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Protection and segregation: the motive forces in improving Aboriginal health in Queensland, 1920–30

The decade 1920–30 was important for Aboriginal health in Queensland. The results of the hookworm surveys carried out along the central Queensland coastal districts between 1918 and 1923 were published. The reforms introduced throughout the 1920s transformed the old style ration and relief depots into permanent, settled, segregated Aboriginal townships, providing a basis for improving health standards. One reason why such townships were created was to ensure that Aborigines married and produced children only among themselves. Another reason was to help Aborigines feel ‘contentment and comfort’.¹

The post World War I phase of the national hookworm campaign ended in 1924. This phase became entwined with the growth of ideas about public health, from which came ideas about Aboriginal ‘betterment’.² Aborigines by now were widely perceived as being in need of ‘improvement’. Not only that, but as surplus labour 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 previous research among indigenous groups had revealed, the rate of infection was high among Aboriginal groups. The report claimed that practically all indigenous groups of north Queensland were affected by hookworm.⁴ Some had 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.

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 only among 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 live in comfort among the white population, although in some cases they 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 the highest rates of infection.¹³

At Barambah near Murgon in the south-east of the State, the rate was clearly much lower than in the north. At Barambah, 142 people presented

with hookworm infection from a population of 602, or 24 per cent.¹⁴ Barambah had begun as a relief depot and, in the space of little over a decade, its residents had become an institutionalised population. The reason for the disparity between Barambah and the northern settlements may have been that such 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. Even the relatively low infection rates of the south suggest that the image of the Aborigines portrayed by the 'betterment' movement was over-optimistic, if not idealised.

A total of 1079 Aborigines were living in this district not including 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 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 age group were infected, or about 10 per cent of the total population. In the camps, out of a total of 417 only 6 were infected. The survey teams tabulated the results, correlating them with the rainfall and climate,¹⁷ but in the last instance the numbers were 'too small for any importance to be attached to these groups'.¹⁸

J.C.S. 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, which consisted of both white migrant labour and the permanent white population, had 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 English, lived in poverty in squalid hovels and kept to themselves.²⁰

Cilento obviously understood workers' habits in the cane cutting districts.²¹

To inform the treatment of Aborigines, the State Health Commissioner 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 for 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 infestation among some migrant groups. In the original investigation in three North Queensland districts, of 1339 Italians examined, 32 per cent showed hookworm infection. 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 who held this extreme view on this subject. In his diary entry for 17 December 1917, prejudice tinged with compassion was apparent:

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 woman 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

A.T. Yarwood, who published a paper on Cilento in 1991,²⁸ found his views both prejudiced and naïve.

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 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 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 of campsites and scores of homes occupied by Aborigines in the various depots, settlements, missions and fringe-camps, only six had privies.³¹ Customary practice prescribed that people 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 made this inevitable. Even where toilets had been constructed they were allowed to overflow and pollute the surrounding areas for some distance.³³ The Queensland protectors were paradoxically placed in this situation: they wanted to leave people alone but at the same time expected that Aborigines should heed public views on health standards. Realistically, however, to expect people who had so recently emerged from bush life to use latrines was a vain hope. No amount of State tuition could persuade reserve inmates to use them regularly.

Two hookworm inspections took place in the period 1920–23, and the second revealed a vast improvement over the results of the first. For example, at Purga mission near Cairns the first inspection had revealed a 70.4 per cent infection rate, but the second inspection showed it had fallen to 45.9 per cent. The latter figure was still too high, however. Despite the 24.5 per cent improvement, the infection rate among Aborigines was two or three times higher than among other groups.³⁴ Other Aboriginal settlements showed improvement too, but their infection rates also 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 on the second. 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 areas 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, improvement generally came because the 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-Queensland survey, as reported by W.C. 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 which was put into operation in 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 ensure 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 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 about follow-up or continuing surveillance.

Except for continuing work among Aboriginal camp groupings, the Australian Hookworm Campaign completed its work at the end of September 1924. The Campaign had national responsibility for monitoring control measures but its diagnostic laboratories were limited 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 hookworm occurred either in Aboriginal institutions close to rural service towns or in the more isolated Christian 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 these objectives were central to the policies of his administration. But despite his attempts to segregate Aborigines from the wider society, outside influences still penetrated his protective net in the form of contact between Japanese mariners and Aborigines. The Japanese maintained fishing communities in the Solomon Islands, and when they came south to harvest fish 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 men, although a number of Japanese women were brought in between 1907

and 1910. Many of the Japanese fishermen took on 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. 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 the Aboriginal reserves and campsites along the Queensland coast annually.⁴⁴ The transfer of communicable diseases between Aborigines and the Japanese was a matter for concern to the protectors and government agents alike. 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, and such 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*, expressing concern about 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 hired by 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 Niro Nagasaki, 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. 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, 'no attended lighting existed' between Cape Grafton and Cooktown.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 Aborigine 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 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, the seaman Nakashiba disappeared into the bush for over a year. Then Gabriel 'discovered 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 overcrowding at the Cairns hospital and the health camps.⁶⁰ Hospital staff had to use tents to house the venereal disease victims who came for treatment. In Cairns, the Customs officials accommodated both the sick and diseased Japanese and Aborigines in the 'alien' stockade. This practice was also 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'.⁶¹

In June 1922 Gabriel received a letter from F.W. Hayes of the Land Office in Cooktown, 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 '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

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 Aborigines. 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, particularly 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 the relief depots. In most cases the bush fringe-camp offered the best 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 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.

Bleakley continued making 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* such institutions 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 was always from among personnel from outside the district, and once employed at the depots the nurses worked under a series of State regulations,⁷⁰ including those of the *Public Health Act 1911*, the *Aborigines Protection Act 1897* and the *Public Service Act 1922*.⁷¹ Medical practitioners, that is, visiting medical officers, billed the Chief Protector for their fees. However, they, came under the control of public health and medical legislation. They undertook to make weekly visits to inspect the hospitals and to treat 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 Hospital 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 then formed part of their annual reports to the Chief Protector.⁷²

White townspeople generally abhorred the practice of white men having sexual relations with Aboriginal women. Townspeople believed that Aboriginal women were the original source of venereal diseases and that their white male partners would bring the infection into white society. It's not known when venereal diseases were passed on to Aboriginal people. In any event, white people were highly fearful of this infection because they knew of its social effects. Alternatively Aborigines did not fear the effects of the disease. On the one hand, Aboriginal groups could not see the infection nor was the disease life threatening. On the other hand, the disease was barely under control but mostly, protection kept white men away from cohabiting with Aboriginal women. In addition, the number of Aborigines who died from venereal causes was small during the 1920s. In the five year period 1920–24, only 18 Aboriginal men and 10 Aboriginal women died from venereal diseases.⁷³ A possible reason why more

Aboriginal males were dying of these disease, than Aboriginal females was that the transmission of infection was partly congenital and partly coming in from outside 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, except for the contact with Asian sailors (which was, as described, difficult to control). 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 more rigorously under the more forceful policy management of 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 diseases.⁷⁴ The decline from the previous five-year period reflects the assiduity with which Bleakley fulfilled his responsibilities. Further, 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 enforced migration meant that where infection was endemic, as with tuberculosis, then the infection remained in the group until the removal of those who were infected. Until that happened, all camp residents remained vulnerable. The following graph (Figure 9.1) shows that respiratory infections—pneumonia, influenza and tuberculosis—caused the deaths of 235 Aboriginal men and 166 Aboriginal women during the decade 1920–29, and almost no cure existed. Of these deaths, 110 were from pneumonia and a further 110 from influenza, of which there were possibly three different strains. The first strain was probably a lingering form of Spanish Influenza,⁷⁶ which killed 52 people in the two years between 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.

For Aborigines who died from disease, entry of their death into the Death and Disease Register was not necessarily a straightforward exercise. Under normal conditions certification of the death of a white person or someone of mixed-descent by rural police, a health worker or a medical

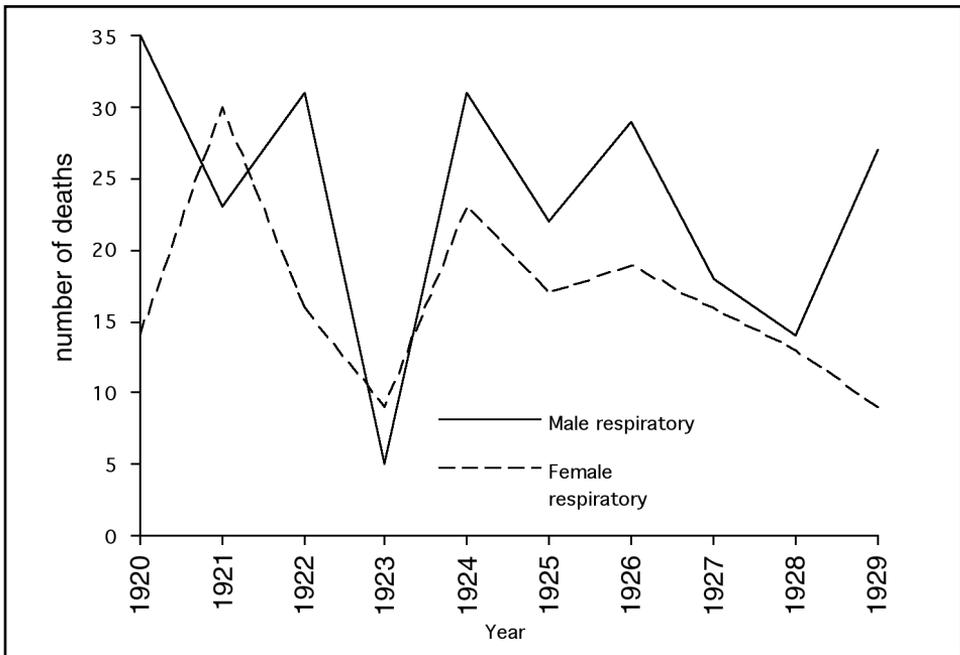


Figure 9.1: Aboriginal deaths from respiratory diseases in Queensland by sex, 1920-1929. Source: Compiled from Table 9.1.

practitioner, was reasonably simple. Great difficulty existed, however, for someone making a determination of cause of death of a full-descent Aborigine. In most cases, problems existed because of the isolated locations where the Aboriginal person died. Certification usually had to be made by 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 deaths.

Recognition or diagnosis of diseases was difficult for health workers. Pneumonia, as in earlier epidemics, became confused with influenza, so the information about Aboriginal deaths can only act as a guide. In the period 1920–29, 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 of the details because the two diseases were often confused. It is interesting to note that while, influenza deaths fluctuated the recorded deaths from pneumonia increased, with exactly the same number of deaths from each—110—over the decade, as Table 9.1 (below) indicates.

Table 9.1
Aboriginal deaths in Queensland, 1920-1929

	1920	1921	1922	1923	1924	1925	1926	1927	1928	1929	Total
Male deaths											
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,	10	4	22	3	17	11	10	8	5	4	94
<i>Sub-total respiratory</i>	35	23	31	5	31	22	29	18	14	27	235
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>	17	15	18	9	42	47	50	72	27	43	340
Total male deaths	52	38	49	14	73	69	79	90	41	70	575
Female deaths											
Pneumonia	1	2	1	1	4	2	4	7	6	5	33
Influenza	9	9	1		10	3	7	1	3	3	46
Consumption,	4	19	14	8	9	12	8	8	4	1	87
<i>Sub-total respiratory</i>	14	30	16	9	23	17	19	16	13	9	166
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>	7	10	7	11	33	33	29	51	28	36	245
Total female deaths	21	40	23	20	56	50	48	67	41	45	411
Total Aboriginal deaths											
Pneumonia	7	6	8	3	11	13	13	17	14	18	110
Influenza	28	24	3	0	17	3	17	1	4	13	110
Consumption,	14	23	36	11	26	23	18	16	9	5	181
<i>Sub-total respiratory</i>	49	53	47	14	54	39	48	34	27	36	401
Nephritis	1	3	1	0	1	2	0	12	1	1	22
Veneral diseases	2	9	1	8	8	6	4	9	1	1	49
Senile decay	6	6	14	4	20	20	28	27	14	19	158
Other diseases	15	7	9	8	46	52	47	75	39	58	356
<i>Sub-total other diseases</i>	24	25	25	20	75	80	79	123	55	79	585
Total											
Aboriginal deaths	73	78	72	34	129	119	127	157	82	115	986

Source: *Queensland State Archives*, Series No., A/58973-58974, 'Death Registers-Where, Cause, 1910-1936'

The increasing number of Aborigines dying from tuberculosis was a cause for concern. In the period 1910-18, the number of Aborigines dying from tuberculosis or similar 'wasting' diseases had increased from two to 27, and then to 36 between 1922-24.⁷⁸ After that the number fell to 5 in 1929. 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 would have spread infection rapidly in government reserves, missions and ration depots.

As relief depots evolved into permanent dwelling places, those who lived there also began developing new forms of social relations: they were indeed coalescing into communities.⁷⁹ The protection and religious policies allowed more permanent marriage relationships to be created. With these came a wider range of diseases not experienced under the earlier social relations. Two types of diseases rose to prominence during this period: diseases related to ageing, including illnesses resulting in 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 28 in 1926. More relevant to this period were deaths from 'other' causes. These rose from 15 to 46 in the five years between 1920-24, then peaking at 75 in 1927 before dropping to 58 in 1929. It is not possible to discuss this category in detail because the information is so limited. Many deaths were recorded 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, in others it was a complex of causes, such as work related accidents, 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 produces 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, Bleakley attempted to improve clinical care at the government and mission depots. He tried new approaches to Aboriginal health services in protective institutions. Typical of these was the system in place at Barambah. The Barambah management, an interdenominational body set up to administer health care to the sick and suffering, helped 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 pneumonic influenza pandemic of 1918–19 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 were employed mainly for their religious convictions, while others did have formal nursing qualifications. The latter type 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 as well as some of the problems faced daily by the staff.

The events 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. An 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 among 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 staff members' actions, and did not think Matron Little had been purposely unkind. 'Natives, too, are difficult to deal with at times when sick', Bleakley

added, 'and are superstitious and mulish, and necessary discipline is often regarded as harsh'.⁸⁶ Life for inmates was often mundane but sometimes traumatic. The staff sometimes became alienated because of their closeness to 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. In March 1929 a baby girl, Maudie Bell, died from syphilis and heart failure at the Barambah settlement clinic.⁸⁹ She was only seven months old.⁹⁰ Earlier that month another child had died, which had 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 Little's resignation 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 on a daily basis by health workers, administrators and inmates.

Aboriginal deaths from respiratory infections made up a large part of some of the problems with which depot, reserve and mission staff had to cope. In general, the types of administrative problems exposed above did contribute to some deaths but the problem was much larger. Aboriginal deaths from respiratory infections in the period 1920-29, as entered in the Death and Disease Register,⁹⁴ suggest that deaths from pneumonia, influenza and tuberculosis were of most concern to the health professionals and the protectors. Aboriginal males died in greater numbers from pneumonia and influenza than females, though the totals in each case were close (see Table 9.1 above). Confusion over diagnoses probably meant that the numbers were not accurate in each category: each could

well have been either higher or lower. Tuberculosis increased almost to epidemic proportions in the mid-1920s if judged from deaths alone, and also exacerbated other respiratory infections.⁹⁵

As noted above, two waves of influenza struck during the period 1924–26, with a further epidemic in 1929 that drove deaths from respiratory infections upwards.⁹⁶ The reasons for the increase lay in the manner in which Aborigines began living in larger sedentary groups and using the houses with limited space and ventilation provided by mission and government authorities. The Queensland Government's protection policies and practices 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 and who lived for the first time in centralised settlements. With them came hygiene-related infections such as leprosy.

Although leprosy had been eradicated from the southern groups it could be transported by cattle and rural labour. In Queensland in 1920 there were 31 lepers, mostly Aborigines, though their numbers also included Torres Strait Islanders, Kanakas, Europeans and Asians. This figure was lower than the 35 in 1910. The number rose to 36 Aborigines in 1925, so it was obvious that leprosy was not about to disappear.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 1925.⁹⁸ 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.

Dr Raphael Cilento endeavoured to describe the problem in one of his reports. He wrote that when the Kuranda (Mona Mona) Reserve started in 1914, the majority of the Aborigines brought there belonged to the

Mareeba tribe, a closely knit group.¹⁰⁰ A few others came 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 clearly showed 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', then outlined the context of treating lepers in Queensland.¹⁰⁴ It should be possible through efficient 'prophylaxis', he said, to eradicate the disease in spite of the problems presented by the heat and humidity of the climate.¹⁰⁵ The problems were inadequate surveillance of suspected victims, inadequate 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 in the coercive protection institutions.¹⁰⁷ It meant full investigations into clinical histories of other members of families. Aborigines did not have 'households' nor simple 'family connections' as white society understood these. An Aboriginal family sometimes involved upwards of 15 small extended families spread over a 30- to 80-kilometre radius. When lepers were relocated 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 developing 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 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 at one living site could readily be infected by a single carrier.¹¹¹

As noted in earlier chapters, 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. He wrote that ‘leprosy amongst Aborigines 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 feet of the Aborigines, nor 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 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 40 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 Tommy’s sons, had been taken by ministerial order to the Peel Island lazaret, but his only grandchild was still at the settlement and was in danger of infection.¹²²

Other relatives were later diagnosed as lepers and removed to Peel Island.¹²³ Hookworm, venereal disease, respiratory infection and leprosy continued to be the greatest health risks to Aborigines.

Following the flu pandemic a phase of their reform took place, despite all this leprosy numbers increased during the period between 1930 – 1940, as shown in Chapter 10.

For full references see Bibliography

Notes

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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, 1970, pp.96-97, (Long talked about the scheme but makes no elaboration); see also, Dawn May, 1994, 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.
5. A/A, 1969/10, Items, 17 I, 17J, and 17K, 'Hookworm Disease and Control', see, W.C. Sweet, 1924, pp.1-13.
6. Cumpston, 'Hookworm', in Lewis (ed.), 1989, 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, 1924, pp.1-13; see also, Gillespie, in McLeod and Denoon, 1991, 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.
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.
15. *Ibid.*, see Table 5, p.10.
16. *Ibid.*, p.12.
17. Cumpston, in Lewis (ed.), 1989, see Table 113, p.242.
18. *Ibid.*, pf.
19. Gillespie, in McLeod and Denoon, 1991 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.
20. Fedora G. Fisher, 1994, pp.45-66.
21. *Ibid.*, pp.45-66, and see p.138; and see also, Geoff Burrows and Clive Morton, 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, 1994, p.46.
25. Gillespie, 1991, 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.
26. Douglas Gordon, 1974, p.111.
27. Cited in A.T.Yarwood,, in MacLeod and Denoon, 1991, pp.47-48. Quote is on p.48.
28. *Ibid.*, pp.54-60.
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, 1924, p.9.
33. *Ibid.*, see Table VI, pf.
34. *Ibid.*, Table VI, pf.
35. *Ibid.*, Table VI, pf.
36. *Ibid.*, p.10.
37. *Ibid.*, pf.
38. W.C. Sweet, 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, 1924, pp.11-12.

41. *Ibid.*, p.12.
42. Ian Howie-Willis, 'Bleakley, J.', in Horton, 1994, pp.134-135; see also, Raymond Evans, 'Bleakley, John William', in Nairn and Serle, pp.325-326.
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'.
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.
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.
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.
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.
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 *QPP*, 23rd Parliament, 1925, Vol. I, pp.1089-1155.
67. *Ibid.*, p.3.
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'.
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'.
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, 1961, pp.170-178, and see also, pp.194-200.
76. Brown, et al., 166, pp.117-119; see also, C.H. Stuart-Harris, 1970, pp.850-851; see also, N.R. Grist, 1979, pp.163-164; see also, F.B. Rodgers (editorial), 1968, pp.2192-2194.
77. See Table 9.1 in Appendix 9.
78. See Table 9.1 in Appendix 9.
79. Long, 1970, pp.176-188.
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.
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.

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 scrawly 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’, going 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’.

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.
94. See column for causes of death in, QSA, Series No. A/58973 – 58974, 'Death Registers – Where, Cause, 1910-1936'.
95. Brown, et.al., 117-119; see also, C.H. Stuart-Harris, 1970, pp.850-851; see also, N.R. Grist, 1979, pp.163-164; see also, F.B. Rodgers (editorial), 1968, pp.2192-2194.
96. See Table 9.1 in Appendix 9; see also, The Chief Protector, Annual Report, 1930, p.1.
97. Cook, 1925 pp.76-185; Cumpston, 'Leprosy', in Lewis (ed.), 1989, pp.208-212 and see Table 100, p.213, pp.420-430.
98. Lewis (ed.), 1989, 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 (ed.), 1989, 99, pf.
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.
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.
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, 1925; this was the result of an investigation in northern Australia during 1924-25, as a Wandsworth Research Scholar from the London School of Tropical Medicine; see also, Lewis (ed.), 1989, pp.207-219; for other biographical information see, John Pearn and Mervyn Cobcroft (eds), pp.87-100.
113. 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.

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’, *op.cit.*, pp.1-2.

121. *Ibid.*, p.1.

122. *Ibid.*, pf.

123. *Ibid.*, p.2.