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House of Representatives Standing Committee on Aboriginal Affairs

Report on

Aboriginal Health and Related Matters in the South-West of Western Australia

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THE STANDING COMMITTEE ON ABORIGINAL AFFAIRS

The Standing Committee on Aboriginal Affairs was originally appointed during the Twenty-eighth Parliament by resolution of the House of Representatives on 29 May 1973[1].

The Committee was re-appointed in the Twenty-ninth Parliament by resolution of the House of Representatives on 18 July 1974[2].

The terms of reference were identical in the Twenty-eighth and Twenty-ninth Parliaments, viz. :

> The Committee is to inquire into and report on matters referred to it by resolution of the House, the Minister for Aboriginal Affairs, or by motion of the Committee within the following terms :
>
> (a) to consult with Aboriginal and Island people on policies and programs for their advancement;
>
> (b) to examine the present situation of Aboriginal and Island people, recommend policies and improvements; and
>
> (c) evaluate the effect of policies and programs on Aboriginal and Island people.

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[1] Votes and Proceedings No.32, 29 May 1973.

[2] Votes and Proceedings No.6, 18 July 1974.

Members of the Committee - Twenty-ninth Parliament

Chairman	..	Mr M.D. Cross M.P.
Members	..	Mr G. Clayton M.P.
		Mr F.W. Collard M.P.
		Mr J.S. Dawkins M.P.
		Mr P.S. Fisher M.P.*
		Mr A.W. Jarman M.P.
		Mr P.M. Ruddock M.P.
		Mr R.W. Thorburn M.P.
		The Hon. W.C. Wentworth M.P.

Clerk to the Committee - Mr C.S. Boorman

Technical Adviser - Emeritus Professor W.E.H. Stanner C.M.G.

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*Mr P.S. Fisher M.P. was appointed in place of the Hon. R.J.D. Hunt M.P. who resigned in May 1975.

C O N T E N T S

F O R E W O R D

This Report contains the record of an examination by the Committee of health conditions amongst the part-Aboriginal people of the South-West region of Western Australia and a set of recommendations intended to remove inadequacies from and to strengthen present health programs. The Committee was impelled to conclude from the evidence put before it that the ultimate aims and goals of policies and programs are not always clear with the result that some interventions in the personal and communal lives of Aboriginals have not been successful. The apparent success of the special emphasis approach taken and recommended by the W.A. Community Health Services, by the Homemaker Service of the Department for Community Welfare, the Aboriginal Medical Service and the New Era Aboriginal Fellowship has been recorded by the Committee in the hope that its principles will be noted more widely.

The matters which gave the Committee cause for grave concern were the extent of malnutrition in children and of alcoholism in adults, and the lamentably ineffective programs for treatment.

In respect of the silent ravages of child malnutrition the Committee considers that all services in the fields of community health, welfare and education should be given and should accept prime responsibility to ensure that all children under their notice are receiving suitable and sufficient food. It considers that parents, communities and governments have a shared responsibility at present not accepted whole-heartedly.

The slogans for 'self-determination' and against 'paternalism' can be and, in the Committee's opinion, are unwittingly used to the disadvantage of children.

The Committee was impressed by the strength of the requests made by Aboriginal people for more effective means of dealing with the complex personal and family problems connected with alcohol. Many connected aspects of what is now an unconcealed tragedy for both Aboriginals and non-Aboriginals are considered in the Report.

The lack of systematic and definitive knowledge of Aboriginal attitudes to the causation of disease and to the positive necessities for personal and communal health seems to the Committee an obvious handicap for medical and health personnel. A recommendation for research in this field is made in this Report to the Australian Government.

R E C O M M E N D A T I O N S

The Committee recommends that :

on Relationship between Various Agencies

1 there should be greater consultation at local community level between all those persons who have an interest in the health care and welfare of Aboriginal people.

(paragraph 36)

on Research

2 the Australian Government sponsor research into Aboriginal attitudes to health and disease.

(paragraph 40)

on Nutrition

3 (a) Aboriginal communities and associations in conjunction with governmental agencies be encouraged and assisted to develop nutritional assistance programs in the form of school meals;

(b) Schools could and should play a more active role in health education programs; and

(c) the Australian Government at least restore the allocation of direct grants to the States for nutritional supplements to the same levels as 1974-75.

(paragraph 95)

on Alcoholism

4 the Australian and State Governments and local governmental authorities should most earnestly consider any positive measures suggested by Aboriginal communities for the control of alcohol.

(paragraph 105)

5 halfway houses should be established by Aboriginal community groups supported by the Department of Aboriginal Affairs, Community Health Services and the Western Australian Alcohol and Drug Authority.

(paragraph 108)

6 the Australian Government should fund a research program into the incidence and treatment of alcoholism in Aboriginal communities. This research could be carried out in Western Australia by the Western Australian Alcohol and Drug Authority assisted, as necessary, by Community Health Services.

(paragraph 113)

7 (a) the Western Australian Alcohol and Drug Authority be a member of the Aboriginal Affairs Co-ordinating Committee; and

(b) a Health Sub-committee be established within this machinery to co-ordinate community health education programs on such problems as alcohol.

(paragraph 114)

8 the Western Australian Alcohol and Drug Authority, in collaboration with Community Health Services, Department of Corrections, Aboriginal Medical Service, and Aboriginal organisations and communities, develop proposals for the management and treatment of habitual drinkers who voluntarily seek, or are considered by competent authority to be in need of, treatment.

(paragraph 115)

9 the Australian Department of Social Security accord special priority to the review of the type of social security payment most suitable for individuals and families affected by alcoholism.

(paragraph 123)

10 the Department of Social Security should make known more widely the pre-requisites for splitting social security benefits and for the Department for Community Welfare to act as warrantee for alcoholics.

(paragraph 128)

on Housing

11 the program for closing down the Reserves should be accelerated and tenancies for the inhabitants in State Housing Commission homes be arranged.

(paragraph 136)

12 the Department for Community Welfare should appoint many additional Homemakers, both Aboriginal and non-Aboriginal, male and female.

(paragraph 138)

13 (a) the Aboriginal Affairs Co-ordinating Committee examine ways in which the various agencies should approach the implementation of properly housing all Aboriginal families by 1982; and

(b) in any case of disagreement between the Housing Commission and the Department for Community Welfare concerning the suitability of an Aboriginal tenant to occupy a conventional town house which has been built from Australian Government funds, the Housing Commission be invited to accept the advice of Community Welfare.

(paragraph 145)

14 the State Housing Commission should accelerate the branch system for the purposes of rent collection, maintenance and, where necessary, on-going referral of tenants to the various support services.

(paragraph 147)

15 the State Housing Commission be asked to report to the Department of Aboriginal Affairs any obstacles placed by local government authorities in the way of construction or allocation of houses built or bought from Australian Government funds.

(paragraph 150)

on Education

16 (a) the divisions of Adult Education and Technical Education of the Western Australian Department of Education should consult with Aboriginal communities to promote school and community health education programs;

(b) Community Health Services and the Australian Departments of Aboriginal Affairs and Health should assist the Western Australian Department of Education to expand school and community health education programs; and

(c) the Western Australian Department of Education should appoint additional Aboriginal teacher aides and home-school liaison officers.

(paragraph 161)

on Recreation

17 the Department of Aboriginal Affairs in consultation with the Community Recreation Council examine the possibility of appointing additional Aboriginal Assistant Recreation Officers.

(paragraph 183)

18 that the Community Recreation Council of Western Australia should be a member of the Aboriginal Affairs Co-ordinating Committee.

(paragraph 184)

19 the Australian Government should subsidise in consultation with Aboriginal organisations, the establishment, especially in rural areas, of community centres for recreation and other social purposes.

(paragraph 185)

REPORT ON ABORIGINAL HEALTH AND RELATED MATTERS IN THE SOUTH-WEST OF WESTERN AUSTRALIA

1 INTRODUCTION

Activities of the Committee

1 On 6 March 1975 the Committee resolved to inquire into Aboriginal Health and Related Matters in the South-West of Western Australia following consultations with the Western Australian Director of the Australian Department of Aboriginal Affairs and the Acting Director of the Western Australian Community Health Services.

2 The Committee advertised its terms of reference in March 1975 and invited interested persons and organisations to participate in the Inquiry.

3 A sub-committee held public hearings in Perth on 21 March 1975 and carried out inspections and public hearings in 3 towns in the South-West of Western Australia from 18-20 March 1975. Further discussions took place in Perth on 18 and 19 June 1975 and in Canberra on 4 June, 29 August and 3 September 1975.

Witnesses

4 Evidence was heard from 88 persons, of whom 34 were Aboriginal. A list of witnesses and persons with whom the Committee held informal discussions is at Appendix 1. Evidence given at the public hearings is available for

inspection at the Committee Office of the House of Representatives and at the National Library of Australia.

Acknowledgments

5 Members of the Committee acknowledge the co-operation of the Premier of Western Australia and the Minister for Health and Community Welfare.

6 Members of the Committee wish to thank those Australian and State Government departments, in particular officers of the Western Australian Department of Aboriginal Affairs, Community Health Services, and all other persons and organisations who gave evidence.

2 SCOPE OF THE INQUIRY

Australian Government Policy on Aboriginal Health

7 Recognising that the health of Aboriginals, whether considered from a physical, psychic or social point of view, is at a lower level than that of the non-Aboriginal population, the Australian Government has developed a National Plan of Health for Aboriginals. In co-operation with the Australian and State Departments of Health, other governmental organisations and the Aboriginals themselves, the aims are to :

(a) lower the infant mortality and morbidity rates;

(b) improve the state of infant and child nutrition;

(c) eliminate growth retardation; and

(d) eradicate infections and chronic disease, including leprosy, trachoma, tuberculosis, gastro-enteritis, and respiratory and ear conditions.

Aboriginal Health and Related Matters

8 The Committee believes that the improvement of health of Aboriginals cannot be considered in isolation from the inter-related effects of housing, welfare, education, employment and recreation. In particular, overcrowded or inadequate housing and unemployment are major contributors to the ill-health of Aboriginals. The Committee also considers that undernutrition and the overuse of alcohol contribute significantly to the health problems of some Aboriginals.

9 In this Report, therefore, the Committee examines these major health problems and the inter-related effects referred to in paragraph 8.

South-West of Western Australia

10 The Committee selected for the purposes of its Inquiry a well defined geographical area in the South-West of Western Australia, which includes Geraldton in the north, through Southern Cross and Hopetoun in the south. This region in Western Australia was recommended by Western Australian Community Health Services as it was known to have major health problems.

11 Three towns in the South-West region, Moora, Gnowangerup and Collie, were selected for inspection and for taking of further evidence by the Committee to provide illustrations of a range of contrasting and similar conditions and problems.

3 ADMINISTRATION OF ABORIGINAL HEALTH AND RELATED MATTERS IN WESTERN AUSTRALIA

Royal Commission into Aboriginal Affairs in Western Australia

12 On 11 July 1973 a Royal Commission into Aboriginal Affairs in Western Australia was appointed by the Western Australian Government to "inquire into and report upon all matters affecting the well-being of persons of Aboriginal descent in Western Australia (with particular reference to their health, education, housing, social welfare, economic and group cultural need) and to recommend such legislative, administrative or other changes as are thought necessary."

13 The Report, released in July 1974, noted the merger between the Western Australian Aboriginal Planning Authority and the Australian Department of Aboriginal Affairs which took effect on 29 June, 1974. The Commission recommended, in part, that the administration of Aboriginal affairs be decentralised to the fullest extent possible and that the implementation of policy of the Department of Aboriginal Affairs in Western Australia should be co-ordinated by the regional office.

Co-ordination of Aboriginal Affairs

14 Prior to 1 July 1972 the Department of Native Welfare was responsible for Aboriginal affairs in Western Australia. On that date the Department devolved its responsibilities to appropriate functional organisations and ceased to operate as an entity.

15 *Current Western Australian State legislation dealing* exclusively with Aboriginals is the Aboriginal Affairs Planning Authority Act 1972 and the Aboriginal Heritage Act 1972.

16 The Aboriginal Affairs Planning Authority was established on 1 July 1972. On 28 December, 1973 enabling legislation was assented to and the Aboriginal Affairs Planning Authority Act Amendment Act 1973 came into force. By an arrangement entered into between the Governor-General and the Governor of Western Australia and incorporated as a Schedule in the Aboriginal Affairs Planning Authority Act Amendment Act 1973 the Australian and Western Australian Governments agreed that the Act would be administered by the State Office of the Australian Department of Aboriginal Affairs. The Director of that Department in Western Australia also holds the statutory appointment of Commissioner for Aboriginal Planning.

17 Under the provision of Section 19 of the Aboriginal Affairs Planning Authority Act 1972 the Aboriginal Affairs Co-ordinating Committee was established. The Regional Director of the Department of Aboriginal Affairs in Western Australia, in his twofold capacity of Regional Director and Commissioner for Aboriginal Planning, chairs a monthly meeting attended by the Chairman of the Aboriginal Advisory Council and designated departments. The Aboriginal Advisory Council consists of 14 Aboriginal members who represent Consultative Committees in each of the 7 regional areas of the State. Each Consultative Committee consists of delegates chosen by Aboriginals from among the main Aboriginal communities in each of the 7 regions.

18 The Heads of the Departments of the Western Australian Treasury, Public Health, Community Welfare, Education and the State Housing Commission are statutory representatives. The Western Australian Police Department and the Australian Government Departments of Education, Labor and Immigration, Social Security and Health are represented by standing invitation. A standing invitation has also been issued to the local representative of the Royal Australian Institute of Architects Aboriginal Housing Panel.

19 The Co-ordinating Committee has established co-ordinating committees in each of 7 administrative regions in Western Australia. These regional committees have representation similar to that on the parent committee and also are scheduled to meet monthly.

Department of Aboriginal Affairs

20 The functions of the Department of Aboriginal Affairs are confined to co-ordination and policy planning. In practice, however, departmental officers become involved in virtually all aspects of Aboriginal advancement. The Department does not have an operational role in any of the functional areas generally accepted as contributing most to Aboriginal advancement.

Roles of Functional Departments and other Agencies

21 The roles of functional departments in respect of health, welfare, housing and education are discussed below.

Health

22 The range of health services provided for the Western Australian community include doctors, nursing sisters, hospitals and other personnel or institutions charged with health care. Special services have been developed for Aboriginals and other disadvantaged members of the community. Community Health Services which was established in 1972 as a branch of the Western Australian Department of Public Health is one such special service. Community Health Services is mainly funded by the Department of Aboriginal Affairs. The Western Australian State Government contributes $100,000 each year. Total Australian Government payments for Aboriginal advancement on health for 1974-75 was $6m, and for 1975-76 is estimated to be $7.1m.

23 The philosophy of the Service is that health services to disadvantaged communities cannot be effective unless other areas of disadvantage such as substandard housing are also removed from the community. To this end the Service aims to work in close co-operation with all other organisations and persons. The aim of Community Health Services is to upgrade the health of and prevent disease in Aboriginal and other depressed socio-economic groups and by a process of education to improve the standard of living in these groups. The 'Targets and Aims' of the Service for 1975 are set out in Appendix 3.

24 The Service is divided into 5 regions namely Kimberley, Pilbara, North-West, Goldfields and the South-West. A full-time Public Health Medical Officer is assigned to each region to direct and support the public health field nurses

within it. Each region is subdivided into areas by population and need. The Service confines its activities to those not handled already by other Services or to areas where other Services do not extend. In addition to the regional medical officer, the establishment strength of Community Health Services in the South-West region at 31 December 1974 was 27, consisting of 4 medical officers, 19 public health field nurses and 4 health assistants. The 4 medical officer positions are unfilled due to a shortage of doctors. Nursing staff turnover is high as it is in nursing generally. However, few staff changes are experienced with Aboriginals employed as health assistants.

25 Another special service is the Aboriginal Medical Service, Perth, which conducts a clinic for Aboriginals. The Service, which began operations in 1973, is administered and staffed as far as possible by Aboriginals. It is funded by the Australian Government. It aims to provide a general service for Aboriginal families and liaises with Community Health Services and other agencies involved with Aboriginal advancement. Over 100 patients use the Service each week and this figure is increasing.

Community Welfare

26 The Western Australian Department for Community Welfare has a statutory responsibility under the Community Welfare Act and the Child Welfare Act for a wide range of problems concerning Aboriginals' social and cultural adjustment to the wider community. The aim of the Department

in the long term is the healthy social adjustment of Aboriginals, the State's major minority group.

27 The Department has 2 major branches, namely Field Services and Institutional Services. The Field Services branch is decentralised, 31 offices in country regions and 10 offices throughout the metropolitan area. A total of 134 permanent field staff are employed. The country and metropolitan regions are broken into 6 major divisions in the country and 7 divisions in the metropolitan area.

28 The Department conducts a Homemaker Service whose function is to assist families to acquire basic home management skills. The Department employs 196 Homemakers and Welfare Assistants on a part-time basis.

29 The Department for Community Welfare has responsibility for reserve housing with the State Housing Commission acting as agent for maintenance if asked to do so.

Housing

30 The State Housing Commission of Western Australia, under the State Housing Act 1946, aims to provide accommodation for any family which satisfies the following basic criteria :

(a) adequate domestic standards, including care of property and grounds;

(b) social behaviour standards common to the community where housing is sought; and

(c) adequate history of rent payment.

31 Following the devolvement of responsibility from the former Native Welfare Department in 1972 the State Housing Commission assumed responsibility for all Aboriginal housing including transitional housing. The Commission's aim is to provide needed improvement in housing conditions and to assist in hastening the progress of integration of Aboriginal families in urban communities. The State Housing Commission accords with Australian Government guidelines as to the type and location of housing built from Australian Government funds.

Education

32 The Western Australian Education Department is responsible for the provision of education for the community and recognises the special needs of Aboriginal people.

33 The Aboriginal Secondary Grants Scheme and the Aboriginal Grants Scheme are the responsibility of the Australian Department of Education.

Other Agencies

34 The responsibilities of a number of other agencies are discussed in later Chapters in the Report. These include the Western Australian Department of Corrections, the Western Australian Alcohol and Drug Authority, the Western Australian Community Recreation Council, the Australian Departments of Health, Education, Labor and Immigration and Social Security and Aboriginal organisations such as the New Era Aboriginal Fellowship.

Relationship Between Various Agencies

35 Evidence to the Committee was that whilst the structure for co-ordination and consultation between the various agencies is available, it is not fully used, particularly at field officer level, to the detriment of the Aboriginal people.

36 The Committee therefore recommends that there should be greater consultation at a local community level between all those persons who have an interest in the health care and welfare of Aboriginal people.

37 In this regard the Committee believes that regional officers of the Department of Aboriginal Affairs should initiate such consultation.

Research

38 Argument was advanced by some witnesses that research is lacking into Aboriginal attitudes to health and disease. The implications for the delivery of health services are all too apparent. To correct the position the Committee understands that the Community Health Services plan to employ a social anthropologist to undertake field research into the health attitudes of part-Aboriginals. The Committee commends this initiative.

39 The Committee believes that the need for research into health matters should be considered jointly by the Australian Department of Aboriginal Affairs and the Department of Health's Interdepartmental Health Committee with a view to sponsoring short and long-term research projects. The concept of field-based research units is worthy of careful consideration by the joint committee.

40 The Committee recommends that the Australian Government sponsor research into Aboriginal attitudes to health and disease.

4 ABORIGINAL HEALTH IN THE SOUTH-WEST REGION

41 The low level of health standards of Aboriginals in the South-West region is apparent from the morbidity statistics for Aboriginals and is shown in Appendix 2. In almost every category the South-West, with a lower population than that of the metropolitan area or the Kimberleys, is in the worst position. From Appendix 2 it can be seen that respiratory diseases and accidents are major areas of Aboriginal morbidity.

42 The Aboriginal population in the towns visited by the Committee in the South-West region has been calculated by Community Health Services in 1975 as follows :

District	Full Descent			Part Descent			Grand Total
	Male	Female	Total	Male	Female	Total	
Moora	2	1	3	286	289	575	578
Bunbury (inc. Collie	1	1	2	350	380	730	732
Gnowangerup	27	22	49	417	371	788	837

The total number of Aboriginals in the South-West is 6563. The South-West contains 28% of the Aboriginal population in Western Australia.

43 A short description of and the health situation in each town follows.

Moora

44 Moora is a rural town situated 195 kilometres north of Perth with an estimated population, including Aboriginals, of 1,600. The Aboriginal population of the Moora district is 578 and of these 300 reside in the township. Almost all of this population are part-blood Aboriginals as seen in the Table in paragraph 42.

45 The standard of living of the part-Aboriginal population varies according to income, individual and family background and the type of housing. Employment opportunities for adult males are limited, the chief sources being Main Roads, Railways and the Shire. The Shire employ 3 Aboriginals on a permanent basis. In addition the Shire has a Special Work Project which provides employment for 6 men for a 12-month period. The other main source of income was social security benefits. There was no opportunity for women to find work locally. School leavers also faced difficulties with employment.

46 Housing for the Aboriginal population in Moora consisted of State Housing Commission homes (19), transitional houses (4), two of which were vacant, and the Reserve. Nine families live on the Reserve which featured substandard metal dwellings and communal toilet and washing facilities. The Committee inspected the Reserve and was appalled at the standard of housing. Garage-like structures, metal clad, unlined, divided by crude partitions which provide little space and privacy; bitterly cold in winter, condensation dripping from roofs and unbearably hot in summer. The houses were not provided with electricity and in many instances

fuel stoves were burnt out or of little use to the residents. Two of the 4 transitional houses which provided an acceptable habitation, with electricity, hot water and septic systems were unoccupied and were badly vandalised as a consequence. Most families at the Reserve were obviously greatly distressed at their situation and are desirous of attaining better accommodation.

47 As discussed in Chapter 7 it is the policy of the Department for Community Welfare to close the Reserve. The State Housing Commission plans to erect 8 new dwellings for Aboriginals in Moora during 1975. The location of the proposed dwellings is being determined by discussion between Aboriginal families, the State Housing Commission, the Department for Community Welfare and the Shire Council.

48 Medical facilities at Moora include a 26-bed District Hospital which services the town and the surrounding Shires of Dandaregan, Coorow and Victoria Plains. The doctor who services the hospital is also the private general practitioner in the town. One public health field nurse of Community Health Services was based in the town. The Committee was informed in evidence that an estimated 6,000 to 7,000 people use the Moora Hospital and medical practice.

49 The following morbidity statistics were presented by the local medical practitioner. During January-December 1974 15% of all patients at the surgery were Aboriginals. In the same period, of a total of 1,846 hospital outpatients, 296 were Aboriginals; inpatient admissions were 235 Aboriginals out of a total of 1,470. The most common cause for hospitalisation amongst Aboriginals was chest infections (37%).

The public health field nurse stated that of these admissions, 55% were Aboriginal children and that 74% of these Aboriginal children were at the time housed at the Reserve, transitional houses or in substandard and poorly furnished State Housing Commission houses. Trauma i.e. accidents, accounted for a further 25% of admissions. The average stay of an Aboriginal patient in hospital was 5.2 days.

50 Other medical and associated problems described by the general practitioner included what was termed 'the neglected child syndrome - cough, dirty running nose, conjunctivitis, infected ears, sore eyes, diarrohea, skin sores, vitamin and weight deficiencies'. The doctor stressed that sick children were usually presented for medical attention at a more advanced stage of illness rather than during its early stages. It was common also for children to attend the surgery without a parent or relative which caused difficulties in diagnosis and subsequent treatment. Other evidence focused on the very low collection rate of accounts from Aboriginal patients using the services of the doctor, the hospital and St John's Ambulance.

51 It was the view of the general practitioner that alcoholism was probably the biggest problem which affected the health of Aboriginals in Moora. In his view excessive drinking exaggerates an observed lack of parental control and interest thereby contributing to the poor health of Aboriginal children.

52 On the question of child care the doctor contended that Aboriginal mothers have difficulty understanding milk mixtures. Breast feeding was encouraged as a more favoured

method of infant feeding. After childbirth family planning counselling and contraceptive advice was said to be offered to all Aboriginal women. Contraception is also purported to be generally available to any patient irrespective of age or marital status.

53 The submission presented by the public health field nurse presented evidence of definite social patterns that affected Aboriginal health. It was suggested that pregnancy is perceived as a deciding factor in the consolidation of a permanent relationship and it is, therefore, difficult to promote contraception. During the selection process the risk of venereal disease was high. Large families were the accepted norm and a great deal of social pressure was exerted on couples to conform to this family pattern. The Committee was concerned at the often desperate situation of some teenage Aboriginal girls who were not interested in further education, who lacked employment opportunities and who often had early pregnancies.

Gnowangerup

54 Gnowangerup is situated in the lower Great Southern area, 350 kilometres approximately from Perth, with an estimated population of 1,000 people of which one-third are part-Aboriginal.

55 There are few job prospects in the town. A Special Work Project grant of $51,000 has been used to employ Aboriginals on the Shire works program and also for the employment and training of an Aboriginal in the Shire office. No permanent positions on the Shire are filled by Aboriginals. In March 1975 approximately 30 Aboriginal males were

registered for work. Accordingly, the main income is from social security payments.

56 Aboriginals are housed on the Reserve (12 families approximately) and in State Housing Commission homes (16 families). Reserve housing is below standard with communal washing facilities. A number of houses have been improved to provide self-contained facilities. The Committee inspected the Reserve and considered that the conditions were deplorable and not significantly different from Moora. (paragraph 46)

57 A survey by the State Housing Commission was carried out in Gnowangerup in 1973-74. It concluded that of the 16 houses, 3 were acceptably maintained and of a reasonable standard, 4 were poor and the remainder substandard. The Shire's Health Officer reported no marked improvement in the standard of hygiene in the homes where the people had moved from the Reserve situation to a conventional house in the town.

58 The Department for Community Welfare has a district officer in Gnowangerup. The Department offers a Homemaker service and 3 women are employed to work with Aboriginals occupying houses in the town. Community Health Services has a staff of 1 public health field nurse and an Aboriginal male and female assistant. The Service uses as a base the Noongar Community Centre established by the New Era Aboriginal Fellowship in 1972, and financed by the then Australian Government office of Aboriginal Affairs. The New Era Aboriginal Fellowship conducts a lunch scheme funded by the Department of Aboriginal Affairs.

59 Medical facilities at Gnowangerup include a District Hospital serviced by a doctor who is also the general medical practitioner in the town. Hospital admissions for the period, January-December 1974, show 36 Aboriginals (9 children and 27 adults) and 332 non-Aboriginals (69 children and 263 adults). Upper respiratory tract infection, including influenza, was the main cause of hospitalisation of Aboriginals followed by trauma. The same pattern was observed in Moora (paragraph 49).

60 A number of witnesses attested to a serious alcohol problem frequently resulting in brawling and injuries requiring treatment in hospital.

61 The hospital conducts a free morning outpatient clinic in conjunction with the medical practitioner, and this is used by some Aboriginals. Private consultations are held at the medical practitioner's surgery each afternoon by appointment but some Aboriginals stated they did not feel welcome.

62 Several Aboriginal witnesses made reference to Gnowangerup's history of racial disharmony in the delivery of health services to Aboriginals. Some Aboriginal witnesses highlighted their dissatisfaction whilst others had no complaints to make or were satisfied with the services.

63 The Committee received evidence from one Aboriginal witness that, in his view, the Gnowangerup Hospital discriminated against Aboriginal people by failing to admit them for inpatient treatment. In addition, it was alleged that a number of Aboriginal families preferred to seek medical care at Katanning or Albany as they believed the Gnowangerup

Hospital was prejudiced against them. This question of alleged racial discrimination was the subject of a question without notice in the Western Australian Parliament. The Minister representing the Minister for Health replied that on investigation some circumstances could have been construed as indicating discrimination and that the staff of the Hospital had been advised to avoid any such circumstances in future.

64 The Committee was concerned at the apparent racial disharmony associated with the delivery of health services in Gnowangerup. The Committee is aware of problems associated with the delivery of health services to Aboriginal communities. Such problems arise in Gnowangerup from a lack of understanding by Aboriginals of the nature of health and disease, the need for early diagnosis and treatment, a lack of sympathy towards these attitudes and to poor communication which exists between Community Health Services, the medical practitioner and the Hospital.

Collie

65 Collie is a coal mining and timber producing town some 210 kilometres south of Perth. The town has an estimated population of 7,000 of whom 200 are of Aboriginal descent.

66 Unlike the towns of Moora and Gnowangerup, there is no Aboriginal Reserve in Collie. The majority of Aboriginals live in State Housing Commission houses in the town. Two further houses are planned by the Commission for erection in 1974-75. In addition, some Aboriginals live in private rented houses.

67 The employment situation is far from encouraging. Little opportunity exists for Aboriginals in the coal mining industry with the development of open-cut mining and automation. The Shire of Collie has completed a number of Special Work Projects and in January 1975 was granted a further sum of $24,000 by the Department of Aboriginal Affairs for 6 men for 6 months for maintenance of gardens. One Aboriginal is on the permanent staff of the Shire.

68 Collie is served by a District Hospital, a group medical practice comprising 4 doctors, 2 public health field nurses of Community Health Services and 1 infant health sister.

69 A spokeswoman for the group practice stated that malnutrition in the Aboriginal community is chiefly due to an unsuitable diet. Gastro-enteritis epidemics are still common. Respiratory tract infections, particularly in children, remain a constant problem and are associated with poor housing and overcrowding. Venereal disease is reported to be increasing in Collie with re-infection from itinerant visitors a constant problem.

70 The medical spokeswoman for Collie considered that social conditions contribute to Aboriginal health problems namely, free access to, and money for, alcohol; assault; unhygienic and overcrowded living conditions; and the itinerant life of a fair proportion of the Aboriginal population.

71 Evidence indicated differing demands for health services from Aboriginals. This is apparent in the request

for treatment outside the usual working hours, problems with decision-making, lack of transport and non-payment of accounts.

72 Hospital admission statistics for the period 1974-75 show a total of 1,722 of whom 148 approximately were of Aboriginal descent. The causes for admission were upper respiratory tract infection, gastro-enteritis and trauma. A breakdown of the incidence of these illnesses amongst those Aboriginals hospitalised was not available.

Conclusions

73 Evidence taken during public hearings in Moora, Gnowangerup and Collie indicates that Aboriginals in these towns have common health problems of nutritional deficiencies, upper respiratory tract infections, gastro-enteritis, alcoholism, trauma and venereal disease. In each town evidence stressed the contributory effects of social factors such as poor employment opportunities, overcrowded and unhygienic housing and lack of education about foods, hygiene, family planning and venereal diseases.

74 The Committee observed that small towns served by one general practitioner and a small hospital seemed to experience serious breakdowns in the delivery of health services due to personality conflicts, community attitudes to cultural differences and lack of basic consultation between the various services involved with Aboriginal health and welfare. The Committee believes that much could be gained quickly and simply by more effective consultation between Community Health Services, the Department for Community Welfare, hospital staff and general practitioners in these towns.

5 NUTRITIONAL DEFICIENCIES

75 Nutritional deficiencies in Aboriginal children throughout Australia are well documented.[3]

76 The Committee concluded (paragraph 73) that malnutrition is a major factor affecting the health of Aboriginals in the South-West of Western Australia. To highlight this point the Committee received evidence that nutrition is a major contributor to the hospitalisation of children for respiratory infections in the region.

Progress

77 Evidence before the Committee is that there has been an increasing improvement in nutritional levels of Aboriginals in recent years. In this regard the Report of the Commissioner of Public Health, Western Australia, stated that field staff of Community Health Services agreed that the nutritional standard of the clientele rose in 1972. More recently the

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[3] Kirke, D.K. (1969) 'Growth Rates of Aboriginal Children in Central Australia'. Medical Journal Australia 2.1005.

Moodie, P.M. (1969) 'Mortality and Morbidity in Australian Aboriginal Children'. Medical Journal Australia 1.180.

Edmunds, R.; Roberts, R.W. and Schlafing, G. (1970) 'The Mortality of Young Children in Western Australia; The Aborigines Contribution'. Australian Parliament Journal 676.

Maxwell, G.M. and Elliott, R.B. (1969) 'The Nutritional State of Australian Aboriginal Children'. American Journal Chemical Nutrition 22.716.

Gracey, M. (1973) 'Malnutrition in Young Australian Aborigines' Journal of the Victorian Diabetic Association.

Hitchcock, N.E. and Gracey, M. (1974) 'Dietary Patterns in a Aboriginal Community in South-West Australia' Unpublished.

Interim Report of Community Health Services for the year 1973, noted that there was a slight overall rise in the nutritional standard of clientele in 1973. In spite of intensive efforts by field staff, gains in some areas of nutrition were counter-balanced by the effects of increased alcohol intake which is presently considered by field staff to be the most pressing hazard to the health of the clientele.

78 The Committee notes the trend towards improved nutritional standards but recognises that it remains a serious problem for Aboriginals, particularly during infancy and early childhood.

Indicators of Childhood Malnutrition

79 In evidence before the Committee in October 1974 the Australian Department of Health stated that the 3 cardinal indicators of childhood undernutrition in a community are :

(a) high infant mortality rates with emphasis on neonatal mortality;

(b) high incidence of diaorrheal and respiratory disease; and

(c) growth retardation.

These indicators are discussed below.

80 Infant mortality rates for Aboriginal infants remain at a high figure. Statistics released in the Department of Public Health Report for the year 1972 indicate that the total Aboriginal infant mortality per 1,000 live births in Western Australia is 76.9 and is 5 times the non-Aboriginal infant mortality of 14.6, bringing the average infant

mortality rate for the State up to 17.2. Comparative figures for the South-West are 27.7, 11.1 and 11.5 respectively.

81 The second indicator, namely a high incidence of diaorrheal and respiratory disease was supported by research carried out by the Head of the Gastroenterological Research Unit, Princess Margaret Children's Medical Research Foundation in Perth. Prominent causes for admission of Aboriginal children to this hospital in 1972 included the following disorders - nutritional anaemia (46%), gastro-intestinal infestations (31%), nutritional disturbances (27%), pneumonia (16%) and for gastro-intestinal infections (9%).[4]

82 The Committee received evidence that the gastro-enteritis ward in the Princess Margaret Hospital is largely occupied by Aboriginal children whose average stay is 30 days as against 6 days for non-Aboriginal children.

83 Growth retardation is the third indicator of present and past malnutrition. A total health audit of the Aboriginal population began in 1973 by Community Health Services and this took the form of detailed medical examinations in various areas, including Gnowangerup and Moora. A total of 1,178 Aboriginals were examined; of these 220 people came from Gnowangerup and 283 from Moora. A full discussion of these health surveys is contained in Appendix 4. The surveys show

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[4] Forbes, D.A.; Williams, E.T.B. and MacDonald, W.B. (1973) 'Morbidity Patterms of Aboriginal and non-Aboriginal Children Admitted to Hospital' Australian Paediatric Journal. 9.248.

that of all persons under 20 years of age only 10% were above the 50th centile for either height or weight by age. A minority fell below the 10th centile for both weight and height.

84 In oral evidence Community Health Services stated that Aboriginal children under 5 years in Gnowangerup at the time of the health audit in 1973 were suffering from a lack of total calories. A lack of protein, certain vitamins and iron deficiencies were also noted in some cases. The gravest nutritional problems were to be found in teenage boys who had low serum iron and folate deficiencies without total calorie deficiencies.

85 The Committee received evidence that an additional factor in the unsatisfactory levels of nutrition among Aboriginals is the abuse of alcohol by some adult parents. This is discussed in Chapter 6.

Approaches to Improvement

86 Evidence presented to the Committee is that nutritional levels in Aboriginal communities will only be improved by a long-term multi-faceted approach.

87 The first approach offered by Community Health Services was that malnutrition should be diagnosed as an illness and people should be educated to recognise that this is an illness which requires treatment.

88 Central to any educational initiative is the need for basic information. Research into dietary and nutritional patterns was called for by a Perth medical specialist who

stressed the enormous ignorance of nutritional standards in the Australian community at large. Similarly, there is a lack of quantitative studies of the dietary and nutritional habits of Aboriginal children and adults. The Committee understands that the Australian Department of Health has at present an active research program into nutritional standards in the Australian community. In addition, research is also being undertaken by the School of Public Health and Tropical Medicine.

89 Some research has been undertaken into the dietary and nutritional patterns of Aboriginals in the South-West region by the Princess Margaret Children's Medical Research Foundation, Perth. One such study initiated by the New Era Aboriginal Fellowship in 1973, concluded that:

(a) dietary patterns and nutrient intake levels are directly related to social differences such as the standard of housing, i.e. Reserve, transitional or State Housing Commission houses;

(b) there is evidence of low energy calorie and vitamin C deficiencies and earlier nutritional deprivations; and

(c) obesity is common in adults, especially in women.

90 The findings in paragraph 89 (a) above support the impact of social conditions on dietary and nutritional standards of Aboriginals which are discussed in Chapter 7 on Housing, Chapter 8 on Education and Chapter 9 on Employment.

91 A third approach is that dietary supplementation such as vitamins, milk biscuits, fruit and lunches for Aboriginal

children should have a high priority. Dietary supplementation is essentially a short-term measure requiring co-operation and co-ordination on the part of responsible agencies. Dietary habits are acquired slowly and progress in this area will inevitably proceed slowly.

92 School lunch schemes run by Aboriginals and funded by the Department of Aboriginal Affairs have been successful in the South-West region. Such self-help schemes like those operating in Gnowangerup and Moora should be expanded as appropriate. These 2 towns have schemes run by different organisations. In Moora an Aboriginal Homemaker organised the provision of lunches for children attending the Catholic Convent School. In Gnowangerup the school lunch scheme is conducted by the New Era Aboriginal Fellowship.

93 The Committee supports the school lunch scheme and in this context notes with regret a downturn in the level of funds made available by the Australian Government in the form of direct grants to the States for the purposes of nutritional supplementation. For the financial year 1974-75 the sum of $460,550 was allocated and for 1975-76 the sum of $324,250 has been provided. Allowing for a change in costs this is a real decrease of 40%.

94 A fourth approach is the role of educational authorities with respect to nutrition. The Committee sought evidence from the Australian and State Education Departments on their role in the field of health education in schools with Aboriginal students. The Committee noted the development in all State Education Departments of branches specialising in Aboriginal education. In particular, the appointment of

Aboriginal home-school liaison officers by the Western Australian Education Department is, in the Committee's opinion, a significant and important trend which should consolidate the more formal role of instruction on such matters as nutrition and hygiene. The Committee believes that schools and teaching staff could and should play a more active role in health education programs than is observable at present. This course of action is evident in the Northern Territory. Teachers of Aboriginal children should be trained to be more aware of problems of undernourishment and poor general health.

95 To raise nutritional levels of Aboriginal children the Committee recommends that :

(a) Aboriginal communities and associations in conjunction with governmental agencies be encouraged and assisted to develop nutritional assistance programs in the form of school meals;

(b) Schools could and should play a more active role in health education programs; and

(c) the Australian Government at least restore the allocation of direct grants to the States for nutritional supplements to the same level as 1974-75.

6 ALCOHOLISM

96 Alcohol is a problem of non-Aboriginals as well as Aboriginals. The Australian Department of Health put the view that :

> ... we see alcoholism as such as a major health problem in this country as a whole. This is particularly marked in groups which are frustrated, under-privileged and suffering from a sense of loss of identity, and this is a similar experience to that seen in other countries of the world.

97 Witnesses representing Aboriginal communities highlighted the abuse of alcohol as a primary cause of continuing ill-health, both physical and mental, and susceptibility to disease. The Committee received considerable evidence on the problems of alcohol for Aboriginals and its attendant negative social effects on individuals and the community.

98 Community Health Services expressed a view that :

> Almost without exception everyone of our field staff says that alcohol is the biggest obstacle to improving health. We do believe that it is a manifestation of the social problems of Aborigines.

99 General practitioners in Moora and Collie referred to the alcoholism problems of their Aboriginal patients. As a result Aboriginals are hospitalised for a variety of reasons

including comas, epilepsy, psychosis, liver failure, poor nutrition and trauma, such as falls, burns and accidents.

Causation

100 Alcohol abuse by Aboriginals stems from a number of inter-related causes. The following sociological factors were described in evidence and are discussed throughout this Report:

(a) lack of employment opportunities;

(b) substandard housing;

(c) the remoteness of the education system;

(d) social inertia and alienation;

(e) feelings of differentness, social rejection and inadequacy; and

(f) lack of recreational facilities and opportunities.

101 An additional factor related to the problems of alcohol in Aboriginal communities in the South-West is the spiritual bankruptcy leading to a disintegration of traditional social structures. Some Aboriginal communities have become caught up in a self-perpetuating pattern of interconnected poverty, ill-health, unemployment and alcoholism.

Approaches to Improvement

102 A multi-faceted approach to preventing alcohol abuse was emphasised by specialist agencies in Western Australia. Their views on how to effect changes in motives leading to alcohol abuse are discussed below.

Community Health Services

103 The agents of change are seen by Community Health Services to be the Aboriginal people themselves. In their view treatment and cure of alcohol problems should develop *from within the Aboriginal community*. Community Health Services continue to encourage Aboriginal people to be involved in finding some solutions of their own to this problem. They believe that in this area non-Aboriginal initiatives will fail. The Committee notes with regret the lack of action by Community Health Services to the problems of alcohol in Aboriginal communities.

104 Aboriginal witnesses in Moora and Collie expressed a contrary view to that held by Community Health Services. They suggested that guidance in the use of alcohol should be provided by government agencies. The view that publicans had a responsibility to prevent alcohol abuse was shared by Aboriginal witnesses in Collie and Moora.

105 The Committee recognises that alcoholism amongst Aboriginal people is frequently due to a sense of desperation and, therefore, recommends accordingly that the Australian and State Governments and local governmental authorities should most earnestly consider any positive measures suggested by Aboriginal communities for the control of alcohol.

Department for Community Welfare

106 The Department for Community Welfare suggested that a *sociological orientation towards cause and treatment of* drinking problems will be more beneficial than the traditional view which emphasises psychological and/or

medical factors. The Committee noted with interest the experimental program being considered by the Homemaker Service which would involve the employment of male homemakers who would provide support for Aboriginal males with a drinking problem. Stable employment and appropriate social drinking rather than total abstinence were seen as aids to prevention.

The Aboriginal Medical Service

107 The Aboriginal Medical Service informed the Committee of its concern about alcoholism in the Aboriginal community and has held discussions with the newly formed Western Australian Alcohol and Drug Authority, the Aboriginal Council and the New Era Aboriginal Foundation about the establishment of halfway houses and treatment facilities. Halfway houses is the name given to residential centres usually run in suburban houses for persons who require supportive treatment.

108 The Committee recommends that halfway houses should be established by Aboriginal community groups supported by the Department of Aboriginal Affairs, Community Health Services and the Western Australian Alcohol and Drug Authority.

109 The Aboriginal Medical Service suggested that special innovative techniques to handle the problem of excessive drinking among Aboriginals need to be developed. The view of the Aboriginal Medical Service was that alcoholism is not the same subject of shame among Aboriginals as it is among the non-Aboriginal community. The Aboriginal Medical Service

believed that the Aboriginal alcoholic tends to have a completely different pattern to other alcoholics and, for this reason, is not amenable to the 'therapeutic community' approach designed for largely middle-class non-Aboriginal patients.

Western Australian Alcohol and Drug Authority

110 The Western Australian Alcohol and Drug Authority was established in November 1974, following the 1972 Royal Commission on Alcohol and Drug Dependence in Western Australia. The Authority under the Western Australian Alcohol and Drug Authority Act 1974, has a treatment, management and rehabilitation function for persons suffering from the consumption or excessive use of alcohol, other liquor, or drugs. Research and educational initiatives directed at prevention and treatment of alcohol and drug abuse are other aspects of the Authority's function.

111 The Committee sought evidence from the Authority on its role with particular patient groups within the community such as Aboriginals. The Authority indicated that, in their view, problems with alcohol are related to general health and social problems rather than to specific illness.

112 The Authority was aware of the negative effect that its work might have in Aboriginal communities if carried out under the label of the 'Alcohol and Drug Authority'. To avoid this, the Authority is considering employing 2 Aboriginal officers under the auspices of the Aboriginal Medical Service.

113 The Authority's chief problem, however, is lack of basic data about the numbers of Aboriginal alcoholics as against so-called 'social drinkers'. This lack of data

makes planning for specialist services for Aboriginal alcoholics difficult. Accordingly, the Committee recommends that the Australian Government should fund a research program into the incidence and treatment of alcoholism in Aboriginal communities. This research could be carried out in Western Australia by the Western Australian Alcohol and Drug Authority assisted, as necessary, by Community Health Services.

114 The Authority stated that the establishment of a co-ordinating committee on health was a high priority. The Authority advocates more health education about alcohol for Aboriginals. It has applied for representation on the Western Australian Health Education Council. The Committee endorses this step and, in addition, recommends that :

(a) the Western Australian Alcohol and Drug Authority be a member of the Aboriginal Affairs Co-ordinating Committee; and

(b) a Health Sub-committee be established within this machinery to co-ordinate community health education programs on such problems as alcohol.

115 The beginnings of a network of treatment centres is being established by the Alcohol and Drug Authority and various Aboriginal organisations. The Committee, however, feels there is a need for immediate attention for those persons classed as habitual drinkers. Accordingly, the Committee recommends that the Western Australian Alcohol and Drug Authority, in collaboration with Community Health Services, Department of Corrections, Aboriginal Medical Service, and

Aboriginal organisations and communities, develop proposals for the management and treatment of habitual drinkers who voluntarily seek, or are considered by competent authority to be in need of, treatment.

116 In November 1974 the Western Australian Department of Corrections handed responsibility for the administration of the Convicted Inebriates Act to the Western Australian Alcohol and Drug Authority. Under the Authority's influence there has been a marked drop in convictions.

Department of Corrections

117 Despite the reduction in convictions under the Convicted Inebriates Act, the Department of Corrections remains concerned at the very high proportion of Aboriginal offenders sentenced to imprisonment.

118 Most offences resulting in longer terms of imprisonment have been contributed to, or associated with, alcoholism. This is illustrated by a screening test for alcoholism administered to 100 consecutive prison admissions at Fremantle Prison in 1972. There were 28 Aboriginals in this screening and all but one had an alcohol problem.

119 Following the transfer of administrative responsibilities to the Western Australian Alcohol and Drug Authority (paragraph 116), the Department now sees its role in Aboriginal alcoholism as one of discussion between various interested groups. A series of seminar discussions have taken place and from these two conclusions have been drawn :

(a) Aboriginal alcoholism is primarily a social problem for which the entire community must develop effective counter-measures; and

(b) treatment programs based on detoxification and initial restoration of health, have a distinct place in the overall treatment plan, but only if follow-up measures are adequate and community attitudes change appropriately.

Australian Government Departments

120 The Committee noted the establishment of an inter-departmental committee on Alcohol by the Australian Departments of Health and Aboriginal Affairs to examine the problems of Aboriginal alcoholism. The appointment of an alcohol and drug adviser to the Australian Department of Health is also noted.

Decriminalisation of Public Drunkenness

121 The Committee received evidence on the question of decriminalisation of public drunkenness. The Committee notes with approval suggested measures for dealing with drunkenness as a social problem requiring rehabilitation. The Committee supports the expansion of treatment facilities for such rehabilitation.

Social Security Benefits

122 The Australian Department of Social Security stated that the question of what sort of assistance needs to be given to alcoholics in the general community was currently being examined within the Department. It is generally agreed that

the payment of unemployment benefit to alcoholics is inappropriate and that the payment of a special benefit is preferable. The diagnosis of a person as 'alcoholic' for the purposes of such a benefit may require a medical certificate. Pending a review of this position no pension or benefit is to be withheld because of alcoholism.

123 The Committee recommends that the Australian Department of Social Security accord special priority to the review of the type of social security payment most suitable for individuals and families affected by alcoholism.

124 The Committee received evidence on the need for payment of all or part of social security benefits to persons other than the principal recipient. Cases of hardship were evident in some Aboriginal families where the male beneficiary believed that social security payments were a kind of 'pocket money' for his own use, whereas other forms of social security such as child endowment, were intended for the upkeep of the family.

125 As regards the payment of social security benefits to a person other than the principal recipient, the Department of Social Security advised that :

(a) in respect to age and invalid pensions, pensions shall be paid to the pensioner or to such other person as the pensioner appoints as his warrantee. If for any reason it is desirable that the payment of the whole or portion of a pension should be made to a person, institution or authority on behalf of the pensioner, the Director-General may authorise payment accordingly; and

(b) in respect to unemployment and sickness benefits, the benefits shall be paid to the beneficiary or to such person, institution or authority on behalf of the beneficiary as approved by the Director-General.

126 The Department estimated that during the last 12 months no more than a dozen unemployment benefits had been paid to other than the principal recipient. The chief difficulty is to obtain evidence to justify the payment of all or portion of the benefit to a warrantee. A further difficulty is to arrange for persons or organisations who are willing to act as warrantees for alcoholics.

127 The Committee sees advantage in the Department for Community Welfare being a warrantee for alcoholics in receipt of social security benefits. In this regard the Committee notes that the Department already acts as warrantee for tenants of some State Housing Commission homes. The Committee recognises that there will need to be close consultation and liaison between the alcoholic beneficiary and the Departments for Community Welfare, Aboriginal Affairs, Social Security and Community Health Services.

128 The Committee recommends that the Department of Social Security should make known more widely the pre-requisites for splitting social security benefits and for the Department for Community Welfare to act as warrantee for alcoholics.

7 HOUSING

129 The policy of the Australian Government in respect to housing is that all Aboriginal families be properly housed by 1982. The policy recognises the extent of inadequate and, in some cases, lack of housing for Aboriginals.

130 In Western Australia the responsibility for Aboriginal housing is shared by the State Housing Commission and the Department for Community Welfare. The role of these organisations and the involvement of local government authorities are discussed in this Chapter.

Department for Community Welfare

131 The Department for Community Welfare is responsible under the Community Welfare Act and the Child Welfare Act for the healthy social adjustment of needy individuals or groups. The role of the Department in Reserve housing and the Homemaker service is discussed below.

Reserve Housing

132 The Department for Community Welfare is committed to the closure of all Reserves. It aims, in conjunction with the State Housing Commission, to close the Reserves within 7 years. The Committee noted that 10 Reserves were closed in a period of 14 months.

133 The order of priority for the closure of Reserves is determined by consultation between the Department for Community Welfare and the State Housing Commission. In those towns where

the closure of the Reserve has been accorded a high priority prospective tenants from Reserves will be offered training in a house similar to that which they will occupy. The Department for Community Welfare plans to staff these units with Homemakers.

134 In the short-term the Department faces a major problem over the closure of its Reserves, namely whether or not to spend money on interim upgrading. Pressure to close the Reserves as quickly as possible and pressure to upgrade the existing standards of Reserves while they remain are creating administrative and financial difficulties.

135 The cost of upgrading Reserves is extremely high. Maintenance and running costs of the Reserves amount to $107,000 yearly. In addition in 1973-74, the Department allocated a sum of $100,000 for improvements to Reserves and of this $87,000 was allocated to the upgrading of the Moora and Derby Reserves. However, the Department has postponed its upgrading of the Moora Reserve as the State Housing Commission's program will permit closure of the Moora Reserve within the next 2 years.

136 In view of the deplorable standard of housing of the Reserves at Moora (paragraph 46) and Gnowangerup (paragraph 56), the Committee recommends that the program for closing down the Reserves should be accelerated and tenancies for the inhabitants in State Housing Commission homes be arranged.

Homemaker Service

137 The Homemaker Service assists clients with problems of home management, budgeting and financial responsibility. There are approximately 151 Homemakers employed by the Service, including 17 Aboriginal women and 4 Aboriginal men. The Department seeks to increase the number of Aboriginals employed as homemakers. The major problem experienced in operating the Service has been the supervision of homemakers, particularly in country areas. Homemakers are employed on a part-time basis working a maximum of 15 hours per week, and are recruited locally. During 1973-74 financial year the sum of $308,000 was expended. The Committee was impressed by the record and reputation of the Homemaker Service and would like to see it expanded.

138 The main problems homemakers deal with are families living in overcrowded conditions with financial worries and severe problems related to excess drinking. This is illustrated in a recent study of the Service in the Perth metropolitan area. Two hundred and three families were interviewed of whom two-thirds were Aboriginal. The main problems reported by families were overcrowding (37%), drinking (21%) and illness (20%). The study further revealed that where there is an increase in the reported prevalence of drinking problems there is a corresponding increase in problems associated with finance and budgeting. Similarly the problem of overcrowding is associated with concern over home management. In the belief that social problems such as these can be mitigated by the Homemaker Service scheme the Committee recommends that the Department for Community Welfare should appoint many additional Homemakers, both Aboriginal and non-Aboriginal, male and female.

State Housing Commission

139 The State Housing Commission's broad objectives are to provide housing as quickly as physical and financial resources permit and at the same time, at a rate consistent with the capacity of other agencies particularly Welfare and Health to provide the necessary support services.

140 The Committee was informed by the Commission that it has now housed those families who have reached standards appropriate to normal urban community living. The Commission is at the present time housing families which, in its view, have the potential to reach such standards.

141 The Commission believes that there is at the present time no more than a handful of families on the waiting list who could handle an urban situation without back-up support services from welfare agencies. Such support services will be required for different periods of time according to the needs of particular families. Without such support there is a high risk of failure which may lead to a community reaction against the total Aboriginal housing program.

142 The Commission believes that the capacity of the supporting agencies has in the past been limited by availability of suitable staff and inadequate funding. Accordingly the Commission adopted the policy of slowing the building rate of houses for Aboriginals while other agencies expanded their support services.

143 On the other hand, the Department for Community Welfare claimed in evidence to the Committee, that some Aboriginals who are ready for conventional town housing, are

not being housed by the State Housing Commission. In their view some 48 families on Reserves could be housed immediately. In addition the Department for Community Welfare claims it is able to provide the necessary support services.

144 The Committee believes that the Australian Government's goal of properly housing every Aboriginal family by 1982 requires the enthusiastic co-operation of the Western Australian State Housing Commission. The Committees notes the arguments advanced by the Western Australian State Housing Commission and the Department for Community Welfare (paragraphs 139-143) and believes that the State Housing Commission should adopt a more flexible attitude to eligibility requirements. The State Housing Commission's apprehension about an increase in failure rate would, in the Committee's view, be largely diminished by regular supervision (paragraph 146).

145 Accordingly, the Committee recommends :

(a) that the Aboriginal Affairs Co-ordinating Committee examine ways in which the various agencies should approach the implementation of properly housing all Aboriginal families by 1982; and

(b) in any case of disagreement between the Housing Commission and the Department for Community Welfare concerning the suitability of an Aboriginal tenant to occupy a conventional town house which has been built from Australian Government funds, the Housing Commission be invited to accept the advice of Community Welfare.

146 The irregular maintenance of Commission houses and the absence of a rent collecting service were two criticisms of the Commission made by Aboriginal tenants. A factor contributing to these criticisms is that prior to July 1972 the Native Welfare Department's housing officer collected rent and offered welfare services as well. In reply, the Commission stated that the establishment of branch offices provides a regular rent collecting service and that there is immediate improvement in property standards and in the state of the account. All towns in Western Australia do not have this service for two reasons. Firstly, the Commission's view is that it should not discriminate either for or against Aboriginals. Secondly, the cost of administering a branch system is high due to the size of the State and the scattered location of communities. Regional offices are, however, being established and to date 5 country branches located in towns and serving a district are either in operation or planned.

147 The Committee recommends that the State Housing Commission should accelerate the branch system for the purposes of rent collection, maintenance and, where necessary, on-going referral of tenants to the various support services.

148 The Committee received evidence that whilst the level of consultation between the State Housing Commission and the Department for Community Welfare is satisfactory at the level of Heads of Departments, it could be improved at field officer level. In this regard it should be noted that the Committee in paragraph 36, has recommended that there should be greater consultation at a local community level.

Involvement of Local Government Authorities

149 Evidence before the Committee was that some local government authorities in Western Australia oppose the movement of Aboriginals from the Reserves into the towns. They hold the view that if housing for Aboriginals could not be scattered adequately in the town they would be concerned about community reaction. The State Housing Commission stated that :

> ... generally speaking, in most towns there are certain areas where they are very reluctant to see us come in at all.

The Committee is gravely concerned by the views held by such local government authorities.

150 The Committee recommends that the State Housing Commission be asked to report to the Department of Aboriginal Affairs any obstacles placed by local government authorities in the way of construction or allocation of houses built or bought from Australian Government funds.

Conclusion

151 The Committee believes there is considerable scope for improvement in the field of Aboriginal housing throughout Australia. The Committee plans to commence an Inquiry into Aboriginal Housing early in 1976.

8 EDUCATION

152 This Chapter discusses developments in the field of Aboriginal education as the Committee considers that as the level of education of Aboriginals rises there is a corresponding rise in the standard of health.

153 In recent years there has been an increasing realisation that many Aboriginal children have been unable to achieve their educational potential through the normal school system. In support of this, a study undertaken by Community Health Services in Gnowangerup and Moora in 1973 revealed that illiteracy is common in Aboriginal adults. In Gnowangerup most adults over the age of 27 are functionally illiterate. In addition, a number of adults under 27 who had attended school into their teens were unable to read adequately.

Developments in Aboriginal Education

154 To overcome the unsatisfactory situation described in the last paragraph major co-operative efforts are required at both Australian and State Government levels. The Committee noted the establishment in all States of special branches to plan for the education of Aboriginal children. Some developments include the provision of special learning materials, appointment of teacher aides, home and school liaison officers, advisory teachers, arrangement of in-service seminars, the purchase of special equipment and the reduction in the size of classes with large numbers of Aboriginal children. In Western Australia 40 Aboriginal teacher aides have been appointed by the State Education Department to liaise between children and teachers and between the school and parents. In addition

various Adult Aboriginal Education programs have been established by the State Education Department. In support of these programs the Australian Government contributed $1,540,000 during 1974-75. Proposed expenditure for 1975-76 is $1,564,000

155 Formal courses in health education are a normal part of school curricula. Opportunities exist in Western Australia for field staff of Community Health Services to consult with teachers thereby enabling them to be attentive to the particular health needs of Aboriginal children. These programs are influenced by the dedication of particular members of school staffs to a substantial extent.

156 Evidence before the Committee highlighted the prevalence of a general low level of health in school of Aboriginal children; lethargy, low energy levels and poor concentration were also cited as commonly observed features. The Committee has observed in Chapter 5 of this Report that nutritional supplement schemes are raising health standards of Aboriginal schoolchildren.

School and Community Health

157 The Committee sought evidence from the Australian Department of Education on initiatives being made in the areas of school and community health programs. The Department's responsibility in regard to Aboriginal education in the States consists of acting as educational consultant to the Department of Aboriginal Affairs in respect of requests for funds for specific projects. In addition, the Department of Education participates in the annual meetings of State Superintendents of Aboriginal education.

158 The Australian Department of Education is directly responsible for the education of Aboriginal people in the Northern Territory. It has, therefore, gained much experience in the application of the programs directed to the educational advancement of Aboriginal people. Based on its experience in the Northern Territory the Department is now operating a number of procedures which could be used as guidelines for State Education Departments. For example, the Northern Territory Division of the Department of Education recently issued a Circular (see Appendix 5) which drew attention to the responsibilities of schools for the physical, nutritional and social needs of Aboriginal schoolchildren. The terms of the circular give considerable latitude to Principals to develop programs appropriate to the schools and acceptable to their communities. The Committee understands that this matter was considered at the meeting of State Superintendents of Aboriginal Education held in September 1975.

159 It is the Committee's view that teachers have a prime responsibility to draw to the attention of the appropriate health authorities cases of undernourishment, absenteeism and ill-health in their pupils regardless of their cultural background.

160 The Committee noted with approval co-operation between the Western Australian Department of Education and Community Health Services with regard to health education. The Committee believes these co-operative efforts should be expanded.

161 The Committee recommends that :

(a) the divisions of Adult Education and Technical Education of the Western Australian Department of Education should consult with Aboriginal communities to promote school and community health education programs;

(b) Community Health Services and the Australian Departments of Aboriginal Affairs and Health should assist the Western Australian Department of Education to expand school and community health education programs; and

(c) the Western Australian Education Department should appoint additional Aboriginal teacher aides and home-school liaison officers.

Aboriginal Secondary Grants Scheme

162 The Aboriginal Secondary Grants Scheme was announced jointly by the Minister for Education and Science and the Minister-in-Charge of Aboriginal Affairs on 15 January 1970. The purpose of the Scheme is to assist Aboriginals likely to benefit from further secondary studies. The Scheme recognises that Aboriginal students need considerable encouragement to continue in an environment which is often, for them and their families, unfamiliar.

163 *The number of students in training at the end of June* 1975, is shown below :

N.S.W.	3960
A.C.T.	24
VIC.	685
QLD	3568
S.A.	737
TAS.	313
N.T.	882
W.A.	1998
TOTAL	12167

164 The Australian Department of Education informed the Committee that at the end of February 1975, approximately 9,400 students were receiving benefits for 1975 and 1,100 applications were outstanding. Of the 1,100, 470 were in *Western Australia. The Aboriginal secondary population in* Western Australia is 2,000 approximately; of these 80 to 90 Aboriginal students attend secondary schools in the South-West region.

165 The Aboriginal Secondary Grants Scheme has been in operation for 5 years and the Scheme appears relatively well known in the great majority of Aboriginal communities. During that period enrolments at various levels have increased, e.g. the number sitting in Australia for the High School Certificate, matriculation or equivalents, has grown from 115 in 1973, to 150 in 1974.

166 *Education officers offer guidance to Aboriginal* Secondary Grants Scheme grant holders in all States. In Western Australia, 8 Education Officers work in this capacity

with case loads of 250 students each. In the view of the Committee, these case loads appear to be excessive. The Committee was informed that the Department is considering placing educational officers in certain towns to deal more effectively with the educational needs of Aboriginal children. The Committee commends this approach to the Department as it would appear to offer a more professionally effective service.

9 EMPLOYMENT

167 The absence of jobs for Aboriginals is an important factor influencing their health. Coupled with this, there appears to be a lack of enthusiasm by employer groups to engage Aboriginals. This could be because Aboriginals on the whole have poor employment records, lack technical training and hold different concepts of work to non-Aboriginals. *Nevertheless, the Committee believes on the evidence before* it that most Aboriginals desire normal employment.

168 The Department of Labor and Immigration has close contact with Aboriginals through the Commonwealth Employment Service. Its officers recognise the need for special assistance for Aboriginals in rural and remote communities who lack employment opportunities, have unsatisfactory job histories and who often lack basic education. Vocational Officers of the Department who visit Moora, Gnowangerup and Collie on a fortnightly basis have observed that the poor general health of Aboriginals is one factor contributing to their poor performance and instability in employment.

169 The Department of Labor and Immigration provided the Committee with the following information on the employment of Aboriginals in the South-West region. The Tables for Moora and Gnowangerup show that on a population basis the employment position for Aboriginals is much worse than for non-Aboriginals.

MOORA

Registered Unemployed Awaiting Placement - 2.5.75

	Adult		Juniors		Total		Grand Total
	M	F	M	F	M	F	
Total Registrants	22	4	12	7	34	11	43
Total Aboriginal Registrants	18	3	8	4	26	7	33

170 Male Aboriginals tend to be registered for unskilled and semi-skilled positions such as labourers, farmhands, and seasonal work in the rural industry. Almost all females are registered for domestic work.

GNOWANGERUP

Registered Unemployed Awaiting Placement - 2.5.75

	Adult		Juniors		Total		Grand Total
	M	F	M	F	M	F	
Total Registrants	43	4	11	12	54	16	70
Total Aboriginal Registrants	37	2	6	4	43	6	49

171 Aboriginal males are registered in the unskilled and semi-skilled areas of employment such as labourers, farm and shed hands, tractor drivers or in other rural work. Some juniors seek trades assistant work but their prospects are

very limited. Aboriginal females tend to be registered almost exclusively for domestic work.

172 A number of surveys have been carried out by departmental officers over the last 5 years showing 3 major problems which limit the extent of Aboriginal employment in Gnowangerup.

173 Firstly, work opportunities, both of a casual and permanent nature, are limited and inadequate in relation to the workforce. Secondly, many local employers believe that Aboriginals are unreliable and are, therefore, not inclined to employ them. Thirdly, as a consequence of these combined factors, many local Aboriginals appear to lack motivation to work.

COLLIE

Registered Unemployed Awaiting Placement - 2.5.75

	Adult		Juniors		Total		Grand Total
	M	F	M	F	M	F	
Total Registrants	33	21	25	74	58	95	153
Total Aboriginal Registrants	11	4	6	9	17	13	30

174 Most male applicants are registered as unskilled or semi-skilled workers, including labourers, farmhands, trades assistant and truck drivers. One female was registered for clerical work, another as a shop assistant and most others seek domestic work.

175 Collie has many Aboriginal people in stable employment such as in the mining industry. The development of the Muja power station and general industrial expansion would make Collie a town with a relatively small Aboriginal employment problem. There may remain, however, a hard core of unskilled people with a reputation for unreliability.

176 The Committee is conducting a separate Inquiry into Aboriginal Unemployment with particular emphasis on Special Work Projects. It is expected that this Report will be tabled in the Parliament towards the end of 1975. It is, therefore, not proposed to discuss this aspect in any great detail in this Report. All that is proposed is to outline briefly in this Report the various employment and training schemes designed to assist the employment of Aboriginals in the general workforce.

Special Work Projects

177 This scheme commenced in 1969 and is administered by the Department of Aboriginal Affairs in conjunction with the Department of Labor and Immigration. Projects are mainly developed by the Vocational Officers of the Department of Labor and Immigration which recommends approval to the Department of Aboriginal Affairs. Emphasis under the scheme is given to the training of Aboriginals and the development of Aboriginal communities. The Committee received evidence on the operation of Special Work Projects at Moora, Gnowangerup and Collie.

Regional Employment Development Scheme

178 This scheme commenced in September 1974 and is administered by the Department of Labor and Immigration. It is designed as an unemployment relief measure. Priority in employment is given to those in greatest need. In areas of large Aboriginal population Aboriginals unemployed provide the majority of those employed under the scheme. Those Aboriginals employed under the scheme receive work experience which could benefit them in other areas of employment. The Australian Government announced in August 1975 that Regional Employment Scheme will be terminated.

National Employment and Training System

179 This scheme commenced in October 1974 and is administered by the Department of Labor and Immigration. It incorporated the previous Employment Training Scheme for Aboriginals which commenced in 1969. The scheme provides subsidies to employers to encourage them to employ and train Aboriginals. Extra provisions under the National Employment and Training System ensure that Aboriginals are not disadvantaged vis-a-vis other participants.

10 RECREATION

180 The provision of recreational facilities which cater for Aboriginal people is seen by the Committee as a contributing factor in reducing social isolation and the demoralising effects of their present boredom.

181 The Western Australian Community Recreation Council has responsibility under the Youth Recreation and National Fitness Act 1972 to promote recreational opportunities in conjunction with local government authorities. The Council employs 20 Recreation Officers with some 45 requests from local authorities for further appointments. Whilst the number of officers is expected to reach about 100 over the next 5 years, present appointments are constrained by a lack of funds and a small administrative secretariat. The Council is financed chiefly from State sources with Australian Government assistance through the Department of Tourism and Recreation and the Department of Aboriginal Affairs.

182 The Council's budget for the last 3 years is shown in the following Table.

	State Government	Other (incl. Australian Government)	Total
1973-74	$ 551,000	$ 100,000	$ 651,000
1974-75	$ 906,000	$ 111,000	$1,017,000
1975-76(est.)	$1,100,000	$ 125,000	$1,225,000

183 The Council's involvement with Aboriginals in the way of youth programs and sporting activities has not been very great to date. However, an increase is anticipated as Field Officers stationed in areas with high Aboriginal population see the need for special programs. One such initiative has been the employment of 2 Aboriginal Assistant Recreation Officers funded by the Department of Aboriginal Affairs. The Committee supports the appointment of Aboriginals to assist the Recreation Officer and recommends that the Department of Aboriginal Affairs in consultation with the Community Recreation Council examine the possibility of appointing additional Aboriginal Assistant Recreation Officers.

184 Recreation, in the Council's view, is one facet of the total social welfare of individuals and groups. The Council expressed concern at the lack of co-ordination in the field between the many agencies with a responsibility in Aboriginal affairs. The Committee noted that the Council is not at present a member of the Aboriginal Affairs Co-ordinating Committee and, therefore, is not represented at regional level. To correct this situation the Committee recommends that the Community Recreation Council of Western Australia should be a member of the Aboriginal Affairs Co-ordinating Committee.

185 The Committee received evidence on the need for Aboriginal people to have their own clubs or centres for meeting purposes and recreational activities. The need is greater in rural communities as Aboriginals living in the metropolitan area have access to a number of social outlets.

Accordingly, the Committee recommends that the Australian Government should subsidise, in consultation with Aboriginal organisations, the establishment, especially in rural areas, of community centres for recreation and other social purposes.

October 1975

M.D. CROSS
Chairman

APPENDIX 1

LIST OF WITNESSES AND PERSONS WITH WHOM THE COMMITTEE HELD INFORMAL DISCUSSIONS

ANDERSON, Mr G.B.	Secretary, Hospital Board, Moora.
AVES, Mr G.	Chief of Welfare Services, W.A. Department for Community Welfare.
BARRON, Mrs M.M.	Private Citizen, Gnowangerup.
BERNDT, Prof. R.M.	Head, Department of Anthropology, University of Western Australia.
BROWN, Mrs E.B.	District Secretary and Treasurer, St John's Ambulance Sub-Centre, Moora.
BROWN, Mr E.B.	Assistant Field Nurse, W.A. Community Health Services, Gnowangerup.
BUZZA, Mr R.E.	Officer-in-Charge of Aboriginal Employment, Department of Labor and Immigration, Perth.
CARSON, Mr W.A.	Treasurer, New Era Aboriginal Fellowship, Perth.
CHILD, Mr R.B.	Health Officer, Shire of Gnowangerup.
CHITTY, Mrs V.A.	Private Citizen, Collie.
COLLARD, Mr F.G.	Field Assistant, W.A. Community Health Services.

COLLARD, Mrs J.	Field Assistant, W.A. Community Health Services.
COLLARD, Mr N.	President, Aboriginal Medical Service, Perth.
COLLARD, Miss R.L.	Student, Perth.
COOK, Mrs P.	Welfare Assistant, Aboriginal Medical Service, Perth.
DAVIS, Dr R.E.	Department of Haematology, Royal Perth Hospital.
de MEL, Dr E.	Regional Medical Officer, W.A. Community Health Services.
DRAYTON, Miss F.	Private Citizen, New Norcia.
DRYSDALE, Mr O.D.	Secretary, Hospital Board, Gnowangerup.
EDWARDS, Mrs H.F.	Private Citizen, Collie.
EDWARDS, Mr R.	Private Citizen, Collie.
EVANS, Dr C.	Deputy Director-General Australian Department of Health.
FRAMPTON, Mrs M.M.	District Officer, Department for Community Welfare, Gnowangerup.
GARE, Mr F.E.	Director, Department of Aboriginal Affairs, Perth, Commissioner, under W.A. State Legislation, for Aboriginal Planning.
GRACEY, Dr M.	Head, Gastroenterological Research Unit, Princess Margaret Children's Medical Research Foundation, Perth.
GRAHAM, Mr J.	Director, Community Recreation Council of W.A.

HALBERT, Ms M.A.	Regional Officer, Department of Aboriginal Affairs, Western Australia.
HART, Mr M.	Private Citizen, Collie.
HILL, Mr C.R.	Private Citizen, Collie.
HILLS, Dr N.F.	Acting Assistant Director, Treatment and Training Branch, W.A. Department of Corrections.
HOWARD, Mr M.C.	Department of Anthropology, University of Western Australia.
JOSEPH, Mrs V.	Private Citizen, Moora.
KHAN, Miss A.	Private Citizen, Collie.
KHAN, Mrs I.	Private Citizen, Collie.
LADEC, Mr J.	Health Inspector and Building Surveyor, Collie.
LANGSFORD, Dr W.A.	First Assistant Director -General, Australian Department of Health.
MARTIN, Mrs E.	Private Citizen, Moora.
McHENRY, Mr B.	Director, Noongar Community Centre, Gnowangerup.
McHENRY, Mrs W.M.	Homemaker Service, Department for Community Welfare, Gnowangerup.
McKENNA, Mr K.M.	Acting General Manager, State Housing Commission of W.A.
MILLAR, Mrs B.	Private Citizen, Collie.
MIPPY, Mr F.	Chairman, Central Midlands Aboriginal Advancement Centre, Moora.

MOLTONI, Mr A.	Businessman, Moora.
MONSON, Mr K.	Senior Social Supervisor for Country Regions, W.A. Department for Community Welfare.
MOUSTAKA, Mr T.F.	Assistant Director, Australian Department of Education, Perth.
NEWTON, Miss J.	Kindergarten Teacher, Gnowangerup.
NORTHOVER, Mrs K.M.	Homemaker Service, W.A. Community Health Services, Collie.
O'BRIEN, Father J.P.	Catholic Parish Priest, Moora.
O'LONE, Mr B.	Aboriginal Legal Service, Moora.
O'NEIL, Dr G.B.	Medical Practitioner, Perth.
PAILTHORPE, Sister W.C.	Field Nurse, W.A. Community Health Services, Collie.
PARR, Mr J.M.	Director, Aboriginal Grants Section, Australian Department of Education.
PITCHER, Mr B.J.	Shire Clerk, Gnowangerup.
PITTENDRIGH, Mr W.D.	District Officer, Department for Community Welfare, Collie.
POUGHER, Dr J.	Medical Director, W.A. Alcohol and Drug Authority.
PRIOR, Mr D.	Private Citizen, Moora.
PRIOR, Mrs R.	Private Citizen, Moora.
PRIOR, Mrs S.	Private Citizen, Cloverdale.

PROWSE, Mr I.	Assistant Director-General (Policy), Australian Department of Social Security.
RAMSEY, Dr D.K.W.	Medical Practitioner, Moora.
REID, Dr B.	Director of Health, Australian Department of Health, Northern Territory.
REID, Dr D.B.	Medical Officer, Aboriginal Medical Service, Perth.
ROBERTS, Mr D.H.	Regional Officer, Department of Aboriginal Affairs, Gnowangerup.
ROCKALL, Sister C.	Field Nurse, W.A. Community Health Services, Gnowangerup.
RYDER, Mrs A.	Private Citizen, New Norcia.
SAMUELS, Ms S.	Vocational Officer, Department of Labor and Immigration, Western Australia.
SHARLAND, Mr K.R.	District Officer, W.A. Department for Community Welfare, Moora.
TANDY, Mr J.L.	Director, Aboriginal Education Section, Australian Department of Education.
TROUP, Dr A.	Acting Director, W.A. Community Health Services.
TURNBULL, Dr H.	Medical Practitioner, Collie.
VAN KEPPEL, Miss M.	Welfare Officer, W.A. Department for Community Welfare, Moora.
VAUGHAN, Mr I.W.	Social Worker, Aboriginal Medical Service, Perth.

VERBRUGGE, Mr R.	Shire Engineer, Collie.
WALKER, Mr T.J.	Shire Health Building Surveyor, Moora.
WITMARSH, Ms P.	Women's Refuge Action Group, Mount Lawley.
WILKES, Mr R.	Liaison Officer, New Era Aboriginal Fellowship, Gnowangerup.
WILLIAMS, Mr B.A.	Private Citizen, Gnowangerup.
WILLIAMS, Mrs L.	Private Citizen, Gnowangerup.
WILLIAMS, Mr M.	Private Citizen, Gnowangerup.
WILLMOT, Mr E.P.	Education Officer, Aboriginal Education Section, Australian Department of Education.
WITTBER, Mr B.H.	Shire Clerk, Tambellup.
WOLFE-OKONGWU, Ms W.	Student, Perth.
WOODS, Mr D.	Private Citizen, Gnowangerup.
WORRALL, Mrs E.	Private Citizen, Moora.
WRAE, Mrs A.	Private Citizen, Gnowangerup.
WRIGHT, Mr B.J.	W.A.Department of Education.
WYNNE, Mrs S.	Private Citizen, Collie.
YAPPO, Mrs B.	Secretary, Central Midlands Aboriginal Advancement Centre, Moora.

APPENDIX 2

MORBIDITY STATISTICS - ABORIGINALS

JANUARY-DECEMBER 1974

	METRO	SOUTH -WEST	NORTHERN	EAST G/FIELD	PILBARA	KIMBER.	TOTAL
POPULATION	7,000	6,500	3,500	3,500	4,500	8,800	
INFECTIVE & PARASITIC	250	778	255	335	143	588	2349
NEOPLASMS	11	21	11	4	8	35	90
ENDROCINE, NUTRITION & METABOLIC	26	98	54	38	36	99	351
DISEASES OF BLOOD AND BLOOD FORM -ING ORGANS	8	12	8	9	4	57	98
MENTAL DISORDERS	24	98	25	31	9	37	224
DISEASES OF THE NERVOUS SYSTEM AND SENSE ORGANS	154	421	124	192	90	213	1194
DISEASES OF THE CIRCULATORY SYSTEM	41	104	61	60	51	96	413
DISEASES OF THE RESPIRATORY SYSTEM	273	1251	377	470	328	699	3398
DISEASES OF THE DIGESTIVE SYSTEM	74	182	62	54	31	119	522

	METRO	SOUTH -WEST	NORTHERN	EAST G/FIELD	PILBARA	KIMBER.	TOTAL
DISEASES OF THE GENITO -URINARY	70	157	94	69	41	160	591
COMPLICAT -IONS OF PREGNANCY, CHILDBIRTH AND THE PUERPERIUM	229	384	185	104	107	307	1316
DISEASES OF THE SKIN & SUBCUTANEOUS TISSUE	57	325	104	151	69	182	888
DISEASES OF THE MUSCULO SKELETAL SYSTEM & CONNECTIVE TISSUE	18	60	37	20	19	57	211
CONGENITAL ANOMALIES	19	15	5	9	4	22	73
CERTAIN CAUSES OF PERINATAL MORBIDITY & MORTALITY	1	20	10	3	7	7	48
SYMPTONS & ILL-DEFINED CONDITIONS	89	573	200	229	129	269	1489
ACCIDENTS, POISONINGS & VIOLENCE	283	829	294	378	165	498	2447

	METRO	SOUTH -WEST	NORTHERN	EAST G/FIELD	PILBARA	KIMBER.	TOTAL
ALT. CLASSIFIC -ATION, POISONINGS & VIOLENCE	33	88	134	41	80	275	651
T O T A L S	1659	5416	2040	2197	1321	3720	16353

Source : Community Health Services, Western Australian Department of Public Health.

APPENDIX 3

COMMUNITY HEALTH SERVICES

TARGETS AND AIMS - 1975

1. IMMUNISATION All immunisation to be carried out on a Doctor's order.

1.1 Tetanus - 90% of adults to have completed at some time in their life the full tetanus course - if course completed over 3 years ago, to have booster.

N.B. Tetanus as an illness DOES NOT confer any immunity on the sufferer.

100% pregnant women to have full status during pregnancy. If over 2 years since gaining full status then to have booster.

100% persons 3 years to 20 years to gain full status or have booster if over 3 years since last immunisation.

100% persons 3/12-2 years to have full course.

1.2 Diphtheria - All children 3/12-6 years to have full status. Follow up of contacts of any cases of diphtheria.

1.3 Whooping Cough - All children 3/12-2½ years to have full status.

1.4 Measles - 100% infant 12/12 to 2 years to have full status.

1.5 Polio (Sabin) - All children over age 12/12 to have full status. 90% adults to have full status.

1.6 B.C.G. - 1. All clients at Hansen's Disease risk 0-5 years above 26th parallel to have had B.C.G.

2. All persons (any age) required to have B.C.G. by Perth Chest Clinic to be vaccinated.

1.7 Rubella - 100% of girls of high school age to be immune by age 12 years. Not to be immunised if pregnant.

1.8 Influenza - Vaccination of young, old and at risk clientele should an epidemic be expected in 1975. (See C.S.L. Handbook Recommendations).

2. HEALTH EDUCATION & HYGIENE

This should involve interaction with and mutual learning between the health team and Aboriginal community.

2.1 Establishment of concensus group teaching methods.

2.2 Establishment of client demonstration methods.

2.3 All activities to be geared to a teaching situation.

2.4 Encouragement of pre-school education.

2.5 Names of client exemplars (opinion leaders) to be kept in register. Exemplars to become involved in health education programs.

2.6 Local witch doctors to be included in 1975 health programs.

2.7 Develop a deeper understanding of the Aboriginal's expectations of such a primary contact health team.

2.8 Encourage self-treatment in the right circumstances. Teach which conditions need urgent treatment and which do not.

2.9 Emphasise preventive methods and community care of patients where possible.

3. ENDEMIC DISEASES

* 3.1 Hansen's Disease

3.1.1 All clientele north of 26th parallel to be examined.

3.1.2 School children to be examined at beginning of each term. To be done by PHFN at time of hygiene inspection.

3.1.3 Special attention paid to direct and collateral descent relations of index case.

3.1.4 Surveillance procedure on all patients who have ever been in the leprosarium: and those on the E Register.

3.2 Yaws

3.2.1 Dissemination of knowledge regarding the disease. All clients with positive serology to receive treatment with follow up under the direction of the Medical Officer.

3.3 Intestinal Parasites

3.3.1 Helminth Disease - (Hookworm, Trichiuris, Ascaris, Strongyloides)

Active case finding within the endemic area under direction of Medical Officer.

Antihelminthic treatment of all infected individuals.

Blanket antihelminthic treatment under direction of Medical Officer.

Education regarding -
soil eradication
(fallow procedure where possible)
toilet training
use of footwear
importance of treatment.

Awareness of the possibility of auto -infection especially with Strongyloides when treating an individual.

Attention to improving diet in infected persons.

3.3.2 Protozoan Disease - (Entamoebae histolytica, Giardia lamblia)

Campaign against other parasites, especially Entamoebae histolytica and Giardia lamblia.

3.3.3 Hymenolepis nana - Exact relationship to gastro-intestinal disturbances is not known.

3.4 Trachoma

As directed by the area Community Health Services Medical Officer. Community Health Services is now responsible for Trachoma throughout the State. All treatment to be on doctor's order.

3.4.1 Active case finding.

3.4.2 Individual and blanket treatments.

3.4.3 Attention to detection and management of the complications of Trachoma.

4. OTHER DISEASES

4.1 Gastroenteritis

Campaign on hygiene.
Campaign regarding cooking methods, baby bottle care and food storage in liaison with C.W.D. Homemakers.
Campaign regarding washing soiled clothing.
Handwashing campaign.
Fly control in conjunction with local health surveyors.
Special attention to water sources of bush camps.

4.2 Moniliasis and Trichomonas

Campagin to detect and eradicate these infections.

4.3 Tuberculosis

Work as directed by Community Health Services Medical Officer or T.B. Control Branch.

4.4 Anaemia

Active case finding and treatment from whatever cause.

4.5 Toxoplasmosis

Survey for.

5. MINOR ILLNESS - Trauma and infection.

Health education regarding prevention of a minor illness becoming more serious. In liaison with doctors.

6. DEPENDENCY PREVENTION

Campaign to prevent total dependency where disease is established.

7 OTHER CASE FINDING

7.1 Malnutrition

Early warning alert system anthropometry.
Serial observation of infants 0 - 36 months.
This will form the basis of a longitutinal study on the growth patterns of Aboriginal children.
Any significant deviation from established curves demands (i) referral to medical officer,
(ii) case investigation,
(iii) remedial action before onset of intercurrent illness.

7.2 Constitutional Diseases - Diabetes
Hypertension
Obesity

7.3 Failure of child development. Developmental screening under the supervision of the Medical Officer.

7.4 V.D - primary cases with contact tracing and follow up.

7.5 Nutritional Anaemias. Note all the nutritional anaemias and iron deficiency anaemia in particular lead to the aggravation of many other diseases. Under direction of medical officer.

7.6 Chronic chest disease in Aboriginal children.

7.7 Routine clinical sideroom urine screening.

7.8 Ear disease.

7.9 Watching brief and client group discussion and solutions regarding - prostitution
alcohol
gambling
child pregnancy
neglected children
delinquency
drug abuse.

Health education in all above fields.

*8. DENTAL HEALTH

8.1 *Note that primary socialisation coincides with* dietary habits which will greatly influence future patterns of sugar consumption.

8.2 Fluoride.

8.3 Sugar control.

8.4 Encouragement of clients to visit dentist at least once in the year.

8.5 Encouragement of dental hygiene.

8.6 Fluoride supplements to antenatal cases.

8.7 Ensure elderly have adequate teeth for mastication.

9. FAMILY PLANNING

9.1 Education regarding availability and use.

9.2 Provision of methods where necessary.

9.3 Education regarding spacing with special reference to polygamous situation.

9.4 Education to the adolescents as well as adults.

*10. PREGNANCY

Concentrated action aimed at improving the health status of the expectant mother.

10.1 Antenatal Care

10.1.1 All pregnant women to attend antenatal clinics on a regular basis - first attendance before 4 months.

10.1.2 Tetanus - All pregnant women to have current full tetanus immunisation status.

10.1.3 Blood - All pregnant women to have recorded blood group and current Treponemal, Rubella and Toxoplasmosis serology.

10.1.4 Urine micro specimen.

10.1.5 All pregnant women to have Pap Smear and endocervical swab M.C. & S. where this can be managed.

10.1.6 Ensure adequate money available and spent on suitable food for the pregnant woman.

10.1.7 Supplemental iron and folate.

10.1.8 Hospital delivery - all deliveries to be conducted in hospital.

10.1.9 Breast feeding - Campaign to ensure breast feeding to age of at least 6 months. Children over the age of 4-6 months require supplementation plus breast feeding. Breast milk can provide additional protein to a child's diet up to the age of 3 year.

10.1.10 Dental Care.

10.1.11 Attempt to record pregestational weight.

11. SIGHT, HEARING AND LIMB CONSERVATION

11.1 Sight

11.1.1 All school children north of 26th parallel to have recorded sight test including +2 lens and recorded other occular abnormalities. Lists to be kept regarding persons who should see ophthalmologists or optometrists.

11.1.2 Notification of concerned persons where applicable - parents
teachers
doctors
Community Welfare Dept, etc.

11.1.3 Preschool sight-testing campaign to include 'lazy-eye' test. Full use of visiting orthoptists to screen as many preschool clients as possible.

11.1.4 Pensioner sight testing campaign. (Special emphasis on finding cataract blindness.)

Encouragement to obtain spectacles where required. (Community Health Services can supply finance when this is essential.)

11.2 Hearing

11.2.1 As above for sight.

11.2.2 Continue to make arrangements regarding ear toilets where required.

11.2.3 Watching brief regarding noise levels 90Db.

11.3 Limbs

11.3.1 Campaign to conserve limbs especially in Hansen's patients.

11.3.2 Campaign regarding chiropody in pensioners.

12. BIRTH & DEATH STATISTICS

UNOFFICIAL but comprehensive investigation and report on all cases of infant mortality and maternal mortality within the Public Health area.

13. PENSIONERS

13.1 Watching brief regarding nutrition, alcoholism and depression.

13.2 Encouragement of local societies to organise pensioner services, e.g. meals,
laundry,
house maintenance,
loneliness, etc.

13.3 Watching brief regarding general health.

13.4 Sight, hearing and limb conservation.

13.5 Liaison with Extended Care Branch staff and Silver Chain.

13.6 Ensure where possible that money from Social Security does not end up in the wrong pockets in regard to the aged Aboriginal.

14. SCHOOLS

14.1 School medicals. Community Health Services is responsible for annual School Medical examinations north of the 26th parallel.

14.2 Hansen's Disease. See 3.1.2.

14.3 Concerned with scabies, lice, nits, etc., with attention to treating the families of cases detected.

14.4 Possibly health education in liaison with teachers.

14.5 Encourage Dental visit at least annually. Ensure lists of carious children detected during school medicals are passed to Dentist where possible.

15. MEDICAL AUDIT

Detailed identification documentation, nutritional anthropometry, morbidity and laboratory data. Collection on individual clients during either mini or maxi surveys. The volume entry to data base will be accompanied by an updating procedure.

During 1975 I.D. information will be collected for data base from every region. Medical Audit mini surveys as arranged with Lab Service by R.M.O.

16. SURVEYS

16.1 Nutritional anthropometry on all clients aged 0-60 months to be performed twice yearly. Point prevelance survey.

17. LIAISON

17.1 Close liaison to be established with all other concerned bodies.

17.2 Non encroachment but working co-operation with such bodies.

17.3 Regular meetings with other bodies to discuss mutual problems.

18. RECORDS

Collection of information for central data base with the aim of more comprehensive Regional and Statewide statistics. Conversion of existing P.H. card to the problem orientated medical record with utilisation of the problem orientated system of management. Pilot trials to be arranged in each region.

19. RESEARCH

During 1975 this service will be contributing to research projects as follows :

19.1 Rehabilitation of malnourished Aboriginal infants. (Prof. Cheek, Royal Chldn's Hosp Research Found. Melb.) Regional.

19.2 Epidem. of duo virus in assoc. with diaorrheal disease. I. Holmes, Uni Melb. Kimberly.

20. TRAINING

20.1 Advancement of your own individual knowledge pool.

20.2 Contribution to Community Health Services knowledge pool.

20.3 Increased activity in recruitment and training of Camp Nurses who are the poor related and established numbers of an Aboriginal community:

20.3.1 with advice from the Field Instructor,

20.3.2 the Aboriginal community should select their own candidates,

20.3.3 Attempt to add compatible health procedures to the recognised traditional belief systems within the particular community.

20.3.4 Register of Camp Nurses. 1/12 basis.

20.4 Establishment of 'early warning devices', i.e. strategically placed persons who can forewarn of impending difficulties.

20.5 Encouragement of gardening and other recognised advances as already started.

21. SPECIALIST REGISTER

Records of patients names who have seen or are to see Specialists to be kept in each P.H.A. (Public Health Area)

22. REPORTS

22.1 Monthly returns from P.H.A. to Headquarters and R.M.O.

22.2 Annual report from all Staff to Headquarters, R.M.O. and R.N.A.

22.3 Situation reports from all Public Health areas on commencement of duties.

22.4 Monthly and Annual reports from R.M.O. and R.N.S. Headquarters.

22.5 Annual and monthly reports from M.O. to R.M.O.

APPENDIX 4

GNOWANGERUP HEALTH AUDIT January 1973

A health audit was conducted by Community Health Services staff in Gnowangerup for three weeks in January. The client population was offered a 'thorough check up'. Due largely to the good work of Sister Wishart there was an attendance of 220 and only one family with pre-school children absented themselves and only a small number of adult males attended. The assistance of a male medical student and evening clinics attracted most of the male attenders.

Some interesting social points emerged :

1. Almost no-one over the age of 27 years was functionally literate - this corresponds to the year in which Aboriginal children started to attend the State school. Older people had either no schooling or attended the mission school. However, a number of adults under 27 who had attended school into their teens were unable to read adequately.

2. Parents' overall attitudes to education were far from Europeans norm. Few of them could name accurately their child's school grade. Few parents were able to assist in any way with children's schooling; with few skills themselves they did not expect their children to achieve much more than minimal literate and numeral efficiency. Since training for upward mobility implied family separations there was no real encouragement for education.

3. A few people from Gnowangerup had never been to Perth. In general, areas of travel from Perth to Esperance. Most had been to Albany, about six people had been to Kalgoorlie. One family whose origin was around Moora had travelled a little more. The most travelled people were men who had worked with shearing teams up as far as the Pilbara, but even these named their routes by stations and had little town experience.

4. All the adult males and most of the families admitted to drinking alcohol - of these, only one, a female who drank very little had not been in gaol for offences involving alcohol. Aboriginal people with few exceptions could not be served in the public bar and could only buy cans of beer from the 'white door' Noongar's bar.

Overall the health was better than expected - the degree of Aboriginal concern about ill health is partly reflected in the attendance. Major problems, newly diagnosed included one four year old with congenital heart lesion and two children both aged four years with congenital syphilis; there was some overt anaemia especially in male children under 5 years. Extremely low serum iron levels indicated that the majority of people at all ages rarely maintained adequate haemoglobin levels.

Serum folate activity was also generally low especially in younger age groups and in older alcoholics. Of the pregnant women seen, only half were receiving any antenatal care.

The most apparent chronic problem was chronic otitis media, in one or both ears. Although ultimately hearing loss is remarkedly small in these children, the degree of day to day deafness varies considerably and many are certainly handicapped at school as a result. Several adults with severe hearing loss had employment problems. One of these, a young man of 27 years with a hearing loss of 80 decibels in both ears attended school to the age of 15 years but still could not read or write. Only one of these children had seen an audiometer before. It appears that when the School Medical Services is known to be coming to the school many young clientele children deliberately absent themselves.

A number of cases of gonorrhoea and syphilis were diagnosed and treatment arranged. A number of women were suffering from trichomonal or monilial vaginitis. Almost all the children had cuts on the feet in various stages of infection and healing - the result of broken glass scattered about the houses.

Of all people under 20 years of age only 10% were above the 50th centile for either height or weight. The minority fell below the 10th centile for both weight and height. The fact that teenagers scored rather better than young children might suggest that the nutritional situation has in fact become worse over the past few years in Gnowangerup.

Another notable problem was the stress experienced by young mothers, who were involved in upward mobility. The health attitudes were interesting. For a large number of the group health was seen as a goal still to be achieved. The chief obstacle was seen to be delivery of services. A smaller but

significant group were quite fatalistic about health problems. Their goal was survival rather than good health. Almost no-one saw poverty or lack of education as an obstacle to health but the need for good housing and self contained washing facilities were recognised.

Many people were not covered by any form of health insurance. In March the clientele were informed of the results of the Health Audit and cases discovered were followed up. This included the treatment of Trachoma, Venereal Disease, assessment at Irrabeena, evaluation of deafness, etc. Some 75 people received treatment as a result of the survey and several were transferred to Perth for major investigation.

MOORA MEDICAL AUDIT

The Medical Audit in Moora was conducted in mid-winter in a rather cold building - the old infant health centre. Community Welfare homemakers again provided a great deal of help with the transport of people. As in Geraldton, local Aboriginal leaders encouraged people to attend. This audit was during term time so local schools were approached and proved most co-operative. 283 clients attended.

Social comments :

1. Illiteracy is quite common among older people as in Gnowangerup.

2. A number of people had travelled quite extensively including visits to Eastern States.

3. Most people living in the area came from that area or from the line to Meekatharra although some had lived in the Kimberley for many years. Many families had their origin from caste children brought from as far afield as Eucla and Wyndham to the Moore River Settlement.

4. The closer proximity to Perth has created an altogether different style of useage of medical services.

Possibly the most worthwhile result in Moora was the early detection of two cases of carcinoma of the cervix both of which have since received treatment.

As it was winter a variety of major and minor respiratory infections were seen.

More severe problems associated with alcohol were seen in Moora than elsewhere. Severe personality disorder generally appeared to be more common though this is well known to be difficult to evaluate in a cross cultural setting. The style of mothering often reflected the several generations of institutional background and may account to some extent for the proceeding problems. A very strong impression was gained that over some time upward mobility had involved leaving Moora so that with few exceptions those who remained were those who had less experience of success.

Unfortunately records of height and weight were discovered to be valueless; the inaccuracies in the recording were not detected for several days - too late for correction. The distribution of Serum Iron Concentrations by age and sex are included.

APPENDIX 5

DEPARTMENT OF EDUCATION

N.T. DIVISION

P.O. Box 4821
DARWIN. N.T. 5794

73/594

6 February, 1975.

GENERAL CIRCULAR NO. 75/9

TO PRINCIPALS OF SCHOOLS WITH ABORIGINAL ENROLMENT

HEALTH, NUTRITION AND HYGIENE OF ABORIGINAL STUDENTS

Some confusion appears to exist over what responsibilities schools have for seeing to the physical, nutritional, and social needs of Aboriginal children enrolled in Northern Territory schools. The recent report by the House of Representatives Standing Committee on Aboriginal Affairs Present Conditions of Yirrkala People has highlighted several of these needs.

As guidance to Principals, therefore, and to give staffs authority for taking appropriate action in local areas, we have prepared the following set of guidelines.

You are assured that the matters listed below are of deep concern to the Minister, Mr Beazley, and this memorandum is issued on his expressed direction. Furthermore, he has written to his colleague, the Minister for Aboriginal Affairs, informing him that we are taking this action, and discussions have taken place involving also the Minister for Health.

Responsible action by school staffs to combat deficiencies in the areas mentioned below can therefore be assured of being given the fullest possible support.

If none of the strategies mentioned below can be made to operate, Principals must contact the Assistant Director (Special Projects) in order to set up a specially funded program for the area.

1. Showering of Children and Provision of School Clothes

The policy operating in the Department of Interior was suspended when the Department of Aboriginal Affairs was set up. The earlier policy required schools to provide showering and ablution facilities for children. Under teacher supervision students were to shower on arrival at school in the mornings, and change into a set of clean school clothes which were Government provided and laundered at Government expense. At the end of the day the school clothes were left at school; and the students changed into their 'camp clothes' to return home.

It is clearly a function of modern education to encourage good health habits, personal cleanliness, and the personal habits of hygiene which will prevent one from contracting serious illness or disease. Teachers, therefore, will recognise the need for health education, amongst Aboriginal children, and for practical demonstration on how to apply the principles of good health.

In localities where homes are serviced with water and showering facilities teachers should require children to come to school clean and cleanly dressed. In cases of neglect by the parent, the school should see it as its responsibility to approach the mother, guardian, etc. about the standards of dress and cleanliness of their children.

. The ablutions block at the school must, of course, always be available for showering by any children in the school.

. Where ablutions facilities do not exist in the camp, then showering and teaching the principles of personal hygiene must become part of the school's health education program, and students will be expected to wash at the school. In such situations, we suggest that the school should endeavour to co-opt parents into supervision of the routine, and also provide, in co-operation with the local Aboriginal Affairs and Health officers, a program of adult education in health and nutrition.

. Where ablution facilities exist neither in the camp nor the school, the Principal should make an urgent report on the matter to this Department so that adequate ablutions facilities can be provided on the next available Works Program.

. The Department of Education is not anxious to employ laundresses at schools. It would prefer laundry of school clothes to be seen as a parent responsibility, but schools may have to make a concerted effort to train the mother, guardian, etc. in this responsibility. In larger communities, the program should become part of the adult education program, and the provision of it should be made part of the responsibility of adult educator appointed to the school staff.

The provision of good and clean clothes is a matter which schools must take up with their parent bodies, and a strategy appropriate to the local community should be devised.

. Some schools may sponsor a roster whereby parents regularly attend at school to launder the school clothes.

. Some schools may decide to roster the older students for laundering as they often do for other monitorial duties.

. Some schools levy the parents and with the money purchase sets of clothes for students.

. Some schools may choose to purchase material in bulk with parent provided funds and have the clothes made up as a continuing school project. The program could be part of sewing and domestic science lessons, involving both children and adults, or it could be a mothers' club activity, or a local group could be encouraged to make it a cottage industry.

In all of the above, the school staff should regard this matter as a natural and practical extension of the education program for both adults and younger children, and if necessary should make use of the provisions already available for part-time instructors.

In cases where some parents consistently neglect the health and hygiene needs of their children and do not give support for the school's health education program, Principals should call in the Community Adviser to assist and should also endeavour to resolve the matter through the Village or School Council.

2. Provision of Meals

It is no longer a general practice for schools to provide midday meals at Education Department expense and there is doubt whether they should. Nevertheless, children suffering

from malnutrition or children who are hungry clearly are in no position to undertake effectively a learning program. The report on the Yirrkala people stated "One of the most serious findings of the Committee in this enquiry was the lamentable state of public health at Yirrkala among young children. The illnesses with which the children are affected vary but those of greatest significance are malnutrition, respiratory infection, diarrhoea, chronic ear infections, infestations by intestinal parasites and anaemia. Probably the worst of these is poor nutrition and that this should be so prevalent in a fertile environment is most alarming." The Committee therefore concluded that "It will be necessary to participate more actively in the feeding of mal-nourished children" and that "one obvious solution to this community problem is to treat the children when they are at school."

Schools must therefore encourage mothers club, mother, guardian etc. to provide, at school if necessary, adequate breakfast or midday meals for their student offspring.

. Where a canteen is provided at the school, the Principal, in liaison with the Community Adviser, should be prepared to make the canteen facilities available for the sale of nourishing food.

. Some schools may choose to sponsor parental activity at the school to provide a midday or morning meal.

. Heads of schools may choose to co-operate with other Government agencies locally or with Aboriginal community ventures concerning the provision and supervision of meals.

. In larger Aboriginal communities the Aboriginal Affairs Town Services Officer (or Community Adviser where no Town Services Officer has been appointed) has the delegation to issue emergency purchase orders to needy families. Where the Headmaster has children attending school hungry or poorly clothed, he should make representations to the Town Services Officer for immediate assistance to the particular families concerned. The continuation of special assistance to any particular family is one for decision between the Local Education Committee and the Aboriginal Council.

. Teachers in smaller localities can be made agents of the Department of Northern Territory Social Welfare Branch and be given the authority to expend money in cases of need or neglect and to receive reimbursement from the Department of Northern Territory.

Several Principals have expressed concern that milk is no longer available at schools since the Government suspended the provision of free milk for school children throughout Australia during 1973. Department of Health officers have indicated that their Minister is not likely to restore, generally, free milk supplies but would be prepared to look at a restoration of supplies where particular need for them can be established. Schools are therefore invited to bring particular pockets of disadvantage to our attention. Our Department will then negotiate with the Department of Health to see whether the provision of free milk can be reinstituted in those areas.

In short, Principals should co-operate in every way possible and be prepared to use their influence, to ensure that Aboriginal children are adequately fed. Although the responsibility for feeding children is not essentially an education function, education and the lives of children are obviously adversely affected if nutritional and dietary considerations are being neglected in children.

3. Health of Children

The report on the Yirrkala people made detailed comment about the extent of respiratory infection, ear diseases, anaemia, intestinal parasites and other health defects in Aboriginal children. In the case of Yirrkala, the Committee stated its belief "that children in need must be given constant attention and that this could best be done while the children are at school". They therefore recommended "that a full-time certificated nurse be attached to the school with facilities to properly supervise the health of children there and to attend regularly to those in particular need".

Health matters are clearly a responsibility of the Department of Health who have at all times been co-operative with school authorities.

. If Principals consider it necessary to have nurses appointed (even part-time) to their school, they should prepare a case urgently.

. In any case, Principals should encourage the use of school premises as an adjunct of the health clinic and should feel free to call in the health officers in cases where such help is needed.

. It should be noted that the Department of Health is in the process of training Aboriginal health workers to carry out some of these functions.

Where the Principal of the school considers that representations need to be made to the Department of Health to combat local problems, he should feel free to contact this Department and we shall make official representation to the Department of Health on the matter.

4. Compulsory Attendance and the Removal of Students from School

The Northern Territory legislation now requires all children resident within 3 miles of an existing public school to attend school if they are within the age for compulsory attendance. The Education Department is in the process of appointing officers to check on school attendance.

Statistics show that attendance at school in Aboriginal communities has fallen away heavily in some communities over the past year. Since it is necessary for schools to be able to bring to the attention of parents the need for children to attend school regularly, the appointment of home liaison officers in the larger Aboriginal schools to commence in 1975, is aimed at establishing and maintaining good rapport between school and home. Schools where such appointments have not been made should make sure that social workers are appraised of the school's concern over any poor attendance. Social workers are available through the Department of Northern Territory at major centres or the Department of Education (Darwin and Alice Springs).

The Social Welfare Branch of the Department of the Northern Territory is also available to assist schools.

In short, non-attendance by children who are under legal compulsion to attend is a serious matter and must be treated as such by Principals.

Several cases have been reported where Aboriginal adults have taken students away from school. Such withdrawal cannot be condoned where it contravens the N.T. Ordinance relating to attendance at school. Furthermore, action which undermines the ability of the school to discharge its functions cannot be condoned.

Principals and teachers should therefore check carefully that it is the child's parent or guardian who initiates any such move, and should not be prepared to deal with anyone who is not the parent or guardian.

. Principals should not hesitate to bring cases of withdrawal to the attention of the Community Adviser, the Town Council, or the School Council.

. In serious cases, the Principal is entitled to invoke police assistance.

Conclusion

Principals should be aware that interdepartmental committees operate between the Departments of Health, Aboriginal Affairs, Northern Territory and Education and they should not hesitate to bring forward matters for listing on the agenda of meetings of those interdepartmental committees. The I.D.C.'s have been valuable means whereby joint action can be taken by several departments to combat complex problems in a local community.

Principals should also make themselves and their staffs familiar with circular 73/1061 issued jointly by the Directors of Education and Aboriginal Affairs in October 1973. The circular will be re-issued.

The whole thrust of these programs is to educate for parental and family responsibility; the strategies outlined here are not aimed at perpetuating a paternalistic system, but have as their purpose the education of the community and its parents to their responsibilities for the well-being of children.

The contents of this circular have been cleared with both the Directors of Health and Aboriginal Affairs and copies will be going forward to appropriate officers of these Departments.

J.D. GALLACHER
Acting Director
Northern Territory Education

R75/664