THALLIKOOL

nursing mothers'
ASSOCIATION OF AUSTRALIA

ABORIGINAL OUTREACH
PROJECT

REPORT - 1987

NMAA MEMO

TO: ALL BRANCH PRESIDENTS

FROM: ELIZABETH MILLS

RE: THALLIKOOL ABORIGINAL OUTREACH PROJECT REPORT - 1987

DATE: 8TH OCTOBER 1987

Dear Ladies,

The enclosed copy of the Tahallikool Aboriginal Outreach Report is a complementary copy for use within your Branch. When you have read the report would you please offer it to others within your Branch for whom it would be interesting or useful.

We are circulating a limited number of complentary copies as widely as possible. If you have suggestions about where the report could be sent, would you please contact me via NHQ. A master list is being kept at NHQ to avoid Duplicating the circulation of these reports.

Yours sincerely,

Elizabeth Mills.
Vice President.

THALLIKOOL *

nursing mothers'
ASSOCIATION OF AUSTRALIA

ABORIGINAL OUTREACH PROJECT REPORT - 1987

BY:
BRENDA FITZPATRICK

*THALLIKOOL - MOTHERCHILD

"You tell me in your words
and I shall tell
my people
in mine."

Grace Close

NURSING MOTHERS' ASSOCIATION OF AUSTRALIA

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NURSING MOTHERS' ASSOCIATION OF AUSTRALIA

- BACKGROUND INFORMATION

Nursing Mothers' was founded in 1964 in Melbourne. The aim was to gather and disseminate information on breastfeeding, and to provide support for those wishing to breastfeed. At the time, breastfeeding was not at all common in the Australian community.

The Association has since grown Australia-wide.

We have over 570 local Groups throughout Australia. These are the mainstay of the Association, and it is from these that mother-to-mother support is given, at a "grass roots" level. Each Group is led by a Breastfeeding Counsellor. The Breastfeeding Counsellor is a mother who has undergone an intensive training programme and who undertakes this role on a voluntary basis.

This mother-to-mother model has proven to be most successful. It is now accepted as an effective approach to community education. The establishment of networks at a local level does indeed meet the specific needs of individual women and of the community generally by disseminating information on infant nutrition and providing support for breastfeeding mothers.

Our Counsellors become involved in many aspects of Nursing Mothers', including community education, Counsellor training, administration of the Association, as well as the gathering and disseminating of breastfeeding information.

We support the work of our Counsellors and the cost of maintaining our National Headquarters in Nunawading, Victoria, by the sale of booklets relating to breastfeeding, lambskins and other mothering aids, plus books and information on breastfeeding.

We have a current membership of 16,000 with a cumulative total of nearly 85,000.

In 1974, we became a company Limited by Guarantee registered in Victoria with no shareholding.

THE PRINCIPAL OBJECTIVES FOR WHICH NMAA IS ESTABLISHED ARE:

(a) to encourage and to give confidence and moral support to mothers who wish to breastfeed their babies;

(b) to create in mothers an interest in breastfeeding as an aid to the art of skilled and loving mothering, thus encouraging close and happy family relationships;

(c) to create an awareness in the community of the importance of human milk, breastfeeding and nurturing and of the need for community support for the nursing mother and her baby;

(d) (i) mother to mother contact, particularly through individual counselling and group activities;

(ii) making available the experience of breastfeeding mothers and the results of research to members of the Association and to other interested persons and organisations;

(iii) co-operation with medical and allied health professions, public health and education authorities and governments;

(iv) public relations and community education, including ante-natal, parental and school education;

(v) liaison and exchange with interested individuals and organisations within Australia and overseas;

(vi) collection, publication and dissemination of information, and the provision of resource facilities;

(vii) undertaking sponsoring and encouraging research and liaison with researchers in Australia and overseas.

nursing mothers'
ASSOCIATION OF AUSTRALIA

NURSING MOTHERS OUTREACH PROGRAMME
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It has long been the concern of the Nursing Mothers' Association (NMAA), both on our National Board of Directors, and through our Counsellors that in some areas of Australia, Aboriginal babies are not being breastfed.

Along with a growing number of public health organisations, we see this factor as having widespread and generally disastrous implications for the Aboriginal people as a whole.

Poor health among Aboriginals could be one of the most serious reasons affecting their success in gaining and holding employment.

It has been stated that the substandard health of the Aboriginal people significantly shortens the life expectancy of those who reach adult life. (See Appendix I)

The substandard health pattern begins during the first three years of life.

The lack of breastfeeding in infancy contributes to the high mortality and morbidity rates in Aboriginal children. (See Appendix I)

Aboriginal babies are generally smaller than other Australian babies. A Sydney Department of Health survey showed that by the age of three, 54% of the children surveyed were stunted in height. (See Appendix II)

The high incidence of diarrhoea and other associated illnesses such as malabsorption, gastroenteritis, pneumonia, as well as anaemia, immunological abnormalities, respiratory tract infections, ear infections and dental caries among Aboriginal infants all stem from poor nutrition. (See Appendix II)

The Aboriginal child is more likely to require hospitalisation and for longer periods than other Australian children.

There is a greater risk of death from dehydration and diarrhoea in Aboriginal children. Figures from Queensland in 1972 show that the infant mortality rate for Aboriginal settlements was 5-10 times that for Australia as a whole, while the birth rate was twice as high. (See Appendix I)

It is known that severe nutritional deficiency can affect brain growth in infants, and by implication, growth in intelligence.

The incidence of breastfeeding among Aboriginal infants is very low. In a NSW assessment of 146 Aboriginal mothers and their children under the age of 5 years, 52% of the babies were being breastfed at birth, 31% at 3 months, and 16% by 6 months. (See Appendix III) This means that most Aboriginal babies are fed an animal or vegetable milk formula.

This problem occurs throughout Australia and is not confined to any one community. It is among urbanised Aboriginal people, as well as those living in small rural communities.

We see therefore a deprived, disadvantaged infant, robbed of his or her natural birthright, his or her own mother's milk.

We see long term harm being done to the infant, and later on, to the adult, because of this one key factor.

Poor health in infancy deprives many Aboriginals of the opportunity to achieve their potential. They become the underachiever at school, and this pattern is often set for life.

The immunological and health giving factors of human breastmilk are well known. Septs taken to assist Aboriginal mothers to breastfeed their babies will produce long range and last benefits to the Aboriginal people as a whole.

Source:

Nursing Mothers' submission to Committee of Review of Aboriginal Employment and Training Programme.

Miller Report, August 1985.

ABORIGINAL OUTREACH I

- AN IDEA GROWS .....

(Text by Jan Mangleson)

1979

Within NMAA, from 1979, Counsellors started an information exchange which led to the formation of an "Aboriginal Activities" network with Hazen Waller as Co-ordinator. A news-sheet was published and sent to the network Australia-wide. Ros Gill of Adelaide, then a Board Member, took over as Co-ordinator in 1981.

1980
Needs recognised

In September 1980, in Coraki, NSW, Group Leader Judy Hibberd and I spoke to a large group of Aboriginal Health Workers about the benefits of breastfeeding. We showed them the film "Breastfeeding, What a Beautiful Thing to Do", and our NMAA literature. We agreed at the time that a film aimed directly at Aboriginal parents was needed, as well as literature and posters showing Aboriginal mothers breastfeeding their babies. All the Health Workers were convinced of the view of breastfeeding and were saddened by the high morbidity and mortality rates among young Aboriginal children. They saw breastfeeding as a way to combat illnesses by giving their babies the protection of anti-bodies and other infection fighters present in breast milk. They were concerned that they had neither the knowledge, the skills, nor the time to promote breastfeeding among their people. Eight of the Health Workers kept in touch with NMAA by being entered on our Interested Medical Personnel list, receiving our Newsletter for six months.

Aboriginal delegates attend International Workshops

Towards the end of 1980, I had the opportunity of visiting Mary Paton, who was organising the Nursing Mothers' International Workshop, at which delegates from breast-feeding organisations around the world could learn from each other the most successful ways of bringing breast-feeding back, especially among the underprivileged peoples of the world.

These delegates came from Europe, USA, Africa, Asia and the Pacific Regions. The workshop had been a dream of Mary's for many years. She was concerned that some delegates from the Aboriginal people should attend, and when I told her of our talk to the Aboriginal Health Workers, she saw them as an ideal group to be represented at the Workshop.

Three Aboriginal women attended the Workshop: Rhonda Morris, Pat Owens and Nola Roberts, Health Workers from the Aboriginal Section of the NSW Department of Health. Nola spoke on "Breastfeeding in the Aboriginal Community" and reported to the workshop a 20% increase in breastfeeding among Aboriginies in the three years previous to 1981. Terry Coyne, a nutritionist from the USA, also from the Aboriginal Health Section, took part as a discussion panel member.

All women learn best from their own people

I spoke to Nola at the Workshop and we both came to the conclusion that Aboriginal women, like the women of all the countries represented, listened to and learned best from their own people. So the concept of training Aboriginal mothers in breastfeeding knowledge to "reach out" to their own people was formed.

Moree - Bernadette Kennedy Denise Ward

Bernadette Kennedy, NMAA Counsellor from Moree, NSW, pioneered the work of training Aboriginal women in breastfeeding skills. Moree has the largest group of Aboriginal people in Australia - over 3,000 - which is one-third of the population of the town. With the encouragement of the nuns at the Aboriginal Mission, Bernadette began giving talks on breastfeeding to mothers at the Mission. Denise Ward, an Aboriginal mother who lives in Moree, became interested in NMAA and applied to train. Bernadette received a small Education grant to help with expenses. Denise completed her training with Bernadette as her Trainee Advisor, and in 1983 became an NMAA Counsellor. She has since gained a job at the Women's Refuge in Moree where her breastfeeding knowledge and counselling skills are needed.

1981

In December 1981, I became a member of the Board of NMAA, and became Co-ordinator of the Aboriginal Activities Network. With the advent of the new structure in NMAA, this network became incorporated into the Special Needs Working Group under the Training Unit.

1983

Application

In mid-April 1983, I attended a Community Meeting at Byron Bay, NSW, where a Social Worker outlined the Wage Pause Programme and its potential for community groups. I saw its possible application to NMAA and our wish to educate Aboriginal mothers. The submission had to be in by April 30th, so much work had to be done in a hurry, mainly by telephone. After consultation with the Department of Aboriginal Affairs, the Commonwealth Employment Service, and the Wage Pause Programme Officers in Sydney and Lismore, the submission was duly delivered.

A Pause

However, the Board decided to delay slightly the application while details were clarified, conditions negotiated and NMAA infrastructure developed. A letter was written withdrawing the application.

A major consideration was the status of employees of the project in relation to the voluntary organisation. The letter was mislaid when the Wage Pause Programme moved office.

Some months later, I received a telephone call from an officer of the Wage Pause Programme who told me our submission was being considered very favourably. The letter of withdrawal had finally reached them but we told them to ignore it. We knew we had to try to achieve what we knew was important. We negotiated final details. Pam Fletcher and I met the officer in Sydney in October to discuss the implementation of

Grant

the grant. On 26th October, 1983, we received a letter from the Deputy Premier of NSW stating that our application had been approved.

ABORIGINAL OUTREACH I

- OBJECTIVES

Cheryl and Skye

1. To encourage, give moral support and confidence to mothers who wish to breastfeed their babies.

2. To create in mothers an interest in breastfeeding as an aid to mothering.

Nursing Mothers' Association of Australia would undertake to train as Outreach Workers two Aboriginal mothers who have themselves breastfed a baby.

These two women would be equipped with skills to help other mothers to breastfeed and give them support, to hold group meetings, go out to communities and talk with them, and offer counselling in specific breastfeeding problems.

Source: NSW Wage Pause Programme
Community Employment Programmes
Application Form - May 1983.

ABORIGINAL OUTREACH I

- THE PROJECT

Employed:	Two Aboriginal women (Lorna Gordon and Grace Close) as Trainee Outreach Workers. One clerical assistant (Wendy Thompson)
Hours:	10.00 to 3.00 Monday to Friday - attendance plus home assignments.
Duration of Project:	26 weeks.
Dates:	December 1983 - June 1984.
Location:	Casino NSW - Infant Welfare Centre (see Appendix IV - Map). Casino was selected as it has an extensive population of Aboriginal people and is relatively close to other Aboriginal communities at Bellbrook, Baruygil, Mallanganee and Bonalbo.
Co-ordinator:	Penny Mears - NMAA Counsellor from Murwillimbah. (Now Assistant Branch President, NMAA Queensland Branch).
Committee:	Julie Gill - Northcoast Regional Representative, Judy Hibberd - Lismore Group Leader, Joy Cullis - Byron Bay Group Leader, Jan Mangleson - Mullimbimby and Ballina Group Leader. (Jan also carried out many of the administrative responsibilities.)
The Trainers:	NMAA Counsellors. These women worked voluntarily, often travelling great distances and needing to bring with them their own young children.
Grant:	$28,000. The grant was to cover the salary of the two Outreach Trainees and the clerical assistant. It also allowed for a contribution to production of a video film, travel costs for training personnel and some administrative costs.

ABORIGINAL OUTREACH I

- THE PEOPLE

Lorna Gordon of Casino and Grace Close of Lismore were the two Trainee Outreach Workers. They were selected by the Committee following assistance from the Department of Aboriginal Affairs, the NSW Department of Health and the Community Employment Service who found four applicants for us.

> It was the first time the CES had to list nine months' breastfeeding as part of the qualifications for a job!

Both Lorna and Grace were experienced mothers of teenage and younger children. They were both aware of the need to improve the health of Aboriginal children and could see breastfeeding as a first, basic step to that goal.

> On the day of their job interviews they brought with them the news of the death of another six month old Aboriginal baby in the district.

Grace was a member of the Seventh Day Adventist Church and had been a leader in group work including group discussions with Aboriginal people. She had been involved in catering and speaking on nutrition to various groups for ten years prior to 1982.

Lorna had been doing a Technical College course which included study of group dynamics, personal development and counselling skills.

Both women were closely attached to the local community. Although Grace lived in Lismore she knew many people in Casino and had relatives living in the area.

This was an important factor in the selection of the Trainees as they would need to draw on local contacts to begin their work.

Wendy Thompson was employed as clerical assistant. She was responsible for the day to day running of the programme and provided an important sense of continuity as volunteers were rostered for intermittent periods. Wendy carried out the Committee's directions, arranged rosters, kept records, paid accounts, hired films, arranged venues, etc.

Baryugul, NSW, 1984.
Wendy Thompson, Granny Long, Grace Close, Jan Mangleson.

In Memoriam

- Lorna Gordon -

Lorna Gordon, who worked in our original (1984) NMAA Aboriginal Outreach Programme, died on 24th October, 1985. She was only thirty-nine years old.

She was very involved in the affairs of her people and was always ready to help those in need.

To her husband, Lindsay, her children and foster children - Lorna, Lindsay, Brenda, Patsy, Felicity and Rocky - and brand new grandson, Joshua, her sudden death by heart attack was a great shock.

Her friends in NMAA also deeply regret her death.

ABORIGINAL OUTREACH I

- THE PROGRAMME

The training programme consisted of the following:

- basic knowledge of the benefits of breastfeeding;
- skills in helping a mother to breastfeed;
- counselling skills;
- stress and relaxation techniques;
- nutrition for the family;
- practical experience in talking to groups of mothers, both Aboriginal and non-Aboriginal.

The first six weeks were spent in intensive training by rostered volunteers (NMAA Counsellors).

Week 1 "Before baby comes" - included ante-natal preparation, mother's diet, nipples, etc. Benefits of breastfeeding.

Week 2 "Feeding your new baby and is he/she getting enough" - included 'relaxed feeding and mothering NMAA style', the 'rush of milk' (the term we used for Let Down Reflex, Low Supply/Increasing Supply.)

Week 3 "Too much milk" - included engorgement (or full and swollen breasts), too much, fast flow, leaking.

Week 4 "Sore nipples/cracked nipples/inverted nipples".

Week 5 "Breast infections (milk fever) and blocked ducts".

Week 6 "Starting other foods, breast refusal, weaning".

The Co-ordinator, Penny Mears, wrote:

"These six weeks were an introduction only and each topic was revised many times during the following months. Also at least one day per week for the first six weeks and after that two or three times a week, extra activities were planned. Grace and Lorna attended most Group Meetings in the region, coffee mornings, Trainee meetings and workshops in neighbouring regions. On returning from one of the first Group meetings, Grace and Lorna both commented on how healthy and happy the babies were, and it made them more determined than ever to promote breastfeeding amongst their people.

Other activities included films from NMAA and the NSW Health Department, Family Planning Lectures, Stress Management, a three-day Nutrition Workship at Ballina Hospital. Grace had also given a talk to us on Good Nutrition as she has been giving these talks to Aboriginal High School students for many years.

Grace and Lorna attended and spoke at an Aboriginal Playgroup in Tweed Heads and addressed High School students at Bonalbo on the "Benefits of Breastfeeding" and incorporated a baby bathing and feeding demonstration, as part of the Personal Development course.

An exciting step for us was holding coffee mornings for Aboriginal mums in Casino where Grace and Lorna prepared and gave a short talk with the help of an overhead projector. Role plays, questioning/listening games, Code of Ethic problems and visual aids played an important part and reinforced the knowledge gained in lectures.

It is important to note our Trainee Outreach Workers, Grace and Lorna, have grown up families and although they breastfed their babies they had to be re-educated and reminded of mothering a new baby."

A close liaison was built up with the Department of Health. Aboriginal Health Workers took the Trainees on field trips. Both Trainees attended live-in courses in Sydney through the Cumberland College of Health Education, conducted by the NSW Department of Health.

Melda Morris of NMAA's Training Unit designed detailed programmes based on Series A Training Programme questions.
(See Appendix V)

ABORIGINAL OUTREACH I

- PROGRAMME FOR ABORIGINAL OUTREACH WORKERS' TRAINING

Week 1 and Week 2:

Monday, 5th December, 1983 -

History of NMAA
Aims, Code of Ethics
What has been achieved
How NMAA works - structure of NMAA (illustrated)
How groups function
Stock (Sales Secretary to demonstrate)
Enrol as Members and fill in training applications
Go home with lactation history and booklets.

Tuesday, 6th December -

Training day with Jan Mangleson. Grace and Lorna to meet other Trainees and Counsellors in the region.

1. Outline of training course (what's involved)
   Timetable finalised
2. Physiology of the breast. Breast atlas.

Wednesday, 7th December -

Benefits of Breastfeeding	Question 15 (NB)
Preparations for Breastfeeding	Question 10
Mother's diet	Question 13
Normal bowel motion in breastfed baby	Question 12

Thursday, 8th December -

What signs to look for	3
Low supply	1
Let down	2

Friday, 9th December -

Fast flow, oversupply and leaking	5 and 6

Monday, 12th December -

Sore and cracked nipples	7 and 8
Inverted nipples	16

Tuesday, 13th December -

Blocked duct and breast infections	9

Wednesday, 14th December -

Introduction of solids	4
Weaning	11
Breast refusal	14

Thursday, 15th December -

Code of Ethics	17/18/19/20/21/22

Friday, 16th December -

Revision

ABORIGINAL OUTREACH I

- FOR THE VOLUNTEER TRAINERS ...

This was a new venture for all concerned. The volunteers were trained (or training) as Counsellors but it was a new role for them to select and pass on appropriate information for the Trainee Outreach Workers.

Jan Mangleson provided this guidance in a memo to all taking part:-

"Here are a few suggestions on how to go about your session.

The basic format could be:

(i) Series 'A' question each day. We will give you a sheet with your question plus the relevant points to cover. (Knowledge)

(ii) Understanding the mother's situation. (Empathy)

(iii) Listening exercises. (Listening)

(iv) Asking questions. (Questioning)

(v) A story about a mother in this situation and how to help her. (Counselling)

Have I scared you off? You could never do it? The following may help:

Series 'A' question each day (see Appendix V) e.g. Question 7 - Jenny with sore nipples. Booklet to read "Abount Breasts and Nipples", also "First Aid for Breasts and Nipples". Mark out the parts that are relevant to the subject. Take it in turn to read alound, a paragraph at a time.

Stop every fifteen minutes and do something else, or have a five minute break, or a cup of tea, etc. Keep each item short - most of us have an attention span of fifteen minutes.

For listening practice, you could read out one or two sentences from "Successful Breastfeeding" on sore nipples or from the booklet, and then ask Lorna to tell Grace what had been said; then ask Grace to tell you what Lorna had said; but both to use their own words. Then write it on butcher's paper. You may like to work out your own exercises for listening and questioning. Keep them simple. The reason for them is to gradually introduce to Lorna and Grace the idea of asking questions and listening to a mother who needs help.

When reading through the booklet, you could stop and ask the Trainees to tell you how they would let a mother know about that, what would they tell them? Lorna and Grace have asked us to put the information in our words, and then they will put it in words to suit the Aboriginal mothers. Then write down their words.

Also, draw many pictures to illustrate, or ask Lorna or Grace to draw a picture. Butcher paper, felt pens and blutack will be available. When one page is finished put it on the wall. Refer everyone to that information if it comes up again.

To help illustrate a counselling situation tell the Trainee Outreach Workers a story, e.g. "there was once a mother and her name was Lisa, and she had this beautiful little baby who was only three weeks old. Lisa wanted to feed this baby, but her nipples were really hurting her, and everyone told her to stop." Keep the language simple and avoid using breastfeeding 'cliches'.

Ask: "What do you think Lisa was feeling about all this?"
(Identifying feelings)

"What would you say to Lisa so that she knew you cared about this problem?"
(Empathy)

Take your time about these two questions. Encourage the Trainees to consider how they would feel in the same situation.

Then ask:
"How would we help her, I wonder?"

Write down all suggestions. Draw Lisa and her baby and her sore nipples. Stick figures will do. Draw her face with tears coming out of her eyes with the pain. Draw a nipple shield on Lisa's breast. Draw baby sucking through the nipple shield.

For each Series 'A' question we will give you the points that should be talked about. Suggest these if the Trainees don't mention them, and show them where the information is in the booklet. As you will all realise, this will be excellent training for each of you.

We appreciate and value your help. Without you, this couldn't be done.

It is probably better for two to come, more practical for baby sitting. Come alone if you would prefer. Wendy will be there to help.

Ring Penny Mears if you would like some ideas for listening and questioning exercises, or other suggestions for your day.

Best wishes to you all and thank you.

Jan."

"There were times when the Trainee Outreach Workers just could not take in any more information. Grace would laughingly say she needed 'to go walkabout' and would sit by herself until she felt refreshed and could continue."

"Early in the programme both Lorna and Grace were very embarrassed when the volunteer Counsellor/Trainees breastfed their babies."

"Health Workers from Lismore felt that the term 'breastfeeding' would make the Aboriginal people feel uncomfortable."

"Both Trainee Outreach Workers were excited after the sessions on women's reproductive systems. They 'couldn't wait till lunch time to tell the other girls'."

ABORIGINAL OUTREACH I

- LEARNING TOGETHER

Outreach I was a learning experience for all concerned. Many plans changed and differences in outlook and attitude were highlighted.

The first weeks

When designing the programme for the Aboriginal Trainee Outreach Workers, the Committee felt that from six to eight weeks of intensive training would provide a base for further activities. It became clear that this was in fact, too intensive.

Trainee Outreach Workers

In hindsight, it was felt that only the patience and perseverance of the Trainees averted early failure of the project. The amount of information passed on and the concentrated sessions were too much for anyone new to the field to take in effectively.

Trainers

The volunteer trainers also found the process daunting. Many of them travelled long distances (see Appendix IV - Map), and brought their own young children with them. The full-time roster placed considerable demands on times for attendance and preparation.

Change

After a few weeks it was resolved to slacken the pace, intersperse the information-giving sessions with visits to local Groups and to allow more time for revision and consideration. While the use of volunteer trainers had some beneficial results, it became clear that it created some difficulties for the two Trainees. They were faced with constantly changing personalities and approaches to the passing on of information.

Wendy Thompson, as the constant figure, undertook most of the revision sessions and she and the Trainee Outreach Workers established a rapport which allowed for easy communication.

Language

These first weeks highlighted the differences in language between the trainees and trainers. Much of the 'everyday' language used by NMAA was unfamiliar to Grace and Lorna, e.g. NMAA uses the term "let down reflex" to refer to the process of milk coming down to the breast. It was weeks before it was realised that one trainee's confusion arose from her interpretation of "let down" as a sense of disappointment.

As trusting relationships developed it became easier to question terms. Some were explained; some were omitted; some were changed. This needed to be an ongoing process.

Another major difference highlighted was the perceived approach to the way information would be disseminated by the two Trainee Outreach Workers.

Spreading the word about breast-feeding

The groups planning the project had foreseen a pattern similar to the way in which NMAA operates, i.e. group meetings with leaders ensuring an education process.

It became clear that the most effective way that word would spread in the Aboriginal community would simply be by word of mouth. Grace and Lorna had extensive contacts in the local community and it was through the more informal lines of communication that they passed on what they learned. Grace and Lorna often referred to the term "bush telegraph". Other women of all ages, often with their children, would call into the centre to see and hear what was going on.

'Standard' activities such as putting advertisements in newspapers evoked no response at all.

There were coffee mornings, sometimes attended by up to twenty-five women. But the Aboriginal community had its own way of disseminating knowledge.

Employment Programme

Aboriginal Outreach 1 was a project funded under the Community Employment Programme. This meant that an underlying objective was to prepare the participants for future employment. In the initial stages there were problems with the Trainees regarding productivity and attendance. One of the Trainee Outreach Workers was often under considerable pressure from family and spent many hours on the telephone.

Work practices

This placed the project advisors in a dilemma. There were some thoughts that they were not being helpful by appearing to condone this attitude and should, in fact, reduce salary for time lost. Others felt that the women just needed to be encouraged to meet commitments more responsibly.

Notes from the Committee meeting held on 22nd May, 1984, state:

"It was decided that even though the Government money was being well spent, the Committee had an obligation to Grace and Lorna, the Government and ourselves not to hand out the money loosely;

meet our obligations by acting more like employers;

to give example and direction to Grace and Lorna right from the start in the case of the rest of this programme and any further programmes;

it was suggested, perhaps, for future programmes all those concerned be paid by the hour and any time off be docked from wages. No comment was made in regard to this suggestion."

Discussions were held with the Trainee Outreach Workers and practices gradually changed. They suggested that telephone calls be limited to breaks and it was accepted by trainers that assignments at home were extremely difficult to complete.

More changes

It is not customary for NMAA Counsellors to be paid to be trained. It was a difficult time for many in NMAA as the situation was worked through to the stage when it was formally accepted tha the Trainee Outreach Workers were on salary. Some people continued to feel that it was not appropriate to make differences between Aboriginal women and white Australian women. However, it was acknowledged that the programme being offered to the Aboriginal women was different from NMAA Counsellor training.

All levels of NMAA discussed the need for a flexible approach as the Aboriginal women were training under an employment programme, and that the status of the Trainee Outreach Workers in the community was enhanced by them being paid to learn.

Grace applied to be an NMAA Counsellor

Concerns about making exceptions were expressed again when, later, the Trainees wanted to train as NMAA Counsellors. When Grace applied for the position she completed a "Lactation History" of her experiences in breastfeeding her own children. This history was lost and later she was asked to complete another. There were some differences in detail that caused some people to call into question how long she had breastfed.

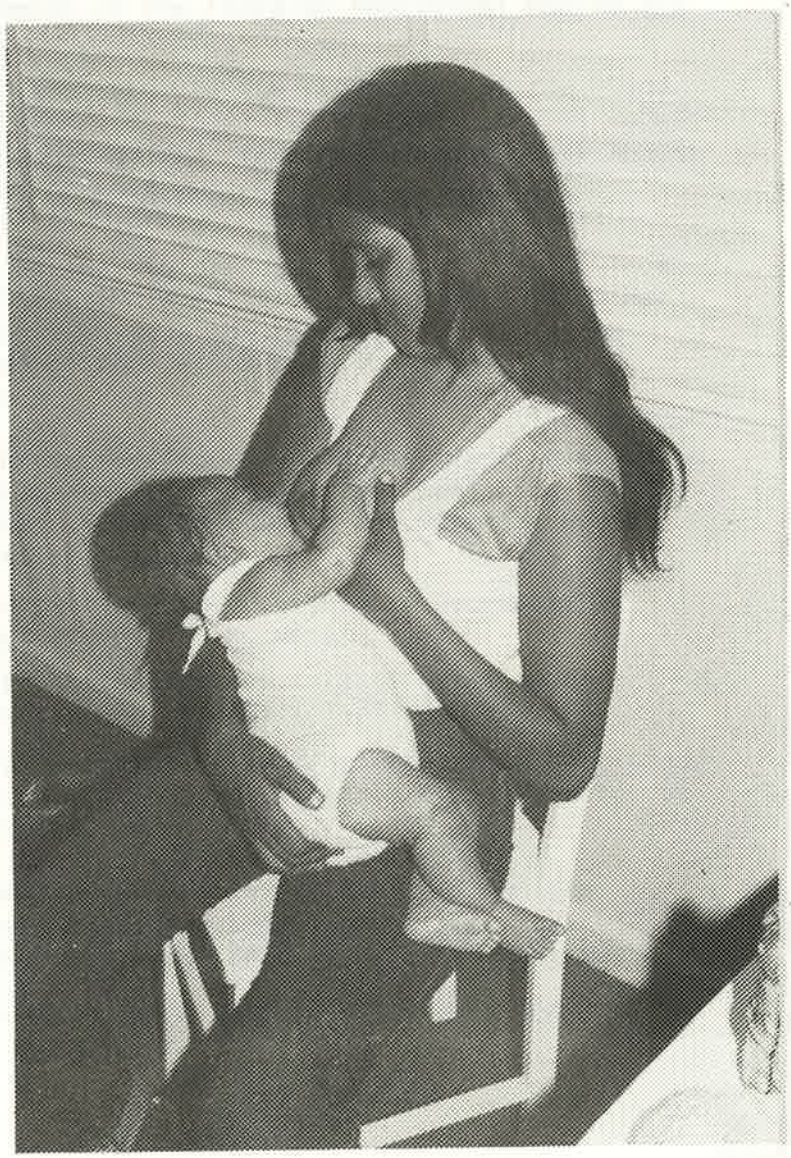
NMAA criteria suggests at least nine months breastfeeding to qualify as a Counsellor. If there was some doubt about that fact some people felt permission to train should not be granted. They believed, again, that differentiating between Aboriginal and white Austalian women was not justified.

Those supporting Grace's application highlighted the difficulty in strict adherence to this practice in a situation where the premise was that there had been very few Aboriginal women who breastfed at all.

Resolution

Eventually, as can happen within the structure of NMAA in special circumstances, it was decided to waive the requirement.

It is clear from all this that many people and attitudes and practices underwent change as a result of the Outreach project.



Many Aboriginal Outreach Worker trainees have been able to use their training for entry into further education. They are all actively promoting breast-feeding in the Aboriginal community in more ways than originally envisaged.

In effect, their influence has extended well beyond the cope of the objectives and breastfeeding promotion has been integrated into a variety of Aboriginal health and education programmes.

ABORIGINAL OUTREACH I

- OUTCOMES

"Everyone's talking about breast feeding!"

Lorna Gordon

After completing the Outreach project, Lorna obtained fulltime employment as an Aboriginal Advisor at a local primary school in Casino. Before her death in October 1985 she did much to spread the word about the benefits of breastfeeding to her people.

Grace Close

Grace was employed by the NSW Department of Health as an Aboriginal Health Promotion Officer. She was later promoted to State Co-ordinator, Preventative Health Services - Aboriginal Health Section, NSW Department of Health in Sydney.

Her achievements in the field of Aboriginal health are numerous:

- she was instrumental in the production of the "Good Tucker for Koonies" leaflet. Wherever she has spoken Grace has stressed the need for balanced diets and in particular the need for children to breakfast sensibly if they are to achieve well at school;
- she spoke at the Conference on "Women's Health in a Changing Society" in Adelaide, September 1985. Her address was seen as a contributory factor in the formulation of four recommendations from that Conference -

  1. That breastfeeding is a woman's right which needs encouragement and support from health care services, from other women and from the whole Australian community.
  2. That work-based child care is a necessity to support breastfeeding women.
  3. That breastfeeding and infant nutrition be promoted among all Aboriginal people.
  4. That an information sharing network on Aboriginal Infant Nutrition, particularly breastfeeding, be instituted.

From her position as Aboriginal Health Promotion Officer, Grace played an important part in the preparation of the video "Babies of the Dreamtime."

Recommendations 3 and 4 were in response to Grace's paper.

"Grace was in tears after one of our (NMAA) group meetings. She said she couldn't help comparing our healthy babies with those of many of her own people."

Lorna and Grace

Both Lorna and Grace addressed a meeting of Aboriginal Welfare Workers and Department of Health personnel. They spoke confidently about the benefits of breast-feeding and compared the healthy babies at NMAA meetings with many of their own families' babies who were generally bottle fed and prone to illness. They also spoke about the voluntary nature of most of NMAA's work.

Coffee Mornings

Both women were responsible for bringing others into the Coffee Mornings to hear about breastfeeding. The more usual means of publicising such as advertisements in local papers were ineffective - no one came! Grace and Lorna talked to friends and relatives and the sessions were attended by anything from 8 to 25 women of all ages. Even grandmothers came to hear what was being said.

Grace and Lorna would lead these sessions. Support was provided in the preparation stages by Counsellors/ trainers who would also attend to help if needed.

Coraki Staff meeting

The Trainees attended and spoke at a Coraki (see map Appendix IV) Welfare Workers Staff meeting. Personnel at the meeting included Aboriginal Health Workers.

Meetings such as this introduced the Trainees to the health system in NSW and, later, when a position became vacant Grace's name was suggested.

Co-operation between groups

From the very beginning of planning and during the implementation of this project, NMAA and the NSW Department of Health, the Department of Aboriginal Affairs and CES staff entered a productive and co-operative working relationship.

Mr. Phil Donnelly, Area Director, Department of Aboriginal Affairs, wrote supporting the initial application. Hospital staff at Casino joined activities initiated by Aboriginal Outreach I and, in turn, provided opportunities for the trainees. Jan Mangleson was a member of the Board of Brunswick Byron Area Health Services (which includes two hospitals and community health programmes). She was an ideal person to make contacts in the field.

The Health Department played the major role in the production of her video "Babies of the Dreamtime" and the Breast Feed poster.

During this period NMAA personnel felt that Government Department response to them altered. The previous attitude of "little mothers" changed to an acceptance of them as informed and effective colleagues in an educative process within the community.

NMAA

NMAA were asked to speak to newly appointed Aboriginal Welfare Workers who are helping their people in the hospital at Casino - liaising with hospital staff on their behalf. The Aboriginal Welfare Workers were also included in the NMAA three-day nutrition programme arranged by a nutritionist from Outreach 1.

Training programme

The NMAA Counsellor/trainers were responsible for passing on information to the Aboriginal Trainee Outreach Workers. They found that their own material could be better organised and expressed more simply.

NMAA Counsellor/ Trainers

Many of the women who were helping to train the Aboriginal Outreach Workers found that their own skills increased:

(i) they really needed to know the material thoroughly;
(ii) their communication skills increased as they sought ways to pass the information to to women of another culture.

Several spoke of realising that a 'teacher-pupil' role was quite inappropriate. The best and most rewarding mode was that of 'mother to mother'. One younger Counsellor felt that she had benefitted from coming to terms with this mode when relating to an older woman.

NMAA

NMAA may now take an advocacy and support role in issues relating to Aboriginal women.

Trainees and Trainers

It is evident that firm and lasting friendships have been forged between the women who participated in this project - trainees, trainers, administrators and co-ordinators.

There is a sense of mutual trust and of women working together. There has also been a real co-education regarding each others' cultures.

Some sections of NMAA have now learned about the Aboriginal community and the inter-related needs of families and workers.

Changes within the Aboriginal community

Grace and Lorna who were initially embarrassed at the sight of other women breastfeeding became quite comfortable in these situations.

The term 'breastfeeding' which Health Workers felt would create a sense of embarrassment became easily accepted in the Aboriginal communities of the Trainee Outreach Workers.

Aboriginal women were talking about breastfeeding their babies.

Whilst there was no data available the observations of participants - both Aboriginal Trainees and Counsellor/trainers - were that there were more women breastfeeding their babies in the months after the project than had been doing so before it.

Poster — A "breast feed" poster was produced.

Video — A video "Babies of the Dreamtime" was produced.

Ante-natal classes — After Aboriginal Outreach I it was felt that there was a need for ante-natal classes for Aboriginal women. An attempt was made to begin such classes but failed when it was found impossible to attract Aboriginal women to attend.

Awareness of the stress on Aboriginal Outreach trainees which arose from the many Counsellor/ Trainers led to the decision that the next programme must include salaried Project Workers. This did occur in Aboriginal Outreach II.

ABORIGINAL OUTREACH I

- POSTER

"Be specific! What exactly do you want to say?"

Viv Hoskins

Purpose: As Aboriginal Outreach I proceeded it became clear that there was a real need for visual materials to communicate the message of the benefits of breastfeeding, and to promote the practice among Aboriginal women.

The response to Viv Hoskins' question - "What exactly do you want to say?" was "Breast feed".

The People: The photographer was Michael Cutcliffe from the NSW Department of Health Education Services.

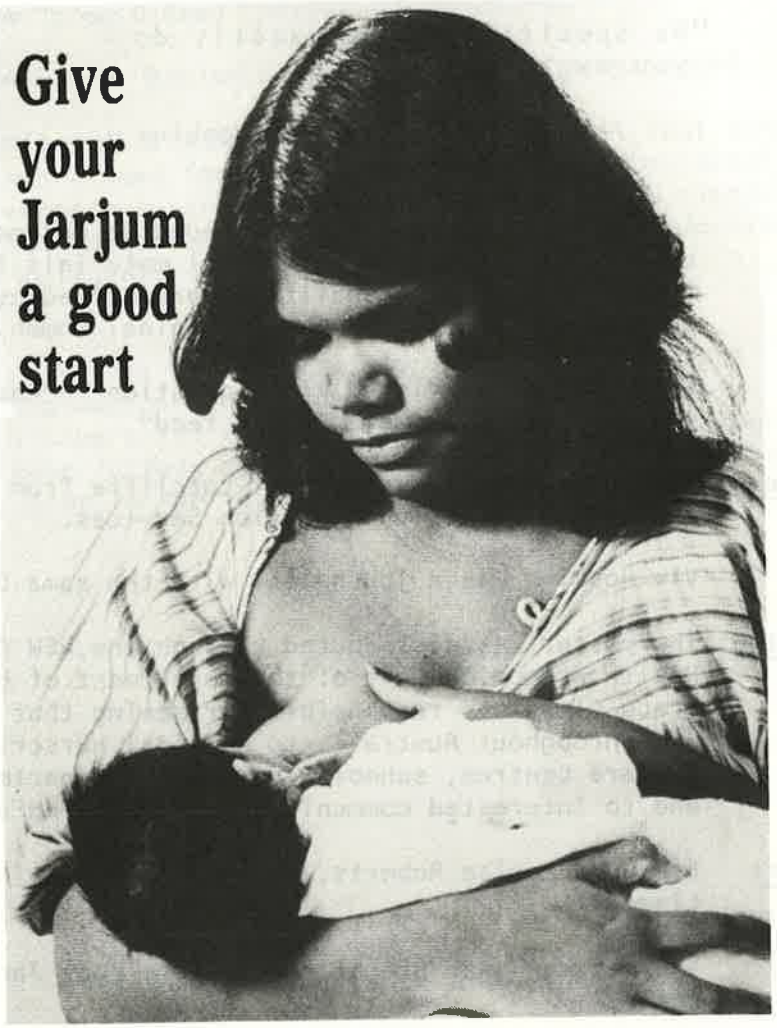
Viv Hoskins was a journalist with the same Department.

Distribution: The poster was distributed through the NSW Aboriginal Health Promotion Unit of the Department of Health. Grace Close was responsible for seeing that it found its way throughout Australia to hospital nurseries, Infant Welfare Centres, schools, government departments, NMAA and to interested community groups and individuals.

The Poster: Featured Louise Roberts, a young Aboriginal woman from Lismore.

The message was "Breast Feed: Give your Jarjum a good start".

Jarjum is the word for baby in the language of the Bunjulung tribe, who live in the Lismore district of NSW.



BREAST FEED

ABORIGINAL OUTREACH I

- FACT SHEET

Koorie Mums!

- Your breast milk is the best food you can give your baby.
- For the first six months of life babies need no other food.
- Breast milk costs no money. It's easy to carry around. It's available any where and any time.
- The temperature is always right.
- Breast milk gives protection from illness. Especially illnesses like diarrhoea which can make your Jarjum very sick.
- Breast feeding means that Mum is always near! That's so important for a Jarjum.

Give your Jarjum the best start in life. Breast milk!

For more information phone your local Aboriginal Health Worker on:

.....

nursing mothers' ASSOCIATION OF AUSTRALIA

This card is a free service by the North Coast Institute of Aboriginal Education, Lismore, and the Nursing Mothers' Aboriginal Outreach Program, P.O. Box 691, CASINO, N.S.W. 2470.

NORTHERN STAR PRINT — LISMORE

This fact sheet was produced in conjunction with the "Breast Feed" poster.

It too has been widely distributed throughout the Aboriginal community in Australia.

It is available free of charge.

ABORIGINAL OUTREACH I

- GOOD TUCKER FOR KOORIES

GOOD TUCKER FOR KOORIES

Grace Long was instrumental in the production of this leaflet distributed widely in the Aboriginal community. She worked in conjunction with the Australian Nutrition Foundation.

Some Tips About Tucker

** Good, healthy tucker means a good, healthy Koorie family.

** Good tucker means eating these foods EVERY day: FRUIT, VEGETABLES, BREAD, GRAINS, MILK, CHEESE, MEAT, FISH, EGGS or CHICKEN, SOYA BEANS, NUTS, LENTILS.

** When a Koorie mum is breastfeeding she needs to eat extra good tucker. Remember: good tucker for the mother means good milk for the baby.

** Drink lots of fresh water. Six or eight glasses a day. Water is important for the body.

** Koorie families NEED a good breakfast. Jarjums need it for their school work. EVERYONE needs a good breakfast to get them through the day.

** BAD TUCKER can hurt a Koorie family.

** Eat LESS of these foods:
FAT - clogs our blood supply; makes us fat.
SUGAR - makes us fat; causes tooth decay.
SALT - gives us blood pressure.

** Exercise is important for Koorie families. It makes us feel good. Keeps us fit. Helps us control our weight.

Good exercises are walking, swimming, playing sport or jogging.

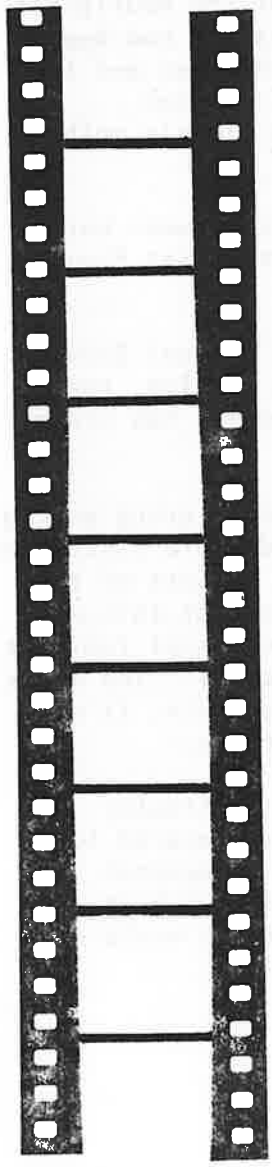
Check with a doctor BEFORE you start exercising. (Don't exercise when you're sick.)

ABORIGINAL OUTREACH I

- BABIES OF THE DREAMTIME

"The video is a good thing. It has a gunge and will reach many people."

Grace Close's mother appears in the video and died the day after making this comment to Grace.
A gunge is a spirit.



Discussions around the planning of Aboriginal Outreach I highlighted the potential usefulness of an audio-visual aid in communicating with Aboriginal women about breastfeeding.

The funds granted for the project included an allowance towards the cost of the production of an appropriate video.

Purpose:

The purpose of the video was to motivate Aboriginal women to want to breastfeed their babies. It was not an instructional film on "How to Breastfeed". The message was that the Aboriginal people had survived throughout the ages with breastfed babies. As the practice of bottle feeding became popular, Aboriginal people - babies in particular - became less healthy and more prone to illness.

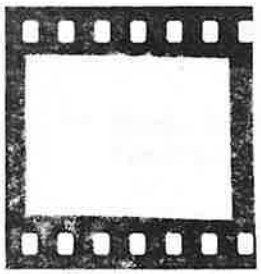
Babies should not be deprived of their birthright but should be breastfed again as they had been in the Dreamtime of the people.

Distribution:

The film was intended for distribution among Aboriginal groups and communities, to Aboriginal Health and Welfare and Community Workers.

By May 1987, ninety copies had been sold throughout the Australian community.

Distribution has been via the NSW Department of Health Education Services and the NMAA Headquarters. (Grace Close has again been instrumental in this distribution).



This was a joint project between NMAA and the NSW Department of Health.

The major contribution to the making of the video came from that department's Education Services section. Michael Cutcliffe was the guiding spirit and camera man.

There was a small working group consisting of Grace Close, Jan Mangleson, Wendy Thompson and Judy Hibberd.

The production of the video took approximately twelve months and involved much community consultation and many visits to locations around the area.

It was decided that the video would focus on healthy babies and the positive results of breastfeeding. The possibility of using 'shock tactics' by showing sick babies was rejected.

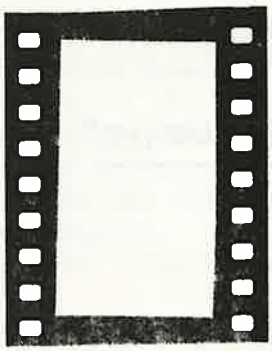
The makers went to the old people of the Aboriginal community for them to talk about what it had been like when mothers breastfed their children and to hear from them their perceptions of earlier generations. Granny Long and Grace Close's mother and aunt participated.

Questions were prepared for the interviewers but no cripting took place - personal responses from participants were used.

Personnel from the Durri Aboriginal Medical Service at Kempsey also co-operated. (This service, run by Aboriginal people for Aboriginal people, has since been disbanded.)

The video features an Aboriginal family group eating a nutritious meal. There was considerable discussion between the makers of the video and members of the Aboriginal community as to whether or not this was an appropriate inclusion as many Aboriginal families no longer come together as a unit at all. The meals are often not very nutritious. Here again, it was decided to present the positive approach.

The makers experienced considerably difficulty finding an Aboriginal mother who was prepared to appear in the video breastfeeding. On several occasions, appointments were made but not kept. A frequent reason was that male partners would not permit women to participate.



A picnic was held for members of the Aboriginal community and it was here that a young mother was found who agreed to appear.

The family groups in the video were a young couple who, with their three-week old baby, happened to call in to visit Grace. Michael had been brought up by Grace and he and Bonnie were happy to be filmed.

Throughout the making of the video a range of individuals and groups viewed the completed footage and provided input to the ongoing process.

The finished product was launched at a party for friends and relatives and supporters of all those involved in its making.

ABORIGINAL OUTREACH I

- MAKING "BABIES OF THE DREAMTIME"

(Text by Jan Mangleson)

"The journey to Baryugil from my home on the coast took four hours, the last hour over a corrugated red dust road. It had taken longer than I expected to reach our destination, with one child car sick, all of us hungry. I had spent the last half hour calculating the time I would have to leave to get back home. I was negotiating "Recommended 35KPH" stretches of road, and at one stage nearly lost the car around a hairpin bend. As we climbed higher heading south-west, I was forced to admire a beautiful wild river broken with rapids, to which the road returned at the bottom of each hill. However, it wasn't until we arrived at Baryugil, my arms still vibrating from the corrugations of the road, that I began to appreciate the countryside to which we had journeyed.

Baryugil is an Aboriginal settlement - a cluster of fibro houses around an open area of ground called the 'square'. It has a primary school, a general store and a daily mail delivery. It is eucalypt scrub country, with red soil, and as Granny Long later confirmed, very cold in winter.

We had lunch in the square under the tall gums. Gran made us some strong hot tea and made us welcome in her quiet, dignified way. Fed and rested, I was finally open to the peace of my surroundings. We were up high on a kind of a plateau, encircled by many hills. The distant mountains were blue against the horizon. Majestic gums reached to the sky. There was a sense of eternity in this land, timeless and beautiful. The stress of civilisation seemed far away. This was the ancestral home of the Bunjalum people to whom Granny Long, the midwife, belonged. "My mother told me I was born someplace there". She pointed to a nearby spot.

We had come to film Granny Long for our NMAA video. Michael Cutcliffe, our cameraman, of the Department of Health Media Unit, Grace Close, Aboriginal Health Promotions Officer for the North Coast Region of the (NSW) Department of Health, Wendy Thompson, secretary of our Outreach Programme, and myself, plus the four children who had come with us. We wanted to know about the way tribal Aboriginal women in the past gave birth, whether they breastfed their babies and how children fitted into their society. Granny Long had been a midwife, as her mother and grandmother had been before her, and she spoke, rather shy and nervous before the camera, but gradually forgetting that, of years gone by.

A large sedan drove past, throwing up dust behind it. The occupants of the car, a family group, waved to us. "That's them over there" said Granny Long, "they've got this nice new house, but they keep coming back". It was then that I learnt why the name Baryugil had sounded familiar to me - a short distance away was an asbestos mine where the Bunjalum people had worked since 1944. It is said that many have died from asbestiosis.

Granny told us that before anyone knew the mine was dangerous, the tailings from the mine were used on parts of the road, under the houses of the community, and around the school play-ground. This had since been removed, and new brick houses were built on a site a few kilometres away. The mine had closed. But some of the old people had refused to go from this beautiful place where death threatened. "This is my home", said Gran, and that was that. Others, like the people in the car, kept coming back."

(Printed in NMAA Newsletter, December 1985.)

ABORIGINAL OUTREACH I

- FINANCIAL STATEMENT

WAGE PAUSE PROGRAM

ABORIGINAL EDUCATION OUTREACH PILOT PROJECT Ref No NWE 1190
NURSING MOTHERS' ASSOCIATION OF AUSTRALIA

Statement of Receipts and Payments
for the period 15.12.1983 to 30.6.1984

RECEIPTS		
Advance 1.		16952.00
Advance 2.		10553.00
Advance 3. (Wage Increases)		1324.00
Interest Received		237.92
		29066.92
PAYMENTS		
Wages paid to		
Grace Close	7784.00	
Lorna Gordon	7784.00	
Wendy Marie Thompson	6598.00	22166.00
Labour-on-costs		
Workers Compensation Insurance	74.46	74.46
Public Liability	-	
Training Costs		
Travel & Seminar Costs	2622.46	2622.46
Capital & Materials		
Equipment	357.00	
Books	241.05	
Stationery, materials and Petty cash	690.37	
Breast Feeding Aids	28.75	
Community Service Announcement	90.00	1317.17
Typewriter		400.00
Video		249.30
Administration		
Typewriter Ribbon	10.00	
Insurance	64.00	
Telephone/Electricity	711.85	
Bank Charges	24.05	
Book keeping/Audit	200.00	1009.90
Bank Balances		
Commonwealth Savings Bank Casino	186.38	
ANZ Investment A/C Melbourne	951.25	1137.63
		29066.92

The balance being held in Bank accounts is for the production of a video, the nature of which precludes completion on due date. The subject of the video is a pregnancy, culminating in the birth of a baby and subsequent breastfeeding. It is anticipated that another two to three months will elapse before it is possible to finalise the video.

$2000 was the estimated cost of producing the video. To date $249.30 of that amount has been spent.

National Headquarters of The Nursing Mothers' Association of Australia has waived charges for out of pocket expenses for Public Liability Insurance, Pay Roll Tax and Administration expenses, including staff time, telephone and postage.
Even so there will be insufficient funds in the Bank accounts to make up the shortfall and the Outreach Project workers have agreed to raise the extra funds necessary to complete the video and to finalise the project funded by the Wage Pause Program.

.....

We certify that the above statement is a full and true record of all money received and disbursed in respect of the abovementioned project.

.....31/7/1984.....
Executive Officer

Pamela M Dagley 31/7/1984
Hon Treasurer

I have examined the accounts and records of the abovementioned organisation. In my opinion the above statement exhibits a true and fair view of transactions for the period shown and that the amounts were expended for the purposes of carrying out the approved project.

J.S. Hancock

Hungerford Hancock Offner 31/7/1984

Auditor
Hungerford Hancock & Offner
Chartered Accountants
Melbourne

ABORIGINAL OUTREACH II

- OBJECTIVE

To give Aboriginal babies the right to be breastfed with long term health benefits, both physical and emotional.

Nursing Mothers' Association of Australia will train Aboriginal mothers who have breastfed a baby and who have the motivation to help others in breastfeeding and nutritional skills.

They will then be assisted to help other mothers achieve these skills.

Source: Community Employment Programme Application Form - June 1984.

ABORIGINAL OUTREACH II

- THE PROJECT

Employed: four Aboriginal women as Trainee Outreach Workers. (Carole Dawney, 33; Leonie Binge, 32 - left the programme; Cheryl Roberts, 19; Annette Randall, 33; Lyn Landers-Cooper, 43 - left the programme; Lorraine Appo)

two Project Workers responsible for the training programme. (Sue Davidson and Jan Mangleson until October 1986 when Sue Lennox accepted the position.)

Hours: Trainee Outreach Workers - 40 hours
Project Workers - 20 hours.

Duration: 52 weeks.

Location:

2 Trainee Outreach Workers)	
1 Project Worker)	Casino, NSW
2 Trainee Outreach Workers)	
1 Project Worker)	Tweed Heads, NSW

(See Appendix 4 - Map)

Administration:
Jan Mangleson

Committee: Previous Committee plus Grace Close and Wendy Thompson. However, the Committee did not really function for Outreach II. The reason formulated is that with paid Project Officers the need had diminished.

Grant: $94,787:00

The grant was to cover salary costs for four Trainees and two Project Workers. It also allowed for travelling and administrative costs.

(A CPI increase was granted during the project.)

ABORIGINAL OUTREACH II

- THE PEOPLE

By Jan Mangleson:

Leonie Binge:

and her husband, Gary, live in Casino with their two sons. Leonie breastfed her two sons, the youngest for 4-5 years.

She helped set up "mothers' mornings" in Casino, which has now led on to a permanent playgroup at the Aboriginal Community Health Centre.

Leonie left Outreach in January 1987 due to a long-standing illness.

Cheryl Roberts:

of Casino, joined Outreach for the final three months of the programme.

She is a young mother of 19 who brought along her breastfed baby daughter, Skye, each day to all our sessions, including training days, trips to Brisbane and even a Health Promotion Workshop in Sydney for a week.

During these three months we watched Cheryl grow from a very shy person to a self-confident young woman. At the end of the programme we had a celebration night out at the Seagull Club at Tweed Heads. Cheryl and baby Skye approached visiting celebrity Tony Barber and spoke to him, proudly gaining his autograph.

Annette Randall:

from Casino worked with Outreach for twelve months and continues to work on a voluntary basis with NMAA. She is training to be a Breastfeeding Counsellor.

Annette has shown great administrative skill and has already set up two TAFE programmes for Aboriginal women, spoken at two Seminars on NMAA Outreach and is planning to commence tertiary studies in Sydney later this year.

She is currently awaiting a new Department of Health position wherein she will be employed as an Aboriginal Health Promotion Officer at Casino. We wish her all the best for her new career.

Carol Dawney:

Carol has lived for all of her 30 years in the Tweed Heads area. She has twelve brothers and sisters and all but one still live close by as well. Her mother and many aunts, uncles and cousins are a wonderful supportive part of the Tweed community.

Before starting our Outreach programme, Carol had had many jobs mostly in the prawn and fish factories. She welcomed the chance to work with mothers and children and to be able to serve the Aboriginal and Islander community.

She has admitted that before she started the programme she was very shy. She now finds an enormous increase in her self-confidence - enough for her to have enrolled in a 3 year Diploma course at the Cumberland College of Health Sciences, and to have started training as a volunteer NMAA Breastfeeding Counsellor.

Her husband, Bob, and three children, Sandy 12, Stuart 8 and Belinda 5, have been pleased with Carol's chance to be able to enrich her life in such a way.

She is held in very high esteem in the local Aboriginal and Islander community and these further studies will enhance it.

Lyn Landers-Cooper:

Lyn had recently moved to the Tweed Valley and was very pleased to be offered the chance to work on our programme. She had been involved in Aboriginal organisations in Sydney and could see the worth of our community-based programme.

Her background in working at the CAE in Lismore was very useful when we were sorting out the organisational aspects at the beginning.

She found her talents could be used to more advantage in Sydney and left the programme after approximately six months. She felt that the information she had learned on breastfeeding and counselling skills could be applied wherever she worked.

Lorraine Appo:

Lorraine, like Carol, was born in the Tweed Heads area and has lived there all her life. She welcomed the chance to be part of the programme after Lyn left and proved to be a valuable member of the team.

She worked very hard and caught up with the information already taught. She is now looking for work with babies or children and feels that her training and knowledge are going to be valuable.

ABORIGINAL OUTREACH II

- LEARNING TOGETHER

Many lessons were learned in Aboriginal Outreach 1, and the process continued in Outreach 11.

Time allocation

After Aboriginal Outreach 1 it was decided to apply for staff time for people responsible for training the Aboriginal women.

However, staff time was less than that available for the Trainees. Difficulties arose because, particularly in the early stages, it became clear that the Trainees were experiencing problems working without direct contact with staff. It was decided to use more staff hours in the early stages and then taper off as trainees became more independent.

However, when two of the Trainees left the programme (at different stages), the problem arose again with the replacement Trainees.

This meant that by the end of the programme the initial staffing allocations had been different from the design in the original submission. Trainers' hours were higher and, as there had been a time-lapse between Trainees leaving and new ones being selected, the total trainee hours were less than originally planned.

Relationships

There were more people directly involved in Outreach II than in Outreach I. When selecting the four Aboriginal women for the programme each was selected on her individual merits.

In hindsight it seems that more consideration could have been given to the "team" selection, i.e. how well the individuals would interact. Relationships between the first four Aboriginal women and between them and the trainers were not characterised by the same degree of friendship or trust that had been evident in Outreach I.

All involved had to come to terms with the industrial aspects of the programme and balance these with the community or voluntary ethos out of which the programme had developed.

As time went on, two Trainees left the programme and replacements were selected with consideration being given to both their own attributes and their ability to work in co-operation with the team.

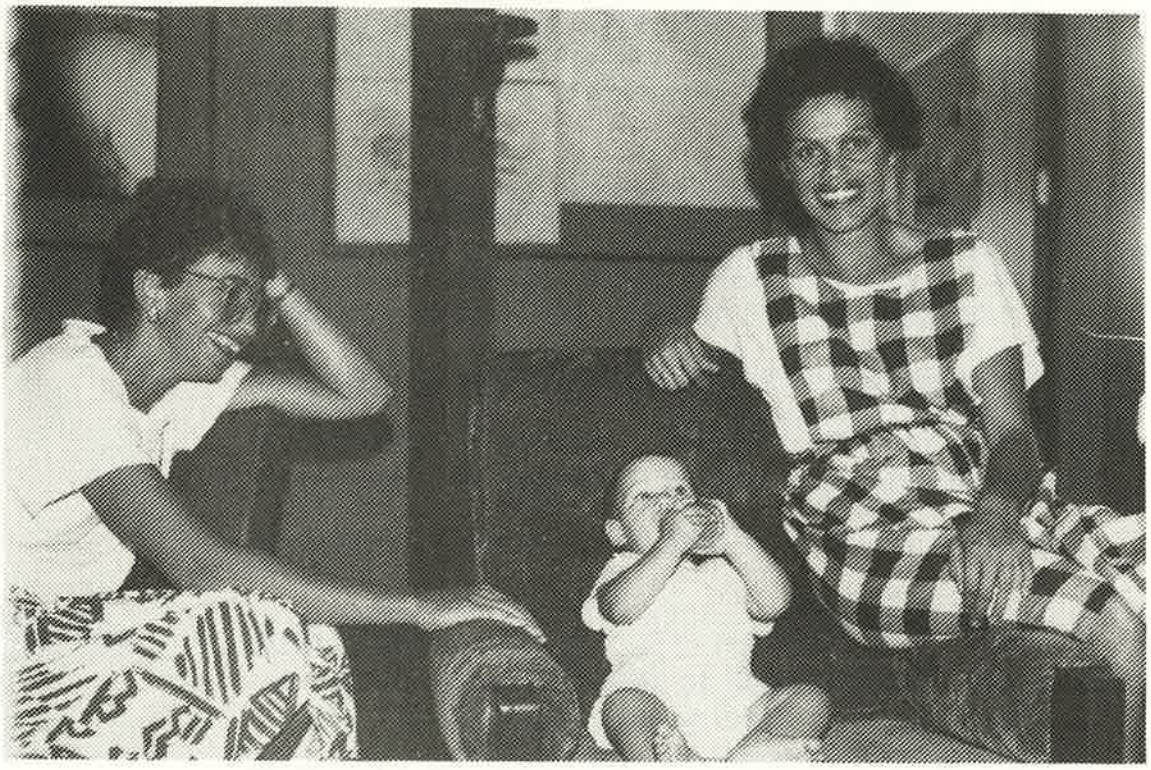
During the process of the programme, lines of accountability and individual responsibilities were gradually clarified so that all participants had a more specific base on which to operate.

Distances

The distances between Casino and Tweed Heads created difficulties when attempts were made to operate the two groups together. Not only was time needed for the travelling but with no public transport available it meant that private cars had to be used. If there were relationship difficulties and lifts were not available it often meant that one or other Trainee missed out on combined sessions.

Location

At Casino a room was available in the Infant Health Centre. This room was a well-equipped one and seemed quite suitable. However, it became clear that Aboriginal women were not comfortable - they simply did not come to gatherings planned there. Eventually, groups at both Casino and Tweed Heads met at places already identified as acceptable to the Aboriginal community.



Lorraine Appo.

ABORIGINAL OUTREACH II

- OUTCOMES

Co-operation between groups

As with Outreach I there were continuing benefits from co-operation between various community and government workers.

Jan Mangleson was invited to lecture on Breastfeeding as part of refresher courses for midwives at the Lismore Base Hospital.

The Northern Rivers College is considering including a similar course of lectures as part of its training course for nurses. This is at the request of the Student Council.

Personnel from the NSW Department of Health have attended workshops on breastfeeding (Lismore Base Hospital). The NSW Department of Health Education Services supported the project and ensure access for trainees to workshops on Women's Health and Drug and Alcohol Awareness.

Aboriginal Outreach II emphasised in the minds of community educators the need for specialised attention to Aboriginal nutrition. Grace Close continued to be an advocate and worked to establish a Diploma Course in Nutrition for Aboriginal people at the University of Newcastle. (There is now some possibility of this becoming a Degree Course).

The People

Carol Dawney:

- enrolled for the Diploma of Health Workers course at Cumberland College. She writes:

"I thought the project was very good as I was very shy when I started the programme. I have met people from all different walks of life. I can just approach people now and not be shy. I have learned how to communicate with different people. I have opportunities to attend seminars to do with what work we have done in the last twelve months. I have learned not to put myself down. I had very low esteem when I started the programme but with help from Jan and Sue I have high esteem for myself now.

I found there was no real difficulty except for when we wanted to help our mothers and we never had the backup we needed.

I have gained lots of experience in dealing with people. I have been accepted to do an Associate Diploma in Health Science and Community Development at Cumberland College in Sydney. I had opportunity to do this through doing this 12 months C.E.P. project. Also I have a job to start in about a month with Aboriginal Health in Tweed Heads. This is for four years until I have completed my course at college. I am hoping the job will become permanent.

I am happy to be able to complete my training as a Nursing Mothers' Counsellor. This was a goal I set at the start of the programme."

It was through contact with Carol that two other young women joined Outreach III.

- Monica Larcombe writes:

"I think the two girls that finished Outreach II have learned a lot out of their training. It really helped me to have Carole and Lorraine working for three weeks at the start of my programme.

I was really interested in the course Carole is doing and hope I can start the same course next year. So, after the success that came out of Outreach II I'm sure Outreach III should be even better.

If I knew what I have learned so far I am sure I would have breastfed my three children a lot longer that what I did. I really thought I knew everything but I didn't.

I know of a lot of Aboriginal and Islander ladies that are really interested in what we're doing so it will help us a lot to know we have their support."

- Gaye Travers writes:

"Through the great success of Outreach II there has been a significant community awareness in the Aboriginal community of the facilities available not only to the Aboriginal race but also to the non-Aboriginal race. The girls in Outreach II are now more confident in themselves by this informative programme that they don't feel out of place at meetings, clinics, health centres, etc.

I feel the training programmes are very worthwhile in the teachings of good nutrition, breastfeeding knowledge and Counselling skills, amongst the Aboriginal community.

Without the guidance and thoughtfulness of Jan Mangleson, Sue Davidson and all the other Counsellors involved to train Aboriginal mothers in these areas, I think most of us Aboriginal mums would still be walking around with our blinders on, unaware of the number of facilities available to us."

- Lorraine Appo:

Lorraine is also planning to do a Nutrition course. She is currently working with Aboriginal health workers at Tweed Heads on a survey of Aboriginal health.

- Cheryl Roberts:

Cheryl was only in the porgramme for approximately ten weeks. She found it quite demanding - she brought her baby, Skye, with her. She would like to become more involved as Skye gets older.

- Annette Roberts:

Annette initiated a Low-Budget Cooking Course. She wrote the submission for the course and will also administer it. The idea for these courses began when it was decided to provide nutritious morning teas for Aboriginal women participating in activities. From this came a focus on diet generally and she proceeded to meet the need for low budget cooking education.

She also initiated macrame classes for Aboriginal women and spoke at an NMAA workshop before approximately 100 people working professionally in the areas of health and nutrition.

Outreach III

From the experience of Outreach II grew the conviction that further work was needed in this area of Aboriginal health.

Outreach III was planned and has since been initiated.

Summary

The objectives of training Aboriginal women and disseminating an understanding of breastfeeding and infant nutrition would seen to have been attained.

The process of dissemination through natural networks in the Aboriginal community has continued.

Educational institutions and government authorities have acknowledged both the need for greater understanding and the suitability of the NMAA approach and philosophy.

Whilst all involved with the project recognise that this work must continue and that processes will evolve and develop, there are clear indications that there is a growing awareness of breastfeeding among the Aboriginal community.

ABORIGINAL OUTREACH II

- OUTCOMES

Building on the success of the poster and the video "Babies of the Dreamtime", it was decided after Outreach II to produce a Resource Kit on Breastfeeding for use by Aboriginal Health Workers.

RESOURCE KIT

Aim: to provide material for health workers to use as a teaching aide when meeting with Aboriginal mothers.

The ten colour-coded units will cover the following aspects of Breastfeeding:

1. Benefits of Breastfeeding - hy is it so good.
2. Getting Ready for Breastfeeding - nutrition, ante-natal preparation, physiology.
3. Breastfeeding in the Early Days - hospital, all babies are different, engorgement, relating to health professionals. W.A. Aboriginal Video.
4. Sore nipples, sore breasts, positioning, etc.
5. Problems - "Dear Della ... too little, too much, etc."
6. Eating other foods - weaning.
7. Being a mother, being a father - the breastfeeding experience, night-waking, shared beds, other children, relatives. Relevant to urban Aboriginal life.
8. When mother is sick, when baby is sick. Prem. babies, low birth weight babies.
9. Breastfeeding and contraception.
10. Old Wives' Tales, the Aboriginal breastfeeding tradition.

"Babies of the Dreamtime" Video.

TEACHING KIT

The kit sections will correspond with the resource kit and will refer back to the resource kit for specific details, e.g. Red Unit 3, para. 10.

Aim: to provide material for health workers to use as a teaching aide when meeting with Aboriginal mothers.

1. Slide Set - with accompanying notes and cassette tape.
   Produced by Outreach.

2. Talk Outline - for ante-natal talks.

3. Posters - relevant to each of the units in the resource kit.

4. Two NMAA Videos - "Babies of the Dreamtime"
   W.A. Video

ABORIGINAL OUTREACH II

- FINANCIAL STATEMENT

NURSING MOTHERS' ASSOCIATION OF AUSTRALIA

COMMUNITY EMPLOYMENT PROGRAM

ABORIGINAL OUTREACH PROJECT NCE 5165

STATEMENT OF RECEIPTS AND PAYMENTS

	ACTUAL	APPROVED GRANT
RECEIPTS		
Grant	94787.00	
Sponsorship	585.27	
Interest	149.21	
	95521.48	
PAYMENTS		
Wages - Target Group	65871.61	69315
Supervisors	22756.83	18701
Wage Increases		1596
	88628.44	89612
Materials	1323.87	1100
Transport	2062.15	2500
Equipment purchase	1092.40	1475
Equipment operation		100
Telephone and administrative expenses	2044.62	
	95151.48	94787
Unexpended funds	370.00	
	95521.48	
Sponsor Contribution		
Workers Compensation Premium	542.37	

Books, films, training course materials, sets of booklets for trainees, manual, and support and administrative assistance from National Headquarters

CERTIFICATE OF QUALIFIED INDEPENDENT AUDITOR

We, Touche Ross & Co of 36 Rutland Road, Box Hill, phone 898-9521, being qualified independent auditors and having read the CEP guidelines and funding conditions do hereby certify that we have examined the books and financial documents of the Nursing Mothers Association Of Australia, phone 877-5011.

In addition, we have satisfied ourselves that:

1. an amount equal to the total of all payments made to the above organisation as grant(s); and

2. that any revenue generated by use of grant funds

have been applied in accordance with the guidelines and conditions of the grant(s).

..... 19/6/1987

FELLOW INSTITUTE OF CHARTERED ACCOUNTANTS
REGISTERED COMPANY AUDITOR

TO BE

CONTINUED -

APPENDIX I

ABORIGINAL INFANTS

LACTOSE MALABSORPTION AND SMALL BOWEL MUCOSAL ABNORMALITIES

By: John D. Mitchell and Ferry Grunseit

Introduction:

There has been ample documentation that our Australian Aboriginal population form a socio-economically deprived minority sub-culture within our society. Their sub-standard health manifests itself in unacceptably high morbidity and mortality levels amongst their infants and children and in a significantly shortened life expectancy for those who reach adult life.

Failure to maintain a normal growth rate pattern is one of the earlier manifestations of deteriorating health in early childhood and growth retardation has long been recognised as a common finding in our Aboriginal infants and children. The role of breastfeeding in maintaining adequate nutrition is now receiving greater emphasis, at a time when early weaning is becoming more widespread. The importance of breastfeeding can be seen by comparing the weights of infants at birth and a few months later. Aboriginals have only slightly lower birth weights than do Australian Europeans and nearly parallel growth patterns occur during the first few months. After weaning from the breast however, growth rates of Aborigines begin to fall and in one study were found to have a mean weight at 23 months which was more than 3 kg. below that the Melbourne European infants. (1) This problem of early growth failure, although varying in degree between different Aboriginal communities, appears to be an almost universal finding.

Since Aborigines have birth weights which approximate to the normal for Australian standards, this fact should always be taken into account when assessing their growth at any later period. Proper assessment of the growth of any Aboriginal child can only be made by cross referencing his/her current growth percentiles with his/her own percentile at birth. This will quite frequently indicate that growth retardation has occurred, even in a child who, at the time of assessment appears to still fit into the normal range for Australian infants of that age. In other words, a few Aboriginal infants will be quite large at birth even by white standards. Such infants may grow normally for the first two to three months and then rapidly fall behind their own expected growth pattern. On first glance these infants may appear to be doing quite well in relation to other Aboriginal children.

With the onset of growth failure various biochemical manifestations of malnutrition appear and multiple nutritional deficiences can frequently be demonstrated. The incidence of anaemia rises and is usually associated with iron and folic acid deficiency. The persistence of the situation was recently shown in one western NSW township where anaemia and iron deficiency anaemia was found in 11 out of 19 part-Aboriginal children aged 6 to 23 months (2). Deficiencies of various vitamins have also been shown in mal-nourished Aboriginal infants (3) and low serum protein levels may occur (4). Abnormalities of immunological function have been reported and may play a significant role in causing the susceptibility of under-nourished children to recurrent and potentially life threatening infections (5).

Many reports have documented the chronicity of respiratory tract and gastrointestinal infections and diseases in Aboriginal children. Pneumonia and acute gastroenteritis remain the most common cause of death during childhood. Data from one state emphasises the problem. In 1972, the infant mortality for Aboriginal settlements in Queensland was 5 to 10 times that for Australia as a whole (6), while birth rates were twice that of the Australian population. This distressing picture is similar in other states with large Aboriginal populations.

Despite far greater awareness of the health problems amongst our Aboriginal children, little appears to have yet been achieved in the field of effective intervention. Major socio-economic problems continue and are accompanied by lack of awareness of health issues amongst poorly educated parents. Failure to breast feed sets the scene for the vicious cycle of inadequate nutrition, recurrent and/or chronic infections, malabsorption and increasing malnutrition. The resulting high morbidity and mortality must then continue to plague our Aborigines.

In view of this depressing scenario the development and assessment of radically new approaches appear to be warranted. One approach, to this end, is to identify problems common to most or all children that might be of importance in producing the high mortality and morbidity. Having identified any such common factor, the feasibility of widescale practical intervention in relation to the problem should receive careful evaluation before implementation. Only then will resources not be wasted unnecessarily on projects ultimately proven to be ineffective.

This approach has been used to evaluate the relevance of lactose intolerance and malabsorption in undernourished NSW Aboriginal children.

Lactose Intolerance:

Over the last decade reports have indicated that the incidence of lactose intolerance in malnourished Aboriginal children is high. (4) (7) (8) Enteric disease, whether bacterial, viral or parasitic is also common. (9) The young infant is presumably exposed to multiple enteric infections which in turn may cause chronic small bowel damage. Chronic malabsorption, diarrhoea and growth failure then tend to occur. We believe this cycle plays a significant, if not central role in perpetuating the cycle of malnutrition, infection, immunological incompetence and generalised nutritional deficiency already discussed.

Small Bowel Mucosal Damage in NSW Aboriginal Children:

Two studies reported in 1973 showed that Aboriginal children referred to Sydney teaching hospitals for investigations of chronic diarrhoea and growth failure almost invariably had marked histological abnormality of the small bowel mucosa. (10) (11) In one of these studies disaccharidase (sugar hydrolysing) enzyme assays showed a high incidence of depression of these enzymes, especially lactase the enzyme necessary for normal breakdown and absorption of the lactose sugar in milk. (10)

Since 1970, paediatricians from the Prince of Wales Children's Hospital have provided a regular consultative service to a number of NSW country towns with substantial Aboriginal populations. The problems seen in these Aboriginal communities proved similar, although often less severe, to those described elsewhere in Australia. Chronic diarrhoea was virtually an accepted norm for the Aboriginal infants and it seemed that frank watery diarrhoea needed to occur before parents became concerned enough to seek medical aid.

Lack of understanding of the significance of the infant's bowel pattern appeared to extend to the attitudes of both nursing and medical personnel in the community. After observing a number of children in hospital with undiagnosed frank lactose intolerance and explosive, fluid diarrhoea we wondered whether milder degrees of lactose intolerance might play a part in perpetuating the mild chronic diarrhoea and probably malabsorption we had noted in non-hospitalised infants in these communities. This hypothesis has been used as the basis for ongoing studies in Aboriginal children.

For the hypothesis to be valid small bowel damage and secondary hypolactasia needed to be a frequent finding in malnourished and growth retarded infants within the community. This was confirmed by performing small bowel biopsies on a group of 14 children under 3 years of age from the Brewarrina district of western NSW, who were also less than the 10th percentile of weight for age by Australian standards. All 14 children were found to have significant histological abnormalities and no mucosal disaccharidase level (lactase, sucrase or maltase) in any of the 14 infants reached the mean of the 'normal range' for our laboratory. The lactase level in 5 of the children was as low as that found in clinical lactose intolerance in healthy individuals. (12)

From these results it appeared that lactose intolerance might indeed be an important cause of the chronic diarrhoea we had observed in Aboriginal infants. This second stage in the hypothesis was tested during a milk feeding trial on infants admitted to the Brewinna District Hospital. (13) In this double and controlled trial, weight gains were compared of children fed either a normal full cream 'powdered' cow's milk formula or a low-lactose milk formula. The low-lactose milk was identical to the normal milk in all respects except for an hydrolysis step during manufacture which had split more than 85% of the lactose to its constituent monosaccharides (glucose and galactase).

At the end of the trial we found the rate of weight-gain of children fed the low-lactose milk had been 70% more rapid than that seen in children fed the normal milk. This result, at least in relation to short term feeding, confirmed the deleterious effect of lactose ingestion in these children. Since these children were only mildly undernourished we consider that the results have very real relevance to Aboriginal infants in other areas of Australia, who will regularly be more severely growth retarded.

Diagnosis and Management of Lactose Intolerance in Aboriginal Infants:

1. 'Subclinical' Lactose Intolerance

The controlled feeding trial in Brewinna has shown that many, and possibly the majority, of even mildly undernourished Aboriginal children under 3 years of age will gain weight more rapidly on a low-lactose diet. Although the effect of the long term use of such low-lactose diets (based on lactose hydrolysed milk preparations) have yet to be fully assessed, it seems likely that children will, in general, thrive better with the use of this type of dietary intervention. The cost of the lactose hydrolysed milk preparation is at present unacceptably high and must hinder the widespread acceptance of this form of management. Mass production and the introduction of more economic manufacturing processes should soon decrease costs considerably. Even the present cost should be weighed against the potential savings resulting from fewer admissions to hospital when considering the potential use of this concept of management.

2. Severe Acute Lactose Intolerance

Our studies and those of others, indicate that all young Aboriginal children with acute severe diarrhoea should be considered to be lactose intolerant until proved otherwise. The diagnosis can be confirmed by one of the following methods:

(a) A Lactose Tolerance Test - (this will usually be a quite inappropriate means of diagnosis other than in specialised units).

(b) Stool testing for the presence of reducing substances. This simple test is a modification of the 'clinical method' for detecting reducing substances in urine. (14) Stools are collected in a square piece of plastic placed inside the nappy. It is removed immediately after the stool is passed (or fluid stools can be collected on plastic after stimulation of stooling by rectal examination, using the little finger). Five drops of the fluid portion of the stool are mixed with ten drops of water in the Ames test tube and a fresh Clinitest tablet is then added. The reading of the sugar concentration is then exactly as for the testing of reducing substances in urine.

Interpretation - in the original description ½% reducing sugar was suggestive and 3/4% or more was considered diagnostic of lactose intolerance. We believe that in Aboriginal children, to consider a finding of ¼% sugar as equivocal and ½% or more as diagnostic of sugar intolerance is a more reasonable interpretation of this test.

(c) A trial of low-lactose milk and low-lactose solids diet. Our experience in Brewarrina and the Prince of Wales Children's Hospital suggests that the 'Clinitest method' of diagnosis produces a significant number of false negative diagnoses. Therefore, it is our practice to assume lactose intolerance in any young Aboriginal child who has persisting diarrhoea. A diet of low-lactose milk and lactose free solids is used as a trial for such children. Subsiding diarrhoea and improvement in weight gain over the next two to four days provides strong evidence for the existence of prior lactose intolerance.

The duration of the low-lactose diet for management of lactose intolerant infants varies considerably with age. In general, the younger the infant the longer the period of secondary lactose intolerance. We suggest that if long term dietary management cannot be used, that the diet should be maintained for at least 6 to 8 weeks in infants under six months of age. At the end of this period, although lactose intolerance is still quite likely, a good weight gain while on the diet will at least 'buy time' for a relatively complication free period of reassessment.

Diarrhoea Unresponsive to a Low Lactose Diet:

A few infants with severe diarrhoea will continue to lose weight after institution of a low lactose diet. Such children should be suspected of having severe bowel damage with decreased ability to absorb even the single sugars (monosaccharides) and the relatively unmodified protein in lactose hydrolysed low-lactose milk. Children in this category are generally at far greater risk of rapidly deteriorating. Special feed regimes ('Nutramigen', 'Pregestamil' and in the severest cases carbohyrate free formulae or elemental oral fluids such as 'Vivonex') will be needed. Preferably such children should be managed by hospital staff with considerable experience of severe gastroenteritis and malnutrition.

Rehydration:

Although not possible to discuss in detail, a few points regarding rehydration are warranted. Firstly, any child with recognisable moderate or severe dehydration must initially be treated by means other than oral fluids. Although intravenous fluids are preferable, intraperitoneal or subcutaneious routes will have a place in management in some areas of Australia. Since oral glucose and electolyte mixtures do not supply enough calories to maintain nutrition, these fluids should be used for only 24 to 48 hours to allow rehydration. After this period diluted milk or milk substitute feeds should be started and increased to near full or full strength feeds over the next 48 to 72 hours. If normal (lactose containing) milk is being reintroduced, a close watch will be needed over the ensuing few days to recognise and manage severe lactose intolerance before dehydration recurs.

The importance of maintaining an accurate daily weight record of all children with acute diarrhoea cannot be over emphasised. Increasing weight nearly always meant that the milk feeding regime being used can be continued, even if some diarrhoea persists.

Conclusion:

This paper has reviewed the topic of lactose intolerance in Aboriginal infants and put forward a 'personal view' of management of the problem. The underlying causes of the bowel mucosal damage producing the lactose intolerance in these children has not been discussed in any detail. Ongoing research and assessment in this area are urgently needed.

We hope that the findings in Aboriginal children of western NSW will form the basis for an effective means of intervention in the field of health care in all Aboriginal children. The widespread introduction of this relatively simple dietary regime should, we believe, not only decrease hospital admission rates but also cut short the length of stay necessary in hospital. Most importantly, however, management of lactose intolerance may decrease the number of life threatening emergencies associated with acute severe dehydration and electrolyte disturbances still occurring far too frequently in these unfortunate children.

Acknowledgments:

We thank the staff of the Paediatric Wards of the Brewarrina District and the Prince of Wales Children's Hospitals. We especially acknowledge the continuedsupport of Dr. Tony Lopes, Sisters Janette Halbisch, Judy Bryant (Brewarrina District Hospital), Janice Montgomery (Prince of Wales Children's Hospital) and Sister May Willoughby and Mrs. June Barker of the Brewarrina Community Health Centre of the Health Commission of NSW.

References:

1. PROPERT D.M., EDMONDS R. and PARSONS P.A. (1968)
'Birth Weights and Growth Rates up to One Year for Full-blood and Mixed-blood Australian Aboriginal Children'.
Australian Paediatric Journal 4: 134-143.

2. POWER K., VOWELS M. and GRUNSEIT F. (1977)
'Survey and Treatment of Iron Deficiency Anaemia in Aboriginal Children'.
(Submitted for publication.)

3. KAMIEN M., NOBILE S., CAMERON P. and ROSEVEAR P. (1974)
'Vitamin and Nutritional Status of a Part Aboriginal Community'.
Australia and New Zealand Journal of Medicine 4: 126-137.

4. JOSE D.G. and WELCH J.S. (1970)
'Growth Retardation, Anaemia and Infection, with Malabsorption and Infestation of the Bowel the syndrome of protein-calorie malnutrition in Australian Aboriginal Children'.
Medical Journal of Australia. i. 349-359.

5. FORD G.W., JAKEMAN M., JOSE D.G., VORBACH E.A. and KIRKE D.N. (1975)
'Migration Inhibition Factor Production by Lymphoid Cells of Australian Aboriginal Children with Moderate Protein-Calorie Malnutrition.'
Australian Paediatric Journal, 11:160-164.

6. '"Borderline Malnutrition" of Many Aboriginal Children'.
A.M.A. Gazette, 27.1.72.

7. ELLIOT R.B. and MAXWELL G.M. (1967)
'Lactose Maldigestion in Australian Aboriginal Children.'
Medical Journal of Australia, 1:46-49.

8. WALKER A.C. and HARRY J.G. (1972)
'A Survey of Diarrhoea Diseas in Malnourished Aboriginal Children'.
MedicalJournal of Australia, 1:904-911.

9. GRACEY M. (1973)
'Enteric Disease in Young Aborigines'.
Australian and New Zealand Journal of Medicine, 3:576-579.

10. HARRIS M.J., DUFFY B.J. and BEVERIDGE J. (1970)
'Studies on the Small Bowel of a Group of New South Wales Aboriginal Children'.
Medical Journal of Australia, 1:356-359.

11. WALKER-SMITH J.A. and REYE R.D.K. (1971)
'Small Intestinal Morphology in Aboriginal Children'.
Australian and New Zealand Journal of Medicine, 4:377-384.

12. MITCHELL J.D. and DUFFY B.J.
'Lactase Deficiency and Malnutrition Amongst Children of an Australian Aboriginal Community'.
Proceedings of the Vth Asian-Pacific Congress of Gastroenterology, Singapore, May 1976.

13. MITCHELL J.D., BRAND J. and HALBISCH J. (1977)
'Weight-gain Inhibition by Lactose in Australian Aboriginal Children - a controlled trial of normal and lactose hydrolysed milk'.
Lancet, 1:500-502.

14. KERRY K.R. and ANDERSON C.M. (1964)
'A Ward Test for Sugar in Faeces'.
Lancet, 1: 981.

Source: New Doctor

Dr. John Mitchell is a Paediatric Gastroenterologist at the Prince of Wales Hospital. Since 1974 he has been visiting the Aboriginal community of Brewarrina on a regular basis to examine and treat the children with gastrointestinal problems and failure to thrive. In the last two years he has been working particularly on the problem of Lactose Intolerance.

APPENDIX II

MALNUTRITION AMONGST ABORIGINES IN THE INNER CITY OF SYDNEY

By: Lou Rassaby

The Aboriginal Medical Service has experienced considerable expansion in the past year, as well as a significant change in orientation toward the health problems it faces. The first was that the Aboriginal Medical Service had, since its inception in 1970, uncovered the 'tip of the iceberg' with respect to the poor health of Aborigines in Sydney. Secondly the health problems encountered were frequently multiple with their roots in socio-economic distress, often chronic or recurrent and basically unaffected by the application of simple curative techniques. Thirdly came the belated recognition that health care services to many country areas were either ineffective, inappropriate or just non-existent and that the Aboriginal Medical Service would have to assume increasing responsibility for Aborigines outside Sydney.

There has been a tendency to study Aboriginal health in rural contexts with the consequent disregard of urban communities and their complex problems. It is now apparent that in Sydney, amidst the densest concentration of health care facilities in the state the morbidity rates amongst Aboriginal children are appallingly high and that malnutrition is widely prevalent.

The operations of the Under-five's Clinic during 1976 and 1977 yielded the following figures illustrative of the poor state of health of Aborigines in the inner city.

70% of the children seen in the clinic had growth weights below the median.
25% of children seen at the clinic had growth weights below the 3rd percentile.

In the 3rd percentile group, 80% were three years of age or younger; 64% were anaemic; 27% had proven lactose intolerance; 60% had parasitic infestation of the bowel proven by stool culture; 32% had at least one perforated eardrum. Of these unfortunate children, 20% had more than two admissions to hospital in the first year of life with an average length of stay of 88 days. This was reckoned to be a conservative figure as the Aboriginal Medical Service received discharge summaries from only four hospitals in the Sydney area, three of which accept apediatric admissions.

Demographic data, furthermore, pointed to a worsening of the situation in the future with 20% of the Aboriginal population being four years of age or younger, and 95% of the women being of childbearing age or younger.

These figures have been supported by the preliminary findings of a Health Commission survey of 185 Aboriginal children in rural and urban centres showing that by the age of three, 54% are stunted in height - evidence of chronic undernutrition, 30% are suffering from present mild malnutrition and 15% from past and current moderately severe malnutrition.

Based on a total population figure of 17,00, the Aboriginal Medical Service estimates that there are 250 Aboriginal children of three years of age or younger presently in need of urgent nutrition intervention in the inner city of Sydney. Malnutrition in this age group is associated with a greatly increased risk of chronic infections.

This malnutrition is related to the poor nutritional status of pregnant women, the prevalence of unsatisfactory infant feeding practices, especially the low incidence of breast feeding with the consequent removal of protective factors in breast milk and the exposure to repeated infection and parasitic infestation which initiates the malnutrition-infection cycle. (Shannon and Gracey, 1977)

Children so affected are unlikely to reach accepted parameters of physical and mental development and thus carry the legacy of poor nutrition and disease into adult hood.

Jose and Welch (1970) in a study of 2,250 Aboriginal children in six settlements in Queensland, found that growth retardation affected 50% of children between the ages of 6 months and 3 years; that the incidence of severe growth retardation was 16% and that this was accompanied by infections and anaemia.

Kamien (1970) in a study of Aborigines in Bourke, demonstrated multiple clinical and sub-clinical vitamin deficiences in all age groups, especially amongst pregnant women and children under three. In this group there were high rates of growth retardation, iron deficiency anaemia and parasitic infestation of the bowel.

Shannon and Gracy (1977), using the sensitive McLaren-Read index of malnutrition on 932 admissions of 624 Aboriginal children to hospital in Perth, indicated an incidence of malnutrition close to 50% with an average length of stay of 12 days, almost twice the figure for the non-Aboriginal population.

In a longitudinal study over 20 years of infant weights at Cherbourg in Queensland, Fysh et al (1977) found that although the mortality rate had dropped dramatically in that time, the morbidity rates remained high and the growth weights low. This study indicated that although the people had learned to use the hospital and health care facilities appropriately, little impact had been made on their nutritional status.

These studies all establish a clear imperative to evolve new, culturally sensitive preventive health programmes that give priority to the nutrition of children and pregnant and lactating women.

The ineffectiveness of past health programmes has, I believe, been due to the ignorance and rigidity of health planners and reflects a complete failure to comprehend the causes and modes of ill-health in the Aboriginal community. There has been a very basic failure to ascribe proper importance to nutrition in health and the role of the mal-nutrition-infection cycle in the first three years of life; a failure to encourage nutrition programmes initiated and implemented by Aborigines themselves and finally, there has been a failure to significantly alleviate the extreme poverty of most Aboriginal communities.

The Aboriginal Medical Service has always acknowledged the pre-eminence of prevention over cure but, until recently, has been logistically unable to implement preventive programmes. It did, however, manage to establish a fruit and vegetable run five years ago as an emergency measure for families in economic crisis or with members nutritionally 'at risk'. All children on or below the 3rd percentile for weight were placed on the run and over the five year period almost a third showed improvement as evidenced by weight gain over the 3rd percentile. It is not, of course, suggested that it was the fruit and vegetables alone which produced this improvement.

In June of 1977 a nutrition committee consisting of a doctor, nutritionist, Aboriginal health worker and accountant was formed to design an appropriate nutrition programme for Aborigines in the inner city of Sydney. It was formulated along the lines of the successful WIC programme (Women, Infants, Children) implemented amongst Arizona Indians in the USA.

Despite favourable evaluation by both federal and state departments of health, the Department of Aboriginal Affairs refused to fund the programme. This was ostensibly because of lack of monies in its budget for Aboriginal Affairs, despite the $16,000,000 unspent from the previous year's budget which returned to consolidated revenue.

The question of funding the first preventive nutrition programme in Australia thus entered the political arena and, following extensive media publicity and intensive lobbying by the Aboriginal Medical Service, the government finally agreed to partially fund the proposed programme for two years. The lion's share of the cost of implementing the programme was born by the Freedom From Hunger Organisation which, in an extraordinary gesture, offered the Aboriginal Medical Service $190,000 to be spent over three years, judged to be the minimum period over which the impact of the programme could be assessed. Behind the fervour with which the campaign for funds was waged lay an important principle - the necessity for community control over future health programmes as against administration by beneficent government departments and their bureaucratic organisation.

The new nutrition programme stands in central relation to the activities of the Under-five's Clinic and the Ante-natal Clinic. The UFC in particular, has been operating successfully for two years and has documented approximately 250 children to date. Using simplified percentile charts and the Road to Health concept as an educational tool the Under-five's Clinic attempts to be far more comprehensive than the traditional outpatient paediatric service and Baby Health Centre.

The essential activities of the Under-five's Clinic rest on the four corner-stones of Treatment, Weighing, Health Education and Immunisation. (Morley, 1973)

Our experience of the Under-five's Clinic has been highly encouraging and we recommend the establishment of similar clinics in other Aboriginal communities. Given the prevalence of undernutrition and malnutrition, weight as a predictor of health is an exceptionally valuable concept to use for diagnostic purposes, for monitoring effects of therapy and perhaps most importantly as an educational device for parents and Aboriginal Health Workers.

The nutrition programme aims at food supplementation to groups considered 'at risk' in the community. Initially these will be pregnant and lactating women and children below the age of three years. It may later include diabetics and the elderly. It has an extensive educational component indivisible from the provision of food so that a 'handout' situation is avoided as much as possible. Patients seen at the Under-five's Clinic or Ante-natal Clinic may be judged at risk according to nine factors (see Appendix).

Once included on the programme, the patients are weighed, baseline biochemical investigations are done and dietary patterns are assessed on a 24-hour recall basis.

The patients then obtain a food parcel at low cost from the nutrition room. Items in the food parcel were selected with consideration given to their known acceptability to the Aboriginal community as well as their nutritional value. They provide high percentages of the Recommended Daily Allowance of calories, protein, vitamins and Calcium for each group of 'at risk' persons (see Appendix B). The parcels will be obtained on the same basis each fortnight after a visit to the clinic when serial weights will be recorded and periodic biochemical investigations done in order to monitor improvements in nutritional status. The programme also has other built in controls for evaluating its success over two years.

Demonstrations of food preparation, audio-visual presentations, reading matter and poster/photograph displays of aspects of nutrition and its relation to health. Great importance will be attached to the informal social setting in which nutritional education will be disseminated. It is hoped that the nutrition room and waiting room will become popular communal centres, educational in themselves rather than relying on formal teaching methods. A nutritious food outlet will also be established in the nutrition room and it will function as a child-minding facility, being permanently staffed by an Aboriginal Health Worker.

Educational materials will be distributed in the food parcels. Themes will be varied with each fortnightly package so as to be comprehensive and of maximal interest to the recipient.

Finally, the parcels are seen as being educational in themselves and it is hoped families will continue to buy foodstuffs of the kinds provided in the parcel.

The programme is an ongoing one with plans for a food co-operative in the near future, expansion of the education programme to include formal classes in cooking, provision of training in aspects of nutrition to Aboriginal health workers and the dissemination of nutritional information and skills to other Aboriginal communities. Apart from an improvement in health the benefits accruing from the programme are many.

Firstly, it will serve as a model for similar self-initiated, self-help programmes in other Aboriginal communities.

Secondly, it will be a source of employment and training for Aboriginal health workers who are going to make the greatest and most significant impact on the health of their people.

Thirdly, the success of the programme will result in a huge cost saving benefit for governmental organisations at present committed to coping with the disastrous sequelae of poor nutrition amongst Aboriginal people. The total cost of the programme is $60,000 per year, whereas the cost of hospitalising our clinic's 3rd percentile children for the same period is at least $250,000.

Underscoring the whole argument for nutrition programmes must remain the recognition that there is unlikely to be any substantial improvement in the physical and mental health of Aborigines until the socio-economic legacy of two hundred years of racism and neglect is finally eliminated.

Appendix A:

1. Birth weight less than 2,500 grams.
2. Weight below the 3rd percentile.
3. Weight for height less than 95 percent.
4. More than two hospital admissions in the first year of life.
5. Psychosocial problems in the family.
6. Age of mother less than 18 years or more than 50 years.
7. Haemoglobin less than 12 gm% or Haematocrit below 38%.
8. Congenital abnormality.
9. Poor dietary pattern.

Appendix B:

Food supplements will be made available at low cost to all children in the 0-3 year age bracket considered 'at risk' according to established (9) criteria. This supplement will provide the following percentages of the RDA for children of this age range:

Calories	67%
Protein	219%
Iron	124%
Vitamin C	216%
Calcium	156%
Retinol	188%

Thiamine	312%
Riboflavin	436%
Niacin	139%

Digestilact will replace the more acceptable Sunshine Milk in those children with lactose intolerance, slightly increasing the provision of iron, vitamin C and retinol.

Food supplements will also be made available at low cost ($2/packet) to all pregnant and lactating women attending the Aboriginal Medical Service and all others 'at risk'. Items were selected with consideration given as their known acceptability in the Aboriginal community as well as their nutritional value.

Food supplementation will contain the following, in fortnightly packages:

1 dozen eggs
500 gm Kraft cheese
750 gm Sanitarium Wheatbix
1.25 kgs Sunshine Milk
14 oranges
115 gm Vegemite

References:

1. KAMIEN M. and CAMERON P. (1974)
'An Analysis of White and Aboriginal Children Under Five Years Admitted to the Bourke District Hospital from September 1971 - August 1972'.
Australian Paediatric Journal, 10:343-349.

2. SHANNON T. and GRACEY M. (1977)
'Aboriginal Children in Hospital'.
Medical Journal of Australia, Special Supplement, 1:11-13.

3. JOSE D. and WELCH J. (1970)
'Growth Retardation, Anaemia and Infections with Malabsorption and Infestation of the Bowel'.
Medical Journal of Australia, 1:349.

4. FISH W., DAVISON R., CHANDLER D. and DUGDALE A. (1977)
'The Weights of Aboriginal Infants: a Comparison over 20 years'.
Medical Journal of Australia, Special Supplement, 1:13-15.

5. MORLEY D. (1973) London, Butterworths.
'Paediatric Priorities in the Developing World'.

6. KAMIEN M., NOBILE S., CAMERON P. and ROSEVEAR P. (1974b)
'Vitamin and Nutritional Status of a Part-Aboriginal Community'.
Australian and New Zealand Journal of Medicine, 4:126-137.

Source: New Doctor Dr. Lou Rassaby has been working at the Aboriginal Medical Service, Redfern, since 1976. He is in charge of the Under-five's Clinic and Medical Advisor with their Nutrition Programme.

APPENDIX III

PROCEEDINGS OF THE NUTRITION SOCIETY OF AUSTRALIA

Vol.3 1978, p.91.

Infant Feeding Practices among Aboriginals in Rural New South Wales

by: T. Coyne and M. Dowling

It is reported that mortality and morbidity among Aboriginal infants living in NSW is several times higher than that of white infants (Moodie, 1969; Kamien & Cameron, 1974). Growth retardation and low blood levels of nutrients have been reported in substantial numbers of children (Edwards, 1970; Kamien et al, 1974). Little is known about infant feeding practices which may be responsible for under-nutrition and the resulting high morbidity and mortality rates.

As part of an assessment of nutritional status of Aboriginal children under five years, interviews were conducted with 146 of the mothers or guardians of a sample of the children. The children's ages ranged from one month to five years with a mean age of 37 months. All of the children except six, lived in rural communities.

Fifty-two (52) percent of the children were breastfed at birth. By three months of age this had dropped to 31% and to 16% by six months. This incidence of breastfeeding at birth is lower than the 77% reported in the Sydney area (Allen & Heywood, 1977).

Either as a first feed or upon weaning 56% of the children were given a powdered cow milk preparation with added vitamins. A further 15% were given apowdered cow milk without added vitamins. Fifty-six (56) percent of the mothers provided vitamin or mineral supplements during the first year of life. Of those, 78% chose a multi-vitamin preparation, 20% gave Vitamin C tablets, 2% iron preparation and 2% fluoride. The average duration of vitamin supplementation was 11 months. Fifty percent of infants were given fruit juices from a bottle; 31% rose hips syrups and 25% cordials. Only 4% of infants were reported to take plain water without added sugar. Approximately one third of the children (31%) were still using a bottle at the time of interview. Of those, 46% were over two years of age and 31% were over three years. Solid foods were introduced into the diet before two months of age in 20% of the children. Forty-five percent of the children were given cereal as their first food. Twenty-five percent were given commercially prepared custards, gels and puddings.

These results reflect some observations that have been made in Aboriginal communities; (i) a low incidence of breastfeeding; (ii) a prolonged dependence on bottle feeding, and (iii) a particularly high use of sugar based liquids and foods. The observation of dental caries was high.

It appears that Aboriginal mothers succumb to the appeals of advertising, for example: the trend away from breastfeeding toward widely advertised infant formulae. There is a great need for Aboriginal mothers to receive acceptable and accurate information on infant feeding.

References:

ALLEN J. and HEYWOOD P. (1977)
'Proceedings of the Nutrition Society of Australia', 2:84.

EDWARDS L.D. (1970)
'Medical Journal of Australia', 2:1007.

KAMIEN M. and CAMERON P. (1974)
'Australian Paediatric Journal', 10:343.

KAMIEN M., CAMERON P. and ROSEVEAR P. (1974)
'Australian and New Zealand Journal of Medicine', 4:126.

MOODIE, P.M. (1969)
'Medical Journal of Australia', 1:180.

APPENDIX IV

NURSING MOTHERS' ASSOCIATION OF AUSTRALIA

TRAINEE QUESTIONNAIRE - SERIES A

Part 1 - Basic Breastfeeding Knowledge and the NMAA Code of Ethics

Instructions

In answering this part of the questionnaire, we want you to show that you have a sound and thorough knowledge of the basic facts of breast-feeding and NMAA policies on the management of breastfeeding described in NMAA publications. You must also show that you are familiar with the NMAA Code of Ethics.

Answer the questions as you can, though you may make your suggestions as a series of numbered points. Some answers will have many points, while others have only a few. You may find it preferable to refer to the similar answers in TIS.1. Please do not make direct quotes - we would like you to answer as far as possible in your own words. Answer all questions.

Keep a carbon copy of your answers.

1. Marie has a baby 3 weeks old. The baby only gained 30 gms (1 oz.) last week and now cries a lot, usually about 2 hours after she is fed. Marie is trying to feed the baby on a four-hourly schedule. She is afraid her milk is going away. What suggestions can you make to help this mother build up her milk supply?

2. Margaret is in hospital and is feeling very tense. Although her breasts feel full, the baby is not getting very much, according to the test weighing. She does not understand the let down reflex. Explain to her -

   (a) what is the let down reflex, and why it is important in breastfeeding;
   (b) how she knows when it is working; and
   (c) how she can help it to work.

3. Pam is anxious because she does not know if her breastfed baby is getting enough milk. What signs can you tell her to look for?

4. Beverley asks us about introducing solids. Her baby is 3 months old. When do you suggest she start, and what signs of readiness should she look for?

5. Helen's baby is 2 weeks old. She has more than enough milk and the baby chokes and splutters at the beginning of a feed when the flow is very fast. What can you suggest to help her with -

   (a) fast flow?
   (b) over-supply of milk?

6. A mother has a problem with leaking milk between feeds. What practical suggestions can you make to help her?

7. Jenny is just home from hospital after the birth of her first baby and her nipples are very sore. What do you suggest to -

   (a) help cure the sore nipples, and to
   (b) prevent them recurring?

8. Unfortunately one of Jenny's nipples has developed a crack. Now what do you suggest?

9. Carolyn had a breast infection with her last baby. She is expecting another baby soon, and is anxious to know how to cope should it happen again. Explain to her -

   (a) what is a blocked duct and how can she recognise it?
   (b) what is a breast infection and how can she recognise it?
   (c) how she should treat both of these, and
   (d) what she can do to prevent recurrence.

10. Marion is expecting a baby in 3 months' time. She wants to know what we suggest that she do to prepare her nipples for breastfeeding. What do you tell her?

11. Nancy's baby is now 10 months old, and she has decided that she definitely wants to wean him. What suggestions can you make about weaning?

12. Judy, a very new mother, rings us in alarm because she is afraid her breastfed baby is constipated. The baby has not had a bowel motion for 4 days. Describe to her what a normal breastfed baby's bowel motions are like, and how frequently they occur.

13. Barbara is expecting her first baby in 3 weeks' time. She asks us whether there are any special foods she should or shouldn't eat while she is breastfeeding. What do you say to her?

14. Val is concerned that she is losing her milk. The baby is 5 months old and has gained well. Both mother and baby have enjoyed long peaceful times nursing, but now the baby seems to finish in about 4 minutes, then loses interest. What do you suggest?

15. You are giving a short talk about breastfeeding to a group of expectant mothers. Briefly describe what you would say about the benefits of breastfeeding.

16. Jill is pregnant and thinks she has inverted nipples. She rings us for advice. What do you suggest -

   (a) for now,
   (b) to help her when the baby is born?

17. A mother has been taking a particular drug. She rings us to find out if the drug will affect the baby. What do you tell her?

18. An insurance agent rings because you are an NMAA Group Leader. He asks for a list of members so that he can give the members information that he says they will find invaluable. How do you respond?

19. A mother phones about her baby. The baby has had diarrhoea and is now unusually lethargic. What do you suggest?

20. One of your Group members is very active in a political movement. She asks you whether she can give a short speech about her cause at the next NMAA meeting. What do you tell her?

21. One of your Group members has weaned her baby to a bottle at 6 weeks. She feels she is a failure and should resign from the Association. What do you say to her?

22. Discussion at a local Group meeting disintegrates into criticism of the local Clinic Sister. What do you as the Group Leader try to do?

(On to Page 3 for Part II - Questioning and Empathy).

Part II - Questioning and Empathy

Questioning

In the practical situation, most mothers do not volunteer much information initially and you will need to find out what the problem is by asking lots of questions.

In these two questions please write down all the questions you think would be relevant to the problem. You may find it helpful to separate your questions into groups, e.g. questions about the mother, and questions about the baby.
You do not need to give suggestions for solutions to the problem, just write the questions you might ask.

1. Shirley rings us and says - "My baby is crying all the time." What questions would you ask to help sort out the situation?

2. Mary says - "My baby is three months old and has not gained weight this week. Should I complement?" What questions would you ask Mary?

Empathy

In this part of the questionnaire, we want to see how you respond to the feelings of the mother you are counselling. Write down a sentence or two that you would make in response to the feelings that these mothers are expressing.

1. "I was so enjoying breastfeeding, but it will have to end now that my husband has lost his job. I'll have to be the bread-winner."

2. "Isn't it great! We are going to have another baby."

3. "I'm so afraid my baby will catch a chill if I bring him to the next meeting: my mother says he is delicate."

4. "The slightest thing makes me weep. I don't feel like doing anything or going anywhere."

5. "The baby has been screaming for hours, and I think I'll hit him if I have to pick him up."