The Australian Journal of
INDIGENOUS EDUCATION

NUTRITIONAL INTEGRATION OF THE ABORIGINAL

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Miss Stacy, who is now studying for an M.A. in Sociology and Anthropology, presented this paper at the 46th ANZAAS Congress in Canberra, January 20th-24th, 1975.

In 1971 the Institute for Aboriginal Development in Alice Springs initiated a health education program and has been working with groups of traditionally oriented Pitjantjatjara people living on settlements, missions and cattle stations south of Alice Springs. Flexibility of the Institute's approach allowed for experimentation and amendment as the program developed.

The method of education employed was to bring groups selected by communities who indicated they wished to participate in the program to Alice Springs for a 2 -3 week residential course. The group participants and the Health Educator lived in a hexagonal building. Here, facilities and equipment similar to those available in the home/camp situation were used by the Aboriginals. There was a non-authoritarian approach by the Health Educator both during the "formal" group discussions and the "informal" continuing interaction with the group participants. The vernacular was used as the medium of instruction. Residential courses were also conducted in the bush where the Health Educator resided with the Aboriginal people.

I have been involved in this program for the past three years. It has produced a range of outcomes not all of which were anticipated. I will discuss one aspect which the program has illuminated, because I believe it has implications which go beyond the scope of this particular project, and which may be relevant to a much wider range of Aboriginal Aid Programs.

In European society, it is assumed by health workers involved in prevention of disease and promotion of health, that if someone expresses a concern about their health, they are prepared to take appropriate action to improve it and so eliminate the concern. Their actions are motivated by the desire to achieve good health. Among many Europeans this assumption has proved correct.

In Aboriginal society, an expressed concern about health does not indicate a desire to take action suggested by health workers to alleviate the concern. They do not share the oft-stated European belief that "health is the most important thing".

In Aboriginal society, relationships - that is, interactions with other people, are the most important things. Actions are performed to express or consolidate relationships. Relationship is the ultimate goal,and desire to achieve this provides motivation to perform actions. In traditional society, these actions fulfilled other wants and achieved less important goals. I believe Aboriginal people apply this principle in their contact with Europeans.

As Health Workers, we establish a rapport or build a relationship so we can teach some aspect of health. The goal is improved health, and the relationship is largely seen by us as the means to that end. The Aboriginal people participate in programs, retain knowledge and sometimes apply it, so they can build a relationship. By relationship I mean interaction. To Aboriginals, interaction is an end in itself and, by contrast with our views, not a means to an end. The goal is the relationship itself.

A Health Educator is employed to change the health practices of her clients in a way that, by the standards of her employers, will benefit them. If Aboriginal people change their health practices, it is not to achieve the Health Educator's goal of improved health, but to achieve their goal of stronger relationships. When they see it is not necessary to perform these actions to achieve their goal, the actions are unlikely to continue, and in my experience, they rarely do.

Over the past three years, I have been busy building relationships so I can teach and learn, and the Aboriginal people have been busy retaining knowledge I gave them, and teaching, so they can build relationships. As we have been working together towards our different goals, the Aboriginal people have expressed other needs arising because of their changing life style since contact with Europeans.

They have clearly indicated they want certain material aspects of our society, for example, clothes, cars and food, although they do not necessarily want to use these in the way we expect them to. They want the services available in European society if these meet a need they recognise, for example, the utility provided by a storekeeper or mechanic. They have also indicated they want white people to intervene in a crisis situation. Many times during courses I have been asked to help. These requests have often come in the middle of the night, and are usually associated with sickness or fighting. Occasionally a need to change child rearing practices is recognised, but because of social pressures the person finds it difficult to implement the change. I am reminded of a young mother who asked if she could give solids to her nine months old baby in my flat, because, she said, "He is hungry and my husband and mother say he is too small to eat".

Although communities express a concern about the illness of their children, I do not believe they associate this with nutrition or hygiene, or see a need to change their child rearing practices. One group, having indicated they did not want to participate in the Institute's program, said simply, "Our people know how to look after children". Aboriginal people have told me that in traditional life, solids were introduced to infants at about one year of age. We believe, for the health of the child, they should be introduced earlier than this. Because of differing beliefs about cause of sickness, it is unlikely that a mother will see the knowledge I have imparted about early introduction of solids as relevant. If she applies the knowledge, it is likely to be for her goal of expressing a relationship, rather than my goal of improved health.

Unless the community defines the need, any attempt to conduct a program will be an imposition, and chances of persistent behaviour changes are minimal. On one occasion, I was told by Europeans that a particular community had asked for a person to teach them how to look after their new houses. After spending time with this group in an informal situation, it became clear they wanted a white person to clean their houses, not to teach them how to do it. Either they did not see the need for cleanliness and co-operated with the Europeans who obviously did, by so doing improving the relationship between the two, or they wanted a clean house, but being unable to refuse relatives, saw the intervention of a white person as a way of achieving this. The situation could be complicated by the fact, that the concepts of neatness and cleanliness are likely to be confused. It is neatness, which is irrelevant to hygiene, that is more likely to be perceived by the Aboriginal people. In this situation, the white person appointed to the position of Health Educator, was unlikely to achieve her goals of teaching Aboriginal people to look after houses.

The Institute provided, as far as was practicable, a climate where Aboriginal people could act in an Aboriginal way, and my involvement with Aboriginals has been on their terms, as it were.

I have found, that as my relationships have developed, my ability to function as a teacher has decreased. On two occasions recently, when I visited communities with the aim of talking to them about the Institute and seeing if they were interested in participating in the programs, I was warmly greeted and taken to the camp where we spent happy hours together. When I broached the subject of my work, they suggested, after an uneasy silence, that perhaps another group may want to go. They appeared delighted to accept me as a friend, but not as a teacher.

I have been able to contrast this feeling expressed about my European teaching role, to that expressed about my European nursing role. People have come to me with acute medical conditions, usually infection or trauma, and asked me as a nurse to "do something". They accept me as a nurse, because in this role I am able to meet a need *they* have defined.*

I have felt a difference in atmosphere when I am contributing to goals defined by Aboriginals, that is, building a relationship or meeting an acute medical need, to when I am trying to achieve goals defined by me, that is, helping people to see a need to change their health practices. When I am with them as a friend, it is good. We talk about relatives and times we have spent together. There is laughter and often long periods of easy silence. When I start to talk about teaching or my work, the atmosphere changes either to one of uneasy silence with withdrawal of eye contact, or to expected European behaviour, for example, politely co-operating in discussion around the topic I have introduced.

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* The results of a modified Osgood semantic differential test which I asked a small sample of Aboriginal people on a settlement to participate in, supported this impression, that European roles of sister, teacher, storekeeper, etc. were accepted to meet needs *defined by Aboriginals*, but the affective aspect of relationships with the Europeans was more important than were their roles.

I think it is significant that when I was trying to find out what the people remembered about my teaching, I found it impossible, when I was with them as a friend, to elicit any information. I produced photos taken during the course they had attended, and similarly the teaching aids used. Their response was a commentary on the human contacts recalled during this time. With this same group of people attending a meeting called by me on another course in Alice Springs, the production of the same pictures caused them to repeat, almost perfectly, the aspects of nutrition and hygiene discussed during the course. These observations and feelings were supported by one Aboriginal group who, while commenting about my visits to them said, "It is good. She just visits and sits down and talks. We don't feel as if we have to say anything or have a meeting". I believe this comment also indicates how these Aboriginal people feel about the numerous meetings they attend when advisors visit to consult with them. If the desire for the contact is initiated by the Aboriginals it is different.

The significance of relationship to Aboriginal people can be illustrated by the role food plays in their society. What we consider food items, they 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 someone is offered part of the kangaroo, the unspoken message accompanying the gesture is not "Here is some first-class protein. If you eat it you will be strong and healthy" but, "You are my relation". If the person refuses, he is not denying his future health, but is denying the relationship.

If, when I am with a group of Aboriginal people I catch a goanna, I know how to divide it, what I am entitled to eat, and, depending on my interactions with that particular group, to whom I give the appropriate portions. It is quite impossible for a tin of corn beef produced from my tuckerbox to replace the ritualistic and social functions of the goanna. Repeatedly, I have noticed, that when bush food is divided, there is an atmosphere of unity and confidence. When European food is produced, this atmosphere disappears and is replaced by 'everyone for himself'. My application of European 'good manners' in this latter situation, has often resulted in my going hungry. We think of the primary function of food in terms of physiological metabolism, whereas perhaps one could say, they think of it primarily in terms of social metabolism.

Availability of food, and relationship of others to the persons who harvested it, are the basis of the nutritional distribution in traditional societies. The fact that the food tastes good, and stops the feeling of hunger, is of secondary importance. European food fulfils the latter desires. Foods preferred are fresh meat, eggs, butter, fruit, white bread, sugar and tea. In some cases Aboriginal people are integrating these foods into traditional eating patterns. I have observed this mainly when there is no money available. The items shared tend to be flour, sugar and tea, because these are relatively less expensive, are bought in large quantities when money is available, and they keep. The result of this integration is not what we would call a balanced diet, and the integration is intermittent. In one community I was told, and in several I have observed, that if money is available, this is distributed to fulfil obligations. Food is bought for the consumption of the individual or immediate family.

As part of my teaching, I attempted to integrate European food into Aboriginal eating patterns. To achieve this, I tried to communicate my understanding of nutritive values of foodstuffs. I adapted my knowledge in a way I thought would be meaningful to Aboriginals, for example, disucssing two food groups recognised by them (*kuka* : meat, and *mai* : everything else). I learnt more about bush food so I could make the adaptations more meaningful, but the Aboriginals continued not to accept my statements of the equivalence of items of bush and European food. I now believe, that because of differing priorities and goals, such adaptations are not meaningful at all. So much for my attempts to integrate European food into Aboriginal eating patterns, which I tried to do because a previous attempt to adapt Aboriginal eating patterns to European food, that is, amoun- of food eaten and the times at which it was eaten, was met with passive resistance and active rejection. This was my experience in Arnhem land five years ago.

From personal experiences as a Health Worker with traditionally orientated Aboriginal people, two things have become apparent :

1. Knowledge about European food and hygiene practices taught, is retained by the participants in the programs, and in some instances this has been passed on to other members of their group. If asked to do so, these people can repeat accurately the nutritional needs of an infant or the germ theory. They are also able to perform actions necessary to apply this knowledge, and on occasions have done so for a limited period, for example, one group bathed babies for three weeks after their return home. In most cases I have

found no evidence of lasting change. I believe this is because of differing values.

2. The Health Educator, as she interacts with the Aboriginal people, finds herself in two roles : a relationship role and a teaching role, and these tend to be mutually exclusive.

The aim of any education program is not to solve problems. Problems are never solved : an intolerable set of problems is replaced by a tolerable set. An educator should, by working through the expressed needs of a community, bring people to a capacity where they can determine their own problems and create their own methods to alleviate them. Unless this occurs, the program is not educational but causes the client to become dependent. In order for the program to have its desired effect, the educator must have a thorough knowledge of the communities with which she is working. She must learn from them how they see the world. Only then can she achieve her aims and help her clients to perceive alternatives. Effective communication can only be achieved by working from the present knowledge and values of the clients.

When working with traditionally orientated Aboriginal groups, to be able to understand them,it is necessary to work in the context of relationships. While doing this, I have found that the nature of these relationships is such that it precludes my teaching role. Once relationships are formed, I believe health teaching becomes irrelevant to the Aboriginal people because their ultimate goal has been achieved. It is this problem which I suggest may be one common to many working with traditionally orientated communities.

To summarize :-

> The nature of the relationship which develops in response to the need to interact in a manner meaningful to the community, is such that it tends to prevent the community worker filling the role which is the reason for his/her presence in the community.

If this is a general problem, the question is, "What is to be done to dissolve this bind?" I have no answer, but believe it is a problem to which the ingenuity and expertise of social scientists and others working in the field could be applied.

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