The ongoing impact of colonisation on childhood obesity prevention: a First Nations' perspective

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As researchers (HS, HB, AC) whose work focuses on ensuring that the voices of those most affected by the research are central to co-designed solutions, we are in the privileged position of capturing the stories of lived experience behind the data. In this perspective, a story of lived experience illustrates the need to reframe the childhood obesity prevention narrative towards a more equitable approach that ensures strategies reach the most socially disadvantaged populations. Here we come together to share Louisa Whettam's story, which captures common themes depicting drivers of disparities in obesity prevalence among First Peoples of Australia. We thank Louisa for sharing her personal story in this perspective piece as part of highlighting First Nations' perspective in relation to the ongoing impact of colonisation on childhood obesity prevention.

Louisa is a resilient, inspirational and passionate advocate for First Peoples. As a Salzburg Fellow, Louisa played a determining role at the Salzburg Global Seminar "Halting the Childhood Obesity Epidemic: Identifying Decisive Interventions in Complex Systems" held in Austria in December 2019.[1] At this meeting, Louisa shared a deeply moving story, describing the impact of colonisation on the health of Australia's First Peoples. Louisa spoke of how the forcible removal of children, racism and the loss of land and culture have contributed to intergenerational experiences of trauma,[2-4] which has been graphically depicted in Supplementary Figure 1. Louisa's story opened up the space for conversations about the impact of colonisation on First Peoples, in Australia, New Zealand and the United States. Through these discussions, the imperative to recognise the impact of colonisation in order to address health disparities became clear. In telling her story, Louisa also reminded us that there is an individual, as part of a family and a community, with a story behind every statistic. In contrast, statistics often present health and social deficits of a population without providing context of the determinants of disparities and overlook the significance of First Nations' cultures.

Louisa's story brought to the forefront that policies and actions to address childhood obesity need to recognise racism and related stressors, as adverse child experiences and social determinants of obesity, and need to understand the lived experienced of those who have been impacted by racism and intergenerational experiences of trauma.[1,5,6] There is no one-size-fits-all solution to address childhood obesity and the disparities experienced by First Peoples. Researchers, practitioners and policy makers need to listen to the stories of individuals in order to understand and address the determinants of health. Louisa has continued to collaborate with Salzburg Fellows based in Australia, the US, Argentina and Ireland as they re-think the impact of colonisation on the equitable access to nutrition and obesity prevention of First Peoples that they serve. With Louisa's permission, we continue to share her story here.

Ongoing impact of colonialism on disconnection from culture and country

Louisa knows first-hand the trauma of being disconnected from her community, her people, her identity and, ultimately, connections to culture and resources that brought with it a sense of security and wellbeing.[7] For Louisa's ancestors, this meant being forced from their lands and natural food sources, working for mere food rations rather than fair wages, which in turn led to poor economic and nutritional outcomes. In Louisa's own childhood, there was the experience of being separated from kin in Gilgandra, New South Wales (NSW), when her family moved to Orange (NSW) as part of the government's assimilation policy:

In Gilgandra, my memories as a child, I remember my Dad was away working in the shearing sheds, my Mum was at home looking after us children. When it came to food, there was a sharing of food. My Uncles and my Dad would go and get a sheep from properties from local farmers. And then divide the meat up among our families. The dripping fat from the sheep was used to cook with, but also used as butter on bread, scones and damper. The firewood was also shared. In Orange, we didn't have that other family support around us and also the food source as well. I remember going to school at times and not having lunch and also waking up at times and not having any breakfast. Even in high school I remember not always having lunch. Whereas when were back home in Gil where we had family, we had the culture of sharing food, but in Orange we were isolated from kinship (and that) cetainly impacted on our food source.

What was considered a gain (in terms of higher-quality housing) from a colonial viewpoint, simultaneously signified a deepening sense of loss and disconnection from their community in Gilgandra and hence culture; an impact that transcended across her family, social and community dynamics:

Both parents had to work in Organge to put food on the table. My Dad would do the day shift and my Mum would do the night shift so that someone would always be home with the kids (three girls and two boys). Two of Dad's nieces were murdered and that experience had a great impact on him, so he was always worried about us as girls.

Louisa also spoke of her family's experience of forced removal of a child and the ongoing trauma this has caused her family:

> My parents also had a real fear of child safety (also referred to as child protection) because their first baby was taken away from hospital after my mother gave birth. The 1967 referundum brought about First Peoples being counted in the census and this is where my Dad always had a fear of census time, particularly questions about how many children were in the household. As a child, you are told: 'you don't talk to anyone, you don't open the front door, and you don't tell anything because they will come and take you'.

These experiences of trauma are pervasive, with cumulative and intergenerational effects.[8,9] The impacts of trauma can affect parenting, family functioning and children's attachment relationships with their care givers, with lasting effects on children's development.[10]

Colonisation, racism and mistrust of health and social care systems

It is clear that the intergenerational impact of colonialism, including The Stolen Generation, extends beyond a disconnection from family, land, culture and inequitable socioeconomic conditions. The Stolen Generation in particular, which refers to the Australian Government sanctioned forcible removal of children from their families, from where they were placed in non-Aboriginal homes or institutions as part of Protection and Assimilation policies during the 19th and 20th centuries aiming to eradicate Indigenous cultures,[11,12] brings about imagery of unimaginable injustice and despair. It has also shaped generations of Australian First Peoples who are fearful of being controlled and harmed by the systems, structures and policies stemming from colonialism. Essentially, policies and practices that in certain instances still serve to reinforce that these fears are indeed warranted; for example, Aboriginal Australian children are 10 times more likely to be removed from their families as non-Aboriginal children.[13] It would seem that even many decades later, systems that are intended to care and support all Australians have instead compounded historical wounds and mistrust.[14]

> In 1989, when I had my first child, they had me in labour for 36 hours, they were even trying to pull him out of me with the forceps until the head doctor came in and said: 'what are you doing? You need to get her into theatre right away, she needs a cesarian'. Then afterwards,

I was refusing penicillin because I am allergic to it. And the doctor who was treating me actually said to me: 'if you were out in the bush, you would be dead, you wouldn't be able to have this baby'. In 1993, when I had my second child, my doctor was really good. But the staff in the hospital stuck me in a room and never came in the room. So my room was never cleaned and they kept the food at the door, which was always closed, so I never knew that the food was there, until my doctor came in and asked me if I had lost my appetite. Not even a knock to say it was there. Not even someone coming to clean the room. Both times I was by myself. I didn't have any family around me. In the Northern Territory there is an Aboriginal midwife that is making a big difference working with government and health, doing Birthing on Country (an integrated, holistic and culturally-appropriate model to improve birthing outcomes for Aboriginal and Torres Strait Islander mothers and babies[15]), and making sure that there are Aboriginal workers in the hospital. Even though there has been disruption of the system to make change, we still have a long way to go.

As illustrated above, Louisa's interactions with systems that do not incorporate an understanding of cultural perspectives reflect historical and ongoing efforts to dismiss the voices of First Peoples, which further compounds experiences of trauma. It was only when Louisa started working in a community services role where she was asked "how do you feel?" as part of the organisation's daily routine "self-care" check-ins, that it dawned on her that it was the first time where she had really been invited to contemplate the answer. Identifying how she felt did not feel like a natural process for Louisa, and in her experience:

> As First Nations people we have faced a lot of atrocities and I think we continue to move forward regardless of the battles that we have to face and a system that continues to be a perpertrator. We are resilient as First Nations people.

Louisa has shared only a tiny amount of her vast traumatising experiences. The lived experience of systemic racism is clearly evident here and one health consequence of this racism is graphically depicted in Supplementary Figure 1.

Intergenerational experiences of trauma and overweight and obesity risk among First Peoples

We now know that abuse, neglect and intergenerational experiences of trauma,

such as those resulting from pervasive racism, increase the risk of the development of obesity.[16] Australian First Peoples are over-represented in obesity prevalence rates.[17] Indeed, high levels of chronic and cumulative stress stemming from loss of culture, identity or lack of social support are key determinants of overweight and obesity.[7,18] Louisa's story emphasises the role that intergenerational and ongoing experiences of trauma can play in maintaining these links[2]:

> I don't think that dietary practices (i.e. access to fruit and vegetables) growing up shaped me very well because I don't have good eating habits. It's a whole new learning. Back then for me, you lived to survive and you lived to try and thrive. Now, you are able to access education around health and nutrition but there has been so much damage. With all the trauma it is hard to just transition out of that head space and simply focus on the fact that these are the food sources that you should be having that are going to help you thrive physically. Because there is so much emotional trauma and you go back to that default mode of surviving. I have knowledge about what is good and good healthy food. Now they are saying that dieting doesn't work, it is about changing your lifestyle. But if you have been in a lifestyle all your life, your history, your ancestors, your whole life is about trauma, how are you supposed to transcend that, change, and tip it on its head? I will eat healthy food but will tend to go back to that default mode. And sometimes today it is still expensive to eat good food, especially when you are feeding a lot of people, you buy what will go around and is going to last.

Louisa highlights that action to address obesity must therefore address the social determinants of obesity, including the impacts of the loss of land and culture for First Peoples. Additionally, Louisa argues that the current food environment is inadequate to address disparities among First Peoples:

> You won't find many healthy food chains in our communities. Instead, there are always fish and chip shops. Fast food restaurant chains that are more accessible. Compared to an affluent community, to me there is a massive difference just in that alone.

Food and nutrition have not been prioritised on the national Aboriginal health policy agenda[19] and Aboriginal organisations have not been sufficiently involved in nutrition policy processes.[20] In limited instances where local government public health policies address nutrition among First Peoples, the focus is on nutrition as an issue of individual responsibility, rather than an

issue of community or social responsibility.[21] An alternative approach to nutrition policy development is one that embraces co-design supporting Aboriginal organisations to participate in the policy process, operationalising First Nations peoples' right to self-determination.[20]

Additionally, the complex trauma that has been experienced by First Peoples, including colonisation (forced separation from land, community, family and cultures), racism and intergenerational poverty and inequity, are not addressed in current obesity policies, health promotion or strategies.[7] Many First People in Australia view current individualistic Western approaches to obesity management as insensitive and irrelevant to their culture and values, which are instead centred on connectedness to each other and the environment.[7] As a result, a biomedical model focus on diet and exercise and omission of racism-related factors, can have unintended effects of discouraging engagement in healthy lifestyles.[7] Implementing a lens of 'personal responsibility' perpetuates stigma and racism among First Peoples.[17]

There has also largely been a disinclination to consider the social and political context driving racialised health inequalities among First Peoples.[22] It is clear that globally, not just in Australia, there is an urgent need for equitable solutions to be co-designed with marginalised populations that *both* recognise *and* address racism and racism-related stressors, not solely race/ethnicity, as social determinants of health and obesity.[1,23]

Solutions for targeting drivers of obesity inequity for First Peoples

It is evident there is an urgent need to include food and nutrition as priorities on the national Aboriginal health policy agenda;[24] this will require consensus from stakeholders and a compelling policy narrative about how priority nutrition issues should be addressed.[19] Current evidence for improving nutrition across the lifespan for First Peoples suggests that community involvement and control over the development and implementation of food and nutrition programs has the greatest potential to improve nutrition-related health outcomes. Ideally, these programs will include multiple components and address the underlying causes of nutrition issues.[19] Foley and Schubert[25] advocate for strengths-based approaches to public health nutrition among First Peoples, which includes working

with existing individual and community assets, rather than focusing on deficits, and empowering individuals and communities to create conditions for optimal nutrition among First Peoples. Public health approaches also need to incorporate historical trauma theory perspectives to shift the blame, shame and guilt from the individual to systematic root causes of health disparity, including racism.[2,5] There is a growing trend towards trauma informed approaches in the health and child and family sectors[26,27] and an increased emphasis on community-designed programs focused on healing and trauma recovery. A Critical Race Theory framework may also be useful in facilitating effective advocacy, program implementation and evaluation of efforts to address determinants of racism (including historical and socio-political roots), which may improve racial equity among health services, systems, and society overall.[28,29]

There are promising signs of progress. A National Agreement on Closing the Gap has been developed in partnership between Australian governments and the Coalition of Aboriginal and Torres Strait Islander Peak Organisations.[30] This formal partnership enables Aboriginal and Torres Strait Islander peoples' voices and expertise to guide decision-making and action to achieve the Closing the Gap targets.[30] These partnerships between governments, health providers and Aboriginal Community Controlled Health Services are also essential to ensure the experiences and expertise of First Peoples are represented at all levels of the healthcare system.[31,32] From Louisa's perspective, she recognises that it is equally important to partner with people who can assist to navigate the 'Western system' to enact and advocate for change among those who perpetuate inequality. Examples from anti-racism (i.e. Civil Rights, Black Lives Matter) movements have shown that partnering with minority groups helps to maintain momentum, provide powerful voices needed to break down siloes and gain the attention from political leaders.[33,34] However, we also need to push for a cultural shift where the First Nations' voices are heard and valued in their own right and this means recognising the true history of Australia:

> Healing trauma will remain challenging until there is national recognition, across all levels, of Gari Yala ('speak the truth' in Wiradjuri language; in this context about Australia's history). Because when you're not

recognising it, and racism is still happening, and the system is still doing a lot of damage to Aboriginal people, you're still traumatising them. So unless you are educating, and people have a true understanding of the Gari Yala, then not all people will want to change a system that continues to traumatise First Nations people, as well as other cultures that are escaping horrific systems and entering this country.

Conclusion

Louisa is an influential community leader and role model to First Nations and non-Aboriginal people alike. She shared her story here because she was invited to participate in the Salzburg Global Seminar, a privilege no other Aboriginal person from Australia has experienced. While we acknowledge that there is diversity among First People of Australia, Louisa's voice is powerful in representing common shared experiences beyond her own. Health for First Peoples in Australia encompasses more than the physical wellbeing of an individual, extending "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".[35] As such, (re)connecting to culture and country is both a protective factor and necessary therapeutic step for mitigating experiences of intergenerational trauma and regain health.[3,7] Through nurturing connections to culture and country and advocating for First Nations peoples' voices to be heard, Louisa is working towards closing the inequality gap experienced by many First Nations people, so that future generations of Australia's First People have every opportunity to achieve their full potential.

Acknowledgements

influencing intergenerational links between maternal and childhood obesity development from as early as conception. Alexandra Chung is a Salzburg Fellow, Public Health Nutritionist and Research Fellow at Monash University focused on equity in obesity prevention policies. Helen Skouteris is a Salzburg Fellow, a Monash Warwick Professor at Monash University with expertise in childhood development and obesity prevention across the life-course, and Director of CRE HiPP.

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Supporting Information

Additional supporting information may be found in the online version of this article:

Supplementary Figure 1: Childhood obesity in Indigenous Aboriginal communities.