FOOD & HEALTH COMMUNICATION ACROSS CULTURES:

Considerations for Health Professionals Working With Remote Aboriginal Communities

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The **Fred Hollows** Foundation

FOOD & HEALTH COMMUNICATION ACROSS CULTURES:
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Table of Contents

LIST OF TABLES & BOXES

LIST OF FIGURES

Foreword

We are delighted to introduce *Food and Health Communication Across Cultures: Considerations for Health Professionals working with Remote Aboriginal Communities*.

The development of the resource follows a structured research process of reviewing the literature, consultations with Indigenous and non-Indigenous advisors, formative research to explore strategies to provide culturally sensitive information and support healthy food choices, and qualitative research to explore and describe the practices, perceived challenges and potential ways forward for nutritionists working in remote Australian Aboriginal communities. *Food and Health Communication Across Cultures* is a product of a comprehensive and rigorous research process conducted by researchers from Menzies and their collaborators, in partnership with the Aboriginal community.

This resource includes a personal reflective journal of Dr Susan Colles who was nurtured and guided by Drs Elaine Lawurrpa Maypilama and Julie Brimblecombe throughout the process. She reflects on her own journey, the critical need for two-way learning and understanding of Aboriginal people's worldview and how it has been shaped by history and culture.

This resource responds to concerns raised over the years by a number of local Aboriginal people, leaders and stakeholders from communities with whom Menzies works, regarding nutrition related issues. It aims to provide in-depth information regarding key issues health professionals should consider when working with remote Aboriginal communities. There are many 'gems' throughout this resource. A case in point, in Section 5.3, is *The Hissy Fit Discussion Board*, exploring with parents how they might manage their children's food choices especially when under the pressure of an "I want, I want" scenario; something that all parents can relate to.

This is a rich resource that draws on both Aboriginal and Western knowledge systems and privileges the process of two-way learning. We trust that health professionals who use this resource will find it invaluable. We thank the Fred Hollows Foundation for the contribution they have made to produce this resource.

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Author Biography & Comments

I grew up in Melbourne, completing all of my schooling and tertiary education there, working for many years as a clinical dietitian and nutrition counsellor, and subsequently as a researcher specialising in weight management and eating behaviour. During this time I also lived and worked in Europe, and travelled whenever I had the chance. More recently, I spent several years working in community development and health management roles in Southern Africa and India and, just prior to joining the Nutrition Team at Menzies, spent time in Adelaide lecturing a Masters course in Nutrition and Dietetics.

Prior to taking on this project I had never visited a remote Australian Aboriginal community. Therefore, at the commencement and to a large extent throughout the duration of the project, one "lens" through which I gathered and interpreted information was that of an inexperienced researcher, nutritionist and project officer new to working with Aboriginal people within a remote setting.

Throughout the project and particularly while in the community I worked closely with Dr Elaine Lawurrpa Maypilama, an Aboriginal woman experienced in cross-cultural health communication and research. During this time Lawurrpa and I worked together as co-researchers; Lawurrpa also acted as my cultural liaison and advisor. I was also guided by the knowledgeable eye of Dr Julie Brimblecombe, worked in conjunction with other community people and along the way consulted with a range of Indigenous and non-Indigenous people who acted as guides and informants. The work of many of these advisors has been described and/or cited in this resource.

Throughout the process I also kept a reflective journal. As I wrote, I realised that my prior experiences living and working in other cultures had provided me with valuable insights into life in the "cultural minority", and had helped to lay a foundation for this cross-cultural work. An early excerpt from my journal recalls, *"...I wandered along the red dirt roads past mangy dogs dozing in the heat and felt a strong nostalgia for Africa. More than just the physical surrounds, I found myself reconnecting with and slipping into a state of being that was not driven by the clock; what I had previously termed 'African time'. Early in my days [in Swaziland, Africa] while agitating to get everyone together and get on with things, my boss had put it succinctly when she stated, 'You've got the clock, but we've got the time!' "*.

Dr Susie Colles

*Dr Susan Colles and
Dr Elaine Lawurrpa Maypilama*

Acknowledgement of Contributors

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Study Participants

The members of a remote Aboriginal community in the Northern Territory's Top End who shared their stories about food and health, and nutritionists who responded to a survey related to nutrition education in remote Aboriginal communities.

Community-based Organisations

Families as First Teachers (FAFT), Shepherdson College, whose staff and members contributed to the formative research and development of the Hissy Fit Discussion Board

The management and Aboriginal Health Workers at the Marthakal Homelands Health Service, who contributed expertise on health communication and promotion

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Thanks to Elizabeth Howell, Illustrator, for her work on the images for the Hissy Fit and Food Discussion Boards

Background

The *Food and Health Communication Across Cultures* resource was developed within the Nutrition Team at the Menzies School of Health Research during a two-year project funded by The Fred Hollows Foundation under the banner of *Nutrition Promotion and Education in Remote Settings*.

The project was conceived in response to concerns voiced over the years by a number of local Aboriginal people, leaders and stakeholders from communities with whom Menzies School of Health Research (Menzies) and The Fred Hollows Foundation work regarding diet-related issues and poor health in their communities. These people identified a need for collaborative work between nutritionists, health staff and relevant people within communities to explore and focus on health-promoting activities that are culturally integrated and inclusive of Indigenous knowledge and beliefs. They saw the need to inform people in the broader community about the origins of diet-related poor health, and holistic actions that build good health and prevent or mitigate disease. Many community members expressed a need to build on existing knowledge and culture; *"what we already know"* and to *"leave some of that knowledge here in the community"* through a two-way learning process, as opposed to more top-down approaches which supplant traditional knowledge with outside information.

These concerns and requests are not unique. The need to acknowledge and include the cultural values, beliefs, language and ways of Aboriginal groups in approaches to health education and promotion has been previously recognised by many people working in this area (see, for example, references [1–5]).

Resource Development

The following activities contributed to the development of the *Food and Health Communication Across Cultures resource:*

1. Literature Review

Early in the process a search for published literature was undertaken on databases including: Science direct; PubMed; Web of Science; EBSCOHost. The search was guided by various combinations of search terms and their abbreviations including: "Nutrition education" (abbreviation, for example – Nutrit* educat*); "Indigenous"; "Aboriginal"; "Nutrition activity"; "Nutrition program"; "Nutrition project"; "Nutrition approach"; "Nutrition intervention"; "Traditional knowledge" and "nutrition"; "Indigenous knowledge" and "nutrition"; "Aboriginal knowledge" and "nutrition". The terms "Indigenous" and "Aboriginal" and "Australia*" were variously added in order to define searches. The term "Food" was also substituted for "Nutrition".

Other methods to identify relevant literature included:

i. Bibliography searches

ii. Library-based searches for relevant books and theses

iii. Web-based searches for "grey" literature on government and non-government websites

iv. Suggestions from guides and informants

Relevant articles gathered during the search were reviewed and compiled into a written report and summary tables (summary tables in Section 2: Consider the Environment and Section 6: Consider Food). Following the initial search, newly obtained literature was continually reviewed.

2. Consultations with Indigenous and Non-Indigenous Advisors

Consultations and meetings occurred throughout the project with individuals and groups from a range of areas. Advisors were contacted and meetings organised most often through mutual introduction or self-introduction and also by chance meeting. Most discussions were informal; some occurred as a single event while others extended over several or numerous occasions. In addition to information derived through the consultations themselves, various sections of this resource have been informed by the author's observations and reflections relating to the process of consulting with Indigenous and non-Indigenous people.

FOOD & HEALTH COMMUNICATION ACROSS CULTURES:
Considerations for Health Professionals Working With Remote Aboriginal Communities

7

3. Formative Research (study 'a')

The aim of this study was to explore strategies to provide culturally specific information and approaches to support food choice and health among people in a remote Aboriginal community.

Research Abstract

In a remote Australian Aboriginal community, purposive sampling identified adults who participated in semi-structured interviews guided by food-based themes relating to the contemporary food system, parental guidance of children's food choice and channels through which people learn. Interpretive content analysis was used to identify salient themes. In discussions, people identified more closely with dietary qualities or patterns than nutrients, and valued a balanced, fresh diet that made them feel 'light'. People possessed basic knowledge of 'good' store foods, and wanted to increase familiarity and experience with foods in packets and cans through practical and social skills, especially cooking. Education about contemporary foods was obtained from key family role models and outside the home through community-based organisations, including school, rather than pamphlets and flip charts. Freedom of choice was a deeply held value; carers who challenged children's autonomy used strategic distraction, or sought healthier alternatives that did not wholly deny the child. Culturally safe approaches to information sharing and capacity building that contribute to the health and wellbeing of communities requires collaboration and shared responsibility between policy makers, primary healthcare agencies, wider community-based organisations and families.

More details of this research have been included in **Appendix i** at the end of this resource.

This research contributed both directly and indirectly to the Food and Health Communication Across Cultures resource. Salient themes and participant quotes have been incorporated as relevant into the text. These inclusions are referenced to the citation:

All numbered citations to this study within the text are denoted by the letter 'a'.

Colles, S., Maypilama, E. and Brimblecombe, J. Food, *Food Choice and Nutrition Promotion in a Remote Australian Aboriginal Community*. Australian Journal of Primary Health, 2014. 20(4): doi:10.1071/PY14033

Critical reflection relating to the processes of relationship building, community engagement and consultation, and formative research also contributed to the resource content.

4. Qualitative Research (study 'b')

The aim of this research was to explore and describe the practices, perceived challenges and potential ways forward in relation to the educative role of nutritionists working in remote Australian Aboriginal communities.

Research Abstract

Nutritionists who work or have worked in remote Aboriginal communities in Australia's Northern Territory within the last decade were identified via purposive and snowball sampling, and responded to a semi-structured survey in 2012. Content and thematic analysis was used to generate themes. Approaches to nutrition education of 33 nutritionists were collected, representing 110 years of working experience in the Northern Territory. Identified themes included: 'Community consultation is challenging', 'Partnering with local people is vital', 'Information is not behaviour', 'Localisation of nutrition education is important', and 'Evaluation is tricky'. Available time, training background and workforce structure constrained practice and those nutritionists with longer experience described a more culturally competent practice. These findings suggest that modifications in structure, training and support of the public health nutrition workforce, facilitation of professional and cultural partnerships, outcome evaluation, and localisation and evaluation of health messages may promote more meaningful nutrition communication in remote communities. These findings can inform and improve public health education skills for nutritionists transitioning from mainstream practice into Aboriginal health settings.

More details of this research have been included in **Appendix ii** at the end of this resource.

The findings of this research contributed both directly and indirectly to the Food and Health Communication Across Cultures resource. Quotes from participating nutritionists have been used to help illustrate ideas and points for consideration. Included quotes and references to information yielded from this study have been referenced to the citation:

All numbered citations to this study within the text are denoted by the letter 'b'.

Colles, S., Belton, S. and Brimblecombe, J. *Insights into nutritionists' practices and experiences in remote Australian Aboriginal communities*. In press, Aust N Z J Public Health, 2014.

5. Personal Reflective Journal

A personal reflective journal was kept wherein the author detailed numerous observations, impressions, experiences, emotions, thoughts and ideas. The journal was a part of an on-going process of activity → experience → documentation → critical reflection → activity → experience → documentation → critical reflection, etc. This process tangibly contributed both directly and indirectly to the progression of this project and the resulting resource.

A final note

It is important to acknowledge that most of the authors, co-authors and reviewers of this resource and related published literature, as well as the key advisors and voices that have collectively contributed, are predominantly inputs from non-Indigenous people. As such, the detailed content and considerations are bound to constitute a skewed perspective. As discussed throughout the following pages, the process of negotiating shared understandings around subjects and issues of the moment requires two-way dialogues between Indigenous and non-Indigenous people. This process was undertaken and explored on a small scale between the primary author (SC) and an Indigenous colleague (EM) however, the broad nature of this project has necessarily relied on literature and views accessed from people and literature within the available time and resources.

Resource Aims

This teaching and learning resource aims to provide non-Indigenous health staff with practical guidance and insights to support critical reflective practice and assist with the participatory process of health and nutrition communication, education and promotion activities that integrate both Indigenous and western belief and knowledge systems.

It additionally aims to:

• Empower Indigenous people to more effectively communicate healthy eating and shopping messages.

• Improve the health and wellbeing of people living in remote Indigenous communities.

• Assist health professionals to work within a strength-based approach, while providing insights into how best to address and manage challenges and perceived barriers that can be present in remote community health.

Who might Benefit from this Resource?

Considerations shared within this resource have the potential to hold relevance for a range of health professionals and workers who spend time in remote Indigenous settings, including:

• Nutritionists

  – Public health nutritionists

  – Community nutritionists

  – Dietitians

• Health promotion officers

• Health project officers

• Health workers

• Community workers

• Community development officers

• Nursing staff

• Other allied health staff

While the proposed content of this resource was initially conceived for nutrition and health practitioners new to the area of Indigenous health, discussions and reflections may also prove of value to health professionals more experienced in remote Indigenous settings or those in rural or urban Aboriginal settings. Although Torres-Strait Islander peoples were not specifically involved during the resource development, it is possible that some content could also be relevant and adapted for use in this area. Finally, some contained concepts may also be applicable to work in other cross-cultural situations in Australia and internationally.

Using this Resource

The Food and Health Communication Across Cultures resource is not a template or rulebook. Rather it contains a range of considerations, ideas and segments titled *'Food for Thought'*

that aim to stimulate reflection, new awareness and professional and cultural learning. Many sections also contain segments titled *'Strategies for Development'* that provide further guidance and

ideas that may be appropriate to incorporate into your working approach. The content is largely designed for contemplation – a personal process for readers to work through then reflect upon as individuals and in conjunction with those around you. The resource could also be used systematically by groups (for example in communities of practice or at weekly staff meetings) and ideas taken away for further personal reflection, learning and action.

Within this resource, Sections 1 to 4 constitute "Part I" and provide a background or backbone that aims to help develop a foundation for your work. "Part II" includes Sections 5 to 7: chapters that build on this foundation through consideration of processes more specific to supporting the two-way, or shared construction and evaluation of food- and health-related information and activities.

This resource does require a significant amount of reading. If short of time, you may choose to work through specific sections that are relevant to the current needs of yourself and the people you work with. Preferably however, you will start reading from the beginning. It is also important to acknowledge that new information and ideas must be slowly and deliberately incorporated into new ways of seeing, new patterns of thinking, and new working practices. While the content of this resource is designed to facilitate these processes, your interactions, experiences and time spent with people in their community are probably the best paths to learning and working effectively in Aboriginal health.

INTRODUCTION & OVERVIEW

After over 50,000 years living a strong, rich and diverse culture, arriving Europeans brought diseases that devastated Aboriginal populations; they also violently and systematically separated and expelled Aboriginal people from their lands, denying them access to traditional food sources bound intrinsically to good physical health and an holistic network of cultural and spiritual practices and beliefs. More than two centuries later, efforts to improve Aboriginal health have largely failed. The health of Australian Aboriginal people fares significantly worse than that of other Australians [7] and is similar to disadvantaged peoples living in lesser developed countries [8]. Within this health gap, poor nutrition plays a considerable direct and indirect role in suboptimal growth and development in children, and the excessive burden of preventable chronic disease in adults [9, 10]. Past decades have seen numerous medical and public health interventions, programs and resources aimed at improving the nutrition and health status of Indigenous Australians [11–13] .

How health is conceived – and is achieved – inevitably alters over time and also between people and cultures. Concepts of health and health promotion are tempered within environmental, social and knowledge structures. Western biomedicine conceives health or ill health as occurring to or within the physical body. This health care system segments the body into parts and diseases that are then treated separately [14]. Clinical health care approaches tend to provide medications and evidence-informed information (face-to-face and/or in written or audiovisual form), then looks to the individual to take ownership and charge of their own health and disease [14]. In this context it is vital that people have access to relevant, understandable health information so they can interpret and find meaning in health issues facing themselves, their families and communities, including possible health promotion and health care options [15–18].

Public health approaches view health from a broader perspective. In addition to the concept of personal responsibility, health is seen to be determined by an array of social and environmental factors [19]. Public health approaches seek to bolster and improve the social and environmental infrastructures that underpin good health [20]. Across these settings health communication can range from national programs and messages delivered in English via multi-media resources, to, in the case of nutritionists working with Aboriginal communities, face-to-face discussions facilitated in shared languages within local community groups. In Indigenous contexts, community initiated and managed health programs and services that integrate the social determinants of health into the health paradigm and occur within culturally safe approaches are most accepted and effective [15, 18, 21–26]. This is particularly so when health communication focuses on the specific needs of individuals, families or groups [22, 27] and modes and messages recognise, understand and integrate contemporary cultural and health-related beliefs, values and practices [3–5, 28–30].

The knowledge and skills of health practitioners are only of value to Aboriginal people if they connect with their concerns and priorities, and are conceptually meaningful and accessible. For Aboriginal people to freely choose to engage in educational activities, they need to have access to meaningful information and see, feel and understand a reason to learn more and become involved [17, 31]. This will be facilitated when health information and new knowledge is constructed in collaborative ways which are relevant and acceptable to Aboriginal people, their families and communities. Changes in the health status of Aboriginal people in part depend on this.

Health and nutrition-related work with remote Aboriginal communities is a challenging and often confronting task [32] and a specialty area that requires specific skills and competencies, many of which develop with experience [33]b. Available resources including time, personnel and funding influence workers' functional capacity, for example, high staff turnover is a major issue that impacts on the effectiveness of both short and long-term projects as well as time available to accumulate depth of knowledge and skills in applicable health areas. Cultivating an ability to work in collaborative and open ways is facilitated by acknowledging and 'knowing' ourselves as cultural and professional beings. There has been a call for non-Aboriginal health professionals to critique their own practice and consider the ways that current public health care approaches challenge or support the situations and values that have led to and continue to maintain Indigenous disadvantage [34].

Naturally a wide range of guides, workshops and resources already exist that address the process and complexity of cross-cultural work in Australian Aboriginal communities. Some of this work has been drawn upon and cited within the following pages. As an extension of this work, the Food and Health Communication Across Cultures resource attempts to take a broad view and novel perspective, as it presents a range of theoretical information, researched ideas, experiences and insights related to the role of health professionals working in nutrition and health promotion in remote Aboriginal communities. The resource makes the case and provides guidance for non-Indigenous health professionals to engage in collaborative, iterative work alongside Aboriginal people. Within the setting of broader health initiatives it is hoped that this process can more fully open shared channels of communication and understanding to create knowledge that positively influences Aboriginal health and wellbeing.

The resource comprises two parts that together consist of seven sections.

PART I: BUILDING A FOUNDATION FOR WORK IN ABORIGINAL HEALTH AND HEALTH COMMUNICATION

SECTION 1: CONSIDER YOUR SELF introduces concepts about cultural identity and knowledge structures as influences on how we see the world, learn and share ideas with others. Readers are encouraged to consider their own cultural identity and how this shapes and affects their views of health and food. The concept of critical reflective practice is examined and a number of tools to assist introspection within cross-cultural work are offered.

SECTION 2: CONSIDER THE ENVIRONMENT discusses the importance of wider historical, cultural and social issues on people's behaviour and health. Suggestions are provided on how worldviews and knowledge systems can differ, and how these differences can influence (and have influenced) misunderstandings, miscommunications and health promotion projects.

SECTION 3: CONSIDER COMMUNICATION highlights the importance of effective health communication. Practices and strategies to enhance cross-cultural and interpersonal communication are explored.

SECTION 4: CONSIDER RELATIONSHIPS discusses the imperative of forging strong relationships with community people, and possible ways to enhance work alongside local counterparts, including mentoring partnerships, reciprocity and practical approaches to two-way learning and sharing. This section also delves into the essentially on-going process of "community consultation" and provides guiding tools.

PART II: APPROACHES TO HEALTH COMMUNICATION, PROMOTION & EVALUATION

SECTION 5: CONSIDER YOUR APPROACH is divided into three parts. Section 5.1 delves into the essentially on-going process of "community consultation", providing discussion and tools to guide participatory approaches. Section 5.2 contextualises and states the need for health information and health literacy, then examines the predominant learning styles of Aboriginal people. Section 5.3 provides an overview of possible health promotion approaches and tools that may be more suited to the preferred learning styles of Aboriginal groups with whom you work.

SECTION 6: CONSIDER FOOD presents a range of notions linked with food, eating-related practices and the health of Aboriginal people and communities. These concepts have been gathered from a range of past and current Indigenous and non-Indigenous sources to offer examples of possible avenues to explore with local counterparts to facilitate discussions and shared understandings related to food and health.

SECTION 7: CONSIDER DEMONSTRATING YOUR EFFECTIVENESS provides guidance on how to evaluate health promotion and education activities with a focus on evaluation approaches, techniques and tools that can be incorporated into a cross-cultural process.

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PART I: BUILDING A FOUNDATION FOR WORK IN ABORIGINAL HEALTH AND HEALTH COMMUNICATION

SECTION 1: CONSIDER YOUR SELF
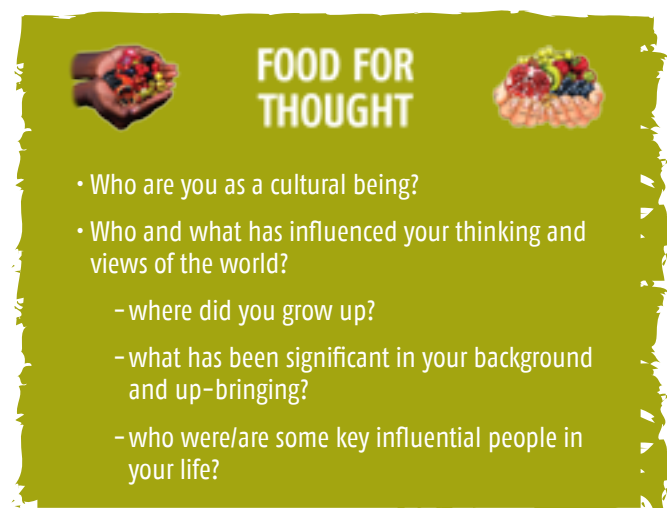
Overview

This section introduces key concepts about cultural identity and knowledge structures and how this influences how we see the world, learn and share ideas with others. Within this section you are encouraged to consider your own cultural identity and how this shapes and affects your view of your world, health, nutrition and food. As part of this process, the concept of critical reflective practice is examined and a number of tools to assist your journey of introspection and cross-cultural work are offered.

Your Personal and Professional "Culture"

Culture denotes patterns of thinking, believing and doing; the wisdom, knowledge and ways handed down from our ancestors. Inherited cultural values held to heart within cultures are often deeply held guides to behaviour. We are produced by culture; we also influence our own culture. Cultures are always in flux [1].

FOOD FOR THOUGHT

- Who are you as a cultural being?
- Who and what has influenced your thinking and views of the world?
  - where did you grow up?
  - what has been significant in your background and up-bringing?
  - who were/are some key influential people in your life?

The culture within which we are raised and educated impacts significantly on one's general approach to life. This also influences, both directly and indirectly, our approach to personal and professional relationships, methods of communication, and views on health and healthcare. The way we 'see' and 'act' in the world is also influenced by formal education, our gender, age, social and financial status. These influences become the accumulated lenses through which we all interact with life.

When we live and grow up around people who think and act in broadly similar ways, we tend to accept our ideas and views of "good" and "normal", maybe even "fixed" and "true". However, views, attitudes and belief systems are generally culture-based. This is evident the world over. The social sciences identify the importance of recognising our way of being as one way of viewing the world, and that other people view the world differently [2]. An inadvertent blindness to other ways of perceiving the world can cause us to see our "truth" as the only truth, and reject difference as wrong. We need to understand our own perspective before we can truly step into the shoes of others.

Dietitian/nutritionist, Dr Annabelle Wilson explored the role of non-Indigenous health professionals in Aboriginal health [3]. She writes,

"...as Whites¹ , we are socialised to see ourselves as racially neutral, but in fact we are not. As dietitians we are socialised to see ourselves as objective scientists. Neither of these are useful positions when working as dietitians in Aboriginal health. We need to know our positions and be aware of how they influence what we do." (p.315)

While it can be challenging and confronting to question our own views and practices, our ability to work effectively in a cross-cultural setting depends on it. The ability to successfully work within other cultures requires not only awareness, knowledge and skills, but an open attitude that fosters a sense of empathy and willingness to "walk in another's shoes". These qualities and characteristics cannot be learned through theory alone.

Culture, Cultural Competence & Cultural Safety

Sharing thoughts based on over 20 years' experience working in Aboriginal health, nutritionist, Robin Lion explained,

"...culture, in terms of patterns of thinking, believing and doing... we had to step back and look at our 'contemporary western culture' and how we are so individualistic and driven by materialism... [We had to see] how that differs to other cultural viewpoints, and that we can't take it that our cultural perspective is going to be others' cultural perspective..." [Robin Lion, Personal communication, 2013]

Culture is learned and shared behaviour; learned in that it is transmitted socially rather than genetically [4]. All cultures of the world have their defining factors but also secondary characteristics that in themselves can change constantly, dynamically influenced by people, societies, and the world [5]. This can be said of western culture and also holds true of the culture of Australian Aboriginal people, of which Hughes writes: (see overpage)

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¹ The use of the term "white" is based on the definition of Kowal (2008) who states: Calling my research participants "White" does not intimate that they all had White skin or identified as White...[ ]..Rather it implies that they willingly and unwillingly, knowingly and unknowingly, participate in the racialized societal structure that positions them as "White" and accordingly grants them the privileges associated with the dominant Australian culture. [Kowal, E., The politics of the gap: Indigenous Australians, liberal multiculturalism, and the end of the self-determination era. American Anthropologist, 2008. 110(3): p. 338-48; (p.341)]

Cultural competence is a skills-focussed term that emphasizes the idea of operating effectively in different cultural contexts. It encompasses the ability to understand, interact and communicate effectively with empathy and sensitivity, with people of different cultural backgrounds. For the individual, working and responding in a 'culturally competent' manner is enhanced through deep awareness of one's own "identity". In work-place settings these skills and qualities are not necessarily innate but can develop over time [7-9].

Individuals also need to be supported by culturally competent organisations. Culturally competent systems should ideally:

• Value diversity

• Be conscious of the dynamics that occur when cultures interact

• Institutionalise cultural knowledge

• Adapt service delivery to reflect an understanding of the diversity between and within cultures

• Have the capacity for cultural self-assessment [8](p. 7)

Indigenous cultural competency has been defined as the ability to understand and value Indigenous perspectives, thus providing the basis upon which Indigenous and non-Indigenous Australians can engage positively in a spirit of mutual respect and reconciliation [9]. **Cultural competence in health promotion** implies the incorporation of culturally sensitive concepts and practices into health promotion activities. **Cultural safety** focuses on the experience of the people receiving or involved in healthcare, or a health-related service [10]. 'Safe service' is defined by those who receive the service [11]. Cultural safety has been defined as,

"...an environment which is safe for people; where there is no assault, challenge or denial of their identity, or who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning together with dignity and truly listening." [12]

Further definitions of words, terms and jargon used to define cultural interactions, community development and cultural awareness can be accessed at http://www.whywarriors.com.au/Definitions.php See also references [13, 14].

Ways of Thinking About & Seeing the World

Vass, Mitchell and Dhurrkay have defined the concept of 'worldview' as

"the way that groups of people categorise and conceptualise their reality. ...the foundational philosophy that informs each group's perception of their respective worlds." [15](p.33)

In a case study report of an AIDS education program, the Aboriginal Resource and Development Services (ARDS) described two levels of worldview that need to be understood before communication and learning can begin [16]. These include: i) the general worldview of a people (that will be learned over time in conjunction with other aspects of people's social and cultural lives), and ii) a more specific view that relates to people's perspective on the subject(s) in question.(p.41)

The skill of 'pattern thinking' that supports an ability to hold and discern numerous coexisting dimensions simultaneously has been described by Aboriginal lawyer, Ambelin Kwaymullina of the Bailgu and Njamal people of the Pilbara in Western Australia [17].

"Imagine a pattern. This pattern is stable, but not fixed. Think of it in as many dimensions as you like—but it has more than three. This pattern has many threads of many colours, and every thread is connected to, and has a relationship with, all of the others. The individual threads are every shape of life. Some—like human, kangaroo, paperbark—are known to western science as 'alive'; others like rock, would be called 'non-living'. But rock is there, just the same. Human is there too, though it is neither the most or the least important thread—it is one among many; equal with the others. The pattern made by the whole is in each thread, and all the threads together make the whole. Stand close to the pattern and you can focus on a single thread; stand a little further back and you can see how that thread connects to others; stand further back still and you can see it all—and it is only once you see it all that you can recognise the pattern of the whole in every individual thread. The whole is more than its parts, and the whole is in all its parts. This is the pattern that the ancestors made. It is life, creation spirit, and it exists in country" (p.14).

This exceptional description highlights that all life is relational. Rather than focus on what things are, knowledge systems in Indigenous cultures tend to sense who people and entities are, and how they are related [18]. Children and adults are required to understand complicated kinship systems[2], skin groups[3] and traditional laws, holding multiple simultaneous representations [19]. These relationships extend well beyond people to include lands and plants, animals, waterways, skies and spiritual realms.

The deep knowledge underpinning the 'truth' of these teachings is however, something that is negotiable. In Yolngu[4] epistemology (theories of knowledge), truth is negotiated. The Yolngu theory of galtha sees there is:

"...no simple communication of an objective truth, but rather an ongoing struggle to weave together a useful understanding out of divergent perspectives. [20](p.76)

In this sense, "truth" is more inclusive than exclusive. Rather than a single objective "truth", truth can be constructed in various, shifting ways; it is contextual, and continually contested.

FOOD FOR THOUGHT

- How do you decide what is true, and what is not?
  - Why do you either choose to accept or question information?
  - Is "truth" a flexible notion to you?
- How do you go about resolving questions about which you are unsure?
- What factors influence your judgements?
- Can you tolerate or "sit with" ambiguity?
  - How does this feel?

Ontology, Epistemology & Paradigms

Ontology refers to 'the nature of reality': how we perceive our reality and our place in it. When viewed according to distinctions defined in modern social science, ontology tends to be grounded in either objectivism or constructionism **(See Figure 1.1)**.

Epistemology refers to 'the nature of knowledge'. This includes how we know and understand our own reality, and how 'good knowledge' is best produced (See Figure 1.1). Knowledge systems and knowledge itself are largely created in an on-going effort to generate *meaning*. Westernized cultures also tend to view reality as *definable*, and separate from our own relationship to it. This notion underpins *objectivism*. Western biomedical research and science continues to search for objective and definitive truth. *Positivism* denotes the theoretical perspective that a single, measurable truth exists. On this, Dr Annabelle Wilson reflected [3],

"As a dietitian, my university training was strongly grounded in positivism. Positivism is the name given to the theoretical perspective that a single, objective reality exists and can be discovered. That is, reality is independent and can be separated from the experiences of individuals and consequently, it can be measured. Positivist philosophies underpin science [21] ...I was encouraged to look for a truth, and taught that there is a scientific basis for disease and diet therapy. I was rarely presented with alternate views. This is not uncommon..." (p. 89)

Alternative views do exist, one being that of *constructionism* (See Figure 1.1). Constructivist views see reality and knowledge as socially constructed, *interpretive* and *contingent*; always changing; relative to each person and group, and their particular situations and circumstances [22]. Knowledge and truth are co-created through human interaction [23]. From this perspective, humans can create multiple interpretations of reality, and "truths" are obtained through agreement [24]. No single person or being knows all, nor can they completely lack bias.

Figure 1.1 (overpage) provides a visual summary of these terms used in the social sciences. These ideas are useful to explore different ways of thinking about and seeing the world.

[2] Kinship systems provide social structuring in Aboriginal societies. Within these often complex and extensive systems, people are named in relation to one another, thus determining the nature of their relationships, obligations and behaviours towards each another.
[3] Skin systems are a method of subdividing the society into named categories which are related to one another through the kinship system. Most language groups use a section or subsection system with four to eight 'skin names'. An individual gains a 'skin name' upon birth based on the skin names of his or her parents, to indicate the section/subsection that he/she belongs to.
[4] The Yolngu (or Yolŋu) are an Indigenous people from north-eastern Arnhem Land in the Northern Territory of Australia. In the Yolngu languages, Yolngu means 'person'.

Figure 1.1: Ontology, Epistemology and Research Paradigms

Adapted from Qualitative Research: Design, Analysis and Representation Workshop Notes, Dr Delwyn Goodrick, ACSPRI Program, 2013

Insights into our own cultural ways of seeing and thinking are imperative if we are to reduce any tendency to privilege one type of knowledge over another, hold closed interpretations of information, and fixed ways of seeing and doing. Of her work with Aboriginal groups in Utopia in Central Australia, nutritionist Susie Summons reflected,

"In the early days I had to stop myself from butting in and saying 'no, no, you do it this way...'. But people do things in different ways, in their own way.... When people can tell the stories in their own way you get the actual story...." [Susie Summons, Personal communication via email, 2013]

CRITICAL DIETETICS

Nutrition and dietetics are relatively new fields of enquiry that have grown within, and emerged from western biomedical science. This genesis has grounded thinking in the areas of dietetics, nutrition, and to a great extent, "food", within an objectivist epistemology and the positivist paradigm.

Critical dietetics is a new movement grounded in critical theory, a research paradigm that encourages reflective assessment and critique on society and culture (See Figure 1.1). Critical dietetics encourages practitioners to reflect critically on their successes and failures, their place in the world, and social responsibility, this includes questioning and challenging current definitions of health, approaches to health care and promotion, and the potential impacts of cultural bias on dietetic practice and public health policy [25, 26]. This new perspective acknowledges food as more than its nutrients, recognizing that human bodies, health, wellbeing and food are complex and contextual notions [2, 25].

Principles of critical dietetics include: making assumptions visible, giving voice to the unspoken, embracing reflexivity, revealing and exploring power relations, encouraging public engagement and diverse forms of expression and acknowledging that there are no value-free positions [25].

For more information refer to the referenced articles (highlighted at the end of the section) and see the Journal of Critical Dietetics at http://criticaldieteticsblog.wordpress.com/journal-of-critical-dietetics/

Critical Reflective Practice

Learning has been defined as *"the process of making a new or revised interpretation of the meaning of an experience, which guides subsequent understanding, appreciation and action"* [27](p.1). This definition highlights the importance of experience to learning. People learn through direct personal experience and also through the experiences of others [28]. For practitioners working in remote Aboriginal communities, experience gained over time clearly impacts on views and approaches to nutrition education [29]b. Considering the cross-cultural context and specialised nature of the role, one nutritionist commented, *"If you haven't lived it prior, you really wouldn't know much..."* [29]b.

Critical reflection is a higher order mental process involved in analysing, evaluating, and creating new ideas and perspectives (For a theoretical overview of ways in which thinking can be hierarchically organised see Bloom's Revised Taxonomy, **Figure 1.2**). The critical thinker begins to analyse their world, their place in it and effect upon it. Supporting concrete experience with self-reflection, particularly critical self-reflection allows us to make new or revised interpretations of experiences that can guide subsequent understanding and action [3, 30, 31].

BLOOM'S REVISED TAXONOMY

HIGHER ORDER THINKING

Creating
Generating new ideas, products, or ways of viewing things
Designing, construction, planning, producing, inventing

Evaluating
Justifying a decision or course of action
Checking, hypothesising, critiquing, experimenting, judging

Analysing
Breaking information into parts to explore understandings and relationships
Comparing, organising, deconstructing interrogating, finding

Applying
Using information in another familiar situation
Implementing, carrying out, using, executing

Understanding
Explaining ideas or concepts
Interpreting, summarising, paraphrasing, classifying, explaining

Remembering
Recalling information
Recognising, listing, describing, retrieving, naming, finding

Figure 1.2: Bloom's Revised Taxonomy

Bloom's Revised Taxonomy was altered from the original 'Taxonomy of Cognitive Objectives' developed by Benjamin Bloom in the 1950s. Bloom's Revised Taxonomy provides a way to organise thinking skills into six levels, from the most basic to the more complex levels of thinking [32].

A precondition for cultural competence is a deep self-awareness of one's own identity [33, 34]. Practitioners must be willing to question what they 'know' and the nature of this 'knowledge', and be willing to evaluate their personal and professional perspectives. This process removes the focus from accumulating information to paying greater attention to our thoughts, approaches, actions and experiences. Critical self-reflection in cross-cultural situations helps to guide learning by revealing new perspectives and providing the framework to develop new possible responses [35] (page 5/6). A commitment to self-reflection also helps to develop *mindfulness*: the tuning of one's awareness and senses into present thoughts and actions [36]. Critical reflection is also a useful form of evaluation that has been identified as a path to "emancipate" non-Indigenous health workers in Aboriginal communities from fixed cultural and personal views [3, 37].

What Constitutes Reflective & Reflexive Practice?

In the context of cross-cultural work in Aboriginal communities, critical reflection can include [3]:

- A critique of the professional's own practice [37]

- Reflection on beliefs, attitudes, values and worldviews [30, 33, 38, 39]

- Awareness of one's assumptions [38], preconceived ideas and stereotypes [40, 41]

- Knowledge of one's limitations [42]

- Questioning motivations to work with Indigenous peoples [30]

- Personal cultural situatedness [43], and an understanding of one's own cultural background [44, 45]

The process of critical reflection seeks to review and relive experiences from as many angles as possible in order to make situations and people more comprehensible. It is not concerned with the how or the how-to of action, but with what we think happened on any occasion, the why and reasons for and the consequences of what we do [36].

Reflexivity is the *"ability to locate yourself in the picture"* [46] (p.11). This is enhanced by self-awareness and reflective practice. Reflexivity fosters *"our capacity to stand apart from ourselves and examine our thinking, our motives, our history, our scripts, our actions, and our habits and tendencies. It enables us to take off our "glasses" and look at them as well as through them* [47] (p.59). In doing so we can strive to understand our complex roles in relation to others, recognising that we are active in shaping our surroundings, and the people around us [36]. Reflexive practice requires us to 'step outside' of our own belief and value systems, our habitual ways of thinking, seeing and relating. This is not easy!

A nutritionist with 18 months' experience working across three remote Aboriginal communities shared her experience of learning:

"As part of my work in three different remote Aboriginal communities I was involved in a number of group activities. Over time, I became aware of feelings of discomfort during long silences while waiting for participant responses. I often found myself trying to fill these silences with more questions or comments, which tended to result in less participant input, and, on my part even greater feelings of discomfort and futility.

One day I decided to share my frustrations with a podiatrist with whom I regularly travelled, and also with my supervisor who had worked in similar settings. After these discussions I resolved to overcome the problem by making a mental note to wait before filling the silences with speech.

...During the next workshop I found that in allowing silence other participants did take the opportunity to voice their ideas and opinions.

...A few months down the track now and I can sit comfortably in silence; I am also beginning to understand that silence is also a form of communication..."
[Anonymous]

Self reflection can be used to help us learn, in turn, altering our perspectives and behaviours. Critical self reflection extends our perspective to consider the reasons why we think and behave as we do. While reflecting more deeply we can review and evaluate situations. Taking the above scenario as an example, deeper critical reflection that includes reflexive thought might ask:

- Why do I feel discomfort in silence? Is this a personal, cultural, professional trait?

- Are others aware of my discomfort?

- How do I influence the situation by feeling edgy and filling silences?

- Am I creating or contributing to a situation or environment that is counter to my own values (for example, perpetuating a power imbalance?)

- Would I do anything differently next time? And why?

- How can I alter my personal, professional and or organisations expectations and practice to manage this?

Strategies to Increase Learning through Critical Reflective Practice

Using critical reflection to gain insights into our own conscious and (often) subconscious thoughts, feelings, values and actions enables us as health professional to move beyond the limits of our past experiences and habits. Critical self-reflection can enable us to explore and experiment with areas of our professional experience which can be otherwise difficult to approach. In doing so, we can locate ourselves in the picture. Consider our surroundings: consider our affect on our surroundings and how our surroundings affect us.

Undertaking to reflect and critique regularly, and choosing ways to do this that suit your style of working, are two strategies that can help to establish on-going learning through critical reflection. Becoming more critically reflective can be facilitated by having a conscious plan in place that guides and helps build a foundation. Three other strategies that can support this change in practice include: keeping a reflective journal, examining critical events and sharing with trusted others. These three "strategies for development" are examined below.

STRATEGIES FOR DEVELOPMENT

Keeping a Diary or Journal

- Use ways and materials to help you record, reflect on and formulate your thoughts. This might include:
  - written notes.
  - dot points.
  - mind-maps or illustrations.
  - voice recordings or note applications on your mobile phone.
  - photos or images that elicit memories you wish to reflect on.

- Set aside times and places (in your diary or planner) that will be devoted to your journal.

- Record current thoughts, observations and experiences, or reflect on past, or possible future actions.

- Strategies to help support critical practice in the work setting include:
  - Keeping a log of activities that you run or are involved in.
  - Recording your experiences and what you *feel*.
  - Reflecting on experiences while they are fresh in mind, recording relevant thoughts after discussions with people, groups or organisations.
  - Reflect on experiences that challenged your assumptions.
  - Contrast past and present experiences and situations, acknowledge change and progress over time.

- Reflect on your previous cultural experiences and identity. This might include writing your own "personal identity story", reflecting on your family history and upbringing. You might also consider:
  - If you have ever lived or worked in another culture or as a member of cultural minority, or in a situation where unequal power relations were in play.
  - How you view other cultural or religious practices outside of your personal belief system.
  - If you have spent time with people, or in places with a different sense of "time" or "personal space", or another way of *being* to your own?
  - How do you perceive that you "fit in" to the Aboriginal community/ies that you work with?

Researcher and nutritionist, Annabelle Wilson [3] tells of her approach to keeping a reflexive diary:

> "I wrote in this journal every time I had contact with Aboriginal workers or community members.... Initially I used a formalised structure with headings but as I became more familiar and comfortable with making reflections, it became a lot more informal. These headings included observation notes (what you see, hear and feel), methodological notes (how to collect data), theoretical notes (critiques of what I was doing, seeing and thinking) and personal notes (feeling statements including doubts, anxieties and achievements). ...As I became more confident in making reflections and using reflexivity, I included notes about how I might change my practice based on my reflections. (p.140)
>
> ...My reflexive journal was a "safe space" where I could debrief, and as my reflections grew in number over time, I gained the confidence to discuss them with others." (p. 292)

Examining Critical Incidents

A particularly useful way to promote professional and cultural learning and competence is to reflect on and explore arising "critical incidents" or challenges. Examining confronting situations allows us to delve deeply into moments of uncertainty, discomfort or discontent [34]. This offers a great opportunity for learning. One nutritionist and researcher discussed strategies that informed her reflective and reflexive practice including,

> "...noticing discomfort, and embracing this rather than pushing it away, was really important. This included thinking about things like what brought on the discomfort (setting? who?) and how I reacted to it. I also began to sit back in challenging situations, and rather than trying to respond immediately, I would think about what in the situation was challenging and what was going on that I did and did not know about. ... For me, always thinking about what I don't know is an important part of reflection. [Annabelle Wilson, Personal communication via email, 2014]

Researchers and practitioners can employ the process of auto-ethnography to write about their own experiences [48]. One university-based educator used this design framework to deeply reflect on a moment of disconcertment during his work in a remote Aboriginal setting [49]. This approach helped to change the way in which he viewed himself, his role, and the world within which he worked:

> "Seeing myself and the people I work with as participants in collective action, creating the world together, has enabled me to rethink my work and the world that emerges as a result of it... I am a participant (not an onlooker) and can only develop a sense of my role, and the responsibilities that go with it in the real world, on a moment to moment basis. Further they are products of the collective action; they are not something that I work out alone.(p.17)

STRATEGIES FOR DEVELOPMENT

Recall a specific recent situation that you found challenging or memorable, then consider:

• How you saw the situation?

• Who else was involved?

• How might others have seen the situation?

  – Might this be different to the way you viewed it?

  – If so, what might have been/be the impact of these varying views?

  – Considering these different views is there anything you would have done/ would do differently in a similar situation next time?

Other questions that may assist your reflections include:

• What do I think / feel / believe / value / understand about my role and boundaries?

• What I can change in my working context?

  – How can I counteract seemingly *given* social, cultural and political structures?

  – How do I and can I work with what cannot be changed?

• How do I gauge the thoughts and feelings of others?

• How can I value and honour the feelings and perspective of others, however different they are from mine?

• Do my actions match up with what I believe?

• When and why do I become stressed? What is the impact of this on my life and practice?

Sharing with Trusted Others

In order to help interpret and extend our internal dialogue it is helpful to seek the input and support of others. Finding appropriate peers and mentors with whom to engage in critical reflective discourses offers an important degree of objectivity, the benefit of other's experiences, and an opportunity to discuss and possibly, to debate.

Relationships and situations where we can share our stories and reflections can include time with Indigenous or non-Indigenous peers, health workers or supervisors, or support groups or networks such as mentoring circles and communities of practice.

FOOD FOR THOUGHT

Other characteristics and practices that may help you to build on your experiences and facilitate learning through critical reflection include:

• A desire to **engage in higher forms of thinking** (See Blooms' Revised Taxonomy).

• Regularly **making and taking time** to engage in formal reflective practice.

• Possessing:

  – **a genuine curiosity to learn**.

  – the ability to **experience uncertainty or discomfort** in order to let new meanings emerge (rather than blocking out the uncomfortable, strange or intimidating).

  – the ability to **use prior knowledge as a departure point for new inquiry** (rather that an over-reliance on prior knowledge and theories that can lead to generalisations [35]).

  – **Respect** for the various ways of seeing and doing things inherent in all cultural beings.

• A willingness to:

  – **identify or question your own assumptions and biases.**

  – **consider that the source of some 'problems' will be with ourselves, rather than with others or the our surroundings.**

  – **share your views and reasoning** and engage others in a process of joint inquiry and reflection.

  – **justify your actions or stance.**

  – **be flexible with your ideas and objectives.**

See also Section 4: Consider Relationships, A Mentoring Relationship with a Local Counterpart.

Engaging in a Challenging Process

Working as a health professional in a remote Aboriginal community can be an immense cross-cultural experience that has the potential to create high levels of uncertainty and stress [50]. In their book, Binan Goonj, Eckerman and co-authors describe a "culture shock" experienced by health workers new to Aboriginal communities [51]. During her work examining the role of non-Indigenous health professionals in Aboriginal health, Annabelle Wilson developed a *Stages of White Health Professionals Model* **(Figure 1.3)**. This model aims to offer non-Indigenous health workers with greater insights and opportunities to reflect on their present situation. She notes that while it is likely that health professionals will progress forward within the model over time, movements forwards and backwards can occur, depending on current circumstances and experiences [3](p.268).
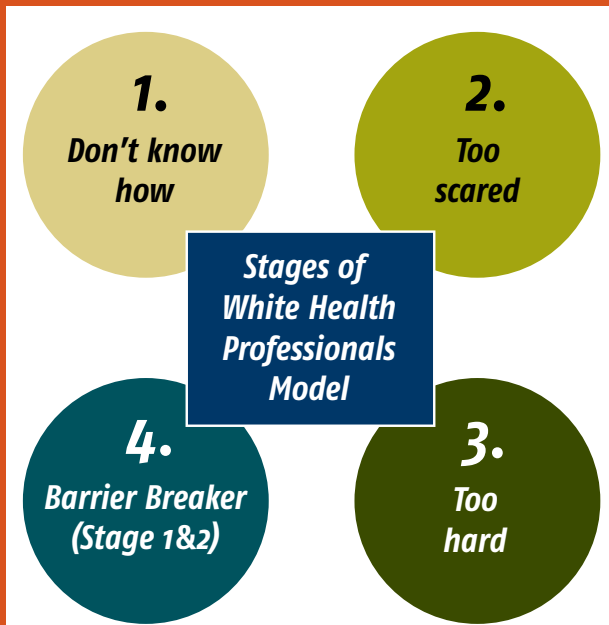
Figure 1.3: Wilson's Stages of White Health Professionals Model

Characteristics of the Stages of White Health Professionals Model include:

1. Don't know how

Ignorance; lack understanding and insights into how to work in Aboriginal health.

Lack of orientation – where/how to start, where/how to move forward.

Feeling overwhelmed, but not necessarily afraid (due to ignorance).

2. Too scared

Fear of failing, not helping and/or doing the wrong thing (based on the reasoning that they didn't know the "right way" to work).

Fear of being racist.

3. Too hard

A focus on external barriers perceived to be outside of the worker's control – e.g., systems, organisations, transport, time.

Failure to reach personal goals and targets leading to frustration and poor motivation.

Failure to engage in work or work effectively; feel like an outsider.

4. Barrier Breaker Stage 1

Aware of the many barriers in Aboriginal health but continue to work regardless.

A realistic outlook.

Significant practical experience and community engagement.

Flexible approach not constrained by fear of "doing wrong" or perception of unbreakable barriers.

Barrier Breaker Stage 2

Characteristics of stage 1 plus a clear awareness of their dominant white racial position and the implications of this; a greater awareness of Aboriginal history and ability to discuss racial issues.

[3](p.268)

FOOD FOR THOUGHT

- Which stage(s) do you identify with now?
- How does your awareness of yourself and surrounds differ from when you first started working in remote Aboriginal communities?
- If you work across several communities, do you feel that you are in different stages within different settings?
- How and why does your perspective and practice alter when you enter a new community?
- Based on the characteristics of the various stages, can you identify particular strategies you can employ that may assist you to work more comfortably and effectively?

Be Open

One characteristic common to those situated in the positivist paradigm, and as such common to the western culture, is *black and white thinking*. This style of thought can label people and situations as either 'right' or 'wrong'. When there is only one perceived way to be 'right', unfamiliar situations or situations outside of our control can easily be branded as 'wrong'. Viewing and judging other groups or cultures from our own perspective and believing (possibly subconsciously) in the superiority of one's own ethnic group is known as *ethnocentrism*.

In a remote services orientation manual [52], anthropologist Dr Jeannie Devitt talks about the cultural missionary – driven by the belief that people should be more like me, and do things more like us. She calls this "the most offensive approach" (p.8), standing in judgement of people, rather than the working with them. The Cultural Orientation Handbook of the Remote Area Health Corps [53] counsels community newcomers to:

> *"...accept community structures and characteristics for what they are. ... [and] work within these structures and characteristics, rather than battling to change what may have been well-entrenched over many generations. ...this includes avoid 'shoulds' and 'oughts'. For example, 'the mothers ought to look after their children better'...or 'they should pick up the rubbish'. ...[take] time to let these first impressions sit until you are able to see what lies beneath them, and gain an understanding of how better to work with them rather than against them".* (p. 11)

For further consideration, listen also to the TED talk, "One Story" at http://www.ted.com/talks/chimamanda_adichie_the_danger_of_a_single_story#t-68600

Consider Your Concept of Time

We and our work are ruled in part by the clock and the calendar. Westernised views break *time* into finite segments and deem it in short supply. In western culture, notions of multi-tasking, time efficiency and achieving more work in less time are generally commended. In remote Aboriginal communities this *"hurry, hurry"* approach often stands in direct contrast to views of time that are more cyclic, focused on relationships and events, rather than outcomes [54]. This dominance of time-centric approaches can undervalue more relaxed approaches to time, and disrupt the lives of local people who are continually exposed to the differing agendas and timeframes of outsiders.

Among non-Indigenous health professionals, estimates of the amount of *time* required to build meaningful relationships within communities, and understand community priorities, has ranged from three to eighteen months, with more experienced practitioners suggesting upwards of one year [29]b. To *"build expertise"*, other practitioners have suggested timeframes of at least five years [3]. For health professionals beginning their remote experience these figures may sound daunting however, rather than rush, the point is to be flexible with your sense of time. It may also be relevant to adjust expectations and ways of judging "success" away from time-oriented outcomes and benchmarks. Reflecting on her clinic-based work in Aboriginal communities, Nutritionist Bethany Prosser reflected, *"progress is often slower than we'd like, but that is actually okay. Forward is better than forcing the matter and finding you've actually made no progress whatsoever."* [55]

Fostering a more time-relaxed attitude and practice will be enhanced by managers and organisations that understand the nature of work in Aboriginal communities. By association, achieving a more time-relaxed manner can be challenged if managers, organisations or other health staff are themselves ruled by time, or view your more flexible approach as "bludging" or incompetence. If this is your experience it may be useful to discuss your views and concerns with your manager or professional mentor.

Further Reading & Viewing

Mahood, K., **Kartiya are like Toyotas. White workers on Australia's cultural frontier**. Griffith Review, 2012. 36. Available at:
https://griffithreview.com/edition-36-what-is-australia-for/kartiya-are-like-toyotas

Babakiueria ("Barbecue Area") [Director Don Featherstone, Australia 1986, 30 min]. Babakiueria is a "political mockumentary" that begins with a group of Aboriginal people approaching the Australian shoreline by boat in order to take possession of this newly discovered land. This film reverses the situation that occurred in Australia, through parody providing excellent insights into racial stereotypes. It presents many contemporary Aboriginal issues including white people as a minority, the unequal treatment of whites by the police, and white children taken from their families. It is well worth a watch. To view search under "Babakiueria" on YouTube. Available to purchase at: http://www.aicainc.org.au/videos/babakiueria-translates-as-barbecue-area/

Kanyini [Director Melanie Hogan, Australia 2006, 53 min]. In this film, Bob Randall, a traditional owner of Uluru, describes the principles of Kanyini and in doing so provides a fundamental understanding of Australia's past. Kanyini speaks of the principle of connectedness through caring and responsibility that underpins Aboriginal life, represented by a connectedness to tjukurrpa (knowledge of creation or dreaming, spirituality), ngura (place, land), walytja (kinship) and kurunpa (spirit or soul). Kanyini is nurtured through caring and practicing responsibility for all things. In his commentary, Bob Randall speaks of the present, talking about why his people are struggling in a modern world and what needs to be done to move forward. To view search under "Kanyini" on YouTube. Also available to purchase online, and may be locally available to rent or hire.

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SECTION 2: CONSIDER THE ENVIRONMENT

Overview

The core functions of health professionals working with remote Aboriginal communities inevitably vary depending on such things as the needs and wishes of funding organisations and community/ies, relevant regional or national agendas or policies, and past and present aspects of the macro and micro environments. While advocating for and aiming to meet the needs of the communities in which they work, as much as possible, health professionals need to be aware of these multi-level factors including the influence they pose to their work and the lives of those they work with. This section highlights the importance of cultural, historic, political, social and economic issues on people's behaviours and health. Various meanings of health, illness and disease are discussed alongside consideration about how these differences in personal and cultural meaning can influence (and have influenced) health communications and outcomes.

The Social Determinants of Health and Nutrition

When health information overlooks the constraints on healthy behaviours imposed by some living conditions, health education or promotion tends to focus on the individual, suggesting they are the source of the problem. When people fail to get better it is then possible to blame the 'victim'. However, when the social, economic and structural factors which either enhance or jeopardise health are acknowledged, individuals or groups cannot be seen as the source of a problem, nor the sole solution. For example, certain social and environmental factors tend to drive substance and alcohol misuse, trauma, violence and incarceration. These factors are all related with poor nutrition and ill health.

Among western institutionalised thinking, the social ecology of a people is increasingly understood as pivotal to physical and mental health. **Figure 2.2** shows a framework assembled by a group at the World Health Organisation [1]. Reading through this figure provides a basis for understanding the extent and complexity of the factors that to a greater or lesser extent determine the processes and pathways that generate health and health inequity.
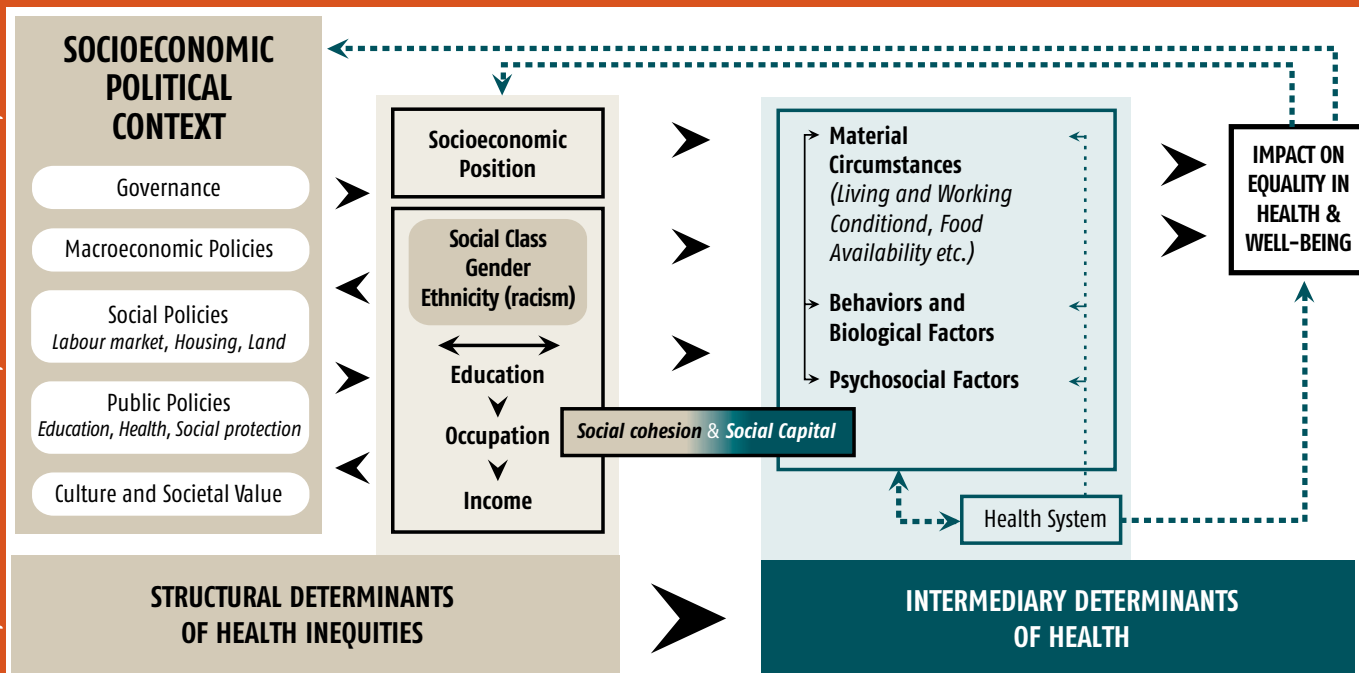
Figure 2.1: The major categories of determinants and the processes and pathways that generate health inequities

This figure defines two major categories of health determinants that impact on equity in health and well-being. Structural determinants include socioeconomic and political contexts and the socioeconomic positioning of individuals and groups, including their social class, ethnicity and opportunities for education and employment. Intermediary determinants include material, behavioural, biological and psychological factors. While structural determinants of health inequities influence intermediary determinants, it is the relationship between all factors that ultimately influence health and well-being.

Available at: http://www.who.int/social_determinants/resources/csdh_framework_action_05_07.pdf

Naturally, healthy lifestyle programs must be considered in a broad context that considers and incorporates social determinants of health within the population to whom the health information is directed [2].

FOOD FOR THOUGHT

Consider a community that you work with:

What are some of the underlying determinants likely to be impacting on people's food-related behaviours and choices, and nutritional intakes?

In attempting to manage illness and promote health, health practitioners can work within individual clinical encounters or within public health approaches [3]. Public health approaches are increasingly viewed within social-ecological frameworks that aim to acknowledge and address factors at multiple levels. In Aboriginal populations, social-ecological approaches have been applied in various ways to chronic disease prevention [4] and programs targeting smoking, nutrition, alcohol and physical activity [5]. Further references are listed at the end of this section.

Table 2.1 lists a range of factors that today can influence the nutrition of Aboriginal Australians living in remote communities. These factors occur across different contexts, from the wider structural or 'macro-environment', to intermediary and 'micro-environments'. These factors are inter-related, often existing beyond one distinct level.

Table 2.1: A range of factors influencing the nutrition of Aboriginal Australians living in remote communities

Level of Influence	Access			Availability	
	Access	Cost	Supply	Demand	Quality
Macro level Physical environment Social environment	Education level Community control / disempowerment / Cultural change Land rights and conservation laws Household infrastructure Distribution of income Misuse of substances (alcohol and tobacco)	Transport cost Community size Nature/ culture of the store enterprise Store management practices: store inefficiencies, debt recovery, external management advice Stock spoilage Pilfering	Community size Prize of food Store management practices Carrying capacity for chillers / freezers Frequency and methods of delivery Range of foods, particulary perishables	Seasonality Education level Display and presentation of fruit and vegetables Transport for shopping Storage facilities	Transportation frequency of delivery, duration, itransit temperatures
Micro level	Access to banking facilities Financial management practices Loss of traditional lifestyle and access to traditional foods Availability of culturally appropriate nutrition information Nutrition knowledge		Knowledge of consumer rights	Access to nutrition information Nutrition knowledge Awareness of relationship between preventable chronic disease and nutrition Brand loyalty	

Adapted from [6](p.389)
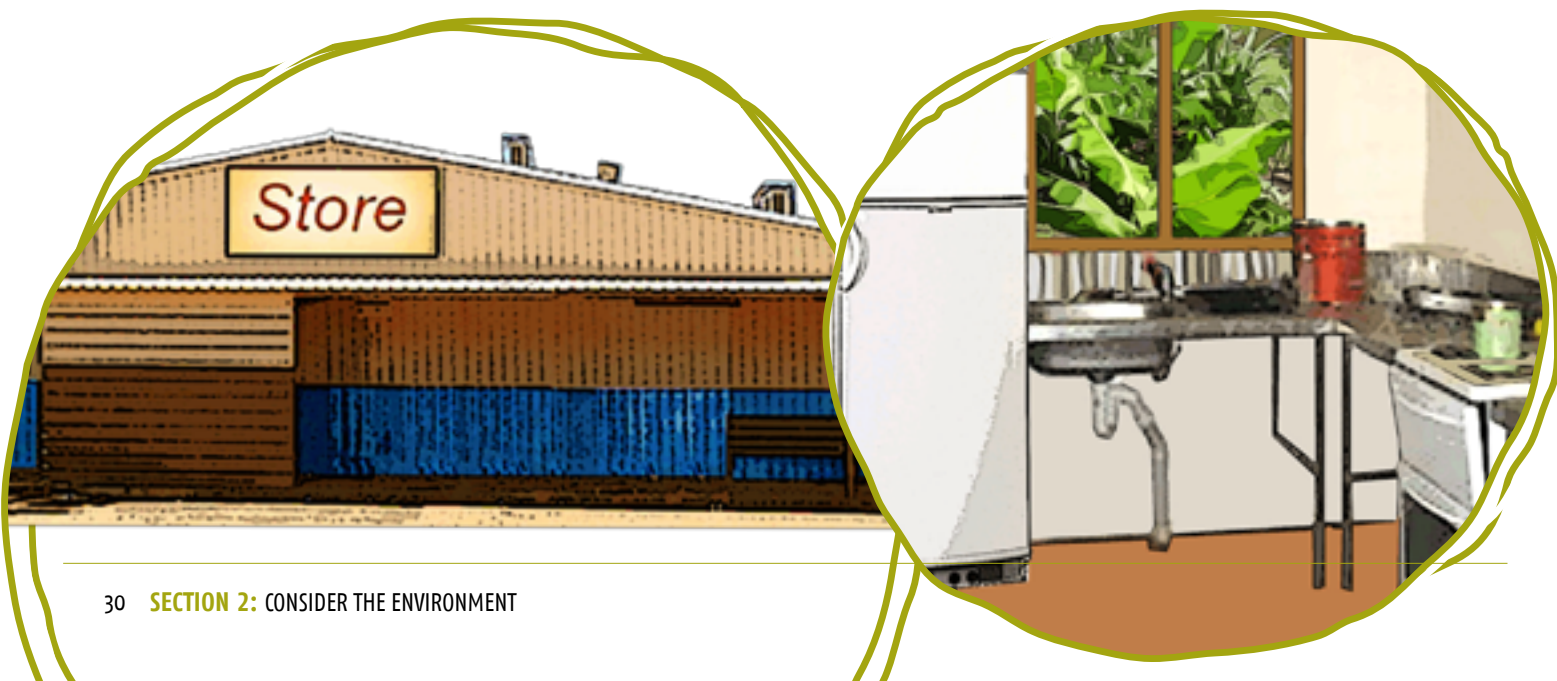
The extent to which economic and social factors impact on food choice in Aboriginal communities is rarely immediately apparent. Nutritionist, Anthea Brand, reflected,

"On an orientation trip to a remote community with a new nutritionist, this colleague noted the poor health status of people and asked if I would assist in developing a cooking and education program to improve the nutritional intakes of families; 'starting with some hygiene education...'.

On discussion with the community it became evident that there was no running water in any of the houses. People were reliant on water trucked into a couple of dilapidated water tanks. The stoves were not functioning in most of the houses and none of the houses had a fridge... The community was located about 1½ hours from the major service facility and 50 kilometres from the nearest store offering fresh food items.

...Rather than integrating an education and skills program which could not succeed given the factors impacting on peoples' ability to achieve good health, we engaged the community to work with environmental health and the shire to improve access to basic facilities and infrastructure. We also worked in with the nearby roadhouse to offer ready made and easy to prepare nourishing meal options which could be prepared with the facilities available." [Anthea Brand, Personal communication via email, 2014]

Gaining a Sense of People's History

A people's history plays a significant part in moulding the cultural lives of their present day. Clearly, the hunter-gather and spiritual heritage of Australian Aboriginal groups continues to influence cultural values and ways of being today. While there has never been one single 'Australian Aboriginal culture', these core cultural values and beliefs do tend to hold consistency among groups. Beyond a culture's deeply held meanings, all cultures change continually, reflecting the individuals and groups constituting its population.

One area of shared 'history' between Australian Aboriginal and non-Aboriginal people are the events of colonisation and the stolen generations. As for many aspects of colonised Australia's short history, non-Indigenous health professionals can forget, overlook or underestimate the intergenerational effects of these forceful acts that continue to play out in people's lives today [7]. For example, intergenerational trauma stemming from, but not limited to, disconnection from traditional lands and rituals, underpinned the switch to rations and camp/mission foods and the demise of traditional diets central to Aboriginal society.

For an examination of the influences of government policy on the food supply and diet of Aboriginal people in general in the Northern Territory from 1870 to 1972 see the PhD thesis of Dr Julie Brimblecombe (p.144). To access go to:
http://www.territorystories.nt.gov.au/handle/10070/232804

Figure 2.1 provides a brief overview of some of the events in the lives of Aboriginal people that followed European arrival. 'Wars', massacres and killings of Aboriginal peoples pepper the length of this history. Readers are strongly encouraged to follow the sourced links for a more detailed timeline and to seek other written, audiovisual and verbal sources and accounts of the history of Australian Aboriginal people both nation-wide and specific to the areas and groups with whom you work.

While it can feel confronting to think about or raise these issues, hearing and reading personal stories can provide significant insights into past and present aspects of people's lives, and serve as powerful reminders that the past continues its impact in the present. It is important to note however, that discussions about these topics are most likely to occur only within strong and trusting relationships. After extended discussions within a remote Aboriginal community [8]a, an older Aboriginal woman shared part of her story, explaining that her mother was not allowed to raise her and could therefore not pass on to her many food-related traditions:

"...I'm a Grandmother, see, but when I was young I never knew my mother... She wasn't there; I wasn't with her, and so she couldn't teach me the way her mother showed her... " [Reprinted with respondent's permission]

For an overview within one community of the different factors impacting on health at different levels from the store, to the household/ family and individual see the PhD thesis of Dr Julie Brimblecombe (p.342). See also an interesting overview, based on available archival historical information, of the different events occurring in one community relating to the development of the food supply (p 424). To access, go to:
http://www.territorystories.nt.gov.au/handle/10070/232804

Figure 2.2: A timeline of selected events in the lives of Aboriginal people following European invasion and settlement

1788

Captain Phillip raises the Union Jack at Sydney.

Aboriginal resistance flares.

New diseases introduced & many Aboriginal people die.

1838

Flour is poisoned and left in shepherds' huts on 'Kilcoy' in the expectation that Aboriginal people now dispossessed of hunting grounds would take it.

Australia Policy' appears. In 100 years the Aboriginal population has reduced from 1,000,000 to 80,000.

Every aspect of Aboriginal people's lives are controlled & confined to reserves administered by government agencies or missionaries.

1937

Assimilation policy Aboriginal people of mixed descent are to be assimilated into white society whether they want to be or not, those not living tribally are to be educated and all others are to stay on reserves.

1965

Integration policy. NT patrol officers 'bring in' and relocate the last group of Aboriginal people the Pintubi people living independently in the desert.

1970

People begin moving back to their traditional homelands. Limited land lease rights are given to Aboriginal people on NT reserves.

1992

The High Court of Australia hands down its landmark decision in Mabo v QLD, deciding that Native Title exists over particular kinds of lands and that Australia was never terra nullius or empty land.

| 1788 | 1810 | 1838 | 1869 | 1888 | 1920 | 1937 | 1962 | 1965 | 1969 | 1970 | 1972 | 1992 | 2009 |

For over 50,000 years Aboriginal people develop and thrive within a strong, rich & diverse culture, living in harmony & partnership with the land & all its inhabitants.
<50,000 – 1788

Aboriginal people begin to be **moved onto mission stations** to be taught European beliefs & used as cheap labour.
1810

Victorian Board for the Protection of Aborigines can order removal of any child to a reformatory or industrial school. Similar legislation passed in other colonies in NSW (1883), QLD (1897), WA (1905), SA (1911). NT Chief Protector becomes legal guardian of every Aboriginal and "half caste" person <18.
1869

Aboriginal population is estimated to be at its lowest at 60,000 – 70,000. It is widely believed to be a 'dying race'. Most Australians have no contact with Aboriginal people due to segregation and social conventions.
1920

The Commonwealth Electoral Act is amended to give franchise to all Aboriginal people, extending the right to vote to Aboriginal people in WA, QLD and NT.
1962

All states repeal legislation allowing removal of Aboriginal children under the policy of 'protection'.
1969

Policy of self-determination & abolition of The White Australia Policy by Whitlam government. The change means having the right to cultural and linguistic maintenance and management of natural resources on Aboriginal land.
1972

Prime Minister Kevin Rudd says sorry to the Forgotten Australians which include migrants and Indigenous people who were victims of abuse in orphanages and institutions between 1930 and 1970.
2009

This information was accessed from the following link, and its subsequent links
http://www.creativespirits.info/aboriginalculture/history/aboriginal-history-timeline-1770-1899

Transitioning to the Contemporary Food Environment

In remote and very remote parts of Australia, the transition away from a hunter-gatherer heritage began as short a time ago as the early decades of the 20th century. In the 1920s, to prevent over-crowding in towns and exert some level of control on people's livelihoods under the Aboriginal Protection policy, the Government set up ration depots in bush areas. In the 1940s, food rations were supplied in lieu of wages to Aboriginal people through cattle stations. From the 1950s, mission-based settlements were organised to accommodate increasing numbers of Aboriginal people. These missions provided rations and generally supplemented available foods through horticulture programs. Increasing land loss alongside increasing access to food rations was one motivating factor that drew Aboriginal people to life in settlements. The first processed food rations included white flour, sugar and tea, and later bread and some meat – mostly tinned and salted [9]. It was not much more than 50 years ago that Aboriginal people were integrated into the cash economy of the Northern Territory [9].

In the 1980s, anthropologist Jeannie Devitt spent time with the Anbarra of the Northern Territory [10]. The people with whom she lived continued to live and eat according to many traditions, yet food rations (including flour, tea, sugar, meat, tinned goods, some spices) were available. Most significantly Devitt notes the availability of refined flour had a significant impact on food-related practices, food security, nutrient intake and physical activity [10]. The introduction of white flour nullified the need to collect, process, produce and consume seed dampers. It also reduced routine reliance on formerly staple carbohydrate

foods including roots and tubers, and possibly nuts. Given this historical substitution, flour can be seen as a "vegetable replacement" and balanced accompaniment to meat [10]. (See also discussion on traditional food groupings in Section 6).

The early popularity of flour, sugar and tea followed by rice, white bread and tinned meat was related to accessibility, transportability, relative durability and convenience [11, 12]. These features still hold relevance in the dietary patterns of people living in remote Aboriginal communities today [6, 13]. Over generations these provided food sources have become a familiar, "normal" part of contemporary Indigenous culture [14]. Challenges lie in debasing or altering access to these recognised and affirming foods that are related to cultural values, existing social norms and engrained food habits [15-17]. The majority of people living in remote Aboriginal communities now primarily rely on available store foods for their body's nutritional needs.

Factors Influencing Access to Traditional Foods

For most Aboriginal people availability of and access to traditional foods is now limited [18]. Many factors have impacted on the ability of Aboriginal people to undertake hunting and foraging and other food-related activities and consume a traditional diet [9, 18, 19]. However it is also an area that has largely been overlooked with few programs designed to support people's access to country to consume more traditional foods. The following list overviews a number of factors, some of which may be relevant to explore with the Aboriginal people with whom you work.

FACTORS INFLUENCING ACCESS TO TRADITIONAL FOODS

Environmental factors

- **Environmental degradation** caused by shock and feral animals.

- Introduction of **foreign and exotic plant species.**

- The increasing incidence of **hot, destructive bush fires** as result of poor land management practices.

- **Depletion of resources and population pressure** with the forced relocation of people into permanent settlement areas.

- **Traditional foods are now difficult to access.** Traditional foods were in the past seasonally available for exploitation, so people ate the most readily available food. The most readily available food is now store food.

- Edible plants available near communities may be seen as **dirty or polluted**.

Social factors

- **The relocation of people into settlement areas** as an historic practice.

- **Changing demographic patterns**, for example, most Aboriginal people now live in urban areas. In remote areas, the relatively greater number of children in settled lifestyles reduces the freedom and capacity of women to forage [20].

- **Cultural loss from generation to generation**. The knowledge required to identify, obtain and prepare bush foods and make and use hunting weaponry has diminished to such an extent that the full potential of available resources cannot be realised. More traditional knowledge is maintained by those who live closer to traditional lands [21, 22].

- People living in areas other than their own lands **may not have rights to forage** in the traditional lands of their hosts, or **laws may prohibit it.**

- **Social laws and customs related to traditional foods** such as kin obligations that dictate the sharing of food and social obligations incurred by borrowing materials (e.g. car, gun, fishing net), can render hunting not worthwhile. Hunting trips may yield only small or single meals.

- Hunting and food preparation activities take **time and effort.** For example, cooking large game in a bush oven such as a kangaroo creates difficulty digging hard earth and accessing adequate fire wood.

- **People are busy and have competing priorities and diversions**. Young and older people are caring for children; responding to kinship and social obligations and other community business; working in the community [23]. Children are required by law to be at school and thus can only participate in traditional activities on weekends.

- **Socially destructive activities** such as gambling, alcohol and drugs.

- **"Laziness"** – referring to not having the motivation [23].

- Some individuals and communities may look on their **traditional foods as inferior** and related to the past [24].

- Subsistence food procurement activities generally not recognised by non-Aboriginal authorities as contributing to livelihoods.

Cost and Availability of Materials

- **High costs** associated with the acquisition and maintenance of equipment, firearms, fishing bait and tackle, 4WD vehicles, boats and fuel.

- **The great difficulty acquiring a gun licence**. Hunters are required by Australian law to possess a valid shooter's licence. To obtain this they must submit to an eye exam and take a written test in English.

Despite these numerous factors, traditional foods continue to hold social and personal meaning for Aboriginal people in remote [6, 9, 25] and urban settings [26, 27].

Economics of Food Choice & Eating Behaviour

In remote Aboriginal communities, living in conditions of poverty is a key factor determining food choice. Conditions of poverty are reinforced by low incomes, fortnightly welfare cycles and a high cost of living. This in turn is related to financial insecurity, household overcrowding, and poor housing infrastructure including facilities for cooking and food storage [28]. *The economics of food choice theory* speaks to the relationship between personal finances and foods purchased. It considers the relationship between the energy cost of food, expressed as the dollar cost per Megajoule obtained ($/MJ), and also the dietary quality and energy density of foods (MJ/kg). Mass-produced, processed foods of high energy density are associated with lower financial costs. Among those living under financial strain, these cheap, high energy foods maximise the energy content of food purchased per dollar spent [29, 30] thus contributing disproportionately to energy intake, influencing the capacity of people living in remote communities to attain a healthy diet [11].

Views of Illness, Disease & Health

The various beliefs that individuals, groups and populations hold about health, wellbeing and illness influence how they perceive illness vulnerability and the extent to which certain behaviours or services may be deemed appropriate or helpful to manage or prevent illness [31].

The World Health Organisation defines health as *a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity* [32]. While this definition is broad, the **western biomedical view of health** tends to focus on each person's body as a separate entity. Driven by objectivist epistemology and the positivist paradigm [33], this biomedical model of health reduces the human body into ever-smaller segments, searching through microscopes for diseases. Once identified, these diseases are labelled according to visible symptoms and pathologies [34] . Diseases are often viewed detached from their surroundings. This deems personal and social factors such as spiritual or religious beliefs largely irrelevant. In the biomedical view, an individual increases their risk of disease through certain lifestyles and behaviours. When ill, the primary objective is to remove or suppress the symptoms. Beyond this, much of the responsibility, including the task of recovery and necessary lifestyle change lies with the individual [34]. We generally consider ourselves to be healthy in the absence of disease.

In Aboriginal populations, concepts of *health* are akin to broader socially-inclusive views that relate more closely to the western notion of *wellbeing* that encompasses all aspects of life contingent on balancing a person's spiritual, social, emotional, and physical being [35, 36]. Spiritual connections to land and ancestors underpin this holistic view [35]. This focus influences people's behaviour & decisions in ways invisible to the eyes of others [37]. An urban Aboriginal community group defined *spirituality* as:

> *"... a feeling, with a base in connectedness to the past, ancestors, and the values that they represent, for example, respect for elders, a moral/ethical path. It is about being in an Aboriginal cultural space, experiencing community and connectedness with land and nature including proper nutrition and shelter. Feeling good about oneself, proud of being an Aboriginal person. It is a state of being that includes knowledge, calmness, acceptance and tolerance, balance and focus, inner strength, cleansing and inner peace, feeling whole, an understanding of cultural roots and deep wellbeing"* (p.52)

In Aboriginal society an individual illness is seen as a social problem, with the most important task being to hold the community together, keeping its spiritual life intact, even if an individual life is put at risk [38]. Origins of illness can arise from natural or environmental causes, spiritual causes or sorcery [36, 39, 40]. For example, spiritual health and illness are associated with both physical and mental health, and factors such as loss of traditional lands, breaches of religious sanctions and social rules of behaviour, or the fulfillment of cultural roles and responsibilities [35, 36]. Cultural wrongdoings or misconduct are considered to cause loss or damage of the spirit in turn resulting in ill physical and/or mental health. As such, illness can be considered the result of a transgression. Having or publicising illness can cause people to feel shame and great embarrassment, even within immediate family [41, 42]. Illness may also stem from magic or sorcery with entry into the body of a malevolent spirit that is outside of one's control.

Remarking on her early learnings while working with remote Aboriginal communities in the Top End, nutritionist Robin Lion reflected on how she and her co-workers learned of different beliefs and views of illness, and also the role of food:

> *"[To understand] the how and why of sickness, we had to realise that food was also a medicine, and that there was the holistic sense. The health of a person was their spiritual, mental and physical health and wellbeing... If there was someone who was sick or had died, people sometimes said that person had been sung, so they'd acknowledge there was a physical cause, a heart attack or an accident, but there was also a sorcery at play.... "*
> [Robin Lion, Personal communication, 2013]

Table 2.2 provides a theoretical comparison of traditional Aboriginal, contemporary Aboriginal & western perspectives, practices and behaviours related to illness and health. This list is not designed to be exhaustive, nor should the statements be seen to represent all Aboriginal cultures in Australia; people may hold alternative and even contradictory beliefs and perspectives. While information on cultural values and practices is valuable, it should act as a starting point and basis upon which to guide further inquiries and build communication and relationships within the communities that you work.

Table 2.2: Traditional Aboriginal, Contemporary Aboriginal & Western Perspectives, Practices & Behaviours Related to Health

Health-related Factor	Traditional [a] Aboriginal Perspectives & Practices	Contemporary [b] Aboriginal Perspectives & Practices	Mainstream Western Perspectives & Practices
Health Paradigm or Worldview	Comprehensive "wellbeing" indelibly linked with all aspects of life – land, law & relationships, past & present, personal & communal. Depended on a person's complete social integration & harmony/balance within an integrated and dynamic system that incorporates the physical, emotional, spiritual and familial[1-3]. Included participation in ceremonies & compliance with Law. Steadfast belief system. People 'look' healthy if they are plump; have glossy skin; shining eyes.	"Aboriginal health" means not just the physical well-being of an individual but refers to the social, emotional and cultural well-being of the whole Community in which each individual is able to achieve their full potential as a human being thereby bringing about the total well-being of their Community. It is a whole of life view and includes the cyclical concept of life-death-life[4]. Associated with stable relationships with family & community members; maintained through nurturing traditions & cultural values, laws & restrictions practices[5]. Views likely informed by numerous factors including worldview, personal &family-based experiences & beliefs related to sickness & health, spiritual views & community life[6,7].	The World Health Organisation defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity[8]." Biomedical model of health: - body reduced & studied through its component parts. - consolidated by scientific understanding however, beliefs changeable. - problematises the body & emphasises personal responsibility for maintaining bodily health[9]. - health is the body operating efficiently; the "absence of disease".
Illness	Ill health could be caused by family misbehaviour One should 'look' and 'feel' sick Origins of illness are either: 1) natural/ physical 2) spiritual or 3) sorcery If people live, they will recover fully. Seek traditional healer & healing practices[2,10]. Bush medicines also well known for treating infections & injuries (thus not just the domain of nankaris/healers).	One should 'look' and 'feel' sick[11,12]. Poor health related to lack of traditional foods and too many store foods[13-18], worry[18,19], loss of spirit[18], consequences of cultural change – breakdown of systems of law, relationships, food system, hygiene, loss of control[13,20]. Poor health can also be associated with or seen as being caused by substance and alcohol misuse, violence, incarceration & trauma. Illness is viewed as part of the matrix of the whole community. Chronic & infectious diseases somewhat 'normalised'[21] however, disease risk/ origins/causes/ processes often unclear[7,11,18,22]. Sufferers may feel shame, fear &/or sorrow[18]. Traditional healing practices less effective[18].	Any breakdowns in the body system means it is not "healthy". Diseases linked with signs, physiological symptoms & medically diagnosed pathological abnormalities[9]. Physical & mental health/illness often viewed separately[9]. Expanded to include social determinants of health[23].
Food & Health	Foods & plant products used for medicine & healing[10]. Food fills up the spirit[2]; food (especially meat) makes/gives blood. Animal foods most linked with strength[24,25]. Eating food a need/desire; stops hunger; feels good[26]. Sought a balanced diet of fresh animal & plant-based foods[24,27-31]. "Wet" foods build strong blood & body; "dry" food weakens blood & body[2,27]. Food availability often dependent on rains and travel to areas where foods are known to grow. Seasonal and climate indicators of great importance in signalling for the right times to eat certain foods. For example, when the gum tree is flowering it means the mullet are fat. Food intake and type strongly affected by seasonality, access and availability. For example, increased protein intakes during goose migration, consumption of water lilies during one time of year only. Food acquisition and preparation associated with high levels of physical activity, especially consumption of high energy foods (animal fat, sugarbag). High energy, sweet foods eaten rarely as they were hard to come by and difficult to access (sugarbag).	Food and diet plays a social role; the health-value of food is not a traditional perspective or concern. Traditional foods highly valued & contain health & healing properties[13,14,16,32-34]. Traditional & store foods judged according to balance & freshness[13,14]. Need to balance traditional foods & store foods[13]. "Good" store foods include fresh fruit & vegetables, meats. "Good food" can include a child's favourite food[17] & long-life foods[13,14]. "Bad" store foods include fatty & sweet foods & takeaways & related to disease states[13,14]. Store foods blamed for ill health[13-15,17]. Basic familiarity with macronutrients & some micronutrients, e.g. iron. Traditional foods still require some physical effort to obtain (fishing, hunting, gathering fruit) but assisted by outboard motors, cars, guns and thus not as active – however these activities are often considered to also contribute significantly to spiritual, physical, mental and social wellbeing as well as providing food. Very little energy output involved in obtaining store foods.	Foods viewed through biomedical scientific framework that groups foods according to nutrient composition[35]. Food provides the body with energy, protein, essential fats, vitamins and minerals required to meet metabolic & other bodily needs. Eating a balanced, varied diet is considered vital to provide the right amounts of nutrients for good health for good health and wellbeing[36]. **All references for Table 2.2 are listed in Appendix iii**

[a]The use of "traditional" denotes life prior to, or shortly after white contact however, given that information have been gleaned from mostly observers accounts, this is only a theoretical guide.
[b]The use of "contemporary" refers to Aboriginal people currently, and their practices in remote Indigenous communities.

Further Reading

Peer-reviewed articles examining social determinants on nutritional health

Lee, A.J., et al., Improving Aboriginal and Torres Strait Islander nutrition and health. Med J Aust, 2009. **190**(10): p. 547-8.

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King, M., An overall approach to health care for indigenous peoples. Pediatr Clin North Am, 2009. **56**(6): p. 1239-42.

Shannon, C. (2002). "Acculturation: Aboriginal and Torres Strait Islander nutrition." Asia Pacific J Clin Nutr **11(Suppl)**: S576–S578.

Useful Books

Rowse, T., 2002, *White Flour, White Power: From Rations to Citizenship in Central Australia*. Cambridge University Press. Explores the colonial practice of rationing goods to Aboriginal people in Central Australia as the material basis for many colonial imperatives.

Fadiman, A. , 1997, *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures*. Macmillan Publishers. A powerful story about how cultural values influence health and health care. This book chronicles the struggles of a Hmong refugee family from Laos, and their interactions with the health care system in California.

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SECTION 3: CONSIDER COMMUNICATION

Overview

Every encounter that we have with another person involves some kind of communication. Communication takes on many forms, occurs in numerous languages and across an increasing number of mediums. In their landmark study and report, Sharing the True Stories [1], Dr Anne Lowell and others conceptualised communication as a process in which people cooperate with one another to create a message or meaning constructed by signs or symbols, the meaning of which is shared and agreed on by those involved (p.i).

Day-to-day communication often involves the exchange of information related to agreed or understood topics; it also occurs in a familiar context and shared language. When we communicate with family or friends, most often we share ways of viewing the world, understand each other's body language, and can readily identify the meaning of chosen words and references. When attempting to exchange information with a person or people from another culture and across different language systems, effective communication becomes a far more complex task. **Figure 3.1** depicts a range of factors that can hinder or enhance communication.
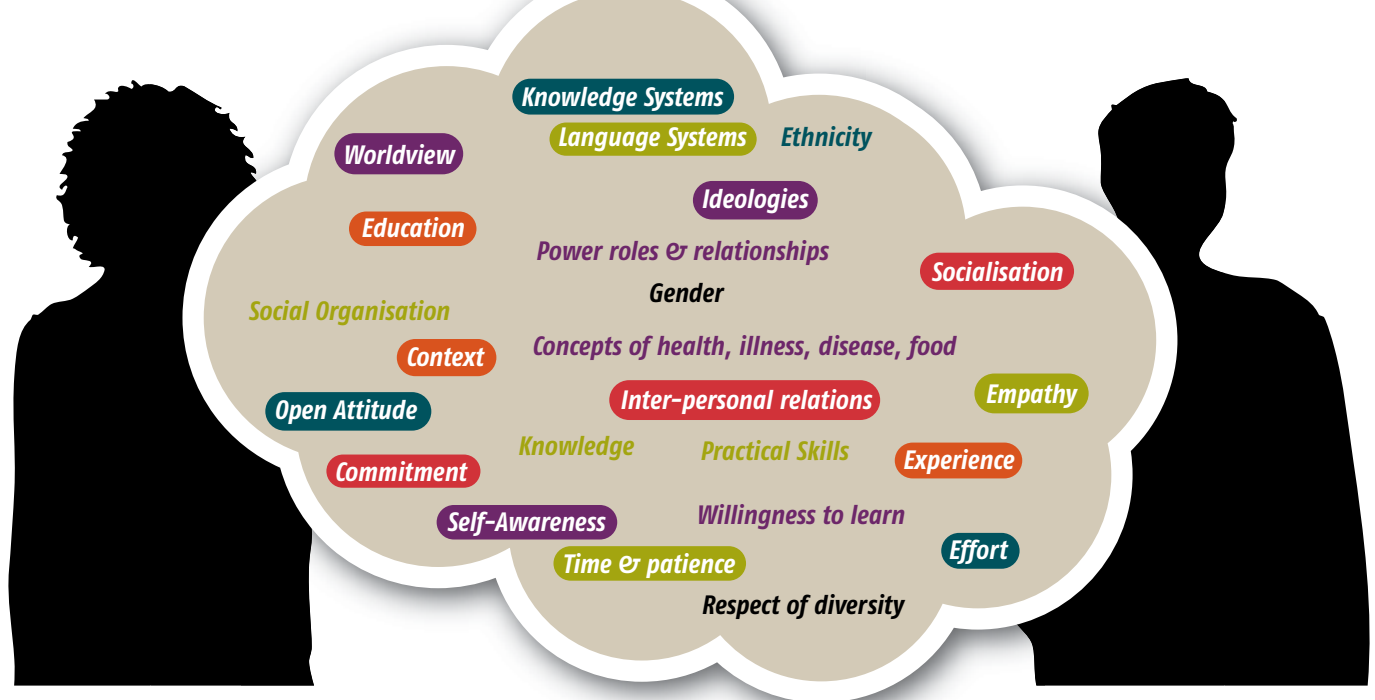
Figure 3.1: A range of cultural and personal attributes that can influence meaningful communication between two or more people

Rather than a simple exchange between a speaker and listener, communication is a highly complex process influenced by numerous factors including cultural differences, power inequalities, systemic and personal factors.

Effective education is far more than the provision of information. Two crucial factors include the quality of the information communicated, and its suitability within any given context [2]. In order to favour productive and beneficial exchanges, highly developed communication skills are required to manage the depth and breadth of people and situations that will inevitably be encountered. Despite best intentions many health practitioners report challenges in this area and episodes of seemingly ineffective communication [3]b. The following section argues the importance of effective communication in health education and promotion, and explores a number of practices and strategies to enhance cross-cultural and interpersonal work.

How well are we Communicating?

While a focus on engendering shared communication may be most productive, being aware of the potential for ineffective communication is important. There are many issues, practices and situations that can and do impede the sharing of health information. Over past decades many examples of severely limited and ineffective communication in Aboriginal healthcare have been reported (see, for example, references [1, 2, 4-9]). Whilst communication breakdown within this context may be commonplace, it is often unanticipated and severely underestimated, remaining undetected in everyday practice [1, 6, 9].

During the 6-month *Sharing the True Stories* study involving staff and Aboriginal patients in a Darwin-based renal unit, extensive miscommunication between the treatment recipients and a range of western healthcare professionals was identified [1]. Despite efforts to facilitate effective communication during 5 videotaped interviews, strong evidence suggested:

- A lack of shared understanding about key health and biomedical terms and concepts for Aboriginal patients (the biomedical model being the only health system discussed).

- The overestimation by both patients and staff as to the extent of their shared knowledge.

- Little attempt to monitor or facilitate helpful exchanges.

- Poor communication was also experienced by patients who spoke fluent English [1].

Trudgen [6] describes a two-way crisis in communication where "dominant culture professionals" are incapable of communicating basic ideas related to health and wellbeing, while Aboriginal people are unable to share the deep wisdom of their own culture, nor explain their present situation (p.77).

Poor or miscommunication between people and groups has a great effect on the balance of power. Poor access to, or understanding of information is innately disempowering. Devitt and McMasters noted that without an understanding of the reasons behind medical treatments, prescriptions and requests to alter health-related behaviours, compliance becomes an issue of obedience [5](p.165). Further, when new information or circumstances are presented that are in conflict with previously held beliefs or values, this inconsistency can create discomfort and confusion, and rejection or avoidance of the situation.

Aboriginal patients and their families have also viewed ineffective communication and lack of meaningful information from health professionals as an intentional withholding of the facts or unwillingness to share the "full story" [2, 4]. In response to failed communication, the Aboriginal people in one report retaliated with deliberate non-attendance at health appointments and resistance to medical prescriptions [4]. The authors noted the flow-on of these consequences to a situation that was likely or literally injurious to the clients' health.

FOOD FOR THOUGHT

- What are the impacts of poor or miscommunication on those with whom you work?

- What factors within your work could be conducive to poor or miscommunication? Consider:

  - Cultural differences

  - Systemic factors

  - Power imbalances

  - Personal factors

  - Specific situations, practices, etc.

- How do some or all of these influence your capacity to engage in effective shared communication?

  - How can you take steps to overcome some of these factors?

Learning more about Aboriginal Languages

In remote Australian Indigenous communities local spoken languages predominate, with literacy levels in all languages, including English, being generally low. Despite this, most non-Aboriginal health staff speak no local Aboriginal language and most contemporary health resources are written in English. Attempts at health communication and promotion in the dominant language invariably disadvantages one side and retards information exchange [3]b.

One challenge of working across languages is the fact that translation of explanations related to biomedical health concepts from English into Aboriginal languages are far from straight forward. Direct or literal translations often fail to hold significance within another culture's worldview, thus failing to evoke meaning [10]. For example, Vass *et al* highlight the absence of western biomedical concepts and lack of corresponding words relating to key biomedical concepts among Yolngu people from northeast Arnhemland [11].

Language is intimately connected to one's worldview. Of food-related vocabulary, nutritionist, Robin Lion referred to traditional foods defined in terms of kinship systems, a plant's or animal's stage of maturity and the processing involved to make the food edible [12]. With regards to the contemporary food system, Aboriginal people are also often expected to understand and recall many new English food-based vocabulary and concepts such as the names of different fruits and vegetables, cooking techniques, brand names and measurements. It can be easy for non-Aboriginal practitioners to fail to realise the foreign and challenging nature of incorporating new terms and ideas into a vocabulary and worldview.

The current structure of most remote public health nutrition requires that non-Indigenous health professionals live in regional centres and travel to a number of communities, often visiting for short to very short periods of time. Across the visited communities, multiple languages (other than English) are often used, with few formal resources existing for those who wish to learn a local language. Under these circumstances, grasping the complexity of another language is challenging. Allocation of communities that share language groups has been suggested as one way to assist language learning of visiting health practitioners [3]b. Organisations also need to acknowledge the importance of non-Indigenous health workers learning local languages, and provide resources to support this endeavour.

It has been said that one cannot really understand another culture unless they can speak the language [6, 11]. Naomi Havens, a mentor and trainer who has spent many years learning Djambarrpuyngu (spoken in Northeast Arnhem land) and more recently Kriol (or Creole, spoken in the northern part of the Cape York Peninsula and Northeast Arnhem land), explained her motivations. She stated,

> "... I kept coming back to the fact that language learning usually begins as a spark of conviction that is hard to keep going. I kept finding that the desire to connect with others more deeply is the single factor that sustains someone through their learning." [Naomi Havens, Personal communication, 2013]

Learning a local language also demonstrates respect for community culture, and provides a means of building relationships and two-way sharing. The following considerations and strategies can help you on your way.

STRATEGIES FOR DEVELOPMENT

- Find out what languages are spoken in the area(s) in which you work

  - Which language(s) do the health workers speak?

  - If languages are written, do people read/write in their own language? [13]

- Ask your colleagues about resources that could help you learn.

  - Contact your regional university, state or territory library, and cultural or arts centres in community communities.

The Living Archive of Aboriginal Languages (LAAL) is establishing an open-access online repository of digital versions of materials produced for bilingual education programs in Australian Indigenous languages in the Northern Territory. Through the website language groups and sites are highlighted on an interactive map, and numerous language-related resources and materials are available.
For more information visit: http://laal.cdu.edu.au/

- Beginning to learn local words can be as simple as pointing at things – house, tree, dog – when walking around the community, and asking the local children how to pronounce the word/name in the local language.

- Learn key words and phrases such as the local words for food and various types of foods, water, children, family, yes, no, etc.

- Writing learned words phonetically may help to remember the new sounds and phrases. One visiting health professional shared:

"While working in communities I used the notes application in my iphone to write down all new words that I learnt… Also, in Pormpuraaw I used to visit two older ladies in my lunch break. They were some of the only people left in the community who spoke fluent Kugu', and really enjoyed sharing new words. It was a good excuse to catch up and clearly show that I was there to learn just as much as to run programs and share information." [Frances Knight, Personal communication via email, 2014]

Using an Interpreter

In health settings in remote Aboriginal communities, funding to support health interpreters is often lacking, and the use of interpreters is sporadic and low [4, 10, 14, 15]. Advocating for increased access to interpreters demonstrates a commitment to cross-cultural health communication. Further, taking time to listen to and seek to understand people is a basic sign of respect [16]. Trained interpreters and interpreting services are becoming more widely available. While services may vary according to state/territory policies, trained interpreters and interpreting services are becoming more widely available. Google "Aboriginal Interpreter Service" to find details of services in your state or territory. Some organisations provide an allowance to support the use of interpreters. Ask your manager, and also enquire within the communities in which you work.

Working with interpreters is a skill that improves with experience. In order to enhance each encounter it may be useful to:

• Seek a recommendation.

• Where possible, use an interpreter specifically trained in health interpreting. Inadequately trained, skilled or experienced interpreters may prompt or edit responses, or translate questions or answers in such a way as to introduce entirely new meaning [1, 17].

• Aboriginal health workers (AHW) may act as interpreters. For AHW who act as interpreters often it may be appropriate to consider asking if they would be interested to seek more formal training [10].

• If asking people within the community to assist with interpreting, consider gender or kin relationships. If unsure, ask an AHW or the health centre manager to provide guidance.

Listen Actively; Listen Deeply

We usually hear only a small part of what we 'listen' to. Moreover, when listening we often tend to focus on ideas and comments that reinforce our views, beliefs and opinions.

Deep listening or *Dadirri* has been used as a research methodology and relevant tool to inform ethical and culturally safe approaches to work within Aboriginal communities. In her book, *Trauma Trails, Recreating Song Lines: The Transgenerational Effects of Trauma in Indigenous Australia* [18], Indigenous scholar Judy Atkinson speaks of the main principles and functions of Dadirri as:

• *a non-intrusive observation, or quietly aware watching.*

• *a deep listening and hearing with more than the ears.*

• *a reflective non-judgmental consideration of what is being seen and heard; and, having learnt from the listening, a purposeful plan to act, with actions informed by learning, wisdom, and the informed responsibility that comes with knowledge (p.16).*

To listen intentionally and consciously, it is helpful to prepare with a positive, engaged attitude and willingness to learn from what people have to say. Set aside preconceptions or opinions; let people speak freely; don't immediately agree or disagree; interpret what you are hearing only after you feel you have grasped the content. Conscious listening will involve the use of your ears, but also your eyes and other senses.

Spoken Communication

In order to 'set the scene' it can be appropriate to communicate a sense of place, time and perspective at the outset of conversations [19]. Place or time can be conveyed by referring to significant and known events such as seasons, a marked seasonal event, or special occasions such as community festivals or ceremonies. Mentor and trainer, Naomi Havens stated,

"Place location is usually the first reference point in my conversations with Indigenous people. We begin with where we are physically to establish a foundation for our conversation about our location before moving into talking about places like our relationships and our emotions." [Naomi Havens, Personal communication, 2013]

Elaine Maypilama suggests we should always set the scene with some background information, an explanation or a story so that we can all share the same perspective. She explains,

"If we are sitting in the same boat but you are rowing in your own way and your mind is somewhere else, and if my mind is in another time or place and I am rowing in my own way – we go nowhere. When this happens we are not sharing stories and we don't agree... When we know what each other is thinking, we can row together and go to the same places and see new things..." [Elaine Maypilama, Personal communication, 2014]

FOOD FOR THOUGHT

- Pointers that can guide effective spoken communication include:

- **Speak slowly** and clearly (but not in a patronising manner) [13, 20].

- **Use fewer words** [20].

- Allow yourself to **use different ways of describing things** [21].

- Choose words and modes of expression that will be **familiar to your audience and that hold or reflect meaning for the listener/receiver**.

- Use culturally neutral language.

  - **Avoid jargon, medical terminology and culturally specific metaphors** [1, 6]. This includes the use of percentages (%).

- **Take time to work through new concepts together** and explain why you believe certain issues and subjects are important to talk about [22].

- **Don't be afraid of periods of silence or breaks in the discussion** [13]; allow 10 seconds or more. People are accustomed to active listening, and may not begin constructing their response until they have finished listening [6]. They need time to gather their thoughts and construct their answer [13].

  - Don't jump in with more words [6] or interpret silence as agreement or misunderstanding [23].

- **Allow people time to discuss issues in their own language as a group**; one person may be more confident with spoken English and will emerge as a spokesperson and then present the group's response.

- **Don't raise your voice** [13] (unless someone has hearing difficulties – which is a relatively common issue among Aboriginal people).

- **Don't interrupt** a person while they are speaking [6].

- **Don't criticise** people directly if, for example, they share information that you don't agree with. Find positive ways to frame responses.

Gathering Information & Cross-Checking

Asking the 'right questions' and framing enquiries in ways that draw out new discussions and ideas, are skills that develop with experience and reflection. In some cultures it is normal to ask a lot of questions. In westernised cultures asking questions and engaging in up-front, direct discussions and debates is an accepted and even lauded communication and learning practice. In Aboriginal culture overt curiosity can be considered bad manners or prompt people to respond by saying what they think you want to hear. For example, yes may not mean YES. Instead it may be a way of procrastinating or avoiding a question without causing offence [13, 23]. There is no obligation for people to answer too many "what" questions. Aboriginal people tend to avoid intense questioning and potential conflict in preference for smooth relations.

A number of reports document frustration on behalf of non-Indigenous medical staff that Aboriginal people rarely ask questions about their health conditions [1, 5, 24]. It cannot be assumed however, that a lack of questions implies lack of questioning, or that information is not wanted. In Aboriginal cultures questioning is a highly qualified activity. In health settings, power inequalities such as lack of shared language, superficial relationships and short appointment times can all stifle communication.

In Aboriginal communities, the most appropriate line and style of questioning is most often dependent on those involved in the discussions [25]. For example, **direct questions** may not be suitable in some situations however, in general, the more senior the person, the less appropriate the use of direct questioning [13]. Further, Aboriginal people prefer not to speak on behalf of others, therefore information relating to other people or the community in general should not be expected [19]. When asking questions it is important to relate all queries to the people involved in the discussion. Aboriginal culture focuses less on the individual and more on family and community relationships. It can therefore be useful to **frame questions** in ways that orient people towards these reference points. For example, rather than ask directly about individual ideas and practices, frame questions around family-oriented scenarios. Other possible lines of questioning may include asking people **how they feel** about particular issues, events or discussions. It can be best to let Aboriginal health workers or other Aboriginal counterparts decide to whom they might direct questions and how best to frame them.

Communication is enhanced when those involved take time to cross-check and build on information that has already been shared or created. The following list offers strategies to consider when providing or cross-checking information:

STRATEGIES FOR DEVELOPMENT

- Introduce new concepts clearly and separately; don't pose multiple questions in a single phrase or run through exhaustive lists.

- Allow people time and space to take in the information presented.

- Don't fear silence after a question. In Aboriginal culture, silence is accepted, and often even carries meaning. Rather than speak immediately, Aboriginal people may prefer to silently collect their thoughts. Allow time for responses to emerge.

- Avoid statements such as, "...you don't eat that every day, do you?" Negative questions can be confusing, and are often judgemental and leading.

- When working within a group, rather than single people out, pose questions broadly and make requests in more indirect ways [20].

- Encourage group discussion.

- It may be easier for people to visualise concepts and ideas if you use tools such as paper to draw on together, photos, image cards etc.

- Be aware that some people may avoid direct eye contact or find eye contact threatening.

During a 7-week student placement in the Top End, a dietitian from Flinders University reflected on how and what she learned over the course of her work:

"…Following on from my reading, and the guidance that I received from my supervisor and other staff who were very experienced in remote Aboriginal health, my most valuable learning experiences came when I began communicating with Aboriginal participants more frequently, and started to understand how the theory played out in practice. I constantly reflected upon my use of language and general presence, and found even over the short amount of time I had been on placement I had changed significantly to better my communication.

Key things I learnt included:

- *sitting at or below the same level as participants when communicating,*

- *giving a person four or more seconds to answer your question,*

- *not making direct eye contact unless you've worked out they are fine with that,*

- *standing back for a while before approaching potential participants,*

- *allowing participants to tell their own story and just subtly use guiding questions rather than using a straight questioning method, and*

- *building rapport at the beginning of working with an Aboriginal participant is extremely important.* [Alana Robinson, Personal communication, 2013]

Body Language

Many Aboriginal people use a comprehensive body language vocabulary that speaks as loudly as words [6]. The recently released book, Endangered Sign Languages in Village Communities: Yolngu sign language' [26] explains that whole conversations can take place without a single word. It is important to note that body language can be read differently by different cultures, and is often hard for an outsider to pick up on or understand. In general, it is most important to become aware of norms in body language in the communities in which you work. For example, norms in eye contact may dictate that some people prefer to look away when addressing you, or to speak looking over your shoulder [6].

Men's & Women's Business

Men's Business and Women's Business refer to certain customs and practices that require strict separation by gender. Some subjects are considered only for the ears of women; other subjects are only for the ears of men. This may affect the ability of visiting health professionals to communicate certain ideas and work with certain individuals and groups, particularly if you are new to the community. When organising meetings or groups, discuss whether or not the topic(s) of conversation are suitable for everyone attending. Alternate arrangements or new ways forward may be required. While the extent to which cultural beliefs dictate gender separation in communities varies, it is important to consider.

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SECTION 4: CONSIDER YOUR RELATIONSHIPS

Overview

Building relationships strengthens our connections and increases our ability to see and understand each other and the world in diverse and shared ways. Within Aboriginal culture it could be said that relationships form the fabric of life – all people and entities exist in relation to one another. In the health services setting, people of Aboriginal and Torres Strait Islander descent have considered establishing meaningful relationships equal to, if not more important than service outcomes [1]. In your role it is likely that community people will first want to get to know who you are, before they want to know the job that you have come to do [2]. For community-based health workers, building relationships is a primary reason why they continue to work within health programs [3-6]b. The "success" of all short- and long-term work across cultures relies on the benefit of strong relationships based on trust and respect [7].

A tendency to undervalue relationships can lead westerners to declare time invested in relationship building to exist outside professional work activities, as low priority or superfluous to core activities. When viewed in this way, relationship building may appear wasteful of time and resources. Public health nutritionist, Frances Knight explained:

"I found this a significant challenge and sometimes barrier in my work. I was a member of a team consisting of doctors, nurses and other allied health professionals. I often felt self-conscious of how my day meeting people, catching up and building relationships in a community was spent compared to their day in a clinic... I felt pressured to justify time spent in communities to my health colleagues and managers when presenting at team meetings or providing field reports. Hence the organisational environment around the practitioner can very much influence perceptions of time and the value placed on how this time is spent." [Frances Knight, Personal communication via email, 2014]

This section considers the imperative of forging strong relationships with community people. Possible ways to enhance working alongside local counterparts are explored including practical approaches to two-way learning and sharing, reciprocity and mentoring partnerships.

Working with Local Counterparts

The involvement of local counterparts in community-based health education and promotion activities and programs is key [8, 9]. From nutritionist's perspectives, local workers such as Aboriginal health and Community-based workers often possess 'insider's' information about their own community – both historical and present [3]b. Nutritionists have described local workers as "enablers, facilitators and advocates", potential "nutrition champions [and] healthy eating role models", and "experts in local knowledge" who provide important links to understanding aspects of local culture, language and people's views and situations related to illness and health [3]b. Commonly mentioned barriers to working with local Aboriginal people has included lack of access and availability [3]b. Health workers in particular, have been viewed as "too busy", "over-burdened", "pulled in every direction"; they are also answerable to the health clinic and therefore difficult to engage in the public health domain [3]b. Those in decision-making positions within organisations and government need to recognise the significance of these partnerships to working in cultural safe ways – and channel the resources to support them.

Visiting health professionals need to recognise that health workers are often approached by multiple people for help and guidance. Hence, an initial not-so-friendly reaction isn't likely to be a personal rebuke. Fear of rejection or over-burdening shouldn't be reasons not to approach people, but are good to keep in mind. A poor reaction may also be a sign to take a different tact or avenue.

Aboriginal Health Workers & Community-based Workers

Throughout Australia, Aboriginal people working in the area of community health may also be known by other titles such as Aboriginal Health Practitioner.

Aboriginal Health Workers (AHW) now constitute a nationally recognised profession. All AHWs complete a certification in health which may have involved a nutrition component however, the extent of this is variable. While AHWs are generally employed through the local health clinic they may also work in areas such as social work, youth work or aged care. Aboriginal health workers are also discussed in The Public Health Bush Book. Volume 1: Strategies and Resources [10] (p.222-3).

Community-based Workers (CBW) may not be specifically trained in health or nutrition and their role(s) can vary depending on their own interests, strengths and funding organisations. Within the community, there are a range of people and organisations involved in food-related activities. These people and organisations have skills and experiences. In the context of food, CBW can include strong women workers, community stores workers such as good food people, community or support centre staff, school nutrition workers, and school canteen staff. Potential counterparts may also be found in women's sheds or centres, arts centres, child and aged care services,

Keep in mind that social kinship rules and "politics" may dictate that by working closely with a particular person it is difficult or inappropriate to come in contact with other groups [2]. Where possible maintain relationships with multiple local and visiting workers. If you are at times in doubt about who to speak to or approach, seek advice from people who have spent significant time in the community.

community health centres, youth groups, health clinics and the church. Some key people and potential counterparts may not be immediately visible, but time spent building relationships within the community will soon lead you to them. Seeking introductions may lead to important opportunities.

Aboriginal Community Nutrition Workers

Aboriginal community nutrition workers offer an essential link between the local community and visiting, non-Indigenous nutrition workers [3, 11-14]. The nutritionists surveyed during the development of this resource were emphatic – especially those with more experience –that working in formalised training relationships is important [3]. Yet over the last decade only a few Aboriginal community nutrition workers have been employed to work alongside non-Indigenous nutritionists in remote Aboriginal communities.

At Apunipima Cape York Health Council, Community Nutritionist, Kirby Murtha and Advanced Health Worker – Nutrition Promotion, Derlene Gray, work together in formal partnership:

"Derlene and I have worked in partnership since mid-2010. Being paired up with a health worker has taught me the subtleties of working effectively in a cross cultural setting. Derlene acts as a cultural broker and assists me to navigate my way around community. She helps me to understand cultural facets that I don't even realise are present and allows me to reflect so I can continue to learn… Along the journey I have also learnt alternative ways to share my nutrition knowledge and provide project support in a less rigid manner. Derlene and I have never embarked on a formal mentoring partnership but have been able to spend time building an honest and supportive working relationship that suits both of our needs." [Kirby Murtha, Personal communication via email, 2014]

Working For Local Counterparts

Aboriginal health workers consider working alongside supportive, culturally competent non-Aboriginal staff as important to job satisfaction and longevity [15, 16]. Non-Indigenous health staff can act as advocates for local workers, highlighting their important role in two-way health communication and culturally safe health programs and services [17]. Visiting health professionals can acknowledge peoples' existing knowledge and skills and help them strengthen these capacities. This might involve local informal training, developing stronger links with AHW training including certificate III and IV (such as helping AHWs complete certificate III and IV level training in health-related subjects and activities), or encouraging, supporting and assisting workers to access other appropriate training and obtain or upgrade formal qualifications. Non-Indigenous staff might also work with funding organisations to help define roles and become involved in a mentoring partnership [6].

See also in this section: Mentoring Relationships with a Local Counterpart

Relationships with Other Non-Indigenous Health Staff

The high staff turnover in Aboriginal health means that relationships are frequently broken and new connections need building. Building relationships with local people in remote communities takes time. It is therefore often the case that new staff and staff working on short-term projects or contracts initially find themselves dependent on other non-Indigenous staff. In order to work most effectively, do some groundwork before deciding on which people or organisations you will seek partnerships. Be aware of differing values, goals and political constraints. Partnerships with the wrong people or organisations can prove detrimental to your work.

When working within or across organisations, effective partnerships require a willingness and ability to work towards a shared view of the situation and be willing to work on complementary approach strategies. Outside of the office it is also important not to engage in, make judgements on, or repeat 'community gossip'.

Building Relationships

Efforts to build relationships and communication pathways can take on many forms and be influenced by numerous factors. In order to build and consolidate relationships consider the following strategies.

STRATEGIES FOR DEVELOPMENT

- **Participate in community festivals, events and open days or other activities,** or accept an invitation to **attend a community ceremony**. Watch local artists and craftspeople at work, participate in on-country camps or activities, church services and sports. Rather than see yourself as a 'technician' or 'expert' try to become involved in the social life of the community [18].

- Go out with local people on **hunting/gathering/fishing trips and eat some local foods**. Respect the cultural foods of others, even if they appear and taste very different to what you are used to. As for all aspects of your cross-cultural work, try to be open to new experiences.

- Try to **live off food from the local store** for a week or so (with an awareness of how much money many local people have to spend on food).

- **Travel around communities on foot**, as opposed to in vehicles (but watch out for "cheeky dogs").

- It may be beneficial to first meet people in informal circumstances without a specific agenda and unfettered by the need to discuss your role. For example, **share a meal or a cup of tea** with local people. This way may mean sitting with the health workers and having a yarn during lunch time or smoko.

Mental health professional, Ernest Hunter examined the importance of the Aboriginal tea ceremony [19]. For health practitioners he found that sharing a cup of tea helped to provide balance, conveyed care and concern, and was an important part of building trust and communication.

- **Foster connections with respected and relevant people in the community.**

- **Avoid tokenistic actions.** This can been likened to the difference between being seen to have done the right thing or 'ticking the boxes', and actual community engagement, where work is carried out in conjunction with the community, and meaning can be drawn from what you do [12](p.161).

- **Be transparent with relevant facts or details.** For example, be upfront with community members about factors created by broader systems and funding cycles that are outside of your personal control. For example, the length of your contract or the likely extent of time you can spend in the community. People can then make up their minds if and how they might want to contribute or be involved.

- **Be respectful.** Based on her work, nutritionist Annabelle Wilson [12] notes,

"...respecting community time and space, respecting cultural boundaries and respecting advice when you are given it, even if it's not what you want to hear. Earning the community's respect is an important milestone learnt through participation in the process. How one goes about obtaining it is unique to every project and community, and how one knows when they have got it is something they learn along the way." (p.163).

- Be willing to **let relationships and circumstances "evolve" naturally** rather than try to control people or situations.

- **Be flexible, spontaneous and "go with the flow"**. For example, accept that due to social obligations or any number of other reasons, from one visit to the next people with whom you feel you are developing a relationship may be unavailable or unwilling to spend time with you. At these times, **be open to other possibilities and opportunities.**

- **Be consistent**. For example, if you say you are going to be somewhere or do something, make sure you are able to follow through, even it if needs to be rescheduled.

Two-way Learning & Sharing

"Initially, my research goal was to become clear about the way that we should work in Aboriginal health. Now, I am no longer searching for 'the way'. I no longer see myself as the 'expert' coming in with the answers... I have come to appreciate that I have some knowledge, the community I am working with has some knowledge, and together we can work out what they might like to do. ...As one individual I can only do so much; together we can do more." Dr Annabelle Wilson [12](p.175)

Many in health care recognise the benefits of two-way sharing between non-Indigenous health professionals and the Aboriginal people and communities within which they work. This builds cultural competence and is integral to a culturally safe approach.

The Origins of Two-Way Learning

The term two-way learning has been used more-or-less interchangeably with bi-cultural and both-way learning. The idea of two-way learning has its roots in school education in the 1980s where Indigenous teacher trainees, most notably Dr. Yunupingu and Nalwarri Ngurruwutthun, recognised and introduced the notion of mixing knowledge systems – imparting Indigenous language and culture alongside Western teachings [20, 21].

Among the Yolngu of north-eastern Arnhem Land, the meeting of two knowledge systems has been likened to the meeting and mixing of two bodies of water [20]. Ganma is the place where salt and fresh water come together and mix near the mouth of a creek. While never fixed or static, the salt and fresh waters continually merge to form something new: the on-going construction of new information and knowledge [20]. In more recent years, two-way learning and sharing between Indigenous and non-Indigenous Australians has been applied to health care, health promotion and research [11, 22-26].

Figure 4.1 shows a painting by Steve Djati Yunupingu (2002) which depicts a two-way approach to health and health-related activities. The painting argues that contemporary community health must be grounded in Yolngu tradition.

Figure 4.1: A representation of Yolngu and Balanda concepts of health

In the words of Elaine Maypilama, *"In the centre there is a child in a womb – they might be male or female, black or white. As this child grows they need to learn from both Yolngu and Balanda education. In Yolngu culture they will always be sitting with people, with Elders, observing and listening... They will learn how to go hunting and find good tucker, and know what to eat and not eat... They will learn our culture, traditional stories, painting, singing, dancing... They also need to learn sports to keep them healthy and strong... And they also need an education in the Balanda ways. This picture shows that we need to work together, work in collaboration to achieve good health and education. If you have gone through all of this then you have a bright future."* [Elaine Maypilama, Personal communication, 2014]

What is a Two-Way Approach?

Two-way learning and sharing is an iterative process, best approached without prior judgements or assumptions. It is not so much about finding 'truths' and producing 'outcomes' as it is about **negotiating reality; generating shared understandings around the subjects and issues of the moment** [22]. Antal and Friedman suggest that this type of process be grounded in three essential values or beliefs: (1) as human beings, all people are of equal importance and worthy of equal respect; (2) as cultural beings, people differ because they possess different repertoires of ways of seeing and doing things; and (3) the repertoire of no individual or group merits a priori superiority [27](p.18). Through taking time to deeply listen, seek understanding and to discuss stories, experiences, thoughts and ideas, everyone contributes, everyone is heard and each party has the opportunity to generate their own meaning. Two-way sharing acknowledges that we are all ignorant and we are all knowledgeable. In two-way dialogues, **both parties are teacher and both are learner, working together.**

The term Djäl-manapanmirr ga räl-manapanmirr has been used to describe two-way sharing [28]. Spoken in Djambarrpuyngu (from Northeast Arnhem land), Djäl-manapanmirr ga räl-manapanmirr represents such ideas as working together in a good feeling; building up strong pathways; giving each other ideas and thoughts and knowledge; teamwork that flows smoothly and confidently.

Inherent to the process of two-way sharing is the **recognition and respect of diversity and being open to consider new values and viewpoints** [29, 30]. Recognising individual, cultural and community-related diversity among Aboriginal people can facilitate feelings of strength, self-worth and wellbeing [31]. In this way, affirming rather than ignoring or negating people's beliefs, values and practices is inherently health promoting. Relating and sharing with each other can also help to realise common ground. **Figure 4.2** depicts a two-way approach to nutrition education and promotion that builds on those aspects of each sphere which are compatible.

Now take some time to recall situations when you have participated in two-way learning or sharing. Use the following questions to guide you, then consider strategies, skills and approaches that might support this approach in the future.

FOOD FOR THOUGHT

Think of a specific situation.

- How did the two-way approach come about?
- How were others involved?
- How, for you, did the scenario play out?
- Do you recall challenging aspects?
- Do you recall rewarding aspects?
- What would you (or did you) do differently next time?

Areas of overlapping interest and knowledge that can be shared and explored
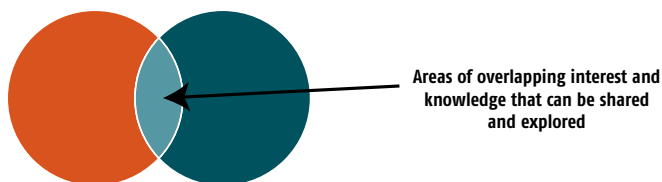
Figure 4.2: A two-way approach to nutrition education and promotion *By expanding our areas of shared or overlapping interest and knowledge we can create an ideal space within which to move forward.*

The benefits of two-way approaches can also extend to processes and structures such as reaching agreement about people's roles, and deciding and defining how all parties will work together.

Facilitating Two-way Learning and Sharing

STRATEGIES FOR DEVELOPMENT

- When sharing or working with local people to create new information:

- Try to ensure all **discussions take place in settings that are comfortable for all parties** (But it is possible that there are times and places where you will feel uncomfortable). Be flexible and opportunistic.

- Allow all parties to maintain a feeling of independence of thought and action, and ensure **dual involvement in decisions and processes that are negotiated.**

- Understand that **all individuals bring with them various strengths, limitations, personalities, views and lived experiences**, and that this will influence their unique contribution to and expression of two-way learning and sharing [30].

- **Move away from the need to find 'answers'**, 'universal solutions' and 'outcomes'. View knowledge generation and learning as a process in constant flux. Be willing to acknowledge and rethink assumptions and **embrace differences and new possibilities.**

- **Learn to admit when you don't know** what to do or how to respond to a particular issue; be truthful with yourself and others about what you can hope to achieve.

- **Ask for guidance** when you are unsure, and **accept that you are learning and will make mistakes.**

- Be aware that much is learned by taking time to **observe and listen deeply**. Let Aboriginal people tell stories in their own way – about themselves, their communities and how they understand their present cultural and health situation. In the book, Trauma Trails [35], Indigenous scholar Judy Atkinson describes *Dadirri*, or deep listening. She writes,

"I will listen to you, share with you, as you listen to, share with me... Our shared experiences are different, but in the inner deep listening to, and quiet, still awareness of each other, we learn and grow together. In this we create community, and our shared knowledge(s) and wisdom are expanded from our communication with each other (p.17)

- Be aware that **not all information will be shared with you.** Some Aboriginal people may be reluctant to share knowledge (of traditional foods, for example), due to fear that knowledge may be exploited. As a non-Indigenous person there will also be situations and knowledge that are not appropriate for your attention. Experienced nutritionist Robin Lion reflects,

"There were occasions when people couldn't talk about specific foods or subjects because either we weren't considered ready or it wasn't deemed appropriate to have that information shared with us. Sometimes the teller was not the right person to share that information..." [Robin Lion, Personal communication, 2013]

- **Persist** in your own learning and in the development of relationships and two-way exchanges with others.

- **Laugh, joke, have fun and don't take things too seriously!** [36]

- **Engage in reciprocity.**

Concepts of Position & Power

In the past and still in the present, the social, economic and political structures in which Aboriginal people live are inherently disempowering [32]. Knowledge too is generally built within structures that are power-based and influenced more by those in authority [33]. Working in two-way partnerships helps to work through power inequalities that can exist on many levels. For example, power inequalities can manifest through poor communication practices such as sole use of a dominant language and fixed styles of discourse and message content that reduce access to health information [25, 26, 34].

Reciprocity

Acts of reciprocity can include the exchange of information and perspectives in the construction of new, shared knowledge and meaningful health messages. In other forms, reciprocity may include services, experiences, or anything that one or both involved parties deem of value. Reciprocity is a way of meeting people "half-way", and sharing. Allied health professionals working in Aboriginal communities regard reciprocity as an important and effective means of building strong individual and community bonds [4, 5, 12].

In her community research, Wilson identified nutritionists who viewed the provision of nutrition information as their part in acts of reciprocity [12]. In this context more experienced practitioners understood reciprocity as part of their service to the community – a contribution occurring in ways determined by the community. Only after being of service did the more experienced nutritionists expect to receive anything in return [12].

Acts of reciprocity:

One Aboriginal nutrition worker assisted community members to collect bush flowers to make funeral wreaths. Her senior colleague saw this as an important element of building relations and trust that extended to her later work running cooking sessions in local community events [Robin Lion, Personal communication, 2013].

Driving health and community based workers to meet other people in the community can provide everybody with a chance to chat about lives or recent goings on. Aboriginal people are often keen for those with cars to take groups out hunting. One nutritionist shared: "When I was based in Gove, working as a nutritionist in North East Arnhem Land, on some weekends I would drive to Yirrkala community and pick up an Aboriginal Health Worker I had befriended with other members of her family. I had the wheels and she had the knowledge of the country and together we would spend a day hunting and collecting [Julie Brimblecombe, Personal communication, 2014].

One nutritionist assisted at a "pamper day" for mothers with young children, helping to paint toenails, find hair colourings and make cups of tea while the women had their hair cut. Taking the time to participate in these activities with the ladies assisted the building of strong relationships and led to more acceptance: "I am welcomed into yards and homes that were otherwise 'off limits' where I previously waited at the fence... The ladies now choose to sit with me at group sessions, and conversations are much more open with silent space that is not constrained, but freer... Spending this time with the women also supported the provision of follow-up clinical care in the women's homes." [Anthea Brand, Personal communication via email, 2014].

One nutritionist reflected: "There had been many funerals in a community with prominent community members passing away. The community seemed very sad. A local organisation who we had been working with to help get people started with backyard food gardens bought a pot plant and made a card for bereaved families in the community and delivered these in person to show their concern and care" [Julie Brimblecombe, Personal communication, 2014].

A Mentoring Relationship with a Local Counterpart

Participating in mentoring partnerships can help to strengthen the knowledge base, capacity and confidence of both non-Indigenous [37] and Indigenous health workers [38]. Mentoring relationships can take on many forms, but may work best when supported by organisations within formalised structures [38]. If this is not the case, possible ways that a practitioner might find or meet a local mentor include getting in touch with the health clinic, AHWs, CBWs or a community-based health organisation to ask if someone can guide you. It might also be useful to get in contact with experienced community workers who will be aware of existing processes or requirements to 'introduce' new staff to the community, or what to do when there are no processes in place.

The following stories relate to the experiences of one nutritionist (whose name has been withheld), and describe two different ways in which mentoring relationships can come about. The first account highlights the importance of patience, perseverance and being open to new opportunities. The second provides an example of what can take place when pre-existing relationships are in place between the organisation that a health professional works for, and individuals and/or organisations within a community.

When I first visited Kowanyama on the Cape York Peninsula in Far North Queensland it was only the second time I had been in a remote Aboriginal community. I was to have been accompanied by an experienced team leader however, other commitments meant that she could not travel. Instead, phone calls had been made to the senior health worker and director of nursing, both promising to help in my introduction process.

Upon arrival, I found herself in a busy clinic with AHWs who, while friendly, did not have the time or energy to spend familiarising yet another new 'white fella' in the community. I found myself waiting out the day in the clinic tea room, introducing myself to anyone who came in.

...On my third trip to the community I was lucky enough to meet the visiting child-health nurse who mentioned that the head of the local women's group was interested in child nutrition. During my lunch break, the nurse took me to the women's centre and introduced me around.

After visiting the head of the local women's group every week for two months and spending a lot of time drinking tea and 'yarning up', one day the ladies informed me that I was 'okay' and that they were going to show me around. Somehow, slowly, an unspoken agreement had developed. From that time on, the head of the women's group became my mentor and working guide while I was in the community.

****

A few years later, I began working in Arnhem land in a remote island community. The week prior to my first visit a senior colleague gave me the phone number of a contact in the community. My colleague had already spoken to this woman and informed her of my work, and my arrival. I made a phone call and spoke to this woman involved in health work and arranged to have a 'yarn' with her. Much to my surprise, when I arrived two women involved in women's health met me and informed me that one of them was going to adopt me as a 'sister', introduce me around in the community and, most importantly, teach me about community ways. The women explained that this was the process for all newcomers to the community, and that I would need to learn their ways.

From that visit onwards I was taught about social structures, the land and the plants and animals that lived on it and how these were important for health. I was taught language words and expected to learn and use these, as well as being expected to 'check in' regularly on the phone with my sister. I try to remain in contact with my sister to this day.

While the above stories demonstrate that mentoring partnerships can evolve over time and remain somewhat informal, it may however, be most productive and beneficial for employing organisations to align mentoring relationships through structured processes. The following strategies may be useful.

STRATEGIES FOR DEVELOPMENT

In order to enhance and strengthen mentoring partnerships it may be beneficial to [38, 39]:

- Involve the local community in selecting mentors.

- Clarify the roles and functions of the mentoring relationship, and identify the learning needs of both parties during shared communication.

- Ensure both parties are willing to learn and modify their practice.

- Engage in formal partnered projects such as the development and implementation of a local health promotion project or event.

- Inclusion of mentoring activities in the job descriptions and work-plans of both health workers and health practitioners.

- Have managerial support and involvement in mentoring arrangements and the development of formal mentoring agreements.

- Monitor the relationship and learning goals.

- Be aware of the limitations that some mentors may face (poison cousins, areas of country not available/forbidden to them, family/health commitments, clan business etc.)

Other Mentoring Relationships & Programs

It can also be beneficial to seek a mentor outside of the community. When considering possibilities, choose to work with people who you feel are the most informed of your present situation, the least biased, and not overly constrained by power relations or structures. This may include:

- An Aboriginal person who is experienced in health and/or nutrition.

- A past or present practitioner from the same field with significant experience working in a remote Aboriginal setting.

- An experienced health professional or colleague who has worked or is working in similar communities.

- An experienced manager who will engage in constructive two-way discussions. (While this might include your own manager, seeking the guidance of people who are not your immediate superior may help to optimise objectivity and guidance).

Mentoring approaches that may be especially useful for new practitioners are mentoring circles and **communities of practice**. Both of these groupings provide safe places to share experiences, feelings, thoughts and insights among people in a similar work environments [40]. These supportive groups may focus on a specific area (for example, focus on work with the community store), or provide a more general support network (for example, for dietitians/nutritionists who work in Aboriginal health). Download guidelines on how to set up a mentoring circles at: http://www.med.monash.edu.au/scs/nutrition-dietetics/research.html

Peer group supervision is another group-based professional support activity that employs a structured process within which a group of peers provide each other with professional support. Peer group supervision does not rely on an established 'expert' to provide guidance. Instead the collective experience of the group is used to identify peer group supervision goals and address these issues as a group. Activities can assist group members with reflective practice, and addressing challenging clinical and professional situations. This process has been used within Queensland Health. More information can be obtained from http://www.health.qld.gov.au/cunninghamcentre/docs/allied/peersupport-fsh-v1.pdf and http://www.peer-supervision.com/index.html

The **Remote and Rural Mentoring Program** has been developed to assist remote, rural, and isolated health practitioners with information about effective mentoring practice, and suggestions on how mentors and mentees can get the best out of a mentoring relationship. For more information see http://www.healthinfonet.ecu.edu.au/key-resources/programs-projects?pid=2111

Further guidance related to mentoring programs can be found in the report 'Heart Health Action in Aboriginal Communities: translating training into practice'. To access go to: http://www.vaccho.org.au/vcwp/wp-content/uploads/2011/03/Health_Action_in_Aboriginal_Communities_eval_Report_Final_2009-09-18.pdf [39].

The Queensland Aboriginal and Islander Health Council (QAIHC) have produced the 'QAIHC Mentoring Guide for Aboriginal and Torres Strait Islander Health Workers and Health Professionals'. This resource should be available via HealthInfonet or contact QAIHC to arrange access to a copy.

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Part I (sections 1 to 4) of Food and Health Communication Across Cultures considered a number of interrelated ideas, frameworks and processes to help build a strong theoretical foundation and guide the practical nature of your work. These included:

Personal aspects –

· **Consciously and continuously being aware of your 'position' and perspective as a cultural and social being and health professional** by, for example, reflecting on culture-imbued beliefs, attitudes and values; being aware of any assumptions and preconceived ideas; critiquing your professional practice; striving to understand your complex role in relation to others (Section 1).

Historical and wider environmental aspects –

· Being aware of the influences of **ever-present cultural, historical, political, social and economic factors on your own life and the lives of others.** These factors shape our views (including views of health, illness and disease), our behaviours and our health (Section 2).

Interpersonal aspects –

· Understanding and incorporating key strategies and practices to **enhance cross-cultural, interpersonal and health communication** (Section 3).

· Relationships are inherent, and even provide a 'scaffold', to support the Aboriginal world-view. This includes relationships with people, animals, nature and on-going relationships with ancestors and beings of the spiritual and mythical world. **Think in terms of *relationships*.** Relationships with people, with communities, with ourselves, and with the various environments in which we live and work. As practitioners, we can prioritise relationship building; support and work in partnership with Aboriginal health and Community-based workers; share in acts of reciprocity; and share stories and strengths two-ways (Section 4).

Part II now builds on this foundation through consideration of processes more specific to supporting the shared construction, communication and evaluation of food- and health-related information and activities.

Section 5: Consider Your Approach is divided into three parts.

· *Section 5.1* delves into the essentially on-going process of "community consultation", providing discussion and tools to guide participatory approaches.

· *Section 5.2* contextualises and states the need for health information and health literacy, then examines the predominant learning styles of Aboriginal people.

· *Section 5.3* provides an overview of possible health promotion approaches and tools that may be more suited to the preferred learning styles of Aboriginal groups with whom you work.

Section 6: Consider Food presents a range of notions linked with food, eating-related practices and the health of Aboriginal people and communities to offer examples of possible health promotion avenues to explore.

Section 7: Consider Demonstrating Your Effectiveness provides some guidance on how to evaluate health promotion and education activities within the cross-cultural process.

SECTION 5.1: CONSIDER YOUR APPROACH TO COMMUNITY CONSULTATION

Overview

If health professionals truly intend to share decision-making with groups and individuals they must create ways to share relevant information and opportunities. Section 5.1 considers ways that health professionals can optimise this sharing through engaging in various approaches, practical strategies and tools with community members.

Community Consultation

The community consultation process has been likened to a needs assessment; an essential first step to identify relevant issues or health problems and provide an early opportunity for the involvement of community members in health promotion projects [1](p.164). While this may be the case, community consultation should not be conceived as straight forward or easy. Nutritionists with experience working in remote Aboriginal communities have described community consultation as a fluid, often impromptu and challenging process that involves a mixture of top-down and ground-up strategies [2]b, and in an urban Aboriginal community as "...a dynamic process that looked very different depending on the people consulted." [3](p.131).

The From the Bush to the Store report on the development of community health services [4], explains that residents in two Top End remote Aboriginal communities did not want to be approached as if they, their community or their culture had all the answers to healthcare, yet they did want to be continually consulted and involved in seeking solutions to health problems. These people did not have fixed ideas about how the consultation should take place, they were most concerned that it did take place.

A good understanding of the community/ies in which you work is fundamental [5, 6], helping to ensure that the skills of outside health professionals interact with the knowledge, skills and perceptions of local people and resident staff, at a time and pace suited to local groups and situations [7]. Community consultation must take place so that new needs can be explored, and any pre-existing programs, strategies or ideas can be reformed to address different identified requirements, or novel issues that have been raised. Nutritionist, Anthea Brand shared:

> *In the community consultation process, too much emphasis on organisational or departmental agendas or priorities can skew perspectives, inputs and guidance.*

> *Given the often high turnover of visiting health staff, many communities may experience a 'consultative-engagement' phase year after year. One nutritionist noted, "in general people have been consulted to death and it's difficult to engage them in proper consultation." [2]b.*

> *Health and nutrition may not always be as much of a priority in the community as it is for you personally and professionally. People may be too busy or worried about other things to talk or think about food and nutrition. Be patient, listen, and be careful not to push too hard if people are not interested or ready to work on something that is not their key priority.*

> *... so much community consultation is tokenistic from the view that health staff often have preconceived ideas about what the community needs and how they are going to address it. Health workers may ask the community for their opinion but will not change their program... For example, part of a needs assessment must include assessment of demographic and health data, but this should be discussed with community in order to incorporate wider health needs and values. Preconceived ideas and strategies should not overpower community consultation, or dominate community directions or priorities. [Anthea Brand, Personal communication via email, 2014]*

Strength-based Approaches

> Strength-based approaches are also known as appreciative inquiry or working from an assets-base.

Strength-based approaches frame enquiries to focus on the positives that already exist in peoples' communities and lives. What is good; what do they value; what makes them feel strong. Acknowledging and working with people's strengths reinforces what people already value, and what they already know. In discussions with members of one remote community, people talked about their cultural ways and traditions; keeping their children and family fed; trying new foods or recipes; navigating the aisles of the community store [8].

> *Instead of asking: What do people need? or What are their problems? Tarun Weeramanthri suggests that health practitioners first need to ask: **What do people know?** and then **What do people value?** [9](p.3)*

Strength-based approaches are superior to a singular focus on problems and needs. Problem-based thinking gets caught up in what is missing; what are the difficulties and constraints [10]. This can be disempowering and counterproductive for the individuals and communities that you work with. It is also a disempowering health development approach. Re-orienting one's thinking away from what is 'wrong', and barriers, can help to bring new perspectives on existing situations [3]. Consider the following:

FOOD FOR THOUGHT

- People's strengths are contained in **encouraging/ affirming/enjoyable/humorous stories.**

- Ask people what makes their **community special.**

- **Why do people live in the community** and not in town?

- Where are people's **favourite places** in the community?

- Their **favourite activities?**

- What do people **value about food?** Other issues?

For further discussion on strength-based approaches go to: http://www.lighthouseresources.com.au/about-us/facilitator-gallery/wayne-mccashen/

Formative Research

The formative research carried out during the development of this resource was one way to begin to relate to community people. Formative research is an open, qualitative form of enquiry carried out at the beginning of a proposal, project or study. In addition, and perhaps in contrast to health statistics and measurements, a formative approach tries not to make too many assumptions before collecting new information. Formative research is process-driven, yet can take place within formal or informal study. For example, the processes incorporated into the formative research in this project helped to think through ways to ask questions and gather information: which questions to ask and of which people; it also helped to bring new perspectives to light.

Formative research can also inform the development of strategies and new ways of doing things to bring about improvement or tackle an issue with the community. This becomes a critical step of a study or project. It sheds light on people's perspectives on the issue of concern, people's existing knowledge, their beliefs and the importance of the issue to people. This information will then shape the approach. Some of this information may already be available in existing literature however, it is important not to assume that people relate to or approach an issue in one community or population in the same ways as another. In some cases there may be pressure to start the action and a rush to "do

something" to address an issue. This pressure may sometimes come from members of the community too. Investing the time at the outset and making sure everyone is clear on why the formative research stage is important, will be of benefit in the long-run.

Formal Research:

All formal research requires structured consideration within ethical guidelines and policies.

If thinking of commencing a small research project, ask for guidance from those with experience within your organisation. See also, for example,

NHMRC Values and Ethics - Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research at: https://www.nhmrc.gov.au/guidelines/publications/e52

Jamieson, L. et al. (2012). "Ten principles relevant to health research among Indigenous Australian populations." Med J Aust 197(1):16-18 at https://www.mja.com.au/journal/2012/197/1/ten-principles-relevant-health-research-among-indigenous-australian-populations

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Participatory Action Research

Rather than think in terms of consultation, it may be beneficial to think in terms of participation – in a process and related activities. Participatory Action Research, or PAR, is a collaborative, democratic, cyclical process where 'findings' are created as the investigation or project proceeds. Participatory action research can be thought of as an approach to social investigation, an educational process, and a way to take action to address community-identified issues or needs. However, rather than an outside health professional dominate proceedings, co-learning and capacity building is promoted alongside inclusive, equitable partnerships that blur the roles of the 'researcher' and the 'researched'. Through a cyclical and iterative process, community-based participatory research can promote greater responsiveness, ability to adapt to new information and situations, and a better balance between research and action for the benefit of all partners [11]. It is important to realise that PAR is not just about involving community people in a project or study; it is an empowering process, often with political undertones. A wealth of literature exists on PAR. See for example the following:

Further reading:

Spooner, C., Flaxman. S. Murray, C., (2008) Participatory research in challenging circumstances, Lessons with a rural Aboriginal program, Evaluation Journal of Australasia, Vol. 8, No, 2, 28–34.

Khanlou, N and Peter, E., (2005) Participatory action research: considerations for ethical review, Social Science & Medicine, Vol 60, 2333–2340.

Web-based information on Participatory Action Research, Planning and Evaluation:

http://portals.wi.wur.nl/files/docs/ppme/UNDPCSOPP-EmpoweringPeople-GuidetoParticipation.pdf

http://www.fao.org/docrep/003/x5996e/x5996e06.htm

http://betterevaluation.org/resources/toolkit/handbook_for_participatory_action_research_planning_and%20_evaluation

http://betterevaluation.org/plan/approach/participatory_evaluation

See also Section 7: Consider Demonstrating your Effectiveness

Appendix G offers a framework and pathway when undertaking research and collecting true stories in remote Indigenous communities. It is called Dhukarr'kurr Yan Marrtji: Larrum Yuwalkku. A Pathway for Collecting True Stories in Remote Indigenous Communities

Practical Considerations in the Process

When approaching community consultation and considering what do people know and what do they value, some questions might include:

> **What are the current community dynamics?**
>
> **Who might you talk to?**
>
> **What is the cultural knowledge base?**
>
> **How do social & economic factors guide people's dietary habits?**
>
> **What has already been tried or done?**

These questions are considered below.

What are the Current Community Dynamics?

Anthropologist, Jeannie Devitt stated *"the best way to understand community dynamics and health priorities is to see people as individuals and interact with them in their community life."* [12] (p.12). While focusing on time spent within the community, in order to ground yourself in a broad information base, it may be useful to:

- Ask community representatives and local government departments if there are community profiles you can read (you may also find information online)

- Introduce yourself, or arrange an introduction at the Shire Council

- Ask how the local Council is formed

- Find out if the Council have views on community health priorities

- Ask local health organisations if they have health profiles and planning/priority documents that you can view. There may be community plans that have been developed by a community reference group

- Consider whose land the community is sited on and who the senior men and women are in that group

- Ask what other health organisations and local community groups are operating in the community. For example, in Cape York the Health Action Teams (HAT) and Local Action Groups (LAG) [13]

Adapted from [14] and [12](p.12/13)

Who Might You Talk to?

Aboriginal communities are not homogenous entities. While the word *community* has come to denote groups of Aboriginal people living in the same geographical space, Aboriginal peoples' associations are more based on language group and forefather's country [15](p. 50). Colonisation relocated almost all clan groups off traditional tribal lands to live alongside one another in communities. Naturally, some present day conflicts arising within communities are sparked by friction between groups who not so long ago lived autonomously on their forefather's land.

In remote communities it is important to strive to hear the stories of all relevant subsections of the community. **Try to establish contact with as many individuals, families, community groups and organisations as possible**. People within different groups may have different issues and ideas that necessitate different considerations and approaches. People and organisations that can help to determine community health interests, worries and priorities include [1, 2, 8, 16-18]:

- Community leaders and elders
- Aboriginal health workers
- Community-based workers

> Aboriginal health workers and Community-based workers are likely to possess insights into community priorities and may already have ideas about ways to address some issues. They are also in a good position to introduce you to other relevant people.
> See also Section 4: Consider Relationships

- Strong women workers
- Aboriginal community and health councils (if possible, attend a meeting)
- Aboriginal boards
- Aboriginal education centres
- Local community members
- Aboriginal project officers or research officers or assistants
- People involved in local sports

- The school and after school groups
- The community store manager and workers
- Healthcare clinic
- Childcare workers
- Women's centres
- Local council/shire
- Recreation centre
- Youth group
- Welfare Officers and Women's / Men's support groups or services
- Homeland centres
- Arts centre
- Aged care & Meals on Wheels

> In order to continue to build and share new knowledge from the right place, local people and health workers will need opportunities to interact with new ideas [18].
> It may take some time for people to reach decisions.

Other useful areas of inquiry include government nutrition and physical activity policies, local health data including child-growth data, Aboriginal medical services, funding organisations and research papers [2]b.

Be Flexible & Opportunistic

- While pre-planning can be helpful at times, plans can and do change. People you may have planned to talk to become unavailable; new people or activities emerge. Your work ebbs and flows. Wherever possible, let it evolve, and avoid focusing on time or deadlines. Working towards this may require open discussions with your manager and negotiations within the agenda of your supporting organisation.

- Being flexible can help to make the most of opportunities as they arise such as discussions that take place incidental to informal activities such as joining in a craft group, chatting while chopping carrots [2, 3], or a chance meeting in the airport or at the store.

- Be aware that it may be difficult to establish contact with some key community people. Often, people who are known to be effective community operators are in high demand by numerous organisations and visiting workers, on top of their own work and family responsibilities. If your introduction or request to meet is ignored, don't take this to heart. Try to make it as easy as possible for these people to meet with you. It may be helpful to reflect on your approach, talk to other people, or try another path [3]. A poor reception often improves upon repeat visits, once people realise that you have been around for a while and are genuinely interested.

What is the Cultural Knowledge Base?

It is generally only in trusting relationships that people have the opportunity or desire to share stories about their life and experiences; the things that they know and value. The listener must also be worthy of the information, and willing and ready to receive it. The following list outlines a number of considerations that might serve as useful starting points for your own reflections, and to future interactions and conversations.

FOOD FOR THOUGHT

- What are the concepts and ways of relating to food which have previously existed, or currently exist in people's experience and language?

- Do families still hunt, collect, prepare and share foods?

- What do people and their families value about their current or traditional food system?

- Are their any local stories (Dreaming; Law...) that relate to food or eating behaviour?

- What do health workers and other community members consider important indicators of health? wellbeing? ill–health/disease? [12]

- What are your own personal thoughts and experiences and values? What indicates health, wellbeing and disease for you?

How do Social & Economic Factors Guide People's Dietary Habits

Section 2 has already considered some of the socioeconomic conditions that can impact and constrain the health and wellbeing and dietary habits of communities, families and individuals. Be mindful that in some circumstances personal questions may provoke feelings of shame, for example, people may feel sensitive when asked about or discussing their living situations. As a starting point to exploring relevant aspects of the lives and people and their community, it may be best to start talking with local workers or people in the community with whom you share a strong and trusting relationships. Consider the following:

FOOD FOR THOUGHT

- How many people share living spaces?

  - This can vary depending on the season; in the wet, people may be isolated from Homelands and stay with family in community.

- What sort of kitchen and household infrastructure do families have?

  - A working fridge? An oven or cook top? Saucepans? Do families lock cupboards? Are there rats or vermin in the house? How often is the power or water supply interrupted?

- How do families proportion and share resources and food? Who buys the food? Who cooks, and how?

- Are there family members with health issues? Do they require 'special' diets?

- How do pay and welfare cycles impact on eating patterns?

- What foods are available in the local store(s)? Do delivery cycles influence this?

What has Already Been Tried & is Currently Working?

Building an awareness of the 'history' of health projects within the community is important in order to optimise learning from past experiences, and build on existing strengths and what has been done well before. A historical perspective also reduces the risk of repeating past mistakes. From a community standpoint, your awareness of past approaches can help avoid despondency or frustration if ideas promoted as "new" have yielded disappointing past experiences, for example, a community garden that was started but never finished.

Health-related activities and outcomes reported in other communities may also be useful to inform approaches in other settings. However, too strong a focus on findings from elsewhere can erode the community ownership; 'successful' projects elsewhere may disappoint if applied to mismatched needs or locations [7].

Knowing of existing programs in each community offers an important means to assess what is currently working and help identify people and agencies to work with. It can also help to promote consistent health messaging across organisations. When it comes to health messaging, inconsistent or even conflicting information causes confusion [18]. One nutritionist observed,

> "In the community where I lived a lot of people were aware of the importance of strong blood, and the need to eat meats and also foods high in vitamin C... I think this awareness has been raised through seeing the same posters in the health clinic, with the nutritionist, in the Mums and bubs groups, and also at the hospital in town. Having a consistent message is very important... It also comes down to the fact that the idea of 'strong blood' holds meaning for people."
> [Clare Brown, Personal communication, 2014]

Existing programs can also act as a springboard to extend pathways and explore further needs. For example, nutritionists have described that the processes of community engagement and consultation have overlapped or run concurrently with program development and/or implementation [2]b. One nutrition practitioner reflected,

> "A good starting point I found was to work with reputable organisations already within the community – even if it was just contributing a small amount to their program as a way in, and from there, gradually consulting with the community as to how to work." [2]b

FOOD FOR THOUGHT

- What past approaches have been undertaken in or by the community?

- Who in the community was involved? And how? Are these people still around?

- What has worked positively in the past, and what has not?
  - Can anyone remember key factors influencing why an approach 'worked' or why it did not?
  - Were there particular enablers or constraints? Do they still exist?

- What about past programs that may have had positive influences/outcomes in other areas?
  - For example people may speak favourably of a video project that focussed on gambling, parents meetings to deal with petrol-sniffing in the community, or a homeland-visiting project focussed on documenting native plant species.
  - What were the elements of these projects that worked and left people with good memories?
  - Could some of these be used to share other health knowledge and messages with other groups/populations in the community?

Feeding Back to the Community is Vital

Feeding back to all relevant people and community groups is an important part of the community consultation process. Reporting back:

- Helps to reinforce trusting relationships

- Keeps communication channels open

- Respects knowledge gained from the community

- Allows people and groups to revisit ideas and messages

- Lets people know and discuss how projects are progressing and keeps people abreast of new developments

- Demonstrates that the work being undertaken is aimed at meeting the community's needs, rather than the agenda of the visiting worker

- Is a symbol of reciprocity

Where possible and appropriate, feedback to the community should primarily be carried out through the Aboriginal health or community workers with whom you are engaged. Two different examples of ways to feed back to communities follow:

During the 12-month study within the community of Minjilang, 3-monthly biochemical, haematological and anthropometric test results were fed back to involved individuals within 2 weeks of the test. These reports were accompanied by discussion of tailored nutrition messages, and often took place within family groups. Most of the feedback was provided by Aboriginal health workers employed within the project [19].

Of her work in a Cape York community, nutritionist Frances Knight shared,

"..even if I was busy I made sure that during every visit I stopped at the local Aboriginal corporation for a chat and a cuppa. While we didn't always directly work together, the staff there saw health-related activities as their business and many were members of the local Health Action Team (HAT). It was not always possible to be present for a HAT meeting, but at least visiting with the corporation staff meant that they were aware of what I was up to in the community. This also gave them an opportunity to offer feedback and suggestions and raise any concerns. These meetings were always very casual and not very long, but they kept communication channels open and informed this important group of my actions and of activities concerning their community." [Frances Knight, Personal communication via email, 2014]

For further consideration of reporting back to community members see Section 7: Consider your Effectiveness

Tools to Assist in the Process

Symbols and images can be very useful ways to communicate within community consultation and engagement. Following are several tools that incorporate visual images, and have been used in remote Aboriginal communities during community engagement and consultation processes.

A 'What Can A Nutritionist Do' Book

Some nutritionists have reported using a visual 'what can a nutritionist do' book as a useful starting point to initiate communication that also helps individuals and community groups determine where a visiting health worker might assist [2]b. In a recent project to develop a shelf labels tool for remote community stores, non-Indigenous project officers used this type of approach to introduce themselves and their work to the community, then let people think about their own priorities and what they might want [20]. When introducing new ideas it is always helpful to explain why these issues and subjects are believed to be important.

Chronic Disease Story Board

The Chronic Disease Story Board (CDSB) was developed in remote Aboriginal and Torres Strait Islander communities as a hands-on, visual communication tool that helps Aboriginal health workers to engage people in discussions about past, present and possible future stories about chronic health conditions within individual and their families. The CDSB consists of a felt base that represents the land, accompanied by small felt circles and emblems which represent adults, children and various health-related behaviours/habits and diseases. Assisted by health workers, participants use these symbols to map out the past, present and possible future health stories of themselves and their families.

This process has helped to identify priorities and open communication channels between health workers and community members. It has empowered people to share their story, make commitments to change health behaviours, and create a 'ripple effect' on to families and communities [21].

For further details go to http://mylearninghealth.nt.gov.au/course/info.php?id=595 and see also Section 5.3 of Consider your Approach

Image of the Chronic Disease Story Board (CDSB)

A guide to a Good Food System in your community

The *Good Food System* approach has been developed by the nutrition team at Menzies School of Health research together with four remote communities, their coordinators and related stakeholders. This guide to a *Good Food System* aims to support community people to look into and check the *food system* in their communities. This information can then be used to increase control and influence over decisions to improve *nutrition and food security* in the community, helping to support greater wellbeing and a longer and healthier life.

In a community many people are involved in the area of food security. The *Good Food Systems* approach brings the relevant people together to form a *Good Food Group*. This group regularly meets with a view to make step-by-step changes supported by an ongoing process of participatory planning, action and reflection. This process can be called the *Plan-Do-Collect-Learn cycle*. Tools have been developed to support this way of working, to help the group to learn about the community's food system and plan actions to improve nutrition and food security in the local community.
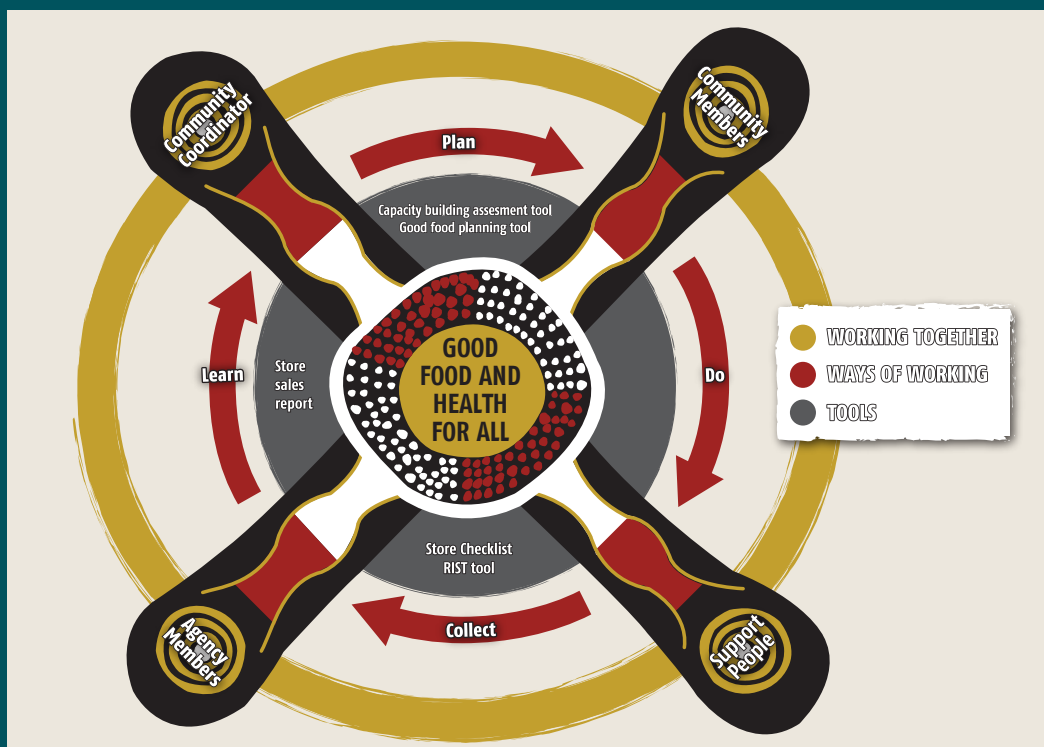
Figure 5.1.1: Overview of how to support a good food system in a community using the Plan-Do-Collect-Learn cycle

One of the tools developed to support a *Good Food System* is the **Good food Planning Tool**. Systematic use of this tool assists users to learn about the current state of the food system in the community, identify which parts are working well, which parts may need extra work, and what can be done to make it better.

The Good Food Planning Tool is designed to be used by a *Good Food Group*, but can be used by any community group working to improve any aspects of the tool's five key areas. For example, the food businesses section could be used by store boards together with store managers and public health nutritionists to consider best practice to support healthy eating in the store.

Figure 5.1.2 depicts five key areas integral to community food security and good nutrition:

· Strong leadership and partnerships

· Traditional foods and local food production

· Food businesses

· Buildings, public areas and transport

· Community and services

Good Food Planning Tool

Figure 5.1.2: The five key areas of the Good Food Planning Tool
Each area has a number of components and associated questions that help users think about what food security and nutrition look like in their community.

Figure taken from *'A guide to a Good Food System in your community.'*

Use of the Good Food Planning Tool has been shown to help different people with an interest in food and nutrition living and working with remote communities to understand better different people's roles and responsibilities and to support each other to improve the food supply and peoples access to food [22]. For example, public health nutritionists found that being involved in use of the tool helped connect them with others in the community, to understand the communities food and nutrition priorities and where they can be of support.

The Good Food Planning Tool can be used together with the Food Discussion Board (see pages 88 to 90).

For more information on the Good Food Systems go to:
http://www.menzies.edu.au/page/Research/Projects/Nutrition/Good_Food_Systems_Project/

Featured resource

www.menzies.edu.au/resources

Resources portal

http://www.menzies.edu.au/page/Resources/Capacity_Building_Assessment_tool/

http://www.menzies.edu.au/page/Resources/Good_food_planning_tool/

Appendix G offers a framework and pathway when undertaking research and collecting true stories in remote Indigenous communities. It is called Dhukarr'kurr Yan Marrtji: Larrum Yuwalkku. A Pathway for Collecting True Stories in Remote Indigenous Communities

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SECTION 5.2: CONSIDER YOUR APPROACH TO BUILDING HEALTH LITERACY

Within supported western urban environments, educational programs that address aspects of a healthy lifestyle can achieve or support these goals and reduce risk factors for and onset of chronic disease [1, 2]. When information delivery is tailored to the social, economic and cultural needs of specific communities, the effectiveness of health education approaches can be further increased [3, 4]. In a systematic and narrative review of randomized controlled trials to compare culturally appropriate and 'usual' health education for type 2 diabetes in urban-based ethnic minority groups, those receiving culturally appropriate health education showed improvement in HbA1c and knowledge in the short to medium term, compared to standard health education [4]. In rural and remote settings in Australia and overseas, the provision of culturally appropriate education using pre-existing cultural structures has been seen to assist in the uptake of Indigenous preventative health-related services [5-10].

Section 5.2 states the need for health information, arguing that health literacy must be conceived as a two-way process in order to ensure all parties have access to the health information. Several health-related concepts are examined, followed by consideration of the predominant learning styles of Aboriginal Australians.

Health Literacy

Health literacy is perhaps most commonly conceived as the literacy and cognitive skills that determine a person's ability to access, understand and use information for health [11]. This constitutes a context- and content-specific notion, such that even a person with highly advanced literacy skills may fail to understand specific health information in certain situations.

In exploratory work on aspects of health literacy in North East Arnhem land, Christie and colleagues have taken a broader stance, defining health literacy as *"the capacity to build and generate shared understandings about health, treatment and health services"* [12] (p.5). Rather than place the onus on one person to communicate or deliver health information (health professionals), or one person or party to understand the health information (clients), Christie re-conceptualises health literacy as a kind of two-way partnership involving **collective action** and **effective communication** [13]. He states,

"It is not so much what the individual client understands, but more the working together of the people and resources which generate shared understandings, agreement and consent around the problem of the moment. It involves honest respectful discussion across the divide between providers and consumers." (p.9)

Consider the following benefits of effective communication and health literacy.

FOOD FOR THOUGHT

A high level of health literacy [14-17]:

- Assists people to **understand health issues and what is happening to them or their loved ones.**
- Enables them to **understand their choices and make informed decisions about their own health.**
- Helps people to **understand the reasons for recommended behaviour change** or treatment therefore providing **an opportunity to decide to act** (unless people are aware of an issue or option they cannot choose to act on it).
- **Assists people to build skills and self-efficacy** to facilitate healthful foods choices and eating behaviour.
- **Promotes motivation and adherence to recommended changes**.
- Assists people to **correctly interpret, recall and internalise information.**
- Engenders **feelings of empowerment** through the acquisition of knowledge, resources and personal or collective skills.
- **Builds trust in foreign medical practices and advice.**

People may decide to ignore, reject or separate themselves from information and situations that make them feel harassed or uncomfortable. For Aboriginal people, incomprehensible instructions are also likely to stand in contradiction to the sense of personal autonomy which endows individuals a sense of freedom to make choices for themselves (See discussion later in this section).

To accept information without understanding requires an act of faith. If people do not understand an issue or the implications of acting in a certain way, medical or health instructions will be a string of illogical directives that hold no meaning.

Future Risk

The western concept of 'future risk' or 'health risk' conjures up visions of a possible problem down-the-line. Depending on our level of understanding and interest, we may decide to take heed of this early warning. Seeking to prevent future health problems is an increasing focus of western medical systems. This is evidenced in primary prevention strategies including screening, vaccines and prophylactic medications such as aspirin. A preventative focus also pervades public health approaches and philosophy. The western notion of risk underpins approaches to health promotion, such as offering early advice and strategies to change lifestyle behaviours.

The notion of future risk has been written about in relation to Aboriginal populations [18]. Alyssa Vass and colleagues observe:

"The concept of risk (as an abstract notion) does not appear to exist in Yolngu worldview. What does appear to be known regarding risk is a much more concrete appreciation for specific and immediate situations that are (potentially) dangerous to one's life. No words seem to exist for 'danger' or 'safety', rather each situation is seen to have its own warning signs, actions to take and outcomes [18](p.36)

The authors noted the absence of a theoretical framework for comprehending "degree of risk", or "how multiple risk factors may interact with each other or vary in impact relative to time and exposure" [18](p.35/6). While these views are theoretical and cannot be assumed to apply to all Aboriginal people and groups, the point is that risk is likely to be seen differently to the western view of risk – and also that worldview constructions can and do change over time.

In the public health arena, many health promotion messages are preventative in nature. For example, an understanding of the western notion of future risk is essential if one is to consider their present actions in the light of future possible health consequences.

How can we share meaningful information about future health risk across two worldviews?

While working with groups of men in Central Australia, nutritionist, Roy Price talks about "protective behaviours". He shared,

"It took me a long time to work out and find ways to engage men in conversations about health and health issues... Food and nutrition are generally considered women's business...

...What I have realised is the importance of symbols; for Aboriginal men particularly the symbol of the shield. Whenever I am addressing a group of men, the first image I use is an icon of a man. In Aboriginal art we see people depicted in a C-shape as if looking from above; this is the same for men and women. But we know if it is a man or a woman by what is beside the image. Women are always depicted with a digging stick and coolamon to carry the food. Men will have beside them a boomerang, spears, and most importantly, a shield.

I would ask the men what the shield was used for – it had many uses. It was sometimes used to start a fire or to carry things, and of course in a fight its significant use was to deflect rocks and spears... **So the shield is a symbol of protection. Using this, we can talk about protective behaviours – wearing a hat from the sun, wearing boots, eating healthy foods... I would draw the men into a discussion using the notion of protection – that a colourful diet is a shield that protects you...** *This did seem to resonate with people, but of course, the cost of fruits and vegetables in remote Aboriginal communities is so high..."* [Roy Price, Personal communication via phone, 2014]

Rather than focus on the prevention of risk factors and things that make people ill, experienced nutritionist, Robin Lion shared that many Aboriginal people prefer to focus on health promotion, supporting good health in ways that are meaningful.
[Robin Lion, Personal communication, 2013]

The hissy fit discussion board explores ways to depict and discuss notions of future risk associated with eating and drinking certain "high risk" foods and beverages, and future health problems. See this resource in Section 5.3 of Consider your Approach and **Appendix A**.

Chronic Disease

Chronic disease or illness was unknown in traditional Aboriginal life. Those who were unwell were expected to show and feel the signs of illness, and either recover or die [19, 20].

In the last two to three decades chronic diseases have grown to devastating levels within Aboriginal society. Accordingly, the term "chronic" is now used commonly in medical and healthcare services. Although this term has been generally adopted by Aboriginal people, many request more information on chronic conditions, and appear confused about the term "chronic" itself [16]. In one report, Aboriginal people were said to have voiced great concern that information about chronic disease was shared only after the point that the illness could be prevented [16]. Aboriginal people have interpreted the failure to communicate important information about disease and disease management as intentional withholding [14, 16].

During discussions, consider people's concept of terms such as chronic disease or chronic conditions. The following strategies provide examples.

STRATEGIES FOR DEVELOPMENT

Consider:

· What do the terms "chronic", "illness" and "disease" mean to people?

 – How do sick people look or act? What happens to them? What can make them get better? Is there anything that can be done to stop illnesses from happening?

· What causes different illnesses? Do people have any control over this?

· How do some illnesses differ from others? For example a flu, ear infection, diabetes, strongyloides infection?

· Which illness names have people heard of? What do these names mean?

Wherever possible, hold these discussions in a mutual or shared language, or in the presence of a trusted interpreter. Areas of mutual interest and understanding can be used as starting points to further explore relevant or confusing concepts and discover points of intersect between western and Aboriginal worldviews [18].

Although you may be seeking people's views on these topics to help inform how you communicate health messages – you are likely to find yourself the one who is being taught. Be open to this. Once people trust you in your work role or have a relationship with you they will want you to learn and better understand their worldview probably primarily to strengthen the relationship but also to help you to be more effective in the work you do.

The Microscope and Germs Workshops held in the Top End and also the Central Desert Region by Aboriginal Resource and Development Services (ARDS) are tangible approaches to considering cause and effect relationships. The microscopes provide concrete evidence of the existence of germs that can now form a basis upon which to build understanding of cause and effect. For more information go to: http://www.ards.com.au/pages/Health.html

All communication is a two-way process. See more on two-way learning and sharing in Section 4: Consider Relationships

Learning Styles

Sharing information and generating new learning is bound to be more successful when styles and approaches match the strengths and preferences of all of those learning, or, the disadvantaged party. While learning styles and strengths of individuals and groups vary, over time, different cultural environments, practices and knowledge systems reinforce certain preferences. Kalantzis & Cope have published a framework of eight interconnected pedagogies, called the *'Eight Ways of Aboriginal Learning'* [21] **(Figure 5.2.1).**
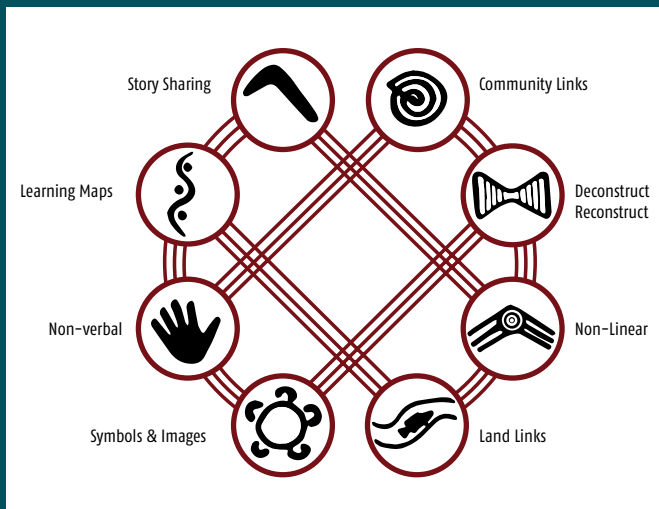
Figure 5.2.1: The 'Eight Ways of Aboriginal Learning'
Each of the eight ways of learning are connected with one another, and each can change in different contexts and settings.

Table 5.2.1 (overpage) incorporates the Eight Ways of Aboriginal Learning into an overview of the preferred learning styles of Aboriginal people identified in the literature. As a theoretical contrast, the left-hand column provides an overview of learning styles considered predominant in mainstream western education. The second column lists styles considered to play a dominant role in teaching and learning within Aboriginal groups. The third column suggests some areas where the eight interconnected pedagogies of Kalantzis & Cope relate to various styles and methods. The final column lists some strategies for development based on these style considerations.

Table 5.2.1: Mainstream and Aboriginal Learning Styles (& Strategies for Nutrition Communication and Education)

Mainstream Learning Styles (People from western backgrounds are likely to be used to, or have a preference for…)	Traditional Aboriginal Learning Styles (People from Australian Aboriginal cultural backgrounds are likely to have a preference for…)	The 'Eight Ways of Aboriginal Learning' [21]	Considerations that may be Useful when Working with Adults from Australian Aboriginal Cultural Backgrounds (The points below are a guide only. Personal learning styles and preferences are likely to occur along a continuum, and be influenced by numerous factors)
Verbal instruction – oral or written. Text-based.	Visual observation & imitation. Image-based.	**Symbols and Images:** People keep and share knowledge with art and objects. Use images and metaphors to understand concepts and content.	Visual learning extends to symbols and images; use visual metaphors. E.g. anatomy of a hunted traditional animal that people may have cut up/ seen cut up, to lead into discussion of human anatomy. See foods within the context of the environment, seasons, in the store. May incorporate: sensing, viewing, reviewing, reading, watching, waiting, listening, exchanging, sharing, conceptualising, assessing, modelling.
Verbal instruction accompanied by demonstration.	Personal trial/error, & feedback, in a 'safe' space. Role modelling of great importance.	**Non-verbal:** People act, make and share without words. Applying intra-personal and kinaesthetic skills to thinking and learning.	Demonstrate many times in actual situations. E.g. parents/family members teach hunting and gathering skills. People may prefer to try & practice new things privately; allow people to decide if and when they might share a new learning or skill. People may feel 'shamed' if asked to answer or perform publicly. Teach by reinforcing correct behaviour and ignoring mistakes.
Practice in contrived/artificial settings that most often focuses on theoretical/future needs & scenarios.	Real life performance/ learning from life experiences that most often focuses on present needs in a relevant context. Learning takes place in familiar environments.	**Land Links:** People work with lessons from land and nature. Place-based learning, link content to local land and place.	Wherever possible, place learnings in context-specific settings that are meaningful & relevant. Allow those who wish to participate in the information sharing to decide the most appropriate setting. E.g. this could be the new, air-conditioned office or it could be under a tree or on country. E.g. a store tour to purchase foods followed by cooking for the family (in the home if people are comfortable and if appropriate – otherwise with familiar utensils and resources). Investigate where people would be most comfortable and/or feel that they are on neutral/safe territory.
Abstract context-free principles that can be applied in new, previously inexperienced situations.	Mastering context specific skills through repetition. Learn by doing.	**Deconstruct/Reconstruct:** People work from wholes to parts, watching and then doing. Modelling and scaffolding, work from wholes to parts (watch then do).	Focus on skills for a particular task, rather than general principles. People learn through repetition (years of observation through cycle of the seasons, etc). Important lessons come from land and nature. People may like extensive discussion; concepts may be returned to; can deconstruct and reconstruct information; repetition deepens learning.

Mainstream Learning Styles (People from western backgrounds are likely to be used to, or have a preference for...)	Traditional Aboriginal Learning Styles (People from Australian Aboriginal cultural backgrounds are likely to have a preference for...)	The 'Eight Ways of Aboriginal Learning' [21]	Considerations that may be Useful when Working with Adults from Australian Aboriginal Cultural Backgrounds (The points below are a guide only. Personal learning styles and preferences are likely to occur along a continuum, and be influenced by numerous factors)
Information oriented. Focuses on reading & writing.	Person oriented (focus on people & relationships); relate to the person, not the "teacher". 'Value; of information related to perceived 'value' of the giver.	**Community Links:** People bring new knowledge home to help their mob. Centering local viewpoints, applying learning for community benefit.	Relationship to the "teacher" is important, thus effort should be put into building relationships before 'jumping into' education provision. Face-to-face exchange important. Learning is often to benefit the group over the individual.
		During a training course run in Cairns, participants from different Cape York communities yarn together about what they would like to see happening in their community – they are supported to think some of these ideas through more fully and put thoughts down to start planning how this would look. They are then supported to follow through with this process when they are back in community so the learning continues. [26]	
Structured learning. Initiated by the teacher. Set rules and guidelines.	Informal, spontaneous learning. Often initiated by the learner. Based on narrative & myth.	**Story Sharing:** People connect through stories. Approach learning through narrative.	People learn because they want to, not because they have to. Ensure people are ready & willing to hear or discuss information. Saying 'I don't know' is not always the lazy or easy way out. It may mean 'I'm not ready yet', or 'it is not my right to speak on that matter', or, 'why embarrass me by asking me to show you I know less than you about this'. Use story- and narrative-based approaches that have personal relevance. Eg. Elders and kin tell stories of ancestors. Narratives & stories should use visual metaphors.
Sequential and linear learning.	Non-linear, holistic learning. View of literacy is broad.	**Non-linear:** People put different ideas together & create new knowledge. Produce innovations and understanding by thinking laterally or combining systems **Learning Maps:** People picture pathways of knowledge. Explicitly mapping/visualising of processes.	May use 'mind maps' (on paper or in sand, etc) to look at the "big picture", to show relationships & pathways, before looking at details. View of "literacy" incorporates social practices that include songs, poems, stories, dance & music.

Based on [22](p.52) (after [23]), [15] and [24]

For an example of an Aboriginal learning map see:
http://8ways.wikispaces.com/e.g.+Nyngan

STRATEGIES FOR DEVELOPMENT

Strategies to enhance teaching and learning in the process of two-way enquiry include [25]:

- Seek and utilise respected local and expert advice.

- Maintain mutual feelings of independence of thought and action.

- Negotiate decisions and processes.

- Emphasise doing / practice / experimentation.

- Learn from the natural environment, where theory and practice can be combined.

- Provide opportunities for people to validate new information; to know it as 'true' on their own terms.

    - People may prefer to experience information in different tangible ways:
    See – Observe – Touch – Read – Hear – Experience emotions

- Provide opportunities to reflect both during and after new experiences.

- Provide opportunities to revisit new learnings (sometimes repeatedly).

- Provide opportunities for people to observe and interact with others in real life situations.

When producing educational resources, focus on the process of learning, rather than particular end points or outcomes.

The Guidelines for intercultural resource production with Indigenous consumers (See **Appendix B**) states, *"often it is the process of resource production, rather than the output, outcome or product itself, that has the most powerful educational effect."* (p.2).

An emphasis on process must include an emphasis on personnel, and face-to-face, iterative work rather than set "end points" and the provision of pre-fabricated advice (see, for example, [12, 26, 27]). While it feels rewarding to achieve pre-ordained endpoints or products, a focus on process quite possibly means that any pre-conceived end point, product or message may over time become altered or even irrelevant as work progresses.

The Person Who Shares or Delivers the Health Information is Crucial

In Aboriginal society, a person cannot represent any other person unless he or she has permission to do so or community approval [28]. To ask someone to speak for another person or people can place them in an awkward or even precarious position [29, 30]. This concept is explored in Jeannie Devitt's community orientation guide which explains that the right to pass on information is not straight forward and can impact on the jobs of health workers [31]. She notes

"a network of social relationships shapes who can say what, when and to whom. 'Knowing' something neither automatically gives you the right to speak, nor does it ensure that anyone will listen or give credence to what you say... These gender, age, status and kin relationships are all factors in the kinds of subjects a person may raise and the manner in which they may raise them. 'The right to know' is thus heavily qualified. The right to speak about one's knowledge is similarly constrained." (p.8)

In the context of education where the sharing is one-way, new information must come from a credible source; the person must be seen as 'qualified' or the 'owner of the knowledge' according to their cultural criteria [32]. Chronic disease, for example, comes from white culture, as has the contemporary food supply. Knowledge of these and other western health-related topics are symbolically 'owned' by westerners.

In **train-the-trainer models** that share western knowledge with Aboriginal people, structured communication occurs, for example, between a nutritionist and a group of trainee Aboriginal health or community-based workers (for examples see [7, 30, 33-36]). Following this education, the Indigenous worker(s) facilitate education in their own communities or other Aboriginal settings.

Within this, and all similar models it is preferable that non-Indigenous workers remain present or contactable as mentors, and for technical and/or participatory support [16, 37]. For example, often lay people in the community who have received some basic nutrition training may prefer to work alongside a public health nutritionist or an AHW as they need time and experience in order to feel confident to consider themselves the owner of that knowledge or adequately qualified or experienced to work alone. Rather than relying on volunteers, these positions may be more effective when formalised, and educators are paid for their role [38].

The Talking about Feeding Babies and Little Kids counselling course (TFBLKCC) has been adapted from a World Health Organisation model by The Fred Hollows Foundation and Menzies School of Health Research. The TFBLKCC provides comprehensive training to develop 'master trainers', or a team of instructors who are predominantly Aboriginal health practitioners and other professionals. The master Instructors in turn train other Trainers to teach Community-based Workers. Community based workers then use this knowledge and counselling skills to teach, counsel and support mothers, carers and families feeding babies and young children. **Figure 5.2.2** shows the basic flow of information. The master Instructors continue to have an ongoing role in mentoring, monitoring and supporting the Trainers. Trainers in turn are best equipped to follow up and mentor the community based workers they have trained.
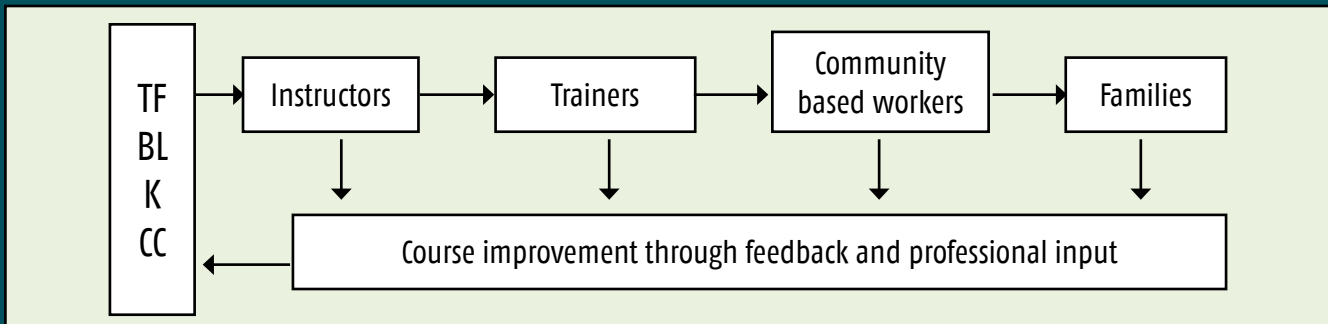
Figure 5.2.2: A Flowchart of the Train-the-Trainer Model for the Talking about Feeding Babies and Little Kids Counselling Course

For more information about The Talking about Feeding Babies and Little Kids Counselling Course go to: www.menziesnutritionportal.edu.au After December 2014 more information will be available at: http://www.menziesnutritionportal.edu.au/areas/talking-about-feeding-babies-and-little-kids-counselling-course-tfblkcc-kit

The **Strong Women, Strong Babies, Strong Culture Program (SWSBSC)** is a longstanding bi-cultural, community development program that respects and supports the Aboriginal way of promoting good health in women and babies during pregnancy and early parenting. Aboriginal women deliver the program to Aboriginal women, combining traditional Aboriginal and current Western knowledge. Aboriginal Grandmothers and identified younger women use the program to promote strong women and strong babies by supporting and passing on traditional ways to pregnant mothers and keeping the Grandmothers Law alive.

For more information about The Strong Women, Strong Babies, Strong Culture Program go to: http://digitallibrary.health.nt.gov.au/prodjspui/bitstream/10137/429/1/Strong%20Women%20Babies%20Culture%20TE.pdf

Age and experience are also important considerations. Wherever possible, work with, and be guided by local Elders. Having Elders and respected members provide guidance about health and nutrition within their community, or share their own experiences related to particular health issues is a culturally appropriate and especially powerful way to place health stories within context for local people. Nutritionist and researcher Dr Julie Brimblecombe, observed health education provided by an older woman [39]. She shares,

"I had the privilege of accompanying an older woman who was employed as a 'strong women worker' with the health centre and had organised to take a group of young pregnant women to a place away from the town for an education session. In the most respectful, caring and nurturing fashion, the strong women worker through her words and actions showed each of the young women that they were valued and cared for. The health message was short, the caring and bonding was strong, and afterwards everyone collected and shared mangrove worms and other shellfish. This woman although older and perhaps perceived by the young women to be in a more powerful position, showed the utmost respect to the young women and they responded positively."(p. 226)

For non-Indigenous health professionals it may be challenging to work with older people. Taking time to build relationships, letting people know your educational and personal background, and sharing your ideas can help them to recognise that you have something to offer.

Information sharing between people who are in a similar situation can also be positive. "Support groups" can generate an increased sense of power as people develop networks and understand that they are not alone. Sharing discussions and hearing the experiences of trusted others can also help individuals to find their own personal meaning.

Personal Autonomy

The notion of personal autonomy is a prominent value traditionally geared towards keeping peaceful and harmonious relations [29](p.14). In the traditional Aboriginal view, people are largely autonomous, independent beings from birth [40, 41]. In the realm of food and eating behaviour, socialisation and education based on principles of autonomy also starts from birth, with children expected to indicate when, where and what they choose to eat. A parents' role is to respect the child's decision, supporting the child's autonomy, happiness and wellbeing by responding to their expressed needs.

Among various Aboriginal groups, notions of personal autonomy related to health behaviours have been described. A Warlpiri man of the central desert region reportedly declared, *"I am boss for myself. I can decide for myself, no one can decide for me,"* [42](p.204). Aboriginal people from Northeast Arnhem land have also talked about "having the right to choose", regardless if they or those around them perceived the effects of their choice may be negative [43](p.393). Lowell et al [16] report Yolngu renal patients using the term "rumbal watangu" (literally *"the owner of the body"*) to explain that they are in charge of their bodies and how they take care of themselves. Participants in this study wanted to make informed choices, but did not want to be told what they should and shouldn't do without just reason [16] (p.206).

Dussart describes the plight of a diabetic patient attempting to recover a sense of personal autonomy within the course of performing kinship obligations and managing his illness [42]:

> *"They [biomedical staff] say that my diabetes will kill me if I do not take pills everyday and if I do not eat right. Sometimes I forget. I eat with my kin. I cannot be selfish and eat my food alone. I cannot do what they tell me to do. I have to decide for myself. They scared me! They told me that I will die if I do not listen. Well, I will die soon anyway."* (p.204)

In one community study an older woman talked about how a sense of autonomy can impact on people's receptivity to health information, stating:

> *"people think that if you start telling the good story, what, are you clever or are you trying to control our lives. They're thinking 'we are not dumb' and they don't want to listen."* [27]b

Attempts by both Indigenous and non-Indigenous health workers to influence the behaviour of another who is not their kin can be perceived as value-laden, insulting or an attempt to exercise power [43]. In this context, Julie Brimblecombe has observed that the setting or social context in which the information is shared is also crucial [39]. She relates,

> *"Despite this strong sense of interpersonal autonomy, I constantly observed the ongoing exchange of educational information between people and the chiding of people for smoking or enacting perceived 'deviant' health behaviour. However the social context was key to the exchange of information, and the acceptance or rejection of the information by the recipient."* (p.226)

FOOD FOR THOUGHT

Enacted personal autonomy can present challenging dilemmas for health professionals who respect Aboriginal cultural beliefs, but have observed the impacts of harmful behaviours and wish to improve the health of the communities in which they work [44]. In respecting an individual's sense of personal autonomy:

- **Support local people** to communicate important health messages in ways they deem most appropriate.

- **Don't force western cultural or health-related ideals onto people**. Acknowledge community values and beliefs, be open-minded and flexible, and respect personal choice.

- **Don't be overly persuasive** but keep in mind that it may take more than one sitting for people to digest and consider the new information.

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SECTION 5.3: CONSIDER YOUR APPROACH TO HEALTH PROMOTION

In order that health information be accessible, styles of communication need to be suited to people's current knowledge base and preferred learning styles, be clear and hold meaning. Section 5.2 stated the need for information about health and building health literacy, and examined the predominant learning styles of Aboriginal people. Section 5.3 takes these ideas further by providing an overview of health promotion approaches and tools that may be more suited to the preferred learning styles of Aboriginal groups with whom you work. Of course, chosen formats and approaches will vary depending on personal and cultural preferences, availability of resources, experience and skills, and other relevant considerations such as participant's access to transport, timing of discussions and staff availability [1].

Narrative Approaches & Tools

Yarning is a culturally appropriate way to gather [2] and share [3] information. Narratives can promote the sort of group discussions that lead to gradual changes in the way people evaluate and relate to their health, body and behaviours, they can build individual and community consciousness [4]. Sitting down and sharing stories also equalises power dynamics and can alter the perception of roles. Through his long involvement and deep relationships with Indigenous people and communities, Professor Michael Christie noted [4],

"The knowability and vitality of the world is preserved and renewed by the creative acts of storytelling. … Being active and aware, and bringing people and ideas together produces a flourishing world. … Storytelling…brings the past and present together in new ways…" (p.33)

Rather than link issues directly to food and health, yarning and story-telling can create interest and provide meaning to information through interesting, enjoyable and real-life issues. While some differences in rules, language or protocols may exist between groups [2], narratives and story-telling brings people together and creates strength through the knowledge that we are not alone.

The Dulwich Centre is an independent foundation based in Adelaide that offers narrative approaches to therapy and community work, training and publishing. One important approach applied by the Dulwich Centre is that of Collective Narrative Practice. This process helps to develop stories – good and bad – while reminding people that we are always linked, and never exist in isolation. The basic steps involved include:

1. Identifying a skill, and naming it.

   For example, this might be an old or a new skill such as traditional methods of hunting, food preparation or cooking, or a new skill such as cooking a stir fry.

2. Relating or linking the skill to a story.

3. Talking about this skill in the present day.

4. Linking this skill to others who share it.

For more information go to: http://www.dulwichcentre. com.au/collective-narrative-practice.html

Stories are useful to help understand what people know and value, what has changed in their lives or thinking, or what has been learned. See also Section 7: Consider Demonstrating your Effectiveness.

Stories can be recorded and shared with others

The italklibrary specialise in helping people communicate information with culturally and linguistically diverse communities by transforming that information into story form, linking traditional storytelling and modern technology. Much of this work is freely available on their website. For more information go to: http://italklibrary.com/

Creating cultural empathy and challenging attitudes through Indigenous narratives is a project that aims to positively influence the health and well-being of Australian Indigenous people by improving the education of health professionals through authentic stories. It is hoped these stories of Indigenous people's experiences of healthcare, both positive and negative, will enhance the development of deep and lasting empathy. For more information and access to multimedia Indigenous stories go to: http://altc-betterhealth.ecu.edu.au/

Yalu Marnggithinyaraw, a community health research organisation from North East Arnhem land, has created many story-based education resources related to chronic disease. Some of these include personal accounts of people's experiences with illness. View and download via http://yalu.cdu.edu.au/healthResources/index.html or search on YouTube.

Sharing Stories takes Time

"I know Balanda [white people] come with a pressure to get things done on time... but they need to slow down or the work and the ideas go sinking... People want to know that their story is valued and being heard; taken seriously. You can ask questions, but you need to allow time for the response... It might be a long wait... If I sit with Balanda for a long time, I can sit and tell my story... Yolngu are shy to talk, we won't give you the full information all at once... When we sit together, we are slowly finding out each other..." [Elaine Maypilama, Personal communication, 2013]

Visual tools can guide and compliment stories

Story boards and discussion boards are useful tools to create narratives and generate stories. Rather than a presentation tool, these approaches can stimulate two-way sharing to bring together old and new concepts, open up novel perspectives and create new shared meanings. For health professionals new to work in remote Aboriginal communities, a discussion board may also facilitate entry and 'orientation' into the community, relationship building, the consultation process and personal and cultural learning.

A Food Discussion Board

A Food discussion board can provide a visual representation of the local food system in order to stimulate new ideas and conversations. **Figure 5.3.1** is an example of a discussion board that was developed in conjunction with a community during the Food and Health Communication Across Cultures project. This discussion board is available to download from **Appendix C**.

Figure 5.3.1: A Food Discussion Board

This discussion board was created in one remote Aboriginal community out of a range of local and generic images related to aspects of the community food system. It was used to initiate new discussions about the foods, eating patterns and the lives of people within their existing food systems.

This Food Discussion Board can be used together with the Good Food Planning Tool (see pages 70 and 71).

A food discussion board can assist people to examine what they already know and do, what they might like to know and do and consider ways to manage perceived barriers and challenges related to their diet and health. This approach might be used to explore or discuss:

- People's traditional and contemporary food system(s) – assess similarities and differences; past or recent changes; how people feel; things they would like to keep or change.

- Ways of knowing and using different traditional and store-based foods.

- How people group different foods.

- How children learn what to eat and develop their eating patterns.

- Favourite foods; cooking techniques.

The material aspects of a discussion board may:

- Be 100% visual with minimal or no text.

- Be presented in a set format or comprise images that are moveable on a felt board, cloth, poster or table. In this way, relationships and priorities will be more easily visually identified and depicted.

- It may be possible to photograph a "moveable" discussion board after a story has been created, then provide a print out of the final board to interested parties.

- Use local photos and images. For example, from the community store, health days, hunting trips, cook ups, school. Be sure to seek formal permission within the community (and possibly also within your funding organisation) to use or print images of people.

- Incorporate images or symbols from other sources. For example, various kitchen appliances; food packaging; aeroplanes or barges that bring food to the community; relevant medical equipment.

See also **Appendix C** to download the Food Discussion Board. These images can be incorporated alongside other local images into new community-specific discussion board.

Chronic Disease Story Board

The Chronic Disease Story Board is designed to provide Aboriginal and Torres Strait Islander health professionals and community-based workers with the knowledge and practical skills to share chronic disease stories in the community setting. See Section 5.1 for more information on the Chronic Disease Story Board. Also, check out the HealthInfonet and http://mylearninghealth.nt.gov.au/course/info.php?id=595

The Hissy Fit Discussion Board

The hissy fit discussion board developed within the Food and Health Communication Across Cultures project (see page 90 and **Appendix A**) was inspired by stories related to the scenario: *"if you are in the store and your child/children/grandchildren are crying 'I want, I want' for coke or lollies, what do you do?"* (For more information on these discussions see reference [5]a in this section and also **Appendix i**). To these scenarios, around half of the respondents talked about adhering wholly to the expressed wishes of the child. The majority of parents and grandparents related difficulty saying no. One grandmother explained,

"in the traditional style a mother or grandmother can't say no if a child wants something to eat... We tell kids what is there; it's up to the children what to choose. If we see it's not good food we tell them this will make you fat or get sick. What they eat, it is up to the children." [5]a

In discussions, some older women viewed the inability to say no to children's demands as a sign of weakness; some associated this with lack of knowledge, or not knowing the story. Older women agreed that the mother is most responsible for responding to children and guiding food choices. Two young mothers who did say no, asserted *"...it's wasting money and is not good for them and there is too much sugar in them. I learned this at school."* And: *"My children don't know how to drink coke and fizzy drinks. I have never given them. They learnt from early age not to drink, because I would like them to grow healthy."* [5]a

Parents play a pivotal role in shaping children's food choices. Aboriginal parents and kin have been observed to support children as active decision-makers in subtle, informal and contextual ways such as paying selective attention, the use of stories, persuasion and encouragement of parental role modelling [8-11]. In this study, parents and grandparents who did say no talked about how they managed the situation. Within a childcare centre, this lead to further discussions among Indigenous staff, young parents and other family members about how these stories might support other young mothers to support children's good food choices.

Firstly the "I want, I want..." scenario was represented visually. Other images for the discussion board were based on people's stories. Where possible these stories were put in context by using images of local scenes. This back drop housed people's stories rendered as images, created by Liz Howell, a local Darwin artist.

Through the linking of stories, scenarios and ideas, the hissy fit discussion board aims to explore with parents how they might manage their children's food choices in the store and at home. A single image such as the hissy fit image, or any other image or scenario, might be used as a starting point. At any point, other visual images can be produced or added by any participant to stimulate new stories, or imagine different present and future scenarios. Footsteps can be placed between images to show relationships and possible linkages [1].

The Hissy Fit Discussion Board is still in a developmental stage, yet can offer some ideas on facilitating dialogue related to strategies for modeling good behaviour and encouraging healthy eating in children.

Autonomous decision-making within traditional lifestyles occurred within a largely safe food environment, where any dangers associated with food tended to yield an immediate response. Contemporary food environments are highly regulated regarding the potential of food poisoning yet make a significant contribution to behaviours and lifestyles that promote chronic disease. This environment cannot be considered safe. Global food systems are now characterised by ready access to food that is mass engineered and highly processed, yet affordable and available. These foods are often highly advertised – especially to children. Under these conditions children need guidance in their food choice decisions [6, 7].

[1] Footsteps to illustrate movement over time have also been used in the Play and Learn Support (PALS) Resource. For more information on the Play and Learn Support Resource Kit contact: Communities for Children Program, East Arnhemland, Anglicare NT. Ph: (08) 8985 0000.See also Section 6 under Hunting as a Benchmark & Metaphor

The discussion board does not provide fixed messages or suggest one pathway over another. It can also be used to touch on aspects of personal autonomy and notions of future risk. **Figure 5.3.2** provides two representations of stories that have emerged.

Figure 5.3.2: Two stories that emerged from group discussions using the Hissy Fit Discussion Board

Stemming from the "I want, I want…" scenario, alternative responses to saying 'yes' included explaining why we are saying 'no', then maybe looking for alternatives such as fruits, nuts, or drinking dilute fruit juice at home. Parents discussed that it is not possible to say 'no' every time, and this is OK. Parents talked about drinking water and thinking about limiting their own sugary drinks, or not eating them in front of the kids. Other stories talked about 'the debil debil' (a local idea of the 'devil'), gathering bush foods, and cooking and having fun as a family.

These story-tellers saw that buying and drinking fizzy drinks can lead to problems in the future such as sore teeth, trips to the clinic, and the possibility of children and parents having to leave their community to go to hospital in town. This relates to the "risk scenario" of not doing something now due to fear of future consequences. These visual illustrations and discussions can assist health communication around concepts of future risk and consequence.

All hissy fit discussion board images appear in **Appendix A.**

Skills-& Setting-Based Approaches

One aim of sharing of information and stories about food and health is to help people build knowledge that can contribute to better health and wellbeing, and when required, to see and feel the desire to alter their choices and hence their behaviours. In order for that knowledge to be translated into health-promoting behaviours, people need environmental and personal support, adequate resources, confidence and skills. Skill-based interventions can support good health by developing skills to facilitate "healthy" lifestyle practices. Building emotional strength is also inherently health promoting. For example, broader views see the potential for skills development to increase feelings of self-efficacy and self-esteem. These approaches are based on the different behaviour change theories that include the construct of self-efficacy such as social cognitive theory. It is important to be aware of these and other theories in order to inform and utilise the most appropriate approach.

In order to facilitate the skill acquisition it is important that these activities are practiced in a realistic setting. Opportunities to practice new skills, especially in context, are of vital importance. Skill-based programs need to understand and be situated within wider physical and social contexts [12, 13]. For example, people's ability to apply cooking skills learned or observed in a class within the home environment.

Interventions which aim to replace existing behaviours with new skills and behaviours might want to explore the meaning of the existing behaviours for people concerned. Existing behaviours, including eating behaviours, can be founded in personal and cultural history and hold strong contemporary meaning [14]. These factors contribute to the reasons why behaviours can be resistant to change, and proposed new behaviours may prove an unsuitable substitute for existing ones [15].

As health professionals we can tend to underestimate or forget the challenges involved in new skills uptake and lifestyle change. Where necessary these inherent challenges and common barriers to adopting and maintaining new lifestyle behaviours should be recognised and discussed. Small successes or shifts should be met with praise and encouragement.

The following pages provide examples of various skills- and setting-based approaches, with particular attention to cooking skills and programs, and the store-based setting. Important settings that are not examined in more detail include aged care facilities, school canteens or breakfast and lunch programs, and crèches. These settings and programs are often very appreciative of the support of nutritionists for collaborations in activities such as reviewing menus, helping with staff training, and providing new perspectives and ideas.

Cooking Skills & Programs

In the formative research that took place within the Food and Health Communication Across Cultures project, community people spoke in detail about cooking. Some talked about traditional cooking methods in the bush and at home. Many expressed a strong desire for greater practical knowledge of and experience with the store foods, especially through cooking [5] a. A number of reports describe cooking programs run with and for Aboriginal groups in local communities (see, for example [12, 13, 16-23]), and also cooking demonstrations [1, 24-26] and cooking classes [12, 20, 21, 23, 27]. These are commonly requested activities [5, 28, 29].

Cooking fresh food requires that the food be accessible and affordable and that functional cooking facilities, as well as dry and cold food storage, are available [30, 31]. Cooking also takes place within a social context. One Aboriginal woman described her family's way:

"No one person in the house makes decisions, but whoever feels like to cook something, they do it themselves... Shopping they make a plan what they want to eat. I hear my boys and they say "what you gonna eat?"... if they want to get different things, that's up to the people – their choice. If a person wants to cook, they don't talk to anyone else, they just go to the shop and bring it back and cook it.

...We don't have a routine like the Balanda... we don't use recipes... We don't want too much food , but if we have it we will give it away to family... We don't have a fridge... If people have a fridge they might keep that food until the next day..." [Elaine Maypilama, Personal communication, 2013]

Nutritionist, Susie Summons, describes her experience cooking within several communities in Central Australia:

"A lot of people don't feel at all confident with their cooking. ...I've had a lot of insights into what people actually cook at home – most people just add heaps of water to a pot then add meat and veg. They don't add flavour to their stews, such as curry powder or stock. ... people just pick out the meat and throw away everything else.

We did a number of cooking activities such as cooking with Aboriginal Health Workers for large community gatherings, and giving out culturally appropriate cookbooks at those gatherings, to cooking in outstations in small family groups. Where possible we utilised food that was available from the community food gardens, and at all times food that was available from the local store. We have also made a short film in language explaining how to make a meat and vegetable stew from affordable ingredients from the shop, in a way that tastes good. After making the film I saw the people involved purchasing the ingredients to make another stew later that day!" [Susie Summons, Personal communication via email, 2013]

Traditionally, both men and women play an active role in food procurement and preparation. Engaging people in cooking can be a good way to involve both men and women [32]. Roy Price, an experienced Central Australian nutritionist reflects on his experiences with wok and flour-drum stove cooking:

"Over the years I estimate that I have engaged 4,000 to 5,000 people in wok and flour-drum stove cooking. The most people that I have ever cooked for at one time was 820 people at a SNAICC conference in Central Australia. We had 40 woks and 40 stoves and 40 cooking teams... I called on every friendship and relationship to make it a success, and it was fantastic – it went off like a U2 concert!

...But I'm not really sure if the cooking work I have done with people could be termed 'successful'. ...When I looked at a Closing the Gap document, I realised that what I was doing was more in line with the best practice principles for sports and recreational programs. ...But I guess another way of looking at it is that there was so much joy shared in the times when there were 50 people cooking food, and another 150 people standing and sitting around waiting... Later people often recognised me and made the link with that fun time we shared. I felt that it gave me some credibility, and created a commonality and something new that we could build on... Aboriginal societies are so relationship-based... Building relationships with people is the most important thing.

...I recall one time when I went into a prison to cook with the men. One man said to me, 'next time you come, bring four sets of equipment so that we can break into our skin groups'. Wow, I had known about skin groups, but it had never even occurred to me to do this! The next time I went I took four sets of equipment and it was fantastic – absolutely everyone was involved." [Roy Price, Personal communication, 2014]

Consider some of the following strategies to help support people to build new cooking skills.

STRATEGIES FOR DEVELOPMENT

When initiating opportunities:

- Pay attention to people's access to cold food storage or working cooking facilities [30, 31].

- Consider the changing availability of ingredients in the local store.

- Provide cooking demonstrations or cook in groups deemed appropriate by the community.

- Wherever possible, include interested men, boys and children.

- Find out the different local recipes that people really enjoy.

- Find out those cooks in the community who are relatively confident and like to be experimental with their cooking, or people who have a reputation of being good cooks. Invite these people to come and cook with you in a cooking demonstration.

- Always keep in mind the initiative of training local people so they can eventually carry out more cooking demonstrations when you are not in the community.

When building cooking skills:

- Provide some background about the different ingredients being used, such as the food origin or how they are manufactured.

- Encourage all people to taste, smell and experience new foods and cooking new cooking methods and food combinations.

- Encourage local people to replicate meals at home. Make this aim clear to participants [13].

- Emphasize the social and enjoyable aspects of cooking or a cooking program.

- Hold the cooking session(s) in an Aboriginal community-controlled setting.

- Keep groups small among families or peers.

- Focus on healthful cooking techniques using simple, affordable ingredients.

  - While it is appropriate to ask about the need for therapeutic diets, in general, a fresh, balanced diet can be appropriate for most or all of the family.

- Use short recipes with few ingredients.

- Build up the self-confidence of participants, many of whom may never have cooked before [22].

- Help people become familiar with where and how to purchase 'new' foods.

A list of cookbooks that have been developed with and for Aboriginal communities are listed in **Appendix D**. See also Section 6 for more discussion on cooking.

Working with the Community Store

Remote community stores make a pivotal contribution to the health of Aboriginal Australians living in remote communities. This is evidenced by positive associations between the store food quality and markers of type 2 diabetes and cardio-vascular disease in people using the store [16, 33]. Community stores make foods available to people. This availability can be influenced by multiple factors. Prominent among them are the attitudes and practices of store managers in relation to supporting nutrition improvement [34, 35]. Other influential factors (which are also in part influenced by managerial attitudes) include how much energy and attention is given to provisioning of recommended foods [36]; in-store promotion and education for local staff members and consumers [16, 33]; and adequate food storage facilities [37]. Store food availability is also dependent on adequate in-store infrastructure including warehousing space, dry storage, refrigeration, and reliable transport and delivery [38]. Seasonal variations that influence available food quality and quantity also occur such as flooding in the wet season where only 'essential' items are stocked and fresh food is even more expensive.

In their role public health nutritionist's have described work with community stores as particularly challenging. Reasons include the need to consider the alternative worlds of business and politics; getting to know the store manager; and navigating the 'nutrition approach' with store management – all of this occurring against the challenging backdrop of work in a remote Aboriginal setting [39]. Nutritionists with experience working with local community stores [39-41] have suggested the following strategies for development:

STRATEGIES FOR DEVELOPMENT

Building rapport with the store manager is very important

One public health nutritionist shared,

> I think it's really, really important to understand that most store managers are people who are trying to make the best of a difficult situation – they are not the enemy! Also, stores are generally understaffed, leaving managers with high workloads, responsibility and stress levels. Sometimes I felt that some of my colleagues treated the store managers with suspicion... and it was easy for store managers to be wary of nutritionists also, especially if their principal point of contact was the market basket survey which they may take as the nutritionist 'checking up' on them. [Frances Knight, Personal communication via email, 2014]

As for most professional relationships, it would likely be beneficial to build rapport with the store manager and the store board members before undertaking monitoring activities or making suggestions or requests. It is important to understand the governance structure of the store. In many cases the store is owned by the community and governed by a store board or committee who are also concerned for the health of people in the community. Wherever possible, endeavour to meet and take time to and get to know these people.

During first meetings and introductions it might be useful to talk about the role and visions of the store manager and store committee, the store's history and the managers' experience of any in-store approaches to nutrition improvement. You will find through these discussions that many people associated with the store share your same vision of wanting to improve food and nutrition in the community. In the remote context, it is also likely that store staff and managers will want to know your story – where you are from originally, what has brought you here, where you have worked before and who you know in the store group.

Take into consideration that store managers are often rushed and may not immediately have time to talk with you. Don't be surprised if rapport building takes place over a number of short meetings as opposed to one long conversation. Also try to engage store staff. Many store workers are eager to learn and can be ideally placed to assist community people to learn about store-based foods.

Building rapport may be enhanced by volunteering to take on activities that aren't necessarily part of your role. These offers to assist the store manager can demonstrate that you are willing to work collaboratively. For example, it may be possible to help cook some meals in the takeaway, be involved in food safety training, or assist with preparation and presentation of fresh fruits and vegetables [40]. Store managers are often supportive of in-store promotion activities such as cooking demos and taste-testing. Other possibilities include becoming involved in stocktake or shelving arrangement – doing some of the physical work with layout rather than just delegating or providing a long "to do" list [42]. Involvement in these activities will also help to broaden and inform your perspective.

Gain some understanding of the role and working environment of the store manager

Working to understand the logistics and pressures of the job, such as existing barriers to ordering certain foods, frequency of delivery and contracts with suppliers can help you to build understanding and tailor strategies and approaches.

Be mindful that the store is also a business and needs to make a profit to survive

Find out the areas the store manager/staff have focussed on, and want to focus on, not just what you might think should be the focus [40]. Frances Knight shares:

> "In my experience, store managers are usually happy to help with any reasonable request. I know an ex-store manager who ran a remote community store for 10 years... He says that a couple of times a year a new dietitian, nutritionist or health promotion officer would drop in – always a 'nice young lady', and always with good intentions – but they would get angry at him because he didn't stock lentils or something similar.... He would explain that he didn't stock them because they wouldn't sell, but eventually he would capitulate and order the lentils. Of course no one would buy them, they'd pass the use-by-date and he'd have to throw them out... Six months later another nutritionist would come and demand the same thing. He called it the lentil cycle!"
>
> [Frances Knight, Personal communication via email, 2014]

This story highlights many things including the importance of gaining a sense of what has been done in the past, and also that increasing food availability and nutrition promotion strategies must occur across multiple levels. in this case, for example, alongside strategies to increase consumers' familiarity with new foods, including methods of preparation and how to incorporate this product within current dietary patterns and tastes, is essential.

Be grateful for people's time and co-operation

Celebrate "small wins". Nutritionists have expressed frustration that it takes a lot of time before any concrete outcomes can be realised [39]. It may also be necessary to re-think previous or imposed markers of "success". (See also Section 7: Consider your Effectiveness).

Consider other useful resources and approaches

Look for recipe books that have already been local produced in the communities in which you work

The Remote Indigenous Store and Takeaways (RIST) Project provides numerous resources and checklists in order to help establish and improve standards for healthy remote stores. To access go to: http://www.healthinfonet.ecu.edu.au/health-risks/nutrition/resources/rist

Remember that you will not be the only health professional approaching the store manager and requesting changes – the nurses, health promotion officer etc., will be talking to the store managers at various times. The Good Food Planning Tool (GFPT) can help to bring all of these people together to make plans on what can be done to help people access more healthy food. The GFPT supports a collaborative and planned approach to making changes in the store, with the store manager, staff, owners and all other interested stakeholders learning together. For more information go to: http://www.menzies.edu.au/page/Research/Projects/Nutrition/Good_Food_Systems_Project/ or http://www.menzies.edu.au/page/Resources/Good_food_planning_tool/

In the NT, the Community Stores Licensing (CSL) program is a government-based initiative with the Stronger Futures Policy to regulate food stores in remote Aboriginal communities in the Northern Territory. Within this program, nutritionists are ideally placed to assist store managers and store boards to build capacity and work towards standards of best nutritional practice.

The Talking about Shelf Labels Flipchart and Resource Package is designed to equip communities to develop, implement, maintain and evaluate a shelf labels project to promote healthy food items in stores to improve health and wellbeing. A limited number of hard copies of this resource are available from the nutrition team at Menzies, or to read more and download a free soft copy go to: http://www.menzies.edu.au/page/Resources/Talking_about_shelf_labels/

See also the wonderful on-going work carried out within the Jimmy Little Foundation. For more information go to: http://thumbsup.org.au/

Forming or becoming involved in a Community of Practice or Mentoring Circles can help support and develop the work of public health nutritionist's, enhancing confidence and the ability to engage with retailers and work strategically [39, 43]. In particular, nutritionists felt more empowered to ensure their nutrition approach considered the store's business objectives, thereby incorporating mutual benefit.

Early childhood settings

Get up and Grow for Aboriginal and Torres Strait Islander settings and Hunting for Health are two popular resources used with younger children and early childhood settings. For more information on these and other resources go to: http://www.health.gov.au/internet/main/publishing.nsf/Content/phd-early-childhood-nutrition-resources

http://digitallibrary.health.nt.gov.au/prodjspui/handle/10137/126

Schools

Let's Dig! is a comprehensive school garden resource that includes a section on nutrition, gardening, food safety and cooking. Go to: http://www.healthinfonet.ecu.edu.au/key-resources/promotion-resources?lid=25553

The SNAP board game covers basic health education topics including our bodies, mental health, environmental health and road safety, and aims to develop awareness of lifestyle health risk factors such as: Smoking, Nutrition, Alcohol, and Physical activity (SNAP). It is designed for players 7 years and up. For more information go to: http://www.snapintolife.com.au/

Refresh.ED is a resource developed by Edith Cowan University to help teachers (kindergarten to year 10) introduce food and nutrition in their classrooms. Online professional learning is also available to teachers. Consider modification to suit local needs. These materials are free to download from: www.refreshedschools.health.wa.gov.au

Community Gardens

Developing, cultivating and maintaining a community garden requires a range of skills, but is also highly dependent on a wide array of cultural, social, structural and political factors, plus other considerations such as workforce sustainability, and supply and demand [44, 45]. Viable gardens can provide community members with increased food security and access to fresh, affordable fruits and vegetables [46], and may present a means of community income [45]. They are also proving an excellent way to familiarise children with the origins and importance of fresh foods, alongside skills development [47]. Gardening also provides an excellent opportunity for physical activity.

For more information on community gardens check out:

- *The Remote indigenous gardens (RIG) network (NT) at: http://www.remoteindigenousgardens.net/edugrow/*

- *NTGardens at: http://ntgardens.org/*

- *the EON Foundation's Kimberley Edible Gardens Project at: www.eon.org.au*

Additional readings include:

- *Christie, M. The Box of Vegies: Method and Metaphysics in Yolngu Research. 2013 11 April [cited 2013 10 September]. Available from: http://www.cdu.edu.au/centres/yaci/pdf/CHRISTIE_Box-of-Veg_YACI%20.pdf*

- *Hunter, E., L. Onnis, et al. (2014) Gardens of discontent: health and horticulture in remote Aboriginal Australia. AIATSIS research discussion paper no. 34. Available from: http://www.healthinfonet.ecu.edu.au/key-resources/bibliography?lid=27311*

- *Hume, A., A. Wetten, et al. (2014). "Remote school gardens: exploring a cost-effective and novel way to engage Australian Indigenous students in nutrition and health." Aust NZ J Public Health 38(3): 235-240.*

- *Hume, A., K. O'Dea, et al. (2013). ""We need our own food, to grow our own veggies..." Remote Aboriginal food gardens in the Top End of Australia's Northern Territory." Aust NZ J Public Health 37(5): 434-441. Available from: http://www.phaa.net.au/journal.php*

Visual Approaches & Tools

Meaningful visual symbols, maps and images can create connectedness and engagement, and portray a clear message or story. In remote Aboriginal communities nutritionists have tended to agree that larger, good quality images, and photos including local community members (with their consent) and recognised reference points are generally well received [28]. Useful visual health promotion tools also include moving images (such as DVDs), and more recently mobile phones and other electronic media [29, 48, 49]. The following section provides an overview of a range of visual approaches to support shared health promotion.

Material Tools

Material resources can contain a range of images and text, and be developed or used to support and compliment more holistic health promotion strategies. In a preliminary investigation to inform future approaches to support health education and interpreting in North East Arnhem land [48], an online survey and interviews with 20 Indigenous health workers and other stakeholders revealed the following:

- Involvement of local Indigenous people in the creation of locally relevant resources is imperative.
- Appropriate and simple [clear] health education resources in communities specifically designed for Aboriginal clients are important.
- The most useful resources to facilitate communication and promote shared understandings were:
  - User-friendly.
  - Interactive and intuitive.
  - Oriented and contextualised to the user.
  - Tactile (eg. felt boards and touch screen, e.g. iPad).
  - Aesthetically appropriate.

Words present on a visual image (even if they are relatively few) can increase the tendency for participants to view the answer as "fixed" [50].

The felt man, developed by Diabetes Australia, is a useful aid to discussions about processes occurring in and to human body. The felt man is a life-sized felt cut out, accompanied by stick-on felt pieces corresponding to bodily systems and organs. For information about felt man kits, including training and an educational DVD, contact Healthy Living NT on 08 8927 8488 or email info@healthylivingnt.org.au

For a recent evaluation of the acceptability of the feltman resource for Aboriginal health workers, see: Browne, J, et al. Feltman: evaluating the acceptability of a diabetes education tool for Aboriginal health workers, Australian Journal of Primary Health; 2014; http://dx.doi.org/10.1071/PY14040

In addition, results of the survey and interviews found that [48]:

- Material resources are often designed to contain and convey information (i.e. they are designed to be didactic), rather than to promote and contextualise various discussions and narratives upon which to build health literacy.
- Resources that require passive viewing and listening fail to engage active involvement and input from the client.
- Resources often include western medical and design concepts.
- Resources, if used, are offered out of meaningful contexts.
- Little if any professional development or training is offered for workers to use material resources.
- Resources are seldom evaluated or followed up, and there are no systems designating responsibility for maintenance, update and storage.
- Resources often lie outside of an integrated approach, as such, the wide range of resources already available are generally not in active or highly productive use.

Report available at http://www.cdu.edu.au/centres/hl/ (p.6/7)

Resources that contain health messages rarely kindle discussions [51].

Another felt resource that has been developed for use by nutritionists working in remote communities is the "day mat". A hand made tool that provides a visual representation of a day that can be used to discuss daily activities, foods and eating patterns.

Well designed material resources can be useful tools for provoking interest, presenting and preserving messages, but they easily drop from use in the absence of a system which will maintain their ongoing use. Suggested means of maintaining circulation include ongoing promotion, regular training in the use of materials, frequent updates and incorporation of the materials into systems and orientation processes for new clinic, store or other health staff [15]. The final points deserve further useful consideration:

FOOD FOR THOUGHT

- While visual imagery can help to evoke and share meaning, caution has been drawn to **differences in the way that images are perceived and understood** among different cultural groups [52].

- **Think about the way in which images are presented.** For example, flipcharts can 'compartmentalise' information, compared to a visual storyboard that displays the whole story [53].

- **Visual imagery in the absence of meaningful communication** can also paradoxically lead to simplistic explanations by outside 'experts', while detailed information presented in a culturally appropriate way is not offered [28]b.

- **Visual misrepresentation** has also been highlighted as a potential problem [28]b. For example, one nutritionist explained, *"[In one resource] I saw a range of carbohydrate foods that are broken down into sugar – ice cream, coke, bread, etc, pictured next to fruit, etc. If you can't read, then you can see that people could easily pick up the wrong message"*.

Multimedia Tools

Justin Mohamed, chairperson of NACCHO explained that for over 40,000 years Aboriginal people have used a culturally-based form of social media called the *Songlines* or *Dreaming tracks* to connect, share, engage and record news and information [54]. Today Aboriginal people and their community controlled organisations have continued these cultural practices by embracing and adopting modern communication technology including television and radio, video making, locally produced television, the internet and more recently social media.

Consent and Talent/Media Release

DVDs and film taken on smart phones and tablet computers can be shared directly with others, be copied, and also be uploaded onto YouTube. In some cases this may be the point of the exercise – an attempt to have a short clip go 'viral' and be seen widely. In other cases showing the footage to a wider audience may not be anyone's intention.

The possibility that film can be shown outside a community should be made known to all filmed participants. Always explain where and how the footage will be used and seek permission to film from all relevant people before filming commences. For example, filming school children on a bush trip or in the school garden may require informing and seeking permission from the school (principal and teachers), parents and children. Most organisations have talent release forms or other appropriate paperwork that requires completion and signing. This may involve multiple forms if several organisations are involved.

In a similar vein, issues of privacy should also be considered when using social media. The appropriateness of posting tweets, facebook status updates, instagram photos, or discussing experiences in communities on public blogs should be carefully considered. Most organisations require specific protocols and permissions. Some communities have already come across these issues and have dealt or are dealing with them. See for example: http://nacchocommunique.com/2014/02/20/naccho-aboriginal-health-social-media-the-new-health-danger-in-aboriginal-communities/

It is also important to ensure you know the views of the community regarding images of deceased persons and to keep images up-to-date as appropriate.
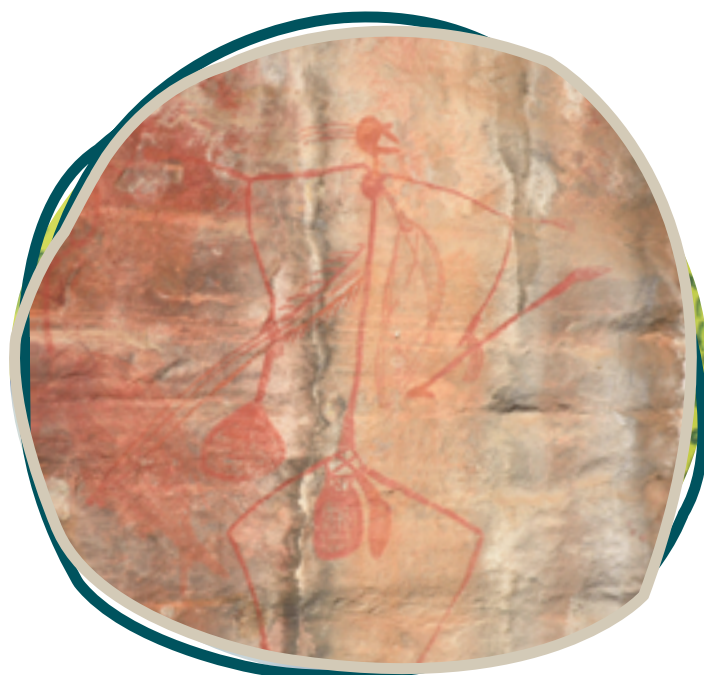
DVD & Film

Making and viewing DVDs are accepted means of conveying messages and drawing attention to health issues [29]. While people seldom want to engage with negative campaigns that shock, scare or disgust them, DVDs appear particularly effective if they incorporate music and/or lyrics, humour/friendly voices and/or well-known Aboriginal personalities [15]. Videos and film can be story-based and, once produced can be viewed repeatedly, are low cost to reproduce, easy to disseminate, and can be presented in local languages and subtitled in English [53]. Conveying health messages on film may also avoid problems that have been associated with face-to-face health programs such as lack of motivation by participants, lack of transport for participants to get to the program, having to run sessions after working hours, staffing problems and having to wait a long time for participants to turn up [1].

Of note, a health literacy project based in clinical settings in the Top End observed that the production of a collaborative DVD is only the start of a process [55]. As used in this project [55], clarity of the spoken message can be checked by having trained health interpreters back-translate the local language version into English. This can highlight areas within both worldviews where concepts and ways of expression are incompatible and need further exploration. Important considerations in the process also include how patients, communities, and Indigenous and non-Indigenous health workers will interact with and benefit from such resources. Evaluation of an animated DVD produced with a voiceover in a local Indigenous language revealed the following [48]:

- A number of words to describe body parts of functions were not commonly used and created difficulty. Some words also held dual meanings. For example, *wata*, which commonly means 'wind', is used for both 'oxygen' and 'carbon dioxide'.

- Some English words that were not translated were poorly understood, such as ' white blood cells', 'percentage', 'plasma', 'litres'.

- The DVD was said to contain too much talking, too few images, and to run too quickly.

- It was suggested that the commentary be broken into smaller chunks that provide more detail so that people can better understand the story.

The full report can be accessed at: http://www.cdu.edu.au/centres/yaci/projects_health_mmedia.html

Many communities have previously worked on projects using video. If people are interested to explore or use this medium, one first step would be to see who in the community has particular skills in this area. For example, some young people may have undertaken training or been involved in other projects; teachers from the school; broadcasting or local media services. It would also be useful to look at DVDs already in circulation. HealthInfonet is a great place to start. A list of all available health promotion resources, including audiovisual tools DVDs can be accessed at: http://www.healthinfonet.ecu.edu.au/health-risks/nutrition/resources/health-promotion

Some videos worth viewing

Feeling Deadly, Working Deadly: Indigenous AOD* Worker Wellbeing Kit is a humorous health-related resource that includes a DVD. To view or find a copy go to: http://nceta.flinders.edu.au/workforce/indigenous-aod-workforce/feeling-deadly-working-deadly-indigenous-worker-wellbeing/ *AOD = alcohol and other drug

Ethel's story and other stories form part of Flinders Closing The Gap Program. Go to: http://www.flindersclosingthegapprogram.com/portfolio/videos

Check out the work of The Jimmy Little Foundation. A range of audiovisual resources including videos and Youtube music are available to view through http://thumbsup.org.au/ The Jimmy Little Foundation also holds regular Music workshops, and manages Indigenous Hip Hop Projects, and could assist in your community. For example go to: http://www.apunipima.org.au/component/k2/item/471-thumbs-up-good-tucker-long-life

For videos, music and hip-hop check out: http://www.indigitube.com.au/index.php?option=com_ictv&task=view&ictvId=278&Itemid=3 Also google "Indigenous hip hop projects"

More ideas and tips for making and taking film are listed in **Appendix E**.

Phones, Internet & Social Media

In communities that have reliable phone and internet coverage, video footage on **smart phones** and **tablet devices** is becoming increasingly popular. Especially for younger generations these are engaging mediums for information exchange that are convenient and relatively inexpensive. In communities without phone coverage, tablet devices still provide a useful means of capturing film that can be edited on the same device.

> For the purpose of health communication, phones, digital cameras and available technologies can be used together with community members in order to help to record:
>
> - What people eat; where they access food; how they cook; with whom they eat and share food [22].
>
> - Foods in the shop that people don't know.
>
> - Aspects related to health or food that people find interesting or confusing, and would like to discuss.
>
> - Aspects related to, or indicative of change related to key messages, stories or discussions (See Section 7: Consider your Effectiveness).
>
> - Cooking demonstrations and workshops, or community health activities or events.

One nutritionist explained her approach and rationale for using mobile phones in her practice:

> *"I'm asking families I'm working with to film their families eating… It might just be a situation where children are eating and sharing food… they record everyday events and what's happening within the family – it's coming from their perspective. When ready, people bring those clips back and then I work with Health Workers or family members and we can talk about it… It's a fun way to work in a group… We can point out the positives that reinforce the story and narrative… local people are in control about what they film, so you can't make any mistakes there, and people love watching themselves… If in fact they're not interested, or it's an inappropriate methodology, they just won't use it…"* [Robin Lion, Personal communication, 2013]

Asking people to record their activities in their own time and space is more empowering than outside workers coming in with a fancy camera. This approach also largely overcomes issues regarding consent or ownership of the images – families are in control of the images they take and can store these and share them as they chose. Issues of confidentiality may be relevant to discuss in some circumstances, for example, if film or images contain outside people, sensitive issues, or may be shown publicly.

The process of **photo-voice recordings** where participants take their own images and tell associated stories have been applied in research settings within Indigenous communities [22, 55]. This approach facilitates cultural preferences and participant ownership; builds trust, skills and capacity; and beneficially alters the power balance between researchers and participants [55].

Tablet computers can provide flexibility and quick access to different information including useful internet sites and film. One nutritionist suggested using this device, "so you can just sit with people and talk and when something comes up you can pull up the appropriate images or animation sequence, or movie or interactive game…" [28]b

Local radio networks are often looking for interesting stories and topics that can benefit their communities. Encourage local people to participate in radio commentaries and talkback. For ideas on how to plan and write a 'radio spot' or for more information on how to use social media including **Facebook**, **Whatsapp**, **YouTube** and **Twitter** see the Community Health Action Pack for Aboriginal and Torres Strait Islander Communities at http://livelonger.health.gov.au/about-the-community-health-action-pack/

Using sms / texts to communicate and send messages does not yet appear to have been used extensively in health promotion activities. Text messaging could be used for handy and cheap reminders. Text messages may require a 'language' that is familiar and used by local people. In general, texting could be considered more equitable, widespread and frequently accessed than internet (which preferentially assists those who have access) and is less likely to be deleted unread than an email.

Further Reading & References

Appendix B contains the resource titled *Guidelines for intercultural resource production with Indigenous consumers.* This short guide was created through collaboration between the Mununukunhamirr Rom Project Team and Dr Anne Lowell of CDU. The resource offers an excellent summary of considerations relevant to the format and content of health communication and promotion resources.

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SECTION 6: CONSIDER FOOD

Overview

Health information will be most likely to generate meaning when communication flows two-ways and is contextualised within conceptual frameworks that are relevant to a people's worldview and knowledge system. Section 6 now attempts to apply an "Aboriginal Lens"[1] to food. In doing so, it considers a range of notions linked with food, food-related practices and the health of Aboriginal people and communities. This compilation of stories, concepts and examples have been gathered from a range of Indigenous and non-Indigenous sources to offer examples of possible pathways that might be jointly explored in order to ignite discussions and build shared experiences and understandings related to food and health.

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[1] This phrase has been previously applied to the health promotion resource title: Using a health promotion framework with an 'Aboriginal lens'. Making Two Worlds Work Project ©. 2008 Available from: http://www.ashm.org.au/images/ATSI/MTWW_Health-Promotion-Framework.pdf

Finding Meaning in Food & Food Practices

Innate 'cultural ways' are only truly known to those who grow up in a culture, or those who live long-term within another culture and speak the local language. Successful cross-cultural health communication requires collaborative two-way processes in order to find and share agreed concepts and meanings [1]. Effective and practical ways to approach and incorporate health and lifestyle discourses must be situated within the every day experience of the Aboriginal people with whom we work [2, 3]. So how can this be done?

One good place to start is to reflect on your own experiences. Reflecting on significant personal experiences helps to consolidate our learning and take it to a new perspective. Anda Fellows, a Red Cross Child and Family Leader, spoke of one such experience. She explains:

> *"A few years back I spent 6 months living with an old women on her homeland. Mostly it was just her and me, but members of her family would sometimes visit...*
>
> *In the times that we simply had no money we became totally dependent on the land to keep us alive. It was only through the grace of this woman's incredible knowledge that I didn't starve! It's amazing how much you talk to the earth, and plead and pray to the earth when you realise you are totally dependent... And the animals too – finally catching a crab and thanking and honouring that animal for giving up its life so that you may continue to live..."*
> [Anda Fellows, Personal communication, 2014]

So too, contrasts may be drawn over time and with other cultural groups in order to better appreciate different cultural values and worldview. This process helps us to reflect on our own views and can build awareness of and sensitivity towards the lives of others [4]. **Table 6.1** provides a general overview and theoretical comparison of both Aboriginal and western perspectives, practices and behaviours related to food. The information contained in this table is based on (and limited to) a review of literature, verbal discussions and observations. As such, the table statements should be read for general guidance and perspective only.

Table 6.1: Summary Table of Traditional Aboriginal, Contemporary Aboriginal & Western Perspectives, Practices & Behaviours Related to Food

Food-related Factor	Traditional Aboriginal Perspectives & Practices	Contemporary Aboriginal Perspectives & Practices	Mainstream Western Perspectives & Practices
Knowing foods / the Food System	Individuals educated throughout every life stage in all aspects & functions of their food system. Traditionally-oriented Aboriginal groups possessed an extremely deep and intricate level of knowledge, discipline, adaptability and innovation in approaches to food acquisition. Eg. the time to harvest a food was determined according to the winds, the tides, the lunar cycle and star formations, the flowering of particular plant species and other signs passed on by clansmen over generations through stories, songs, dance and experience[1]. Some knowledge related to foods (eg. the role of blood) considered highly sacred[2].	"Food comes from our ancestor's country, it is part of our history, & in painting, the land, songs & stories... We share this with the land; it connects us to the land. Food is part of our identity and keeps our spirit strong; we are strong like the cycad"[3]. Origins of contemporary foods/system poorly understood; lack of familiarity with many foods, tastes, food uses. "Know" products by previous social uses, packaging & shelf placement [1,4] Brand loyalty.	"McDonaldisation" – standardisation of foods, service, tastes = decreased variety[5]. "Know" foods through use/sight/ brand & taste. "Know" macro & micronutrient composition through nutrition labelling, ingredient list &/or brand name. Often no in-depth knowledge of purchased foods' production or origin, processing/ manufacture, ingredients – although consumers slowly demanding more whole/ organic/fresh foods & practices.

All references for Table 6.1 are listed in **Appendix iv**

Food-related Factor	Traditional Aboriginal Perspectives & Practices	Contemporary Aboriginal Perspectives & Practices	Mainstream Western Perspectives & Practices
Child Socialisation to Food	Socialisation & education of children and adolescents about their country & its food sources carried out informally & contextually using subtle & indirect means such as parental role modelling & child observation of daily activities[6]. Parents do not structure meal times or actively "feed" a child; the choice of when & what to eat considered the child's alone[7].	Socialisation & education around food still seen to start from birth & be carried out in informal & contextual ways, eg. paying selective attention, the use of stories, and encouragement of parental role modelling[6–8]. Parents place high value on child's autonomy & happiness – even if aware child is making poor food choices[9]. Parents respond to child's desires[7,8] Children can have significant influence on family food purchasing patterns & where money is spent[10]. Children appear to eat largely the same food as the family[11]. Children losing the taste for traditional foods[1,9].	Western experts largely promote an "authoritative" style of parenting; a "firm but fair" approach[8]. May initially feed on demand but ultimately encourage a "feeding pattern". Encouraged to introduce variety of foods. Will steer child towards or away from foods as considered appropriate; intervene in food choice & eating behaviour[12]. Food often used as reward for other behaviours.
Social Role of Food	The animal & plant kingdoms & foods & eating practices/rituals accepted as one with people, country, role, identity (including totemic identity), Law, ceremony, teaching, learning & the spirit world[13,14]. Process of collecting/acquiring and preparing food often complex and lengthy – could involve multi-day hunting parties or long sessions of physical labour (washing, rinsing, grinding grains and nuts) during which other important socialisation rituals took place.	Diet primarily a 'social', not 'nutritional' or 'health' behaviour[15]. Food seen as communal property, shared with kin. Traditional foods highly prized for social, taste & health properties [1,4,16–19]. Hunting/gathering endows sense of wellbeing[13,20]; mostly a weekend activity[3,21,22]; good when financially poor[9,17]. Store foods integrated into family harmony[23], cohesion & collectivism[18,19]; food choices reflect learned taste preferences, economic status, mobility, setting & availability[15]. Takeaway & ready-to-eat foods are convenient & negate the need to shop, prepare, cook &/or share food[24] Also described as "lazy" food[4,9].	Diet plays both a social & nutritional role. Sharing meals with family/friends, going out for dinner, birthdays, weddings, etc. Linked with personal & peer image through food advertising; brand names; fast foods, posting pictures or updates about food on social media. Class (eg. haute cuisine) & identity (eg. Vegetarian/vegan). Foods & eating/lifestyle behaviours linked with body image; social approval/stigmatization. **See Germov, J. & Williams, L. (eds) for overview**[25]
Gender roles	Separate domains of 'men's business' & 'women's business'. Hunting prestigious yet uncertain. Gathering provides daily subsistence. Men principal hunters; prepared, cooked & distributed large game. Women gathered plant foods, honey & foraged for smaller animals.	Gender roles possibly becoming less defined. Women more responsible for "gathering" & organising family food via the store[10]. Hunting & gathering activities still ideologies & skills held in high cultural esteem. Men's connection to food supply has weakened. Partaking in the family meal seen as one way for men to preserve a connection to food, their identity & wellbeing[19].	Gender roles generally less defined[5]. Women more responsible for family food acquisition and meal preparation.

All references for Table 6.1 are listed in **Appendix iv**

Food-related Factor	Traditional Aboriginal Perspectives & Practices	Contemporary Aboriginal Perspectives & Practices	Mainstream Western Perspectives & Practices
Food Groupings	Food categorized according to origins of meat & plant foods, plus subgroups[20,26]. Foods from both groups needed for a balanced meal & diet. A wide variety of food was eaten and people were never dependent on a single or a few food types.	Traditional foods categorized according to meat & plant-based foods[1,4]. Traditional foods separate to store foods. Store foods defined as "good" and "bad", but many store food unknown. Wish to balance traditional & store foods[4,27].	Nutritional science talks of five main food groups. A healthy, balanced diet includes a combination of specific quantities of foods from all groups[28].
Food Variety	Characterised by diversity; a range of animal & plant foods across all seasons.	Diets characterised by lack of variety: high in refined carbohydrate & fat, low in fruits & vegetables, with little seasonal variation.	An extraordinary variety of fresh foods available due to modern food manufacturing practices, transport, distribution & retail practices. Huge variety of processed foods but decreasing variety of ingredients.
Meal Patterns	People sought food when the need/hunger arose[13,20,29]; ate when food was available. Fresh foods hunted or foraged are eaten in one or two sittings, some foods need preparation or storage (i.e. foods that would be poisonous without special treatment).	Generally no set daily meal pattern; breakfast possibly most stable meal. People actively seek out food when hungry; this approach encouraged from birth[8].	Generally three main meals per day; may eat one, two to three courses. Growth in culture of mid-meal snacking driven by food industry[30].
Food Access & Acquisition	Clan practices supported sustainability, ensuring that people never took too much, left enough for reproduction/for the next season; engaged in practices such as burning off to allow germination. Accessing "wild" foods imperative for survival. Hunting and foraging using in-depth knowledge & skills passed down through generations & traditional technologies (eg. fish traps). Within constraints, preferences people ate what was seasonally available & what people "know"[13,20,29,31] Groups could relocate to other areas if required, eg. in times of drought. Land was also primary resource for clothing and building materials, food.	Access[17,32–37] & intakes[34,38] of traditional foods generally limited by environmental, social & material constraints or physical constraints (too sick to go out on country). Can also be associated with sorry business or other ceremonial factors (country 'closed' due to mourning). Access to store foods dependent on macro and micro factors, eg. food supply[39]; financial situation/demands/cycles[31,33,40–42] **See Brimblecombe et al 2014 and Brimblecombe 2007 for overview of determinants of food choice & nutrition[27,43].**	Food stores & outlets ubiquitous & open all hours. An extraordinary variety of fresh & processed foods available due to modern food manufacturing, transport, storage, distribution & retail practices. The cheapest food is often the least nutritious; more expensive foods more nutrient dense[44]. Purchase for convenience; taste; hunger management; cost & other available resources; environmental influences & cues (familial, social, political); life course stage/ events; health & other values & beliefs; impulse & habit. **For overview see Sobal, J. & Bisogni, C 2009[45].**
Food Proportioning & Distribution	Available foods shared among family & kin according to strict Law and social custom[13].	Traditional foods still bounded by Laws of distribution & reciprocity among family & kin[17]. Cooked communal meals bound by custom of reciprocity. Takeaway foods are exempt. Poverty & unequal wealth distribution cause strain & 'hum-bug' (demand sharing)[46]. Although demand sharing also based on generosity & reciprocity[46], efforts to reduce hum-bug negatively impact on food behaviour (shop less often; buy less fresh fruit; more takeaways; lock cupboards; separate fridges)[17].	Common portions sizes have increased. Meals may be shared in a family situation however, often meals eaten separately & may members of family may eat different foods. An increasing percentage of meals prepared by others & consumed out of the home.

All references for Table 6.1 are listed in **Appendix iv**

Food-related Factor	Traditional Aboriginal Perspectives & Practices	Contemporary Aboriginal Perspectives & Practices	Mainstream Western Perspectives & Practices
Food Preparation & Cooking	Most foods eaten fresh or lightly cooked, soon after they were hunted or foraged. Some foods consumed whole, or as a singular 'ingredient'[47]. Three main methods: baking in hot ashes; roasting (lightly) on hot coals; steaming (lightly) in an earth oven[48].	Preference towards simple meals that include moist, cooked foods[33] (eg. one pot stews) with few food combinations; dislike too many ingredients in one meal. Household cooking occurs on a cook-top, over an open fire or in ashes. Recipes seldom used.	Meals often complex; made up of numerous foods, ingredients & flavours. Household cooking reducing in proportion to ready-made, takeaway & restaurant meals. Microwave ovens popular. Decreasing knowledge & interest. Celebrity chefs & shows popular.
General Dietary Behaviours & Preferences	Seasonal diversity in range of animal & plant foods available. Preferences for: meat & animal foods; meat cooked rare[2,9]; fat & fatty organs[49]; sweet-tasting foods[13,20,29,48]; moist foods (builds strong blood & body)[2,13]. Freshness vitally important[13,29].	Diet generally characterised by lack of variety; no seasonal variation in processed, energy-dense foods high in fat & refined sugars & low in fresh fruits and vegetables[31,33,39,50-52]. **See Lee 1996 for overview[50].** Food choice influenced by availability of food in store [24,53,54]. Preferences for: meat & animal foods, meat cooked rare[4]; sweet-tasting foods & sugar[41,52]; takeaway foods[10]; long-life foods[17,27,39]; fresh fruits & foods (but limited by cost, availability & lack of cold storage[55])[1,4].	Western cuisine now encompasses a wide variety of food choices within multicultural societies. In general preferences for: meat-based meals (although vegetarian cuisines becoming more mainstream); convenience foods & drinks. Higher per capita intake of fruit and vegetables than Aboriginal communities, but still below recommendations[56].
Dietary Fats	A delicacy reserved for those – usually men – of high social standing. Lauded for taste & health qualities. Available in small quantities, infrequently[49].	Fat in diet mainly obtained through high fat foods such as fatty cuts of fresh & frozen meat; tinned meats; packaged biscuits; hot & cold chips & fried takeaway foods. Margarine, butter, oils used less frequently.	Fat in diet mainly obtained through high fat takeaway foods; cakes and pastries, margarine, butter & oils used in cooking. All readily available, in any quantity.
Sweet Foods	Sweet tastes highly prized but available infrequently & in small amounts. Sweet foods included: sugarbag (native honey – most highly sought), honey ants, sweet gums, seeds & nectars[48].	Sweet tastes a flavour preference. Very high intakes of sugar (often in milky tea) & sweetened fizzy drinks, especially coke; a dietary habit very resistant to permanent change [52]. Sugar and sweet drinks linked with diabetes[4].	High intakes of sweetened fizzy drinks & sugary foods including processed foods, confectionery & spreads. Link between sugar and dental caries well known.
A "Healthy" diet	A deep understanding and desire to eat foods that constituted a quality, fresh, balanced diet [13]. Balance of animal and plant-based foods. Animal foods most linked with strength. "Wet" foods build strong blood & body; "dry" food weakens blood & body. Special foods for particular groups, eg children & elderly.	Associated with balance, variety, natural fresh food, dietary control, inclusion of fruit and vegetables, limiting fatty and sweet foods (similar to traditional & Western concepts). Common notion of 'good' and 'bad' foods, generally based on Western input. Traditional foods highly valued & considered to have healing properties but only a small component of actual diet. Need to balance traditional & store foods.	Scientific approach used dietary guidelines based on food composition. Foods, food components, food production methods, physical outcomes, psychosocial outcomes, standards, personal goals, & as requiring restriction. The natural, fresh, seasonal foods that comprised the traditional Aboriginal diet still regarded as the benchmark of a "healthy diet".

All references for Table 6.1 are listed in **Appendix iv**

[a] The use of "traditional" denotes life prior to, or shortly after white contact however, given that information have been gleaned from mostly observers accounts, this is only a theoretical guide.
[b] The use of "contemporary" refers to Aboriginal people and practices currently living in remote Indigenous communities.
[c] Cycads have been used as a food source, and also as a sacred or medicinal plant in Australia for at least 4,300 years. Cycad products are used for initiation rites and other important rituals and ceremonies.
[d] Flour/bread seen as substitute for seed dampers, thus may be considered a plant food (Devitt, J. Contemporary Aboriginal Women and Subsistence in Remote, Arid Australia PhD Thesis thesis, (1988))
[e] While the range of processed foods on supermarket shelves is increasing, the range of ingredients used in these "new" foods is decreasing
[f] Underpinned by high food costs, poor availability of healthy food choices, limited capacity for household food storage, poor knowledge related to nutrition and budgeting, and early links with provided food rations

Health communication and health promotion messages that focus on specific symptoms, problems, or components of risk or disease, often become fragmented and meaningless. Therefore, building meaning can also come about by discussing information in the context of people's daily lives. In this process, generative words and phrases provide 'cultural keys' that can be used as touchstones to communicate knowledge and experiences across two different worldviews [5]. Finding local words or English descriptive equivalents that portray positives, strengths or desirable qualities can help to build meaning and ways of relating to new or unfamiliar foods. While you spend time in community and accompany people as able on hunting, fishing or gathering trips consideration of the following may help to find meaningful points of overlap or approaches:

STRATEGIES FOR DEVELOPMENT

Consider and discuss:

- How do people hunt, collect, prepare and share foods?

- How is food incorporated into knowledge and teachings?

- How do the Aboriginal people you work with come to understand what foods are safe and what foods are poisonous in their homelands?

- How long did it take to build the understanding people have now about their homeland food?

- In an unfamiliar land, who would people trust to inform them what foods are safe or poisonous?

Consider also:

- What is valued about traditional foods?

- What meanings are derived from these foods, including social meanings?

- What are people's favourite foods? Why?

- How do certain foods make people feel?

- Does anyone know any stories (Dreaming, Law) that give/gave guidance related to food uses and eating behaviour?

- Can animals such as wallaby, turtle and emu be used as useful starting points when talking about anatomy and bodily processes?

Dr. Jamie Mapleson, Health Educator with Aboriginal Resource and Development Services (ARDS Inc.) shared that people's knowledge of animals and anatomy is an excellent starting point. There is often a great understanding of anatomy of animals that people eat; this has the added benefit of encouraging a process of two-way learning and allowing you to work from peoples existing knowledge base (which are important aspects of adult education).

For example stories about kangaroo or wallaby can be useful in trying to explain or depict our body using sugar or energy. In the dry season, there's not much food for the kangaroo. It has to work hard to get the food. In this season the tail is lean; but in the wet season when there's lots of food and not much work is required to get the food, the kangaroo's tail is fatty. In remote Aboriginal communities, it's more like the wet season for the wallaby – all the time with lots of food at the shop, and no exercise.

Living or sharing experiences related to better health and wellbeing is one important way of supporting people to create new meanings, change attitudes, and choose to live and behave in different ways. Kama Trudgen, an Arnhem Human Enterprise Development (AHED) Facilitator[2], tells a story that illustrates this powerfully:

"In 2012, a long term friend and client, Dianne Birritjalawuy, asked me for help to manage her chronic health problems. This began an unexpected journey...

We explored much information together, sharing knowledge and ideas about health, nutrition and diet. When I suggested that food could be used to help heal Dianne's body this was a new concept. Dianne had some knowledge that diabetes was caused by eating sugar, but was not convinced how this worked, or that she had any power to change her health. She did not realise how unwell she was feeling, and that changing her diet would revitalise her energy and sense of wellbeing.

During our discussion I felt something was missing – an experience that could move someone to a place where they were empowered to discover that they have the ability to transform their own health. If you have no tangible experience that food choices impact your health, why change? I wished I could give Dianne the opportunity to experience 'health'.

...And then in late 2013 Dianne had an acute health scare that left her wheelchair bound with symptoms of unstable ischemic heart disease and uncontrolled diabetes. In response to this I offered Dianne the best substitute I had available with my resources at that time – I agreed to cook dinners for Dianne for one week. She embraced this opportunity, and also followed recommendations for other meals...

This experience was transformative. Dianne went from being unable to walk short distances, to experiencing a new level of energy and vitality. Her weight and blood sugar levels normalised, and she was able to walk up hills with ease. The new reality she was experiencing made her hungry for more information and tools to carry on this new way of life! We continued to meet to share personal experiences, workshop information, watch relevant educational DVDs together, sample new foods, share recipes and explore together alternatives that could work in Dianne's circumstances.

...Within three months, other community members started to notice Dianne's tremendous transformation. People saw her experience as evidence that nutrition and lifestyle interventions are powerful and effective, and also something achievable by them in their own community. This caused a chain reaction, with community members actively seeking out support to see this same transformation in their own health. A key tool in the information sharing process was to actually bring this information to life.

Today, a group of interested ladies continue to meet regularly to sample alternative foods and recipes and work out individual solutions for healthy whole foods that they enjoy, and to find ways to get access to these in their remote location." [Kama Trudgen, personal communication via email, 2014]

Supporting positive experiences, acknowledging strengths and drawing on the rich and powerful meanings of food and food-related activities within a people's traditional food system can all be salient generators or reference points to build connections and find meaning within a second food system or domain [6].

Hunting as a Benchmark & Metaphor

Nutritionist and researcher, Julie Brimblecombe observed that in traditional Yolngu life, hunting and gathering activities were intertwined with Yolngu identity, involved in forming the basic economic and organisational structures of society [7]. Food also belonged to a system of knowledge embodied over countless generations that connected all people's lives and actions. A deep understanding of the complex, integrated nature of the traditional food system was said to have made food choice relatively straight forward. In traditional lifestyles, the hunting of game is indelibly linked to religion and custom; for example, hunting plays a role in the initiation of boys to men, and fresh meat is esteemed as "currency", paid by the young man to the Elders for teaching him Law [8]. Hunting a homeland is also considered part of being responsible custodians for that land, linked to being trustworthy with the knowledge handed down from the ancestors [9].

Anthropologist Sydney Mintz states that *"meaning is the consequence of activity..."* [10](p.14). Today in remote communities, hunting and gathering are weekend activities for most [11]. Seeking traditional foods has also been talked about as particularly useful when financially poor [12]a. In addition, traditional hunting activities are talked about with a sense of cultural satisfaction and wellbeing [12a-14]. Successful hunters continue to be esteemed [15]. The following story, shared by nutritionist Frances Knight, highlights this continuing value:

"...While on a three day camp a few hours out from Pormpuraaw we had to take two young boys back to town because one needed his penicillin injection... On the way back to the camp we saw a goanna and stopped so the boys could catch it... we tied it to the front of the troupy [large cross county vehicle] and drove the rest of the way to the camp. ...When people saw it everyone came rushing to the car – they were so excited. All of the kids were clapping the two boys on the back; the men at the camp, including some elders came up, inspected the goanna and, once satisfied, shook the boys hands and told them they'd done really well. The boys were grinning from ear to ear with pride. They cooked the goanna on the fire that night and it was shared with everyone." [Frances Knight, Personal communication via email, 2014]

Participation in hunting and gathering activities may [12a-16] or may not [17] be considered healthcare advice by Aboriginal people. Using significant metaphors as benchmarks for behaviour, can tap into aspects of people's lives from which they draw meaning.
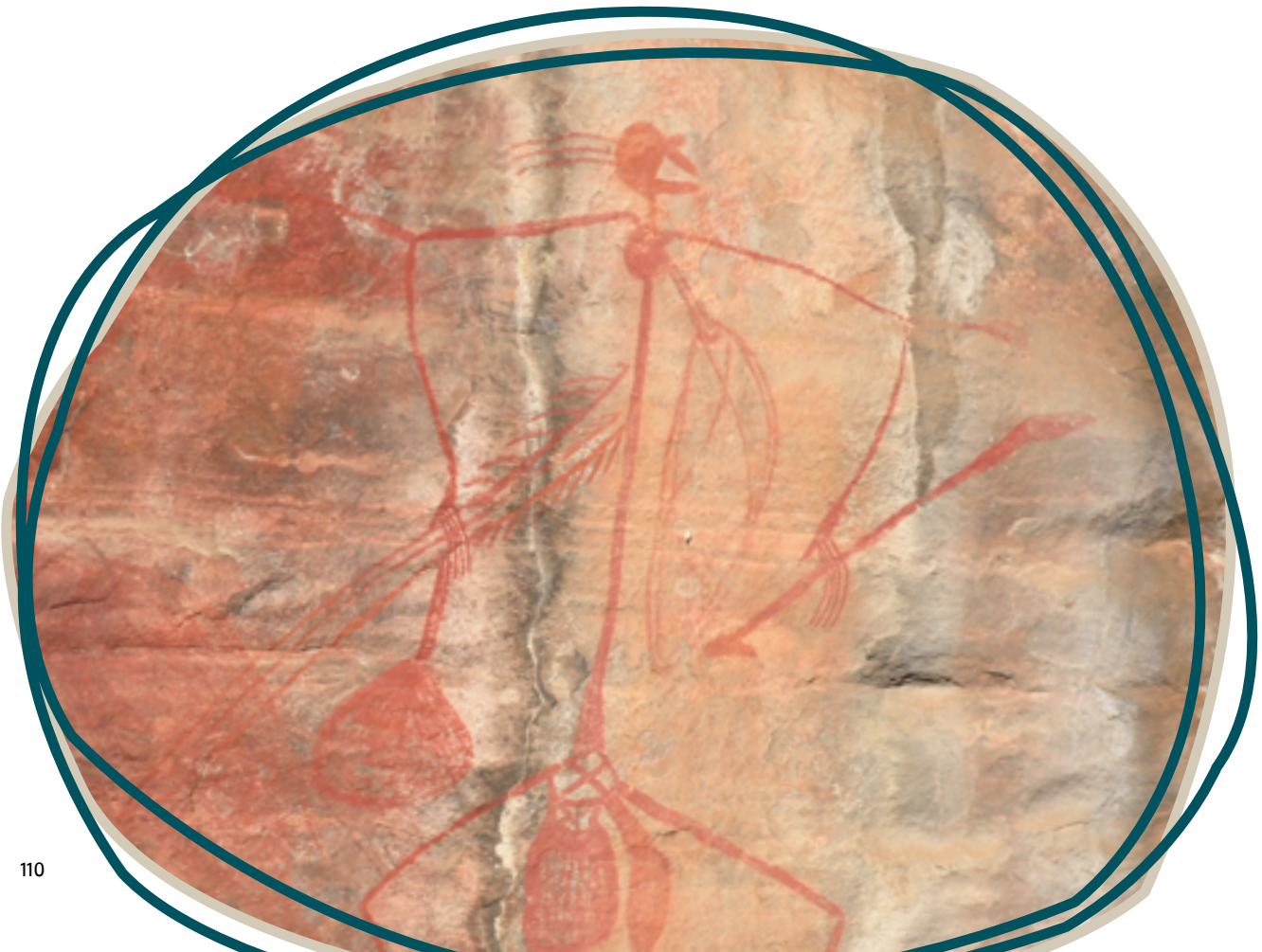
The Play and Learn Support (PALS) Resource Kit is a health promotion initiative that uses hunting as a metaphor. The PALS resource kit was developed in response to concern throughout many remote Indigenous communities about several health conditions among young children including underweight babies and failure to thrive, young children with coordination issues, and children with hearing and vision and other communication problems. This kit has been developed in conjunction with Indigneous and non-Indigenous Yolngu, Anindilyakwa, Wubuy and Kriol speakers of the North East Arnhem and Groote Eylandt regions of the Northern Territory.

The PALS kit uses teachings, guided by images that are based on conversations around the seasons and hunting for bush tucker. **The concept of tracks used for hunting in different seasons provides a meaningful cultural comparison to child brain development; the tracks are likened to neural pathways in the brain**. Again guided by images, conversations can move on to explore the importance of providing good strong experiences for mothers and children, in order to promote a deeper understanding of brain and physical development, and ultimately develop ways to strengthen these tracks (or pathways) during a child's first three years. **The metaphor of the seasons is used to represent the timely acquisition of developmental skills such as using the hands, connecting with others, talking and understanding**.

While the PALS resource does not exclusively focus on food and nutrition, this is a culturally meaningful resource that helps to communicate a number of vitally important child health and development messages. A number of nutritionists have received free training in administering the PALS resource. As health professionals, we can also recommend to local childcare and health workers that they receive training in the use of this kit in order to enhance their skills and support and encourage other workers and carers to guide parents and grandparents through this valuable conversation.

In addition to, and beyond its intended purpose, the PALS resource, and its chosen concepts could be used by nutritionists in such ways as:

- To explore alongside community members their local ecology and cultural practices around hunting and gathering.

- To include discussion of the types and textures of foods that may be appropriate as the child comes into different developmental stages or 'seasons', and strategies for feeding children and families.

- To draw on and share stories of how parents learned about foods and what they ate as they were growing up; if their own parents cooked, and if so, how? These discussions can be used to help parents draw on and learn from their own experiences.

- Explore the good things that parents are doing now – acknowledge the constraints that people live within and recognise people's strengths and skills.

For more information on the Play and Learn Support Resource (PALS) contact: Communities for Children Program, East Arnhemland, Anglicare NT. Ph: (08) 8985 0000

Another powerful example of using traditional practices and behaviours in health communication is the use of the shield as a symbol of protection; a metaphor through which to talk about protective behaviours. For further discussion on this, see Section 5.2, page 75.

Traditional Foods & Food–Related Values

As Table 6.1 suggests, perhaps the most highly prized components of the Aboriginal hunter-gatherer diet were the relatively few energy-dense foods – depot fat including marrow, organ meats (liver, heart, kidneys and brain), blood, fatty insects and marine mammals, and honey [13, 14, 18-20]. The fat from animals such as emu; euro; lizards; witchetty grubs; echidna; kangaroo; turtle or dugong was valued for consumption and also used as rubs on various parts of the body including the face, eyes, ears, hair and chest to cool the body, keep the skin smooth and glossy and prevent it from drying [13]. The bright yellow fat was particularly lauded [21].

In hunted animals, the importance of meat was inextricably bound to its fat content. Meehan notes that "people constantly discuss the best time to collect various foods so that the animals will be in the most desirable condition for eating, that is, when they are 'fat'" [14].

Among the Anmatyerre of Central Australia, Devitt described how "every animal killed was immediately checked for fat content and there was expressed disappointment if they were 'boney ones', carrying little fat" [13].

Among the Kukatja, living in the far south-east Kimberley Region of Western Australia, Peile noted that the term 'putarri' (having much fat) had come into general use to mean "beautiful". In contrast, a thin animal containing little fat around or with the meat was regarded as mungulpa, or "rubbish" meat [22].

While fats were highly prized in the traditional diet of most Australian Aboriginal groups, the actual quantities of fats consumed in the diet was low.

Today, traditional foods continue to be highly prized for social and cultural ceremonies for taste, and are considered to promote healing and general health and well-being [20, 23-25]. For example, whole foods such as shellfish are known to have a cleansing affect on the body and blood [5]. Parents have also stated that traditional foods such as fish, yams, kangaroo, turtle, turtle eggs, oysters and crabs are good for growing children, and protect against the bad effects of store foods [24].

Sugars and sweet-tasting foods were, and continue to be other prized dietary items. Sugarbag (native honey – eaten wax, bees, and all), honey ants (that live in nests a meter deep and store honey in their abdomens), and also sweet gums, seeds (ironwood) and nectars (of grevillea, hakea and banksias flowers) were a frequent and leading focus of foraging activities [8, 13, 14, 18].

Bush Honey (Sugarbag)

In Aboriginal traditions, honey is imbued with such desirable qualities that its gathering and continued supply were explained in mythology and controlled through painting, songs, ceremony and custom [8]. In her book, Bush food: Aborginal food and herbal medicine, Jennifer Isaacs explains that in east Arnhem land from Yirrkala to Maningrida, the bush-honey ancestor of the dwuwa moiety, named Wuyal, found the first sugar-bag, and paintings, songs and ceremonies recorded his activities, forming the basis of present-day hunting, harvesting and sharing of honey [8].

Warlpiri people have stated that bush honey does not cause diabetes like sweet foods made with refined sugar, but in fact can assist recovery [25].

Food Qualities

In contexts where two food systems exist, good knowledge associated with one domain can provide a solid foundation for understanding the second [26, 27]. In remote Aboriginal communities, nutrition education delivered within broader programs has highlighted the qualities of familiar traditional foods, upholding and comparing these food and lifestyle characteristics with healthful western foods and dietary recommendations [28–30]. In the context of health communication, valued qualities, food groups or types of traditional foods can be used to draw parallels with available foods in the contemporary food supply.

FOOD FOR THOUGHT

- Anthropologist Jeannie Devitt, speaks of a host of quality terms used to describe particular food items among the Anmatyerre of Central Australia. For example, meats are traditionally thought of as *'fat meat'*, *'lean meat'*, *'tough meat'*; fresh fruits might be *'ripe' or 'unripe'*; other foods *'dry'*, *'fresh'* or *'rotten'* [Jeannie Devitt, Personal communication via email, 2014]. (See also Table 6.3: The Anmatyerre classification of foods, later in text).

- Dietary qualities including 'balance', 'variety', and 'freshness' have been used in relation to traditional and the contemporary food systems [12a, 16] (these qualities are discussed below).

- Generative words and concepts, such as foods that make people feel *'light'* and *'heavy'* have been used to draw parallels between traditional and contemporary foods and practices [12]a. In these discussions:

"Feeling light"

or eating foods that produced a *"feeling of lightness"* was associated with *"feeling energetic and happy"*; a sense of wellbeing. One grandmother described *"feeling active, walking, feeling good inside the head and the body, feeling fresh. When you're in good shape, doing the right thing..."* This positive state was associated primarily with the consumption of traditional foods, and also fresh fruits and vegetables.

"Feeling heavy"

was associated with *"bad"* foods including takeaway, high fat food and powdered milk. This was felt within the body and mind, described as, *"sitting down, ordering takeaway. Being lazy, asking other people to do their work..."* [Mother, 30 years]; *"getting stuck...feeling addicted to the store food; feeling sick."* [Grandmother] Several people also described feeling heavy when they had no choice but to eat bad food.

- An appendix in the 2003 version of the Dietary Guidelines for Australian Adults contained two specific recommendations for Indigenous Australians [31]:

Choose store foods that are most like traditional bush foods

Enjoy traditional bush foods whenever possible

This document noted that a diet based on traditional foods is generally consistent with the Australian dietary guidelines such that they both include fresh plant-based foods, fish and seafood, lean meat and poultry, and wholegrain cereals [31](p.258).

Figure 6.1 (see overpage) provides a pictorial example of the notion of choosing store foods that are most like traditional foods. It might also be appropriate to consider using different designated food groups to explore similarities and differences between foods. Comparisons might also be made in how various foods grow or where they come from, for example, from the sea, the bush etc. Foods with particular nutrients could also be discussed and compared, for example, the Kakadu plum has approximately 300 times the amount of vitamin C to that of an orange, which is considered a "high vitamin C" food. Many other plant foods are similarly packed with nutrients.
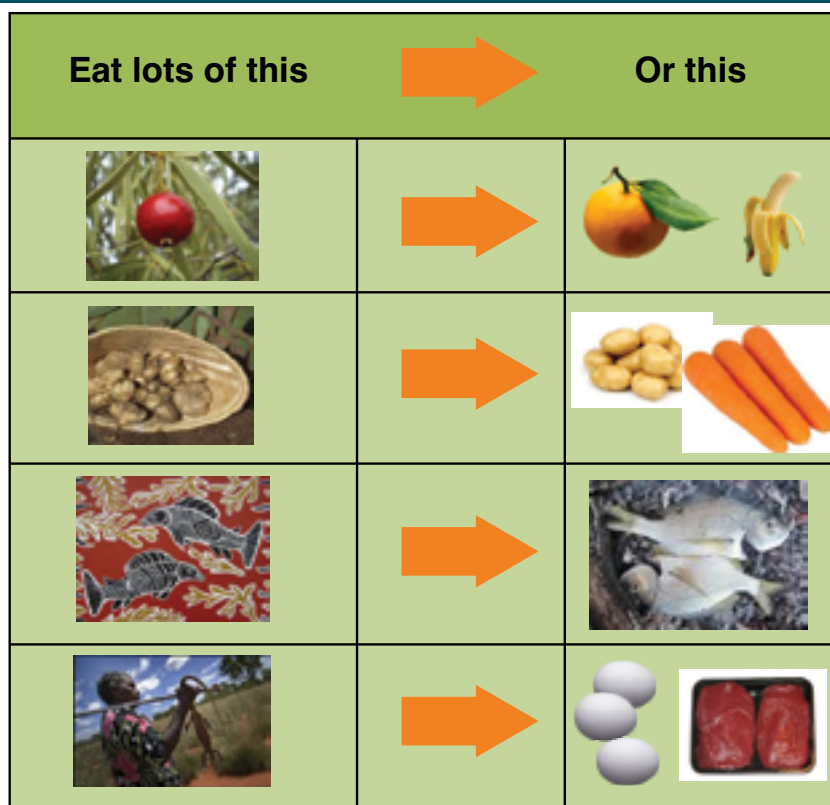
Figure 6.1: A pictorial guide to help communicate the idea of foods that contain comparable qualities to traditional foods

Food Groupings

Within traditional food systems, Aboriginal people understood and grouped their foods in meaningful ways. One example of a traditional food classification system is that of the Anmatyerre of Central Australia [13]. These desert-dwelling people classified foods into **plant and animal categories**, distinguishing grubs *(tyape)* from other animals *(kere)*, and plant foods according to those with seed-bearing capabilities *(ntange)* from others *(merne)*. There was also a category for sweet substances *(ngkwarle)*. **Table 6.2** shows the traditional Anmatyerre classification of foods.

Table 6.2: The Anmatyerre classification of foods

Within this system, an individual item of food was identified by its broad resource category name, followed by its particular name. For example, meat of bearded dragon was referred to as' kere amwelye'; meat of kangaroo, 'kere agherre'.

Category	Description
Kere	Animal flesh including mammals, reptiles and birds
Tyape	Varieties of grubs
Merne	Fruits, tubers and leaves
Ntange	Edible seed varieties
Ngkwarle	Sweet substances including those from ants, native bees, nectars, lerps and sweet gums
Kwatye	Water

Table reproduced (and amended) with author permission from [13](p.96)

Of note, the Anmatyerre classification of foods also includes some contemporary store-bought foods, for example, beef is *kere*, flour is *ntange*, cocacola is *ngkwarle*, alcohol is *ngkwarle* [32].

Among coastal dwelling Yolngu of the Top End, foods comprising the traditional diet have also been classified in two major categories depending on their origins: animal foods and plant foods [5] – *Gonyil* (or Matha-yal, Merrpal', Matha-bira, Nänarr'yal) foods signified the meat and protein foods; *Murnyan'* (or Dhäkadatj, Ngayangay', Buku-bira') designated plant and vegetable foods. In this categorisation scheme, sub-classes existing within each category, such as *borum* (fruits), *guku* (honey), *ngatha* (root foods), *mangutji ngatha* (seeds) and *mudhungay* (cycad foodstuff) [5].

Rather than impose a pre-determined set of food groupings based on the western nutrient-based focus, it is relevant to explore how people categorise their traditional foods. This knowledge might then be used as a means to incorporate store-based food, or as a basis or starting point for discussions. Reflecting on discussions within the two food systems that took place in Wadeye (Port Keats), nutritionist, Robin Lion explains the *Murrinh-Patha* words and symbols used to define people's traditional food groupings:

"People categorised foods that were hunted, mainly by the men... These foods were small and large animals and made up a group 'ku'. Plant foods were given the symbol 'mi'... Plant foods that grow below the ground, and above the ground...

We did a lot of classification of foods according to language and how people classified them and then fitted that information into a western model. But it was always 'you tell us if this food isn't in this particular group...', so there was a lot of dialogue that went on over a long period of time..." [Robin Lion, Personal communication via email, 2014]

Discussions around traditional food groupings are incorporated in the Talking About Feeding Babies & Little Kids Counselling Course.
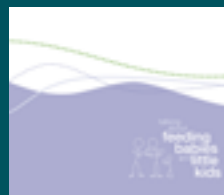
Early on in the **Talking About Feeding Babies & Little Kids Counselling Course** participants are encouraged to explore and identify food groupings used within their community through the use of prompting questions such as:

Why do you think that people group foods?

Did the old people in the area that you are from have a way of grouping foods? If so, how?

Following discussions about people's traditional food groupings, another way to group foods is introduced – the Australian and Torres Strait Islander Guide to Healthy Eating [33].

Community groups can ultimately decide how best they would like to group their foods, and these groupings are used throughout the course to facilitate further discussions.

For more information about The Talking about Feeding Babies and Little Kids Counselling Course go to: For more information about The Talking about Feeding Babies and Little Kids counselling course go to: www.menziesnutritionportal.edu.au After December 2014 more information will be available at: http://www.menziesnutritionportal.edu.au/areas/talking-about-feeding-babies-and-little-kids-counselling-course-tfblkcc-kit

Balance

The desire for balance in our lives and in our diets is an essentially universal aspiration [16, 34, 35]. For Aboriginal people, a diet that regularly included a variety of animal and vegetable-based foods was highly regarded and considered balanced and correct [5, 14, 36].

Work led by Julie Brimblecombe and Elaine Maypilama with people living in one remote Top End community highlighted the notion of **balance** as an overarching quality and attribute to promote a good life and well-being [7, 16]. Within this holistic view, the notion of *balance* was also used in conversations around food and diet, including the predominant impression that a lack or loss of balance has occurred between the two food systems [16]. This was seen to have manifested in three ways: (a) too much reliance on purchased food rather than traditional foods, (b) too much reliance on pre-prepared take-away foods, and (c) a lack of food variety.

Jeannie Devitt has referred to the notion of balance established between minimising the effort required to procure food, and maximising the certainty of a regular, high quality supply [13]. This cost versus benefit scenario relates to the uptake of white flour as an easy replacement for seed dampers and other formerly staple carbohydrate foods such as roots and tubers. Given this historical substitution, it could certainly be suggested that flour came to be a "root vegetable replacement", and as such may be viewed as a kind of vegetable itself, accompanying the meat to provide a "balanced" meal.

Aboriginal people have also spoken of balancing traditional foods with Balanda [white man's] foods [12a, 24]. Concepts of balance have included *"...buying only vegetables and getting meat from the sea or bush"; one Grandfather also suggested "they should balance the food from the shop"*, referring to the need to stock more fruits and vegetables, and fewer "bad" foods. Health – or lack of it – was very much related to the diminishing role of the traditional diet, and the ensuing (over) reliance on store foods [12]a.

Paradoxically, the natural, fresh, seasonal foods that balance and characterise the traditional diet of Aboriginal Australians represent in essence, the benchmark of what current nutritional scientific thinking considers a 'healthy' diet. This concept of balance both underpins, and is underpinned by the quality of dietary *variety*.

Variety

Most early observers of traditional Aboriginal diets describe a varied and ample range of both animal and plant foods, with diversity provided on a day-to-day and seasonal basis, supplemented by 'feasts' when large game animals had been successfully hunted [18, 36, 37]. Across the realms of animal- and plant-based foods, variety was further ensured by exploiting diversity in land and water habitats, and the cyclic availability of foods with the changing seasons. In contrast, the contemporary diets of Aboriginal people are characterised by a lack of variety: diets high in refined carbohydrate and fat, and low in fruits and vegetables, with little seasonal variation [37-39].

Traditionally-oriented Aboriginal groups possessed an extremely deep and intricate level of knowledge, discipline, adaptability and innovation in approaches to food acquisition. For example, the time to harvest a food was determined according to the winds, the tides, the lunar cycle and star formations, the flowering of particular plant species and other signs passed on by clansmen over generations through stories, songs, dance and experience [16]. **Seasonal calendars** provide a visual representation of the intricate relationships and knowledge that local groups possess with the seasons, and local geography and ecology of their traditional lands including 'seasonal indicators' that reveal which foods are ready and available for exploitation.

Consideration of the seasons or a locally available seasonal calendar can add to discussions that build on the concept of *variety* alongside comparison of the all-year availability and consumption of standard store foods. Seasonal calendars have also been used in food-related discussions to place and group available store foods with comparable qualities [40].

Figure 6.2 provides an example of a seasonal calendar.

Figure 6.2: Seasonal Calendar of the Nauiyu or Daly River region

The Ngan'gi Seasons calendar was developed by key knowledge-holders of the Ngan'gi language from Nauiyu Nambiyu (from Daly River in the Northern Territory) and CSIRO, as part of a Tropical Rivers and Coastal Knowledge project on Indigenous socio-economic values and rivers flows in northern Australia.

Reproduced with permission, CSIRO, 2014. For more information go to http://www.csiro.au/Organisation-Structure/Divisions/Ecosystem-Sciences/Ngangi-Seasonal-Calendar.aspx

For another example, see the Miriwoong Seasonal Calendar of the Miriwoong people of the East Kimberly area of Western Australia. Available at: http://www.mirima.org.au/calendar/

Freshness

Aboriginal people living a traditional lifestyle placed an extremely high value on the freshness of food [18]. Meehan has noted that the Anbarra were fastidious about the freshness of food, smelling food that was a few hours old before cooking or eating it [14]. She relates the example of fish, observing that the state of a fish's eyes was always discussed, and sometimes seemingly fine fish are discarded when only a few hours out of the water because they were considered too old. In the traditional lifestyle, most foods were eaten fresh or lightly cooked soon after they were hunted or foraged.

During the formative research for this resource, the significance of fresh food was most evident among the older women. One grandmother explained, *"Our people used to live with good fresh food every day… it's natural food… it was fresh all the time."* [12]a. In the community store, inadequate supply of fresh fruits, vegetables and meats, and shelf items passed their use-by date were frequently discussed. A major limitation of fruits and vegetables was their short life span. They were deemed *"'one day' food…healthy food, but it's just for a day…"* [12]a. Frozen and tinned foods were also seen by some to lack the quality of freshness. A number of older respondents discussed at great length their desire to grow fresh food within the community. In discussions around food and health, *fresh foods* and *freshness* can be useful notions to describe aspects of the traditional and contemporary food systems [12a-16].

The Contemporary Food Supply

The following pages consider the notion of *nutrients* in foods, in health, and in health communication. We then go on to examine perspectives on three specific nutrients: sugar, fat and salt. These nutrients dominate the food supply, substantially altering the taste and appeal of foods. These nutrients are the focus of many a nutrition and marketing campaign; they also must be listed on a nutrition information panel. Mainstream health messages related to our contemporary food supply tend to be skewed towards those suited to the will of the food industry, and to those nutrients that can be most easily manipulated in food production and daily diets. A focus on these three nutrients is necessary however, it must be noted that focusing on these three nutrients obscures the benefits and necessity of other nutrients and essential elements in and of food. These components include *trace elements* that comprise natural plant essences too small to be seen with the naked or 'microscoped' eye.

After consideration of sugar, fat and salt, a range of strategies for development are offered, designed to stimulate other alternate perspectives and approaches to health and nutrient-related discussions.

It is important to realise that many people may not believe in the notion of a food being 'bad' and 'causing illness', or that fat travels in the blood and can stick to the side of the vessels, or that certain vitamins contribute to attributes such as bright eyes or healthy skin.

These, and other people may be interested to learn more detail about western science perceives metabolic processes such as the digestions of food; how fat or protein is absorbed and stored in the body; or how vitamins and minerals are incorporated into bodily processes.

Sharing this information in meaningful ways can only take place within two-way discussions. Some of the examples contained in the following pages can help to equip health professionals to engage in these conversations.

Talking about Nutrients

The natural, fresh, seasonal foods that comprised the traditional diets of Aboriginal Australians were, and continue to be, highly nutritious; in essence representing the benchmark of what current day scientific thinking considers a 'healthy' diet. The foods readily accessed or available for sale to Aboriginal people in remote communities today however, are by comparison devoid of health-promoting properties. Because of this, many Aboriginal people suffer from recognised (and often unrecognised) nutrient deficiencies that compromise their body's strength, immunity, health and wellbeing. Poor health is innately disempowering, often presenting tremendous obstacles and burdens.

"Chronic health conditions such as diabetes and ischemic heart disease hugely impact quality of life and the ability to pursue one's passions. Acute flare ups can require travel to distant hospitals for care and investigations, place stress on family members, and require time for recovery. This burden of disease also has a huge impact on people's energy and concentration levels, their sense of vitality and self-esteem. The stress of chronic diseases and their effects on individuals and their families also adds to the myriad of other stressors people are experiencing in a context of welfare dependence and other complex socioeconomic challenges.

From this place of depleted energy, vitality and strength, it is incredibly difficult for people to take on new information about nutrition and lifestyle, or to adopt significant changes that they do not value or have no experience of, let alone overcome addictions such as nicotine and sugar."
[Kama Trudgen, Personal information via email, 2014]

Table 6.3 summarizes and compares the nutritional characteristics of the traditional hunter-gatherer diet with the present day dietary pattern of Aboriginal Australians living in urban, rural and remote communities.

Table 6.3: A Basic Comparison of the Nutritional Characteristics of the Traditional Hunter Gatherer Diet with Contemporary Aboriginal Diets

The hunter-gather lifestyle afforded a varied diet that was balanced nutritionally, and within all aspects of life. In contrast, foods available and accessible within the contemporary food system offer macro and micronutrients in qualities and quantities that are not conducive to physical and mental health.

Characteristic / Composition	Hunter-gatherer lifestyle	Contemporary lifestyle
Energy density	Low	High
Energy intake	Usually adequate	Excessive
Nutrient density	High	Low
Protein	High	Low-moderate
– Animal sources	High	Moderate
– Vegetable sources	Low-moderate	Low
Carbohydrate	Moderate (slowly digested – Low GI)	High (rapidly digested – High GI)
Complex carbohydrates	Moderate	Moderate
Simple carbohydrates	Usually low (honey)	Usually high (sucrose)
Dietary fibre	High	Low
Fat	Low	High
– Animal sources	Low (polyunsaturated)	High (saturated)
– Vegetable sources	Low	Low
Sodium:potassium ratio	Low	High
Physical activity level	High	Low

Adapted from [37]

The concepts of 'nutrients' and 'nutrition' have stemmed from the western worldview. These notions represent increasingly common ways to view and think about our food. Other ways to think about food might include 'convenience' or 'value for money'. These two slogans are popular advertising catch-cries of the food industry to promote sales and profit. Other perspectives on food include the 'Slow Food Movement', growing your own food, and organic farming. People with these views tend to view foods in a more holistic sense, considering broader ecosystems and environments, and realizing that pre-processed, pre-packaged, pre-frozen foods can never provide the depth of nutrition that is available from hand picked, nature-ready, foods. Aboriginal people have viewed the foods that they eat in terms of *balance*, *freshness* and *variety*. These diet and lifestyle aspirations also constitute broader, more qualitative ways of seeing and relating to food. While dietary values such as balance and freshness are essentially universal [16, 34, 35], they can be undermined by socioeconomic factors or too narrow a focus on specific nutrients, or convenience.

Thinking of food in terms of its constituent nutrients reduces "whole foods" into smaller parts. These smaller parts are most often the *macronutrients* fat, carbohydrate (sugar) and protein, or *micronutrients* including salt, other minerals, vitamins and trace elements. The qualities and characteristics of some macronutrients can sometimes be seen, for example, white carcass fat, red muscle protein and white grain starch. Micronutrients however, are largely undetectable with the naked eye. They may be detectable by taste, but these qualities are often either masked by the concentration of other ingredients, or the food's original taste qualities no longer exist.

Today western nutritional science relies on the chemical reduction and quantification of nutrients of known composition. In dietetic science these measured chemical profiles form the basis of the biomedical understanding of food. These biochemical figures are considered to represent objective markers of disease or health, and often inform food and lifestyle recommendations. In addition to biochemical measures, mathematical equations are also used to approximate nutrient requirements and health, such as calculating energy (kilojoule) or protein requirements, and body mass index (BMI). Within the setting of the western positivist paradigm and wider political, economic and business-oriented dynamics, **Figure 6.3** offers one conceptual view of interlinked place of food and nutrients within the mainstream western worldview.
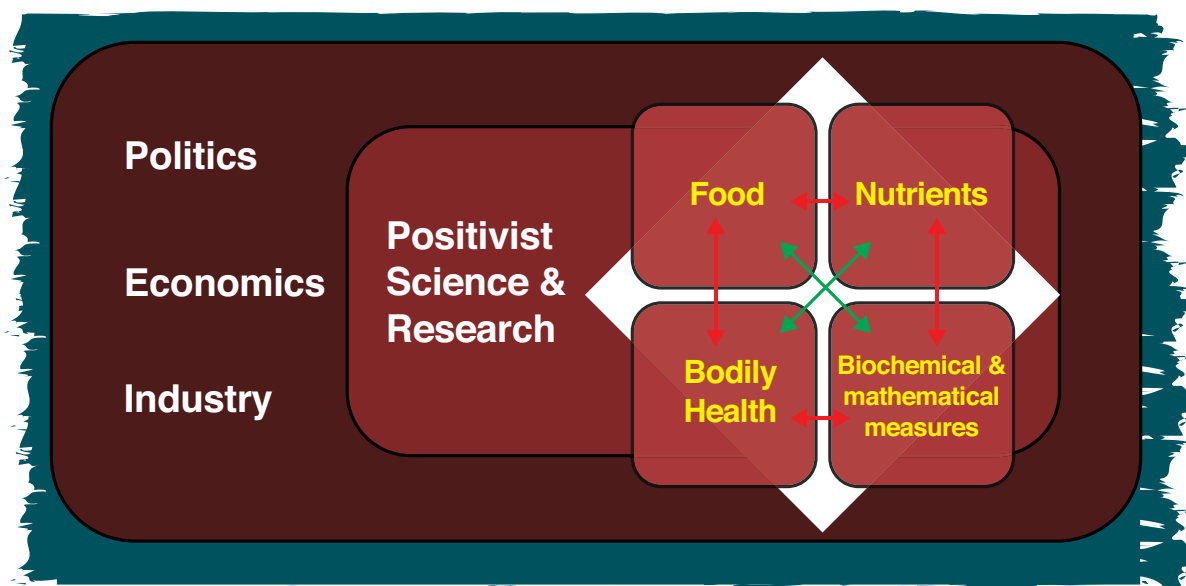
Politics includes public health policy and funding (power relations).

Economics includes the "economics of food choice".

Industry includes biotechnology, "functional foods" and food marketing.

Figure 6.3: A Conceptual Diagram of the Place of Food and Nutrients within the Western Scientific Worldview, and Wider Politico-Economic Environment

Sugar

Sugars occur in countless forms and taste combinations in nature however, most sugar consumed today comes from corn or cane sources stripped of trace elements, mechanically and chemically altered, and intensely concentrated in flavour. The colonisation of Aboriginal people imposed numerous social, economic and environmental factors that progressively restricted access to the traditional foods while reinforcing patterns based on cheap, long-life foods [16, 41, 42]. In one Central Australian community in 1987, average daily intakes of sugar were estimated at 50 teaspoons per person per day; the highest recorded average was 93 teaspoons per day [43]. Decades after the introduction of refined sugar, bringing about a sustained reduction in sugar consumption in remote Aboriginal communities is a major challenge. Three years after a community-wide health program in a remote Top End community, store turnover of fresh fruit and vegetables remained significantly higher than pre-program levels however, the turnover of sugar and high-sugar products had returned to baseline [30].

Despite some understanding that too much sugar is 'dangerous' and linked with diabetes and dialysis, there is little doubt that most Aboriginal people, like other populations, have a sweet tooth. Sweet foods and especially sweetened fizzy drinks are valued and highly sought. Sales data collected from four remote community stores (across NT and QLD) during the Menzies Good Food Systems project consistently placed cola within the top 10 most purchased products, often appearing in two size varieties.

Figure 6.4 offers an example of the typical top ten store sales.

Products people are buying in Hypothetical Store (May - Jul 2011)

1. Territory Hi Fibre Bread 650g
2. Coca Cola 1.25mL
3. Coca Cola 375mL
4. Hamper Corned Beef 340g
5. Sunshine Milk Powder 900g
6. Black & Gold Raw Sugar 2kg
7. Eggs 12 Pack
8. Fray Bentos Steak & Kidney Pie 425g
9. Sunshine Milk Powder 400g
10. Bushels Tea Bags 100's

Figure 6.4: A Hypothetical Representation of Typical Store Sales Data in a Remote Aboriginal Community over a Quarterly Period

The top ten selling product are mostly highly processed foods that do not need cold storage and can be conveniently consumed without the need for excessive ingredient combining or preparation. These foods all lack the qualities of freshness, are low in ingredient variety and do not represent a balance of foods available

Fat

Like sugars, the chemical composition and taste qualities of fats are infinitely diverse in nature. Although today's wider food industry does offer some variety in the range of fats available, fats purchased from remote community stores are predominantly in the form of fatty foods, including processed tinned meat and takeaway foods fried in cheaply produced and highly processed oils that have been altered from their original nature. Store turnover of butter, margarine and cooking oils are comparably low [44].

In the traditional diet, fat was highly prized, sought after, and lauded as more than a form of food (see Table 6.1). Today, people still place high value on the fatty organs and depots of traditionally consumed animals from the land and sea. While these values may or may not have been transferred onto high fat contemporary food items, nutrition and health messages that advocate for a low fat diet, in particular lean meats trimmed of excess fat, stand in direct contradiction to traditional endeavours. Further, in the context of poor food security, recommendations to avoid high energy sources may not be appropriate or achievable. Regardless, western nutritional messages still demonise many different types of fat. The report, *The Fats of Life* [20], notes,

> "Over the last three generations Westerners have learned to think of fat (especially animal fat) as something that is unwanted, superfluous, in excess to bodily requirements. We have been taught to trim fat from meat before cooking; those who carry too much fat on their bodies are suspected of being undisciplined and gluttonous. Fat-reducing programs and products proliferate in Western societies. This way of thinking about fat (or any bodily substance) is peculiarly Western." (p.53)

To the greatest extent, these attitudes stem from the fact that the domesticated animals and factory processed, hydrogenated fats dominant in the contemporary food supply are indeed often detrimental to good health. However, factory processed fats and the foods that they are introduced into are not uniform, and consist of numerous various qualities. These nuances can be challenging to convey across cultures due to the similar appearance of most oils [20, 45]. Discussions related to the different types of oils and their chemical structures may be appropriate and desired by local health or nutrition workers. It has been suggested that a feasible overall solution may be for community councils to develop food and nutrition policies for community stores that contract store managers who agree to abide by these guidelines [45]. For example, these policies could include the use of COMBI steam ovens rather than deep-fryers in takeaways, a practice which has become popular across communities.

While many people in Aboriginal communities appear to have picked up on the fat message, unfortunately this may have been generalised to all fats, including fat from wild hunted foods that is likely to confer benefits to health and wellbeing when consumed in balanced amounts.

Salt

Traditional Aboriginal diets were typically low in sodium. Coastal dwelling people had access to salt-water fish and seafood in order to meet the body's requirement for salt and salty flavours. Aboriginal groups in the Kimberly reportedly liked to cook meat and fish on beached driftwood [22]. Among the Kukatja of the Western desert, the importance of animal blood and internal organs, especially that of the kangaroo, has also been emphasised for its salt contribution [22]. In Aboriginal communities today many people enjoy salty tastes. One nutritionist shared a story from a nutrition-related workshop, explaining, *"one week we talked about salt and blood pressure. At lunchtime when we did some cooking I didn't bring any salt. This seemed to work well enough as nobody complained too much, but the next week everyone brought their own salt!"* [33]b

Salt is a mineral and micronutrient available in conjunction with many natural food sources. It is also available in its concentrated form, acting as a cheap and sought after flavourant and widely engineered as a food additive that doubles as a preservative. Contemporary food processing practices add salt and salt derivatives to most processed foods. As such, global sodium intakes have soared. Most dietary salt in remote Aboriginal communities is derived from processed foods more than salt added at the table or into cooking [46]. In remote Aboriginal communities, a general awareness of a link between salt consumption and high blood pressure may or may not be known.

"Knowing" the Store Foods

Within all cultures there are customs and rules (and now political and trade/business regulations) that govern food-related representations and practices connected with food production (agricultural, processing and manufacturing), food distribution, preparation and consumption. To an extent, these regulations and practices govern how we see and know food.

At the personal level, we feel most safe and comfortable eating the foods that we have grown up with. Familiarity with foods is nurtured early in life through repeated food exposures and observation of loved ones and role models [47-49]. As adults if we are not familiar or confident with foods we will not eat those foods unless over time they become familiar, accessible and affordable, and we have the means and skills to prepare them.

In the formative research carried out within this project, many Aboriginal people expressed a strong desire for greater practical knowledge of and experience with the store foods – experience with the foods on the shelves in cans, bags and boxes, especially through cooking [12]a. Lack of familiarity of store food was the most frequently cited barrier to cooking. One Grandmother noted, *"[Our] people don't know how to cook foreign food. We are not recognising the food or familiar with the food and how to cook it...and when to use it."* [12]a

Through an "Aboriginal lens", many foods now available to purchase in remote Aboriginal communities are *"mixed foods"* [50]. While some foods slot into existing frameworks, others exist outside of people's understanding or reference and therefore holds no or little meaning in their life. This notion is linked with the story of an old man from Central Australia who saw the imperative in taking young people out bush as often as possible. This man knew that young people had to *"get a taste"* for their traditional foods. He realised that *"you can't want what you don't know"* [51]. Further illustrating this point, one nutritionist working in Queensland's Cape district mused:

"Imagine if one day all over Australia, people walked into their local supermarket and found that the bread, rice and pasta, meat, fruit and vegies, and the canned and frozen foods were gone. Instead the supermarket shelves creaked with yams and water lily, stems and panja nuts, native fruits and berries, freshwater turtles, wild goose eggs, echidna and fish wrapped in paperbark ready to cook. How many people would know what to buy, how to prepare it and how to cook it?" Cited in [52] (p.S578)

Views of Store Foods

In the 1990s one researcher observed that Aboriginal people had uncritically accepted all forms of European foods as good for eating [53]. While this may be the case for some, tribal Elders [54] and community members alike [1, 55] have asked **why** white people provided such a poor quality diet, and why the cheapest, most affordable foods are particularly damaging [19]. Aboriginal people living with chronic diseases have also spoken disparagingly about the introduced diet and the link that they have experienced between the foods they eat and their ill health [1,12a, 55–57].

Some foods have been described as undesirable or unhealthy *"worry foods"* [58]. The notion of worry has been linked with sorrow, isolation, using up people's life energy; worry *"eats an individual up inside"* [20](p.54). Others have described foods as *"bad"* foods that make people sick, give them weak blood and affect their children's growth [24, 25]. In this project's formative research negative labels were particularly applied to takeaway foods, linked with *"fat in the blood"*, blockages *"inside the chest"* and *"heart attack"*, and store-purchased high fat and sugar foods referred to as *"dangerous"* foods, *"killing the body inside"* [12]a. Fresh fruits and vegetables have also been known as *"risky"* or *"one day foods"* due to their short period of freshness and relatively great expense [16].

Some contemporary foods have also been described as "good" foods. In this context, it is important to note that notions of 'good' may relate to food price, convenience, familiarity, taste, freshness, strength building, or what is considered as normal. In one study, the most commonly named good store foods included fruit, vegetables, meat, weetbix and damper [24]. Bad foods included sweet foods, coke/soft drink and junk food [24]. Other Aboriginal people have also demarcated 'good' and 'bad' foods in ways that mirror current public health messages [12a, 59]. It has been suggested that nutrition education that focuses on foods to avoid can result in people being most familiar with 'taboo' foods[3] [7].

In this project's formative research several people described choosing or *"knowing"* store foods by knowing where to look for the shelf and "knowing the packing" [12]a. Along these lines, nutritionist Frances Knight remarked on the notion of brand loyalty:

"Many store managers will talk about the remarkable brand loyalty in Indigenous communities. Even if another brand is brought into the store (often by a well-meaning, optimistic store manager), and this product is half the price, people will still purchase the brand they are used to… One manager told me that they were not able to get Heinz baked beans for a month during one wet season (roads were closed and this was not an essential 'fly in item') and even though he had plenty of other brands of beans, they did not sell at all – and people complained that there were no beans! He put this down half to literacy – people know the labels and graphics but not the words – and half to comfort or loyalty to the brand they had always used." [Frances Knight, Personal communication via email, 2014]

Within notions of store foods as *good or bad, expensive, risky or worrying*, Aboriginal people have lacked understanding of the origins and processes of the contemporary food supply and felt ill-equipped to make informed food choices [12a, 56] of foods that are healthy, and they will enjoy [7]. Lack of consumer food knowledge has been negatively associated with child feeding practices [24] and the nutritional status of Indigenous Australians in remote communities [60]. People in one remote community have also associated the new food system with feelings of being out of control, and out of balance [56]. Many Aboriginal people also feel they lack knowledge and understanding of the present day health issues [5, 55, 61, 62]. These are the very health issues with which some store and takeaway foods are associated. This underpins the important job of chronic disease educators and all health staff to build health literacy two-ways. A clear understanding of a 'problem' is required if people are expected to take action. Importantly, Aboriginal people have felt that deeper knowledge of the new food system would support people to include a greater variety of foods in their diet [56].

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[3] Within different cultures, food taboos often stem from religious or social ideals that aim to guide behaviour away from harmful choices, or towards behaviours that efficiently utilize or protect scant resources [Meyer-Rochow, V. B. (2009). "Food taboos: their origins and purposes." J Ethnobiol Ethnomed 5: 18]. In Aboriginal society many food taboos appear to have risen from the unified Aboriginal worldview and creation beliefs that see all food as fashioned by the ancestral spirits and often living representations of these spirits. These taboos, arisen as Law in the Dreaming, are communicated through songs and legends that instil and reinforce the belief that dreadful consequences will befall people who break a taboo [Isaacs, J. (1987). Bush food: Aboriginal food and herbal medicine, Lansdowne Publishing Pty Ltd]. Food taboos generally occur at specific times or during special ceremonies. For example, some foods, often of animal origin, were considered taboo for women during menstruation, pregnancy or lactation. In the NT, the rich damper made from cycad nuts was forbidden to women and children unless authorized by older men [ibid]. In the desert there is a great taboo on spilling water.

The following pages offer numerous further reflections on nutrients and strategies to assist to inform perspectives and build shared understandings related to store foods.

STRATEGIES FOR DEVELOPMENT

Researchers, practitioners and Aboriginal people [16, 30] have understood that knowledge of traditional food systems can be used to support and build understanding of the new foods and food systems.

Relate current day practices to traditional practices. For example,

Contextualize nutrition education whenever possible in relation to people's traditional foods and food system using qualities that they personally value; customs they can relate to.

Frame discussions within information regarding food origins, history, cultural practices, processes of production, distribution, and preparation.

Compare arduous, time consuming tasks such as extracting wild honey or collecting honey ants [13, 18], and traditional Laws about sharing wild honey, to the ease of acquisition and social eating standards associated with sweet, sugary drinks and foods.

Compare the sugar content of water and low sugar options available in the store to high sugar items, and to traditionally consumed sweet foods.

The ARDS Diabetes Pathway

The ARDS "Diabetes Pathways" poster is designed for education purposes, in dialogue with Aboriginal people. The poster image uses the metaphor of a river and tributaries to depict various life pathways. Early on in the river, a 'warning period' is highlighted when a person first has a raised blood sugar level. The river traces the course of the disease and possible preventative and management measures. The poster is available in English and Djambarrpuyngu versions and and can be purchased at: www.ards.com.au

While fat was highly sought after, it may be useful for people to reflect that these preferred foods were not available frequently, and the carcass fat of hunted animals was shared by many people and according to strict cultural rules [63]. Furthermore, wild animals are active and carry much smaller intra-abdominal fat depots and intra-muscular fat compared to "domesticated" animals such as cattle and sheep [64].

Processed fats can be contrasted with the fats and oils of free-living animals that have a lower proportion of saturated fat, higher levels of mono-unsaturated fatty acids and poly-unsaturated fatty acids, a balanced omega-6/omega-3 ratios fatty acid ratio and higher abundance of conjugated linoleic acid [64-66]. These differences in nutrient context are reflected in the differing qualities of the fats. This notion is considered shortly.

When discussing weight management it can be useful to use the analogy of wild animals. Wild animals such as the wallaby have to move around a lot to find their food, and depending on the seasons they may or may not have much food to eat. (See also the Strategies for Development section earlier in this section, under the heading Finding Meaning in Food & Food Practices)

Also consider the type of diet that wild animals eat. The meat in the shop comes from animals that are fed each day. These animals don't need to look for their own food, and grow up inactive in pens. Humans are also animals who these days eat regularly and don't move much. Steps taken to alter this way of life, such as regular walking, hunting and accessing traditional foods, can assist with weight loss and wellbeing.

Share information two-ways

Following is an account of two-way sharing about sugar that occurred during the Food and Health Communication Across Cultures Project:

Two Aboriginal health workers had organised a health day for a group of people from a nearby homelands settlement. During the discussions about diabetes, the Felt man was used to help explain what diabetes is and how it affects the body. After this, the focus turned to diet.

Almost exclusively the participant's attention was drawn to sugar, and blamed it for bringing diabetes. One older woman was particularly vocal that sugar is "bad" and should be avoided. During the discussion the AHWs began to explain that many foods contain sugar, including potatoes and yams, and fruits. At this point the discussion became confusing. Most people from the homelands still collected yams and seasonal fruits on a regular basis.

*We then made a distinction between foods that contain **fresh, natural sugars,** and foods and drinks that contain **factory-processed sugars**. We talked about balance, and how foods grown on the land have a balance of sugars and are eaten in balance with other foods. When foods and especially drinks and lollies are made in the factory, they are made of mostly sugar, and the balance is lost.*

We went on to talk about the seasons, and how the changing seasons bring about different cycles of foods that are good to eat. This was compared with the sweet store foods and drinks that are there all the time, and that people might consume every day of the year. The cycle of the seasons was also a helpful metaphor to discuss that sweet foods are only one part of what people need to eat to keep their body strong.

After the workshop, a number of the participants accepted my offer to wander up to the store and look at some foods that they were keen to learn about, and also find some alternatives to sweet things. We looked at fruits and vegetables, in particular vegetables such as broccoli and cabbage that people had never cooked with before. We talked about how to use them in stews, and one of the ladies bought some to try. (Later it was agreed that we would cook using these vegetables in the next workshop). We also looked at some alternatives to sweet drinks, such as fruits, sugar-free cordials, and concepts such as using half water (or soda water) and half 100% fruit juice. We also talked about using less sugar in the family pot of tea.

Later that week I had an opportunity to visit the homelands and go hunting close by with two of the women from the workshop. We looked for sugarbag, collected yams, and also tasted some bush tomatoes. The women explained that as well as tasting sweet, the sugarbag had medicinal properties and helped to soothe a sore throat. They explained how to cook the yams in the coals. We talked about the healing qualities and fresh, natural, not overly sweet flavours of these traditional foods, and compared them to the very sweet taste of processed store foods, and how they make our teeth ache!

Avoid 'negative' nutrition messages that recommend eating less of "taboo" or "bad" foods. Rather, focus on "positive" food messages. This notion is inherent in a strength-based approaches. On a related note, one nutritionist reflected:

> *"I remember talking to people about hiding food in their backyard so people wouldn't come and eat it all. Food security always played a massive part in people's diet... The two weeks between welfare payments, and the cycle of feast and famine... I never went down the road of telling people to cut the fat off meat – I would just leave it alone. Eating food – real foods rather than sugary drinks and processed stuff was the most important part..."*
> [Richard Ball, Personal communication, 2014]

Use visual concepts to aid discussions. For example,

Use cuts of meat from the store or images of meat to show the layer of hard white fat around domesticated animals

Use lumps of butter to show how much fat is in commonly consumed foods such as tinned ham and fried takeaways

Hidden fats:

· Use greaseproof paper / newspaper / butcher's paper. Put / rub high fat foods with it to see the "hidden" fat.

· Boil fatty domesticated meats and let the fat rise and cool at the top.

Be mindful of visual concepts that include text or numerical representation that are not understood. For example, of nutrition panels, nutritionist Clare Brown observed:

> *"Quite often I tried to work through nutrition panels with people, using the 'per 100 grams' column to compare foods, but I often felt that this was a concept that was not useful or meaningful for people. The fact that it requires us to think in relative terms, and also the fact the English literacy and numeracy skills are often low... Also things are never clear cut – one product might be low in fat, but high in sugar or salt... and there's also the different types of fats..."* [Clare Brown, Personal communication, 2014]

Nutritionist Alex Wetten was involved in the development of The Wadeye Sugar Story. Alex explains,

This project initially came about through discussions with a local Wadeye BRACS media person who had identified interest within the community for a culturally appropriate and highly visual resource to help explain the 'Sugar Story' to local people in their local language of Murrinh-Patha. Along with store sales data, community health reports and related dietary research, this collectively formed the basis for a rationale to develop this community resource.

The vision was to improve understanding in Wadeye about how sugar and carbohydrate foods are processed in the body, while incorporating traditional understandings about sugar foods and comparing the challenges of obtaining sugar foods historically versus present day. The BRACS media person was also able to work around the language barrier through his involvement with interpreters and community leaders.

I assisted with developing this story while also touching on health issues associated with excess sugar consumption. It was agreed that it was best to keep the story positive and build a strong foundation of understanding. This was done through discussing why sugar/carbohydrates are needed by the body to live, outlining all the key roles sugar/ glucose plays in the body and elaborating on the need to get the balance right. At all times, the emphasis was on making the story culturally appropriate, accessible to the local audience and giving the full/deeper story rather than superficial understandings.

My help was then requested to develop a 'script' that could then be translated into Murrinh-Patha. Revisions of the script were done via email and further ideas were often generated this way. Strong Women Workers and their coordinator were also involved in the script development and editing. I also consulted with other dietitians, nutritionists and health professionals to ensure they were happy with the content and direction of the script. This was one of the more challenging aspects. While most feedback was constructive, some feedback though focused on perceived barriers, missed the point of what we were trying to achieve, built too much information into the story and were not always culturally appropriate.

Importantly, local interpreters and community leaders were enlisted to translate the resource into Murrinh-Patha, and the BRACS media person consulted with local community people about the script and key messages to check whether these were culturally appropriate and well understood.. The BRACS media person also took on all the IT and video building aspects...

So far, the project has been released on the local TV and general feedback has been positive. Evaluation still needs to be completed to identify whether the content is useful and meaningful for the community, including reverse translation of the script. The resource could also be used further at community health events and for general education sessions, individual or in groups (key parts can be extracted once we have subtitles in English).

What have I learned from this project?

• Projects like this are exceedingly difficult to sustain unless a local champion with strong links to the community is passionate about the issue and willing to push the project along.

• The process of undertaking a reverse translation of the script to help identify a 'common language' and validate the story has shown a number of challenges in translating concepts.

• Consider carefully the breadth of people involved in the consultation period. Limit to key representatives and be clear from the outset about the vision for the project.

• There is a certain window that arises – capacity comes and goes quickly. Seize opportunities when they arise. Hatch a new plan if a key contact suddenly disappears from the scene.

The sugar story is available in its original version to view on YouTube www.youtube.com/watch?v=UGgZJjJ1S8w. The written English version of the story is listed in **Appendix F**

Provide practical approaches to accompany information-based strategies. For example,

If informing people about the quantity of sugar in common foods and negative health effects associated with high sugar consumption, combine this with interactive sessions to measure out the number of teaspoons of sugar in fizzy drinks, juice, sports drinks and other beverages. These activities can also be used to highlight and compare fat and salt contents of relevant foods.

Help people to learn about how to use spices and other food flavourings through practical approaches to cooking. (See also Section 5.3)

In order to help to communicate more about the western view of digestion, the Talking About Feeding Babies and Little Kids (TAFBLK) counselling course introduces the Nutrient Story in one of its earliest sessions. These discussions make use of a range of visual, experiential, story- and information-based tools to help build meaning first to broader ways of considering and relating to food in the local community and culture. Discussions related to nutrients and digestive processes are outlined below.

The Talking About Feeding Babies and Little Kids (TAFBLK) Nutrient Story

One process to facilitate discussions about nutrients and digestion involves giving each participant a piece of fruit, asking them to close their eyes, and then to take a bite. As people relax they are guided through an internal visualisation that follows the path that that mouthful of fruit through their digestive system. Starting in the mouth the visualisation might flow something like:

As you chew the fruit, the juice, the soft flesh and the hard skin are broken down into smaller and smaller pieces as you move the fruit around with your tongue and grind it with your teeth. Water, called "saliva", is flowing into your mouth to make the food more moist and help to break it up.

When you swallow the food it travels down the back of your throat along a tube into your stomach. Place your hand over your stomach. Can you feel the food in there?

Special chemicals made by the body help to break the food down even more and it mixes together with anything that you ate earlier. It is now like a milky liquid. This is what is happening to your mouthful of fruit right now.

This milky liquid now flows like a river from your stomach and into your bowel. The food is now in very small pieces, and we call these small pieces nutrients. The nutrients are tiny sugars, vitamins and minerals. They are too small to be seen with our eyes – these pieces of the food can now fit through the wall of the bowel and move into our blood stream...

So what started out as a bite of fruit is now crossing through the wall in your bowel and into the blood in your veins, which are like many small rivers that carry the blood back to your heart.

The heart then pumps the blood carrying your little pieces of apple, that are now broken down into nutrients, all over your body.

Some of the apple does not move into the blood. This is the part called fibre. It continues to move through the bowel taking with it all kinds of other waste that the body does not need. Finally this fibre and other waste reaches the end and is pushed right out of your body....

For more information about Talking about Feeding Babies and Little Kids go to: www.menziesnutritionportal.edu.au

These paintings were done by community members to show different food groups and how to eat in a balanced way

Practical reinforcement within a personalised approach. For example:

Accompany people to the store to locate and discuss all of the various names for sugar (and fat) on food labels.

An AHW related that the visiting nutritionist had taken his father to the store and discussed alternative ways of gratifying his sweet tooth, such as substituting lemonade for soda water with a little fruit juice [67].

Nutritionist Clare Brown reflected,

"I always had a lot of trouble talking about foods and salt. People seem to know that salt is not good for the heart and for blood pressure, and they know that 'hamper' [processed tinned ham] is high in fat and salt... In cooking demonstrations I would try to keep the salt away, and use other ingredients to flavour the meal, but before some people even taste a meal they always want to put salt on it. Maybe this is because they aren't so used to using other spices and sauces...I always tried to encourage people to taste the food first – before adding salt." [Clare Brown, Personal communication, 2014]

Rather than focus exclusively on nutrients, talk about other qualities and ways that people identify with foods.
Understanding and exploiting food qualities may be an especially useful and culturally appropriate way to build understanding around the various sources of fat in the food supply. For example:

In discussions, stay alert for any descriptive words used by local people that may offer meaningful descriptions to help distinguish various kinds of fats. These cultural views can for a basis upon which to discuss useful distinctions about:

· animal and plant fats

· bush and domesticated fats [20]

· natural and factory fats

· In relation to meat, the terms fat meat and lean meat have been applied [32]

Within these groups, it can then be possible to define fats further by using qualitative terms, for example:

· good and bad fats [12]a

· soft and hard fats [28]

· yellow and white fats [20]

In discussions around "soft and hard fats" and "yellow and white fats" it becomes possible to define and place value on traditional bush meats. Many free-living animals have yellow-coloured fat due to the high beta-carotene content of grass diets [20, 21]. These animals also have soft fat, compared to grain-fed domestic animals that produce hard white fat.

In the remote Aboriginal community of Minjilang [28], with guidance people were readily able to distinguish between types of visible fats as "soft fat" on traditional foods, and "hard fat" on store purchased meat.

Senior Aboriginal Health Promotion Officer, Bernie Shields, listed the ways the Aboriginal people that she worked with could relate to food. In her discussions she spoke with people about:

· The "jobs" of the food in relation to health and health qualities

· "Sometimes" foods

· "Worry" foods and worry about preservatives and chemicals

· Everybody in the family can eat the same good food, even those with diabetes [Bernie Sheilds, Personal communication, 2013]

During her time as store nutritionist for ALPA stores in NT, Clare Brown found that the links between food and health that resonated with many people – especially the health and store workers were: knowing the foods that are good for the blood, promoted glossy skin, shining eyes, and health in general. [Clare Brown, Personal communication, 2014]

Reinforce and be consistent with health messages. For example:

One nutritionist talked about how she kept reinforcing a relevant health message,

"I used sugar displays in the store quite often. People would become quite interested in them, and be shocked at the amount of sugar in some drinks and foods. One of my store workers was very involved with the demonstration kit...

Early on I always reminded [this store worker] how much sugar was in commonly sold drinks. We were always talking about it. I only ever drank water in front of her, and we would always push 'water is best'. We would also discuss the amounts of sugar in drinks when we went places... try to work out how much sugar someone in the street would be getting from the bottle they carried...

When we started the sugar in drinks demos this is when she gained more confidence in telling other people about it... I think all of the repetition and reinforcement helped support her to pretty much stop drinking soft drinks and juices and swap them for water..." [Clare Brown, Personal communication, 2014]

Social Norms & Practices

People's social environment can directly influence their daily choices, behaviours and health. So too, food and eating behaviour are inextricably linked within a social and cultural context. Rather than a biological phenomena, meanings attributed to foods can be largely influenced by their social uses [10, 68]. In the traditional sense, living within the bounds of customs and practices was an essential element in Aboriginal social structure, with most, if not all aspects of food acquisition and eating practices performing a highly social and often ritualistic role. Comparing a traditional approach to more contemporary notions of food and nutrition, Stacey [69] wrote:

> *"What we consider food items, they would consider a means of performing ritualistic and social functions. The division, sharing and eating of a kangaroo is a means of interacting with other people. When somebody is offered a part of a kangaroo, the unspoken message accompanying the gesture is not, 'Here is first-class protein. If you eat it, you will be strong and healthy', but 'You are my relation.' If a person refuses he is not denying his future health, but he is denying the relationship."* (p.18)

While rituals can lose their meaning and significance over time, in remote Aboriginal communities [25, 70], as elsewhere [10], prevailing social norms and acquired food habits and tastes are often deeply held. The challenge of renouncing engrained foods habits and styles of eating is emphasised in the following statement by an Aboriginal man with diabetes:

> *"...And [health providers] say, "Hey, you're taking too much sugar, take it easy". "Sugar's nothing!", some [Aboriginal] people say — I'm talking about old generation — "Why you telling me about my diabetes? In the first place, who brought the sugar here? You!" They point to the white people, you know. "You brought the sugar here. We can't stop now because you caught us, it's sweet! We like it! [laughter] You can't tell us to stop!"* [55](p.502)

Exploring the meaning of current cultural and behavioural patterns linked with health is imperative to build significance into health communication and promotion. Awareness of how people value and derive benefit(s) from certain activities also helps to understand the possible implications of proposed change. For example, while the proposition of changing behaviour may seem beneficial and appropriate through one cultural lens, within another cultural setting and value system this may not be the case.

Cultural norms around gender roles change over time. On the family and social life and interests of men in remote Central Australian communities, one nutritionist reflected *"Gender roles seem to change with the dynamics of culture. For example, many of our staff are reporting a strong interest from men in child rearing and child nutrition discussions. This is an important point to consider, but I think the key is to be led by local health staff and community leaders."* [Anthea Brand, Personal Communication, 2014].

Traditionally, men played a vital role in child rearing [49]. Perhaps this is a sign that men are regaining the role they played traditionally that was undermined or quashed by missionaries and Europeans who introduced different gender roles.

The following pages address some traditional and contemporary social norms and practices that are relevant to consider within the context of health communication and promotion.

Sharing & Reciprocity

Sharing and reciprocity are integral features of traditional Aboriginal culture that include foods, goods, services, and also knowledge. In traditional Aboriginal societies, division and sharing arrangements associated with food were often complex and occurred according to traditional Law upheld by strict cultural practices determined by kin obligations [14]. Correct ways of sectioning meat such as kangaroo was an important part of traditional law, and exclusively the business of men. The most prized parts of the animal, the offal, heart, liver, kidneys and brains, often went to senior tribal males [8]. After division, male relatives generally received preferential consideration in the allocation of game, then passed the food on to women and children as they saw fit. The giving and receiving of food was considered a persistent and overt expression of social relationships.

> Strict rules that governed the sharing of food were reinforced through myth. For example, a story from Yirrkala tells of two ancestral beings, Djirid the kingfisher and Damala the eaglehawk, and the consequences of greed and lack of food sharing. These two birds were preparing for a fishing trip. The small son of Djirid was looking for crabs and fish at the water's edge. He caught many and in his hunger and eagerness quickly made a fire and cooked them. His father and Damala asked him for some but he refused and ate all the food himself. The two older men were silently furious, and when they returned from their fishing did not give any of their catch to the young boy. The boy pleaded and cried out for food and began to scratch himself strangely. As he did so his body sprouted feathers and he changed into a kingfisher. The two men also changed into birds and followed the small boy into the sky [8].

In remote Aboriginal settings, contemporary food choices and eating behaviours have been related to the cultural practice of reciprocity, involving the (sometimes enforced) sharing of food [25, 71, 72]. However, in a cash economy with high levels of need and poverty, the notion of food (and money) as common property, is being challenged. In one remote Aboriginal community, parents talked about increased child food insecurity with families no longer sharing food and helping each other [24]. Many people also refer to family helping each other with food during the off-pay week when money is short.

> For more discussion on reciprocity, see also Section 4: Consider Relationships

Humbug

In the culture of sharing, requests or sometimes demands for food – both spoken and unspoken (for example, loitering near cooking food or near a supermarket check-out while relatives shop) – have been termed "demand sharing", also colloquially known as "humbug" [71]. This feature of Indigenous culture allows people to express their need to have or take something from others, and others have an obligation to provide. While the extent of this form of demand sharing may vary between family groups, communities and regions, 'humbug' can impact on several aspects of food-related behaviour [25].

For example, in the community store, shopping can be carried out in ways that attempt to avoid or minimize requests by extended family for purchased food [25]. When money is received, shoppers may spend a large proportion at the store at once, when others also have money to buy food (such as welfare payment days), and in order to avoid repeat visits that increase vulnerability to food requests. Expensive perishable foods such as fruits and vegetables may also be considered too risky lest they be requested and consumed by extended family [23]. In this context, takeaway and ready-to-eat foods can be considered not only convenient (negating the need to shop, prepare and cook); they also exist outside of traditional custom, therefore negating the need to share [73]. One nutritionist noted:

> *"The concept of planning ahead and 'saving for later on', was not common among the Aboriginal people I worked with. Instead, people are more likely to buy a quick meal so they can suppress their hunger immediately, don't have to share, [and] the food doesn't get humbugged..."* [33]b

This approach to food and eating is also linked with the notion of personal autonomy that grants both adults and children the right to choose when, where and what to eat [49, 56, 59] (See more discussion on personal autonomy is Section 5.2).

In the home, further attempts to prevent loss of food and invested money mean that once purchased, provisions are generally consumed rapidly. Some parents also have locks fitted to fridges, cupboards or strong-boxes to stop relatives helping themselves. These locks may reduce the availability of food to children, if the key holder is not present.

Although much has been made of the notion of "demand sharing", Altman emphasizes that this is just one way in which sharing occurs within kin-based societies, and that sharing is also a value founded on generosity and reciprocity [71]. Sharing is a very deep part of who people are.

Sharing & Not Overeating

Sharing and reciprocity are values and behaviours related to the Aboriginal worldview that places emphasis on relationships, the social and collective. This focus conveys many societal benefits [71] that could be seen as missing in western societies that predominantly focus on the individual. These different views can offer challenges to health professionals working across cultures. Nutritionist Robin Lion has talked about the need to support the custom of sharing as opposed to westerners seeing it as a problem or weakness [40].

> Imagine if Aboriginal people were the dominant society and were concerned about the non-Indigenous tendency to avoid sharing, and to keep things to ourselves. How difficult would it be Aboriginal people to change this habit amongst us?

In Aboriginal culture, stories, similes and metaphors warn of the implications of failing to share food, overeating or being greedy. In the desert regions, for example, expressions have referred to being greedy for food [22], such as:

> *"When a person eats too much meat, breath is blocked, meat is blocked in the intestines"*
>
> *"That man there is greedy, he is like a crow, he won't give away any meat...."*
>
> *"He ate and finished it [all] like a wedge-tailed eagle. He tore the limbs apart..." (p.98)*

Myth is also often used to extend the senses beyond the seen physical world [74]. While these mythological stories relate more often to the acute physical side effects of eating too much (given that chronic disease did not exist), they also reinforce deeper social values.

In her doctoral dissertation Amanda Lee [19] refers to two stories that emphasize problems associated with overeating. The first talks about a 'stranger' from Oenpelli [Gunbalanya], who wants to eat a lot of turtle gravy and meat while on a holiday at North Goulburn Island. It relates,

> *"So we said to this man, 'We're just warning you because we come from the salt-water side. We are coastal people, we know everything about turtles. We know you will be sick if you eat too much.' Anyways, he was annoyed and he wouldn't take any notice. So, he ate just the same as the others and that night he was very sick. He got a bit better but he was still sick."* (Lamilami 1974:221), cited in [19](p.378)

The second talks about the dangers of eating too much honey.

> *"...somewhere there in Yiwadja country. One day these people went out hunting, and there was with them a young man. He was very strong, very active. He got a lot of 'sugarbag', wild honey. And he ate and he ate till he was really full. So he said, 'I'll cross this creek.' He walked over with a lot of his friends. Everybody crossed the creek and he came after, and as he crossed the creek he got this pain. 'What happened?' they asked. 'I think, well I must have – I've eaten too much wild honey.' But he kept on walking till they came to a camp. They all settled down, but he was sick that night. He was in pain. They said to him, 'We can't do anything.' They tried their best to make him better and make him strong. But they couldn't do anything. He got worse and worse, until he died."* (Lamilami 1974:17), cited in [19](p.378)

Family Togetherness

For many Aboriginal people strength and wellbeing is derived from having and being part of a strong family group; these important relationships also extend to kin and country [75]. Due to the effects of illness, communities are losing many of their senior men and women. This affects close family, and also the stability and strength of the entire community and cultural life. Small communities, with their relatively smaller populations, are more vulnerable [57]. Chronic and serious illness for people living in remote Aboriginal communities very often means time off country, away from families while they receive treatment in a city hospital. Those who need on-going treatment such as renal dialysis patients, periods away from family in foreign environments is often repeated and extended [57].

Separation from family can cause great anxiety over the care of children or grandchildren, and feelings of isolation, even to the extent that it may affect recovery from illness, or adherence to on-going treatment [57]. Stress in itself plays a significant part in illness [72, 76]. As Dussart noted,

"If patients can withstand physical discomfort associated with chronic illness, they find their separation from the settlement and their kin insurmountable. While their kidneys may get cleansed some hundreds of kilometres away, their sense of identity decays, their sense of usefulness turns toxic, and their relatives are deprived of their caring roles as well." [72](p. 204)

That 'good health' can prevent time away from one's community may offer a perspective useful to sensitize some community members to join in discussions, change their attitude, or think differently about the way they view or feel about the foods they eat.

Given the priority and value that many Aboriginal people place on maintaining strong relationships, the prospect of time away from one's family or community may be significant. In this context the concept that 'good health' can promote family strength and unity and prevent time away from one's community. In his work, nutritionist, Richard Ball, stated:

"I used skills of life coaching to try to tap into something that was going to motivate people. I found talking about going off country for dialysis probably one of the most powerful ways to motivate people... the idea of not seeing their children grow up... This really tugged at the heartstrings of what was important to people..."
[Richard Ball, Personal communication via phone, 2014]

In another example, a senior Aboriginal health worker and council president in one community made a poster that caused a lot of community discussion:

The poster illustrated that skinny kids have to fly into hospital three times more than children who are growing well, and that skinny children and their carers spent a lot more time away from their family and community.
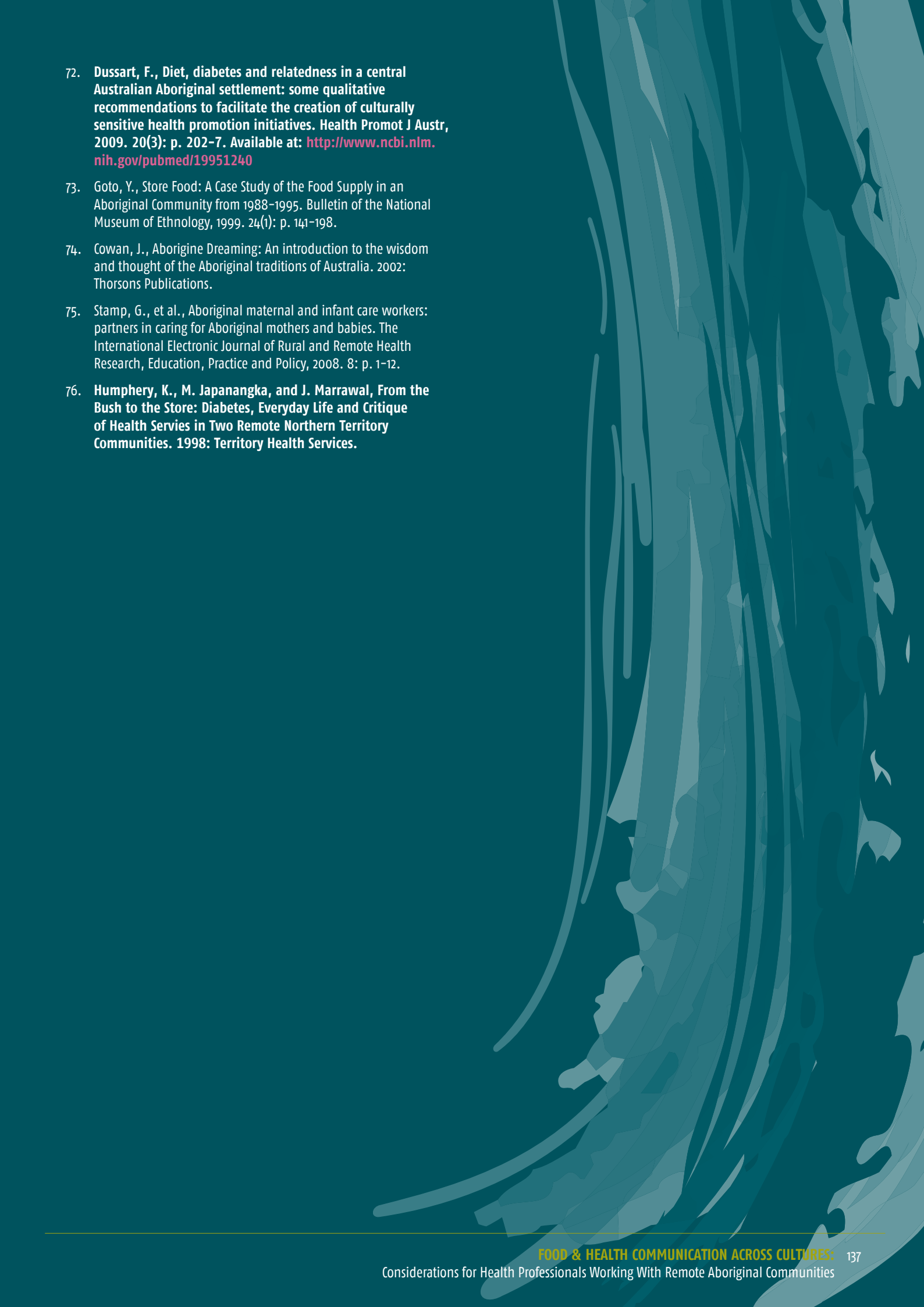*(THS 1997), cited in [67](p.60)*

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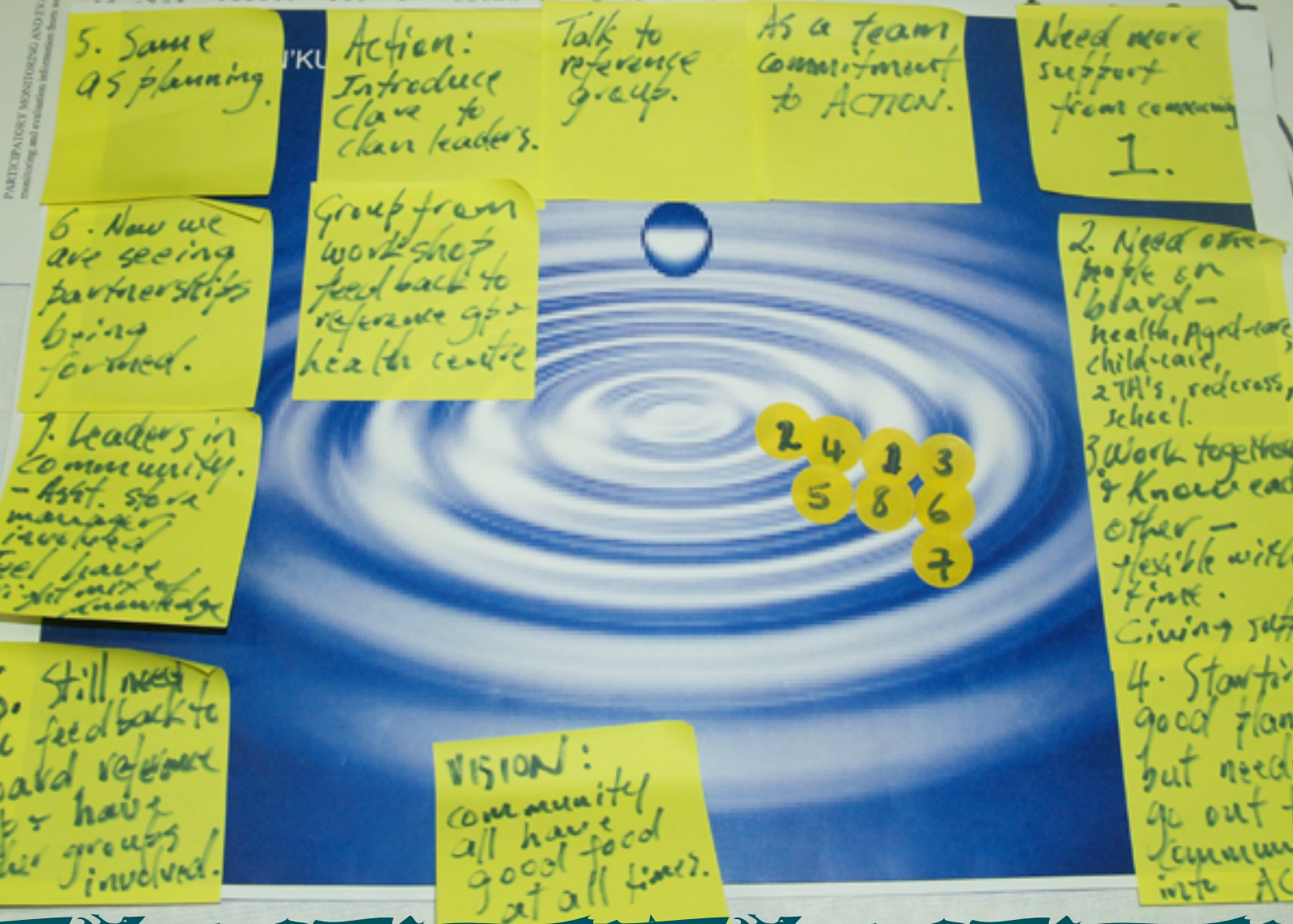
SECTION 7: CONSIDER DEMONSTRATING YOUR EFFECTIVENESS

Overview

Whether a health communication, education or promotion activity sits within a broad program or constitutes a "one-off" project, finding a suitable method of demonstrating effectiveness is an essential part of the process. It is important to consider that all evaluation activities that involve remote Aboriginal communities should be embedded within a community control model.

Approaches to health communication, education and promotion aim, in general, for one or more of the following goals:

1. Improved health literacy among individuals and family groups.

2. Promotion and adoption of healthy personal and family lifestyle choices.

3. Change to social norms that support "unhealthy behaviours".

4. Promotion and support of organisational practices and public health policies that uphold and sustain the first three goals [1].

These overarching "health objectives" underpin approaches to health programs and promotion in remote Aboriginal communities [2, 3].

Evaluating progress made towards achieving these goals can show what has gone well, what has been the effect and identify changes needed for improvement [27](p4-42).

As discussed throughout this resource, public health approaches in remote Aboriginal communities need to consider specifics of local cultural, socio-economic and other health related traits, including the local and broader environments and systems, and community health-related structures, groups and services. Any evaluation approach must occur within cross cultural partnerships that promote information exchange and sharing are views the local situation through both a western and Aboriginal lens.

The following section provides guidance on how to evaluate health promotion and education activities, with a focus on evaluation approaches, techniques and tools that can be incorporated into a cross-cultural process in remote Aboriginal communities and are consistent with the community control model.

Community Control is a process which allows the local Aboriginal community to be involved in its affairs in accordance with whatever protocols or procedures are determined by the Community. The term Aboriginal Community Control has its genesis in Aboriginal peoples' right to self-determination. Organisations which adopt a vertical approach to health, inconsistent with the Aboriginal holistic definition of health, as defined by the National Aboriginal Health Strategy, are excluded. For more information see http://www.naccho.org.au/aboriginal-health/definitions/

Why Evaluate Health Promotion & Education Activities?

Evaluation provides a systematic way of judging the value of something by examining the process and/or finding out the impacts or effects of a program or activity, including who has (or has not) benefited and what aspects of the activity contributed (or did not contribute) to the desired goals [4, 5]. When effectively carried out and communicated, this process can feed into an ongoing cycle that supports or informs "best practice". In terms of Aboriginal health, evaluation of activities can provide communities and families with increased understanding and therefore control over important determinants of their health and contribute to health improvement [2].

Evaluating health communication, promotion or education activities also assists practitioners to reflect on their professional and personal approaches, hone their own skills and the accumulated skills of organisations, and influence governing and guiding policies to best support and positively contribute to the people and communities with whom they work. For example, evaluating aspects of work can assist practitioners to:

- Share, promote and influence effective approaches among other practitioners and governing agencies working in remote indigenous communities.

- Inform future approaches and programming of activities.

- Be accountable to the people they work with and for.

- Be accountable to funding bodies, and advocate for future funding opportunities.

- Contribute to the body of evidence linking good nutrition with increased health and wellbeing.

- Learn as a health professional, gain expertise and stay motivated.

Evaluation in Remote Aboriginal Settings

While a range of nutritionists have acknowledged the importance of evaluating health promotion activities in remote Aboriginal communities, many feel confronted by the concept of evaluation, and felt that they lack the skills and time [6]b. Compounding these challenges were feelings that the process of evaluation was "... fluid, organic; it kind of flowed so there was never a particular program to actually evaluate." [6]b. Particularly when involved in short-term, sporadic or ad hoc health promotion/education workshops or discussions, it can be challenging for practitioners to evaluate what has taken place, and their role in it. The organisation funding the activity may also influence when, where and how assessments take place. For example, in the organisation where one remote nutritionist worked "...evaluation was seen as a `city workers' concept and was not [considered] practical in the outback by management..." [6]b.

Evaluation is a process that human beings do every day. It is a part of the decision-making process.

In "formal" evaluation it is important that participants understand why evaluation questions are being asked and activities are taking place. In order to help give meaning to the concept of evaluation, in an Aboriginal setting the process has been likened to hunting for animals:

"...during an evaluation people need to read the signs, plan what to do next, try to carry out their goal, and then see if they have been able to achieve what they wanted, before doing it all over again." [7](p.27).

Rather than think of the evaluation as something done at the end of a session or program, assessment should be viewed as 'part and parcel' of all activities, ideally situated within practices that support best practice and continuous quality improvement [8, 9]. That said, one nutritionist recounts,

> *"A very experienced paediatrician once told me that in remote settings we do 'evidence-informed practice' rather than 'evidence-based practice'. The evidence doesn't always exist so we need to keep our minds open to innovative approaches that may help to shape future 'best practice.'"* [Kirby Murtha, Personal communication via email, 2014]

While there is no template or rulebook, the following considerations are designed to offer a basis or starting point for discussions and activities that can assess or evaluate the work that we do.

Who Should Evaluate?

In the context of research, and the 'external, consultant-evaluator' model, Michael Christie discussed the "judging observer", a characteristic supported by western culture in which situations or worlds are viewed separately, independently and objectively [10](p.4). Of Aboriginal people, Christie noted *"Yolngu can not, will not involve themselves as judging observers"* ; instead positioning themselves as *"generative participants"*, first and foremost engaged in the processes of customary communal life (p.6). While local people's views and inputs into all health activities and programs are essential – including guidance and administration of evaluation processes – difficulty 'objectifying' life may sometimes render formal assessment best driven by an 'outsider'. Of nutrition projects, Priestly saw that the role of the community nutritionist could be viewed as both an 'insider' and an 'outsider' [7]. She writes:

> *"We are outsiders as we are not members of the community group and not Aboriginal yet we are insiders as we have been involved with the project since its inception and ultimately we have shaped its course."* (p.30)

Some organisations provide support positions that focus on health promotion and evaluation. These individuals are ideally situated to advise on or guide local evaluation activities. In essence, nutritionists working with remote communities need to support and empower Aboriginal people to evaluate their own projects and determine what they want to know.

Working with Organisations & Funding Bodies

The challenge of evaluating activities in a remote Aboriginal setting can be compounded by interplays between community, organisational and bureaucratic cultures. Mismatches can occur between the needs and wants of the community, and key performance indicators (KPIs) such as "measureable" health outcomes requested by supporting organisations and funders. "Top down" approaches, where project strategies and outcomes have already been decided by people and organisations removed from the direct community context are a significant source of divergence and disharmony.

Following are a number of strategies that may help to manage the process and interplay of cultures to make evaluation most useful for communities and the funding bodies and organisations overseeing and supporting your work.

STRATEGIES FOR DEVELOPMENT

- **As a general guideline, work with local people, within local structures, and adapt to local needs.**

- Evaluation processes need to be considered and planned for from conception. As such, at the outset of a contract or project, examine any indicators that relate to you or the work in which you are involved. Outcome measures that seem unreasonable or unachievable should be discussed early on with the relevant people. This may, for example:

  - Stimulate useful discussions about the proposed outcome(s); the appropriateness of these measures and/or how desired indicators can be achieved.

  - Lead to amendment of the measure (or goal).

  - Flag desired outcomes or KPIs that require further resource allocation and/or need on-going consideration.

- Work with local people, within local structures, and adapt to local needs.

- Establish multifaceted steering committees and/or working groups to guide projects towards its agreed outcomes.

- Undertake process evaluation throughout the project.

- Feed back process-related information and results to all parties involved throughout the project in a timely manner – not just at the end.

- Mismatches between community desires and those of overseeing organisations or funding bodies must be addressed on both sides.

  - Be clear and honest with community members about what you can realistically hope to achieve so that informed decisions can be made.

  - Discuss disparities with supervisors, organisations and/or funders.

- **Consider evaluation as a learning and sharing experience for everyone, finding out what is working and how.**

What to Evaluate?

Judgements must be made on what is of value, and what is important to do, learn, or evaluate. These decisions are based on perspectives, influenced by factors such as cultural and family upbringing, one's age, gender, personality, and life experience. Broader social determinants also influence these views. Within health services, judgements on what is important to learn, do, or evaluate are often directed by policies, and framed within financial structures. **While it could be assumed that all health promotion inherently aims to increase health, people from different cultural backgrounds uphold notions of health differently. When making decisions about what to evaluate, always consider whose interests an evaluation is primarily to serve.** This may be one or more of: community members, groups, or a community-based organisation; health or community worker(s); other health practitioners and staff; a funding body or government or non-government agency.

> Early in the process, decisions about what to evaluate, and by which standards and means, ideally take into account and merge the various wishes and requirements of all key stakeholders. It is here that different views of what holds value or importance, and how best to gauge "success" can first be addressed.

A review of evaluation approaches across a range of Australian Indigenous community health promotion initiatives [11] cited valued indicators of change including:

- Improved participant satisfaction

- Community co-operation and networks

- Greater feelings of personal or group empowerment

- Altered beliefs or attitudes

- An increased sense of self-worth

- Strengthened capacity (of an individual, family or community) to manage particular health issues

- Improved health literacy

For health promotion and literacy projects to strengthen and empower communities it is relevant and useful to focus on qualitative outcomes of, for example, a personal, social or relational nature [12]. Valuing relationships formed is another method by which Aboriginal community members and health workers have evaluated "success" of a program [13] or health clinic [14].

In their discussion of the journey of learning, Yunkaporta and McGinty [15] also noted the importance of process:

> *"In the Gamilaraay [1] worldview, learning pathways are not direct and the outcomes and the journey are one and the same. This logic can be seen in the language. For example, the word for search and find is the same – ngaawa-y, and the word manila-y means hunt, search and find simultaneously [6]. This indicates that the process is as important as the outcome, or rather that the outcomes are integral to the process."* (p.62)

In this way, *process evaluation* (rather than *impact* or *outcome evaluation*) has been viewed as the most useful on-going focus when assessing community nutrition projects in the short to medium term [7]. From its conception, engaging in an on-going process of action and reflection can aim to systematically build on strengths, rather than rigidly working towards pre-ordained expectations and goals without considering the process steps along the way.

Feed Back To & From the Community

The term *feedback* tends to suggest a one-way approach. In addition to providing relevant information or stories to the attention of those interested and involved, feeding back to the community is also an opportunity to stimulate new considerations and discussions. The importance of reporting back to community members has been highlighted previously (See Section 5.1: Feeding Back to the Community is Vital). In the realm of health research, people in remote Aboriginal communities have voiced concern and annoyance over being studied and analysed, and the gathered information not being fed back [6, 17]. In the area of evaluation, the feedback of results and findings is key to engaging people in a continuous communication process that supports ongoing knowledge development.

The best way to share findings might best be decided by community members. Forms of communication may involve sitting around for a yarn, or visual or oral methods including photos, posters, songs, paintings, or a DVD. Aboriginal health workers and community workers are key people who can share the stories of consultations and evaluations with their community. When people in the community begin to discuss the stories and information that you have been sharing, this can be taken as a sign that these ideas are deemed relevant and important [18].

Useful Techniques & Approaches

The remainder of this section first considers a series of points put forward by Garrow and Collins [20] that offer a succinct guide to planning and assessing cultural evaluation processes in community-based programs. This is followed by an overview of techniques that can be used to frame overall assessment perspectives, including strength-based approaches and formative research, and culturally appropriate methods such as narrative, visual and context-based approaches that might include any combination of watching, listening, talking to people, keeping records of what is being done, writing things down, paintings, drawings, music and songs, photos and measuring [3]. More recently, ideas to enhance communication and process have included the use of mobile phones and video recording.

See Section 5.3 and **Appendix E** for more information about using mobile phones and film in health communication and promotion

Reflecting on our own thoughts and actions is an important part of self- and process evaluation. Our reflective skills can be enhanced by working alongside a cultural liaison, health worker or personal or professional mentor. Viewing situations through a reflexive lens is also an important part of any evaluation process. This skill helps to highlight our complex roles in relation to others [19]. The process of keeping a reflective diary is also considered.

See Section 1: Consider Your Self for a discussion about critical reflective practice and reflexivity

[1] The Gamilaraay or Kamilaroi are Koori people from areas extending from around the Hunter Valley through to the Warrumbungle Mountains in the west and up through areas in south west Queensland.

As an overview, Garrow and Collins outline a range of perspectives and considerations key to planning and assessing cultural evaluation processes in community-based programs [20]. They include:

1. Evaluation starts in the planning stage of the program.

2. Evaluative criteria should include:

   a. Degree of involvement, control and consultation with the Aboriginal communities with who you are working.

   b. Use of the Aboriginal definition of health.

   c. Use of an action research model , or similar methodology.

   d. Degree of social and cultural sensitivity.

3. Incorporate a level of monitoring by the Aboriginal people involved.

4. Include process, impact and outcome evaluation measures and link them with Aboriginal monitoring.

5. Recognize the development of understanding and knowledge about evaluation being a two-way process.

6. Consider Aboriginal styles of gathering information, including:

   a. Aboriginal response to direct questioning.

   b. Context-based inquiry.

   c. Importance of non-verbal communication.

   d. Importance of observation in gathering information.

7. Recognize informal participation as important and valuable.

8. Time frame needs to acknowledge Aboriginal perception of time.

9. Recognise, in part, Aboriginal culture has incorporated non-traditional evaluation elements, for example, statistical measurement.

10. Use Aboriginal styles of distributing information and findings.

11. Respect the culture. Including acknowledging:

    a. Extended family relationships.

    b. Reciprocity.

    c. Avoidance relationships.

    d. Aboriginal styles and approach to decision-making and action.

    e. Time orientation.

12. Recognise that evaluators need to advocate with stakeholders for the adoption of these guidelines.

Strength-based Approaches

Coming from a strength-based perspective is an effective approach to health promotion, including strategies that form its evaluation. Strength-based approaches use affirming language to draw out and draw on a project or program's successful elements. Strength-based approaches can seek to find out what felt right or good; what elements built the energy of the participants; what has been successful. The various approaches to evaluation considered below can all incorporate a focus on individual, family and community strengths.

See also Section 5.1: Consider your Approach to Community Consultation

Research-based Approaches

While research is an empirical process interested in generating new learning, theories and knowledge, evaluation is more of a judgemental process that assesses findings against known criteria or standards. These judgements are then used to make decisions. The overall purpose of evaluation is to determine the effectiveness of a specific program or model.

Both qualitative and quantitative research methodologies can be used to gather information used in evaluation. Quantitative refers to the measurement of objective information that often includes numbers, percentages, ratios and statistics. Qualitative measurements generally use words rather than numbers, referring to descriptions related to quality or worth. Qualitative methods of collecting information generally constitute more open forms of enquiry (See also Section 5.1).

For a useful discussion on the similarities and differences between "research" and "evaluation go to: http://betterevaluation.org/blog/framing_the_difference_between_research_and_evaluation

See also Section 5.1: Consider your Approach to Community Consultation for further discussion and reference related to research approaches

Narrative & Story-based Approaches

Narrative and story-based techniques and tools offer highly relevant ways to explore people's experience of services, programs, discussions, actions, and more.

Why stories?

Stories give people a voice.

People tell stories naturally.

Stories encourage reflection.

Stories can deal with complexity and context.

People remember stories.

Stories can carry hard messages and issues that can be difficult to discuss.

Stories provide a 'rich picture' and can increase awareness and understanding.

Stories provide a real basis for discussion and equalise power relations [21,22].

The Most Significant Change

The Most Significant Change (MSC) technique is a useful story-based evaluation tool that is a qualitative evaluation approach. The MSC technique helps to uncover or explore the positive and sometimes unexpected aspects of programs or activities. Rather than a deductive process that evaluates work based on expected outcomes, the MSC technique is inductive. Stories related to views of significant change in a given context begin with open questions that invite detailed descriptions of participant's own experiences. In its full form, a series of MSC stories are collected from a range of stakeholders to evaluate the most noteworthy or important outcomes of a program, project or session. These collective narratives are then analysed and synthesized to build the most significant change story [23]. Participatory monitoring and evaluation within large programs, or short-term or one-off education sessions, a full or modified MSC technique can be a useful tool. When constrained by time or other resources, a modified MSC technique can collect a small number of stories, or have group discussion consider the most significant change stemming from a program or activity.

In stimulating participant reflection, an evaluator can ask:

Looking back over [the defined time/process], what do you think was the most significant change in your life/in your community as a result of your involvement with this particular project?

Most significant change stories can:

- Uncover unexpected insights and changes
- Identify shared or independent values
- Provide local people with a voice and encourage discussion and debate
- Foster engagement and ownership of monitoring and evaluation data
- Build participant and staff understanding thereby adding 'meaning' to activities
- Be used in reports to facilitate stakeholder engagement [23]

For more information of MSC check out the following clips:

https://www.youtube.com/watch?v=H32FTygI-Zs

https://www.youtube.com/watch?v=NkuJ69zKScU

For greater discussion on Narrative and story-based approaches see Section 5.3: Narrative Approaches & Tools

Visual Techniques & Tools

Section 5.3 considers a number of visual approaches and tools that can assist in health promotion activities. Many strategies for development are also relevant to evaluation activities. For example:

- **Use photos or images** either taken during an activity (with consent) or related to the activity to stimulate discussion
- Join with participants to **create a poster** based on the teachings from the session. This might incorporate images from around the community, or during the session
- Many people in remote Aboriginal communities now have a phone and the technology to take images of themselves and their family. In order to evaluate the uptake or impact key messages, stories or discussions (or as a useful accompaniment to any stage of food-related discussions), people can **use smart phones or other devices to capture voice, photos or video recordings**. These can then be shared confidentially or within people's chosen group(s). For example:
  - Stories or role plays enacting learnings can be filmed and watched back to stimulate fresh discussion
  - People can take footage in the wider community: People may choose to film foods in the shop they still don't know or aspects of life related to health or food they find interesting or confusing

All of these approaches will be most effective when trust has been established and issues of confidentiality are addressed. Be mindful that any photos or videos taken or shown publicly will require informed consent.

The following story highlights how the process of working alongside a community to create a DVD to support gardening knowhow and nutrition education also doubled as an important form of evaluation. One Central Australian nutritionist explained,

> "We wanted to tell the whole story – from standing on the soil with a seed in your hand, to growing and harvesting the fruit and vegetables, to working with the food, to the food on the plate…. We worked with the community members who had been involved in the gardens, discussed the concepts to include in the filming process, and then the filmmaker recorded community members discussing those concepts in language. I had also given the people some information, and then they thought about it and translated into their language and according to their worldview… The film was later translated and English subtitles added. The result is a story told by community members about their gardens in their own words.
>
> …The first time people watched the film they were laughing and pointing. The second time they watched it they were saying 'oh, so that's what you do with the water', and 'that what you do with the seeds.' …the response to the DVD demonstrated that people have captured the knowledge and do understand. In conjunction with my own observations and reflections this has been useful to know what adjustments we might make in this project…" [Susie Summons, Personal Communication. 2013]

Where all parties are in complete agreement, it may also be helpful to **film one-on-one or group education activities** in order to later watch and jointly analyse the session. This technique has been used during clinic-based education sessions involving health professionals and renal patients, revealing extensive mis-communication that would have otherwise gone undetected and unaddressed [see for example [24, 25]].

Filming education activities or the delivery of programs or sessions is also a useful self-assessment tool. When watching the footage, try to look openly and objectively at:

· Your use of language and choice of words (for example, using the word "should" when "may" or "could" might be a better choice).

· Your actions and body language (for example, where you position yourself in relation to others; crossing your arms; pointing).

· Be particularly reflective of any areas where you felt or feel uncomfortable or challenged.

Evaluation tools or self-measurement scales that make use of images that hold meaning can also be useful. For example, fires to cook or warm by are often the focal point of family groups. Fire is also viewed as a decision-making structure within some Yolngu communities. Marika and co-workers explain,

> "The fire in the middle is the hearth, it represents a place where people talk, where the fire burns. This is the wanga, home, where you feel most comfortable. The coals, lirrwi, date you back to the land, this is the connection. The mind is on the land, not in the clouds. This is a system connected to the ground and curved around signifying level headedness. It represents collective, consensus thinking that is a big part of our communal title of the land". [26](p.409)

The Fire Tool

To use a fire tool within evaluation activities, make or find an image or symbol of a fire. This might be a paper image, a photo, some sticks and red cellophane, or you may be in a position to sit around a real hearth. The fire then becomes the central point or focus.

Now ask participants to gather or choose something to symbolise or represent themselves or their own responses. People may also work in pairs or as an entire group. Symbols to use around the fire might include plastic or paper animals, or any other chosen objects.

In response to certain scenarios, ideas and situations, participants are asked to place their symbol at a distance from the fire that represents how they feel. The relative distance from the fire provides an evaluative measure.

In the Menzies Good Food Systems project, visual measurement and evaluation is also undertaken using **the ripple tool**. An Aboriginal project officer involved in developing the ripple tool explained,

"Not far from here there is a waterhole where children swim. When no one is there, you can sit and watch the water – it is lovely and calm. If I dropped a pebble right in the middle of this waterhole then the ripple comes out… the first ripple, then the second ripple, and third ripple… The message starts small but as the ripples fan out it gets bigger and bigger until the whole community knows… In this community the story of good food started small, but now the ripples have spread out to the school, the childcare, the stores…" [Elaine Maypilama, Personal communication, 2013].

The Good Food Systems Ripple Tool is depicted in this image as a felt board. It has also been used in other forms, including paper-based images.

For more information about the Good Food Systems project and the Ripple Tool, go to:
http://www.menzies.edu.au/page/Research/Projects/Nutrition/Good_Food_Systems_Project/
http://www.menzies.edu.au/page/Resources/Capacity_Building_Assessment_tool/

The ripple tool concept can be used to facilitate dialogue on any program or activity to provide an indication of progress. Similar to this process are evaluation rubrics, which comprise a collectively developed set of criteria that describe what you would ideally like to see or what you would like to be happening if a program/activity is working really well. An evaluation rubric can essentially list the best practices that you wish to see, then be used to evaluate where the program or activity is against this. For further information see:
http://aea365.org/blog/e-jane-davidson-on-evaluative-rubrics/
http://betterevaluation.org/resources/guides/rubric_revolution
http://betterevaluation.org/evaluation-options/rubrics

Styles of Questioning

In western culture, the asking of questions – direct or otherwise – is an accepted social and communication practice. Aboriginal cultures that use negotiation, symbols and story-telling, for example, view verbal questions in different ways. Section 3 considers culturally appropriate styles and methods of questioning and eliciting information. These considerations are all relevant when participating in evaluation activities. Some additional points for consideration follow:

In western mainstream practice, evaluative, open-ended questions often focus on individuals or participants, for example,

"What parts did you/didn't you like?" or *"How would you like to do things next time…?"*

While these questions can be of value, in Aboriginal societies the focus may be more on relationships than individuals. It can therefore be appropriate to frame questions towards this reference point. For example, during her work in Aboriginal communities, one researcher and nutritionist changed the question used to evaluate people's knowledge of a program from *"what can you tell me about [the program]?"* to *"tell me about your relationship with the [program] worker you had the most contact with"*. [13](p.190)

In the case of health and food communication, an appropriate reference point might most often be the family.

Other possible lines of appropriate questioning may include **asking people how they felt or feel about a particular topic, teaching or session**. When framing questions it is important to **orient people within a place and time**. Likewise, enquiries need to **be specific about times, events or places**. Knowing which questions to ask often takes time, evolving through experiences, interactions and evaluations and reflections.

Aboriginal groups may **prefer to provide group feedback** rather than individual comments. In this way it may be appropriate to pose one or more questions to facilitate group discussion.

A Reflective Diary

Reflecting on the processes and activities that you are involved in is another legitimate and important form of evaluation. In this pursuit, an ongoing professional activity diary or log can be of great use in order to systematically record, compare and reflect on activities and experiences. For example, as you move through a process to develop resources, tools, systems, projects, procedures or programs, record all observations and experiences, including the people and organisations with whom you interact, that you deem relevant. In addition to other benefits, this documentation can be used to facilitate reflection on thoughts and ideas for new strategies or processes, or barriers and solutions that were met or developed with the group.

For greater discussion on critical self-reflection and reflexivity see Section 1: Consider Your Self

Appendix G offers a framework and pathway when undertaking research and collecting true stories in remote Indigenous communities. It is called Dhukarr'kurr Yan Marrtji: Larrum Yuwalkku. A Pathway for Collecting True Stories in Remote Indigenous Communities.

References & Further Reading

Websites that offer further information:

http://www.aiatsis.gov.au/research/docs/ethics.pdf – useful for needs analysis, identifying risks and barriers to program development

http://www.diabetes.health.wa.gov.au/docs/1887%20 BestPraciceModel19402.pdf – useful for program development

http://www.naccho.org.au/aboriginal-health/health-promotion-and-prevention/ – guidelines to consider for program development/evaluation

http://www.lowitja.org.au/sites/default/files/docs/Health_Promotion_Tools_Scoping-Study.pdf – another guiding document

http://www.aes.asn.au/ – The Australasian Evaluation Society (AES) is a member-based organisation that exists to improve the theory, practice and use of evaluation in Australasia. The AES offers regular workshops and courses.

http://betterevaluation.org/plan/approach/developmental_evaluation – A useful site that describes Developmental Evaluation – an evaluation approach that can assist social innovators develop social change initiatives in complex or uncertain environments.

http://betterevaluation.org/ – An international collaboration that shares information about options (methods or tools) and approaches to improve evaluation practice and theory

Resources that offer further information:

The Public Health Bush Book. Volume 1: Strategies and Resources [33]. Available at: http://www.health.nt.gov.au/Health_Promotion/Resources_for_Good_Practice/index.aspx

Using a health promotion framework with an 'Aboriginal lens'. Making Two Worlds Work [2]. Available at: http://www.ashm.org.au/images/ATSI/MTWW_Health-Promotion-Framework.pdf

Thinking, Listening, Looking, Understanding and Acting as You Go Along. Steps to Evaluating Indigenous Health Promotion Projects [3]. Search for at: http://trove.nla.gov.au/work/14739801?selectedversion=NBD12523839

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See also further reading in the reference list:

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11. **Mikhailovich, K., P. Morrison, and K. Arabena,** *Evaluating Australian Indigenous community health promotion initiatives: a selective review.* **Rural and Remote Health, 2007. 7: p. 746. Available at: http://www.rrh.org.au/articles/subviewnew.asp?ArticleID=746**

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27.   *The Public Health Bush Book. Volume 1: Strategies and Resources.* **New Edition, ed. N.T. Government. 2007. Available at: http://health.nt.gov.au/library/scripts/ objectifyMedia.aspx?file=pdf/65/41.pdf&siteID=1&str_ title=Bushbook%20Volume%201.pdf**

Appendix i
Details of Formative Research (study 'a')

Aim: To explore strategies to provide culturally specific information and approaches to support food choice and health among people in a remote Aboriginal community.

Setting & Sampling: A large remote Aboriginal island community (population ~2,000) in the Top End[1] of Northern Australia, approximately 550km east of Darwin. Eligible participants were male or female community residents of various age and social standing, aged 18 years and over. Using predominantly purposive sampling methods, individuals representing different language and family groups were identified by a senior community member and invited to participate.

Data Collection: Interviews were conducted over 2011 to 2013, facilitated either solely by a local Aboriginal researcher (EM), or jointly with the resource author (SC) during 6 x 3-4 day community visits. Discussions took place in agreed locations, most often sitting outside people's homes or on school grounds. Interviews were conducted either in the local language or both English and the local language. On most occasions participants were accompanied by family members or kin. Dialogues lasted 30 to 80 minutes and were semi-structured to promote the sharing of stories.

The research was guided by four overarching research questions (listed in bold italix in Summary Table B). Stemming from these, a series of prompts were developed through an iterative process that took into account published literature, comments from co-researchers and informants, and author expertise. Participants were first asked to share a story about "food", then asked, where did you learn this? Prompts along these lines continued for "good food"; "store foods", "meat", "fruit", "vegetables", "fat", and "sugar". Additional prompts related to "where store foods come from", and notions of health, overweight, how adults and children learn, and what respondents might like to learn. The following scenario was provided: "if you are in the store and your child /children /grandchildren are crying 'I want, I want' for coke or lollies, what do you do?"

Data Analysis: Conversations were translated and transcribed in real-time or audio recorded and transcribed later. EM and SC discussed all content. Interview coding was undertaken twice during data collection, and at completion using Nvivo 10 software (QSR International). Interpretive content analysis [6] was used to identify salient themes relating to the four research questions.

Summary of Results:

Thirty people participated in the study. Summary Table (i) summarises participant characteristics.

Summary Table (i): Participant characteristics of the total group in study 'a'

Gender	21 females (70%); 9 males
Age[1]	42.9±13.9 years (approx); 18 to 60+ years
Number in household[1]	9.3±4.5; 3 to 20 individuals
Number of children[1]	2.8±1.5; 0 to 6 children
High school completers	55%
Fridge in household	20 participants (67%)
Oven/cooktop/microwave in household	30 participants (100%)

[1]Values listed as Mean±SD; Range

Summary Table (ii) lists key themes that emerged from discussions.

Summary Table (ii): Research questions and identified themes in study 'a'

How do people view store-based foods; what broader concepts are they related to?

People identify with foods and dietary qualities, rather than nutrients.

Good food makes me feel "light"; bad food makes me feel "heavy".

When people eat too much they become "the wrong shape" and can't do things.

In the store people can follow their personal feelings; you, yourself have to decide

What do people know, and want to know, about the contemporary food system?

People want practical approaches; cooking skills are highly valued.

In the store, how do adults guide the food choice behaviour of children?

Some mothers feel "a bit sad inside" to say no to their children; others can say no.

What are the channels through which people take on information about food, and wish to take on information about food?

People learn by watching and emulating key people; parents can also learn from children.

A network of community-based organisations is involved.

Appendix ii
Details of Qualitative Research (study 'b')

Aims: To explore and describe methods of communication, education practices, perceived challenges and the potential role of nutritionists working in remote Australian Aboriginal communities in order to inform future public health efforts.

Setting & Sampling: Nutritionists who were currently working or have worked within the last decade in remote Aboriginal communities in Australia's Northern Territory were identified through purposive and snowball sampling.

Data Collection: Upon consent, all nutritionists responded to a semi-structured survey via face-to-face interview, phone interview or email. Questions were pilot-tested and developed based on the project goals and on available literature and the authors' knowledge and experiences. Box (i) lists the series of questions presented to all participants. The terms "nutrition" and "nutrition education" were not pre-defined; respondents could make their own interpretation.

Box (i): Nutritionist survey used in study 'b'

1) How long did you/have you worked in the role of nutritionist in remote Aboriginal community/ies?

2) How many communities do you service? How often do you/did you visit each remote Aboriginal community? On average, how long was each visit?

3) In your role, how do you determine community priorities regarding nutrition?

4) In your role, what do people living in remote communities ask you for; what do they want to know?

5) What are your main nutrition messages?

6) What nutrition resources do you use when providing information on general nutrition and nutrition related to chronic disease, eg. diabetes?

a. What do you consider to be the pros and cons of available resources/programs? What has worked; what has not?

b. How are these tailored to the local environment?

c. How do you evaluate their use in each local context?

7) Do you see any gaps related to nutrition education in the remote Aboriginal context?

8) What materials/resources/information do you think would be of most use to you to assist you in your workplace?

9) Do you work with Aboriginal health or community workers? If so, how?

All face-to-face and phone interviews were carried out by one author (SC) who asked each question in sequence plus additional clarifying questions or probes. Interviews lasted between 30 to 80 minutes and were audio-recorded and transcribed by the interviewer shortly after. Email respondents were provided with a list of the guiding questions. Any response ambiguities were clarified via email or phone, and the emailed transcript altered accordingly.

Data Analysis: Interview coding was undertaken at the end of data collection using Nvivo 10 software (QSR International). Interpretive content analysis [6] was used to identify salient themes. Data analysis was triangulated with two authors coding the data while reading the collected responses to each question. Assigned codes were compared and contrasted and reoccurring patterns of meaning identified, and connections made between codes and emerging themes were revised in the re-reading of transcripts.

Summary of Results:

Thirty three nutritionists participated in the study. Figure (i) provides a diagrammatic representation of the five key identified themes.

Figure (i): A diagrammatic representation of themes generated from the data in study 'b'

Five key themes identified within the data are represented within the five figure columns. The first two columns relate to processes that were seen as imperative to underpin health education and promotion: community consultation and engagement, and forming and working within partnerships with local Aboriginal people. The final three themes relate more directly to nutrition education: considerations of the relationship between knowledge and behaviour; the need to localise approaches within the context of remote Aboriginal communities and also to the needs of each individual community; the challenges inherent in evaluating nutrition education and promotion in this setting. All of these key themes appeared vulnerable to personal, professional and environmental constraints, particularly time, workforce structure and training background. Overarching all themes, practitioner perspectives and approaches appeared influenced by a practitioner's extent of experience in remote Aboriginal settings.

Appendix iii
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Appendix iv
References for Table 6.1: Summary Table of Traditional Aboriginal, Contemporary Aboriginal & Western Perspectives, Practices & Behaviours Related to Food

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Appendix A: The Hissy Fit Discussion Board

The following pages contain all of the images developed within the Hissy Fit Discussion Board. Please note that this resource is still within a developmental stage, yet can offer some ideas on facilitating dialogue related to strategies for modeling good behaviour and encouraging healthy eating in children. Use any or all of these images, including any other local or other suitable pictures, symbols, stories or objects (eg. foods, packaging, knives, plants) to help build upon discussions that explore aspects of eating behaviour linked with children, and by extension their parents. These discussions can also extend to consider how eating patterns today can influence the health of children and adults in the future.

The following images have been designed so that they can be printed as an A4 page. Each page includes an image and an accompanying 'story'. The resource can then be used in A4 format. Alternatively, the pages can be folded into A5 to reveal the images only. The accompanying text can then be used by the facilitator, or read later, after participants have spoken about their own interpretations and stories.

The 'footsteps' on the final page can be printed and then cut into strips and used to link ideas and images.

For more information on the Hissy Fit Discussion Board see section 5.3: Consider your Approach to Health Promotion
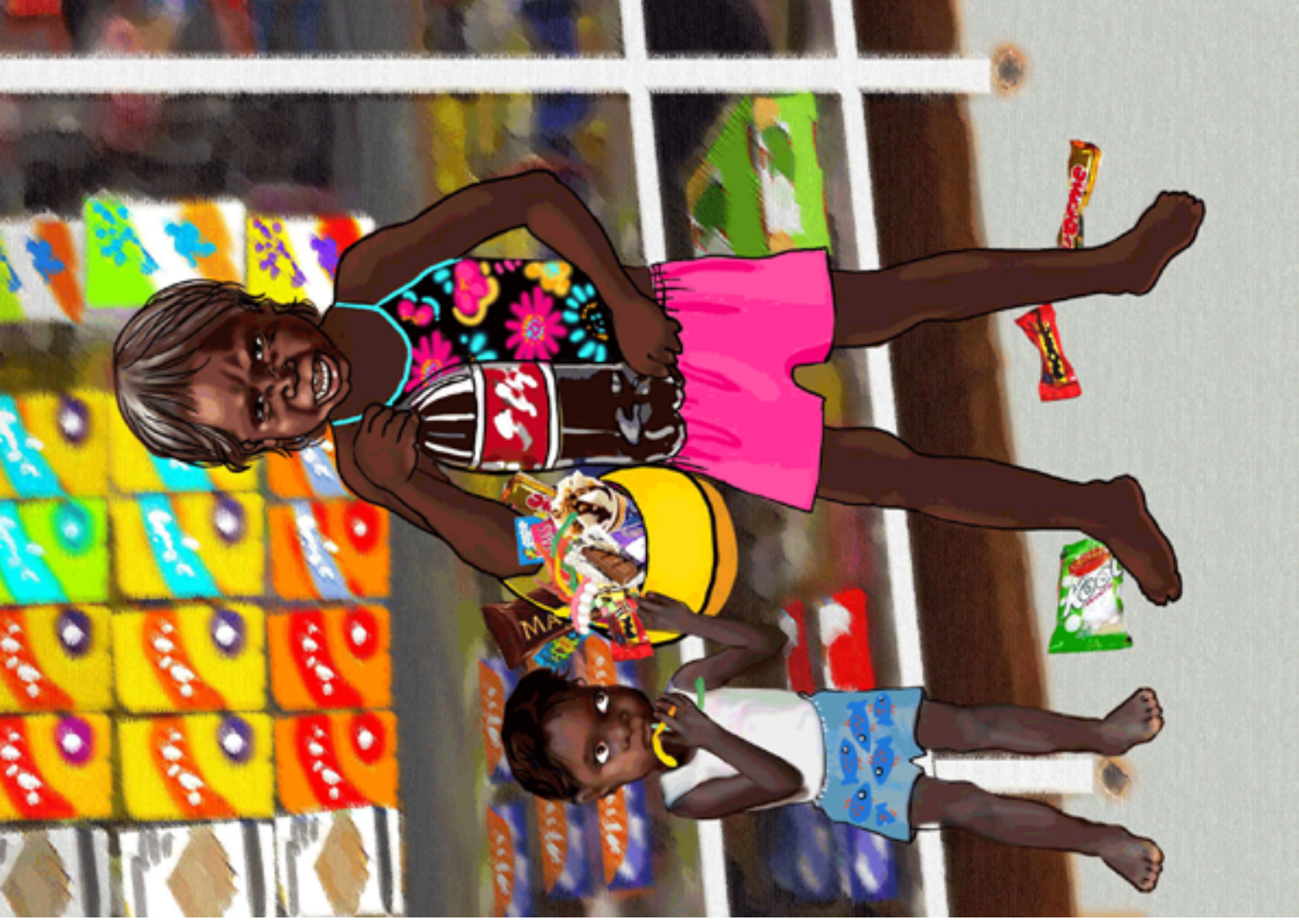

These images (also displayed over the following pages) are available to download via www.menzies.edu.au/foodacrosscultures

The "hissy fit".

The children want their mother to buy them some soft drink & lollies.

They are saying, "I want, I want, I want..."

Saying "no" to coke and lollies.

The mother is saying "no" to coke. She knows the story of sugar and soft drinks and has closed her heart to them.

She might be saying, "there is too much sugar, that sugar makes you sick. It makes your teeth ache and fall out, and it's wasting money".

In order to keep the children happy, they all talk about other things that they could eat, or do.

Saying "yes" to coke and lollies.

The mother or father might say "yes" to coke and lollies.

This mother might be saying, "sugar and soft drinks are not good for you, but you can have them if you want…"

Sometimes they might also say "no" and find other ways to keep their children happy.

Looking at fruit in the store.

The mother is telling the children to look at the colourful, sweet fruit and choose one or two pieces that they might like. She's explaining that these are good foods for a healthy body and life.
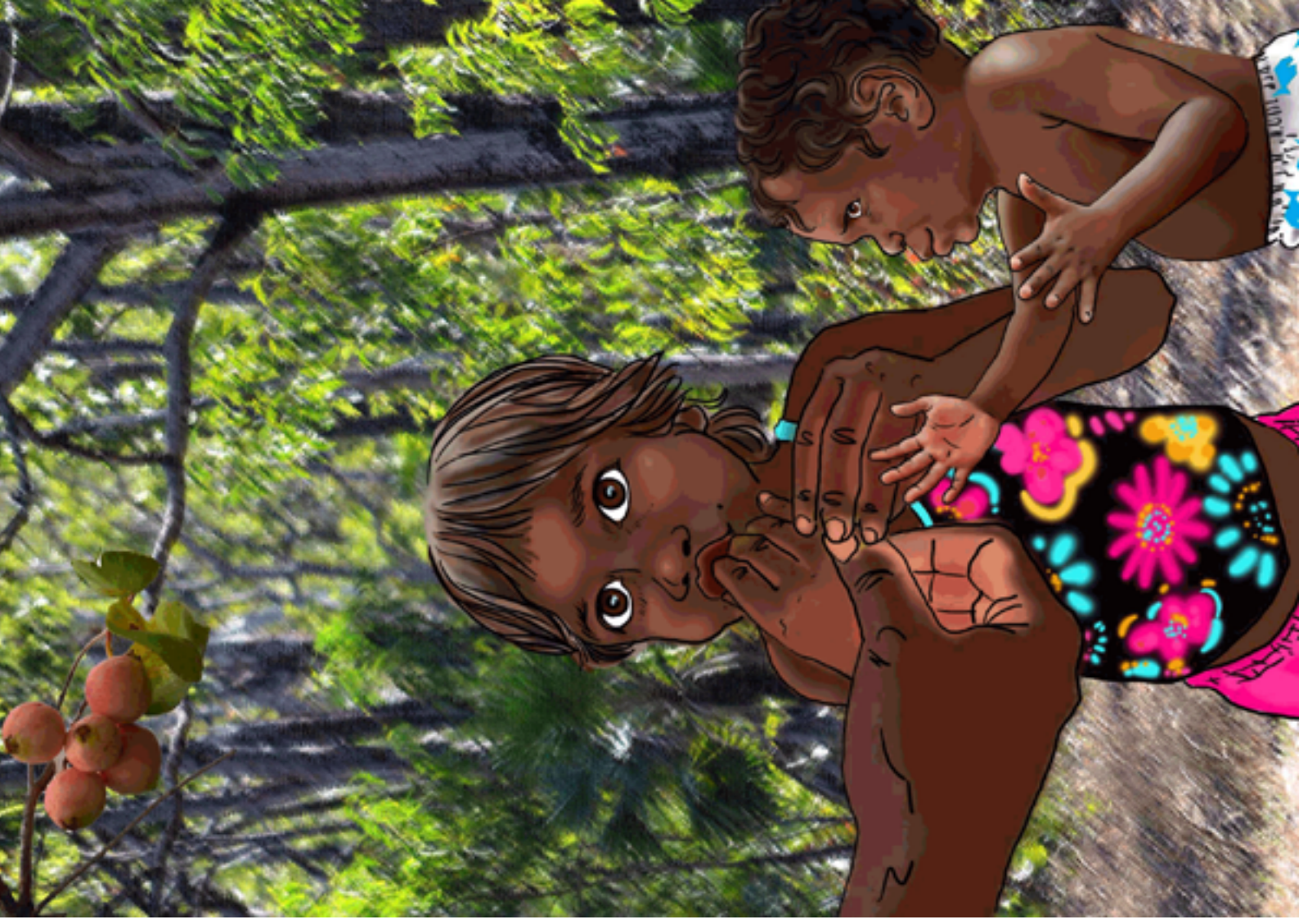
Looking at other healthy food in the store.

The little girl likes dried fruits and nuts. Her mother has suggested that she can choose some to buy.

Tasting bush foods.

The children are out bush with their family. They are collecting and tasting all of the sweet fruits that are in season.

The mother and her family encourage the children to eat their traditional foods.

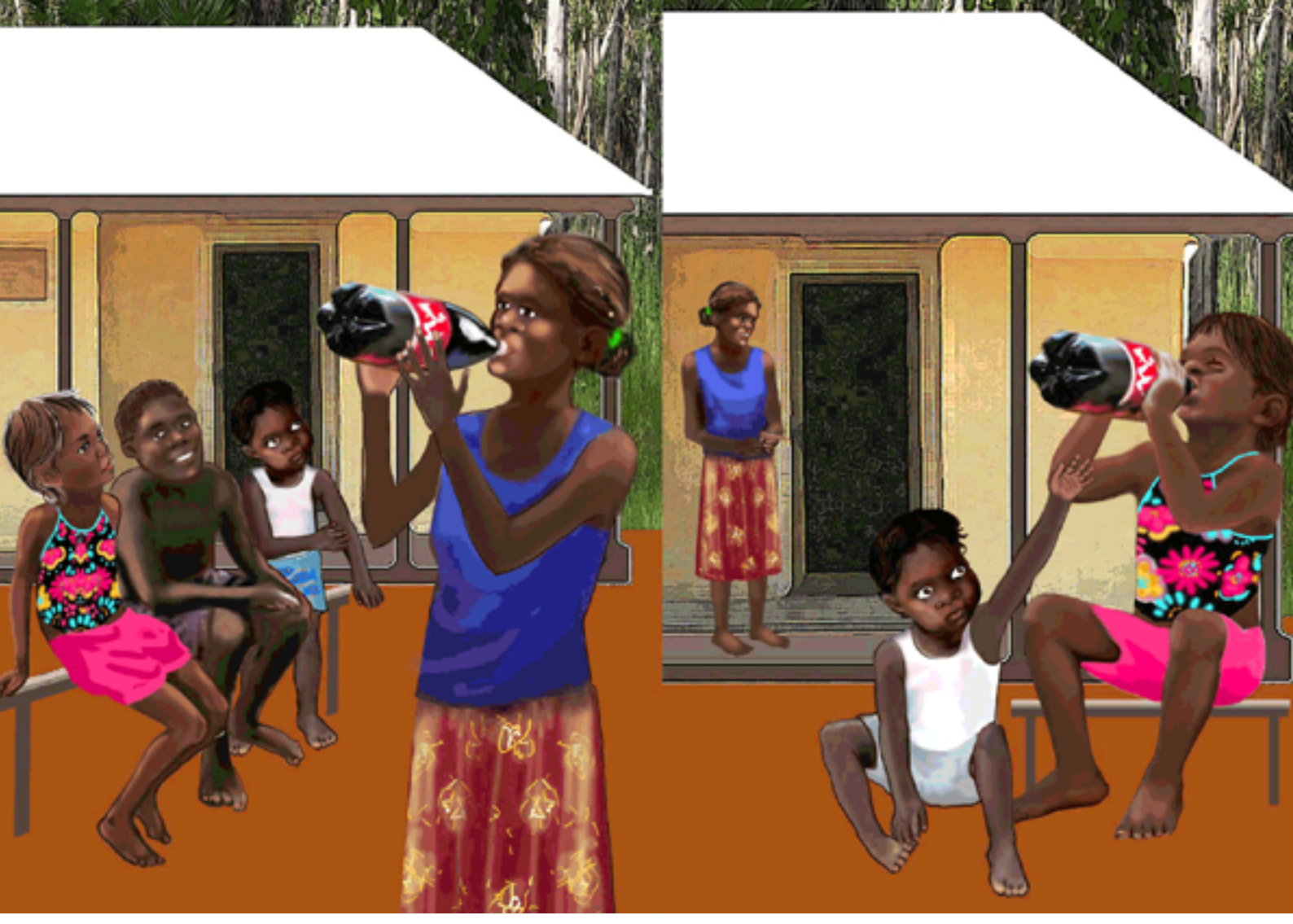The "debil debil" is in those foods. It will make you sick.

The mother is telling the child that the debil debil is over there, and will make them sick if she touches too many of those foods.

Drinking coke at home.

The mother knows that coke is not good for the body, but she drinks it anyway.

Children learn what to eat and drink by watching their parents and family.

Drinking water at home.

The mother is drinking less coke, and trying to drink water in front of the children.

Children learn what to eat and drink by watching their parents and family.

Drink fruit juice with added water.

This mother is adding water to fruit juice to make it "a bit weak, not so strong, so sweet tasting…"
She could also add soda water instead of plain water. The mother knows that sugar and soft drinks are bad for children's health and she only allows them sometimes.

Rotting, painful teeth.

Drinking too much soft drink and eating too many sweets gives children and adults painful rotting teeth, and makes their bodies weak. Sooner or later they will probably need to visit the health clinic.

Cooking with the family.

Instead of buying snack foods in the store the family have returned home and are cooking a meal together. Parents and family can teach children how to cook traditional foods and store foods.

Family fun and exercise.

Instead of buying snack foods in the store the family are playing a game together. Soon they will go and collect some crabs.

Children and adults need to be active to be healthy.

The children have become weak and sick. They are going to the clinic.

Too many of the wrong store foods can make children weak and sick. They feel unhappy and can't play and join in.

The boy has become very sick.
His mother needs to leave the
family and go with him to the
hospital in town.

Children that don't eat enough good food can become
skinny and sick and spend time away from their family.
This makes everyone feel unhappy.

Looking into the future.

The foods that children (and adults) eat today, can affect their health in the future. These are discussions around future "risk".

What can happen to children who drink too many sweet drinks and lollies, and don't eat fruit and vegetables?

Footprints to indicate movement over time.
Use footprints to link up images, ideas and actions as they have the
potential to move and change over time.
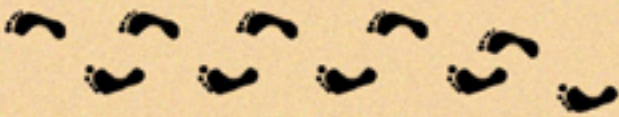
Appendix B: Guidelines for intercultural resource production with Indigenous consumers

Developed by Dr Anne Lowell and Mununukunhamirr Rom Project Team

- Work with local registered interpreters as much as possible and / or other community members with relevant knowledge and skills (just because someone speaks the language this does not mean they necessarily have the skills for interpreting which is a highly specialised job and requires specific training and skills development)

- Identify existing resources and evaluate these for relevance to the target group – avoid redoing what is already available.

- The most important consideration in resource development is how to ensure *effective communication* with the target group. There are many factors you will need to explore with your co-workers and potential users.
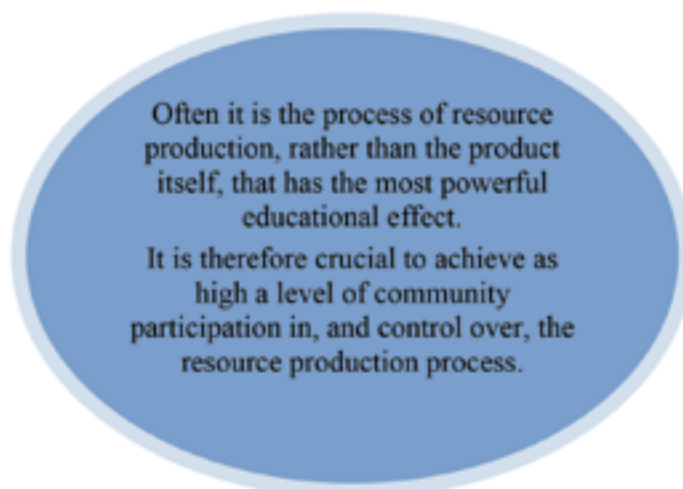
The format of the resource

- Through consultation with the target group identify the preferred language or languages to be used in the resource.

- Do the majority of people read this language or does it need to be spoken?

- What communication style is most appropriate? For example, should the content be directive or informative? A resource which lists 'do's and don'ts' can be interpreted as 'controlling' or offensive to some people. An 'informative' approach which provides a clear and detailed explanation might be more effective to enable people to make genuinely informed decisions based on a strong understanding of the information. (A simplistic approach can be interpreted as deliberate with-holding of information from the consumer)

- Identify what approach to sharing information is most appropriate e.g. one option is to use a 'narrative' approach which is story-based. For example, use of case studies, interviews and role-play can provide a powerful means of contextualizing information and strengthening understanding.

- What learning strategies are preferred in this group? For example, do people use a lot of repetition? Illustrations? Do people prefer audio only (e.g. tapes, audio CD or audio plus visual (video, DVD, computer CD)?

- If you use text-based resources (book, pamphlet, flip chart) – will the users be sufficiently literate in the language you chose for the resource?

- Does this format suit learning preferences? (e.g. with a flipchart the previous page 'disappears' – review and repetition is therefore difficult unless each 'page' remains visible e.g. laid out one by one or concertina style which allows for a narrative or 'storytelling' structure, repetition and revision.)

- What delivery mechanisms are available? VCR? (In some communities DVD players are now more common in homes). Computers? CD players? Many communities now provide computer access to community members - schools, council, knowledge centres etc.

The resource content

- What skills and knowledge is this resource intended to develop? It is crucial to recognise and build on existing knowledge and skills and not to make incorrect assumptions about the extent – or lack of – existing skills and knowledge. Identify and include relevant information/knowledge from the community perspective.

- Information from a non-local source (e.g. Western health services) needs to be fully explained in a way that is meaningful. It is common practice in resource development to use 'simple English'. However, Yolngu strongly state that they want the 'full story' not the 'tip of the story'. Incorrect assumptions about the extent of shared understanding of underlying concepts result in ineffective communication.

- Present the information in clear (not simple) English that is as 'culturally neutral' as possible to enable accurate interpretation. Culturally-specific metaphors, terms and concepts need to be avoided or fully explained.

- Working closely with one or more skilled interpreters throughout the planning and development of the resource is the most effective way to ensure effective communication will be achieved. Working with a small group can provide a range of perspectives as well as a range of cultural and linguistic expertise.

- Discuss each concept or idea to find out the best way to achieve a shared understanding – look closely at the cultural knowledge underlying each concept and ensure that prerequisite knowledge is fully explained.

- Ensure that visual images are consistent with, and enhance, the oral message – from the users' perspective.

- Trust local knowledge about the most effective approach to education.

Community participation

- A clear explanation of unfamiliar concepts or information is necessary to enable people to make an informed choice. As well, concepts and cultural knowledge from the local perspective related to the aim and content of the resource must be recognised and integrated for the information to be credible and relevant.

> Often it is the process of resource production, rather than the product itself, that has the most powerful educational effect.
>
> It is therefore crucial to achieve as high a level of community participation in, and control over, the resource production process.

Appendix C: The Food Discussion Board

The Food Discussion Board is available to download via
www.menzies.edu.au/foodacrosscultures

Appendix D: Cookbooks that have been developed with & for Aboriginal communities
(in alphabetical order)

Deadly Tucker Cookbook

This colourful cookbook provides 39 low cost, step-by-step, easy to prepare recipes, including soups, main dishes, salads and vegetables and desserts. These recipes come from the FOODcents for Aboriginal and Torres Strait Islander People in WA Project. All recipes are rated for suitability for people with diabetes. To order to do: http://www.healthyfuture.health.wa.gov.au/Health_topics/ASTI-FOOD/ASTI_FC-order.pdf

Feeding your mob with fruit & veg: bush tucker tips (2008)

The Feeding your Mob recipes are based on a fruit and vegetable cookbook put together by the former Mid North Coast Aboriginal Partnership. The book includes 'bush tucker tips' so that Aboriginal and non-Aboriginal people can become familiar with foods that have been part of the Aboriginal diet for many years, and try some of these traditional ingredients when preparing Aboriginal food. For more information and to order go to: http://www.healthinfonet.ecu.edu.au/key-resources/promotion-resources?lid=14519

Flavours of the Coast, Koori Cookbook. Recipes from the Aboriginal and Torres Strait Islander people of the Illawarra and Shoalhaven (2014)

This cookbook was developed through the Be Stronger Live Longer project funded by the Australian Government, Department of Health, Local Community Campaigns, and contain a wide variety of seafood and other dishes based on traditional recipes of the Aboriginal and Torres Strait Islander people of the Illawarra and Shoalhaven in NSW. For more information or to order additional copies of the cookbook contact the National Heart Foundation of Australia (NSW Division) – Illawarra on (02) 4232 0130 or 1300 36 27 87 or heartfoundation.org.au. To download the cookbook go to: https://www.heartfoundation.org.au/SiteCollectionDocuments/Koori%20Cookbook.pdf

Flour drum Stove Cookbook

A flour-drum stove can be used for cooking healthy family meals when camping or when there is no electricity. The Flour drum Stove Cookbook was developed by nutritionist Roy Price. It explains how to make and use a flour-drum stove, and includes recipes that are suitable for families in remote areas far from big supermarkets and specialty food shops. For more information and to view and download the Flour drum Stove Cookbook go to: http://www.ethicalnutrition.com.au/Flour-Drum_Stove.htm

Good quick tukka: cook it, plate it, share it

The Good quick tukka (GQT) program was developed by the Queensland Aboriginal and Islander Health Council. It offers a 10 week course, but it can be adapted to suit the needs of a community. The aim of the GQT program is to increase the number of meals being prepared at home among Aboriginal and Torres Strait Islander people. The philosophy of the project is to increase cooking skills, and to have fun gathering, preparing and consuming nutritious meals, and to pass on recipes to family and friends at home. A facilitators manual is also available. For more information go to: http://www.healthinfonet.ecu.edu.au/key-resources/programs-projects?pid=669

Kat Kat Cookbook – for the urban hunter-gatherer

Kat Kat originated from a photovoice research project conducted with the Wathaurong Aboriginal Cooperative that asked people to take photos about their experiences of food. Kat Kat was created to give Aboriginal people a cooking show that supported urban hunter gatherer identity, eating a healthy diet and having fun cooking. Hunting and gathering is about seeking out foods that are good for your body and the land, and getting exercise every day. For more information and to download the cookbooks go to: http://www.wix.com/wathaurong/katkat#!goodies

Kukumbat gudwan daga: really cooking good food (2009)

Kukumbat gudwan daga: really cooking good food is a cookbook of up to 100 healthy recipes for feeding ten or more people. The recipes are diverse, including traditional recipes such as kangaroo tail stew and introduced favourites such as spaghetti. Created by women from the women's centres of Manyallaluk, Gulin Gulin and Wugularr in conjunction with a chef and a nutritionist from the Fred Hollows Foundation, the cookbook uses local ingredients and provides step by step photographs. For more information and to order go to: http://www.healthinfonet.ecu.edu.au/key-resources/promotion-resources?lid=16869

Living Strong Cookbook

The Living Strong Cookbook was developed in response to requests from many community members who over the years attended Healthy Weight and Living Strong Programs. The cookbook provides a variety of healthy recipe ideas and some traditional cooking for people and families to enjoy. The recipes encourage people to use more vegetables, fruit, lean meat and fish to make quick and easy nutritious meals. To view and download go to: http://www.gofor2and5.com.au/LinkClick.aspx?fileticket=wJUcIbDsfyo%3D&tabid=476

Mangarri palya (cooking good food) (2010)

This recipe book was developed during the Mangarri palya community cooking and nutrition project in the four western desert communities of Kintore, Mt Liebig, Papunya and Ikuntji in the NT. It offers collection of recipes that can be used as a starting point from which to run healthy cook-up activities which engage and educate young people and adults, both men and women. For more information go to: http://www.healthinfonet.ecu.edu.au/key-resources/promotion-resources?lid=18613

South East Queensland Bush Food Recipes

This cookbook contains a range of recipes using traditional bush foods of the south eastern region of QLD, plus many useful tips and information on the origins, characteristics, uses and sources of bush ingredients. It was produced by the Nutrition Promotion Unit, Metro South Hospital and Health Network – Queensland Health. For further information or to provide feedback contact Nutrition_Promotion_Unit@health.qld.gov.au. To download go to: http://www.health.qld.gov.au/metrosouth/nutrition/docs/booklet-bush-food.pdf

Appendix E: Ideas & tips for making & taking film

It can be very powerful to film the stories of prominent community people. For example why and how people in the community have lost weight and/or become more active; stories of people buying/hunting/collecting, preparing and cooking food – in the bush or in the community; people telling the story of their experience being diagnosed and/or managing a chronic disease. Other ideas might include footage from health and cultural events, children's performances and sporting activities.

If a community group are interested in making a film about a food-, health- or wellbeing-related topic, following are a few tips that may facilitate the process.

General Tips for Telling Stories:

· Use a narrative approach – it is a traditional approach, and can inspire empathy. (See Section 5.3).

· It's easy to incorporate still photos or pictures of local and familiar foods, people, places to help build the story.

· Cartoons and/or puppets are often well received by both children and adults.

· Incorporate humour that is developed and owned by local people, and appropriate to the style of communication.

· When giving a message – less is better. One to three main messages – One key message may be best.

· People share stores and entertainment; they don't share advertising and negative messages that are generally seen as 'preaching'.

If you have no, or limited funds available, you or the group might like to:

· Think about who else in the community has relevant experience, skills and equipment that could assist or become involved.

· Enquire at a local university if there are film students that might be interested to take on projects.

· Think about posting the project on Pozible – www.pozible.com a crowd-funding platform and community for creative projects and ideas.

· Try contacting an Aboriginal and Torres Strait Islander television outlets or broadcasters (such as Imparja, Goolarri (GTV35), National Indigenous Television and Larrakia TV). It is possible that they will work with organisations and communities to help develop social marketing materials.

General Tips for Filming

· Always consider lighting

· When filming people with dark skins:

· Use a reflective board (even some cardboard covered with foil) under the face to reflect light up under the eyes

· Spray water lightly on the face to add shimmer

· To make one or more people look more powerful, film them from below; position the camera to look up at them

· To make people look more quirky or a bit silly, film them form above, or have them looking up

· Film at eye level to have the person being filmed look direct and engaging

· To depict movement, walk with people as you are filming

· Bumping = film with 2 smart phones from different angles, eg. one in close and one out from an angle, then share the footage and edit

· When recording sound, use an earphone microphone or get a separate recorder/microphone

· Watch out for background noise that can ruin audio such as cicadas or wind

· To find music to add to the footage, look up "free music" sites that list many songs you can safely use without potential copyright issues.

· For smart phone 'apps' – 3 minutes is a good length of time for downloads – no longer

· FiLMiC PRO is an app that allows you to take greater control of the camera in your phone.

· Keep in mind the 'rule of thirds' when composing visual images. This technique can create more tension, energy and interest in the composition, rather than simply centring the subject in the frame.

· 'Lead room' or 'nose room' refers to the space in front and in the direction of moving or stationary subjects. Well-composed shots leave space in the direction the subject is facing or moving.

These tips are available to download via
www.menzies.edu.au/foodacrosscultures

Appendix F: The Wadeye Sugar Story

The English version of the Wadeye Sugar Story.

Also available to view on www.youtube.com/ watch?v=UGgZJjJ1S8w.

This is a small film about how eating good food helps to keep our bodies strong/healthy. It is also a story about sugar. Why we need sugar. What it does inside our body. The good and bad things about sugar. And the main message in this story is to eat and drink healthy foods that don't contain too much sugar.

This story will have ten parts:

1. What is sugar?
2. Our bodies need sugar to live
3. Our taste buds love sweet tastes
4. It used to be hard to find sweet sugary foods
5. The really sweet sugars and the not-so-sweet sugars affect our bodies differently
6. What does too much sugar do to our bodies?
7. Too much sweet, processed sugar can cause diabetes (sugar sickness).
8. Which foods and drinks have too much extra sugar?
9. What foods can help to keep our bodies healthy?
10. A healthy diet and being active helps keep our bodies, minds and spirits strong

1. What is sugar?

- Sugar is sometimes called glucose or carbohydrate.
- The sugar we drink in tea and fizzy drinks and eat in sweet biscuits and lollies comes from a plant.
- This plant is called "sugar cane" (pic). In factories the sugar cane is processed to become sugar (pic) .
- Other plants that contain sugar are yams and all fruits. Sugarbag has sugar too. But the sugar in these foods is natural. Their sugar is not processed.

2. Our bodies need sugar to live

- Blood flows around our body like water on the land flows through big and small rivers. Our blood takes the sugar from foods and drinks and carries it around our body.
- Our brain needs sugar. Sugar helps our brain to think and learn new things.
- Our muscles need sugar too. The sugar feeds our muscles to keep up strong and give us the energy to move around and stay healthy.
- Without sugar, we would die.
- But eating and drinking too many sweet and sugary things can make our bodies sick.

3. Our taste buds love sweet tastes

- In the bush, bitter foods were often dangerous – they were poisonous and could kill us.
- But sweet tastes usually meant that a food was safe to eat.
- The sugar in these sweet bush foods also gave our bodies the small amounts of sugar that we needed.
- Now in the shop, many foods have added processed sugars.
- Many foods and drinks are very sweet and we add lots of sugar to tea as well.
- We eat and drink much more sugar than our bodies need.
- Our taste buds still love sweet tastes, but they don't know that too much sugar is dangerous.

4. It used to be hard to find sweet sugary foods

- Sugarbag takes time and energy to collect. We only get a small amount at a time, and we exercise our muscles to get it. It is a treat to have on special occasions.

- In the bush, the fruits and different yams were only available in their season.

- With the old way, when all food came from the bush there was no diabetes.

- There was lots of walking and exercise and people ate very little sugar.

- Now in the store, foods and sugars are always there. When we want it we just go to the shop. Now we hunt in the shop!

5. The really sweet sugars and the not-so-sweet sugars affect our bodies differently

- Many foods have sugar in them, but our taste buds do not always know...

- Food and drink that tastes really sweet usually has a lot of processed sugar added to it. Like.... (pics).

- Too much of the really sweet sugary foods can be harmful for our bodies, especially when we eat and drink sweet foods as children and continue all of our life.

- We should eat and drink more of the foods and drinks that don't taste so sweet. Like Weetbix, fruit, grain bread, pasta, yoghurt and milk.

- Foods that don't taste so sweet are usually better for our bodies.

6. What does too much sugar do to our bodies?

- When we eat too much sugar, our bodies can become out of balance.

- Too much sugary foods makes our bodies unstable. One minute we might feel full of energy but soon after our mood changes and we can feel tired, unhappy and angry [show waves].

- Eating and drinking too much sugar rots our teeth and gives us bad breath.

- Eating and drinking too much sugar can make us put on weight and become "the wrong shape".

- This extra weight can give us pain and make the organs in our bodies out of balance (show all the different organs).

- Too much sugar causes our blood and the arteries (the walls of the river) to become damaged.

- The river can also block up like a river that can't flow. Sugar is like lots of logs and branches in the river, clogging up the flow. Particularly if we don't walk and move around.

7. Too much sweet, processed sugar can cause diabetes (sugar sickness). When we always feed our bodies too much sugar, over time our organs become tired and stop working properly.

- In sugar sickness/diabetes, our bodies can't take all of that sugar out of the blood.

- Most of the sugar that we eat and drink stays flowing around the river in our blood. This sugar can't get used by the brain, the muscles, the liver (show organs).

- All this extra sugar in our blood causes more problems for our bodies. It can affect our eyes and our feet and hands.

- Saying NO to very sweet foods for us and our children can help us say NO to diabetes.

- If we have diabetes (sugar sickness), we need to be careful about all the sugar foods. We shouldn't eat too much and we should walk and be active.

8. Which foods and drinks have all this extra sugar?

- Foods and drinks that have lots of sugar often taste very sweet... Can you think of a few?

- Sugar, soft drink, juice, iced coffee drinks, cordial, ice cream, cakes, biscuits, lollies, chocolate, sugary tea.

- Soft drinks. Coca cola, lemonade, Fanta, Pepsi, creaming soda, all the soft drinks have lots of sugar added to them (Show soft drinks pictures).

- These drinks have nothing in them that is good for our bodies. Just too much sugar.

- One big bottle of coke (1.25L) has 33 teaspoons of sugar. That's more than half a cup (show amount of sugar from soft drinks for one day, one week, one month, one year, one lifetime). It is also this much sugarbag (comparison).

- Think about how much sugar your body will have if you have these sugary drinks most days (show animation of adding lots of sugar to water, how it goes think and syrupy, cloudy etc. Now think about what this does inside our bodies).

- Fruit juice also has lots of sugar in it. A lot of this sugar is from fruit, but when you have juice instead of fruit a lot of the nutrients that our bodies need has been removed. All the fibre (roughage) that is good for our organs and digestion is taken away and what is left is the sweet liquid. We are much better off eating the fruit and drinking water. Your body will feel better and will thank you for it.

9. What foods can help to keep our bodies healthy?

- When you go to the store, chose the foods that are most like bushfoods! These are the foods that are not too processed (lots of pictures to reinforce this concept). Show: Beans, fruit and veg, bush meat, brown rice, musili, oats, soup mix, canned veg, etc.

- Get lots of vegetables, fresh or frozen or canned. The frozen ones are just as good for our bodies as the fresh ones! They can be just as fresh too.

- Chose healthy meats that have more muscle and not too much fat. Bush meats are the best.

- Choose dairy foods like milk, cheese and yoghurt that are not so sweet (chocolate or coffee flavour). Low fat dairy foods are the best.

- Choose fresh, canned or dried fruit rather than the juice.

- Choose the breads, rice and flours that have more brown colours and seeds in them. This is more like bush foods and good for our bodies.

- Water is the best drink to have. Drink lots of water. Your body will thank you for it. (Film poring glass of water)

- Let your children and family know that too much sugar in foods and drinks is not good for their body. Say NO to fizzy, sugary drinks.

- The diet soft drinks can be good to try if you find it hard to swap these drinks for water. Diet soft drinks taste sweet but do not have any sugar in them.

- Water is the best drink.

10. A healthy diet and being active helps keep our bodies, minds and spirits strong.

- When we are healthy it is easier to do the things we enjoy, like being with family, playing sports, working, learning and walking. We feel good about ourselves and good about others.

- Your body doesn't need extra lot of sugar. Try cutting down on sweet foods and drinks.

- Eat more foods that are like bush foods.

- Your body will feel strong, balanced and light.

- Making small changes and choosing the foods and drinks that make us healthy is important. This will keep us happy and help us live a longer, more active life.

- A question we can all ask is what can I do to be more healthy? And what can we do to make Wadeye a healthier place to live?

Images to use:

Food plate (ATSIGTHE)

Demonstrate teaspoons of sugar in drink

Show images of sugarcane to processed sugar

Exercise, how this helps our bodies too

Examples of healthy food

Egg in coke, Gatorade and water for a week (egg experiment)

Compare how much sugar in a bottle of coke vs a banana or apple. How many bananas/apples?

This English version of the Wadeye Sugar Story is available to download via www.menzies.edu.au/foodacrosscultures

Appendix G: Dhukarr'kurr Yan Marrtji: Larrum Yuwalkku

A Pathway for Collecting True Stories in Remote Indigenous Communities

Dhukarr'kurr Yan Marrtji: Larrum Yuwalkku means:
Searching for the truth;
The right pathway;
Heading in the right direction;
Following a protocol;
Keeping to the path;
A framework.

This guide offers a pathway to assist people to work effectively with local Aboriginal people to collect information in remote community settings.

Sometimes when new people come into a community they work by themselves, and according to their own pre-existing cultural and/or professional ideals. These people can only collect the 'surface story'.

The process of collecting information, for research or other reasons, needs to involve people working together, who can complement each others skills and share understandings.

Following is a step-by-step process that provides a framework and pathway when undertaking research and collecting true stories in remote Indigenous communities.

THE FIRST STEPS: CONSIDERATIONS FOR CONDUCTING SAFE & ETHICAL RESEARCH IN A REMOTE INDIGENOUS SETTING

Step 1.1:
All researchers should be aware of ethical concerns and document ethical considerations and obtain ethical clearance accordingly

This link to the Menzies ethics website states the different documents that need to be referred to in preparing ethics applications and considering ethics issues:

http://www.menzies.edu.au/page/Research/Ethics_approval/

This link is a guide to Indigenous ethics as seen within one context:

http://yalu.cdu.edu.au/healthResources/research.html

Step 1.2:
When planning research, first find and form connections within the community

– Enter the community through existing relationships.

– Spend genuine and sufficient time with community people.

– Listen deeply.

– Introduce yourself and share some of your own story

– Take steps to be accepted; bring people together; demonstrate reciprocity or two-way actions: that is responding to positive actions with other positive actions.

– Avoid a "hurry hurry" attitude and approach.

Step 1.3:
Selecting local co-researchers/local workers

– Be guided by community elders, custodians and local advisors.

– Follow fair employment processes.

– Work with a group to maximise perspectives and inputs, and minimise individual pressures.

It is often best to collect stories slowly over a longer period – this allows more flexibility.

Step 1.4:
Researchers and co-researchers work together side-by-side

Discuss, negotiate and plan the research methods and the roles and responsibilities of all involved. Ensure shared understandings. Guide each other and work to individual strengths and social etiquette.

Understand and seek out the required training and resources – other people; knowledge; money; time.

Non-Indigenous researchers need competence in working collaboratively with local experts who have a deep understanding of communication practices and protocols in the local setting.

Indigenous co-researchers need a clear understanding of the research aims and desired outcomes.

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Step 2.1:
Share the Research Story
with the Community

Providing a clear understanding of the research project enables community members to create a picture in their minds. This process is important for finding both co-researchers, and participants who are interested to share their story.

Explain why you are doing the research and what you want to achieve.

Allow time for sharing of the research story within the community then seek support from community people.

If people recognise something – if it is familiar or understood by them, then they will be more likely to accept it; work with it; respond to it.

Step 2.2:
Finding Participants

Do you want to interview a broad demographic sample, or a more specialised sample?

Potential participants might hear about the research story when it is shared with the community, or through family, friends or colleagues. Some might be approached by a local co-researcher who has an understanding of a person's availability and potential.

Be opportunistic.

Share your research story again. Allow people to ask questions. Assess their level of interest. If willing and able to contribute, make a plan with participants about when, where and how they will participate in an interview.

Step 2.10:
Feeding Back the Story to the
Community

Give participants the option of hearing the ideas and information collected from all of the stories. This might be done in larger or smaller groups. In addition to sharing the stories and research findings this provides an opportunity for checking the consistency and completion of ideas.

As appropriate, feed back the themes derived from the interviews to other groups of people in the community. This can help to share, verify and understand the ability to generalise the findings. Other community members may have more stories to add.

It can be great to share the project and the community's contribution at a community event such as a Healthy Life Festival.

The findings of the research should also be written up and fed back to the community in a formal report. Think about providing an oral report on video to communicate more effectively with people who are not literate in English.

Let the participants and others know what you will do with the findings.

Step 2.8:
Translating and Transcribing the Interviews

Reflecting on each interview and taking time & care during translation and transcription helps to ensure that we have captured the true story – that the person's true voice is being heard.

When translating into Standard English, interpretations need to stay true to the original meaning:

– Discuss specific words to find an appropriate translation

– Go over and over ideas/themes/words – listen to the interview again

– Researchers and co-researchers should reflect on interviews again after translating & transcribing each story

Step 2.9:
Cross-checking and Verification

Give participants the option to check that you have recorded their true story. Community researchers can advise how people may best verify the story, for example by reading the transcription or though a verbal discussion.
It may be necessary to translate the story back into the original language.

Allow participants to alter or add to their story.

Ask again if quotes can be used in reports or publications, and how the individual wishes to be identified/de-identified. If necessary, add this to the consent form.

REMOTE INDIGENOUS COMMUNITIES

Step 2.3:
Conduct the Interview When, Where and in the Language that Suits the Participant

In order to make people feel comfortable and to help to equalise any 'power imbalance', allow each participant to choose when and where they would like to share their story.

Use people's preferred language throughout all communication at every stage of the research – consultation and planning, obtaining consent, conducting interviews.

Researchers should be flexible and also consider other relevant cultural factors such as seating, location, timing, arrangements.

Indigenous co-researchers may conduct the interviews in local languages while the non-Indigenous researchers are present. Sometimes however, it may not be advisable for non-Indigenous researchers to be present.

Step 2.4:
The Process of Informed Consent

All participants will need to be provided with details about the process and purpose of the study, and provide informed consent. Consider:

– The details that needs to be conveyed in the project statement.

– The clearest language & expression.

– How to maximise and verify participant understanding.

– Written versus oral consent.

– Whether it may be most appropriate to obtain final formal consent after the interview process.

– Does consent need to include later use of quotes, names or images?

– Provide choice about remaining anonymous or being identified.

Taking food/beverages to the interview to share, or providing a food or electricity voucher after the interview may be suitable in order to thank people for their time and valuable contribution.

Step 2.6:
Recording Methods

Recording methods might include audio and /or video recording, or hand-written notes.

Consider participant preference (during the consent process), available resources, data required or desired.

Also remember to record the time taken for the interview.

Step 2.5:
Sharing True Stories: the Interview Process

After the participant understands and agrees to the research process, ask: "are you ready to share your story?"

Allow each participant to tell their story in their own way.

Don't rush – allow people the time that they need.

Follow the agreed research methods and chosen ways of gathering information (see also overpage/later discussion: How will the Stories be Collected?) and recording information (see step 2.6: Recording Methods).

Step 2.7:
Reflecting on the Interview

Researcher discussions following the interview provide an opportunity to synthesize the stories and information collected, and produce a clear shared understanding.

Researchers and co-researchers can share interpretations and reflections immediately after each interview, and add contextual thoughts to provide explanations, such as why someone gave short answers.

People want to know their story is valued and being heard.

FURTHER CONSIDERATIONS WHEN COLLECTING STORIES IN REMOTE ABORIGINAL COMMUNITIES

HOW WILL THE STORIES BE COLLECTED?

Methods you can use include:

- In-depth/narrative interviews
- Focus groups
- Semi-structured questions/questionnaires
- Structured surveys
- Photographs such as in photovoice methodology
- Video-recordings

ALL STORY COLLECTION METHODS SHOULD CONSIDER:

- Social relationships within the community.

- Social and cultural appropriateness and acceptability.

- Language and effective communication practices.

- The possibility that people will agree, say what they think you want to hear, or say 'yes', when they really mean 'no'.

- Available time and resources.

GATHERING STORIES AND INFORMATION:

Guiding questions, themes, products or images can act as prompts to start people talking, elicit further information, or clarify part of people's stories. It might also be appropriate for one of the researchers to share some of their own story/experience.

Limit and define quantitative aspects in questions. For example, inquiries that relate to time should be linked to known periods such as seasons or community events.

People's sense of individual autonomy or self-dependence means that people will not speak for others. Questions need to be addressed only to the participant, rather than relating inquiries to others or to the community in general.

Pilot test any guiding questions or images. Ensure they successfully guide the process but do not influence people's responses and allow them to share in-depth ideas and knowledge from their own perspectives.

The development of this resource occurred through a collaboration of researchers from Galiwin'ku community, Menzies School of Health Research and Charles Darwin University.

Dhukarr'kurr Yan Marrtji: Larrum Yuwalkku is available to download via www.menzies.edu.au/foodacrosscultures

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Dhukarr'kurr Yan Marrtji: Larrum Yuwalkku
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