Chapter ten.

¹¹⁶ AA, A/192811, 690/8/106, NH&MRC Grants, see, 'memo from Cook to Director of SPH&TM, dated 5 September 1929', p.1-6.

¹¹⁷ *Ibid.*, p.1.

¹¹⁸ *Ibid.*, pf.

¹¹⁹ *Ibid.*, see graph on p.7, depicting a dramatic increase in the numbers of lepers for 1928.

¹²⁰ Cilento, 'Preliminary Report On Leprosy Nth Qld', pp.1-2.

¹²¹ *Ibid.*, p.1.

¹²² *Ibid.*, pf.

¹²³ *Ibid.*, p.2.

APPENDIX 9

Table 9.1: Aboriginal deaths in Qld, 1920-1929

	1920	1921	1922	1923	1924	1925	1926	1927	1928	1929	Total
Males											
Pneumonia	6	4	7	2	7	11	9	10	8	13	77
Influenza	19	15	2	0	7	0	10	0	1	10	64
Consumption, TB, phthisis	10	4	22	3	17	11	10	8	5	4	94
<i>Sub-total respiratory</i>	<i>35</i>	<i>23</i>	<i>31</i>	<i>5</i>	<i>31</i>	<i>22</i>	<i>29</i>	<i>18</i>	<i>14</i>	<i>27</i>	<i>235</i>
Nephritis	1	2	1	0	1	1	0	11	1	1	19
Veneral diseases	2	8	1	5	2	4	3	5	0	0	30
Senile decay	5	4	12	2	15	12	20	17	7	10	104
Other diseases	9	1	4	2	24	30	27	39	19	32	187
<i>Sub-total other diseases</i>	<i>17</i>	<i>15</i>	<i>18</i>	<i>9</i>	<i>42</i>	<i>47</i>	<i>50</i>	<i>72</i>	<i>27</i>	<i>43</i>	<i>340</i>
Total male deaths	52	38	49	14	73	69	79	90	41	70	575
Females											
Pneumonia	1	2	1	1	4	2	4	7	6	5	33
Influenza	9	9	1		10	3	7	1	3	3	46
Consumption, TB, phthisis	4	19	14	8	9	12	8	8	4	1	87
<i>Sub-total respiratory</i>	<i>14</i>	<i>30</i>	<i>16</i>	<i>9</i>	<i>23</i>	<i>17</i>	<i>19</i>	<i>16</i>	<i>13</i>	<i>9</i>	<i>166</i>
Nephritis		1	0	0	0	1	0	1	0	0	3
Veneral diseases		1	0	3	6	2	1	4	1	1	19
Senile decay	1	2	2	2	5	8	8	10	7	9	54
Other diseases	6	6	5	6	22	22	20	36	20	26	169
<i>Sub-total other diseases</i>	<i>7</i>	<i>10</i>	<i>7</i>	<i>11</i>	<i>33</i>	<i>33</i>	<i>29</i>	<i>51</i>	<i>28</i>	<i>36</i>	<i>245</i>
Total female deaths	21	40	23	20	56	50	48	67	41	45	411

Source: Queensland State Archives, Series No., A/58973 — 58974, 'Death Registers - Where, Cause, 1910-1936'

CHAPTER 10

From bush to urban life: aspects of Queensland indigenous people's health, 1930-1940

The transformation of the Aboriginal population between the census in 1901 and that of 1933 was dramatic. The latter census surprised most observers in that all racial and different cultural groups which constituted the components of the 'Aboriginal' population were now observably sustaining themselves. The means of defining who the Aborigines were in 1933 were adjusted and this meant that membership of the total group defined as Aboriginal had to increase. With the increasing numbers of Aborigines came the economic depression of 1929-32, which dominated life for most Australians, including Queensland Aborigines. It impacted on them with increasing severity as drought affected the pastoral industry, making Aboriginal pastoral labour almost totally redundant. That in turn affected the relations between the Chief Protector and Aborigines as he sought to provide for Aboriginal social, economic and cultural welfare. These factors influenced the disease patterns among Aborigines and the health systems designed to care for them.

In Queensland the health structure consisted of public hospitals which were either under the control of local hospital boards¹ or control bodies administered by local commissions.² On Aboriginal reserves and

¹ These local hospital boards consisting of health staff who worked for the hospital and local residents nominated by locally-based organisations.

² These local commissions were bodies appointed by the State Government and the hospital staff made up the membership of the local commission of the hospital.

missions the health administration was the responsibility of missionaries and the personnel working in clinics on government depots (or, as they were becoming known, 'Aboriginal settlements').³ This was the general structure the indigenous people faced as their style of living and their habits changed. Technological improvements in communications, including telephones, wireless and air transport all helped reduce the isolation of Aborigines no less than rural white pastoral families. Although there were still problems about transporting sick Aborigines around the State, mission stations in most locations were fairly readily able to contact medical aid. The Queensland ambulance service was one cooperative organisations that was supported financially by individual members. When members became ill and incapacitated they were guaranteed transportation to hospital ambulance services, and even along the coastal regions to Thursday Island the sick came by sea. The Queensland ambulance organisation approached the Chief Protector about the possibility of membership being extended to Aboriginal groups. The service was a voluntary one, and did not discriminate in taking Aborigines when called to do so.

During the late 1920s the pastoral industry in Queensland maintained a high demand for Aboriginal labour, despite the onset of the economic depression, and prolonged drought.⁴ By 1930, however, the depression had begun to deepen and widen into the rural sector, and this caused wide-spread unemployment among Aboriginal rural workers.⁵ This mass redundancy of Aborigines meant that Aboriginal workers had

³ 'General review of existing Medical Services in Northern Australia', p.4, in Australian Archives, (AA), Series No. A/431/1, Item, 46/2123.

⁴ Bleakley, *The Aborigines of Australia*, pp.172-177; see also, Dawn May, *Aboriginal Labour*, pp.104-146.

⁵ Bleakley, *The Aborigines of Australia*, p.177; see also, Rowley, *Outcastes in White Australia*, pp.48-49.

to remove their families from the refuge they enjoyed on freehold and leasehold lands in the western and northern parts of the State, and that in turn affected the missions, government reserves and fringe-camps who had to take the bulk of this displaced population.⁶

As Aboriginal pastoral workers' incomes dried up, rural Aborigines relied increasingly on government assistance. This brought more Aborigines under the control of Aboriginal settlements, including both mission and government reserves. As Bleakley, and other writers, explained the protection legislation provided for funds to be deducted from Aboriginal incomes and transferred directly to a trust account managed by the Chief Protector. The money was reinvested by the Chief Protector in interest bearing Commonwealth bonds. The Chief Protector could then call on these funds to pay for the welfare needs of Aborigines in Queensland.⁷

A further impact of the depression was that the rise in the number of Aborigines on government and mission settlements forced State authorities to re-define who the people were who now made up the Aboriginal population. Many Aborigines of mixed-descent not previously living on government reserves or on mission settlements now moved there as permanent residents, and began to participate in industrial programs operated by the Chief Protector. These redundant workers then became permanent recipients of government and church relief. The depression changed both the nature of the Aboriginal population and the

⁶ At the same time the 'Aboriginal Station Hands Award' was suspended which aided this mass migration of Aborigines away from pastoral properties, see Bleakley, *The Aborigines of Australia*, p.177. For more detail on this event see Dawn May, *Aboriginal Labour*, p.121-130; see Rowley, *The Destruction*, pp.48-66; Long, *Aboriginal Settlements*, pp.98-99.

⁷ Bleakley, *The Aborigines of Australia*, pp.166-177.

Government's Aboriginal protection policies. That in turn had a trickle-down effect on Aboriginal patterns of illness and mortality.

The Aboriginal population had been increasing from a total of 5,261 full-bloods and 951 half-castes in 1901 to a total Aboriginal population of 15,676 in 1933, and many government services, including the Chief Protector's Office, were forced to adapt. All government services changed from temporary relief programs into permanent services of protection. The Chief Protector's Office, as seen in earlier chapters, always adopted the practice of over-estimating the total Aboriginal population, and in 1932 it initially put the estimated total Aboriginal population at 17,706.⁸ In 1938, a 'Report On the Office Of The Chief Protector Of Aboriginals', produced by the Chief Protector's Office, said that 1,707 people of full descent were living a nomadic life. In addition, there were 2,657 people of full-descent who had settled on missions. Those compiling the report classified some Aborigines as 'detribalised' people of full-descent who numbered 560 people living in bush camps. An additional 500 people from this group could be found on local town camping sites, or other reserves around Queensland. A further 1,310 people were on pastoral properties as dependants of workers, and of these 225 were receiving direct departmental relief. The largest number of full-descent Aborigines, a total of 1,496, were living on government settlements. Approximately 390 of this group were on southern church-administered mission settlements and government depots, which included Yarrabah (Anglican), Palm Island (government) and Mona Mona (Lutheran). The population of the last three settlements consisted of workers from cattle

⁸ 'Aboriginals General', see in this file, 'Report On Inspection Of The Office Of The Chief Protector Of Aboriginals, dated, 24 August, 1932', pp.1-34 (this figure appears on p.1), in QSA, A/58856, Item 36/9457 and 37/2324.

stations or people occupied in some other form of rural employment, and their total was 2,130 men, women and children.⁹

The report then outlined people of mixed-Aboriginal and other racial descent who were called 'half caste' Aboriginals. Of this group 50 people were what the department described as 'living in Aboriginal conditions.'¹⁰ Then there were 360 in employment on cattle and sheep stations, a further 457 people in other forms of employment, and 800 men, women and children who were dependants of the pastoral workers. Finally, 1,422 lived on Government settlements and 946 on church mission establishments.¹¹ A small number of people subsisted in bush camps beyond the daily reach of the Chief Protector's office. The number of people who relied on services provided by the Protector's office in one way or another amounted to 15,010 people of both 'full-' and 'half caste' descent.¹²

This figure was the most realistic yet produced by the Chief Protector and was considerably lower — by a margin of 2,700 — than that given in 1933 and also lower than earlier inflated figures. The estimates had fallen progressively, as mentioned in previous chapters, from 26,670 in 1901 to 22,508 in 1911 and 17,104 in 1922 before rising to an inflated final total of 17,967 in 1933. The 15,010 mentioned in the previous paragraph was not a public figure but represented a much more realistic total than had previously been acknowledged.

The health services received by Aborigines living on government reserves, in fringe-camps and on missions had to be modified to meet the changing demographic and economic circumstances. The administration

⁹ *Ibid.*, see 'Report On The Office Of The Chief Protector Of Aboriginal, dated 25 May 1938', pp.1-13.

¹⁰ *Ibid.*, p.1.

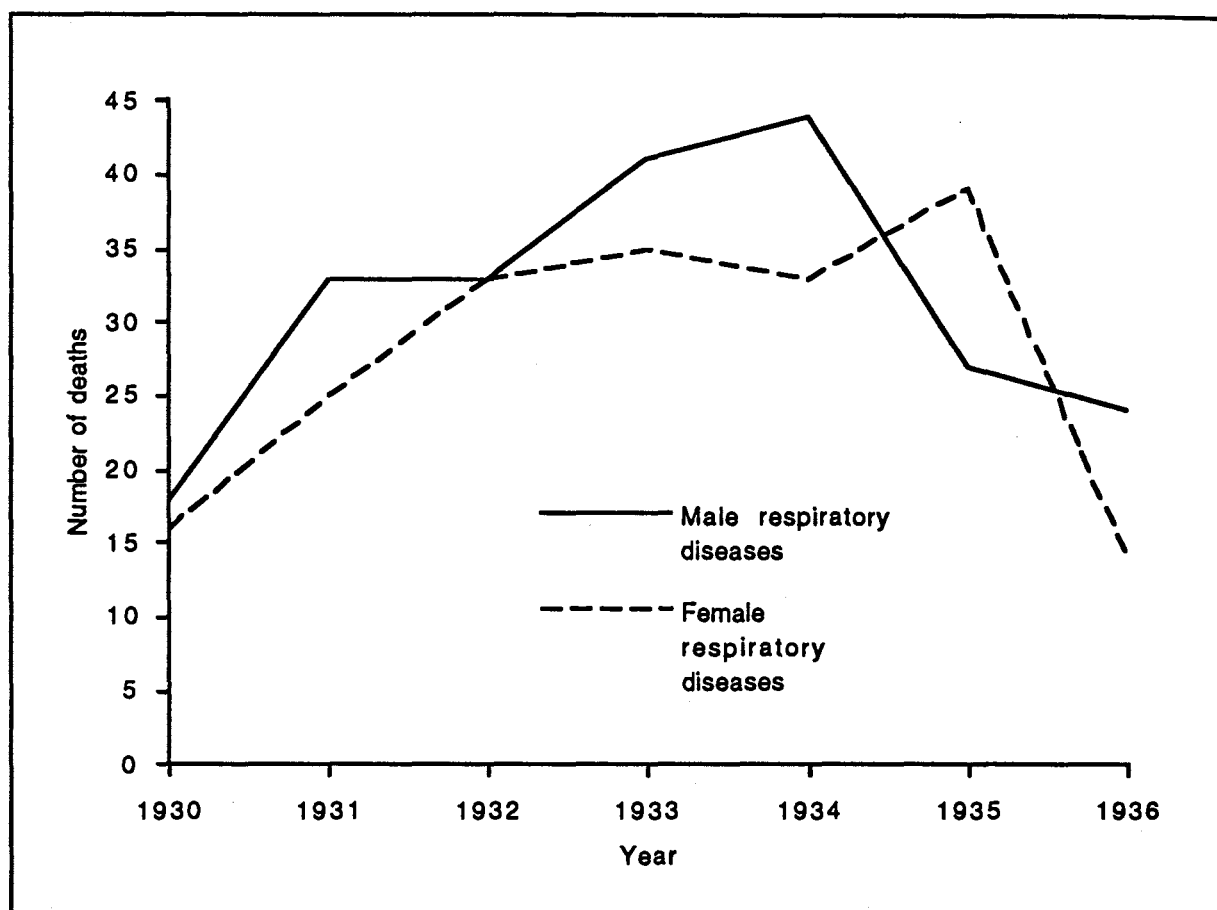
¹¹ *Ibid.*, pf.

¹² *Ibid.*, pf.

previously based on protection had to now adapt its practices on Aboriginal communities which were not only growing rather than diminishing but were also becoming a racial as well as a social and political grouping. Among the measures adopted were that depots now had direct access to general practitioners and their surgeries on a contract basis. Where possible these doctors were supported by fully trained nurses employed by the State. The creation of the Royal Flying Doctor Service in the mid-1930s also improved contact between isolated Aboriginal groups and the medical system.

In the period 1930-35 reports of the number of Aboriginal people dying from diseases such as pneumonia, tuberculosis and venereal disease, continued to show an increase. Reports of deaths from pneumonia (see Table 10.1, in Appendix 10 below) rose from 24 in 1924 to 38 in 1934, before falling in 1936 to 17 deaths, which represented a considerable improvement in just two years. Male reportedly dying from pneumonia consistently outnumbered females, a phenomenon for which there is no documented explanation. By contrast, female deaths from tuberculosis appear to have outnumbered those of males. The most likely explanation is that tuberculosis was partly a disease of the creche. This meant that women were most vulnerable because they slept in confined spaces huddled together with lots of children, all breathing the same air. Reports of Aborigines dying from tuberculosis rose from 10 in 1930 to a peak of 29 in 1935 before dropping back to 18 in 1936. Aborigines notified as dying from venereal disease rose from 5 in 1930 to 24 in 1934, and then fell to 18 in 1936. No figures could be located for the period beyond 1936, but the implications are that reported deaths reached a high point in 1935 and declined thereafter.

Figure 10.1: Aboriginal deaths from respiratory diseases in Queensland by sex, 1930-1936.



Source: Compiled from Table 10.1

There had been a long term decline in tuberculosis in the general population. At Federation in 1901 tuberculosis deaths occurred at a crude rate of 89 per 100,000, but between 1921 and 1925 the rate had dropped to 62 per 100,000 deaths;¹³ it continued falling well beyond the period of this study.¹⁴ The number of reported deaths among Aborigines, as seen above, fluctuated widely between 1920 and 1936, generally rising throughout the 1920s, peaking in 1934 and subsequently falling (see Table 9.1 of Appendix 9, and also see Table 10.1 below).

Up to the 1930s separate infectious disease hospitals were established in most States as a means of dealing with tuberculosis.¹⁵ In Queensland the disease was classified as a notifiable disease in 1904 and a body set up by public spirited individuals to fight the disease made efforts to stem its spread among Aborigines in 1902.¹⁶ A medical officer, Dr Eleanor E. Bourne, was appointed to inspect the Queensland schools for tuberculosis and other diseases. Since the first decade of the century school children were screened for tuberculosis and other illnesses. Not until after the Second World War, however, did tuberculosis vaccinations become widely available in Australia. The Koch vaccination called "tuberculin" was the form used most in Australia and was introduced in the 1920s. In France Albert Calmette and Camille Guérin had produced a successful vaccine. These two scientists

worked together for 13 years from 1908, attenuating bovine bacilli to create the vaccine, culturing their bacilli on ox bile and potato. After years of animal testing they began human trials in 1921, and in 1923

¹³ F.B. Smith, 'Tuberculosis and bureaucracy: Bacilli Calmette et Guérin: its troubled path to acceptance in Britain and Australia', in *MJA*, Vol. 159, 20 September 1993, pp.408-422.

¹⁴ *Ibid.*, p.408.

¹⁵ *Ibid.*, pf.

¹⁶ W.E. Roth, *Annual Report Of The Northern Protector Of Aborigines For 1902*, QPV&P, CA. 6-1903, QGP, Brisbane, 1903, p.14; see also, Chief Protector Of Aborigines, *Annual Report, QV&P, 1901-1904*; see also, QSA, A/58853, 'Venereal - Aboriginal General', see notes under Aboriginal VD Camps - Cooktown which go back to turn of century; see also, QSA, A/44681, 'Chief Protector's Corro', see Dr Roth's Progress Reports 1904-1906.

announced confirmation of a safe vaccine, effective in infants for up to three years and probably longer.¹⁷

Probably long before 1930, tuberculosis became endemic among the Aboriginal groups living in the northern tropical areas of Queensland.¹⁸ Since the turn of the century Aborigines (a term which included Torres Strait Islanders until 1932) were known to suffer from tuberculosis, and could have benefited from a vaccination because they were dying from the disease.¹⁹ No attempt was made to do so until after the Second World War.

The incidence of such ravaging infections, as well as other diseases and illnesses, began to expand once people from the cattle and pastoral stations moved to what became government Aboriginal settlements, missions and fringe-camps. The number of government settlements did not increase in the south during this period but their resident populations grew. With this population growth came higher incidences of a range of illnesses, included under the heading 'other diseases' (see Table 10.1). More deaths were notified as work related and due to violence between Aborigines themselves. These categories of reported deaths were beginning to emerge during this period. Under 'other diseases' are also included diseases such as typhus, typhoid, swamp fever, measles and some deaths not identifiable. New types of diseases, already mentioned, began to enter the record during the 1930s. Notified deaths due to diseases of lifestyles such as diabetes and heart related deaths formed the most numerous, however.²⁰

¹⁷ F.B. Smith, 'Tuberculosis and bureaucracy', in *MJA*, p.408.

¹⁸ *Ibid.*, p.408.

¹⁹ *Ibid.*, pp.408-410.

²⁰ 'Death Registers - Where, Cause', 1910 to 1936, in QSA, Series A/58973, file no. 58974, and see deaths from 1930 to 1936.

Although official leprosy figures were not available, leprosy in general was falling. Nevertheless, in indigenous groups the disease appeared to be on the increase but surveillance systems could not help to settle the problem. Reports claimed that leprosy had spread to a number of Aboriginal populations in the northern part of the State (for total figures compared with Western Australia to 1925 see Table 10.2, in Appendix 10, and other data presented in this chapter relates only to selected Aboriginal groups). At the same time, the important change relating to leprosy was that it was becoming a killer disease. Deaths of Aborigines reported as being infected with leprosy began to enter the death register (which I record under other diseases), and it was previously believed to be only a disabling disease. It mutilated people's bodies and affected their economic prospects. It caused physical weakening and wasting of body tissue, destroying important organs and, like tuberculosis, was difficult to distinguish between some other infections such as yaws and syphilis and to diagnose by the untrained eye in some stages. Reports indicated that leprosy in Queensland had spread from its early locations around the Rockhampton region and moved to other locations. The confidence which some administrators and medical workers held of containing it by monitoring it among Aboriginal patients proved to be a vain hope. Some people thought of applying methods of disease controls to Aborigines as were used with white urban patients, but this failed. As Cook mentioned in his reports to the National Health and Medical Research Council, strict monitoring was the plan.²¹

²¹ Cook, *Leprosy in Australia*, pp.76-185; see also, Cumpston, 'Leprosy', in Lewis, Cumpston, *Health and Diseases*, pp.208-212, and see, Table 100, p.213, and see also, pp.420-430; see also, 'NH&MRC Grants - Cilento', see graph attached to 'memo: Report from Cecil Cook of School of Public Health and Tropical Medicine' dated 19 June, 1940, pp.1-7, in AA Series No. A 1928/1, Item 690/8/106.

In a report read at the fifth session of the Federal Health Council in March 1931, Raphael Cilento reminded participants that a resolution, a year earlier, had proposed the adoption of a system of recording all new cases of leprosy in Queensland, and advised them that this system had now been implemented. The collected data would be reported to the director of the division of tropical hygiene of the Commonwealth Department of Health. All of this effort was to contribute to better understanding of the epidemiology of leprosy and to better administrative control of lepers in Australia.²²

On the same subject, very little had changed in the way of treating lepers or of knowing what the patterns of distribution were in the early 1930s. Cecil Cook, speaking at the second international pacific health conference held in Sydney during September 1935, added nothing new to his previous report of his work in the mid-1920s.²³ Both Western Australia and Queensland still practiced segregation as the primary treatment for leprosy.²⁴ The main difference between the two states was that Western Australia had many Aborigines living beyond government contact whereas by 1930 Queensland Aborigines were almost fully maintained on missions and government settlements. Even so, leprosy control proved difficult to administer, and for medical follow-up, in Queensland, because of the scattered and isolated locations of the missions and those groups in contact with missionaries, which

²² Cook, *Leprosy in Australia*, for Western Australian data see, pp.45-75, and for Queensland, pp.76-197.

²³ 'International Pacific Health Conference, 3-6 September 1935', in AA Series No. A1/1, 1935/2301, the document may be found on pp.1-88, in Commonwealth Department of Health (CDH) file 35/2301, see also, 'covering letter from J.H.L. Cumpston dated 12 March 1936', pp.1-2.

²⁴ Susanne Saunders, 'Isolation', see also Saunders, 'A Suitable Island Site', unpublished BA (hon.) thesis, Murdoch University WA, 1986, and subsequently published with some modification by NARU, NT, 1988; see also, Rogers, 'Australia Prophylaxis on Leprosy', in *MJA*, October 18, 1930, pp.525-527; see also Rogers, 'Pacific Health Conference 1930', p.31, in CDH, file 35/2301.

contradicted Cilento's remarks of 1931, a factor raised by him some years earlier.²⁵

As early as 1927, although the Queensland figures on leprosy was falling (see Table 10.2. below), Cook advised the Medical Research Council that, based on his own unpublished information, leprosy was increasing and that 'the prophylactic system in Queensland had failed.'²⁶ Cook was unable to explain the increase in leprosy in 1927, but he pointed out that 'no proper regular system of surveillance and re-examination of contacts existed...[and] patients often received premature discharge without returning...to their homes.'²⁷ That meant some people either never went home or did so years later. Cook believed also that the system of screening for leprosy was failing among Aborigines because 'untrained medical practitioners could not detect the symptoms of leprosy, and medical officers failed to understand the level of infectivity of leprosy.'²⁸ Furthermore, 'individuals suffered from the prospects of losing a livelihood if detected, particularly if they had to provide for a family, and the fear of separation from...family members.'²⁹ He regretted the failure to contain the disease, since following his earlier revelations 'it might have...been hoped that conditions today might reveal an improvement in procedure'³⁰ for containing of the disease.

²⁵ Cook, *Leprosy in Australia*, pp.74-197; see also, Lewis, *Cumpston, Health and Disease*, pp. 207-210; see also Cecil E. Cook (Wandsworth Scholar), 'Report On The Establishment Of A Joint Lazaret At Darwin', dated June 1925, p.2, and then see his statement in, 'International Pacific Health Conference, pp.1-88', in Commonwealth Department of Health (CDH) file 35/2301, p.31, in AA Series No. A659/1, 44/1/657 - 'Leprosy'.

²⁶ 'Cecil Cook, Memo to Dir., SPH&TM, dated 5 September 1929', in AA Series A/192811, 690/8/106, 'NH&MRC Grants', p.1.

²⁷ *Ibid.*, p.1.

²⁸ *Ibid.*, pf.

²⁹ *Ibid.*, pf.

³⁰ *Ibid.*, pf.

In contrast to Queensland Cook believed that in New South Wales, the disease had been eradicated because of the energetic and thorough application of care and follow-up practices by the Department of Health. He feared, because he was unable to say conclusively, that leprosy might now be on the increase in the north of that state. It was rumoured that some of the Queensland Aboriginal labour migrated south for seasonal work. In doing so these workers would subsequently become infected by Aborigines from New South Wales. When these new carriers returned with full-blown leprosy they would enter Queensland lazarets as a cost to Queensland tax payers.³¹ Cook claimed that records of admissions to Peel Island Lazaret showed an increase in the number of lepers, and without evidence he offered southern Aboriginal migration as a cause. He went on to say that the number of reported new cases of Europeans contracting leprosy was increasing and was a worrying feature of the general increase.³² He and others believed that the results of his 1925 study had enabled a plan of action for combating the disease to be implemented in New South Wales. He went on to assert that 'the environment in the damp Queensland coastal regions should have prompted vigilance',³³ but no epidemiological study had occurred since his own in 1925.³⁴

Writing later in the decade, the Chief Quarantine Officer wrote that as early as 1930 leprosy 'continued its insidious course, and the slow but continual discovery of new cases, particularly in the Rockhampton area, represents perhaps the most pressing problem of the moment.'³⁵ He was

³¹ *Ibid.*, pf.

³² *Ibid.*, pf.

³³ *Ibid.*, pf.

³⁴ *Ibid.*, p.1, see also, 'Preliminary Report on Leprosy In North Queensland: by Sir Raphael Cilento to the NH&MRC', June 1938, pp.1-4.

³⁵ AA, Series No. A/1928/1, Item 635/38. 'Report from Chief Quarantine Officer (General), Steamship Blgs, Eagle Street Brisbane, to Director General Of Health, Canberra', dated 10 September, 1938.

discussing the general reported spread of leprosy in Australia, a matter raised later at a meeting of the Federal Health Council in 1931. The Commonwealth Government, some thought, was best placed to research the incidence of leprosy and its spread.³⁶ Close surveillance, as Cook had suggested late in the 1920s, appeared to be the preferred strategy. Close monitoring of suspects, and regular reporting on the progress of patients and their families, together with the close cooperation between State health agencies, was required. In Darwin at this very time such methods were already being practiced.³⁷

At a 1932 conference on the problems facing Australia in the tropics³⁸ Cilento emphasised the point that adequate medical services were an important part of developmental activities in the tropics.³⁹ He argued that Australia with its dependencies had 'the largest tropical possession in the British Empire.'⁴⁰ This took account of Northern Territory, Papua and the Pacific Island possessions which were much bigger in area than African and South American tropical areas. Institutions such as the Australian Institute of Tropical Medicine, had been created in order to eradicate many of the diseases introduced between 1860 and 1900. At the same conference Dr H.E. Molesworth endeavoured to explain his belief that leprosy was an example of the

³⁶ *Ibid.*, p.1.

³⁷ Ralph Doherty, 'Cecil Cook - Frontiersman Of Australian Health', in J. Pearn and M. Cobcroft, *Fevers and Frontiers*, Amphion Press, Brisbane, 1990, pp.87-94; see also, S. Saunders, *A Suitable Island Site: Leprosy in the Northern Territory, and the Channel Island Leprosarium*, Published by the Historical Society of NT, 1990; see also, Ellen Kettle, *Health Services in the Northern Territory - History 1824-1970*, ANU, NARU, Darwin, 1991, pp.86-131; see also, press cutting on this file of, *The Sydney Morning Herald*, (SMH), 19 Aug, 1932, article entitled, 'Medical Science, Australia's Problem in Tropical Areas, Dr Cinento's Address: Tropical Colonialism', in AA, Series No. A 1928/1, Item 635/38.

³⁸ SMH, 'Cilento's Address: Tropical Colonialism', pf.

³⁹ *Ibid.*, pf.

⁴⁰ *Ibid.*, pf.

'operation of natural selection.'⁴¹ He postulated that the disappearance of leprosy from parts of Europe related directly to the medieval regulations, better housing and nutrition and the depopulation of Europe following the Black Death. The conference did not dismiss these propositions, but recommended intensive investigation of the factors which aided the spread of leprosy, and of its distribution and control measures in Australia.⁴²

A month after the conference, Cilento wrote to Cumpston, Commonwealth Director-General of Health, pointing out that he had prepared an itinerary for a proposed examination of Aborigines suspected of being infected with leprosy. He had prepared the schedule in consultation with Bleakley, who had helped arrange visits to missions, government settlements and distant Aboriginal camps.⁴³ Cilento arranged to travel between October and November 1932. He wanted to visit Townsville, Cairns and the Atherton Tableland regions before returning to Brisbane.⁴⁴ Cilento advised Cumpston that a number of people around Rockhampton were also suspected of being infected. These people now showed signs of leprosy and were younger members of the same family of a positive case he had identified in the late 1920s. The original contact had been removed to an institution at Aberfield, near Moto.⁴⁵

Briefly, the circumstances of this case were that an Aboriginal man had been identified as having contracted leprosy but he had never been

⁴¹ AA, Series No. A 1928/1, Item 635/38, see *SMH*, dated 19 August, article on same page with title, 'Leprosy, Influence Of Natural Selection'.

⁴² *Ibid.*, pf.

⁴³ AA, Series No. A 1928/1, Item 635/38, 'Memo: Cilento to D-G Commonwealth Health, dated 12 October, 1932'; this memo comes both with a typed itinerary and a seven paged report entitled, 'The Leprosy Problem In Australia', p.1.

⁴⁴ *Ibid.*, see attached 'Itinerary', p.2.

⁴⁵ *Ibid.*, see 'Memo: Cilento to Cumpston', dated 12 October 1932, p.1.

isolated. As a result two of his sons contracted the disease and were sent by Ministerial Order to the Peel Island Lazaret.⁴⁶ In other Aboriginal depots used as disease camps, whole families were infected and this case was no different from earlier ones reported. The patient lived with his children who also produced grand children who had then become infected. Another distant relative of the patient, a man named Barney, was the father of three (two girls aged 19 and 23, and a brother of 21) who were all admitted to Peel Island a year earlier. Another relative among this family group had also been sent to Peel Island, and this man was the first Aboriginal person to be scientifically diagnosed as contracting leprosy at Mona Mona.⁴⁷ All of these cases were members of the local Kuranda people, and many of them had married into peoples from as far north as Cape York who had been brought down to Mona Mona government depot. People from the northern country also came to Mona Mona for other reasons and entered the pool of infection by what might be described as forced migration for health reasons. In any event, the first case, as previously mentioned, appeared to be from the Kuranda Ranges, and this batch of leprosy cases was identified by the Health Department as the 'Kuranda series'.⁴⁸

The surveillance structures put in place at the turn of the 1920s and 1930s to diagnosis of leprosy, yaws and tuberculosis were not easy to put into practice. Aborigines suffering from these diseases moved or were removed from the places they wished to settle. Similarly, when health workers came to observe the infections in the bush the wasted tissue of the leper was normally matted with soil or body fluids such as blood and pus and could not be diagnosed immediately. Isolating family members

⁴⁶ *Ibid.*, pf.

⁴⁷ *Ibid.*, pf.

⁴⁸ *Ibid.*, see final para under initial heading, 'Early Records', p.1.

within certain cattle and sheep properties was a further complication.⁴⁹ In a report entitled 'A Brief Review of Leprosy in Australia and its Dependencies', Cilento stated the dilemma:

When the question of the Aboriginal was investigated, the problem was seen as complicated. The native habit of changing their names repeatedly further disguised relationships already marked by the haphazard use of terms brother, father, uncle, cousin, etc. Their complete dread of white society's medicines, made...[Aboriginal patients accept] surgical possibilities...in hospitals utterly impossible....[It was only possible] to contemplate...complete segregation for all Aborigines diagnosed with leprosy.⁵⁰

This report appeared in the records of the seventh session of the Federal Health Council, held 20-22 March 1934. Cilento used this venue to further claim that it was 'utterly untrue' to assume that Aborigines would cooperate like white persons. Aborigines, he argued, feared the unknown which often controlled their responses. Anything outside their experience in the way of medicines frightened them and, as a consequence, they would not return for follow-up treatment nor would their relatives give them up to authorities.⁵¹

Evidence from the report revealed that eight lepers from a number of settlements had been isolated on Peel Island. These Aboriginal patients came from Mona Mona and were discharged from Peel Island as cured. They belonged to the same family and closeness of their relationship suggested that the pool of infection was confined to one family.⁵² This was a further complication which arose in monitoring the progress of notified cases of infection among Aborigines. A survey of the whole of the Mona Mona settlement commenced in November of 1932 and it

⁴⁹ *Ibid.*, see under heading 'tracing contacts', p.1.

⁵⁰ AA, Series No. A 1928/1, Item, 690/8/106, see Sir Raphael Cilento, Preliminary Progress Report: Leprosy In North Queensland', pp.1-4.

⁵¹ AA, Series No. A 1928/1, Item 635/38, 'Memo: Cilento to D-G Commonwealth Health, dated 12 October, 1932'.

⁵² *Ibid.*, pf.

uncovered the fact that two people had died from leprosy, a woman in 1916 and a man in 1928. Similarly it indicated that another male, Billy had been sent to Peel Island in 1925.⁵³ The team conducting the screening found 20 females and 3 males who presented with 'suspicious skin conditions requiring re-examination from time to time.'⁵⁴ In the same year, but only a few months later, the team found 5 females and 6 males in this same category, and listed them for checking every six months.⁵⁵

In the period from 14 July 1934 to 23 March 1935, several of the males were diagnosed as positive. These patients included one suspicious patient deemed positive in 1932. By Ministerial order all were despatched to Peel Island.⁵⁶ The following year two females, Violet and Edith, who had been considered suspects in 1932, were identified as positive leper cases. Both women left for Peel Island in September of 1936.

In the following year a National Health and Medical Research grant of £1,000 allowed a mass screening program to take place of all Aboriginal residents at Palm Island, Yarrabah and Mona Mona. The subsequent report claimed that the researchers took swabs from all people aged five years and over.⁵⁷ Cilento sent his Minister a memo on 23 March 1937 which reported the results of the confidential screening exercise on Palm Island, Yarrabah and Mona Mona Aboriginal settlements.⁵⁸ By 1937 the

⁵³ AA, Series No. A/1928/1, Item, 690/8/106, see 'Sir Raphael Cilento, Preliminary Progress Report: Leprosy In North Queensland', p.2.

⁵⁴ AA, Series No. A 1928/1, Item no. 635/38, see 'Memo: Cilento to D-G Commonwealth Health, dated 12 October, 1932'; this memo comes both with a typed itinerary and a seven paged report entitled, 'The Leprosy Problem In Australia', see under heading, 'Progress Of The Infection', p.2.

⁵⁵ AA, Series No. A 1928/1, Item no. 635/38, 'Leprosy Problems In Australia', pf.

⁵⁶ *Ibid.*, pf.

⁵⁷ *Ibid.*, pp.3-4.

⁵⁸ QSA, Series No. A/58640, 'Report on Mona Mona - Health & Medical', see copy of 'memo: from R.W. Cilento, Director-General of Health and Home Affairs to Minister For Health and Home Affairs, Queensland, dated 23 March 1937', pp.1-4, with 4 page attachment.

Mona Mona population had grown by only 23 to a total of 207 males and females since an earlier survey in 1932.⁵⁹ The Mona Mona population of 207 (96 males and 111 females) revealed only 11 suspected cases of leprosy.⁶⁰ This figure was surprising given the urgency expressed in Cilento's letter to the NH&MRC on 28 October 1938.⁶¹ A year earlier he wrote in his report on Mona Mona, that he had

inspected all the natives with particular reference to leprosy. Six registered as suspect lepers from the swabs obtained from them. Of these, three proved positive, namely Elsie Hunter, Myrtle Hunter and Roy Hobson and steps have been taken to remove these persons to Peel Island. A list of their intimate contacts and relatives and also those of Lindsay Baker, now at Peel Island, Mable Green and Gilbert Martin should be made out by the Superintendent, and careful watch kept for skin lesions in these or other people. They should be examined at least twice a year and preferably every six months for five years for early evidence of leprosy.⁶²

Cilento was clearly perturbed about the suspected spread of leprosy, and his concern was for infection among both Aboriginal groups and the wider white society.⁶³

Cook's 1940 report looked at the wider incidence of leprosy which was reported among Aborigines among some indigenous groups in Queensland. The report indicated the numbers of lepers in government depots, lock-up hospitals, and missions.⁶⁴ Working from records compiled by Dr Croll (a medical researcher employed by the Queensland Government), Cook could only account for 50 lepers. This number

⁵⁹ QSA, A/58640, see copy of 'Report by the Director-General of Health and Home Affairs, to Queensland Minister for Health and Home Affairs, dated 23.3.37', pp.1-4.

⁶⁰ *Ibid.*, see attachment headed, 'Mona Mona', pp.1-4.

⁶¹ Cilento, in AA, Series No. A 1928/1, Item 690/8/106, see 'memo from Cilento to Chairman of NH&MRC, dated 28 October, 1938' p.1; see also 'memo: Cecil Cook to Acting Director School of Public Health and Tropical Medicine, Sydney, dated 16th August 1940.

⁶² QSA, A/58640, see Cilento, in 'Copy of Report by the Director-General of Health and Home Affairs, to Queensland Minister for Health and Home Affairs, dated 23.3.37', p.2.

⁶³ *Ibid.*, see 'covering memo to Cilento's Report to Minister, dated 23 March 1937'.

⁶⁴ AA, Series No. A 1928/1, Item No. 690/8/106, see 'Memorandum, Report On Leprosy in Queensland, 19 June 1940, by Cecil Cook, pp.1-8, (including graph showing increase of leprosy throughout Queensland).

consisted of 25 cases at Palm Island, five at Fantome, two at Yarrabah, eight at Mona Mona, five at Woorabinda, two in the Torres Strait, one at Normanton and, finally, two at Mapoon.⁶⁵ Of the 30 lepers that Croll had located on Palm and Fantome Islands Cook saw only 18 people with leprosy. One of them showed signs of leprosy on the lower section of the leg with no skin change. One case showed cherry type lumps opposite other nodes consistent with early leprosy. Some people also presented with a tinea (fungal skin infection) in various forms and swelling of the nose and ear lobes, the body parts that often reveal early signs of infection.⁶⁶

Cook was critical of Croll's data, but the figures had been double checked by Dr Johnson of the Queensland Health Department. In 1939 Croll found, and reported on, 201 suspected specimens he had taken from 57 patients. The eight reserves, depots and settlements mentioned above had the greatest prevalence of leprosy out of a total of 21 known locations where Aboriginal groups congregated. Between 70 and 100 per cent of all people were inspected at the 21 settlements, but only 18 swabs resulted in positive identification of Aboriginal inmates who had contracted leprosy; however, 16 of these subsequently produced no reading when checked by Dr Johnson of the Queensland State Health Department.⁶⁷

In 1940 Peel Island leprosarium was converted into a lazaret for whites only. Fantome Island and a small part of Greater Palm Island, became segregated as a temporary detention and screening depot for Aborigines exclusively. Despite his earlier claims that a surveillance and treatment system was in place, Cook noted that no proper record keeping existed, and reported that this was a great handicap to the health

⁶⁵ *Ibid.*, p.2.

⁶⁶ *Ibid.*, p.2. Cook indicated that Croll's data was suspect.

⁶⁷ *Ibid.*, p.3.

authority's capacity to keep track of lepers.⁶⁸ Very little information was available to rural medical general practitioners when and if they were presented with a patient and the doctors had to make the original diagnosis. Cook was critical of this ignorance in the profession because the number of Aboriginal leper patients was increasing. More specifically, however, was the fact that the big increases were occurring in the white population and, according to Cilento and Cook, the need to separate Aboriginal from white patients appeared to be because of the racial prejudice of white patients, and the segregated institutions had little to do with medicine.

In 1934 a new Department of Health and Home Affairs took control of the office of the Chief Protector of Aborigines.⁶⁹ Prior to this date the Secretary for Home Affairs maintained control of the office of the Chief Protector Aborigines. Cilento became the first Director General of Health and Medical Services for Queensland on 28 April 1935, and subsequently carried out extensive surveys among Aboriginal mission and government settlements in that State. Cilento's views on Jews and Aborigines later became a matter of controversy but, in his own defence, he argued that he did try consciously to channel his department's resources to tackle Aboriginal health problems systematically. In doing so, however, his chief obstacle was the parsimony of both the Queensland and Commonwealth governments, which prevented him developing a Statewide Aboriginal health strategy in Queensland.⁷⁰ As a result it was virtually impossible for him to provide better primary and preventative

⁶⁸ *Ibid.*, p.5.

⁶⁹ Fedora Gould Fisher, *Raphael Cilento: A Biography*, QUP, Brisbane, 1994, pp.83-175; see *Health Act Amendment Bill, 1934*, QPP, (vol. 175, 1934), p.1580, quoted in Fisher, *Raphael Cilento*, p.313.

⁷⁰ A.T. Yarwood, 'Sir Raphael Cilento And 'The White Man In The Tropics'', in MacLeod and Denoon, *Health And Healing*, pp.47-63; see also, Fisher, *Raphael Cilento*, see pp.67-69, and see also pp.212-214.

health services for Aborigines in Queensland, or to improve on the limited knowledge of the poor health of the State's Aborigines.

Some health programs in Queensland did fortunately come to Aborigines in rural towns and on pastoral properties. One instance was the program to combat trachoma, an eye infection mentioned in earlier chapters, which became a public health threat, mainly in rural Queensland in the 1930s. Like hookworm, trachoma was a disease resulting from poor hygiene practices, and subsequent infections were readily passed from one person to another. According to Dr Rogers of the Queensland School health program, poor hygiene in toilets at home, using dirty personal handkerchiefs and wearing articles of dirty clothing formed the main sources of infection. Other sources were flies. Flies landed on the infected eye, and quickly transferred the diseases to others in close contact with the infected person. Remedies required a trip to the local doctor or nurse, if available, for treatment. Alternatively, children could see the part-time ophthalmic officer who visited the schools twice yearly. Instruction in eye health in schools, and on the dangers of eye disease and its treatment, was also a preventative measure with some beneficial effects.⁷¹

The school-oriented programs involved numerous Aboriginal children, many of whom by the 1930s were going to country schools run by the Education Department as well as to schools on Aboriginal settlements such as Woorabinda (previously Taroom), Cherbourg (or Barambah) and Yarrabah near Cairns. In addition the school medical program visited other mission settlements as far north as Cooktown and

⁷¹ Benenson, *Communicable Diseases*, pp.441-444; see also copy of report entitled, 'Trachoma In Queensland School Children'.

even Mornington Island in the Gulf of Carpentaria.⁷² At the beginning of the period the Wilson Ophthalmic School Hostel opened in Brisbane, located close to city-based eye specialists who could quickly treat rural patients infected with trachoma or whose eyes became damaged by the effects of trachoma. Many children, including many Aboriginal camp, reserve and mission children, who failed to respond to normal treatment in their home towns were sent to this institution.⁷³ In 1932 Dr P.R. Patrick, the medical officer of the school health program, toured the areas of infection and remote islands, and he chose many of the first intake of patients to the government funded eye hostel.⁷⁴

Once in the hostel the children received free treatment and tuition on health and hygiene. The average length of stay was initially two years, but this was reduced. Patrick wrote that since the 1912 survey, three further surveys had been conducted in the years before the 1930s. The rate of infection was reduced from 20 per cent to three per cent between 1912 and 1940. The severity of the disease, Patrick believed, had been greatly reduced because of the regular local inspections and treatment, support from local general practitioners, education in hygiene and finally the opening of the Wilson Ophthalmic School Hostel. By the 1940s 71 country towns were included in the State-wide school health inspection round. At least 5,417 children were inspected, and this included many in Aboriginal camps or, as Patrick called them, 'way-side camps'.⁷⁵ Patrick wrote that although trachoma was present in most parts of Queensland it was mostly found west of the Great Dividing Range. Although it was

⁷² Long, *Aboriginal Settlements*, pp.102-136, and see also, pp.139-172; Long does not mention the school health program, which is referred to only to show that the education department serviced Aborigines on reserve and mission schools.

⁷³ 'The Queensland School health program', p.1.

⁷⁴ *Ibid.*, p.2.

⁷⁵ *Ibid.*, p.1.

difficult to quantify, the prevalence of trachoma in Queensland appeared to be higher among 'less hygienic sections of the community'. The disease had no respect for person, race or class and most rural people were vulnerable during an epidemic. 'The lower standard of hygiene is no doubt the reason for its greater prevalence in the coloured children,'⁷⁶ Patrick wrote, 'but a low standard is not confined to the coloured folk.'⁷⁷

The vice president of the International Organisation Against Trachoma, according to a memo written later to the Director General of Health, wrote to the Prime Minister's Department in February 1934, asking for details of the presence of trachoma in Australia.⁷⁸ Cumpston wrote back saying that trachoma did exist in Australia and had done so since the early days of colonisation, but the medical profession now believed it to be a condition of decreasing importance.⁷⁹ Cumpston said the disease had practically disappeared from urban coastal regions of Australia. In most States trachoma still existed but had consistently disappeared as housing and living conditions and diet improved.⁸⁰ The disease was confined to dry and dusty areas of western and northern Queensland and Western Australia. In all States except Victoria, trachoma was no longer a notifiable disease but it still remained a public health problem in Queensland. School inspections continued there and coastal retreats were sometimes provided for children suffering

⁷⁶ *Ibid.*, p.2.

⁷⁷ *Ibid.*, pf.

⁷⁸ AA, Series No. A 1658/1, Item 807/1/5 pt 1, see Memo for Director General of Health dated 26 September 1934, which came through Australia House in London to the PMs Dept, p.1.

⁷⁹ *Ibid.*, see copy of 'memo: from J.H.L. Cumpston, Director-General of Health to the Official Secretary High Commissioner's Office Australia House London, dated 5 April, 1934'.

⁸⁰ *Ibid.*, see 'memo: from Cilento to Director of Health Canberra, dated 6 November 1931, on nutrition and trachoma'.

infections.⁸¹ Trachoma became more of a social stigma among rural dwelling society rather than a major health risk, although it persisted well past 1940.⁸²

Since the onset of the depression, Aborigines had adopted a highly mobile pattern of living while looking for work. This was not associated with traditional or customary styles of living but arose from economic necessity. Changes in technology were bringing the Australian economy and in particular the general health system much closer to once distant and isolated Aboriginal communities than previously. The Queensland health system in 1930 consisted essentially of a primary health service built on access to general practitioners, with a tier of hospitals in urban and rural centres. This system included services to Aborigines in hospitals for infectious diseases and mental illnesses. Although medical practitioners needed a stable population of potential patients to survive on a fee-for-service-basis they essentially clustered around, and often became dependent on hospitals.⁸³ The structure then was a public hospital based health system in which hospitals were managed by boards of local citizens, and medical representatives who determined hospital policy. As might have been expected, fee-for-service was the principal source of doctors' incomes, but the other sources of income included government subsidies and fund raising by the local community hospitals who mostly used private general practitioner services. Some hospitals were managed by a government appointed commission rather than by local boards.⁸⁴ Finally, there were private hospitals which were mostly located in prosperous agricultural regions and in urban areas near the

⁸¹ Cumpston, in AA 1658/1, Item 807/1/5 pt 1, 1, 'Ophthalmia Disease Trachoma', p.1.

⁸² *Ibid.*, pf.

⁸³ AA, Series No. A/431/1, Item 46/2123, 'General Review of existing Medical Services in Northern Australia', p.4.

⁸⁴ *Ibid.*, pf.

coast.⁸⁵ A major deficiency of this structure, the 'General Review of Medical Services' said, was that doctors tended to lose their professional skills because of isolation and an absence of continuing in-service training. Isolation in rural towns often kept doctors out of touch with new developments in medical science and technology.⁸⁶

In 1936 those hospitals which were operated by boards came under amended legislation through the *Hospitals Act 1936*. This legislation provided for the grouping of hospitals in adjacent areas under the control of district boards. By 30 June 1940, there were 21 of these district boards around Queensland which controlled 32 hospitals.⁸⁷ Each board consisted of a chairman and from four to nine members. The board membership was drawn from local government authorities, and interested local residents who raised money from public donations to the hospital and a representative of the Government.⁸⁸ Each year the Government made grants of £10 per occupied bed to each hospital from its 'Golden Casket' lottery fund. Grants were made to 'base hospitals' in towns such as Cairns, Rockhampton and Townsville all of which received special grants for buildings and other purposes. Towns such as Cooktown, were ports where quarantine arrangements had to be supported by local hospitals. Such support grants helped to cover the costs associated with the detention of aliens and servicing people with infectious diseases such as poor foreign sailors and, finally, indigent Aborigines who were suspected of being unable to pay their hospital bills.⁸⁹

In Queensland there were 22 hospitals not controlled by hospital boards. In these establishments local committees made decisions about

⁸⁵ *Ibid.*, pf.

⁸⁶ *Ibid.*, p.5.

⁸⁷ *Ibid.*, pf.

⁸⁸ *Ibid.*, pf.

⁸⁹ *Ibid.*, pf.

operating policies but left repairs and maintenance to committees which raised funds for that purpose. The local committees largely focused on access rules, staffing conditions, operating budgets and hospital fund-raising for expansion programs. The number of members was fixed by the hospitals themselves and some members were elected by subscribers while others took their place as government appointees.⁹⁰ The committees could raise money but not through loans, and the government contributed £1.10.0 for every £1. raised by the hospital. Like the public hospitals, profits from the Queensland Golden Casket Art Union were used to fund grants of £10. a bed, or approximately half the amount needed to operate these hospitals. In addition, there were private hospitals and maternity hospitals.⁹¹ Aborigines were treated in almost all subsidised hospitals but, as with the general public, privately operated institutions reserved the right to refuse entry to those who could not pay for their services. The publicly funded bodies sometimes refused people access because they wanted to protect their white patients from Aborigines, or from poor white vagrants. Some hospitals also thought that Aborigines could be treated at the relief depots or, as they became known, Aboriginal settlements, to which they sent their Aboriginal patients if a settlement was nearby.⁹²

In 1928 the Australian Inland Mission's Flying Doctor Service began operations from a base at Cloncurry in western Queensland. Although its headquarters was in Melbourne, the real nerve centre was Cloncurry.⁹³ Cloncurry and Charleville each had base hospitals, and most patients were flown there. In 1935 these two hospitals were equipped with X-ray

⁹⁰ *Ibid.*, pf.

⁹¹ *Ibid.*, pf.

⁹² Long, *Aboriginal Settlements*, pp.176-188.

⁹³ Maisie McKenzie, *Fred McKay: Successor To Flynn Of The Inland*, Boolarong Publications, Brisbane, 1990, pp.36-65.

machines by the Commonwealth Government. With this equipment it was possible to screen patients for both tuberculosis and cancer.⁹⁴ These services became available to those Aborigines who were in contact with mission, reserve and country towns.⁹⁵

Other ambulance services were provided by the Queensland Ambulance Transport Brigade. In January 1931 Mr Browning of the Brigade wrote to the Chief Protector Bleakley asking for financial support. The reason was that

considerable assistance had already been given to Aborigines and now the subsidy was being reduced to three shillings and six pence in the pound. The protector of Aborigines should contribute to their costs as some of the Aborigines had expressed a willingness to contribute but could not do so without his permission.⁹⁶

Browning went on to tell Bleakley that the Brigade had attended 40 accidents involving Aborigines and 90 Aborigines were transported to hospitals in the Tully and Ravenshoe areas and surrounding station properties. Fourteen of these cases were serious and a total of 928 miles had been travelled without payment from those Aborigines serviced.⁹⁷ This Ambulance Brigade committee was anxious to know if consent could be given to recover some of the costs if Aboriginal families could contribute to the fund. On 24 July 1933, Bleakley replied saying he agreed with the idea of encouraging Aborigines who held paid employment to contribute to the organisation if they wished. Many employers were responsible for their employees and they should be approached. Bleakley, however, felt no need to draw funds either from taxpayers or from

⁹⁴ AA, Series No. A/431/1, Item 46/2123, 'General Review of existing Medical Services in Northern Australia', pp.6-7.

⁹⁵ Maisie McKenzie, *Fred McKay*, pp.46-77.

⁹⁶ AA, Series No. A/58856, 'Queensland Ambulance Transport Brigade: Hospital', see 'note from Browning to Chief Protector dated 9 January 1931'.

⁹⁷ *Ibid.*, pf.

Aboriginal people's savings as a contribution to the service.⁹⁸ At the same time more clinics and reserve hospitals were built on the settlements as the number of unemployed Aborigines living on government settlements increased.⁹⁹

On Aboriginal reserves and missions, primary health care was based on health clinics managed by general practitioners located in nearby towns and staffed by professional nurses with support from Aboriginal male or female employees.¹⁰⁰ The contract doctor could visit at regular intervals or as needed. Most Aboriginal mission stations along the northern coast of Queensland were operated by either Anglican or Lutheran churches. In most cases the Bush Nursing Society of Queensland provided the nurses employed in the mission clinics. These nurses were usually posted to regions isolated from general practitioners.¹⁰¹ Such isolation meant that the nurses had to rely on police protectors to transport Aborigines to base hospitals and sanatoria, which were sometimes located hundreds of miles away.

Some patients, particularly those with mental illnesses, were difficult to transport. By 1933 complaints came to Bleakley's notice about the way police were continuing an old practice of moving people away as unwanted vagrants by organising free rail passes to shift them out of town.¹⁰² The incident arose as a result of an insane Aboriginal person receiving press coverage in the *Brisbane Courier*. The circumstances recounted by the newspaper were that the patient was transported by

⁹⁸ QSA/A58856, Item 36/9457 and 37/2324, 'Aboriginals - General', see 'Letter from Home Secretary's Office, Brisbane, to the Queensland Ambulance Transport Brigade, dated 24 July 1933'; see also, Bleakley, *The Aborigines of Australia*, pp.167-178.

⁹⁹ *Ibid.*, pp.198-204.

¹⁰⁰ Bleakley, *The Aborigines of Australia*, pp.277-283.

¹⁰¹ AA, Series No. A/431/1, Item 46/2123, 'General Review', pp.11-12.

¹⁰² QSA, A/44746, 'Transportation of Insane Aborigines', see press cutting *The Brisbane Courier*, of July 13, 1933, entitled, 'Mental patient transported by train', see also, article in *The Melbourne Truth*, dated Sunday, 22 September, 1935, entitled, 'Pitiful Freight'.

police in a train from Townsville to Brisbane. The Police Union complained to the Commissioner of Railways, M.J.W. Davidson, about forcing police to transport sick Aborigines and prisoners in the normal compartments used by other passengers. The union argued that the Railway Commission should put an extra carriage on the train for transporting insane or dangerous passengers under police escort.¹⁰³

That was not the end of the issue for on 4 January 1935, Senior Sergeant Howard wrote a memo to the Railway Commissioner saying that in escorting

insane patients, or Aborigines suffering from venereal disease or other contagious disease, the practice adopted here was to phone the District Superintendent for Railways at Cairns on the day previous to the escort leaving, giving full particulars...and...if the escort consisted of insane patients, or Aborigines suffering from contagious or infectious disease they would be sent forward on a goods train...A spécial carriage...[usually] provided the space to convey lepers, insane patients and others, and that this carriage...[could not] be attached to the mail train but...[had to] go...by goods train.¹⁰⁴

The secretary for Railways, G.A. Murton, replied soon after, saying he was not aware of any problem in transporting insane patients from Cairns to other places. Moreover, Murton pointed out to the district superintendent at Cairns that

it was distinctly unfair for Aborigines to be placed in sleeping berth apartments on the 266 up from Cairns to Townsville and then to ask other people to get into these compartments at Townsville and occupy them to Brisbane.¹⁰⁵

Murton went on to say that the Railway Commission had received no application for either the insane or Aborigines to travel on the 266 to Townsville, and he saw no reason why an extra carriage was needed, a

¹⁰³ *Ibid.*, see 'memo: from Cairns Police Station dated 4 January'.

¹⁰⁴ *Ibid.*, see 'memo: from Senior Sergeant Howard on Transporting of insane or Aborigines', on 4 January 1935'.

¹⁰⁵ *Ibid.*, see undated (possibly October 1935) 'reply from Murton, Secretary to Commissioner for Railways'.

view he passed on to the Superintendent in Cairns.¹⁰⁶ On 26 November 1935 L.E. Toohill, the Inspector for the Commissioner of Police wrote to the Commissioner for Railways about an insane Aborigine from Palm Island who had been refused travel by mail train from Cairns to Townsville.¹⁰⁷ The difficulty continued for three years until W.L. Lipp of the Cairns Police Inspector's Office declared that he was

of the opinion, [that] the Railways Department...[could not] legally refuse to convey any insane or Aboriginal by mail train. If a relative of an insane patient purchases the ticket, the Department cannot refuse to convey that patient, neither could they, nor do they, attempt to prevent an Aboriginal from travelling by this train.¹⁰⁸

The argument ended there, but sickness continued forming a major part of reserve managers' reports to Bleakley. Between January 1933 and March 1935 seven people were removed from Woorabinda (previously Taroom) to Palm Island with leprosy.¹⁰⁹ Some people with limited infection received treatment or were possibly screened for diseases at Palm Island. These people were sent to leprosariums or kept at Palm before being cleared to return to their homes. If they harboured dangerous infections they were detained under either the Aborigines protection or health and infectious diseases legislation. If people living on relief depots, missions and government settlements were identified as carriers of leprosy then they could be removed immediately on confirmation. Sometimes confirmation came from local hospitals and at other times from Brisbane, a normally slow process, in both instances, that could take months.

¹⁰⁶ *Ibid.*, pf.

¹⁰⁷ *Ibid.*, see 'letter from Toohill dated 26 November, 1935'.

¹⁰⁸ *Ibid.*, see memo dated 18 November 1938.

¹⁰⁹ QSA, A/58831, 'Health Weipa', see memo on 'Suspected Lepers examined at Woorabinda by Dr Blackburn from Duaringa, on 30 August, and 1 September 1933. This file contains names of people committed to Palm Island.

Patients from the Cape went first by boat to Cooktown, and then either received further treatment there or were transported further south to depots. While they travelled they were bedded down in aliens' wards or quarantine compounds. On 21 April 1933, J. Collard of the Home Secretary's Office, the department in charge of government works, wrote to the Minister for Agriculture, F.W. Bulcock,¹¹⁰ about repairs to the Cooktown hospital buildings. In a quotation of £640.14.0 for the repairs, Collard told the Minister that repair to buildings remained a matter for the hospital to deal with, and that the Department of Works carried out building on new structures only.¹¹¹

In November 1933 Collard wrote to the hospital board indicating that the building repairs related to the alien's ward which was in a state of disrepair.¹¹² He said further that if the building was demolished the aliens, and including Aborigines, would be accommodated in the general wards. On the same day the chairman of the hospital board sent a telegram to the under secretary of the Home Secretary's Department in Brisbane to say that work had commenced on repairing the building at the Cook Hospital, in Cooktown, called the aliens' ward. It was to be demolished and would leave no accommodation for aliens unless a new building replaced it. He also suggested that the front portion of the aliens' ward would be allowed to remain.¹¹³ The matter was sent on to the Department of Public Works at the end of November that year to

¹¹⁰ Denise K. Conroy, 'Bulcock, Frank William (1892-1973)', in John Ritchie (gen. ed.), *Australian Dictionary of Biography*, Vol. 13, 1940-1980, pp.292-293; see also, D.B. Waterson, *A Biographical Register of the Queensland Parliament 1860-1929*, p.24; see also, (QSA, A/58863, Item 36/688 - 'Aboriginals General and Hospital Boards', see, 'letter from Collard to Minister for Agriculture, dated 21 April, 1933'.

¹¹¹ *Ibid.*, pf.

¹¹² *Ibid.*, see 'hand written letter from Collard to Home Secretary, dated November 21, 1933'.

¹¹³ *Ibid.*, see 'telegram dated November 21, 1933'.

consider what action could be taken.¹¹⁴ That was not the end of this matter because on 7 June 1934 Home Secretary Collard visited the Cooktown police station where the old alien's ward was located.¹¹⁵ He found that the walls of the compound were falling down,¹¹⁶ and that Aboriginals suffering from leprosy and venereal disease were being placed in the police cells while awaiting transit by launch at Cooktown.¹¹⁷ Many of these people had already been transported from the Cape York Peninsular on their way to Fantome Island leprosarium via the health screening depot at Palm Island. Minister Bulcock consulted Inspector Sydes of the Department of Works and arranged to re-erect a new compound on the hospital grounds and demolish the old building at the police station. The Minister felt that 'the presence of these infected natives in close proximity to police officer's quarters, and the cells of white civilian offenders was wholly undesirable.'¹¹⁸

In the meantime the Home Secretary and Chief Protector had each visited the site. Nothing happened before October 1934 when the secretary of the Cook Hospital wrote on behalf of his board to the under secretary of the Home Secretary's Department. He complained that there was insufficient room for Aboriginal patients and that the work should proceed immediately.¹¹⁹ In January 1934 the district supervisor of the Department of Works had assessed the site for both the removal of the old cell and the erection of a new 'room stockade' at a total cost of

¹¹⁴ *Ibid.*, see 'letter from Home Secretary's Dept., to Cook Hospital dated 30 November, 1933'.

¹¹⁵ *Ibid.*, see 'one page Memo: Under Secretary to Home Secretary, dated 18 July, 1933'.

¹¹⁶ *Ibid.*, pf.

¹¹⁷ *Ibid.*, pf.

¹¹⁸ *Ibid.*, pf.

¹¹⁹ *Ibid.*, see 'letter from Collard to Under Secretary Home Dept., dated 17 October, 1934'.

£334.16.0.¹²⁰ This meant removing the wooden cell from the police station at Cooktown and erecting a stockade in the hospital grounds — a simple and straight forward task. In addition Sydes recommended that the wall be dug to a depth of 18 inches 'to prevent blacks from scratching their way out.'¹²¹ The following month, the deputy Chief Protector, Mr O'Leary, wrote to the under secretary in the Home Secretary's Department about the matter.¹²² He made the point that he had received no advice about who was to pay for the structure. He said that the expenditure involved should be charged to Aboriginal standing accounts, the funds to which the project could be 'legitimately charged.'¹²³ Since the structure would most benefit the Police Department, the local protector felt that they should be consulted about the costs.¹²⁴ In mid-1935 building plans and specifications were passed between the Home Secretary's Department and the Department of Works, but nothing was decided that year.¹²⁵

On 3 February 1936 O'Leary wrote a memo to Bleakley saying that while on his way to Thursday Island he stopped at Cooktown, where he had drawn the Cook Hospital secretary's attention to

an apparent misunderstanding by the local hospital committee regarding the isolation ward recently removed from the police station site....The secretary of the hospital committee and others were inclined to argue that patients admitted to this ward, i.e., venereal disease or leprosy cases, were under the control of the

¹²⁰ *Ibid.*, see 'quotation form prepared by F.R. Sydes, dated 3.1.35', (see remarks at bottom of quote).

¹²¹ *Ibid.*, pf.

¹²² *Ibid.*, see 'letter from Deputy Chief Protector to the Under Secretary, Home Secretary's Department, dated 7 February 1935', p.1.

¹²³ *Ibid.*, p.1.

¹²⁴ *Ibid.*, p.2.

¹²⁵ *Ibid.*, see 'Memo from Deputy Chief Protector of Aborigines to the Chief Protector of Aborigines, dated 3 February 1936', pp.1-2.

Protector of Aborigines who was responsible for their general care...support and treatment as ordered by the medical officer.¹²⁶

O'Leary believed that the hospital patients, irrespective of the nature of the complaints, should remain the responsibility of the hospital until cleared of disease, or infection.

In correspondence at this time O'Leary alluded to another problem. He said that the Cook Hospital committee claimed that the nursing staff objected to attending Aborigines with either leprosy or venereal diseases. In addition this hospital had no native staff to do the job of attending to sick Aborigines. In the past Bleakley had paid a subsidy to the hospital for Aborigines to be employed to clean and attend Aboriginal patients. This subsidy had been withdrawn, possibly during the depression, and this left the nursing staff to carry out the work. O'Leary recommended that the department undertake to pay the wages of a suitable native married couple to be obtained from Palm Island settlement to look after and give treatment to the patients in the isolation ward.¹²⁷ These employees would be under the supervision of a matron and they would feed patients from food prepared in the hospital kitchen. The status of this Aboriginal couple would be equal to ward attendants and they would be employed as such. O'Leary said he felt sure the hospital would accept these arrangements.¹²⁸

With regard to the building, O'Leary said that the proposed new building would be unsuitable for the accommodation of Aboriginal patients. There were only two cells and an enclosed front verandah with a high galvanised iron wall. No exercise yard was planned, and in the heat of the tropics the compound would be unbearable. The Cook

¹²⁶ *Ibid.*, p.1.

¹²⁷ *Ibid.*, pf.

¹²⁸ *Ibid.*, pf.

hospital secretary discussed these views with O'Leary and agreed with him. In addition they both insisted that it would be better to raise with the Department of Works the possibility of expanding the yard by about 20 to 30 metres. The yard, O'Leary suggested, should be made large enough to allow for shade to fall across the yard from nearby trees and 'thus provide relief from the insufferable conditions in the building when humidity rose, and for patients to exercise in the open air.'¹²⁹ Inter-agency agreements like this would prove to be important because the new legislation passed by Parliament in 1934 was just beginning to provide greater control by the Chief Protector over the health and social conditions of Aborigines, whose number by legislative fiat now included both people of mixed and full descent.¹³⁰

Later in February, Bleakley wrote to the Department of Health and Home Affairs pointing out that he had never taken up with the Minister the problem of how the new infectious disease compound would be staffed, nor how the patients would be fed or who would be responsible. He said O'Leary had discussed a plan to meet these contingencies with the secretary of the Hospital Committee. Now that the building was completed the Committee's attitude had shifted. It now claimed that 'the responsibility for the treatment of Aboriginal patients [was] no longer one for the hospital but one for the local protector.'¹³¹ Bleakley accepted that the hospital secretary was possibly talking about Aborigines confined in the cells normally used by police for Aboriginal prisoners. He was adamant, however, that the attitude of his department was that if Aboriginal patients required treatment, no matter whether they were

¹²⁹ *Ibid.*, p.2.

¹³⁰ Bleakley, *The Aborigines of Australia*, pp.178-179.

¹³¹ QSA, A/58863, Item 36/688, - 'Aboriginals General and Hospital Boards', see 'letter from J.W. Bleakley, Chief Protector of Aborigines, to Under Secretary, dated 25 February 1936', pp.1-2.

accommodated in the compound or actually in the hospital ward, it was the hospital's function to provide any necessary treatment.¹³² Bleakley's stance may have been at odds with the general attitude of other government agencies but it was appropriate for someone such as Bleakley to be concerned with improving the health and social conditions of Aborigines under such a desperate economic circumstances as the economic depression. Bleakley believed that O'Leary's recommendations of 3 February 1936, were reasonable and that the department should make an offer along the lines of O'Leary's recommendations.¹³³

Bleakley was strong on protecting his portfolio interests and this was reflected in the changes made to the protection legislation. The changes in 1934 had made it possible to appoint missionaries as protectors of the people on their missions. Samuel Eric McKay, superintendent at the Weipa Mission was appointed as a protector in the district of Somerset. Additionally, William Frederick McKenzie, superintendent at Aurukun, and Joseph William McCullough, superintendent at Mitchell River, were all given greater powers as protectors.¹³⁴ Following these appointments other superintendents of government and missions establishments thought that they should also be appointed, and Bleakley agreed when he made a series of new appointments on 22 August 1934. Some of the newly appointed protectors were the Palm and Fantome Island superintendents, the Lutheran missionaries at Mona Mona and Cape Bedford, and the government settlement managers at Woorabinda, Cherbourg, Purga and Yarrabah. In addition, the Police Magistrate at Townsville and the visiting justice to Palm Island were also made

¹³² *Ibid.*, p.1.

¹³³ *Ibid.*, p.2.

¹³⁴ QSA, A/A58856, Items, 36/9457 and 37/2324, 'Aboriginals General', see, letters re: 'Aboriginals and Appointments regarding Illtreatment of Northern Aboriginals, letter dated 7 May, 1934'.

protectors. The reason given for these appointments was to minimise the chance of outsiders interfering with Aborigines.¹³⁵ As far as policy was concerned, the objective was meant to keep costs of policing to a minimum. Increasing the number of protectors also meant maintaining the racial miscegenation policy where Aborigines of mixed descent married and had children within their own racial grouping, and keeping the intact full-blood groups as isolated as possible from influences of white culture and contact. Policies with respect to the care and protection of Aborigines were organised within the departments, and so 'outside interference' could be avoided. The Queensland public, during the period 1936 to 1937, began to demand a greater political say in the way the Chief Protector was managing affairs relating to Aborigines.

The Chief Protector's office was placed under the Department of Health and Home Affairs in 1934. As this transition was being effected Bleakley was required to report directly to his Minister on the operations of his office rather than to the Cilento the departmental head. These arrangements changes in 1938. Bleakley's first report to Cilento outlined the policies from 1914 to the late 1930s, when Bleakley had assumed responsibility for protecting Queensland Aborigines. In that time, the health policy had been to

provide accessible machinery for medical treatment and relief, take measures for the discovery, prevention, isolation and treatment of disease and the promotion of better health conditions in the interest of the European as well as the Aboriginal community.¹³⁶

It was clear to him from his recent visit to northern missions that the missions ought to be given greater support in managing their operations.¹³⁷ Bleakley drew attention to the fact that at all locations

¹³⁵ *Ibid.*, pf.

¹³⁶ *Ibid.*, see 'Chief Protector's Briefing Report to Minister, dated 25.5.1938', (see clause (e)), p.4.

¹³⁷ *Ibid.*, pp.4 and 4 (a).

where Aborigines had been concentrated there was evidence of a serious lack of financial resources. The shortage of capital was due particularly to the slump in charitable contributions and the increase in maintenance costs.¹³⁸ An equally serious reason for Bleakley's concern was the depletion of traditional Aborigines' food sources as a result of which 'nomads' were sending their children to missions and reserves and also drifting from their bush living sites to the fringes of white settlements in increasing numbers.¹³⁹ Although it was not possible to quantify this at the time, the population of people of both full- and mixed- descent had increased substantially, increasing the missions' dependence on government aid. Unemployment and an increasing population rendered the missions' task doubly onerous.¹⁴⁰

Under new circumstances of working together, Cilento and Bleakley adopted very similar points of view. In a report to his Minister on 23 March 1937,¹⁴¹ Cilento wrote that 'settlements are large concentration camps where natives are isolated from the white population and where any education or training they receive is relatively valueless due to lack of outlet.'¹⁴² He was convinced that the real problem among Aborigines was, to a very great extent, a medical problem.¹⁴³ What this meant was that it was a problem encompassing 'all aspects of welfare from diet to working hours and working conditions.'¹⁴⁴ This was a movement away

¹³⁸ *Ibid.*, p.4.

¹³⁹ *Ibid.*, pf.

¹⁴⁰ *Ibid.*, pf.

¹⁴¹ QSA, A/58640, 'Report on Mona Mona - Health & Medical', see on this file, in particular, 'copy of covering memo from Cilento to Minister for Health and Home Affairs, dated 23 March, 1937', pp.1-20.

¹⁴² *Ibid.*, p.1.

¹⁴³ *Ibid.*, pf.

¹⁴⁴ *Ibid.*, pf.

from the colonial policy of protection and towards one of total control based on health. Cilento further explained his views in these words:

The developmental scheme put forward some years ago, ...that a native state should be built up on the Torres Straits, Cape York Peninsular, Palm Island axis, with gradual concentration towards this axis of true native stock, and gradual dispersal from it of near-white stock, is the only solution that is a progressive one.

He doubted whether such a plan could be properly implemented under the present departmental structure and protection policy. He was, nevertheless, certain that the plan he was proposing was necessary to 'solve the native problem in a way that...[would] be to the advantage of the native...and prevent conflict between white labourers and coloured.'¹⁴⁵

As Cilento's responsibilities for the protection of Aborigines grew he made a field trip to inspect some of the missions, in particular, the Seventh Day Adventist mission at Mona Mona. This trip was not the first time Cilento had travelled to the reserves but his main purpose was to carry out a health inspection of the Mona Mona population. Once there, he commented on the isolation of the settlement and the state of the roads in the wet season. After conducting the medical screening of most of the Aboriginal population he found six cases of suspected leprosy. Of these, two females and a male gave positive swabs. Cilento took immediate steps to have them removed to Peel Island. He also prepared a list of their intimate contacts and relatives. He knew from his earlier research of other Aborigines who were already at the leprosarium from this mission and asked the superintendent to do as he had done in the past and collected information on the contacts and relatives of suspected lepers. He added further that the mission population should be examined each year for further spread of the disease. In addition he located three

¹⁴⁵ *Ibid.*, p.4.

cases of venereal disease, each of which showed suspicious signs of old infections. This suggested that there could have been a latent source which could appear at later investigations.¹⁴⁶

This mission was ill-equipped to carry out the monitoring which Cilento had previously advocated, with regard to leprosy surveillance, as it lacked medical facilities and the missionaries only had experience in first aid. Most medical conditions were simply left to take their course, and that in turn meant that emergencies would inevitably arise. Whenever anything serious happened the sick were taken either to Cairns or Mareeba. A store of standard medicines was kept at Mona Mona but they were extremely poorly equipped, Cilento wrote, and they needed better stocks of medicines if only for routine ailments and medical disorders. Additionally, no nursing equipment was available to deal even with something as simple as minor cuts and injuries from accidents.¹⁴⁷ The conditions at Mona Mona were also present at other missions and so Cilento recommended that all Aboriginal stations should carry minor medical supplies.¹⁴⁸

Poor medical facilities at Mona Mona, Yarrabah and Palm Island were not the only deficiencies of these settlements. At all three the inmates suffered from poor diet. Of the three missions, Mona Mona had the least deficient diet even though the population there ate no meat. Cilento concluded that their food was unable to 'compensate for the absence of haemoglobin, iron and copper salts and other materials present in meat, and the diet...[would] not be satisfactory until some

¹⁴⁶ *Ibid.*, p.2.

¹⁴⁷ *Ibid.*, pf.

¹⁴⁸ *Ibid.*, pf.

adequate substitution...[was] made.'¹⁴⁹ Whichever way Cilento turned anomalies appeared to which no easy solution was available.

In Queensland in 1930 to 1940 the Aboriginal population was deeply affected by the catastrophic economic depression of 1929-32. This forced people accustomed to living on sheep and cattle properties to migrate to mission and government reserves. The combined burdens of economic depression, population increase, changing definitions of Aboriginal identity, an evolving pattern of reforms of Aboriginal settlements together with new patterns of disease, poor health servicing and hygiene practices created many stresses for all concerned. As a result, the health structure and the system of protection entered a set of circumstances where all three were brought to breaking point. Despite changes in technology which brought Aborigines and other patients closer to better health care and ambulance services, problems persisted with the escort system used to bring Aborigines from remote regions for some time to come. The method of escorting Aborigines across the State by police acting as surrogate health workers had commenced at the turn of the century. This practice suggested that both the Chief Protector and police went to some trouble to care for sick Aborigines, yet the idea of moving people around the state by force, and making them travel thousands of miles for health treatment, now appears draconian. Disease health and healing in Queensland did improve the condition of life as borne out by the increases in population and a curb on some infectious diseases. Others newly developed diseases however, joined with such diseases as leprosy and tuberculosis to persist among indigenous groups, but I make mention of these issues in the conclusion which follows.

¹⁴⁹ *Ibid.*, p.3.

APPENDIX 10

Table 10.1: Aboriginal deaths in Queensland, 1930-1936

Males								
Disease	1930	1931	1932	1933	1934	1935	1936	Total
Pneumonia	14	15	18	21	22	16	12	118
Influenza		3	1	12	3	1	1	21
Consumption, TB, phthisis	4	15	14	8	19	10	11	81
<i>sub-total of respiratory diseases</i>	18	33	33	41	44	27	24	220
Nephritis		2	1	3				6
Venereal diseases including syphilis	2	5	13	9	13	7	3	52
Senile decay	24	38	28	21	20	50	24	205
Other diseases	17	36	52	32	27	29	24	217
Total	61	114	127	106	104	113	75	700

Females								
Disease	1930	1931	1932	1933	1934	1935	1936	Total
Pneumonia	10	11	16	11	16	14	5	83
Influenza		3		6	2	6	1	18
Consumption, TB, phthisis	6	11	17	18	15	19	8	94
<i>sub-total of respiratory diseases</i>	16	25	33	35	33	39	14	195
Nephritis		2				1		3
Venereal diseases including syphilis	3	9	12	11	11	2		48
Senile decay	13	14	14	18	18	36	15	128
Other diseases	12	27	42	33	22	19	14	169
Total	44	77	101	97	84	97	43	543

Source: Queensland State Archives, Series No., A/58973 — 58974, 'Death Registers
— Where, Cause, 1910-1936'.

Table 10.2. Queensland and Western Australian leprosy Totals, 1900-25

Year	QLD	WA
1900-1905	67	2
1905-1910	84	18
1910-1915	56	8
1915-1920	57	6
1920-1925	31	17

Source: J.H.L. Cumpston, 'Health and Disease in Australia', pp.207-219,
and W.S. Davidson, 'Havens of Refuge', pp.124-127.

Conclusion

In this thesis I have examined aspects of disease, health and healing among indigenous people in Western Australia and Queensland between 1900 and 1940. I argue that the natural history of disease was an important element in shaping and influencing the interaction between the indigenous people and the various members of the settler community most concerned with them — government protectors, missionaries, pastoralists and health workers. I conclude that in the history of contact between the indigenous peoples and outsiders such as Asians, Pacific Islanders and Europeans in Western Australia and Queensland, diseases were a major influence on indigenous people and on the way governments intervened in socialising indigenous groups.

Prior to contact with outsiders, indigenous groups had harboured a range of infectious diseases, the most important of which was yaws. Indigenous peoples possessed a system of ideas of sickness and health based on the reverential awe of sorcerers. As far as we are able to discern, sorcery was probably no match, in pre-contact times, for infections such as yaws and syphilis, and customary methods of healing were certainly unable to cope when outsiders began breaching the isolation in the past century or two. When western medicine was combined with official State protection policies and practices, they became part a set of powerful social processes within both Aboriginal and settlers social relations, which resulted in the incorporation of indigenous groups into rural life in both States.

Disease forced the governments of Western Australian and Queensland to introduce measures to control the spread of infections by

creating strict management regimes in an attempt to limit contact between settlers and Aborigines. Despite these limits, contact proceeded and with it diseases which caused sicknesses, crippling bone disorders and premature ageing. These effects coupled with widespread hunger forced governments and religious missionary societies to develop policies of protection. In turn, they created a network of institutions which began to change Aboriginal relief depots into permanent settlements. In the meantime, however, some diseases became endemic and spread widely and speedily throughout Aboriginal groups. Protectors, health workers, missionaries and pastoral employers were forced by the protection policies to concentrate Aborigines in particular, into centralised depots, settlements and reserves, from which they were unable to escape disease, sickness and death. These became the means through which people's physical and social well-being were destroyed by introduced diseases.

The growth of the indigenous population created problems for the government, missionaries, settlers and Aborigines themselves because it intensified the effect of disease on populations concentrated on relief depots, mission stations and reserves. People of full-descent doubled their numbers while the population of peoples of mixed-descent more than trebled. The sex balance began by favouring males, but gradually protection policies corrected the imbalance.

Contrary to contemporary popular thinking, there was no protracted dwindling of the Aboriginal population but a resurgence to levels possibly higher than ever before. These circumstances, in contrast to present conventional wisdom, were both created and assisted by the policy and practice of protection. Aboriginal females of both full and mixed descent benefited most, but so did the aged males of full descent.

Changes to official criteria for classifying indigenous people created problems of access to medical practitioners and hospitals. Confusion arose over who could or could not use 'native' hospitals and mission clinics. Those who failed to gain such access drifted to the fringe of society where a new type of missionary, who specialised in proselytising the peoples of the fringe-camps, helped them gain access to health care by other means.

Segregated programs and facilities such as government reserves, ration depots, 'native' lock-up hospitals and missions did offer limited access to medical treatment, but outside the segregated structures the fee-for-service, user-pays medical system on which most white citizens relied always presented barriers to Aboriginal people seeking access to hospitals and doctors' surgeries.

Aborigines did not, nor could they, realise the threat from diseases. Settler society, too, was ignorant of indigenous people's thinking regarding illness and the power of sorcerers. Missionaries were also ignorant of some of the indigenous social organisations and of the diseases from which the mission inmates suffered. Settlers had limited knowledge of the threat of poor hygiene in the camps of the workers they employed. This ignorance resulted in Aborigines living on missions, depots and fringe-camps polluting their own living sites. When governments began attempting to attend to these new health threats the solutions led to other social, economic and cultural problems

Although no data was collected in Western Australia to reveal the extent of mortality created by the Spanish Influenza pandemic in that State, the protection system did limit its impact. In Queensland, however, the Spanish Influenza pandemic did highlight the inadequacy of government and missionary approaches to health care had become

obvious. The reforms which followed brought primary and public health closer to indigenous people. Nevertheless, these reforms brought their own administrative problems, by introducing professionally trained staff from outside the mission and protection agency workers' backgrounds and more open settlements. The rise of greater self-interest among Aborigines themselves meant that depots and settlements had to account more for the needs of inmates. The lack of access to medical practitioners and to hospitals remained a barrier to good health and hygiene. This in turn primary and public health problems caused the maintenance and spread of infections, in different ways in both States.

In Western Australia, blindness, crippling bone disorders, hunger and sickness forced the government to create a role for protectors to feed, care for and remove the sick to within reach of medical treatment. Temporary locations such as telegraph stations and camps on the fringes of mining towns became so overcrowded with people seeking relief that depots, reserves and church missions were created to solve the problem. Soon these locations became permanent living places, and later developed into established Aboriginal settlements.

In Queensland sick Aborigines in distant rural and bush settings had to be escorted hundreds of miles by police who acted as unwilling surrogate health workers. Police officers confronted by diseased people lacked the proper administrative support from their department in dealing with sick and diseased Aborigines. Under these circumstances they devised *ad hoc* solutions which conflicted with departmental directives.

The relief depot clinics were not able to deal with the disaster imposed on the southern institutions. The deficiencies which were exposed highlighted the need for reform, and subsequent reforms were

intended to shift health care from the model based on compassion to one based on professional care. Meanwhile, government and mission relief depots began gathering permanent populations during the 1920s. Many groups with incurable infections brought their families with them, and this process transformed depots into permanent settlements. Due to the inability of indigenous patients to access mainstream medical and hospital services, this administrative strategy meant the development of clinics and hospitals which exclusively serviced indigenous people.

When protection was instigated around 1900, in both Western Australia and Queensland, hopes were high that the ravages the stresses of encroaching settler society and the diseases suffered by indigenous people would come under control. The enthusiasm with which protection began in 1900 had faded by 1910. Indigenous populations did recover under the protection policies in place during the study period. Subsequent constraints of segregation of the sick on remote islands or on government and mission reserves, failed to halt the diseases affecting the indigenous population in the extremities of both States. Poor hygiene in environments occupied by indigenous people, even in traditional bush camps, meant that almost all suffered from infectious diseases. The bush dwellers and hunters did not escape either the pre-contact endemic infections which they brought with them to their dwelling places or the new types of diseases nurtured in the new social circumstances on the fringes, missions and government reserves. Similarly, as relief depots, government reserves and missions were transformed into modern indigenous settlements, even more exotic diseases emerged to threaten their future. Indigenous people must have been aware from the beginning of the promise of western medicine, but they could hardly

have been expected to appreciate that the promise would never be delivered.

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