Addressing Uncomfortable Issues: The role of White health professionals in Aboriginal health

Thesis submitted by

Annabelle Wilson

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School of Medicine, Faculty of Health Sciences

Flinders University

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Dedication

This thesis is dedicated to my Grandmother, Mignon McDonald (1926-2002), whose memory reminds me to stand up for what I believe in.

Acknowledgements

There have been many people who have assisted me in completing this PhD journey over the past three and a half years.

I would like to acknowledge and thank all of the Aboriginal people who have had input into this research. This includes a significant number of community members and Aboriginal workers in the two communities in which this research is based. It is difficult to express in words the deep impact that you have had on this research and on myself. Through sharing your life stories with me and challenging me as a White dietitian and researcher, you have greatly enhanced my understanding and appreciation of the complexity of Aboriginal health. You have shown me that history can never be forgotten, and I will endeavour to convey this message through my future work. For your input I will always be grateful.

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Thank you to the *eat well be active* Community Programs and SA Health for providing the opportunity to undertake this PhD and for providing financial assistance, including a scholarship in 2008 and a "top-up" scholarship from 2009-2011. I also thank them for being flexible enough to support me to follow an area of inquiry that was my interest. I must also thank the health services and other sites that have provided a physical "space" for me to sit and complete this research, as

well as acknowledge the financial assistance I received in the form of an Australian Postgraduate Award from 2009-2011.

Finally, I would like to thank my family. Without your unconditional support, this journey would not have been possible. To Mum, Dad, Katie and my boyfriend Trevor - thank you for your constant encouragement, discussion and distraction from this research when I needed it most.

Declaration

I certify that this thesis does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

Signed

Annabelle Wilson

Abbreviations

ACEO	Aboriginal Community Education Officer
AEW	Aboriginal Education Worker
ABS	Australian Bureau of Statistics
ACRAWSA	Australian Critical Race and Whiteness Studies Association
AHCSA	Aboriginal Health Council of South Australia
AHW	Aboriginal Health Worker
APD	Accredited Practising Dietitian
CALD	Culturally and Linguistically Diverse
CBOPI	Community Based Obesity Prevention Intervention
CINAHL	Cumulative Index to Nursing and Allied Health Literature
CPD	Continuing Professional Development
CRCAH	Cooperative Research Centre for Aboriginal Health
CSR	Critical Social Research
CSS	Critical Social Science
CT	Critical Theory
DAA	Dietitians Association of Australia
EWBA	*eat well be active*
FAHRU	Flinders Aboriginal Health Research Unit
HIA	Health Impact Assessment
JADA	Journal of the American Dietetic Association
N & D	Nutrition and Dietetics
NAIDOC	National Aborigines and Islanders Day Observance Committee
NHMRC	National Health and Medical Research Council
OP	Obesity Prevention
OT	Occupational Therapist
PHAA	Public Health Association of Australia
SA	South Australia
SANN	South Australian Nutrition Network
SDoH	Social Determinants of Health
USA	United States of America

Note on Style

In this thesis, I use British spelling unless part of a direct quote with American spelling. This means that for concepts posed by American writers – for example "color evasion" and "race cognizance" I have used the British spelling, "colour evasion" and "race cognisance", unless part of a direct quote.

To refer to the *eat well be active* Community Programs and *ewba*, I use lower case italics, as stipulated in the Style Guide for this program. However when a sentence starts with *ewba,* I capitalise it i.e. *Ewba.*

To maintain confidentiality, I have deidentified the majority of people and places in this thesis. The main exception is when I refer to Aboriginal people who were mentors to me for this research. They have all given permission to be named in this research.

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Publications and conference presentations arising from this research

Wilson A, Magarey A, Jones M & Kelly J 2011, Strategies for best practice in community-based obesity prevention in Aboriginal communities, paper to be presented at 21st Australian and New Zealand Obesity Society's Annual Scientific Meeting, 20-22 October 2011, Adelaide, Australia.

Wilson A, Magarey A, Jones M & Kelly J 2011, One dietitian-researcher's experience with a paradigm shift, paper presented at 1st Critical Dietetics Conference, 19-20 August, Toronto, Canada.

Wilson A, Magarey A, Jones M & Kelly J 2011, Bringing Race into popular dietetic discourse, paper presented at 1st Critical Dietetics Conference, 19-20 August, Toronto, Canada.

Casey L & **Wilson A** 2011, Using relationships to enhance the translation of evidence to practice in Aboriginal health, poster presented at 29th Dietitians of Australia conference, 26-28 May 2011, Adelaide, Australia.

Gregoric C & **Wilson A** 2011, Cross disciplinary collaboration in dietetics and education, poster presented at 29th Dietitians of Australia conference, 26-28 May 2011, Adelaide, Australia.

Wilson A, Lappin C, Leaver C, Manders M & Reid M 2011, From evidence to practice in Aboriginal health: challenges and potential solutions for practitioners, Workshop presented at 29th Dietitians of Australia conference, 26-28 May 2011, Adelaide, Australia.

Wilson A, Magarey A, Jones M & Kelly J 2011, Alternative approaches to building an evidence base in dietetics, poster presented at 29th Dietitians of Australia conference, 26-28 May 2011, Adelaide, Australia.

Casey L & **Wilson A** 2011, Bridging the gap: building relationships and sharing the journey together, paper presented at 20th Australian Health Promotion Association conference, 10-12 April 2011, Cairns, Australia.

Wilson A, Magarey A, Jones M & Kelly J 2011, Promoting and improving Aboriginal health: the role of structural factors and the self, poster presented at 20th Australian Health Promotion Association conference, 10-12 April 2011, Cairns, Australia.

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Wilson A, Magarey A, Jones M, Kelly J 2010, Aboriginal peoples' experiences with a mainstream healthy eating and physical activity program, in the Collaboration of Community-based Obesity Prevention Sites (CO-OPS) book of Case Studies for Community-based Obesity Prevention, Paul Kelly Design to Print, Geelong.

Wilson A, Magarey A, Jones M, Kelly J 2010, Community based obesity prevention in two Aboriginal communities, paper presented at Collaboration of Community-based Obesity Prevention Sites (CO-OPS) National Workshop, 20-21 October 2009, Melbourne, Australia.

Wilson A, Magarey A, Jones M, Kelly J 2009, Aboriginal peoples' experiences with a mainstream healthy eating and physical activity program, paper presented at Collaboration of Community-based Obesity Prevention Sites (CO-OPS) National Workshop, 26-27 November 2009, Melbourne, Australia.

Wilson A, Magarey A, Mastersson N & Jones M 2008, Transferability of evaluation tools from a community-based, childhood obesity prevention intervention for use by practitioners, poster presented at Public Health Nutrition Conference, 11-12 July 2008, Adelaide, South Australia.

Summary

This research investigated the role of White health professionals in addressing Aboriginal health in South Australia. Set within the discipline of nutrition and dietetics and the area of obesity prevention, it explored the practice of White health professionals from the point of view of Aboriginal and White workers.

This research arose from practice dilemmas I experienced as a dietitian working in rural and remote South Australia. Willing and interested to work in the area of Aboriginal health, as a new graduate dietitian I lacked the confidence to do so. Hence, I embarked on this research in order to explore the challenges involved in working in Aboriginal health in greater depth, with the view of suggesting some ways forward for myself and other White health professionals working in this area.

The setting for this research was the *eat well be active* Community Programs, a community-based, childhood obesity prevention program in South Australia. Located in one rural and one urban community, I sought to explore how this program was delivered to the Aboriginal communities within the larger rural and urban communities. Throughout the course of the research, I broadened the focus to include dietitians across South Australia, in order to assess the wider context in which White health professionals work in Aboriginal health in the area of nutrition and dietetics.

In order to conduct ethical research, I worked closely with Aboriginal community members and workers in both *eat well be active* communities, through building and maintaining relationships and activities of reciprocity. I engaged in reflexive research where I took note of my observations, reactions and learnings and used these to inform my actions, practice and research. In engaging in reflexive research, I assessed myself and my position, including identifying my Whiteness and the impact of this on the research. I also underwent a paradigm shift when I identified that the initial plan for the research was not suitable. This research is positioned in a social constructionist epistemology and uses a critical theoretical approach, specifically theories of structuration and emancipation. Critical social research and reflexivity are the methodological approaches. I kept a

reflexive journal and conducted 41 semi-structured interviews with White health professionals and Aboriginal health workers and one focus group with White health professionals; all of which formed the data for this research.

This research identified that there are a number of elements to the practice of White health professionals that make it ideal when they are working with Aboriginal communities. However, such ideal practice does not always occur and this research sought to identify why. The organisation, profession and individual were identified as systems within the wider system of Aboriginal health. Within these systems, I identified structures (rules and resources) that either constrain or enable the practice of White health professionals with Aboriginal people. While many White health professionals focussed on external factors that constrained their practice, using structuration theory, I identified the role of individuals in creating and maintaining barriers and enablers, thus highlighting their agency. Therefore, the role of individual, White health professionals in addressing factors that constrain or enable their practice was highlighted. This included an awareness of oneself, in particular one's Whiteness. It was also identified that White health professionals progress through a number of stages in their work in Aboriginal health, from not knowing how, to being scared, to finding it too hard and ultimately being able to practice regardless of barriers.

In summary, this research identified that moving forward in Aboriginal health requires White health professionals to look at themselves, which generally requires them to address uncomfortable issues.

1. Introduction

This research grew out of my desire, as a White dietitian, to find the "right" way to work in Aboriginal health. As a new graduate dietitian working in rural and remote South Australia (SA) in 2007 and 2008, I struggled to work with Aboriginal clients and communities in ways that simultaneously met their needs and the expectations of the health service I was working for. It was for this reason that I began a PhD, with the intention of identifying "best" ways for White dietitians and other health professionals to work in Aboriginal health. I hoped that this research could help dietitians who are in a similar position to me when I was a new graduate: unsure and slightly fearful, but desperately wanting to help.

For the last three and a half years, I immersed myself in Aboriginal health. I worked in partnership with Aboriginal workers and community members. I learnt about Aboriginal culture and history by spending time with Aboriginal people. I learnt the power of listening, and I listened to many stories. I stepped out of my comfort zone and learnt what it feels like to be in the minority. I identified my privileged position as a non-Aboriginal, White, young woman and learnt how to incorporate an awareness of this position into my practice as a dietitian. I asked many questions, for which I did not always find answers. I considered alternative approaches to research and engaged in a paradigm shift in order to conduct more appropriate and meaningful research. In doing so, I have re-oriented many of my initial ideas and expectations about working in Aboriginal health. These are just some of the elements of my journey; a journey that I document and share through this thesis.

This research uses a critical approach and is concerned with asking questions. How do White health professionals work in Aboriginal health? What is their role in addressing Aboriginal health? What makes their work hard and what makes it easier? These are just some of the questions I ask, in the context of the discipline of Nutrition and Dietetics (N & D), and the area of obesity prevention (OP). As I will demonstrate, there is a lack of research that addresses these questions in the context of N & D and OP. My interest in N & D as a discipline comes from my professional background as a dietitian. My interest in OP also stems from my professional background, and that the opportunity to undertake this PhD was provided through the *eat well be active (ewba)* Community Programs, a community based, obesity prevention intervention (CBOPI) in SA.

In the remainder of this Introduction, I further explore the practice dilemmas that led to this research, briefly highlight the contemporary issues surrounding the health and nutrition of Aboriginal people in Australia, identify the lack of research in N & D and OP in relation to the role of the White health professional in Aboriginal health and outline the research and thesis structure.

1.1. *Practice dilemmas that led to this research*

I first developed a strong interest in Aboriginal health through my work as a dietitian in rural and remote SA in 2007 and 2008. After graduating with Honours in Nutrition and Dietetics in 2007, I received a scholarship to work in rural SA. I was an enthusiastic, new graduate dietitian based in a rural location but also responsible for outreach services to two remote communities. Due to the high population of Aboriginal people in these locations, my job involved significant work with Aboriginal communities. Expected by the health service to engage in one-to-one clinical consultations and health promotion activities during the single or bimonthly plane trips to these communities, I had a challenge on my hands. Being a new graduate dietitian, I had very little training in working with Aboriginal communities, apart from three Aboriginal cultural awareness sessions conducted at university. I found there was a lack of information about "how" to work with Aboriginal communities. Consequently, I was concerned about my work with the Aboriginal community, and wanted to get it "right".

Delivery of programs to Aboriginal people was a priority of the health service. However at a higher level, there appeared to be less consideration of (a) the perceived needs of the community members and the relationship of this to the needs of the health service, (b) resources and capacity within the communities needed to deliver outcomes and (c) feasibility of delivering outcomes within the health service's ideal timeframe. Importantly, I now acknowledge that while I experienced these issues within the health service I was working for, they are not isolated to this one organisation.

Such disconnect between the health service and the communities was not necessarily the "fault" of the health service. Over my year of work I came to appreciate that the milestones and goal posts set by mainstream[1] services and funding bodies do not always match up with the needs and

[1] In using the term "mainstream" I am referring to health services delivered for the entire community, not specific to the Aboriginal community. This is in contrast to Aboriginal community controlled health services.

capacity of communities. A lack of communication and shared experiences between the two seemed to exacerbate the problem and I often felt like a negotiator trying to find a "middle" outcome that suited the needs of both. Additionally, I became quite disillusioned when I could not "find" 'the "right" way to work. I was anxious, and when I thought that I was not making a difference, I assumed that must be because of my inadequate practice.

This, as well as the many discussions I had with Aboriginal people who lived and worked in those communities during that one year, inspired me to do a PhD and create some evidence for how mainstream services and Aboriginal communities may work together in a way that better suit the needs of the Aboriginal people, and ultimately lead to better outcomes in their health and nutrition. I also wanted to encourage conversations between dietitians about the difficulties of working in Aboriginal health and to normalise these difficulties, rather than having dietitians think that they are something to be ashamed of, as I did.

Throughout this PhD journey, my goals and ideas have changed significantly. While this research does still consider how one specific, mainstream program has worked with Aboriginal communities (the *ewba* Community Programs), this research has become so much more. It is not only about whether programs and practice of White health professionals with Aboriginal people are well delivered. It critically considers the prerequisites for delivering a good program in Aboriginal communities. To allow such a change, I engaged in a deep self-reflection and paradigm shift, which will be explored in-depth in this thesis.

1.2. *Australian Aboriginal people: introduction to health and nutritional status*

In Chapter 2, I demonstrate that the health and nutritional status of Australian Aboriginal people is significantly poorer than that of non-Aboriginal Australians. Australian Aboriginal people suffer from preventable, lifestyle diseases such as diabetes and kidney disease at much higher rates that non-Aboriginal Australians (Vos, Barker et al 2007a). Aboriginal people are more likely to be overweight or obese than non-Aboriginal people (ABS 2008a). Their life expectancy is significantly less (ABS 2010). Aboriginal people have had their traditional food supply removed, land taken away and families torn apart, all of which have significantly affected their health and nutritional status (Lee 1996).

Clearly, there is an urgent need to address Aboriginal health. Nutrition can contribute to the development or prevention of lifestyle diseases and the development or prevention of overweight and obesity (National Health & Medical Research Council 2005). Consequently, it can also influence life expectancy. Addressing the nutrition of Aboriginal people in Australia is one way to address these shocking health statistics. This research asks what White health professionals, working in N & D or OP, can do to address these health issues. It uses a Whiteness theory lens to take the position that it is the responsibility of White health professionals to bring about change in Aboriginal health.

1.3. *Absence of discipline specific research*

Within the mainstream dietetic and OP literature, there is a plethora of information about the poorer nutrition and weight status of Aboriginal people, both in Australia and overseas, compared with non-Aboriginal people. There is information about nutritional status, malnutrition, growth, results of dietary interventions targeting diabetes, food supply, food security in Aboriginal populations and factors at the level of infrastructure that impact on the health and nutritional status of Aboriginal people. Similarly, it is well-known within the nutrition profession in Australia that nutritional intake of Aboriginal people, especially in rural and remote settings, is "poorer" than that of non-Aboriginal Australians, which is associated with "poor" access to food and "poor" food quality in rural and remote locations. Such literature constructs and reinforces nutritional issues of Aboriginal people as "Aboriginal problems". These issues will be explored in depth in Chapter 2.

However, there is a lack of research that considers the nutrition of Aboriginal people as a problem of White health professionals, including dietitians. There is also a lack of literature in the discipline of N & D that looks at what White health professionals can do to help close the gap between Aboriginal and non-Aboriginal people with respect to nutrition. While similar writings are present in disciplines including nursing, social work, medicine and occupational therapy, these conversations are yet to be had in N & D and OP. There are some writings about the sociology of food and nutrition, but such information is not always readily accessible to many dietitians and OP practitioners/ researchers who generally lack training and familiarity with the concepts needed to quickly and easily interpret and use this work. Furthermore, as will be demonstrated in Chapter 5, almost all this research is based in the positivist paradigm and even when a "qualitative" approach is used, an epistemological/ methodological and/ or theoretical standpoint is rarely acknowledged.

In this thesis I explore the use of paradigms and theoretical standpoints alternate to the traditional, positivist view in N & D and OP.

1.4. *Research Outline*

The research addresses three questions:

1. How do White health professionals, working in N & D and/ or obesity prevention, practice in Aboriginal health?
2. What are the factors that influence (constrain or enable) this practice?
3. How can White health professionals move forward in their practice with Aboriginal people and ultimately address Aboriginal health and nutrition issues?

In order to answer these questions, I have used a social constructionist epistemology, critical theoretical approach, critical social research (Harvey 1990) and reflexivity methodologies and a variety of methods (Chapters 5-6). I conducted semi-structured interviews with Aboriginal and White health professionals. This included dietitians, White health professionals with extensive experience in Aboriginal health and Aboriginal and White workers involved with the *ewba* Community Programs. Therefore, a critique of the *ewba* Community Programs forms a significant part of this thesis. This research was based primarily in the two communities in SA where *ewba* was implemented from 2005-2010, rural Community A[2] and metropolitan Community B[3]. A part of the study was also conducted more widely across South Australia. Further details about methods and geographical locations will be provided in Chapter 6.

As a White researcher, I was aware of ensuring my research was ethical. I worked in collaboration with Aboriginal mentors, workers and community members. I spent large amounts of time building relationships and getting to know the Aboriginal people I worked with. I engaged in reciprocity with Aboriginal mentors, workers and community members to "give back" in return for the information and support they gave me. I ensured the relationships I built were maintained. I shared the findings of this research with all of the Aboriginal people I worked with and obtained their feedback. As a White researcher, I obtained a heightened awareness of my racial difference. I engaged in deep self-reflection and reflexivity in order to explore and learn from the experiences I

[2] This community has been deidentified to maintain confidentiality
[3] This community has been deidentified to maintain confidentiality

encountered during this research. Described in detail in Chapter 7, using reflexivity made my research more ethical with Aboriginal communities, and greatly enhanced my practice as a dietitian.

In this research, I have deviated from the traditional way that research is done in N & D and OP. This has posed a great challenge, particularly because I still seek to make my research accessible and useful to dietitians and those working in OP, whose work and research primarily come from a positivist theoretical position. This represents one of my challenges: how to make my research accessible to my colleagues but at the same time, keeping it true to its epistemological and theoretical foundations.

1.5. *Thesis structure*

In this chapter I introduced the research, including the practice dilemmas that led to this research and the key questions. I alluded to many issues that will be expanded on throughout this thesis.

In Chapters 2, 3 and 4, I review the literature necessary to introduce this research. In Chapter 2, I highlight the scope of nutrition issues Aboriginal people in Australia face today, and their relationship to past events including colonisation. I also discuss the history of Aboriginal people in Australia. In Chapter 3, I discuss N & D as a discipline and OP as an area of practice. In particular, I present a review of the research that has been done (in Australia and internationally) in these two areas in relation to Aboriginal health. This review demonstrates the lack of varied research in Aboriginal health that has been conducted in N & D and OP. In Chapter 4, I present the concept of race, and I discuss Whiteness theories that will be used to guide data interpretation in this thesis. A review of race and Whiteness theories in the N & D and OP literature is presented. This review demonstrates that race as a concept and Whiteness theories have not been widely discussed in N & D and OP, especially in relation to Australian Aboriginal people.

In Chapter 5, I present and justify the epistemology, theoretical approach and methodologies used in this thesis. This is followed by Chapter 6, in which I outline the methods used in this research, including a focus on how I ensured this research followed ethical principles for research with Aboriginal people.

In Chapters 7 to 11, I present the results of this research. I begin with Chapter 7 which explores my journey through this research, using reflexivity. I focus on my learnings related to Aboriginal health, race and Whiteness as well as my experience with a paradigm shift. I demonstrate how these learnings influenced my practice. In Chapter 8, I describe the practice of White health professionals with Aboriginal people, gleaned from semi-structured interviews. I demonstrate the ideas that these workers have about what makes "good" or "ideal" practice in Aboriginal health. In Chapter 9, I explore the organisation as a system, and structural factors within it identified to enable and constrain "ideal" practice. In Chapter 10, I explore the profession and individual as systems, as well as the structural factors within them that enable and constrain "ideal" practice. In Chapter 11, I present a model that summarises stages that White health professionals go through in their work with Aboriginal people. This model provides some practical ways to move forward in Aboriginal health, based on the stage that a White health professional is at.

In Chapter 12, I discuss the results presented in Chapters 7 to 11 as well as present a number of recommendations for practice. In presenting my conclusion, I demonstrate that to move forward in Aboriginal health, White health professionals need to undertake a deep self-reflection which involves addressing uncomfortable issues.

2. Literature Review 1: History and health status

In this chapter I provide an overview of the history of Aboriginal[4] people in Australia. I acknowledge the colonisation of Australia and the effects of British settlement on Aboriginal people. I demonstrate my understanding of the continued effect of history on the lives of Aboriginal people today, including the impact on their diet, health and nutritional status. Providing this information enables me to argue later in this thesis that any work that dietitians do with Aboriginal people in Australia today must take account of and acknowledge these past acts. In this chapter I aim to present information in a way that is respectful of Aboriginal people and their history and acknowledges their perspectives of events, past and present. Accordingly, I have sourced material that gives Aboriginal accounts of history and preferably is written by Aboriginal people themselves. The chapter provides evidence for the need to address nutrition and OP in Aboriginal people in a way that does not perpetuate the colonising acts of the past.

First, I explore the process of colonisation of Australia from 1788. Second, I describe how colonisation has been perpetuated through the policies and practices towards Aboriginal people in Australia since 1788. Third, I discuss the health status of Aboriginal people across history, with a focus on contemporary times. The connection between this health status and history is acknowledged. Finally, I explore the diet and nutrition of Aboriginal people in detail from past to contemporary times.

2.1. *Colonisation of Australia*

At the time of colonisation, Aboriginal people had their own cultural ways of life. British settlers brought a very different understanding and different culture, with different values and attitudes toward land, economic theory and religious philosophies (Gale and Brookman 1975). British settlers also had guns, horses and held the belief that they had the right to take over the continent which led to situations that blatantly discriminated against Aboriginal people (Mattingley and Hampton 1988). British settlers were instructed to 'treat indigenous inhabitants as British subjects'

[4] This research is set in South Australia where Indigenous peoples of the land self-identify as Aboriginal rather than Torres Strait Islander. Hence I have used the term "Aboriginal" when referring to Aboriginal people involved in this research as a consideration of people's preference. I have used the term "Indigenous" only when consciously wanting to refer to Aboriginal and Torres Strait Islander people collectively, or as an alternative when a document I have referenced refers to "Aboriginal and Torres Strait islander" peoples. I only use the term "Aborigine" when part of a direct quote as this term is less favoured by Aboriginal people due to its association with negative colonisation practices (Kelly 2008).

(Hollinsworth 2006, p. 69). With their actions and motivations based in British law, Christianity and European culture were totally foreign to Indigenous people (Mattingley and Hampton 1988).

Consequently, there was an extensive culture clash. The extent to which culture clash is negative depends on whether the two groups of people (a) recognise each other as human beings and (b) share similar values (McConnochie 1973; Eckermann, Dowd et al. 2006). Traditional Aboriginal people and British settlers had two very different ways of understanding the world, meaning that shared understandings and collaboration were highly unlikely.

2.1.1. Traditional Aboriginal culture

Australian Aboriginal people have one of the longest cultural histories in the world (Singh, Andrew et al. 2001). This history developed after the ancestors of Australian Aboriginal people migrated to Australia more than 50 000 years ago, from South-East Asia (Broome 1994), or since the beginning of time in the Dreaming, the time of creation for Aboriginal people (Singh, Andrew et al. 2001). This is equivalent to 2400 generations (Mulvaney and Kamminga 1999). Aboriginal people were an extremely diverse group. For example, at the time South Australia (SA) was settled by the British in 1836, there were over 40 independent groups of Aboriginal people in SA, each of which had clearly defined territory and knew the land intimately (Mattingley and Hampton 1988).

Before colonisation, Aboriginal people had adapted to their environments and developed a cultural way of life which they had maintained for thousands of years (Eckermann, Dowd et al. 2006). Traditional Aboriginal culture had kinship laws and a strong sense of community which enabled Aboriginal people to know where they stood in relation to both outsiders and other members of the tribe (Broome 1994). Aboriginal culture was very much based on sharing and was much more community-based than traditional Western culture which tended to be individualistic (Broome 1994).

2.1.2. British culture from the sixteenth century

From the sixteenth century, European society was impacted by the Industrial Revolution and the development of capitalism, and was involved in slave labour, establishment of military power and trade (Hollinsworth 2006). The British people began to explore many countries and their empire expanded through Africa, Asia and the Pacific (Hollinsworth 2006). Such expansion was

underpinned by British Imperialism which was based on the ideology that Britain had the right to govern the world's "lesser" people who generally were not White (McHugh 2004). After Australia was discovered by Dutch soldiers in the 17th century, many European countries were keen to claim sovereignty, and a competition ensued (Hollinsworth 2006).

2.1.3. Terra Nullius

Claiming Australia as terra nullius is one of the key ways in which Indigenous peoples have been, and continue to be, excluded from the national rights in Australia (Elder 2007). International codes of conduct in the 18th century stated that nations could acquire new land by peaceful settlement if the land was unoccupied (Singh, Andrew et al. 2001). Terra nullius has been described as "a land belonging to no-one" and was used to describe Australia when it was settled, (Singh, Andrew et al. 2001). Australia was deemed to be an "unoccupied continent" because the land had not been used in the way that the British settlers perceived it would have been if it were occupied (Eckermann, Dowd et al. 2006; Elder 2007). For example, there was no agriculture or town or city settlements (Eckermann, Dowd et al. 2006) and the British settlers did not recognise a system of government (Singh, Andrew et al. 2001), even though Aboriginal groups had their own well-developed codes of law (Mattingley and Hampton 1988).

If these systems had been recognised at the time of settlement, the colonisers would have been forced to 'legitimise their colonisation and enter into a treaty with the Aboriginal landowners' (Singh, Andrew et al. 2001, p. 24). Instead, Australia was "settled" rather than "conquered", avoiding the need for a treaty or compensation (Eckermann, Dowd et al. 2006; Hollinsworth 2006). The land was legally taken from Aboriginal people through the act of raising of a flag, and declaring the land 'the sovereign territory of the English monarch' (Elder 2007, pp. 149-150). When British settlers arrived and the land was claimed, the colonisers saw it as empty and they began to clear land, fell trees and quarry rock (Elder 2007). Over the next 150 years, Aboriginal people were physically removed from their land, using force and violence (Elder 2007), and any reaction to this colonising process was considered rebellion as opposed to war (Eckermann, Dowd et al. 2006). From the point of view of the settlers, colonisation and actions such as these were based on a belief in superiority and also the commonly held belief that Aboriginal people could not expect to forever remain in exclusive possession of the whole continent (Eckermann, Dowd et al. 2006). The end result of colonisation was dispossession. It is argued that colonisation

was not a one-off event that involved claiming of the land, but rather continued through time and continues today (Eckermann, Dowd et al. 2006).

2.1.4. Effects of colonisation

The impacts of colonisation on Aboriginal people are deep, far-reaching, have been perpetuated through the history of the last 200 years and cannot be underestimated. Some of these effects are discussed here.

Loss of traditional way of life

Since colonisation, Aboriginal people have experienced a great loss of many aspects of their traditional life, including a loss of control over their food supply and diet. Many of the changes from a hunter gatherer lifestyle to a 'westernised' diet are due to 'complex political, economic and social factors' (Lee 1996, p. 39).

Death and illness

British settlers generally perceived Aboriginal people as "noble savages" and as a "dying race" who would not be able to survive in the modern world (Hollinsworth 2006; Elder 2007). Aboriginal people were seen to be different in terms of language, values and lifestyle, and incapable of becoming useful participants in developing colonies; they were seen as an archaic people, destined to disappear before the racial and cultural superiority of the Europeans (McGregor 1997).

Colonisation and subsequent settlement caused a large number of deaths of Aboriginal people due to destruction of the land which destroyed their food supply (Eckermann, Dowd et al. 2006). For example, forests were cut down and domestic animals were introduced, sheep and cattle destroyed waterholes and turned grassland into semi-desert. When Aboriginal people speared sheep and cattle because they were starving, they were punished by settlers. In pastoral areas, Aboriginal people were driven away from their land so it could be used for farming and agriculture hence they were unable to hunt, gather, perform ceremonies or care for waterholes on their land (Reynolds 1982). Aboriginal people also contracted diseases that were introduced by Europeans including smallpox, leprosy, influenza, whooping cough, measles, typhoid, leprosy, syphilis and sexually transmitted infections. Susceptibility to these new diseases was increased by the demoralisation and trauma Aboriginal people experienced as a result of colonisation (Reynolds 1982; Eckermann, Dowd et al. 2006).

Violence

Settlers used violence to physically remove Aboriginal people from the land, as well as to establish and maintain power and control. Justification for such actions included a belief by some that Indigenous people could 'legitimately be killed, poisoned or moved on because they were vermin infesting the land non-Indigenous colonisers sought to make productive' (Elder 2007, p. 155) and Aboriginal people themselves were represented as being savage and cruel (Elder 2007).

Aboriginal women were particularly susceptible to violence from White men. Many women and girls were sexually exploited (Mattingley & Hampton 1988) or coerced into sexual acts with the promise of food or improved living conditions. Aboriginal women were at high risk of contracting sexually transmitted infections and pregnancy but when pregnancy occurred White men rarely acknowledged their offspring, and these children were often removed from their mothers' care in line with government policies (Hollinsworth 2006). These "mixed race" children were seen as a threat to White Australia (McGregor 1997).

Indigenous people responded to this violence with reciprocal violence, through guerrilla warfare, as well as petitioning to governments including colonial, state and British (Elder 2007). However Aboriginal people were at a disadvantage due to the devastating effects of disease and de-population (Hollinsworth 2006). What White settlers recorded as 'Aboriginal outrages', 'atrocities' and 'affrays' were actually acts of retaliation against brutalities committed by White people (Mattingley & Hampton 1988, p. 41). Aboriginal men, women and children were murdered through massacres, for example at Myall Creek in 1838 (Hollinsworth 2006). Violence from White settlers was recorded well into the twentieth century; for example, as one Aboriginal author explains, 'in 1945 the manager at Mt Dare Station was prosecuted at Oodnadatta for chaining six of our people by the neck, some for four days, and having struck them with a chain' (Mattingley & Hampton 1988).

By 1947, the population of Australian Aboriginal people had fallen between 50 and 90 percent from what it was in 1788 (Eckermann et al 2006). In addition to the physical violence, in the process of colonising Australia, British settlers forced their culture, systems, education methods and ways of interacting onto Aboriginal people with the result that Aboriginal ways of knowing and doing were destroyed.

2.2. *Policies and practices since 1788*

In this section, the major policies and practices that have impacted on Aboriginal people in Australia since colonisation in 1788 are outlined. It has been argued that every Act imposed on Aboriginal people from the 1890s until the 1960s can be considered as an example of institutionalised racism embedded in cultural violence (Eckermann et al 2006). The policies and practices discussed are summarised in Table 2.1.

2.2.1. Note on South Australia

Interestingly, the colonial history of SA is slightly different to that of other states, because SA was established as a humanitarian colony. It was settled by "free" settlers as opposed to convicts, who settled other states which were known as penal colonies (Gale 1972).

This is particularly relevant to this research because ideals alleged to be present in SA as a humanitarian colony, including liberal ideas of social reform, humanitarian ideals and freedom, were intended to enable Aboriginal people to assimilate and become an intrinsic part of South Australian society (Gale 1972). In 1834, Governor Hindmarsh proclaimed that anyone who mistreated Aborigines would be punished and therefore one aim of SA as a colony was to treat Aboriginal people humanely and fairly (Gale 1972). However despite this good intent, the reality of colonial experiences within SA became similar to those in the penal colonies. The quest for settlement and land, as well as European dominance and ideals, competed with the fair and humane treatment of Aboriginal people. For example, Aboriginal people were prevented from bathing in the River Torrens (Karrauwirraparri), or holding corroborees on Sundays (Mattingley & Hampton 1988). This demonstrates a point that will also be evident throughout the forthcoming sections – that sometimes in Australian history there was good intent with respect to Aboriginal people, but often conflicting intents and priorities got in the way.

Table 2.1: Main policies/ practices/ eras in Aboriginal history in Australia from 1788-2010

Era	Major events	Effects on Aboriginal people
Pre-invasion		• Aboriginal people were long adapted to Australia's climate & topography • Sustainable, hunter-gatherer lifestyle within a recognised territory • Strong connection to the land • System of law/ roles/ relationships in place
Colonisation (1788) & Early settlement (1788-1880s)	• Conflict	• Movement away from colonised areas • Myall Creek massacre (1838) in NSW; 28 Aboriginal people shot
Segregation & protection (1890-1950s)	• 1901 – White Australia Policy & Australia becomes a Federation. Aboriginal people are not to be included in the census • 1911 – Aborigines Act is passed in SA – emphasis on control of Aboriginal people – Chief Protector is the legal guardian of every Aboriginal and 'half-caste' child • 1914 -1918 –World War One • 1939-1945 World War Two • 1939 – exemption certificates introduced	• Minimal contact with White settlers • Aboriginal people can only move freely with exemptions & permits • Massacres in WA & central Australia, led by police officers e.g. Mistake Creek Massacre, 1915; Coniston massacre, 1928 • Aboriginal people seen as irrelevant
Assimilation (1950s-1960s)	• 1951 – Commonwealth Government Policy of Assimilation stated that all Aboriginal people should attain the same manner of living as other Australians • 1960s – Federal Council for the Advancement of Aborigines and Torres Strait Islanders established (lead body for advocating for Aboriginal rights) • 1965 - Prohibition of Discrimination Act (SA) • 1965 – Charlie Perkins led freedom ride through Western NSW • 1965 – equal pay awarded to Aboriginal pastoral workers (introduction delayed for 3 years) • 1967 – Referendum to count Aboriginal people as citizens in the census ('yes' vote of 90.77%)	• Removal of children to homes or foster care • Training of children in non-Aboriginal values • Rigid control of social behaviour • Australia perceived as a racist society internationally • Aborigines Protection Board replaced with a Welfare Board • Continued deaths of Aboriginal people due to disease, neglect, poor diet

Table 2.1 (continued)

Era	Major events	Effects on Aboriginal people
Integration (1967-1972)	• 1968 – National Tribal Council established • 1970 – Aboriginal Legal Service established in Redfern, NSW • 1971 – first Aboriginal community controlled health service established (Redfern, NSW)	• Aboriginal people encouraged to join the White community while still retaining their own culture
Self-determination (1972-1975)	• 1975 – Tent Embassy • Whitlam Government – aimed to restore Aboriginal power in economic, social & political affairs • 1975 –White Australia Policy abolished • Introduction of Commonwealth Department of Aboriginal Affairs	• Treatment of Aboriginal people became a major political issue • Decline of blatant discrimination • No recognition of Aboriginal disadvantage
Self-Management Stage 1 (1975-1988)	• Aboriginal community organisations told to operate within Government policy Decrease in Government expenditure on Aboriginal programs and organisations • 1976 - Aboriginal Land Rights Act • 1983 - Bob Hawke in power • 1988 – Bicentenary of British settlement	• Land Rights a central issue – proposal for a National legislation attacked by states • Increase in awareness of effects of British settlement on Aboriginal people but lack of action • Aboriginal resistance more noticeable to mainstream Australia
Self-Management Stage 2 (1988-1996)	• 1989 - 1989: ATSIC established as a statutory authority • 1991 – Aboriginal Deaths in Custody Report released; Council for Aboriginal Reconciliation (CAR) established • 1991-1996 – Paul Keating in power • June 1992: Mabo Decision (High Court) • 10 December 1992 – Redfern Speech (Paul Keating) • December 1993: Native Title Act passed (Senate) • 1993 – International year of Indigenous people • 1996 – John Howard in power; Pauline Hanson & One Nation party; Wik decision • Refusal of Government to say sorry • May 1997 – 'Bringing Them Home' Report released and removal of children found to be genocide	• 1996 - John Howard - focus on 'practical reconciliation' where 'basic entitlements as citizens are endorsed but specific rights as Indigenous people are constrained or denied within mainstream political and administrative practices' • Significant increase in awareness of the effects of colonisation but continued lack of system wide response

Table 2.1 (continued)

Era	Major events	Effects on Aboriginal people
2000s onward	• 2000 – Reconciliation March at Sydney Harbour • May 2000 – Council for Aboriginal Reconciliation presented Government with a Declaration & Road Map towards reconciliation, including proposals for a treaty • May 2004 - Howard & Vanstone announced the abolition of ATSIC and the mainstreaming of Indigenous programs across Government portfolios • 2005 – Social Justice Report released – informed development of Close the Gap campaign • April 2007 – Close the Gap campaign launched • 2008 – Formal Apology from Kevin Rudd, Prime Minister • Aboriginal Primary Health Care Access Program (announced in 1999-2000 Commonwealth Budget) • National Strategic Framework for Aboriginal and Torres Strait Islander Health (2004) • Cultural Respect Framework for Aboriginal and Torres Strait Islander Health (2004) • Close the Gap (2005) - calls for Federal, State and territory Governments to commit to closing the gap in life expectancy	• Formal recognition of the effects of colonisation on Aboriginal people represented a significant step in the journey of reconciliation • Partnership with Indigenous people stressed • Focus on the future • Focus on relationships between Aboriginal and non-Aboriginal Australians

Source: Human Rights and Equal Opportunities Commission 1991; Commonwealth of Australia 1997; Hollinsworth 2006; Couzos and Murray 2007; Kelly 2008

2.2.2. Mid 1800s: segregation & protection

Segregation occurred during the 1850s and 1860s and involved placing Aboriginal people onto missions and reserves (Hollinsworth 2006). Protection legislation arose from the belief that Aboriginal people, in danger of being 'overwhelmed by the culture of the new colonisers', were offered protection initially by the British Crown and later by the Australian state (Elder 2007, p. 157). This legislation was extremely paternalistic; controlling where Aboriginal people could live and where they could work (Elder 2007). It is well argued that these policies did not have the best interests of Aboriginal people at heart, were largely ineffective at protecting Aboriginal people, abused basic human rights and freedom of movement and led to conditions that demoralised Aboriginal people and made them dependent on colonisers for daily living (Hollinsworth 2006).

Within 10 years of settlement of South Australian colonies, most Aboriginal people had become dependent on the state's welfare systems through loss of land and food supply, poor nutrition, illness and cruelty. In response to these situations, missionaries and humanitarians advocated the establishment of missions (Gale 1972; Commonwealth of Australia 1997). This was supported by the Government who believed that it would assist with conformity and assimilation of Aboriginal people into mainstream Australian society. By 1956, Missions were the main agency providing care, rations, shelter and education for Aboriginal people. Many Aboriginal people were forcibly removed from their homes and sent to missions across the state (Mattingley and Hampton 1988; Brodie and Gale 2002).

While missionaries themselves had good intentions, 'their activities contributed significantly to the breakdown of the fabric of traditional society and the destruction of culture' (Mattingley & Hampton 1988, p. 175). They not only encouraged and enforced Christian rituals, but they also suppressed traditional rituals such as initiation law (Mattingley & Hampton 1988) and there was no recognition or acceptance of the well-established traditional order of Aboriginal culture and spirituality. Food supply was controlled and Aboriginal people were forced to eat the White man's food which was rationed to them including flour, sugar, tea and tobacco. Due to the ease and permissibility of access compared with traditional foods, over time these foods were incorporated into Aboriginal peoples' way of life (Shelley 1981).

Exemption

During the time of segregation and protection, in some states Aboriginal people could apply for exemption passes where they became exempt from being Aboriginal. In SA, these were introduced in the late 1930s (Mattingley & Hampton 1988). An issue of an Exemption Certificate enabled an Aboriginal person to assimilate into White society and leave all traces of their Aboriginality behind. In order to do this, the Aboriginal person had to display exemplary behaviour from a European perspective and cut off all contact with Aboriginal people who were not exempt – except their mother, father, sons and daughters (Hollinsworth 2006; Elder 2007). Having an exemption certificate allowed Aboriginal people to drink alcohol, obtain various Commonwealth social services benefits and to talk to White people without being charged with consorting (Mattingley & Hampton 1988). However, exempt people were not allowed to live on reserves and a number of authors highlight how exemption had alienating effects on Aboriginal families by splitting up families and causing rifts between groups (Mattingley and Hampton 1988; Hollinsworth 2006).

The Stolen Generations

Beginning during the time of segregation and protection (around 1863), but continuing far beyond this into the 1970s, was the removal of Aboriginal children from their families, also known as the Stolen Generations (Commonwealth of Australia 1997). In some cases, children were placed in institutions established to house children who had been removed from their families. Removal of Aboriginal children from their families was one response to the growth of "mixed race" people and was seen as 'the means to completely disperse the Aboriginal population' (Hollinsworth p. 2006, 107) and "breed out" Aboriginality (Singh, Andrew et al. 2001). Removal of children from their Aboriginal families was also justified by saying that children would have increased opportunity (Commonwealth of Australia 1997). However, the inquiry commissioned by the Government into the Stolen Generations found that this act was primarily one of genocide (Commonwealth of Australia 1997). An Aboriginal woman, Vi Deuschle, said that 'Aboriginal people saw assimilation as a form of genocide, because it was expected by Europeans that Aborigines would move into mainstream society and forgo their own Aboriginal identity' (Mattingley & Hampton 1988, p. 54).

This report, entitled "Bringing Them Home: National Inquiry into the Separation of Aboriginal and Torres Strait Islander Children from Their Families" (Commonwealth of Australia 1997) acknowledged the intergenerational trauma this separation from family and culture has instilled and the wide-ranging impacts on Aboriginal society (Singh, Andrew et al. 2001). The

report found that many children were discouraged from family contact, taught to reject their Aboriginality, subjected to harsh institutional conditions, forced to learn English, told that their parents had died or left them and many were forced to work without wages (Commonwealth of Australia 1997; Hollinsworth 2006). Many received excessive physical punishment and were at risk of sexual abuse. One in six stolen children spoke of excessive physical punishment; and one in five living in institutions and one in four who were adopted reported sexual abuse (Commonwealth of Australia 1997). While fifty four recommendations were made from this report, in 2001, less than nine had been implemented (Singh, Andrew et al. 2001). In 2008, there were still many recommendations from this report that had not been implemented (Calma 2008).

It is estimated that from 1910-1970, between one in three and one in ten Aboriginal children were forcibly removed from their families (Commonwealth of Australia 1997). These effects are still felt today. For example, in 2008, approximately one in 12 Aboriginal and Torres Strait Islander people aged 15 years and over had personally experienced removal from their natural family (ABS 2010). It is important to acknowledge that policies of the past live on through the parents and the grandparents of today's children (Eckermann, Dowd et al. 2006). While Aboriginal children are no longer allowed to be taken from their families or institutionalised, 'the effects of almost 150 years of such treatment left deep scars on individuals and our society as a whole. Many of our people who were put into foster homes and institutions are still searching for their identity' (Mattingley & Hampton 1988, p. 171). Furthermore, many of today's children live with grandparents, meaning that experiences of fifty years ago have a direct impact on the life choices, including current health seeking behaviours.

Despite the documentation of the effects of the Stolen Generations in the Bringing Them Home Report, the instances of removal of children were not formally acknowledged by the Australian Government until Kevin Rudd formally apologised to Aboriginal people on 13 February 2008. During this speech, he apologised for the removal of children and the profound grief, loss, suffering, indignity and degradation this has inflicted on Australian Aboriginal people (Rudd 2008).

2.2.3. Assimilation

During World War Two, many Aboriginal men and women assisted in the war effort at home or overseas. Following the war, around the time of the 1950s, the Federal Government moved

from a policy of segregation to assimilation. New White immigrants were encouraged to assimilate into society and Aboriginal people were expected to as well. The move towards assimilation was also stimulated by the observation in the 1940-50s that the proportion of the population that was part-Aboriginal was increasing, not dying out (Hollinsworth 2006). There was a call for a policy that would 'reduce the financial burden of supporting dependent Aborigines' (Hollinsworth 2006, p. 112) and address complaints received from people and organisations regarding the conditions on missions and mistreatment of Aboriginal 'wards' (Hollinsworth 2006, p. 121). This led to changes in the Aborigines Protection Act and saw an end to the protection/ segregation era and a start to assimilation.

A beneficial policy?

The Assimilation policy was introduced in 1951 with the aim of (1) removing discriminatory legislation and practices for Aboriginal people; (2) incorporating Aboriginal people into the economy using welfare measures in the short-term and training and education with a view to employment in the long-term; and (3) educating non-Aboriginal Australians with the view of them valuing traditional Indigenous culture and peoples (Hollinsworth 2006). The original Assimilation Policy clearly stated that:

> *All Aborigines shall attain the same manner of living as other Australians, enjoying the same rights and privileges, accepting the same responsibilities, observing the same customs and being influenced by the same beliefs, hopes and loyalties (in Eckermann et al. 2006, p. 26).*

While assimilation was a change from protection/ segregation, some questioned whether this change in policy really led to a change in the attitude of the people delivering the policies, due to the persisting presence of institutional racism and cultural violence (Eckermann, Dowd et al. 2006). Aboriginal people themselves were not consulted on the policy (Hollinsworth 2006).

For Aboriginal people, assimilation brought with it 'legal pressure to be just like White Australians' (Eckermann, Dowd et al. 2006, p. 27). This involved (a) cultural assimilation which entailed the adoption of non-Indigenous culture by Aboriginal people and (b) biological assimilation which entailed sexual relations between Aboriginal and non-Aboriginal people, resulting in 'generations of lighter and lighter skinned children until Indigeneity is eradicated' (Elder 2007, p. 159). Both forms of assimilation relied on the removal of Aboriginal children from their families (Elder 2007).

In theory, assimilation aimed to provide a standard of living for Aboriginal people that was similar to that experienced by the settlers. However, in reality it can be argued that it took the rights of Aboriginal people away even further. For example, governments controlled where Aboriginal people could live and who they could marry. Some Aboriginal people were moved off missions and reserves because of the increasing population at these places. They were moved to Adelaide and other cities and towns but did not receive any preparation for living in these new conditions (Gale and Brookman 1975). As reported by Mattingley and Hampton (1988, pp. 52-53), Aboriginal people had 'been conditioned by generations of institutionalisation' and as such were not able to adjust easily to these new conditions. As described by David Unaipon, an Aboriginal man, in 1936 'living on Government settlements tends to the degeneration of natives and encourages parasitism' (Mattingley & Hampton 1988, p. 57).

2.2.4. Self-determination

The 1950s and 60s were a time of Aboriginal activism. In 1965 Charles Perkins led "freedom ride" bus tours in New South Wales in order to protest against racial discrimination. Throughout the 1960s, European settlers became increasingly aware of the injustices faced by Aboriginal people (Singh, Andrew et al. 2001). Some people in society, including church groups, began to advocate for Aboriginal people and support them in their bid for social justice. This led to the start of the self-determination era. In 1967 a referendum was held and over 90% of settlers voted to include Aboriginal people in the census which also gave the Federal Government the power to legislate for Aboriginal people in all states (Singh, Andrew et al. 2001). It was not until after this referendum that Aboriginal people were officially recognised as equal Australian citizens and the Government legislated to provide national health, education, housing and employment programs. Self-determination has been defined as 'the story of Indigenous people's resistance and sovereignty' (Elder 2007, p. 148) and involves the countering of non-Indigenous stories about Indigenous people with stories about Indigenous peoples by themselves (Elder 2007).

The introduction of the self-determination policy by the Whitlam Government in 1972 facilitated the gradual return of political power to Aboriginal people (Lee 1996; Eckermann, Dowd et al. 2006). For example, Aboriginal people were entitled to award wages and received social security entitlements and small groups of Aboriginal people were assisted to reinhabit traditional lands. In theory, the self-determination policy enabled Aboriginal people, for the first

time since British settlement, 'to identify their needs and priorities and the best ways of meeting them' in the national agenda (Singh, Andrew et al. 2001, p. 29). A Department of Aboriginal Affairs was established to assist in meeting the needs of Aboriginal people and Aboriginal organisations in the areas of health, legal services and housing were established (Singh, Andrew et al. 2001). This shift in policy and direction enabled increased self-identity and self-expression to develop:

> *At last the White man is beginning to hear the Aboriginal point of view. This is because Aborigines, largely seeing themselves as part of the general community, have awakened to a sense of self-identity. They are beginning to express their views through their own publications and through the normal commercial press. They have formed their own organisations and groups (Gale & Brookman 1975, p. 8)*

This indicates a shift from the prior held view that Aboriginal people were the White man's "problem" (Gale & Brookman 1975).

In 1971, the first Aboriginal Community Controlled Health Service[5] was opened in Redfern in Sydney. This was the result of a community movement; Aboriginal people felt that existing health services discriminated against them and were not appropriate (Eckermann, Dowd et al. 2006). The first community controlled organisation in SA also opened in Adelaide in 1971; Nunkuwarrin Yunti (as it has been named since 1994), is managed by Aboriginal and Torres Strait Islander people (Nunkuwarrin Yunti 2006).

In 1976, the Northern Territory land rights legislation was introduced by the Federal Government, whereby large amounts of land were returned to Aboriginal people and they were also able to make claims for crown land. Similarly, the Pitjantjatjara Land Rights Act was passed in 1981 and Aboriginal land rights legislation was passed in NSW in 1983, which gave communities land rights to their traditional lands.

2.2.5. Self-Management

The next era was self-management from the mid 1970s to the mid 1990s. It had similar aims to previous eras, but emphasised the accountability of Aboriginal groups for their decisions and the management of finances. Community controlled health services, housing and self-

[5] A health service delivered and controlled by a specific Aboriginal community, for that Aboriginal community. The health service is controlled by the community through a locally elected board of management.

help programs were established. However, many of these programs were inspired and supervised by non-Aboriginal people and large amounts of money were spent on consultative fees and salaries for non-Aboriginal experts, supervisors and administrators, many of whom made decisions for, not with, Aboriginal people and communities. When programs failed, there was a public outcry of wasted taxpayers' money (de Hoog and Sherwood 1979). This can be described as a "blame the victim" response which is explained as 'if the problem and the solution are developed by outsiders and the program fails, then it becomes easy to blame the recipient' (Eckermann, Dowd et al. 2006) (p. 29).

The self-management era involved the release of a number of key publications including the Bringing Them Home (Commonwealth of Australia 1997) and Aboriginal Deaths in Custody Reports (Human Rights and Equal Opportunities Commission 1991). Many non-Aboriginal Australians were shocked to hear these reports and did not know whether to believe these atrocities which appeared to go against Australian values (Eckermann, Dowd et al. 2006).

In the 1990s the Aboriginal and Torres Strait Islander Commission (ATSIC) was developed. This was the first body where Aboriginal people had control and were legally able to make decisions for Aboriginal people (Elder 2007). This was a statutory authority with increased Indigenous control (Singh, Andrew et al. 2001). However, this was later abolished by the Federal Government with allegations of misconduct in 2004 which meant the national, representative voice of Aboriginal people was silenced (Elder 2007). A National Indigenous Council (NIC) was established in its place, with the purpose of advising the Government on issues affecting Aboriginal and Torres Strait islander people (Vanstone 2004). However, while this group was made up of Indigenous people, they could only advise the Government and did not have power to make and implement decisions (Elder 2007). There was mistrust of this group with its Government elected members, and it disbanded in 2008.

The Government continued to refuse to apologise for past atrocities and there was no treaty or recognition of Aboriginal sovereignty. However, they did support a reconciliation movement by the people and at a practical level through improved services in health, housing, education and employment (Eckermann, Dowd et al. 2006). In March 2000, 250 000 people joined in the Peoples' walk for Reconciliation across the Sydney Harbour Bridge and the Prime Minister John Howard was given the Reconciliation Document by the Council for Aboriginal Reconciliation (Singh, Andrew et al. 2001). He refused to make a public apology on behalf of

the Government. A climate of racism developed after the election of the Howard Government in 1996 (Singh, Andrew at al. 2001). Pauline Hanson, the leader of the 'One Nation' political party, was elected during the Howard Government's first term in office (Singh, Andrew et al. 2001). Known for its race-based-politics, this added to the climate of racism.

2.2.6. 2000s onwards

From the year 2000 onwards, there are four main national programs and frameworks that have guided Aboriginal health policy: the Aboriginal Primary Healthcare Access Program, the National Strategic Framework for Aboriginal and Torres Strait Islander Health, the Cultural Respect Framework for Aboriginal and Torres Strait Islander Health and Close the Gap.

Aboriginal Primary Health Care Access Program

The Aboriginal Primary Health Care Access Program was announced in the Commonwealth budget in 1999-2000. This program was focussed on improving access to and provision of primary health care services to Aboriginal people (Kelly 2008).

National Strategic Framework

The National Strategic Framework for Aboriginal and Torres Strait Islander Health was endorsed by the Australian and State/Territory Governments through their respective Cabinet processes and signed by all Health Ministers in July 2003 (Department of Health & Ageing 2003). This document built on the 1989 National Aboriginal Health Strategy and addresses approaches to primary health care and population health within a contemporary context (National Aboriginal and Torres Strait Islander Health Council 2004). This document calls for shared responsibility, 'partnerships between Aboriginal and Torres Strait Islander organisations, individuals and communities and a number of Government agencies across all levels of Government' and 'concerted action across and beyond the health sector' in order to address Aboriginal health (National Aboriginal and Torres Strait Islander Health Council 2004, p. 1) by focussing on nine principles including working together, cultural respect, accountability and a holistic approach.

Cultural Respect Framework

The Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004-2009 (Australian Health Ministers' Advisory Council 2004) was developed as a guiding document to strengthen relationships between the health care system and Aboriginal and Torres Strait Islander peoples. It recognises and builds on the same nine principles in the National Strategic

Framework for Aboriginal and Torres Strait Islander Health and highlights the importance of health services having strategies across four dimensions including knowledge and awareness, skilled practice and behaviour, strong relationships and equity of outcomes (Australian Health Ministers' Advisory Council 2004). So far, this has remained as a high-level document and has not yet been implemented at the practice or service level.

Close the Gap

The Close the Gap campaign was launched by Oxfam Australia and the Aboriginal and Torres Strait Islander Social Justice Commissioner Tom Calma on 4 April 2007. This arose from the 2005 Social Justice report which called for equity in life expectancy and health status between Aboriginal and non-Aboriginal Australians within 25 years (by 2030) (Calma 2005). It was also highlighted that the Federal Government was spending 70 cents per capita for Indigenous people compared to one dollar for non-Aboriginal people which challenged a common belief in Australian society that Aboriginal people get more Government funding (Oxfam Australia 2007). All levels of Government were lobbied by Tom Calma, Oxfam Australia[6] and ANTaR[7] to commit to achieving health and life equality by 2030. In his speech at the launch of the Close the Gap campaign on April 4 2007, Tom Calma called for 'bipartisan support to make overcoming this difficult challenge a national priority'. He stated that 'all governments need to work together collegiately, in partnership with Indigenous communities and all sectors of Australian society'. He also highlighted that reaching the goal of equality in life expectancy would require 'a focus on the social determinants of health – living conditions, overcrowding in housing, education and employment.' Importantly, he highlighted that 'this is not just a health sector responsibility. This requires a whole-of-government, cross departmental approach' (Calma 2007). In 2011, Close the Gap involves commitment from state, federal and territory Governments to do so and is supported by over 40 Indigenous and non-Indigenous organisations. It is an indication of the changing perspectives of mainstream Australia that over 140 000 Australians took up the opportunity to sign up through a number of websites including Oxfam and ANTaR (Holland 2011).

Despite the presence of campaigns such as Close the Gap in Australia today, Indigenous health does not enjoy the same status as that of mainstream Australia. Various forms of

[6] Oxfam Australia is an independent, not-for-profit, secular, community-based aid organisation that is part of a global movement dedicated to fighting poverty and injustice.

[7] ANTaR – Australians for Native Title and Reconciliation is an independent, national network of mainly non-Indigenous organisations and individuals working in support of justice for Aboriginal and Torres Strait Islander peoples in Australia.

racism and discrimination, from individuals and institutions, continue to impact on Aboriginal people's lives and opportunities (Hollinsworth 2006). This will be explored further in Section 2.3.6.

2.3. *Health Status*

Aboriginal people experience poorer health compared to non-Aboriginal people in Australia (Eckermann, Dowd et al. 2006) with an unacceptably large health gap for disease and injury (Vos, Barker et al. 2007a). Prior to British settlement, Aboriginal people were generally in good health (Lee 1996) and there was no evidence of the lifestyle diseases that are prevalent today (Lee 1996). There are many health issues that affect Aboriginal people in contemporary times. A complete discussion of all of these issues is not able to be presented here. Rather, a selection of issues, with direct relevance to N & D and/ or OP are discussed.

2.3.1. Defining health

Aboriginal and non-Aboriginal people have both similar and different definitions of health. For many Aboriginal people, health is seen as more holistic and people-centred than the western view of health (Eckermann, Dowd et al. 2006). An Indigenous definition of health was developed by the National Aboriginal Health Strategy Working Party (1989, p. x):

> *Health does not just mean the physical well-being of the individual but refers to the social, emotional, spiritual and cultural well-being of the whole community. This is a whole of life view and includes the cyclical concept of life-death-life.*

In contrast, a commonly cited Western view of health is:

> *Health, which is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realisation requires the action of many other social and economic sectors in addition to the health sector (World Health Organisation 1978)*

It is evident that for most Aboriginal people, health has a cultural component, as well as a greater reference to the whole of the life course, self-determination, community health (as opposed to individual health), culture, dignity, justice, family, land, ties with the past, a vision for the future, hope and stability (Eckermann, Dowd et al. 2006; Boddington and Raisanen 2009). Aboriginal approaches to health care traditionally place emphasis on illness being caused by social or spiritual dysfunction (Maher 1999). In terms of treatment, traditional

Aboriginal culture utilises bush medicine for specific symptoms or injuries, traditional healers and singing/ chanting and external remedies to treat medical conditions (Maher 1999). In contrast, Western models of health have traditionally been based on the biomedical model, and more recently, primary health care. The biomedical model sees the body as a set of "parts", whereby a healthy body is one where all the "parts" are working properly (Baum 2008). This approach fails to consider disease within the context of the lives of people and the impact of mental health on physical health (Baum 2008). Instead, it views the person as compartmentalised and without their environments (Eckermann, Dowd et al. 2006, p. 154). Primary health care emerged after the second World War when there was a large growth in the international health care industry but no corresponding increase in world health and focuses on the prevention of illness (Wass 2000). Primary health care is based on a number of principles and documents, including the Alma-Ata declaration (World Health Organisation 1978), the Ottawa Charter for health promotion (World Health Organisation 1986) and the Jakarta Declaration (World Health Organisation 1997).

Important to consider when discussing health is the concept of "worldview", or how we see the world. This is based on ideas and beliefs people have about the world and the things in it (Christie 1984). Traditionally, Indigenous and western worldviews are different, meaning that concepts such as health may be understood differently. Generally, one worldview or idea becomes "dominant", based on the dominant culture and ideas at the time. The worldview that a practitioner and a client hold will impact on how health care is delivered because practitioners 'tend to act naturally from the perspective of their own world view' (Eckermann, Dowd et al. 2006, p. 148) which in turn will affect the uptake of health care by Aboriginal people. This can lead to difficult interactions between White health professionals and Aboriginal clients/ patients and decreased patient "compliance" and satisfaction because they are working from different conceptual frameworks (Maher 1999). Therefore in order to improve health, it is important for White health professionals to consider their own worldviews and the worldviews of those they are trying to reach (Eckermann, Dowd et al. 2006).

2.3.2. Population

In June 2006, 517 000 Australian Aboriginal and Torres Strait Islander people made up approximately 2.5% of the total Australian population (ABS 2010). The median age was lower than for the non-Aboriginal population (21 years compared with 37 years) and the majority

lived in regional areas (43%) with 32% living in major cities and 25% in remote areas (ABS 2010).

2.3.3. Life expectancy

Over the period 2005-2007 the national gap in life expectancy between Aboriginal and Torres Strait Islander people and non-Aboriginal people was estimated to be 11.5 years for males and 9.7 years for females. This equates to a life expectancy of 67.2 and 72.9 years for Aboriginal and Torres Strait Islander males and females respectively, compared with 78.7 and 82.6 years for non-Aboriginal males and females respectively (ABS 2010). This appears to be a decrease in the gap between the life expectancy of Aboriginal and non-Aboriginal people reported previously (16-17 years less – 78.5 and 83.3 years for non-Indigenous mean and women respectively compared to 59.4 and 64.8 years for Indigenous men and women respectively) (ABS 2010). These two sets of estimates were derived by the ABS using different methods, with the newer values using information from the ABS Mortality Quality Study which is considered by the ABS to improve the quality of the estimates (ABS 2008b). However, this is debatable and many practitioners and researchers in Aboriginal health continue to cite the 16 to 17 year gap (J Glover 2011, pers. comm., 5 April).

2.3.4. Burden of disease

The burden of disease of Australian Indigenous people is two and a half times greater that of the burden of disease of the total Australian population (Vos, Barker et al. 2007a). In all age groups, Aboriginal people have a lower life expectancy, higher mortality and are sicker than non-Aboriginal people (Vos, Barker et al. 2007a). In 2003, the leading causes of disease burden in Indigenous communities were cardiovascular disease, mental disorders, chronic respiratory disease, diabetes and cancers.

Eleven risk factors identified for diseases common in the Aboriginal population are tobacco use, high body mass, physical inactivity, high blood cholesterol, alcohol, high blood pressure, low fruit and vegetable intake, illicit drugs, intimate partner violence, child sexual abuse and unsafe sex (Vos, Barker et al 2007b). If Aboriginal people experienced the same burden of disease rates attributed to these 11 risk factors to non-Aboriginal people, then 29% of the total burden of disease seen in Aboriginal people could be avoided (Vos, Barker et al. 2007b). Therefore these risk factors are important to target when looking at interventions to improve Indigenous health. As a number are related to nutrition and body weight, this provides a rationale for exploring N & D and OP in this research.

2.3.5. Lifestyle (non-communicable) diseases

There has been an increase in "lifestyle" or non-communicable diseases in Aboriginal communities in contemporary times (Lee 1996). These diseases explain 70% of the difference in the burden of disease between Aboriginal and non-Aboriginal Australian people (Vos, Barker et al. 2007a). Data from the 2004-2005 National Aboriginal and Torres Strait Islander Health Survey (ABS 2010) demonstrated that Indigenous people had a higher prevalence of most types of long-term health conditions compared with non-Indigenous people. This difference was greatest for kidney disease and diabetes/ high sugar levels where the overall, age standardised rate of disease in Indigenous people was 10 and three times the rate in non-Indigenous people respectively (ABS 2010).

Two thirds of the burden from diabetes was found to be from high BMI and physical inactivity (Vos, Barker et al. 2007b). Of those Indigenous people aged 15 years and over who reported their height and weight, 38% were of a healthy weight, 28% were overweight and 29% were obese (ABS 2008c). Therefore, fifty seven percent of Indigenous people over 15 years of age were overweight or obese, an increase from 48% in the last survey. This is higher than the proportion of overweight and obesity in the total adult population in 2004-2005, which was 54% (ABS 2008c). It was found that Indigenous women were one and a half times more likely to be overweight or obese than non-Indigenous women (ABS 2008c). When considered as a single risk factor, high body mass was the second leading cause of the burden of illness and injury among Indigenous Australians in 2003, accounting for 11% of the total burden of disease and 13% of all deaths (Vos, Barker et al. 2007b), indicating the importance of addressing this risk factor amongst Australian Aboriginal people. .

2.3.6. Factors influencing the health of Aboriginal people

In addition to the eleven risk factors identified, other factors continue to influence the health of Aboriginal people today. These include poverty, unemployment, challenges with educational outcomes and poor housing; all of which Aboriginal people experience disproportionately compared with non-Aboriginal people (Australian Council of Social Services 1974; Eckermann, Dowd et al. 2006; ABS 2010). Additionally, colonisation practices in society and health care settings continue to negatively affect the health of Aboriginal people today. These include a lack of Indigenous health models, dominance of the biomedical model, and Western views in health research, policy, planning and praxis and everyday personal and institutional racism (Sherwood and Edwards 2006). In 2008, 27% of Aboriginal and Torres Strait Islander

people aged 15 years and over had experienced discrimination in the last 12 months. Similarly, 11% of Aboriginal or Torres Strait Islander children reported experiencing bullying at school because they were Indigenous (ABS 2010).

In summary, multiple factors influence health and all these should be considered when assessing the health of and working with Aboriginal people. This is important because it acknowledges that health is not only a product of individual choice.

2.4. *Diet and nutritional status: from past to present*

Diet and activity, including fruit and vegetable intake, are two of the eleven risk factors contributing to disease in Australian Aboriginal people (Vos, Barker et al 2007b). The diet and nutrition of Aboriginal people changed with the colonisation of Australia as demonstrated in this section.

2.4.1. Traditional diet: Pre-colonisation

Prior to European settlement, Aboriginal people lived a traditional hunter-gatherer lifestyle, which involved high levels of physical activity (Shelley 1981; Lee 1996). Diets were seasonal, low in energy and high in nutrients. They were typically high in protein, low in sugars, high in complex carbohydrates and micronutrients, low in saturated fat and high in polyunsaturated fat (Lee 1996; Hunter 1997; Gracey 2000; Shannon 2002). Diets were generally meat-oriented with vegetable food an important supplement (Lee 1996). Most Australian native animals have a much lower fat content than domestic animals such as sheep and cattle, which decreases the fat content of the overall diet (Naughton, O'Dea et al. 1986). Large and small vertebrate animals, snakes, lizards, fish, ant larvae, eggs, termites, edible vegetables, fruit, fungi and poisonous yams were sought (Shelley 1981), depending on geographical location, climate and season (Lee 1996). The amount of food eaten also varied; with daily intake generally being 'subsistence intake', supplemented by 'feasts' (Lee 1996, p. 9).

Food was distributed according to Traditional Law and based on cultural practices and kin relationships (Lee 1996). There were rules about which food could be eaten, when and by whom. For example, during the initiation of young men, some foods were forbidden, while other foods could only be eaten by breastfeeding women to improve milk supply (Shelley 1981). There were specific cultural practices about collecting food. Children learnt about food gathering and preparation from their mothers. At about age six, boys began to hunt with their fathers, while girls stayed to learn food gathering skills from their mothers (Broome 1994).

Men generally hunted alone or in pairs for larger animals, while women hunted and gathered in groups (with children) for foods such as small animals, eggs, fruit, vegetables, reptiles and insects (Shelley 1981). Generally, food was eaten straight away after collecting because storage was difficult. Food was generally nutritious because it was rarely overcooked or refined (Lee 1996).

2.4.2. Contemporary diet: Post-colonisation

After British settlement, access to traditional foods was denied and Aboriginal people were forced to eat a diet higher in refined carbohydrates and saturated fats (Burns and Thomson 2008). This has contributed to the higher prevalence of lifestyle diseases (Section 2.3.5).

Poison Food

In appalling acts of violence, food and water were used as a vehicle to poison Aboriginal people, as described by Mattingley and Hampton (1988, p. 41):

> *In the South-East and elsewhere poison was used in waterholes and provisions likely to be taken by Nungas[8], though naturally such acts were not usually recorded by the Goonya[9] who committed them. In a well documented case at Port Lincoln in 1849 five Nungas died after eating flour mixed with arsenic.*

This highlights the extreme links between colonisation practices, food availability control (and abuse) of Aboriginal people.

Rations – food control

Food became an integral way that British settlers controlled the land and Aboriginal people (Mattingley & Hampton 1988, p. 19). As land was destroyed, and there was less food available for Aboriginal people to hunt and gather, White settlers began to bribe Aboriginal people with food such as white bread (Mattingley & Hampton 1988).

In SA in the mid nineteenth century, government rations began to be distributed at feeding stations (Mattingley & Hampton 1988). This was partly to address malnutrition, although rations were not necessarily adequate in kilojoules and nutrients (Shelley 1981). Rations consisting of flour, rice, sugar and tinned or salted meats were distributed three times a day and fruit and vegetables and fresh meat/ seafood were occasionally provided.

[8] Term used by Aboriginal people to refer to a South Australian Aboriginal person
[9] Term used by Aboriginal people to refer to a White person

The ration system had a negative effect on the health and morale of Aboriginal people for a range of reasons (Mattingley & Hampton 1988). Rations were given as a reward for good conduct and withheld for punishment (Mattingley & Hampton 1988). The ration system promoted sedentary dependence and undermined the traditional hunter-gatherer lifestyle. Specific responsibilities for food, traditionally allocated to men and women separately, were no longer necessary and this interrupted traditional roles (Mattingley & Hampton 1988). The rationing system continued for over a century and deprived Aboriginal people of all responsibility for their own diet, as for most other aspects of their lives (Rowley 1970; Mattingley and Hampton 1988). In the 1960s, Commonwealth social service payments/ cash grants began to take the place of rations (Mattingley & Hampton 1988).

Relationship between food and colonisation

Many Aboriginal people continue to associate food with colonisation practices. Today, there are guidelines about how Aboriginal people can access traditional lands and what they can take (Government of South Australia 1988). In this research, rural and urban based Aboriginal people discussed the ongoing impact of being controlled in many areas of their lives, including food choices. Aboriginal community women said:

> *[Since colonisation] Aboriginal people have never had a choice what to eat. They have always just had to eat what was there. That means that they don't necessarily know what is healthy and what is not. They just eat what is there because that's what they were always told to do. So, we need to educate Aboriginal people about what is a healthy choice [Reflexive Journal*[10] *10/12/2009, p. 105]*

Other Aboriginal people discussed often the "addictive" nature of Whitefella food including white flour and sugar that they received in rations, and the continued impact of this today. These stories highlight the very real power that past events have on the food intake of Aboriginal people in contemporary times, and therefore the need to consider these stories today.

Diet of Aboriginal people today

Today, while traditional foods still play a role in the diets of some Aboriginal people, European food is considered acceptable and more accessible to most Aboriginal people (Lee 1996). A much smaller range of traditional foods are consumed today, due to several factors including

[10] The use of a Reflexive Journal in this research will be explained in Section 6.6.2.

land damage by stock and feral animals in rural and remote areas (Lee 1996) and lack of access in urban areas. Additionally, some Government policies (such as conservation and land management) forbid Aboriginal people to hunt and gather food, unless they are living in their own communities on their traditional lands (Singh, Andrew et al. 2001). Aboriginal people tend to concentrate on collecting highly prized traditional foods that are not necessary for survival but add dietary variety. In general, Aboriginal people obtain more food from local shops than off the land, even in remote parts of Australia (Horwood 1981).

A number of studies have looked at the contemporary diets of Aboriginal people. The majority of these studies have been done in remote communities. While the Aboriginal communities that were part of this research were urban and rural, not remote, this information is still relevant as many Aboriginal people are transient and do move between these different communities. These studies demonstrated that Aboriginal people tend to have higher intakes of refined carbohydrates (including sugar, white flour and carbonated drinks) and lower intakes of fruit, vegetables and wholemeal bread when compared to the Australian average (Lee 1996; Brimblecombe and O'Dea 2009). However, due to difficulties in accurately assessing the intake of food in remote communities, these values may be debated (Brimblecombe, Mackerras et al. 2006). The diet of Aboriginal people, especially in remote communities, has been shown to be affected by the increased cost of food in remote communities, lack of food variety, lack of availability of healthy foods, infrequent delivery of fresh food and often poorer storage facilities which can decrease food quality (Lee 1996; Lee, Leonard et al. 2009).

Fruit and vegetable intake

The 2004-2005 National Aboriginal and Torres Strait Islander Health Survey provided information about the fruit and vegetable consumption of Aboriginal and Torres Strait islander people in Australia. When comparing the fruit and vegetable intake of this group to that of non-Aboriginal people, it was found that a similar proportion did not meet the daily intake of vegetables (89% compared with 86%) however, the percentage not meeting the recommendations for fruit was higher (55% compared with 46%) (ABS 2008a). It was found that a higher proportion of Aboriginal people living in remote areas reported not eating fruit and vegetables than those in non-remote areas (20% compared with 12% for fruit, and 15% compared with 2% for vegetables) (ABS 2008a). In 2003, insufficient fruit and vegetable consumption contributed to 3.5% of the total burden of disease in Indigenous Australian people (Vos, Barker et al. 2007b).

2.4.3. Room for improvements

The statistics in this section represent huge potential for improvements in Aboriginal health in Australia. However, there are no simple answers to the issues surrounding Aboriginal health, which is complicated by the complex interplay of many health, social and economic factors and will require a wide range of initiatives to increase prevention and cure from both mainstream and Indigenous health services (Vos, Barker et al. 2007a). Considering the past atrocities committed by White people towards Aboriginal people, it is important to consider what their role might be in addressing the problem, while at the same time acknowledging the need to work with Aboriginal people because they are best placed to develop solutions for Aboriginal people (Mattingley and Hampton 1988; Wilkinson 2002).

Clearly, there are multiple influences on the health of Australian Aboriginal people including dietary risk factors and historical events. Therefore, a multipronged approach to address Aboriginal health is necessary. Addressing nutrition and obesity are likely to be important. This warrants a focus on N & D and OP as areas of practice, as is the focus of this research.

2.5. *Chapter Summary*

In this chapter, I have summarised Aboriginal history in Australia since colonisation in 1788. Many atrocities have been committed by White people towards Aboriginal people since then. Unfortunately, many White people in Australia today are unaware of these atrocities. By presenting this chapter about some of the events and impacts of colonisation, I have acknowledged them and demonstrated my understanding of their continuation and impact throughout history and today.

In this chapter I also described the policies and practices implemented by Australian Governments and the many detrimental effects of such policies and practices on Aboriginal people. I have discussed nutritional status, diet and health of Aboriginal people from colonisation to contemporary times and demonstrated that there is a direct link between events of the past and the diet and health of Aboriginal people today. This includes the role of risk factors, including diet and obesity, which demonstrate the potential for further research and action in the areas of N & D and OP. By presenting this information and highlighting the relevance of past and contemporary events, I demonstrate that this relationship cannot be denied when working with Aboriginal people in contemporary times. Therefore an awareness and understanding of history must be incorporated into the practice of dietitians with Aboriginal people in contemporary times. I explore this issue later in this thesis.

3. Literature Review 2: Nutrition & Dietetics and Obesity Prevention

The high prevalence of lifestyle diseases amongst Aboriginal people and the role of diet and body weight as risk factors (as discussed in Chapter 2) is a rationale for exploring N & D and OP in this research. In this chapter, I consider the origins of N & D as a discipline and OP as an area of practice. For N & D, this includes a consideration of what constitutes dietetics as a profession, training and introduction to the Dietitians Association of Australia (DAA). For OP, this includes a summary of the history of the area of practice, with a focus on the area of community-based obesity prevention. In this chapter, I also review research in the areas of N & D and OP with respect to Aboriginal health.

3.1. *Introducing Nutrition & Dietetics*

This section considers the history of dietetics in Australia, the role of DAA as the peak professional association for dietitians, the role of the dietitian, places of work, training and relevance of N & D to the social determinants of health. It demonstrates that (a) the roots of dietetics are embedded in science, (b) the profession is relatively "young" in Australia and (c) the profession has diversified since its origins in Australia. The focus is dietetic history and practice in Australia only. This is to limit scope, and to maximise the relevance of this discussion to this thesis.

3.1.1. History in Australia

Dietetics emerged in Australia in the 1930s. The emergence can be traced to a growing appreciation of the link between diet and health in the late nineteenth century and a visit from American doctors and hospital administrators in 1924, who recommended that every general hospital in Australia should have at least one dietitian for every 100 beds. Prior to the presence of dietitians, nurses were responsible for dietary care of patients in hospitals (Nash 1988).

The first dietitians in Australia were either from North America and had college qualifications in home economics (including biochemistry), or nurses from Australia who had completed some dietetics training in England. The first hospital to employ a dietitian was the Alfred Hospital in Melbourne, with Mabel Flannery from Seattle starting in 1930. Other hospitals in Melbourne soon followed.

Over time, dietitians began to work in other states. In New South Wales, the State Hospital Commissions encouraged hospitals to pursue the recommendations from the American visitors and establish dietetic departments. In 1934, a department was established at Sydney's Royal Prince Alfred Hospital, and Edith Tilton from the Unites States of America (USA) was appointed as the first dietitian in 1936. The first dietitian in Hobart was appointed in 1933 and in Perth in 1939.

3.1.2. Professional Association

Over the course of the history of dietetics in Australia, there have been a number of bodies that have represented and supported dietitians at both the state and national level.

State

The timing of the formation of state/ territory associations representing dietitians is presented in Table 3.1. This helps to demonstrate the history of dietetics in Australia.

Table 3.1: Historical overview of formation of state associations representing dietitians (Nash 1988)

State Organisation	Year formed
Victorian Dietitians Association	1935
NSW Dietitians Association	1939
West Australian Dietetic Association	1951
South Australian Dietetic Association	1969
Queensland Association of Dietitians	1972
Northern Territory Dietitians Association	1976
Tasmanian Branch of DAA	1984

National

The Australian Dietetic Council (ADC) held its first meeting in May 1950, after a draft constitution paper was prepared in 1946. This council discussed general nutrition issues affecting the Australian population, nutrition research, and issues affecting dietitians such as salaries and working conditions. National support for dietitians continued to progress, with the Australian Association of Dietitians holding its inaugural meeting in Canberra in 1976. In 1983, the Australian Association of Dietitians was re-named and registered as the Dietitians Association of Australia. All state associations became formal branches of DAA. From 1983 to 1988 a number of areas of interest to dietitians were formalised into a number of separate DAA committees, one of which was Aboriginal nutrition (Nash 1988).

DAA today

The roles of DAA have diversified since its beginning in 1983. Today, DAA has been described as 'a self-regulatory professional body which sets standards for best practice, fosters professionalism and provides a mechanism for internal disciplinary procedures for the protection of members, the public and the credibility of the profession' (DAA 2006a). DAA is involved in the coordination of a number of activities, including an annual national conference, national interest groups, the accreditation of Australia N & D courses, the development of the document outlining National Competency Standards for Entry Level Dietitians in Australia and the development of evidence-based practice guidelines and practice recommendations. DAA coordinates the Accredited Practising Dietitian (APD) and Accredited Nutritionist (AN) credentials, which are approved by the Federal Government in place of professional registration (DAA 2006b). It is not necessary to be a member of DAA to practice as a dietitian because dietitians who are not members of DAA can apply for APD status. DAA has also developed a Constitution (DAA 2010) and By-laws, including a Code of Professional Conduct and Statement of Ethical Practice to which APDs are committed (DAA 2006b).

3.1.3. Role of the dietitian

While the role of the dietitian has diversified over time, there has always been a large focus on the link between diet and disease. This may be related to the high value placed traditionally on science which is thought to increase the value placed on dietetics (and other allied health professions) by the medical profession (Nash 1988; Nicholls 2009).

When dietetics emerged in Australia in the 1930s, the role of the dietitian was defined as:

> *To work in close association with members of the medical staff in both diagnosis and treatment of illness; to become involved in the education of nurses; and to fulfil the role of catering administrators with full responsibility for control of food service departments and their budgets (Nash 1988, pp. 6-7)*

In 2004, the International Confederation of Dietetic Association defined a dietitian as:

> *A dietitian is a person with a qualification in nutrition and dietetics recognised by national authorit(ies). The dietitian applies the sciences of nutrition to the feeding and education of groups of people and individuals in health and disease. The scope of dietetic practice is such that Dietitians may work in a variety of settings and have a variety of work functions (DAA 2005)*

DAA has also described the purpose of the dietetics profession as to contribute:

> *…to the promotion of health and the prevention and treatment of illness by optimising the nutrition of communities and individuals. It utilises scientific principles and methods in the study of nutrition and applies these to influencing the wider environment affecting food intakes and eating behaviour (DAA 2005)*

The first two definitions place strong emphasis on the use of scientific principles and methods. However, the third definition emphasises the promotion of health and prevention of illness which, historically, was not necessarily considered part of the dietitian's role. Furthermore, DAA recognises that the role of the dietitian continues to change and grow (DAA 2005). They acknowledge that 'there are several models of health care provision that can be implemented to ensure equity to access to dietetic services in a cost effective manner' (DAA 2006b).

Terminology: dietitian or nutritionist?

The term "dietitian" refers to a health professional with a high level of university training which includes extensive clinical, or practical, training. In Australia, dietitians are currently not required to be registered. At the time of submission of this thesis, there was discussion about pursuing registration of dietitians in Australia. DAA created the trademark "APD" which is a credential for dietitians that indicates a commitment to continuing professional development. This trademark is recognised by law and it is the only national credential for dietitians that is recognised by the Australian Government, Medicare, the Department of Veterans Affairs and most private health funds (DAA 2005).

On the other hand, the term nutritionist is not protected by law. It is a non-accredited title; therefore people with different levels of knowledge and experience in nutrition can refer to themselves as nutritionists. Nutritionists do not necessarily have clinical or practical training. However, in 2007, DAA introduced the Accredited Nutritionist (AN) credential which provides formal recognition of nutritionists in Australia (DAA 2011a). Accredited Nutritionists are university trained and have expertise in public health nutrition, community health and/ or tertiary education related to nutrition but not dietary counselling or therapy (DAA 2011a). In Australia, APDs are able to use the AN credential, while other professionals with a high level of tertiary experience and work experience in human nutrition can apply for use of the AN credential (DAA 2011a). This means that while some dietitians choose to call themselves nutritionists; nutritionists do not have dietetic training and therefore cannot call themselves

dietitians. In this thesis, I use the term dietitian to refer to dietitians/ nutritionists who are eligible for APD status with DAA. Therefore they have all completed a relevant university degree in N & D with a practical component.

3.1.4. Training of dietitians

Internships for dietitians were introduced in several Australian hospitals in the 1930s. Professor William Osborne, known as the 'father of dietetics in Australia', set up a postgraduate Diploma in Dietetics at the University of Melbourne, from which the first two students graduated in 1938. By 1967, a new course in N & D had been established at the University of Sydney, and prospective dietitians were being encouraged to get a university qualification. Training options were different in different states, but generally included an initial science degree or other diploma, followed by a year of hospital training (Nash 1998).

After the formation of the Australian Association of Dietitians in the 1970s, there were changes to training standards, with the development of a document called "Recommended Minimum Guidelines for the Professional Training of Dietitians in Australia" which was used to assess courses offered to students (Nash 1998). From 1975 to 1978, postgraduate diplomas in dietetics were introduced at Flinders University of SA, Queensland University of Technology, Western Australian Institute of Technology (now Curtin University of Technology) and Deakin University at Geelong. A prerequisite for entry into all of these courses was a Bachelor of Science with biochemistry and physiology.

In general, university training requires a four year Bachelor degree in N & D or a two year Masters degree in N & D preceded by a Bachelor of Science (or similar). In 2011, there were 17 DAA accredited courses in Australia that were accepting enrolments, an additional five that were accredited but not accepting enrolments, and three that had recently sought accreditation (DAA 2011b). These were a mix of undergraduate (Bachelor) and postgraduate (Masters & Diploma) courses.

3.1.5. Where do dietitians work?

Today, dietitians work in a diverse range of fields and settings including community and public health, clinical, education and private practice, where they engage in duties including assessing individual nutrition needs, developing personalised eating plans, engaging in

nutrition research, training health care professionals and developing nutrition communications, programs and policies (DAA 2011a). At the end of 1988, there were over 1300 dietitians practicing in Australia (Nash 1988). In the 2006 census, using the 2006 Australian and New Zealand Standard Classification of Occupations (ANZSCO), there were 2589 dietitians reported to be working in Australia (209 male) (ABS 2006a), indicating the numbers have increased since 1988.

In 1988, 45% of dietitians worked in hospitals, 15% in private practice, 9% in community health, 3.7% in educational institutions and less than 2% in private industry (Nash 1988). Today, DAA collects data about the number of DAA members who work in different areas. However, this information does not represent full time equivalents; members can have more than one work area and students/ members who are retired or not working are not included. Despite this, this information does give some idea of the proportion of dietitians working in different areas. The most popular areas for dietitians to work are inpatient/ outpatient facilities and private practice, which is consistent with those statistics presented from 1988 (Table 3.2).

Table 3.2: Work areas of DAA members in Australia (current as of 27 April 2011) (DAA 2011, pers. comm., April 27)

Work area	Number
Inpatient/Outpatient facility (including public, private, aged care, psychiatric)	1,383
Private practice/Consultancy (excluding industry)	862
Community nutrition	468
Government department/Non-government organisations	354
Research/Education	346
Industry (including consultants)/Marketing/Public Relations	191
Public health	179
Mixed Practice (regularly undertaking three or more areas of work, including private practice)	167
Food service	139
Do not work in nutrition and/or dietetics	115

3.1.6. Relationship to Social Determinants of health

As highlighted in Section 2.3.1, the biomedical model has been the predominant way of understanding health in Western countries, including within the N & D discipline. However, in N & D there has been a shift in recent times towards engaging with other approaches, including primary health care. Of importance to consider when taking this approach are the social determinants of health (SDoH). The SDoH attempt to provide an explanation for the

gross inequalities in health observed between and within countries (Marmot 2005). The 16-17 year gap in life expectancy between Indigenous and non-Indigenous Australians (Section 2.3.3) is an example of such an inequality (ABS 2006b). The SDoH have been described as:

> *…the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities - the unfair and avoidable differences in health status seen within and between countries (World Health Organisation 2011)*

The SDoH can be described at the upstream, midstream or downstream level. That is, there are factors at the upstream (macro), midstream (intermediate) and downstream (micro) level that contribute to disease (Turrell 2002). Upstream factors include social, physical, economic and environmental factors such as education, employment, income and housing; midstream factors include psychosocial factors (for example stress, self-esteem and social support) and health behaviours (for example food and nutrition, smoking and alcohol) and downstream factors include physiological systems (for example endocrine) and biological reactions (for example hypertension and body mass index) (Turrell and Mathers 2000). Of importance to mention in the context of Indigenous health is also the role of history and continued dispossession and discrimination as a determinant of health (Nettleton, Napolitano et al. 2007).

Action to address these determinants can also occur at the upstream, midstream or downstream level. While it is noted that focussing on upstream factors is likely to result in the greatest impact because this is where the "problems" originate, societal level changes are the most difficult to bring about and the most politically sensitive (Turrell 2002). Therefore Turrell (2002, p. 48) advocates that 'attempts to tackle health inequalities should focus on all three levels of influence'. While dietitians have embraced primary health care and there has been some consideration of the SDoH, action to address these determinants still only tends to occur at the downstream level.

Considering the focus of this research on the practice of White dietitians and other health practitioners with Aboriginal clients, it is pertinent to assess the extent to which practitioners have a role at the downstream, or point of care level, in addressing the social determinants of

health. It has been shown that action at this level can impact on health inequalities. For example, health promotion programs concerned with changing individual behaviour have been less effective with people who are more socioeconomically disadvantaged (Whitehead 1995). Turrell (2011) presents evidence that clinician characteristics can contribute to the quality of care and outcomes received by disadvantaged patients. Therefore, it is relevant to explore the practice of White health professionals with Aboriginal people.

3.2. *Nutrition & dietetic research in Aboriginal health*

A search of Australian and international literature was conducted in March 2011 using Medline and CINAHL (Cumulative Index to Nursing and Allied Health Literature) databases to identify publication trends in the area of Aboriginal health in N & D. These two databases were chosen as they are commonly used by dietitians and medical and allied health professionals as a source of peer-reviewed literature. Major journals used by medical and allied health health professionals are generally indexed in these databases. While I acknowledge that other literature may exist elsewhere, I limited this search to journals that the majority of dietitians would likely be exposed to (if they were to search the literature), in order to identify what is present in popular dietetic discourse. Throughout this thesis I refer to this as "mainstream" literature.

3.2.1. Australian Search

Search strategy

The search strategy used in both of the databases is outlined (Table 3.3). All five steps were performed, in order, in March 2011. The search was not limited by date. In Medline, words were searched as keywords. In CINAHL, words were searched as keywords in all text.

Table 3.3: Steps of search used for literature review in Medline and CINAHL databases for review of Australian literature in the area of nutrition and dietetics and Aboriginal health

Step of search	Keywords searched
1	Nutrition dietitian OR dietician OR dietetics
2	Aboriginal OR Indigenous
3	Nutrition AND (Aboriginal or Indigenous)
4	Australia
5	Australia AND [Nutrition AND (Aboriginal or Indigenous)]

Choosing relevant papers

Using the above search strategy, 106 and 65 papers were identified from Medline and CINAHL respectively. However, not all of these papers were directly relevant to nutrition. I assessed relevance by reading the title and skim-reading the abstract. Papers that were not included were those concerned with: birth weight, lung disease, respiratory function and hospital admission with no apparent connection to nutrition. Thirty one papers in Medline and 31 in CINAHL were deemed as irrelevant.

Results

The remaining 75 and 34 papers from Medline and CINAHL respectively were classified, using their titles, into categories (Table 3.4).The number of papers in each category and a definition for each category (unless it is self-explanatory) is provided (Table 3.4).

Table 3.4: Categories and number of papers in each category from Australian literature review about nutrition and dietetics and Aboriginal health (n=171)

Category	Definition	Medline	CINAHL
Breastfeeding		0	3
Clinical	Causes of nutrition-related diseases	5	1
Diets	What people eat	6	1
Disease management	Managing nutrition-related diseases	1	0
Food insecurity		1	1
Food supply	Food cost; food access	3	2
Interventions	Programs or approaches designed to address nutrition or nutrition-related diseases; evaluation of health care	10	13
Methodology	Study design	0	1
Not relevant	Articles deemed not relevant	31	31
Nutrition policy		2	1
Nutritional status: general/ nutrient levels		13	5
Nutritional status: growth	Growth rates; reports on growth	8	1
Nutritional status: malnutrition /under nutrition	Malnutrition or under nutrition; general or specific nutrients	16	3
Prevalence/ outcomes	Prevalence of nutrition-related disease e.g. diabetes, renal disease	9	0
Social research	Effects of social conditions on nutrition	2	1
TOTAL		**106**	**65**

This review demonstrates that while there is a body of literature exploring Aboriginal health within the area of N & D, it is mainly focussed on reporting interventions/ programs to address nutrition-related diseases (n=23), general nutritional status (n=18), malnutrition or under

nutrition (n=19) or growth (n=9). This indicates that the literature is focussed on Aboriginal health at the level of reporting on nutrition-related disease – whether it be about prevention, management or nutritional status related to these diseases.

3.2.2. International Search

A similar search was conducted in April 2011, not limiting the review to Australia, in order to identify international research. Steps one to three of the search strategy were used (Table 3.3) in Medline and CINAHL databases, and the search was not limited by date.

From Medline, 450 papers were identified. Classifying these papers as for the Australian review was not feasible due to the large number. However, they were critically assessed by reading the title and skim-reading the abstract and the international review supports the findings from the Australian review, i.e. the majority of the papers were concerned with nutritional status or nutrition intervention programs. There were two papers from Canada and the USA that specifically commented on adapting nutrition programs (Hassel 2006) or measurement tools for use in Aboriginal communities (Wein 1995). However, apart from these papers, the review did not offer any new insights.

From CINAHL, 238 papers were identified. Similar papers were identified to those in the Australian and Medline international reviews. However, this review did offer some new insights, identifying some additional papers from Canada. Similar to those identified in Medline, one paper discussed validating a culturally appropriate questionnaire in Inuvialuit people in Canada (Pakseresht and Sharma 2010). Two studies looked at factors that influence what Canadian Indigenous people eat (Willows 2005; Mead, Gittelsohn et al. 2010), and one of these supported the findings of this review stating that 'most of the literature documenting the health of Aboriginal peoples is primarily epidemiologic, and there is limited discussion of the determinants that contribute to health status' (Willows 2005, p. S32). One paper described how best to include Indigenous people (and ethnic minority groups) in intervention trials in New Zealand which highlighted the need for more time and funding when including these groups (Ni Mhurchu, Blakely et al. 2009) while another highlighted the importance of colonisation in history and the need to take this into account when designing and delivering nutrition programs (Mundel and Chapman 2010).

Finally, through a separate internet search I identified a document released by Dietitians of Canada outlining the role of Registered Dietitians in Aboriginal Communities (Dietitians of

Canada 2005). This highlights the awareness of this organisation with regards to specific issues that influence Aboriginal people, their nutrition and the subsequent care that is provided by dietitians.

3.2.3. Conclusions

This search of publication trends demonstrates that the majority of literature, both Australian and international, around Aboriginal health and nutrition is focussed on nutritional status and nutrition intervention programs. There is a small amount of literature from Canada and New Zealand that considers other issues in nutrition including colonisation and determinants of healthy eating. However even with this literature, this review demonstrates that there is a lack of social research in N & D related to Aboriginal health. Importantly, there is no assessment of the practice of dietitians/ nutrition workers in Aboriginal health, or of barriers and enablers to this practice. Instead of focussing on what dietitians/ nutrition workers can do to enhance practice with Aboriginal people, there is a large focus on actual conditions. This gap highlights that there is a need to:

- Explore alternative areas to those commonly researched including nutrition-related diseases/ prevalence/ outcomes/ nutritional status of Aboriginal people;
- Critically assess the practice of dietitians in Aboriginal health, including barriers and enablers to practice; and
- Consider what dietitians can do to move forward/ work better in Aboriginal heath.

I explore these areas in this research. Such areas of inquiry encourage the focus for action to be placed on the White health professionals. In the next section, I introduce OP and present a similar review for that area.

3.3. *Introducing obesity prevention*

While obesity is also a problem in adults, with 67.5% and 52.1% of Australian men and women respectively overweight or obese in 2000 (International Obesity Taskforce 2011), the initial call for action around obesity has been in children, young people and the families that support them. This is due to the large increase in childhood obesity and the potential to reduce adult obesity in the long-term by targeting this group (National Obesity Taskforce 2003). Ten percent of the world's school-aged children are overweight or obese and in Australia, the prevalence of overweight and obesity is increasing in children aged 2-18 years by approximately one per cent each year (Lobstein, Baur et al. 2004). In 2007, 22% and 24% of

Australian boys and girls respectively, aged 2-16 years, were overweight or obese (Department of Health & Ageing 2007). Worldwide, mean population trends in adult BMI were determined using recent, national health examination surveys (Finucane, Stevens et al. 2011). Worldwide, age standardised prevalance of obesity increased from 4.8% in men and 7.9% in women in 1980 to 9.8% in men and 13.8% in women in 2008, with mean BMI increasing in both women and men between 0.4-0.5 kg/m2 per decade (Finucane, Stevens et al. 2011). Clearly, overweight and obesity is a significant problem affecting the developed world.

People who are overweight or obese are at greater risk of developing a number of diseases, including cardiovascular disease, stroke, type two diabetes, cancer, osteoarthritis, kidney disease and respiratory and musculoskeletal problems and may experience low self-esteem or social discrimination as a result of the condition (World Health Organisation 2000). In addition, children who are overweight are 50% more likely to become overweight adults (Lobstein, Baur et al. 2004).

3.3.1. Causes of overweight

There has been an increase in children's consumption of non-core foods (including soft drink, crisps, takeaway, confectionary, sugars and sugar-based products) over the past 20 years (Cook, Rutishauser et al. 2001). There is also evidence that physical activity in defined contexts, including active transport (in many countries), school physical education (especially in the USA and Australia) and organised sport (especially in Australia) is declining (Dollman, Norton et al. 2005). The 2007 National Australian Children's Nutrition and Physical Activity Survey found that children do not eat enough fruit and vegetables and non-core foods contribute significantly to energy intake. Similarly, while the majority of children aged 9-16 meet the guidelines for physical activity, this declines with age and very few meet the recommendations for electronic media use (Department of Health & Ageing 2007).

These are some examples of changes in societal norms which support positive energy balance in individuals, which is the fundamental contributor to overweight and obesity. However, it is acknowledged that there is no one single cause of obesity, and that individual behaviour alone cannot explain the rising levels (Swinburn, Egger et al. 1999; National Obesity Taskforce 2003). An "obesogenic environment" has been described, and this environment facilitates positive energy balance, and therefore obesity (Swinburn, Egger et al. 1999). The "obesogenic environment" refers to political, sociocultural, physical and economic

factors in an individual or community's micro or macro environment that promote obesity. Other authors have supported the role of the environment in the development and maintenance of obesity (Kumanyika, Jeffery et al. 2002; Swinburn and Egger 2002; Catford 2003). Consequently, there has been a movement away from individual-focussed programs which may show short-term results, but often lead to weight gain when the program ends (Catford 2003), towards societal or community level interventions (World Health Organisation 2000; Kumanyika, Jeffery et al. 2002). These are seen as the key for tackling the obesity epidemic, and 'can begin to counteract the powerful forces that lead to steady population weight gain' (Kumanyika, Jeffery et al. 2002, p. 430).

3.3.2. Community-based obesity prevention

This has led to the concept of community-based obesity prevention interventions (CBOPI) internationally and in Australia, which are often aimed at young people and their families. A CBOPI represents a whole of community approach to effect changes in macro and micro environments across political, physical, sociocultural and economic domains (Swinburn, Egger et al. 1999). What is targeted for change is ideally determined by the community. CBOPIs allow for a focus on supporting multiple groups at different levels in the community and change across many sectors (not just health), including parents and families, consumers and communities, schools, health services, food industry, transport and urban design, sport and recreation, media and marketing and local and national government (Catford 2003).

CBOPIs are relatively recent and evidence of effectiveness is limited but increasing. Prior to the emergence of CBOPIs, prevention programs/ interventions were predominantly single setting and school-based (Summerbell, Waters et al. 2005). Additionally, there has been a lack of high quality and relevant program evaluation techniques (Swinburn, Bell et al. 2007), meaning that evidence previously collected about effectiveness of a number of childhood OP interventions is not of high quality and/ or is of little relevance. Consequently, there was a call for OP programs with high quality evaluations, including the need for height and weight measurements, comparison sites and sufficient process and contextual information, in order to identify what works and does not work to prevent obesity (Swinburn, Bell et al. 2007). While CBOPIs are not going to manage obesity, ideally they play a preventative role by preventing movement from the healthy weight into the overweight and overweight into obese categories.

Individual action is also required for people who are overweight to move into the healthy weight range and people who are obese to move into the overweight range.

CBOPI in Australia

In Australia, a number of CBOPI "demonstration projects" have been delivered with the view of expanding this body of evidence. The first were delivered in Victora at the "Sentinel Site for Obesity Prevention". This refers to three projects targeted at different age groups including: "Be Active Eat Well" (rural town of Colac, families of 5-12 years olds, began in 2000); "Romp and Chomp" (Greater Geelong area, families of 2-5 year olds, began in 2004); and "It's Your Move" (East Geelong/ Bellarine area, families of adolescents aged 13-17 years at five high schools, began in 2004). All three programs focussed on healthy eating and physical activity and involved multi-setting, multi-strategy interventions that focussed on building community capacity, with program evaluation and monitoring that included comparison sites (Bell, Simmons et al. 2008). In 2008, results were published for "Be Active Eat Well". Children who received the intervention had gained less weight (mean: -0.92kg, 95%CI: -1.74 to -0.11) and showed lower increases in waist circumference (-3.14cm, -5.07 to -1.22), waist to height ratio (-0.02, -0.03 to -0.004) and body mass index z-score (-0.11, -0.21 to -0.01) than children in comparison sites (after adjustment for baseline variables). Consequently, it was concluded that a community-capacity building approach to promote healthy eating and phsyical activity is effective in reducing unhealthy weight gain in children (Sanigorski, Bell et al. 2008).

A number of CBOPI programs on a similar scale, with varied goals and target audiences, have followed these in Australia. These include "Good for Kids, Good for Life" in the Hunter New England area of New South Wales, "Fun 'n Healthy in Moreland" in suburbs of Melbourne, Victoria and the *ewba* Community Programs in SA.

3.4. *Obesity prevention research with Aboriginal communities*

Considering the higher prevalance of overweight and obesity in socially disadvantaged groups, including Aboriginal and Torres Strait Islander people (National Obesity Taskforce 2003), a relevant question is whether CBOPI programs to date have focussed specifically on Aboriginal and/ or Torres Strait Islander groups. Of the six programs mentioned above, only one ("Good for Kids, Good for Life") has a specific component for Aboriginal people. The others are focussed on targeting the community in general rather than singling out specific groups and aim to reach Aboriginal people through their intervention with the wider community

as a whole. Therefore it is also necessary to consider international examples to identify what strategies might be useful when delivering CBOPI in Aboriginal communities in Australia.

3.4.1. In Australia: Good for Kids, Good for Life

Good for Kids, Good for Life is the only CBOPI I identified in Australia that has a specific component for working with Aboriginal communities. Aboriginal community is one of seven program streams, each of which focus on a specific area. The other streams are: primary and high schools, children's services, health care providers, community organisations and local sports clubs, social marketing and evaluation. The program is delivered by the Hunter New England Health Service in NSW and is part of the NSW Government's Live Life Well campaign (Trindall, Allen et al. 2007). It began in 2005 and is concerned with preventing obesity in children aged up to 15 years (Trindall, Allen et al. 2007). Settings for the program include schools, childcare services, health services and community with 'a significant focus and investment across all streams in ensuring the program reaches Aboriginal kids' (Trindall, Allen et al. 2007, p. 1).

The rationale for a specific stream for Aboriginal community was based on the 'marked disparity in indicators for health between Aboriginal people and other people across the Hunter New England (HNE) area' (Trindall, Allen et al. 2007, p. 1). It was acknowledged that extra investment would be required to ensure equitable health outcomes for Aboriginal children and consequently, for every one dollar spent overall on community interventions, three dollars were allocated to reaching Aboriginal children through community interventions (Trindall and Bell 2008).

Several other considerations were made about how best to deliver the program to Aboriginal people. First, a number of program strategies were adopted to help ensure cultural safety and appropriate program delivery, including the employment of Indigenous staff, an Aboriginal Advisory Group, over 40 consultations with Aboriginal community members and youth and an equity-focussed Health Impact Assessment (HIA) which assessed whether the planned approach was likely to produce a positive health impact in Aboriginal children (Trindall and Bell 2008). The HIA was modified before use to make it more appropriate for use with an Aboriginal community; for example allowing extra time to undertake it. The HIA resulted in the formation of over 80 recommendations for amending the program in order to maximise the benefits and minimise the harm of the program to Aboriginal children. This process ensured

that 'the program (was) better positioned to meet the needs of Aboriginal children and not exacerbate existing inequalities in health status' (Trindall and Bell 2008, p. 34).

The example of "Good for Kids, Good for Life" demonstrates how a mainstream program can also be delivered specifically with an Aboriginal community. It highlights the importance of using suitable processes and approaches to discover community needs, which are likely to differ between communities. If Aboriginal people are to be reached by a program, steps such as these are more likely to enable delivery of a culturally appropriate service.

It is also important to mention that while not CBOPIs, there have been a number of related programs to address weight as a risk factor in Australian Aboriginal people. For example, a number of programs targeting risk factors in Aboriginal people, including obesity and diabetes, have been delivered in urban (O'Dea, Cunningham et al. 2008) and remote Australian Aboriginal communities (Lee, Bonson et al. 1995; Rowley, Daniel et al. 2000).

3.4.2. International Programs

Due to the lack of CBOPI delivered specifically with Aboriginal groups in Australia, a general literature search was undertaken, to identify any international programs. Of particular interest was whether these programs addressed the needs and preferences of Aboriginal people and communities in their program and if so, how. The search was widened to OP in general and no specific age group was used to maximise chances of identifying relevant papers.

Search strategy

A literature search was conducted in November 2010 in Medline and CINAHL databases. The same rationale was used to select these databases as was described for N & D in Section 3.2. The following keywords were searched separately and then combined with "and":

- Aboriginal or Indigenous
- Obesity prevention

Fifteen papers were identified. All the papers refer to OP in some context, whether that be through a focus on obesity prevention specifically, or nutrition/ diabetes and/ or physical activity programs that were also designed to prevent obesity. The purpose of this review is to identify whether programs concerned with obesity prevention (or related areas) use specific strategies to be regardful of Aboriginal peoples' and communities' needs and preferences. Therefore the specific focus of the programs are less important than the strategies used. This

example demonstrates that when looking for peer reviewed evidence about Aboriginal health, it is sometimes necessary to widen search strategies.

Results

Of the 15 papers, 11 reported on a specific program or intervention (Table 3.5). Strategies used by programs to be regardful of the needs and preferences of Aboriginal people and communities are identified. Other papers have not been included in the table because they are reviews or have a more general focus but are discussed in more detail later (Conroy, Ellis et al. 2006; Teufel-Shone 2006; Cinelli and O'Dea 2009; Ruben 2009). The majority of the papers referred to OP in North America, including Indigenous people of Canada, the United States of America and Hawaii.

Table 3.5: Review of international programs, with a component of obesity prevention, run with Indigenous communities

Study (Location)	Program Details	Target group	Strategies to be regardful of Aboriginal peoples' and communities' needs	Results
Anand, Davis et al (2007) (Six Nations Reserve, Ohsweken, Canada)	Household-based with visits from Aboriginal health counsellors to assist families in setting healthy eating & physical activity goals (intervention & control)	Aboriginal families	• Involvement of whole family to recognise importance of role-modelling • Based in the home to build on the strengths of the family • Six Nations Health Committee reviewed & commented on study results	Compared to control, intervention group: • Increased consumption of: water (sig) • Decreased consumption of: fats, oils, soda pop, trans fats & sweets (sig)
Beckham, Bradley et al. (2005) (Hawaii)	1. Lifestyle Enhancement Program (LEP); 2. KidFit; 3. Hawaii Community Resource Obesity Project (HCROP)	Native Hawaiian people	Multi-focal, holistic, blends traditional medicine with complementary healing methods	N/A
Stevens, Cornell et al. (1999); Caballero, Clay et al.(2003); Davis (2003); Stevens, Story et al. (2003) (North America)	Pathways *Schools serving American Indian children in Arizona, New Mexico, South Dakota. 3 year, school-based, randomised, controlled intervention*	N=1074 American Indian children from 3rd-5th grade	• Study protocols approved by tribal school and university authorities • Involvement of American Indian people from multiple communities • Combination of constructs from social learning theory & principles of American Indian culture and practices • Indigenous learning models incorporated • Culturally sensitive, age appropriate questionnaire developed (measures PA, diet, weight related attitudes & cultural identity) • Ethnic identity scale developed, allowed comparison of intervention effectiveness in children with more or less strong American Indian cultural identity	*Diet , PA & anthropometry* • No significant reduction in body fat • Reduction in % energy from fat in intervention schools (sig) *Attitudes/ knowledge* • Some positive changes in knowledge, attitudes & behaviours in int schools • Significant increases in knowledge and cultural identity in intervention compared with comparison schools; retained significantly over three years. • Increase in intervention cf control schools e.g.: knowledge of nutrition and PA messages

Table 3.5 (continued)

Study (Location)	Program Details	Target group	Strategies to be regardful of Aboriginal peoples' and communities' needs	Results
Daniel, Green et al. (1999) (British Colombia, Canada)	Community-based diabetes prevention and control	Registered Indian population (adults)	• Integration of Aboriginal logic and belief systems with epidemiological knowledge of the determinants of diabetes and theories of behavioural and environmental change	• Few changes in quantifiable outcomes
Harvey-Berino & Rourke (2003)	Maternal participation in an obesity prevention plus parenting support program (compared to control – parenting support only)	Mothers & preschool children	• Delivered one to one in homes by an Indigenous peer educator	• Children in intervention group compared with controls: gained less weight over four months compared with controls (not sig); decreased energy intake (sig)
LaRowe, Wubben et al (2007) (Wisconsin, USA)	Healthy Children, Strong families	American Indian Families from three tribes with children aged 2-5 years	• Respects each community's cultural and structural framework • Reinforces cultural values • Based on social cognitive and family systems theories • Emphasis on traditional American Indian learning (storytelling, family activities, reflecting on lessons learned & goal setting) • Learning from elders • Partnership between Tribal Council, tribes and University • Involvement of community mentors	N/A
Paradis, Levesque et al (2005) (Canada)	Kahnawake Schools Diabetes Prevention Project	Mohawk children aged 6-11 years	• Participatory research at all levels (planning to evaluation) • Community ownership • Local community control • Culturally appropriate healthy lifestyle interventions	• Not many positive (significant) changes

Table 3.5 (continued)

Study (Location)	Program Details	Target group	Strategies to be regardful of Aboriginal peoples' and communities' needs	Results
Saksvig, Gittelsohn et al (2005) (Remote Canada)	Sandy-Lake school-based diabetes prevention program	Native Canadian children from grade 3-5 (7-14 year olds)	• Used ecological model and social cognitive theory • Native North American learning styles: learning through observation and practice, storytelling, cooperative learning, intergenerational learning, role modelling, emphasis on tradition, use of humour • Family included	• Increase in knowledge about foods low in fat, overall health knowledge, dietary self-efficacy and with meeting the dietary intake for fibre (stats available)

It is evident from Table 3.5 that these programs developed specific strategies to be regardful of the needs and preference of Aboriginal people and communities. Most notably, the programs were run (from planning to evaluation) in partnership with communities (Caballero, Clay et al. 2003; Paradis, Levesque et al. 2005; LaRowe, Wubben et al. 2007), traditional methods of learning or belief systems were used (Daniel, Green et al. 1999; Caballero, Clay et al. 2003; Paradis, Levesque et al. 2005; Saksvig, Gittelsohn et al. 2005; LaRowe, Wubben et al. 2007), Elders, other community members or family were included (Caballero, Clay et al. 2003; Saksvig, Gittelsohn et al. 2005; Anand, Davis et al. 2007; LaRowe, Wubben et al. 2007), and culturally specific tools were developed where needed (Caballero, Clay et al. 2003). Home visiting with an Aboriginal worker was also a common strategy (Harvey-Berino and Rourke 2003; Anand, Davis et al. 2007). While the results, where reported, are mixed, the studies reported good involvement from Indigenous participants. Participation is viewed by researchers involved in OP in Indigenous communities internationally as a positive outcome, suggesting the importance of programs that are regardful of needs and preferences of Aboriginal people.

Evidence from additional papers

Two reviews were also identified which considered OP programs with Indigenous groups in Canada (Conroy, Ellis et al. 2006) and American Indian communities (Teufel-Shone 2006). These two reviews suggest that OP programmes with Indigenous people in North America have taken an approach that assesses cultural appropriateness, suggesting that these are important elements for participation and thus success.

Conroy, Ellis et al. (2007) identified six articles that described childhood OP programmes from 1980 to 2005. Of these, three were run with Canadian Aboriginal people. There is minimal discussion in this review about specific practices used in these programs. However, it is evident from the summary of the studies that two of the three studies utilised at least one Aboriginal worker to work with the Aboriginal people (Conroy, Ellis et al. 2006).

Teufel-Shone (2006) conducted a review of tribal OP and treatment programs in the USA. This involved reviewing a number of 'less academic' sources due to the fact that these programs are often reported through word of mouth rather than in academic journals. She highlights that Indigenous communities tend to take a group approach to health promotion, and programs tend to target groups such as co-workers, families and communities. Consequently, health promotion with Indigenous communities tends to employ strategies that

promote a friendly form of peer-pressure to promote collective behaviour change and emphasise group pride or loyalty (Teufel-Shone 2006, p. 225). This is in contrast to individual-type strategies often used in non-Indigenous culture, which tend to ignore the influence of and the social connections between people (Teufel-Shone 2006). For example, 'the individualism of the biomedical model, and perhaps of mainstream society, has overshadowed and perhaps devalued a group-focussed approach' (Teufel-Shone 2006, p. 228).

Other useful strategies reported by Teufel-Shone (2006) include building and reinforcing social cohesion and collective efficacy, using friendly competition as motivation and aspiring to change local norms and policies by assuring high visibility of alternate behaviours and engaging formal and informal leaders. She gives examples of three programs that have been run in tribal communities as far back as the 1980s. For example, team weight loss programs where collective body weight is recorded and the 100 Mile Club where participants accumulate 100 miles of walking or jogging within a specified time period. Teufel-Shone (2006) criticises an approach where programs that have worked well in White communities that are poor or ethnically diverse, are modified slightly (for example graphics are changed to look more Indigenous) and delivered to Indigenous communities. This approach does not enable the creation of program based on cultural strengths, values and philosophies of Indigenous people, nor do they incorporate culturally distinct social behaviours (Teufel-Shone 2006, p. 228). In conclusion, Teufel-Shone (2006) outlines the need for programs to be (a) group-focussed and (b) have an Indigenous focus, developed in the context of the strengths and culture of the specific group. The two reviews generally support the strategies presented by the other studies (Table 3.5).

The final paper reports on a quantitative study, using a survey, that highlighted the differences in perceptions towards body weight in Australian Aboriginal adolescents compared with non-Aboriginal adolescents. The study found that Aboriginal adolescents were more likely to desire weight gain than non-Aboriginal adolescents (Cinelli & O'Dea 2009). Aboriginal children also received stronger parental advice to gain weight (Cinelli & O'Dea 2009). The paper concludes that when planning obesity prevention programs, it is important to consider these cultural perceptions around body weight, to avoid presenting a conflicting and/ or culturally inappropriate message (Cinelli & O'Dea 2009).

The reviewed papers developed programs that were regardful of Aboriginal peoples' needs and preferences, suggesting that this is a suitable approach to take if seeking to reach

Aboriginal people. Clearly, there is limited evidence reporting on useful strategies for obesity prevention in Aboriginal communities around the world. In particular, there is a lack of evidence about obesity prevention with Aboriginal people in Australia. This view is supported in a review by Morris (1999) who identified a lack of well-designed studies that assess the health needs of Aboriginal Australians. Furthermore, Ruben (2009) identifies that the evidence of effectiveness of interventions to address obesity and under nutrition only exists in the general population, or in groups from developing countries, not for Indigenous groups. Therefore, this area warrants further research.

3.5. *Chapter Summary*

In this chapter I provided extensive background information on the two major areas considered in this thesis: N & D and OP. I placed each in the context of Aboriginal health and considered what research has and has not been done in this area. I demonstrated there is limited evidence in relation to N & D and OP and Aboriginal health, but did demonstrate evidence for the importance of a culturally specific approach in OP and related areas.

In particular, I demonstrated that:

- N & D is a relatively young profession in Australia and traditionally is based extensively on the empirical-analytic sciences;
- the majority of research in the literature about Aboriginal health in the area of N & D is related to intervention programs, nutritional status and nutrition-related diseases. There is a lack of information focussing on the role and practice of the White dietitian;
- CBOPI is one type of obesity prevention, and the strategy relevant to OP in this thesis;
- within Australia, only one large scale CBOPI was identified that has worked specifically with Aboriginal people. In the international literature, there are some reports of OP in Aboriginal communities.

The evidence I presented in this chapter warrants investigations (in N & D and OP) that go beyond nutrition disease states, prevalence and interventions in Aboriginal communities. This includes investigating the role of the White health professionals in Aboriginal health, including factors that affect that practice and therefore ultimately impact on the health and nutrition of Aboriginal people. Investigations are warranted at the level of interaction between the Aboriginal client/ community and White health professional. Considering the importance of developing strategies that are regardful of Aboriginal peoples' and communities' needs and preferences, it is worth considering how programs that do not develop such strategies are received by Aboriginal communities.

4. Literature Review 3: Race and Whiteness Theory

In this chapter I present an alternative framework for considering N & D and OP in the context of Aboriginal health. As identified in Chapter 3, investigations in N & D and OP in Aboriginal health include nutrition disease states, prevalence and interventions. Race and Whiteness theories are concepts that promote and enable alternative explorations into the issues surrounding Aboriginal health in N & D and OP. If dietitians and OP practitioners/ researchers are going to begin new areas of inquiry in Aboriginal health, then they need new tools to do so and race and Whiteness theories are two such tools. Theories of race aid in making race visible; consequently presenting it as something that can be considered and addressed. Theories of whiteness make the White race visible and encourage White people to think about where they fit as part of a racialised society. Specifically, use of Whiteness theories allow the focus to be placed on the White health professional as the agent with the opportunity to change rather than the Aboriginal person, which is often the case in popular health discourse.

I begin this chapter with common definitions of race, the importance of race and a discussion of the racial terminology used in this thesis. This is followed by a brief review of the use of race as a concept in the literature in the areas of N & D and OP, demonstrating the gap in this area. I then discuss Whiteness theory, beginning with a historical overview of the development of this theory in the USA from African American writers and then consider Whiteness theory in the Australian context. I review the literature in N & D and OP and Whiteness theory, again demonstrating a gap in the literature. I finish by discussing key concepts in Whiteness theory including using it as a tool to explore (a) how White people see themselves and (b) how White people see Aboriginal people.

4.1. *Race*

4.1.1. Defining Race

Race is a category that can be used to classify individuals and groups, like class or gender. The use of race as a system of societal classification has changed with time and by location. For example, in America before the Civil War, class was inextricably linked to race because the White working class wanted to separate themselves from the Black slaves, and therefore strongly identified as White (Roediger 1991). In Australia, race was very much a part of life up until the 1970s when the White Australia Policy was abolished (Stratton 1998). This policy stipulated race was the factor that decided who could enter the country.

There are multiple ways of defining race and consequently providing a single working definition presents a challenge. It is also often confused with similar, related concepts including ethnicity. I present definitions of race from key authors in the area.

Biological definitions of race

Prior to the 1930s, biological definitions of race were popular (Omi and Winart 1994). When using this definition, race was attributed to hereditary characteristics and it was believed that there were certain physical and behavioural characteristics that could be ascribed to certain races and these could be explained by genes (Omi and Winart 1994). A biological definition of race is described by American sociologist Milton Gordon as 'differential concentrations of gene frequencies responsible for traits which, so far as we know, are confined to physical manifestations such as skin colour or hair form; it has no intrinsic connection with cultural patterns and institutions' (Gordon 1964, p. 27).

Associated with a biological definition of race was the idea that certain races were biologically inferior to others (Omi and Winart 1994). This idea was present when Australia was colonised and Aboriginal people were perceived to be a "dying race" (Chapter 2). In Australia, a biological view of race was common in the medical profession before and during the time of the White Australia Policy (Anderson 2002). For example, there were many scientific experiments conducted with Aboriginal people to ascertain if they were biologically similar to the White race (Anderson 2002). While used more commonly in the past, a biological view of race is still held and used in some areas today (Krieger 1996).

Categorical and social definitions of race

Michael Omi and Howard Winart are two key writers in the area of race in the USA. They present a theory of racial formation and state that race has traditionally been understood by relying on one of three categories: ethnicity, class or nation (Omi and Winart 1994). Ethnicity constructs of race emerged in the 1920s to 1930s and look at race as a social category. On the other hand, class theories explain race by reference to economic processes; that is the creation and use of material resources. Nation-based approaches consider race in terms of the coloniser and the colonised and explore the racial distinctions that reinforce colonial domination (Omi and Winart 1994).

Race has also been described by Nancy Krieger, a social epidemiologist with an interest in social justice who has published in the area of race, as a 'social (not biological) category, referring to social groups, often sharing cultural heritage and ancestry [defined by] possession

of selective and arbitrary physical characteristics (e.g. skin colour)' (Krieger 1996, p. 134). This definition is extended by Raj Bhopal, a Professor of Public Health, to include reference to the increasingly used self-definition of race: 'the group a person belongs to as a result of a mix of physical features, ancestry, and geographical origins, as identified by others or, increasingly, as self identified' (Bhopal 1998, p. 1970). Race may also be defined as a 'socially constructed abstraction', which means that race is not seen to imply inherent characteristics, but rather only becomes a concrete entity when racist structures and practices make it explicit (Harvey 1990, p. 193).

Controversies in defining race: ethnicity & culture

Clearly, with multiple definitions there is controversy in defining race. This is identified by some authors themselves. Omi and Winart (1994) state that each of the three definitions of race they provide (ethnicity, class and nation) is lacking in some area; their definitions do not refer to the other areas that may help to understand race including social conflict, political, organisational and cultural/ ideological meaning.

There are also inconsistencies between the use of the terms "race" and "ethnicity". Some authors indicate that "ethnicity" has been increasingly used in place of "race" in the literature with the intention of avoiding biological connotations of race (Cooper 1991; Crews and Bindon 1991) (Omi and Winart 1994). For example, Krieger (1996) presents race and ethnicity as interchangeable. Other authors use the two terms separately; Bhopal (1998, p. 1970) defines ethnicity as 'the group a person belongs to as a result of a mix of cultural factors, including language, diet, religion, ancestry and race'. "Race" may also be confused with "culture", as in the past in Australia, race has been used as a signifier of culture (Stratton 1998). However, in recent times, 'there has been a movement away from essentialism in which race was thought to determine culture, to a situation in which culture is the privileged term and race has become a signifier of cultural difference' (Stratton 1998, p. 72). The differences in use of the terms, as described here, can lead to ambiguity and confusion with terminology, highlighting the need to define these terms to avoid ambiguity (Section 4.1.2).

4.1.2. Racial terminology used in this thesis

As demonstrated in the preceding discussion, it is important to define racial concepts when using them. In this section I define how I have used the terms "race" and "White" in this thesis.

Race

In this thesis I take a social view of race. That is, that race cannot simply be defined through biology, but rather is a way of categorising people based on a mix of their physical features, ancestry, geographical origins, social, cultural and political heritage (Krieger 1998; Bhopal 1998). A social view of race seeks to understand race from these multiple aspects, as opposed to solely a biological aspect. When talking about race in this thesis, I am referring to the characteristics that make up a group of people including and most importantly, social and cultural factors. I also take the view that race is a socially constructed category, meaning that different people have different ideas about what race means based on their life experiences. I acknowledge that relationships between races are generally not neutral and that within the field of race relations there are oppressive systems and unequal power relations, and there is usually a dominant group that benefits from dominating other groups, as discussed by Krieger (1996).

White

In this thesis I use the term "White" to refer to members of the dominant racial culture[11] who were involved in this research, or more broadly to refer to the dominant racial culture in SA or Australia. I also use this term to refer to myself as a member of the dominant racial culture which allows me to highlight the relevance of my position as a White person and acknowledge the impact of this on how I have conducted and analysed this work. In line with the use of the term "White" in other literature, I capitalise it (Kowal 2008).

Despite my use of the term "White" in this thesis, there is still some debate about the use of this term and its meaning. Some writings imply that the term "White" has little value in gauging ethnicity or race (Bhopal and Donaldson 1998). Others highlight the change in use over time. Jon Stratton, an Australian academic and Professor of Cultural Studies, has published about the role of race in Australian society. In his book "Race Daze" (Stratton 1998) he explores how "White" is a culturally constructed category that has changed over time in Australia. For example, in early colonial Australia, "White" referred to British people, but by the 1960s "White" came to include Northern European people and eventually other European people including Southern Italian, Greek and Maltese people. This is also explored by Warwick

[11] In using the term "dominant racial culture" I am referring primarily to race but also the culture (for example ideals) that surrounds this group. I acknowledge that there are other aspects to dominant culture, including class, gender, sexuality, gender and ability and highlight that this thesis does not attempt to address these elements within the context of the topic, due to their large scope and the inability to do them justice here.

Anderson, an academic based in Sydney, Australia with a background in biology, medicine and public health and an interest in race. He states that 'during much of the nineteenth century, being "White" in the Australian colonies usually meant claiming British ancestry' while 'later, it sometimes became diffused into the general, and more obscure, category of Caucasian' (Anderson 2002, p. 2). I argue that, using the term "White" is appropriate, and consistent with an approach used by Emma Kowal, a medical doctor and anthropologist working extensively in Aboriginal health research in Australia. She writes that:

> *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 2008, p. 341)*

This is reiterated by Kelly (2008) who highlights in her PhD thesis that in Australia, "White" or "Whitefellas" is a term used (a) by many Aboriginal people to name White people in relation to themselves and (b) some White people (including myself) to describe themselves in relation to Aboriginal people, especially when discussing issues related to colonisation.

Therefore in this thesis, I do use the term "White". When I began this research, I did not feel comfortable using this term but I now recognise its importance. Using the term White acknowledges the racialised nature of Whiteness, rather than leaving it an unmarked, unnamed and invisible category (Frankenberg 1993). It also identifies that I do not report on the experiences of non-Aboriginal people who are also non-White (for example Asian people) in this research, an important aspect highlighted by (Kowal and Paradies 2005). I use the term "White" to refer to the White people I interviewed in this research. I use "non-Aboriginal" if this was used by a participant in an interview and when citing from a source that refers specifically to "non-Aboriginal" or "non-Indigenous" people.

As explained in Footnote 4 (page 8), I use the term Aboriginal, rather than Indigenous, when referring to the Aboriginal people involved in this study as that is the preference of the participants themselves. I also use the term "non-White" to refer collectively to groups of people who are not White, when not solely nor specifically referring to Aboriginal people.

4.1.3. The importance of addressing race

Regardless of the controversy associated with defining and using the term race and related concepts, it has been identified as important to incorporate into everyday language and research. In order to move past racism, it is necessary to acknowledge race (Omi and Winart 1994). Race has been a crucial factor in the formation of Australia and Australian history and talking about race is important because 'stopping people talking about it actually inhibits the ability of those who want to confront the likes of Pauline Hanson' (Stratton 1998, p. 13). Krieger (1996) suggests that the discomfort around language that describes race relates to the fact that such language exposes, or challenges us to articulate the frameworks and assumptions that inform our work. She stresses that unless terms are clearly defined and truths about race and racism are confronted, then research and programs cannot take into account how health is shaped by, for example, discrimination, culture, slavery and conquest. Consequently, I have chosen to address race in this thesis in order to use it as a lens through which to explore how practice in Aboriginal health might be improved, in the areas of N & D and OP.

4.1.4. Race in the N & D and OP literature

A search of publication trends was conducted to identify whether race had previously been explored in the context of N & D and OP.

Search strategy

Searches were performed in February and April 2011 using Medline and CINAHL databases separately. These databases were chosen using the same rationale described in Section 3.2; that is to identify the extent to which race had been explored in the literature that the majority of N & D and/ or OP health professionals/ researchers would be most likely to access. Six different searches were performed in each database (Table 4.1).

Table 4.1: Searches performed in Medline and CINAHL databases to identify research in nutrition and dietetics and obesity prevention related to race

Keyword search	Number of papers identified	
	Medline	CINAHL
Race and (nutrition or dietetics or dietitian or dietician)	1630	1537
Race and (nutrition or dietetics or dietitian or dietician) and social^	143	232
Obesity and race	2049	1095
Obesity and race and social^	196	180
Obesity prevention and race	27	95
Obesity prevention and race and social	4	13

^Used as a key word in light of my focus on a social view of race

Discussion

From Table 4.1, it would appear that there is a plethora of literature about N & D and obesity and race, with Medline returning 1630 and 2049 papers respectively, and CINAHL 1537 and 1095. However, the high number of papers returned is deceiving. First, when consulting the titles, the majority of these papers appeared to be irrelevant because it was not obvious how many of them were connected to race. Second, when the title did clearly indicate that the paper was connected to race, this connection was generally between nutrition/ health/ weight outcomes or prevalence and different racial groups. That is, these papers appeared to be comparing physical activity, dietary intakes, dietary behaviour, anthropometric measures, dietary attitudes, weight status or obesity prevalence between different racial groups. The majority of these studies use a form of statistical inquiry or numerical reporting.

The search was narrowed using the keyword “social” to try and capture if there was any literature focussed on a more social view of race, or research using social research methods. This did significantly reduce the number of papers identified by the databases with Medline returning 143 and 196 for N & D and OP respectively and CINAHL 232 and 180. However, from a detailed look at this literature, it did not appear to differ significantly from that identified in the search without the keyword “social”. That is, it was still primarily concerned with reporting differences in nutrition or weight outcomes or prevalence between different racial groups. There did not appear to be use of social research methods. The majority of these studies were from the USA and the racial groups were generally black and White Americans, or White Americans and another group such as Mexican or Hispanic people.

This search indicates that in the areas of N & D and OP, the literature around race is primarily concerned with health outcomes between different racial groups. The implication here is that race is used as a way of classifying people based on characteristics/ attributes rather than as a social construction. This is similar to an approach identified in nutrition literature as political arithmetic (Murcott 2002) when social issues (for example race) are used to attempt to explain nutritional issues (such as dietary intake or weight status). It has been identified that while some may consider approaches like this to be social nutrition research, they do not illustrate experience or consider how different contexts affect experience (Schubert, Gallegos et al. 2011). Therefore, there is a lack of literature in the areas of N & D and obesity prevention that truly explores race from a social perspective. Furthermore, there is a lack of literature about Indigenous peoples as a racial group worldwide, and there is a definite lack of literature about Australian Aboriginal people. There is very little literature that uses race as a social construction to explore practice of health professionals. It is important to note that this review was only performed in two databases which have a primarily medical/ allied health focus. It is possible that some literature exists in these areas in other disciplines, such as sociology. However, the majority of dietitians and OP practitioners/ researchers would be less likely to search for information or publish in these alternate areas. Consequently this review was limited to searching those databases that would be commonly used by this group of professionals and therefore can be considered the "mainstream" or "popular" discourse source for their work and research.

In summary, this search of publication trends demonstrates that there is a lack of discussion about race, as a social construction, in the areas of N & D and OP. While the health of Aboriginal people in Australia is an area of interest in both N & D and OP (as highlighted in Chapters 2 and 3), this has not been explored in the context of race. Hence there is a gap in the literature about what an exploration of race could bring to N & D and OP in the area of Aboriginal health.

4.2. *Whiteness Theory*

Whiteness theory/ studies refer to an emerging area of race studies where race is critiqued in terms of the dominant, White culture. A key writer is Ruth Frankenberg (1957-2007), a sociologist who was instrumental in the development of the field of Whiteness Studies and author of the seminal Whiteness text "The Social Construction of Whiteness: "White Women, Race Matters". She described Whiteness as (a) a location of structural advantage/ race

privilege, (b) a standpoint from which White people look at themselves, others and society and (c) a set of cultural practices that are usually unmarked and unnamed (Frankenberg 1993). Aileen Moreton-Robinson, a Geonpul woman from Quandamooka (Moreton Bay, Australia) and an academic who has written in the areas of Whiteness, feminism and Indigenous sovereignty describes Whiteness:

> *Whiteness remains the invisible omnipresent norm. As long as Whiteness remains invisible in analyses "race" is the prison reserved for the "Other". (Moreton-Robinson 2000, p. xix)*

She highlights there are many different ways of constructing and using Whiteness theory, demonstrated by its application in varied disciplines and from multiple theoretical perspectives, including feminism and education (Moreton-Robinson 2004). Historically, Whiteness was given meaning only in relation to "other" races because the power and privilege it accrued had severe implications for these "other" groups (Carey and McLisky 2009). However, Whiteness is an increasingly important field of study in naming "White" as a race and White people as an important part of racialised discourse. By identifying this position of White authority, one can move towards undermining it (Dyer 1997).

4.2.1. Historical overview

Whiteness studies emerged in the international literature in the 1990s from critical race theory and scholarship from African-American writers.

Early African-American authors

Prior to the emergence of Whiteness theory in the 1990s, there is a body of work from African-American scholars that is now seen to precede Whiteness theory (Moreton-Robinson 2004). These scholars describe the lives of African-American people and make some reference to White people. This work 'illuminated the significance of Whiteness as a discursive formation that has material effects, shaping the lives of both White and non-White people' (Moreton-Robinson 2004, p. viii) and this work sought to point out that 'race in the US was not a 'Negro problem' but a 'problem among Whites' (Roediger 1991, p. 6)

William Edward Burghardt (W.E.B.) Du Bois (1868-1963), a Black American sociologist, writer and civil rights activist born in the late 19th Century, has written extensively on the topic of White supremacy. One of the most famous of these writings is "The Souls of White Folk",

originally published in 1910 and then revised and republished in 1920 (Du Bois 1969). Du Bois was one of the first to identify Whiteness and White privilege:

> *...long before the recent discourse on racism and critical White studies, Du Bois called into question White superiority and White privilege, and the possibility of White racelessness and/ or White racial neutrality and universality (Rabaka 2007, p. 2).*

For Du Bois, writing about White supremacy was not only to provide a radical criticism of racism, but also to provide an affirmation of black humanity (Rabaka 2007). In this key writing, he presents his views about race relations in the context of Whiteness, including demonstrating the dominance of White supremacy:

> *How easy, then, by emphasis and omission to make children believe that every great soul the world ever saw was a White man's soul; that every great thought the world ever knew was a White man's thought; that every great deed the world ever did was a White man's deed; that every great dream the world ever sang was a White man's dream.' (Du Bois 1969, p. 31)*

As his writings in White supremacy developed, Du Bois developed his "gift theory". This theory highlighted what Black people could "add" to society, or what they brought to American society. This includes a 'meekness and humility which American never has recognised and perhaps never will' (Du Bois 1971, p. 339), a spiritual role, a historical role and the idea that 'modern democracy rests not simply on the striving White men in Europe and America but also on the persistent struggle of the Black men in America for two centuries' (Du Bois 1971, p. iii). Therefore, in his writings, Du Bois has not only made evident the privilege and dominance of the White man, but also the strengths of the Black man.

The American Civil War (1861-1865) was also important in the historical development of Whiteness studies. David Roediger, a professor of history who has written about racial identity and class, highlighted that during this time, Whiteness became more of an issue for White workers (Roediger 1991). Prior to this time, 'White workers could fashion identities as "not slaves" and as "not Blacks"' (Roediger 1991, p. 13). However, with the Civil War, 'emancipation (of Black people) removed the ability of White workers to derive satisfaction from defining themselves as "not slaves" and called into question self-definition that centred on being "not Black"' (Roediger 1991, p. 170). There was concern that freedom for Black people would lead to degradation for White people. Consequently, White people were required to consider their self-identities.

James Baldwin (1924-1987) was a Black American writer and social critic who explored issues including race, class and sexuality in mid-20th century America. In his collection of essays "Notes of a Native Son" (Baldwin 1965), he discusses what it means to be a "Negro" in America and the relationships that exist between black and White people. He talks about the presence of "Negro" people in America and how it is not possible to return 'to a state in which black men do not exist' (Baldwin 1964, p. 148). He speaks of a 'new society' where 'inequalities will disappear, vengeance will be exacted; either there will be no oppressed at all, or the oppressed and the oppressor will change places' or there will be 'an elevation of status, acceptance within the present community' for "Negro" people (Baldwin 1965, p. 16). Importantly, he highlights that 'this world is White no longer, and it will never be White again' (Baldwin 1965, p. 149). Through this discussion, Baldwin highlights that Black people are there to stay in America, and have just as much right to be there as White people. It is likely that writings such as this acted as a call for White people to start examining themselves as racialised beings when it was identified that Black people were not simply going to disappear. As he discusses in relation to an all "Negro" Hollywood movie – 'the questions it leaves in the mind relate less to Negroes than to the interior life of Americans' (Baldwin 1965, p. 43). That is, literature and popular media regarding black people led White people to begin questioning themselves.

Similarly, Toni Morrison, a Black American novelist and professor, questions 'how free I can be as an African-American woman writer in my genderized, sexualized, wholly racialized world' (Morrison 1992, p. 4)? Morrison questions American literature and poses questions related to Whiteness and blackness, for example 'what parts do the invention and development of Whiteness play in the construction of what is loosely described as "American?"' (Morrison 1992, p. 9). She highlights that such a critique had not occurred in 1992 (when the book was written) because of "indifference" to these matters (Morrison 1992, p. 9). In terms of literature, she feels that while investigations into the mind, imagination and behaviour of slaves (African-American people) have occurred, 'equally valuable is a serious intellectual effort to see what racial ideology does to the mind, imagination and behaviour of masters' (i.e. White people) (p. 12). Similarly, I am interested in the examination of the White health professional, and what happens in their mind, imagination and behaviour when working with Aboriginal people.

These writings by African-American authors and others highlighted that Whiteness exists by bringing to the forefront White people's reactions to black people. These authors have posed questions and thought deeply about their role in society as black people and of not being part of the dominant racial culture. These authors assisted in highlighting that while there has been investigation into race at the level of the oppressed, there has been very little from the oppressor. This provides rationale for examining the role of the White health professional in Aboriginal health which, as indicated by these authors, has not been explored in detail.

Contemporary Whiteness Studies

The majority of contemporary writings on Whiteness studies are from the United States of America (USA) and written in the late 20th century. Importantly, the majority of this work positions race and Whiteness in the context of slavery and immigration, rather than with dispossession and colonisation of Native American people (Moreton-Robinson 2004). This is a major weakness when translating these writings to the context of Australian Aboriginal people where dispossession and colonisation are the relevant issues for this group of people. In addition to key authors I have already introduced (Ruth Frankenberg and David Roediger), other key contributors to contemporary Whiteness studies include Janet Helms, Theodore Allen, Peggy McIntosh, Richard Dyer, Richard Delgado and Jean Stefancic. Janet Helms is a Black American professor who has worked extensively in the areas of White and Black racial identity, especially as they relate to counselling. Theodore Allen (1919-2005) was a self-educated and working class individual and researcher of white supremacy in the USA. Peggy McIntosh is a feminist and anti-racist activist and has written in the areas of race, class and gender privilege. Richard Dyer is an English professor of film studies. Richard Delgado and Jean Stefancic are key writers in the area of critical race theory, which has relevance to Whiteness theory because it assesses race, racism and power, including White supremacy (Delgado and Stefancic 2001).

In key texts, these writers acknowledge the importance of White people beginning to talk and write about race (Dyer 1997). This is a theme that will be picked up on again later in this thesis in relation to the White health professionals in this study. Each of these authors explore Whiteness, or how race is constructed in White people's lives (Roediger 1991; Frankenberg 1993; Allen 1997; Delgado and Stefancic 1997; Dyer 1997). However, the texts differ in the specific aspect of individual or societal Whiteness theory that they explore, demonstrating the potential for diverse applications of this work. For example, Frankenberg (1993) explores how

race affects the lives of White women while Dyer (1997) explores how White people have been represented – primarily how they have represented themselves – in visual media, especially photographs, over the course of history. These texts have paved the way for later work in Whiteness studies, including some of which has been undertaken in Australia.

Whiteness studies in Australia

Whiteness studies remain relatively underdeveloped in Australia (Hage 1998) but there are some texts that explore it in the Australian context; either through Indigenous people or immigration. Generally, these two issues are explored separately. While the focus of this thesis is Indigenous issues, some texts focussing on immigration have been included in this discussion due to the small body of work that discusses Whiteness in the Australian context, for example Hage (1998) and Stratton (1998). It is important to include an Australian perspective in this thesis because this research was planned, undertaken and analysed within the Australian context.

Ghassan Hage, born in Lebanon and now a professor of anthropology and social theory in Australia, has written about nationalism, multiculturalism, racism and migration. In his book "White Nation" (Hage 1998), he draws on Whiteness studies and focuses on immigration and Indigenous issues to explore the idea of White supremacy in a multicultural society. Similarly, Stratton (1998) explores multiculturalism and the concept of core/ mainstream culture in Australia. Aileen Moreton-Robinson (2000) discusses Whiteness within the context of Australian feminism and how this affects Indigenous women. Anderson (2002) considers the construction of White Australia from a medical point of view. There are also a number of collections of essays that demonstrate how Whiteness theory has been used in multiple disciplines in the Australian context (Moreton-Robinson 2004; Carey and McLisky 2009). Furthermore, the Australian Critical Race and Whiteness Studies Association (ACRAWSA) publish an ejournal which highlights the use of Whiteness studies across disciplines and in different contexts.

4.2.2. Whiteness theory in the N & D and OP literature

A search was conducted to identify whether Whiteness theories have been utilised in N & D and OP research. No separation was made between international and Australian literature due to the likelihood of a small amount of literature in this area.

Search strategy

Searches were performed in February and April 2011 using Medline and CINAHL databases separately. Five separate searches were performed in each database (Table 4.2). These databases were chosen using the same rationale described in Sections 3.2 and 4.1.4.

Table 4.2: Searches performed in Medline and CINAHL databases to identify research in nutrition and dietetics and obesity prevention related to Whiteness theories

Keyword search	Number of papers identified	
	Medline	CINAHL
Whiteness	237	35
(Nutrition or dietetics or dietitian or dietician) and Whiteness	0	1
Obesity and Whiteness	0	0
Obesity prevention and Whiteness	0	0
Allied health and Whiteness	0	6

Discussion

I have included the total number of papers identified about Whiteness (in all areas) to demonstrate that in itself, this is a small area of research within the medical/ allied health field. Of those six papers identified from CINAHL about Whiteness in the area of allied health, those that were relevant were related to social work, sexuality, multicultural education and social identity. Two were not relevant and were related to biomechanics and tooth-whitening.

Clearly, there is an absence of research that utilises Whiteness studies in the areas of N & D and OP. The one paper identified by CINAHL (Table 4.2), is about dental bleaching agents and not relevant to the topic area (Zouain-Ferreira, Zouain-Ferreira et al. 2002).

This search of publication trends demonstrates that in the areas of N & D and OP, as well as medicine and allied health, the use of Whiteness theory to guide and/ or interpret research is minimal. As for the previous review about race, it is likely this work may be published in journals that are not indexed in Medline or CINAHL. However, as I am trying to demonstrate what is and is not part of popular N & D and OP discourse, it has been important to limit my search to databases commonly used in these areas.

In summary, there is an absence of literature that brings N & D and OP together with Whiteness theory, and an absence of literature that uses Whiteness theory to guide interpretation and understanding of work in these areas, in particular work in Aboriginal health. Therefore, this represents an area for growth in N & D and OP. In particular, what Whiteness

theory can add to understandings of the term race and the role of White health professionals in Aboriginal health.

4.2.3. Whiteness theory: key concepts

In this section I review key concepts related to Whiteness theory discussed in some of the key texts written by the authors presented in the preceding sections. This is not a complete summary of all concepts related to Whiteness theory; only those that are (a) important for an understanding of Whiteness theory and/ or (b) will aid in interpretation of the data from this research are included. Strengths and limitations of each key concept in relation to this study were considered. Concepts identified in key texts, including major strengths and weaknesses of each concept, are summarised (Table 4.3). I have divided these key concepts into two areas, through which I discuss them in this thesis: (1) how White people see themselves and (2) how White people see non-White people. I have used the term “non-White” here because these theories position White people against a multitude of non-White groups including Indigenous people, black Americans, Mexican Americans and Hispanic Americans.

Table 4.3: Summary of key concepts related to Whiteness theory and strengths and weaknesses of each concept for this study

Key text	Key concepts	Strengths	Limitations
Frankenberg (1993)	• Colour blindness/ colour evasion • Whiteness as an "unmarked" or invisible category • Race cognisance • Social geography of race • White-centred standpoint • Racially neutral • Power evasion	• Seminal Whiteness text	• Written in the Unites States of America • Discussion centred on black Americans and Hispanic-Latino people, not Indigenous people
Hage (1998)	• Nationalism/ White nationalist/ White nation • Tolerance • Discourse of enrichment – • Discourse of Anglo decline •	• Australian	• Discussion is centred around migrants, not Indigenous people
Helms (1984; 1987)	• White racial identity	• Stage theory (able to be related to results from this research)	• Written in the United States of America • Focus on Black Americans, not Indigenous people
McIntosh (1998)	• White Privilege		
Moreton-Robinson (2000)	• Standpoint of Indigenous women • Whiteness is invisible or "raceless" • Awareness of standpoints • Construction of race by dominant groups	• Australian • Focus on Aboriginal people	• Focus on women only
Stratton 1998	• Official multiculturalism • Everyday multiculturalism • National identity • Removal of race from Australian discourse • Culturalism • Cultural Pluralism • Core Culture • Mainstream Australia • Tolerance	• Australian	• Discussion is centred around multiculturalism, not Indigenous people

How White people see themselves and other White people

A number of authors consider how White people see themselves as White people. Authors that consider this issue include Frankenberg (1993), Hage (1998), Stratton (1998), Moreton-Robinson (2000), Helms (1984; 1995) and McIntosh (1986).

Aileen Moreton-Robinson (2000) uses the example of feminist scholarship to demonstrate how White people perceive themselves as the norm and as such, often do not feel the need to identify their standpoint or justify their position. She highlights how historically, White feminists have explored oppression but have not discussed their own subject position, standpoint or identified their privilege, which is considered crucial to a discussion regarding oppression. 'The privileged subject position and standpoint from which White feminists conceptualise and write is not made visible in their work' (Moreton-Robinson 2000, p. 33) and

> *...the work of these feminists recognises that White race privilege makes a difference to women's life chances. Yet these authors fail to appreciate that their position as situated knowers within White race privilege is inextricably connected to the systemic racism they criticise but do not experience*

Moreton-Robinson (2000) argues that not presenting a standpoint is based on the assumption that all women, regardless of race, have similar experiences of being a woman and therefore the White, middle-class woman has the right to speak on behalf of all women. However she argues that, 'the experiences of Indigenous peoples means that their interpretation of events will be different to White people' (Moreton-Robinson 2000, p. 32). and that Aboriginal women 'speak not from a position of race privilege but from one of race oppression' (Moreton-Robinson 2000, p. 63). This suggests it is important to identify whether White health professionals participating in this research identify their standpoint, and to identify my own standpoint as a White, middle-class, female researcher. The latter is considered in Chapter 7.

Moreton-Robinson's points are reinforced by other authors who identify that Whiteness has been unmarked, unnamed and invisible (Frankenberg 1993; Moreton-Robinson 2000, Moreton-Robinson 2004, Carey and McLisky 2009). Frankenberg (1993, p. 70) argues that even when it is not acknowledged, race shapes the lives of White women: 'race shaped the lives of all the women I interviewed in complex ways, at times explicitly articulated and at other times unspoken but

nonetheless real'. Similarly, key spaces in society, including the health system, have been described as being perceived as racially neutral (Moreton-Robinson 2000) when in reality they are not. The idea of the White race being racially neutral was identified by Frankenberg (1993) because some of the White women in her research felt that they did not have a culture. From this, Frankenberg (1993, p. 192) advocates that 'rather than viewing White culture as "no culture", we need to analyse the social and political contexts in which, like race privilege, White cultural practices mark out a normative space and set of identities, which those who inhabit them, frequently cannot see or name'.

White Racial Identity Theory

Janet Helms presents a theory of White racial identity (WRI) that can be used to describe how White people see themselves in relation to people of other races. Specifically, WRI is a stage theory or stepwise process by which White people come to develop a racial consciousness, acknowledge and accept their Whiteness and what it means to be a White person in a society where White is the dominant race (Helms 1984; Helms 1995). This theory was developed in the USA and when referring to the interaction of White people with other races, generally refers to "Black" (African American) people. Despite the different context, significant parts of this theory are transferable to the Australian context and to this research. In this thesis, I specifically use WRI theory to explore how White health professionals (including myself) recognise and come to terms with their own Whiteness, rather than using it to explore their reactions to Black people. This fits with ideas previously presented through Whiteness theory, which positions White people as the agents of change.

Traditionally, racial identity theories were posed about the racial identity of "people of colour" living in the United States of America (Helms 1983; Helms 1995). Theories of WRI are significantly different to racial identity theories for non-White people because of power differences that result in different processes of acquiring a racial identity (Helms 1995). WRI is likely to be a useful theory when considering the practice of White health professionals with Aboriginal people in this research, especially because it places a focus on the White health professional and what stage they are at with regards to acknowledging their racial standpoint. Furthermore, WRI is important to consider in health care because 'diagnosis of the particular racial identity statuses governing participants' behaviours can make interventions potentially more relevant' (Helms 1995, p. 191).

In Australia, White people represent the dominant culture and Australian society is largely based on White norms (Katz and Ivey 1977). Therefore, White people do not have to come to terms with their Whiteness in everyday life (Katz and Ivey 1977); they can choose to exist in environments that allow them to remain in their particular stage of racial consciousness (Helms 1984). In fact, many White people, living securely in the dominant racial culture, do not acknowledge that they belong to a race and in doing so they deny the attitudes and values that are often associated with the White race (Helms 1984). By denying their Whiteness, White people are able to deny any personal responsibility that they may have for racism (Katz and Ivey 1997). As White people are the benefactors and beneficiaries of racism in societies dominated by White people, for White people to have healthy racial identities, they need to increase their awareness of racism and how it can work to their advantage (Helms 1993). Being comfortable with using the term "White" is a necessary step in developing a WRI (Helms 1993).

Helms describes six stages of WRI (Helms 1984; Helms 1995) (Table 4.4). This model is designed to be interactive and permeable because individuals may be in more than one stage at once and/ or move between stages (Helms 1995). Table 4.4 also details how the stage of racial identity relates to how White people see themselves or other White people. Every individual has the potential to move through the six stages; when all stages have been experienced this is called "maturation" (Helms 1984; Helms 1995). Whether or not maturation is achieved depends on an individual's unique cognitive processes and the racial environments and issues to which they are exposed (Helms 1984; Helms 1995). The stages are designed to enable the processing of increasingly more complex racial information; consequently an individual who has experienced more stages will have more mechanisms through which to process race-related material and respond to situations (Helms 1995).

Table 4.4: The stages of White Racial Identity as described by Janet Helms (1984; 1995) including general characteristics of White people in each stage and their responses to themselves and/ or other White people

Stage	General characteristics	Responses to self/ other White people
Contact	• Ignore racial differences or see them as unimportant • Have the idea that 'people are people'	• Unaware of themselves as having a race • Denial, obliviousness or avoidance of anxiety-evoking racial material
Disintegration	• Become aware that racism exists • Caught between internal standards of human decency and external cultural expectations	• Forced to acknowledge that he or she is White; usually accompanied by feelings of guilt & depression • Acknowledgement that if they conform to White norms then this may be denying black people humanity by treating them in a racist manner BUT if violates the White norms that advocate mistreatment of blacks, may be ostracised by other Whites • Disorientation, confusion & suppression of information
Reintegration	• Tendency to stereotype • Characterised by fear and anger, may be hostile towards Blacks	• Positively biased towards own racial group • Distortion of information in an own-group enhancing manner
Pseudo-independence	• Interested in racial group similarities & differences • Cross-racial interactions occur but may be limited to black people perceived to be 'special' or similar to Whites	• Passivity - the previous motivation to either avoid or seek blacks no longer exists • Re-shaping racial stimuli to fit one's own 'liberal' societal framework
Immersion/ Emersion	• Tries to understand ways in which they contribute to, and benefit from, White privilege & racism	• Process of re-education (self and other Whites) • Searching for an internally defined positive racial identity as a White person • Life choices may incorporate racial activism

Table 4.4 (continued)

Stage	General characteristics	Responses to self/ other White people
Autonomy	• Values cultural diversity & accepts racial difference • Actively seeks opportunities to be involved in cross-racial interactions; approaches them with respect & appreciation • Differences (between blacks and Whites) not perceived as deficits & similarities not perceived as enhancers • Members of either racial group accepted as individuals	• Secure in their racial identity • Has the capacity to relinquish the privileges of racism • Flexible responses to racial material

White Racial Identity theory raises a number of points that can help explain how White people see themselves. For example, the stage of WRI that a person is at will affect how they work with White people, in particular those who may be working through an awareness of their own racial identity. More aware White people play a role in assisting other White people to develop a racial identity. Helms (1984) also discusses how White health professionals (counsellors) at different stages of racial identity may relate differently to their White clients in relation to race issues that are raised (Table 4.5). When two people work together they generally bring with them different stages of racial identity (Helms 1984). Identifying which stage each person is at enables predictions about the quality of their relationship and working outcomes related to race (Helms 1984). For example, responses of White counsellors in different stages of WRI to race issues raised by White clients are listed in Table 4.5. While Helms' work focuses on counsellors, it could equally apply to practitioners or researchers working in N & D and OP and therefore this is an important model to consider when interpreting the practice of White health professionals with Aboriginal people in this research.

Table 4.5: Responses of White counsellors in different stages of White racial identity to race issues raised by their White clients (Helms 1984)

Stage	Characteristics
Contact	• Ignores or minimises racial issues that impact on the White client • Knows that while some White people are biased against blacks, therapists should not be and the therapy skills taught should be applicable to all clients, regardless of their race
Disintegration	• Been exposed informally to the idea that typical counselling techniques do not work with Black clients • May suggest that there is no way that Blacks and Whites can interact effectively (idea likely to be passed onto client)
Reintegration	• Believes that they should not be biased against Blacks (equalitarian philosophy implicit in most training programs) • Attempts to hide negative feelings towards blacks but may still come across e.g. in body language
Pseudo-independence	• Can provide the client with information and guidance to help them understand racial issues that impact on them • Counsellor's knowledge is more intellectually diverse than it is affectively diverse • Difficulty in empathising with emotional dimensions of clients' concerns
Immersion/ Emersion	N/A not identified as a stage in Helms (1984)
Autonomy	• Willing to tackle real racial issues • Actively searches for racial issues of feel they would be beneficial to therapy • Feels comfortable in own racial identity • Able to empathise with client's frustration and anger – even when directed at White people • Able to assist the client in their search for a more tolerant world

Similarly, Helms identifies that the WRI of researchers is important. Helms (1993) encourages White researchers to be more self-conscious in their inquiries when doing cross-cultural research. Unresolved White identity issues can have a negative impact on the research process and outcomes, because the assumptions associated with unresolved White identity impact on decisions that researchers make. If appropriate decisions are not made and alternative race-related cultural perspectives are not identified, there is a risk that the researcher will add to the 'existing body of racially oppressive literature' (Helms 1993, p. 242). Therefore this thesis involves an examination of my own WRI (Section 7.3.3).

White privilege

White privilege is another important concept to consider when identifying how White people see themselves. Peggy McIntosh (1986, p. 1) describes White privilege as an 'invisible knapsack' or 'package' of unearned assets that White people can count on 'cashing in' every day. She describes 46 things that White people can do without being concerned about their race, or reactions of others because of their race, including speaking in public, renting a house or being in the company of people from the same race. She describes how Whiteness acts as a form of protection from many things, including hostility, distress and violence. Importantly, she highlights the invisibility of White privilege – White people are 'taught to recognise racism only in individual acts of meanness' rather than 'in invisible systems conferring unsought racial dominance from birth' (McIntosh 1986, p. 18). White people are taught not to see the 'unearned power' (McIntosh 1986, p. 13) that White privilege confers upon them. McIntosh (1986, p. 19) questions what White people will choose to do with this advantage when they become aware of it:

> *...it is an open question whether we will choose to use unearned advantage to weaken hidden systems of advantage, and whether we will use any of our arbitrarily-awarded power to try to reconstruct power systems on a broader base.*

Therefore, it is of interest to consider whether White health professionals working with Aboriginal people are aware of White privilege, and if so, what they do with this awareness.

Using key concepts of Whiteness theories, in this section, I have shown that there are multiple ways that White people perceive themselves. These concepts will be revisited in Chapters 7-11 in the context of myself as a White researcher and the White health professionals who were participants of this PhD research. In the next section, I consider how White people see non-White people, using further concepts of Whiteness theory.

How White people see Aboriginal people

A number of authors also discuss how White people see non-White people. For the purposes of this research, non-White can be extended to include Australian Aboriginal people. Authors that consider this issue include Frankenberg (1994), Hage (1998), Stratton (1998), Moreton-Robinson (2000) and Helms (1984). Of interest to consider is the extent to which reactions to non-White people presented by these authors are observed in the White health professionals participating in this research.

Frankenberg identified two concepts to describe White women's reactions to non-White people. First, "colour-blindness" which refers to 'a mode of thinking about race organized around an effort to not "see", or at any rate not to acknowledge, race differences' (Frankenberg 1993, p. 142). Colour blind women believed that acknowledging race difference was an act of prejudice. These women felt 'it was "bad" to see difference and "good" not to' (Frankenberg 1993, p. 146) while 'seeing race meant being racist and being racist meant being "bad"' (Frankenberg 1993, p. 147). Frankenberg however, argues that avoiding naming colour is also a way to avoid acknowledging power differences present between races (1993). Colour blindness, which is essentially selective acknowledgement of a person's racial difference, is a form of oppression because it denies the effect that race has in people's lives. For example, referring to Jewish people as a religion rather than a race, which

> *involves a selective attention to difference, allowing into conscious scrutiny – even conscious embrace – those differences that make the speaker feel good but continuing to evade by means of partial description, euphemism, and self-contradiction those that make the speaker feel bad (Frankenberg 1993, pp. 156-157).*

The second group of women identified by Frankenberg (1993) were race cognisant. These women believed it was important to acknowledge difference and they were more likely to identify themselves as White people. These women understood that race makes a difference in people's lives and they felt that racism is a significant factor in shaping contemporary society of the USA (Frankenberg 1993). Importantly, race-cognisant women were able to identify that all White people, including themselves, had a role in racism. They actively questioned their role in racism and how to proceed when they felt that they had been involved in racism. They were also keen to 'engage systematically in the process of making change' (Frankenberg 1993, p. 187) and this included speaking about issues (those who 'transformed silence into language') and activism (those who 'transformed language into action') (Frankenberg 1993, p. 176). Of interest to consider in this research is whether White health professionals exhibit signs of colour blindness or race cognisance.

Ghassan Hage (1998) describes a White Nation fantasy which is one way that White Australians may react to non-Whites. This "fantasy" is created by White people in response to multicultural

Australia and can be considered 'a fantasy position of cultural dominance born out of the history of European expansion' (Hage 1998, p. 20). Hage (1998, p. 18) describes how White people, whether they are racists or multiculturalists, 'share a conception of themselves as nationalists and of the nation as a space structured around a White culture, where Aboriginal people and non-White "ethnics" are merely national objects to be moved according to a White national will'. Hage (1998) argues that many of the practices that are perceived to be racist (such as tearing a head scarf from a Muslim woman's head) are in fact nationalist, because they result from a White person's concern with national space. That is, much of the negative responses of Australian people to immigration, particularly Asian immigration, are due to a concern with an invasion of national space. Therefore, he argues that White nationalists are concerned with continually asserting their White dominance and Whiteness, which is expressed through their need to "control" who does and does not occupy Australian space.

Similarly, Stratton (1998) discusses the concept of Australian national identity that has been proposed by individuals such as Pauline Hanson, founder of the One Nation political party. Hanson presented a view that Australia should have a 'unified and homogenous' culture (Stratton 1998, p. 39). This view of national identity is exclusive of the Aboriginal and Torres Strait Islander accounts of history that have been important in the development of an Australian national identity. Stratton (1998) describes how John Howard, previous Prime Minister from the Liberal party, referred to a "core culture" which is the culture of "mainstream" Australia. This "core culture" is a culture of the elite and of the majority. Immigrants and Aboriginal people are encouraged to assimilate into this "core culture" of "mainstream" Australia. For example, Howard and Hanson have advocated for Aboriginal and Torres Strait Islander people to be considered 'ordinary Australians', where they do not receive any special recognition or benefits, such as financial assistance (Stratton 1998, p. 42). However, Aboriginal and Torres Strait Islander peoples have continued to argue that they be 'regarded as racially distinct' and that their diversity be appreciated (Stratton 1998, p. 42). It is important to consider whether Aboriginal accounts of history are acknowledged by White health professionals participating in this research and participants' views about how Aboriginal people should be regarded.

Hage (1998) describes "tolerance" as one way in which White people in Australia respond to Aboriginal people and migrants; White people are "tolerant" of or "put up with" the cultural diversity

in Australia. He describes how the concept of tolerance is only relevant to the dominant culture, because those who are in a position to be tolerant are also in a position to be intolerant (Hage 1998). He describes tolerance as another nationalist practice, because it is concerned with managing national space (Hage 1998, p. 94). That is, White people can choose who to be tolerant of (Hage 1998; Stratton 1998). For example, after the White Australia Policy was abolished and the migration of non-White people into Australia began, Australia became more tolerant of European people who began to be considered part of the 'cultural core' (Stratton 1998, p. 84). Hage (1998) argues that tolerance and intolerance tend to co-exist because even when people are encouraged to be tolerant of difference, the power to be intolerant is not taken away from them. That is, the advocacy of tolerance never really challenges the intolerant person's capacity to exercise their power to be intolerant (Hage 1998). However, intolerance may also be more covert. This idea of tolerance presented by Hage (1998) highlights how the public perception regarding the ways ethnic people are treated is often different to how they are really treated i.e. Australia is generally perceived by White people as a tolerant society, but White people still hold the power to be intolerant, and this is often exercised, as a nationalist practice. In relation to this research, this calls into question whether white health professionals are tolerant or intolerant of Aboriginal cultural and personal values and preferences.

Hage (1998, p. 117) also describes the ways in which White Australians respond to people of other cultures through the 'discourse of enrichment', which he refers to as 'a manual for the proper usage of ethnics'. This refers to the idea that migrants and others from different cultural and racial backgrounds in Australia exist for the sole purpose of "enriching" the dominant culture. This is reflected through the idea of the multicultural fair where food, music and other elements of different cultures are on show. Traditionally, White people have walked around at these fairs to "take in" the culture/s on show and "enrich themselves" from 'the various stalls of neatly positioned migrant cultures' (Hage 1998, p. 118). Hage (1998, p. 122) considers a similar concept in relation to Aboriginal Australians, where they are seen as useful when they can add an element of Australianness to Australia, but once they have done that they are no longer useful and should 'please go back to your bush so we can enjoy being enriched without you annoying us with your presence'. This raises questions about where Aboriginal people and their preferences and needs fit within mainstream health systems.

Moreton-Robinson (2000) discusses how Aboriginal women are perceived by White women to be a group on which they can pass comment and judgement, from their often unacknowledged, White-centred standpoints. While many White women who perceive themselves as being anti-racist are often well-intentioned towards Aboriginal women, 'their behaviour and intentions have not always been interpreted in the same way by Indigenous women' (Moreton-Robinson 2000, p. 94), and this may also be the case for White health professionals. For example, White feminist anthropologists have interpreted the histories of Aboriginal women from their White-centred standpoints and this can result in the publication of partial truths about Indigenous peoples. White women will continue to 'unconsciously and consciously exercise their race privilege' (Moreton-Robinson 2000, p. 127) and this affects how they interpret and perceive Aboriginal women. Importantly, White women tend to forget that Indigenous women pass judgement on their White standpoints. That is, Indigenous women do not necessarily hold the standpoints of White women in the same regard as White women hold them (Moreton-Robinson 2000). This is important for White women to remember when working with Aboriginal women.

In this section, I have demonstrated there are different ways that White people respond to non-White people, which can be extended to Aboriginal people.

4.3. *Chapter Summary*

In this chapter I argued that providing a single, workable definition of race is a challenge because of the multiple definitions that exist. However, it is an important concept to consider when working in a country like Australia where race has been an important element of history (Stratton 1998) and can enhance our understandings of interactions between different racial groups. I discussed the emergence of Whiteness theory in the 1990s in the USA, primarily from African American writers who suggested White people needed to look at themselves. Contemporary Whiteness theory includes writings on how White people see themselves, and how White people see Aboriginal people (or people from other races). This information will be used to critique the practice of the White people interviewed in this research, and myself as a White dietitian-researcher.

I demonstrated that there is an absence of literature about race and Whiteness in the areas of N & D and OP. That is, N & D and OP have not used race and Whiteness theories as tools to investigate and understand issues around Aboriginal health. Consequently, in this thesis I seek to bring together the areas of N & D / OP and race/ Whiteness and explore what race and Whiteness can add to the understandings of these areas about how White health professionals can work in Aboriginal health.

5. Research Foundations

In this chapter I outline the epistemology, theoretical perspective and methodology that guided this research. In the process of identifying, using and developing the epistemology, theoretical foundations and methodology for this research, I underwent a paradigm shift from a positivist to a critical approach. In this chapter I discuss this paradigm shift and the resulting epistemological, theoretical and methodological foundations on which this research is based. These represent vital foundations for any research, and consequently this chapter is important in justifying how and why I have conducted this research.

5.1. *Epistemology*

Epistemology is about how we come to know. It is 'concerned with providing a philosophical grounding for deciding what kinds of knowledge are possible and how we can ensure that they are both adequate and legitimate' (Maynard 1994, p. 10). The nature of knowledge and the process by which it is acquired and validated is of interest to epistemologists (Gall, Gall et al. 2007). In any research, it is important for the researcher to outline their epistemological stance because epistemology heavily influences how a researcher approaches, conducts, interprets and presents research (Crotty 1998).

Crotty (1998) identifies three epistemological approaches including objectivism, constructionism and subjectivism. Objectivism says that there is an objective truth and that meaningful reality exists independently of human consciousness and experience. That is, objects exist and human interpretation is not necessary to establish the meaning of these objects. On the other hand, constructionism and subjectivism acknowledge the role of humans in creating meaning; constructionism suggests that meaning is created when a subject interacts with an object, while subjectivism suggests that meaning is constructed through something other than an interaction between an object and a subject, for example through a dream (Crotty 1998). To clearly identify epistemology and associated concepts, Crotty (1998) suggests addressing four elements in research (Figure 5.1).

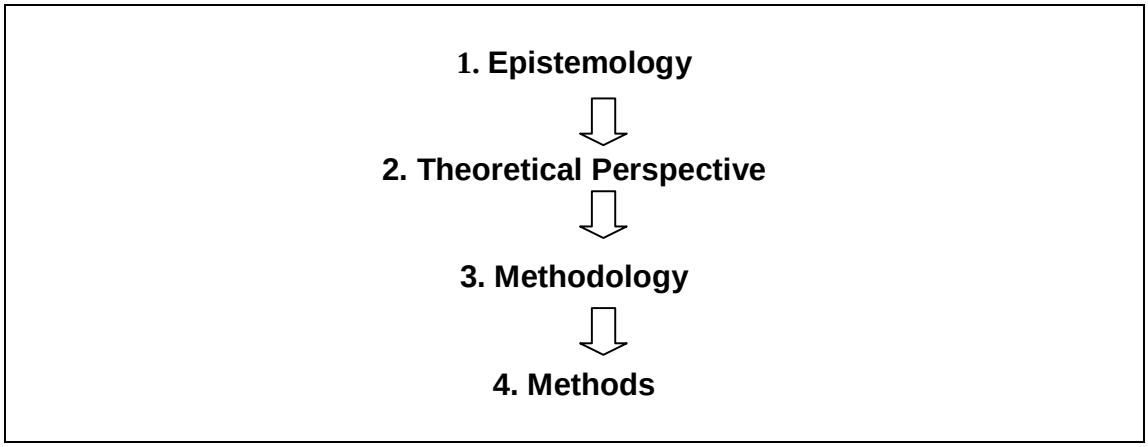

Figure 5.1: Four important elements to identify in the research process (Crotty 1998)

This is the model I used in planning and undertaking this research. Throughout the rest of this chapter, I outline the epistemology, theoretical perspective and methodology that I used in this research (and how they are related), as well as that which I initially planned to use. I describe how and why I came to make these changes. In Chapter 6, I outline the methods used in this research.

5.2. *A paradigm shift in epistemology*

During this research, I experienced a paradigm shift in epistemology which impacted strongly on my approach to research and choice of final methodology and methods. This paradigm shift was also necessary in order to use race and Whiteness theories and gain a deeper and pragmatic appreciation of them. It also enabled me to take a more appropriate approach with Aboriginal communities and obtain results that were more meaningful and relevant to these communities.

5.2.1. Initial approach: Positivism - silent but dominant

I began this research with a strongly objectivist epistemology and positivist theoretical perspective, meaning that I was intent of finding "the answer". 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 (Nicholls 2009). In my university training, 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:

> *…universities are not devoted to the production and distribution of fundamental knowledge in general. They are institutions committed, for the most part, to a particular epistemology, a view of knowledge that fosters selective inattention to practical competence and professional artistry. (Schon 1983, p. vii)*

Despite the predominance of positivism within areas like N & D training, it is rarely acknowledged as the theoretical foundation on which research, practice and training in this area is based. For myself as a dietitian-researcher, the first step in shifting my epistemological and theoretical orientations was to acknowledge that positivism was the philosophy that underpinned my thinking and reasoning as a professional and researcher. I did not see positivism as *one* way; I saw it as the *only* way. This idea is supported by Etherington (2004, p. 34) who highlights that positivism is the dominant story within academia, holds enormous influence, and 'can be hard to challenge as simply one of the ways of doing research'.

5.2.2. Problems with the initial approach

As described, at the beginning of this research I took an objectivist epistemology and positivist theoretical position. However, over time this approach became somewhat limiting for my research. I identified that the methods I was planning to use to collect data would not fully allow me to answer the questions I wished to explore.

The initial question for this thesis was concerned with measuring the effectiveness of the *ewba* Community Programs in Aboriginal people compared with non-Aboriginal people. I planned to do this by using *ewba* questionnaires designed to measure nutrition and physical activity behaviours, attitudes, environments and knowledge and compare responses of Aboriginal and non-Aboriginal respondents. The rationale for this question was to consider how to make nutrition care, and OP programs, more effective for Aboriginal people. Exploring this question with an objectivist epistemology implied I could measure effectiveness as an objective concept. However, I came to see that what makes a program effective is different for each person and depends on many factors including their life experiences and expectations. In understanding effectiveness in this way, I use a constructionist epistemology because I recognise the influence of experience in creating a meaning of effectiveness for an individual. Additionally, use of the questionnaire would not have produced "good quality" research defined by a positivist orientation. Due to the extremely small sample size of Aboriginal respondents, statistical analyses would have been less

meaningful. “Effectiveness” is also a commonly used term in studies with a positivist orientation, used to indicate positive results of a statistical nature. This was not what I wanted to imply through the use of this concept in my research, therefore it made sense to search for alternate ways of knowing and thinking.

Searching for an alternative was one of the most challenging parts of this research. It required me to question the very foundations on which most of my university training and professional identity were based. Through engaging with Aboriginal workers and community members, I came to see some of the differences between Aboriginal and White ways of knowing. In order to conduct respectful research, I did not wish to privilege one way of knowing over another. Consequently, I took a constructionist epistemology in this research, which enables me to acknowledge that there is no one truth, rather reality and meaning is socially constructed. Additionally, as I spent time in Aboriginal communities, I came to appreciate that program effectiveness depends on additional factors, including the practice of the individual workers involved. While the reason for my paradigm shift was initially associated with a desire to find more suitable methods, over time it became more than this, including different ways of seeing and approaching the world and my profession.

5.2.3. Prevalence of positivism within nutrition and dietetics: A review

Traditionally, research in allied health (including dietetics) places a large amount of faith in objectivity. The historical connection of dietetics to science was demonstrated in Chapter 3. Potential reasons for this include a desire to be closer to the medical profession and to elevate allied health professionals above the general, or lay, public (Nicholls 2009). Additionally, the majority of allied health training is based on quantitative methods and research, which is generally grounded in the positivist paradigm (Sobal 2001). Consequently practitioners become reluctant to challenge the views they developed during their training, which ‘give them confidence in their practice’ (Nicholls 2009, p. 526).

A positivist theoretical orientation is generally associated with quantitative research. Quantitative research is usually deductive because it tests a hypothesis. Characteristics of deductive reasoning include: large amounts of data, data collection usually ends before analysis starts, data is usually numerical and usually collected at the start of a study (Nicholls 2009). On the other

hand, qualitative research is generally associated with inductive reasoning which seeks to gather data and produce a theory from this data. It begins with a problem and 'meaning and understanding are constructed as part of the process of discovery' (Nicholls 2009, p. 531). It seeks to understand how and why people behave in certain ways (Swift and Tischler 2010). The lack of evidence about the topic of inquiry in this thesis led to this research becoming inductive. Therefore, a qualitative orientation involving an exploration into the context in which White health professionals work in Aboriginal health was considered to offer the greatest potential for new insights into this complicated area of practice.

A review of the literature was conducted within the area of N & D to highlight the dominance of positivism in mainstream nutrition and dietetic research, even in qualitative research. By mainstream I mean journals that are (a) accessed commonly by dietitians/ researchers in the area and (b) publish the majority of the work about the dietetic profession. This gives some insight into the challenges I experienced in questioning the dominant paradigm within this profession. It is acknowledged that qualitative research is likely to add a great deal to dietetics in understanding the complexities of food-related behaviours (Swift and Tischler 2010). Other reasons to use qualitative research in dietetics include: when phenomena cannot easily be measured, when knowledge is limited, to describe the context of phenomena, to validate theory, to describe an unfamiliar community or culture and to determine causal explanations of phenomena in their natural settings (Harris, Gleason et al. 2009). The fact that there is often no "correct" approach to qualitative research, for example choice of a data collection technique, can be daunting for dietitians (Draper and Swift 2011) who may be used to quantitative approaches where the research process is generally more prescriptive. This may be a barrier to engaging in qualitative research.

This review was limited to N & D and does not include obesity prevention. This is because I am interested in considering qualitative research in the context of a profession, and the implications of the findings from this review in the context of that profession. Additionally, when experiencing a paradigm shift, I was interested in how the issues I had been experiencing were considered in my profession.

Review methods

In order to identify the type of and approach to qualitative research in the popular dietetic literature, a search of major nutrition journals, written in English, was conducted using Medline in November 2010. No limit was put on the date of the papers. The international journals searched were: Appetite, Asia Pacific Journal of Clinical Nutrition, Canadian Journal of Dietetic Practice and Research, European Journal of Clinical Nutrition, Journal of the American Dietetic Association (JADA), Journal of Human Nutrition and Dietetics, Nutrition Research, Nutrition Reviews, Journal of Nutrition Education (prior to 2001), Journal of Nutrition Education and Behavior (post 2001) and Journal of Nutrition. The Australian journal, Nutrition and Dietetics, was searched separately as it is not indexed in Medline but important to consider as this research is Australian. These journals were chosen as they were deemed to be commonly accessed by researchers and practitioners in N & D, and often considered for submission of traditional dietetic research. When combining all of the journals searched through Medline, a total of 42 027 papers were identified.

Initially, "qualitative research" was used as a keyword search term within the named journals. Four papers were identified. To broaden the search, "qualitative" was used for a key word search instead. Searching for this term within the international journals identified above retrieved 354 papers (Review 1). This represents 0.8% (354/ 42 027) of the total literature in this area. When the journal Nutrition and Dietetics was searched separately, using the same key word, 75 papers were retrieved (Review 2). In both cases, approximately 10% of papers were selected at random to be included in this review (Review 1, n=36, approximately every tenth paper selected; Review 2 n=9, approximately every eighth paper selected). Any papers or letters to the editor that considered qualitative research in dietetics in relation to general methods or methodology were saved for a separate discussion (n=6). In April 2011, four papers published as a series in late 2010 and early 2011 about doing qualitative research in N & D were identified (Swift and Tischler 2010; Draper and Swift 2011; Fade and Swift 2011; Pilnick and Swift 2011). This perhaps indicates the growing awareness of increasing the quality of qualitative research in this discipline. These papers have been incorporated into the discussion where relevant.

Discussion of papers reviewed

A detailed summary of the papers reviewed can be found in Appendix 1. The majority of topics covered included attitudes, beliefs, exploration of behaviours and perceptions and these words were often in the title of the paper, along with the word "qualitative".

For each study, I considered whether the authors discussed the following: epistemology, theoretical framework, methodology, methods and approach to data analysis. I also considered if the study was a mixed method study. A summary of the number of papers that referred to each of these elements is provided (Table 5.1).

Table 5.1: Number of papers reviewed in Review 1 (n=35) and Review 2 (n=9) that identified research epistemology, theoretical framework, methodology, methods, approach to data analysis and were mixed methods studies

	Review 1, International (n=36)	Review 2, Australian (n=9)
Epistemology	3	0
Theoretical framework	11	2
Methodology	7	0
Methods	36	9
Data analysis	24	7
Mixed methods studies	11	2

Important points to discuss in relation to these papers are the lack of the use of the terms epistemology, theoretical framework and methodology, the use of mixed method studies, use of quantitative principles to assess qualitative research, inconsistent use of the term “qualitative” and a lack of dietetic research that merges into sociology.

Epistemology, theoretical framework, methodology, & methods

The table demonstrates that qualitative studies reviewed in mainstream dietetic journals rarely refer to the epistemology underlying the research. Zero papers used the term “epistemology”, but three papers referred to it in some way (Germov and Williams 1996; Harrison and Jackson 2009; Scarpello, Poland et al. 2009). While a number of the review articles did highlight that different philosophies underpin qualitative and quantitative research (Abusabha and Woelfel 2003; Fade 2003), this is not discussed in the context of epistemology. Few referred to a theoretical framework, and when they did, it was usually a framework that guided interpretation of the research rather than the entire research process. Some of these theories were the theory of planned behaviour (Bai, Middlestadt et al. 2009), an ecological model of practice (Devine, Jastran et al. 2004), social cognitive theory (Nelson, Kocos et al. 2009) and theory of behaviour change (Paisley, Beanlands et al. 2008).

Few of the papers reviewed referred to methodology and when they did this was not specific, for example reference to "qualitative methodology" without describing what this meant (Hart, Herriot et al. 2003; Pelletier, McCullum et al. 2003; Sellaeg and Chapman 2008). In some papers, the term "methodology" was used interchangeably with "methods" (Witt Strain, Hershcopf et al. 1992). Some studies showed a greater understanding of the term methodology and used approaches including grounded theory (Briley, Roberts-Gray et al. 1994; Devine, Jastran et al. 2004) and ethnography (Quandt, Shoaf et al. 2006). In contrast to a lack of discussion about epistemology, theoretical framework and methodology, all of the studies reviewed described their methods and most described their data analysis methods (Table 5.1). This highlights the greater familiarity of N & D researchers with the concept of methods as opposed to epistemology, theoretical framework and methodology.

While there is a growing awareness about the benefits of qualitative research in dietetics, many dietitians are unsure how to go about qualitative research and are likely to find the qualitative research literature difficult to use, because of their greater familiarity with quantitative approaches (Swift and Tischler 2010). A four part series published in the Journal of Human Nutrition and Dietetics provides guidance about qualitative research for dietitians, highlighting important concepts including ontology, epistemology and methodology in an accessible way, is one way that this barrier may be overcome (Swift and Tischler 2010; Fade and Swift 2011; Draper and Swift 2011; Pilnick and Swift 2011). By bringing concepts such as ontology and epistemology into a mainstream dietetic journal, it is hoped that dietitians will feel more comfortable with using these terms in research and ultimately, dietetic discourse.

Mixed methods studies

When considering how qualitative methods might be used in dietetic research, Abusabha and Woelfel (2003) advocate for a combination of qualitative and quantitative methods. They use the example of using focus groups to identify what questions should be on a survey. A number of the studies reviewed combine qualitative and quantitative methods (Briley, Roberts-Gray et al. 1994; Griffiths and Bentley 2005; Carels, Harper et al. 2006; Adams, Bowie et al. 2008).

The use of qualitative studies to inform quantitative studies appears to be a common use of qualitative approaches in N & D. While this is one use of qualitative research, it is not the only

use. Dietitians may not be familiar with other uses for qualitative research. This lack of familiarity of the dietetic profession with qualitative research is identified by Fade (2003) who reviewed the frequency of qualitative research that appeared in the Journal of Human Nutrition and Dietetics from 1990 to 2002. Over this 12 year period, only nine papers were identified and a number of key methodological elements (e.g. approach to sampling and analysis) were not discussed, raising questions about the quality of the papers (Fade 2003).

Qualitative research in dietetics: based on quantitative principles?

Qualitative research has yet to be fully embraced by the N & D profession (Swift and Tischler 2010). One way in which this is demonstrated is through the use of quantitative principles to evaluate qualitative research. In N & D, qualitative research is often seen as inferior to quantitative research (Harris, Gleason et al. 2009). It is suggested that if qualitative researchers can demonstrate and describe a sound design and methodology which utilises an objective approach (considering validity and reliability) then this attitude can be shed (Harris, Gleason et al. 2009). Indeed, some of the papers reviewed do consider strengths and limitations of their studies in terms of quantitative principles. For example, a commonly cited limitation is small sample size (Shepard, Neumark-Sztainer et al. 2006; Ip, Mehta et al. 2007; Yeatman, Player et al. 2010). However, other researchers in N & D are aware that trying to underpin 'qualitative research with quantitative principles' (Fade 2003 p. 147) is not ideal and 'assessing work in one paradigm using the conceptual and methodological tools of a different paradigm' is a limitation of some qualitative research (Sobal 2001, p. 189). This has been described as methodolatry; the process by which researchers privilege research methods over seeking out meaning and understanding (Chamberlain 2000). Being constrained by method can limit understanding in qualitative research (Chamberlain 2000). For example, having a larger sample size may limit the depth of analysis and consequently the amount of interpretation and meaning that can be derived. However, the production of qualitative research that upholds quantitative principles is reinforced by popular dietetic journals. For example, JADA states that qualitative research will only be considered for publication if it is carefully planned with attention to the research questions, uses appropriate strategies and methods, has a systematic analysis of data and attends to the issues of reliability and validity. This lack of understanding of qualitative research and underlying principles is likely to be limiting the kind of qualitative research published in these journals.

Definition of 'qualitative' and related terms

The use of the term "qualitative" is not consistent between the studies reviewed. It is used in some studies to describe a mode of data collection or topic that involves a subjective topic such as attitudes or beliefs (Hart, Herriot et al. 2003; Shepard, Neumark-Sztainer et al. 2006; O'Kane, Craig et al. 2008). In other studies, "qualitative" refers to the tool that collects the data, rather than to the philosophy behind the research. For example, a food record that describes what participants ate but not how much (Witt Strain 1992), a system of classifying food into healthy and unhealthy rather than testing a numerical nutrient value (Carels, Harper et al. 2006), a "qualitative" description of foods eaten (Novotny, Rumpler et al. 2001) or 'qualitative' data that is produced from a tick-box questionnaire and subjected to a frequency analysis (Adams, Bowie et al. 2008). These highlight the multitude of ways in which the term "qualitative" may be used and interpreted in N & D.

Lack of qualitative research from a social science/ sociological viewpoint

In the mainstream dietetic literature, there is a lack of qualitative research that merges into the discipline of sociology. Some of the studies reviewed would meet the criteria for "good" qualitative research if it was judged by quantitative principles, as posed by some authors (Harris, Gleason et al. 2009); for example Devine, Jastran et al. 2004 and Felton, Nickols-Richardson et al. 2008. However, these studies lack a discussion of factors that are important in qualitative research with a more sociological slant, including identification of an epistemological and theoretical position. Some papers do attempt to use theory, for example one paper which refers to the 'structuralist work of Levi-Strauss, Barthes & Douglas' (Scarpello, Poland et al. 2009, p. 109). However, they do not describe how their work is or is not structuralist.

A sociological approach to food and nutrition has been discussed (Germov and Williams 1996; Germov and Williams 2008). They argue that nutrition research has been grounded in the positivist paradigm, and that the observed preference for quantitative data is due to the 'dominance of biomedicine as a health paradigm in the area of nutrition' (Germov and Williams 1996, p. 98). They highlight the lack of dialogue between social and biomedical scientists which helps to explain the lack of interdisciplinary research on food and nutrition (Germov and Williams 1996). Greater dialogue between practitioners and researchers in social science and N & D would broaden dietitians' understandings of qualitative research and provide new and exciting areas of

inquiry. Murcott (1998; 2002) has also provided some discussion about the sociology of food, including approaches to discussing inequalities in the area of nutrition.

Considering the lack of Australian, American and English dietetic research with a sociological slant, it is important to consider whether a body of literature exists in journals not reviewed here. I followed up a number of references cited in studies included in the above review that referred to a sociological viewpoint of food and nutrition (Dibsdall, Lambert et al. 2002; Ludvigsen and Scott 2009). However, these studies were not necessarily dietetic focussed, did not provide any new information not identified from this review and, like the majority of studies reviewed, did not identify an epistemological or theoretical position.

Critical dietetics: an emerging area

The preceding review considered the type and extent of qualitative research in the mainstream dietetic literature. Importantly, critical dietetics is a new approach to dietetic practice and research that sits outside these mainstream journals and comments on issues including gender, size, class and ability.

Established in 2009, the critical dietetics movement was launched at a workshop held at Ryerson University, Toronto, Canada entitled “Beyond Nutritionism: Rescuing Dietetics through Critical Dialogue” (Aphramor, Asada et al. 2009). This was attended by theorists, researchers, practitioners, students and advisors. A Declaration was published, demonstrating the commitment of the workshop attendees to Critical Dietetics, and as an invitation for colleagues to get involved and become signatories of critical dietetics (Aphramor, Asada et al. 2009). Critical dietetics is grounded in critical theory and encourages practitioners, researchers, educators and students to engage with paradigms other than those which are dominant in dietetic training and ask questions about how the dietetic profession might move forward.

Critical dietetics creates a space to enable discussions around gender, race, size, class, ability, dietetic epistemology, post-structuralist approaches to dietetic education and art and poetry in the context of dietetics (Aphramor, Asada et al. 2009). It acknowledges that food is more than the nutrients that constitute it; an idea also explored by Simmons (2009) who challenges dietitians to move beyond “nutritionism”: a reductionist view that breaks down food into its constituent parts.

Critical Dietetics is committed to exploring a number of ontological and epistemological questions including what counts as knowing in dietetic practice, how dietitians come to know what they do and do not know and what is rendered silent in dietetic discourse? It involves a significant departing from familiarity for most dietitians who traditionally are not trained in this area. 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 (Aphramor, Asada et al. 2009).

The first issue of the peer-reviewed Journal of Critical Dietetics was released in 2011. This journal provides a space for the publishing of work that may not be represented in other dietetic journals. The first International Conference of Critical Dietetics was held in Toronto, Canada in August 2011, and I presented two papers at this conference, based on this research. In discovering and engaging with critical dietetics at this conference, I felt liberated from previous concerns I had about my work not fitting anywhere within the dietetic profession. In engaging with other critical dietitians, my passion for research outside of that presented in dominant dietetic discourse was reignited, and my decision to depart from familiarity in this research in order to address what I believed in was reinforced.

Critical dietetics represents an exciting new area, and it is one of the spaces where work from this research fits. I see this work fitting in the area of critical dietetics for a number of reasons. First, through this research I seek to find new ways to understand the experiences of White health professionals working in Aboriginal health. I seek to take a view that is alternative to the dominant paradigm that positions Aboriginal health "problems" as Aboriginal problems. Second, in this research I use a critical approach, and explore the issue of race in Aboriginal health using Whiteness theories. In doing so, I moved outside the paradigm that I was trained in, I have questioned this paradigm and recognised its limitations in this topic of inquiry. Finally, Power (2011, p. 13) writes how the dietetic profession has reinforced the use of the positivist and reductionist paradigms, or medical model, in an attempt to be 'valued' more within the area of medicine. She highlights how critical dietetics provides an opportunity to no longer accept these paradigms as 'the ways in which things should be done' and consequently to stop perpetuating their use. Similarly, I write this thesis with the stereotypical view, held by many Australians and White health professionals in Australia, of Aboriginal health "problems" as Aboriginal problems. In

writing this thesis and by using Whiteness theory, I choose to no longer accept that dominant discourse, and question how White health professionals can have agency for these "problems".

Summary and implications

From the review of qualitative studies in popular N & D journals written in English, it is clear that positivism is the predominant epistemological approach to research in N & D, including qualitative research. However, this is rarely acknowledged. Qualitative research in mainstream N & D journals rarely identifies an epistemological, theoretical and methodological standpoint and much of this qualitative research is still "measured" against principles for quantitative research. There is also a lack of dialogue between dietitians and sociologists, which limits the cross-disciplinary research that could occur. Finally, use of the term "qualitative" is inconsistent across studies and qualitative research is often used as a precursor for quantitative research rather than on its own. An exciting and innovative area for growth is critical dietetics. This opens a space for educators, researchers, practitioners and students to provide a critical analysis of issues related to dietetics while integrating epistemology, theoretical perspectives and methodology into research.

The dominance of positivism within qualitative research and the general lack of awareness and understanding of this type of research within N & D poses a challenge for dietitians, like myself, who do qualitative research. Engaging in a paradigm shift has required me to address uncomfortable issues. Importantly, positivism still has its role in N & D and I am not suggesting that this is not important. Rather, I am advocating for dietitians to become aware that this is the perspective they primarily work from, and to potentially consider some alternative approaches. As a dietitian-researcher, I aim to do high quality qualitative research that is judged in its own right, not through quantitative principles. However, I also aim to reach dietitians through my research. Therefore, a question in my mind at this time is how to do justice to qualitative research and not compromise on the importance of underlying elements like epistemology and theoretical approach, while still making this work accessible to dietitians who work from a positivist foundation, but may not be aware of this. An important question is how this can be done, if it can be done. At this stage I feel that to make my work accessible to dietitians, I need to maintain some connection to positivism. The dominance of positivism within qualitative research also provides an opportunity for critically minded dietitians to assist in educating colleagues and peers about the importance of critical paradigms and practical advice about how to incorporate it into this work.

A critical reflection on this review

Since completing this review in late 2010, I have reflected back on it. I believe that this review is important in that it demonstrates the strong affiliation to positivism within the dietetic profession. It also clearly highlights how positivism is commonly used, even in qualitative research, without always being explicitly stated. At one point in time, the journals from which I conducted this review were where I obtained most of my information as a dietitian-researcher. As many dietitians are still likely to be in a similar place to where I was, I believe this review is useful in pointing out some of the dominant discourses in popular dietetic research to people who are at this stage. However, after engaging more closely with the critical dietetics movement, I have been able to appreciate other sources of dietetic research that sit outside of these mainstream journals. Therefore, I do not think that the comments in this review apply to the nutrition and dietetic profession as a whole. My observation that some of the new types of work I am engaging with do not appear in mainstream nutrition and dietetic journals was reinforced by Schubert, Gallegos et al. (2011, p. 5) who highlighted that 'socially engaged scientists' are undertaking nutrition-related research, but this research 'rarely appears in nutrition journals'.

This review was primarily focused on the area of dietetics, and did not consider the area of public health nutrition. I am aware of a body of literature within this area that describes the new nutrition science project, which proposes new principles to guide nutrition science and highlights the importance of social and environmental aspects of nutrition science, in addition to more traditional, biological aspects (Cannon and Leitzmann 2005). This literature could potentially add some new insights into how similar approaches may be transferable into more traditional dietetic research.

I have also noted that in my attempt to be "objective" and review every tenth paper in Review 1 and every eighth paper in Review 2, that I did not necessarily get to review papers from all of the different journals. Furthermore, in this review I considered whether papers discussed epistemology, theoretical framework, methodology and methods. This is in line with the approach advocated for by Crotty (1998) and used in this research. While these are fundamental concepts, I acknowledge that this is only one approach to research and not all papers will use the same terminology. Additionally, it may not always be appropriate to use these concepts, especially by name, and an author is likely to be guided by their audience and the journal they are publishing in.

5.3. *Revised epistemological position: Constructionism*

As a result of the factors outlined in Section 5.2, including the review of mainstream N & D literature and my reasons for engaging in a paradigm shift, the epistemological position I take in this thesis is constructionism. Also known as social constructionism, this position states that reality is experienced, or constructed, by the individual (Denzin and Lincoln 1994). Consequently, there is no one true, valid interpretation of reality because meanings emerge from people's interactions and experiences (Crotty 1998).

Social constructionism is a relatively broad term that encompasses a number of theoretical approaches. Vivien Burr, a psychologist and academic, provides an overview of social constructionism (Burr, 2003). She states that while social constructionist writers do have a number of characteristics in common, there is not one description that describes them all (Burr 2003). Social constructionism is a theoretical orientation which underpins many newer approaches to research including critical psychology, discursive psychology, discourse analysis, deconstruction and post-structuralism and offers radical and critical alternatives (Burr 2003).

Social constructionism became well-known after the key text "The Social Construction of Reality"; written by German and American sociologists Thomas Luckmann and Peter Berger respectively in 1966 (Berger and Luckmann 1966). Social constructionist inquiry is 'principally concerned with explicating the processes by which people come to describe, explain or otherwise account for the world (including themselves) in which they live' (Gergen 1985, p. 266). It differs from empiricist assumptions that emphasise knowledge as an internal representation of the state of nature (Gergen 1985). Instead, it says that humans socially construct the world and at the same time they experience it as if the world is pre-given and fixed (Burr 2003, p. 13). In highlighting the role of individuals in creating reality, a social constructionist epistemology simultaneously acknowledges that truth is not neutral. Truth, or reality, is constructed by an individual and is therefore political, ideological and permeated with that person's values (Rouse 1996). If truth is not neutral, then social constructionism invites us to critically assess those factors that influence creation of our own truths. Factors which influence White health professionals' views about Aboriginal health and Aboriginal people, and therefore their truths and realities about these issues, will be explored in this thesis.

Social constructionism questions approaches where knowledge is taken for granted as simply existing; that 'what exists is what we perceive to exist' (Burr 2003, p. 3). It recognises knowledge as shaped by historical and cultural factors and therefore the ways in which we understand the world are shaped by culture and history (Gergen 1985). This is important because in this research I explore how past experience and knowledge of Aboriginal history influence the practice of White health professionals with Aboriginal people. Using a social constructionist epistemology enables me to acknowledge the importance of this connection. Social constructionism also acknowledges that knowledge and action go together, whereby certain situations invite certain actions from people. In this research, this idea is explored in the context of White health professionals' practice with Aboriginal people.

Social constructionist approaches challenge grand, or meta, narratives. Grand narratives are abstract ideas that are presented as comprehensive explanations of experience or knowledge. Generally, they are deeply embedded in a particular culture (Halverson, Goodall et al. 2011). The dominance of positivism in dietetics could be considered a grand narrative. Taking a social constructionist view, whereby the world and the people in it are seen as socially constructed, allows grand narratives to be challenged because they can be seen 'as one of the many discourses that are possible among others that have equal value' (Etherington 2004, p. 21). As described by Etherington (2004, p. 21) in taking this approach 'we can begin to deconstruct fixed beliefs about their power and invite other ways of thinking'. This is an important use of a social constructionist philosophy in this research, and the approach that is used to challenge these dominant constructions (in N & D) is a critical approach to research (Section 5.4).

Using a social constructionist epistemology in this research is also beneficial because it does not require me to privilege one type of knowledge over the other. That is, it enables the recognition of multiple discourses such as views of Aboriginal and White people, and different approaches to research (such as positivist and critical approaches). For example, in this research I listened to stories from a range of people, including White health professionals, Aboriginal health professionals and Aboriginal community members. By using a social constructionist epistemology, I was able to value and give voice to these multiple discourses. In not requiring a judgement about the validity of knowledge to be passed, social constructionism encourages researchers to value different kinds of knowledge and can potentially avoid competition between different types of

knowledges, such as that which exists between science-based and experiential forms of knowledge in dietetics (Liquori 2001).

As demonstrated in Figure 5.1, epistemologies provide the meta-theory or knowledge framework for research and theoretical perspectives follow-on from them. In Section 5.4, I highlight how a social constructionist epistemology is compatible with a critical theoretical approach. However, before moving on it is vital to consider the shortcomings of the epistemological position used in this thesis, in particular considering that my critique of positivism in dietetics (Section 5.2.3) is largely based upon the observation that this position is rarely recognised nor critiqued by those who use it. Social constructionism, in particular early versions, has been criticised for not adequately addressing the issue of power (Cromby and Nightingale 1999). This shortcoming has been addressed in later versions of social constructionism, for example through the work of Foucault (Cromby and Nightingale 1999). This shortcoming is addressed in this thesis through the use of critical and Whiteness theories. My use of a critical theoretical approach and Whiteness theories return an analysis of power to the research. These theoretical perspectives recognise power through discussion of dominance and privilege of certain groups (for example White health professionals and Aboriginal people) over others.

5.4. *Revised theoretical perspective: Critical Approach*

One way to challenge norms and structures in society (or dominant social constructions) is through use of a critical approach. Critical social researchers perceive that there is unequal control over resources and power. Therefore a critical approach is concerned with moving beyond the dominant values of society and identifying the structures that influence what happens on the surface of social reality (Neuman 2000; Haralambos, Holborn et al. 2004).

In this research, I use a critical approach to explore the issue of race in Aboriginal health. The theoretical tool I use to do so is Whiteness theory. A critical approach was deemed to be a suitable approach for this research because it allows the inequities between White and Aboriginal Australians to be acknowledged and addressed, using a Whiteness theory lens. It also enables the dominant discourses in N & D research to be challenged. A critical theoretical approach is also compatible with a social constructionist epistemology, which, as described, acknowledges that there are multiple views, truths and realities, and that these are shaped by experience. A critical

theoretical approach acknowledges that some of these views (constructions) are more dominant than others, and seeks to challenge them and/ or present alternative views. In doing so, a critical approach acknowledges that there are multiple views. That is, when a researcher challenges dominant ideas, they must be aware that different ideas exist in order to present alternatives to the dominant discourse.

A critical approach to research is informed by critical theory (CT), which was established in Germany at the Frankfurt School (Held 1980). Since this time, other critical approaches based on critical theory have been developed. One such example is critical social science, which is a metatheory of social science that 'had its most sustained expression by the Frankfurt School' (Fay 1987, p. 4). Considering the importance of CT in informing the approach of this research, it is important to briefly review the history of this theory.

5.4.1. History of Critical Theory

Critical theory emerged in Germany in the 1920s as a response to the development of technical knowledge within the area of positivist science and the contribution of this science to the oppression of the working class (Campbell and Brunting 1991). In 1923, a group of German scholars including Max Horkheimer, Theodor Adorno and Herbert Marcuse founded the Institute of Social Research, which later became known as the Frankfurt School. Other theorists with some connection to the Frankfurt School include Friedrich Pollock, Erich Fromm, Franz Neumann and Otto Kirchheimer.

Critical theory was seen as a catalyst for the types of changes that would be necessary to overthrow capitalism, and consequently, was seen as part of the working class revolution (Fay 1987; Morrow and Brown 1994). The origins of CT can be traced back to Karl Marx, however CT supplemented traditional Marxist ideas with social psychology and cultural theory, to explore areas such as 'the "irrational" forces that blocked the working class from recognising its own interests' (Morrow and Brown 1994). However, when the working class failed to overthrow Hitler in the 1930s, these theorists abandoned their ideas about CT. By the 1940s, the ideas proposed by the Frankfurt School had become marginalised; there was disillusionment with earlier versions of CT and it consequently became isolated from other developments in the social sciences.

Despite this isolation in the 1930s and 1940s, CT experienced a revival in the 1960s. This was led by Jurgen Habermas, a German born sociologist and philosopher, as a result of his disenchantment with key aspects of traditional CT from the Frankfurt School. Another theorist important in the development of contemporary critical theory is Anthony Giddens, a British sociologist. His approach is described as different from, but generally complementary to, that of Habermas. Both have stressed that they do not provide a distinct approach nor are they specifically concerned with certain methods or techniques (Morrow and Brown 1994). These two theorists will be discussed in more detail in Section 5.4.2.

Importantly, while different critical theorists have different approaches to CT, they all seek to examine, critique and address contemporary social and political issues. Today, critical theory provides a base from which researchers, practitioners and disciplines can question issues of concern and interest, where they have come from and where they are headed as a profession, such as the example of critical dietetics.

5.4.2. Key concepts within a critical approach relevant for this research

Relevant concepts for this research that fall within a critical approach include structuration theory (system, structure and agency) and emancipation.

Structuration Theory

Giddens' structuration theory provides an alternative view of the relationship between agents (individuals) and structure presented in other theories of society. Other theories of society include action theory, which privileges agency by saying that the actions of agents create societal structures, and functionalism and structuralism which tend to privilege structure by saying that the societal structure determines the actions of individuals (Kaspersen 2000). Furthermore, structuralist and functionalist theories tend to view structure as an external condition that constitute the parts of a whole. These theories have both been criticised; for example action theory has been criticised for not acknowledging that structure can influence the actions of individuals, while structuralism/ functionalism have been criticised for not recognising the agency of individuals (Kaspersen 2000).

On the other hand, Giddens presents a different definition of structure to structuralist, functionalist and action theories, and describes a different relationship between agents and structure. For Giddens (1982), structure has a virtual existence, as opposed to it being an external condition. Giddens (1982; 1984) defines structure as the rules and resources that are found within social systems. Rules and resources, or structure, are factors that can either constrain or enable the actions of individuals. Giddens (1984) describes agency as not the intentions people have in doing things but their capability of doing those things in the first place.

An important concept required to understand the theory of structuration is that of "system" or "social system". Lars Kaspersen, an Associate Professor of Sociology, has written about Giddens' structuration theory. He describes a system as something that is produced when the actions of agents are situated within a specific context, and are reproduced across a specific time and space (Kaspersen 2000). Similarly, Giddens (1982, p. 36) describes a social system as something that consists of 'reproduced practices'. Systems are created through the process of structuration, which is defined as the production and reproduction of social practices across time and space (Giddens 1982). Therefore, systems can be defined as 'the outcomes of the contingent acts of a multiplicity of human beings' (Giddens 1982, p. 35), because systems are created through the actions of humans. In Giddens' view, systems are not the same as structures, rather systems are made up of structures (the rules and resources within them).

These definitions have important implications for the relationship between systems, structure and agency postulated by Giddens. If systems are made up of interactions between agents, then systems are inextricably linked to the actions of agents – that is, they cannot be independent (Kaspersen 2000). Consequently, the actions of agents both produce and reproduce a system, and human agency is an important element in the creation of systems. In undertaking any action, agents use the structures (rules and resources) that are part of that system. Through using these structures in their action, agents unknowingly reproduce the structures. Therefore, structure is continually recreated through the actions of agents, who draw on it whenever they act (Kaspersen 2000). Using structuration theory, social practices of agents are described as "recursive" because they both rely on structure and reproduce structure through their action. This 'recursive nature of social life' described by Giddens (1982, pp. 36-37) is referred to as the "duality of structure" which means that 'the structural properties of social systems are both the medium and the outcomes of

the practices that constitute those systems'. For example, by speaking the English language, an individual contributes to maintaining the English language (Giddens 1982; Kaspersen 2000). These points demonstrate two key features of structuration theory; that the individual is positioned as 'a reasoning, acting being' and that neither the subject (agent) nor object (society) is more important in determining action (Giddens 1982, p. 8).

Giddens describes agents as capable and knowledgeable, and as having practical and discursive levels of consciousness. An agent is capable in the sense that for most actions, there is always the possibility of 'doing otherwise' (Giddens 1982, p. 9). An agent is knowledgeable of the society within which they act, and the conditions of their action within that society. All action by agents is purposive, meaning that actions have a motivation. This motivation may sit at the level of discursive consciousness (in which case the agent can describe the motivation through language) or practical consciousness (in which case the agent cannot describe the motivation using language, such as their knowledge of the rules and principles of the English language) (Giddens 1982). Giddens states that reflexivity is the key to agents being capable and knowledgeable, because they are able to reflexively monitor their actions, whether that be at the level of discursive or practical consciousness. "Reflexive monitoring of action" is the process whereby agents take into account the situations around them, and adjust their actions accordingly. This process enables individuals to 'actively reproduce the social world around them' (Tucker 1998, p. 89). Reflexive monitoring of action is crucial for good practice because it enables the possibility of changing patterns of action (Kaspersen 2000).

In this thesis I use structuration theory to explore the relationship between agents (White health professionals) and systems and structure (rules and resources), as defined by Giddens. As will be highlighted in later chapters, some White health professionals presented a view of structure similar to traditional structuralist/ functionalist perspectives, whereby structure was perceived as an external factor that severely constrained their practice in Aboriginal health. I also noticed the commonality of this perspective amongst White health professionals when I was working as a dietitian in Aboriginal health. I also use structuration theory to demonstrate how White health professionals, through their "usual" practice, often perpetuate their own White privilege and can therefore be complicit in a system that does not always regard the needs and preferences of Aboriginal people.

In this thesis, I consider Aboriginal health in South Australia as a system. It can be considered a system because it has been, and is, produced and reproduced over a specific time (since establishment of SA as a humanitarian colony in 1836) and in a specific place (South Australia) through the actions of agents (White health professionals, Aboriginal people and the Government, for example). Within this larger system of Aboriginal health, there are smaller systems. In this thesis I identify three smaller systems including the organisation in which a White health professional works, the profession to which they belong and the White health professional themselves as an individual. These three elements can be considered systems because like Aboriginal health, they exist in a specific time (the present) and a specific place (locations in which this research was conducted). Furthermore, I demonstrate that these three systems each have structures (rules and resources) that guide the actions of White health professionals, and are reproduced by them.

In this thesis I seek to identify what rules and resources are present in each of these systems (organisation, profession and individual) that constrain and enable the practice of White health professionals. If, within these three systems, the view of structure presented by Giddens is used, then structure is something that shapes the actions of White health professionals and is shaped by it. This suggests that these professionals do have the agency to address their actions and therefore address these systems, because through their day-to-day actions, they perpetuate the structures they report to constrain their practice, and systems are made up of these structures. This is in contrast to a structuralist/ functionalist view of structure which presents individual action as being defined by structure, and therefore the agency of individuals as much less.

Giddens' structuration theory provides one explanation for how White health professionals may become emancipated from the perceived structural factors that constrain their practice, through their ability to influence structure. However, ideas about emancipation are also presented in detail by Jurgen Habermas and are worth considering for this research.

Emancipation

Emancipation is a broad term used to describe various efforts to obtain political rights or equality. The work of Jurgen Habermas has been described as 'an endeavour to reunite theory and

practice in the twentieth-century world' (Giddens 1985, p. 124). In order to do so, Habermas developed a theory with a practical intention: the self-emancipation of people from domination and structure (Held 1980). This is consistent with a critical theoretical approach which is interested in identifying oppressive features of societies and how oppressed groups and/ or societies may become liberated, or emancipated, from these oppressive forces (Fay 1987; Campbell and Brunting 1991).

Habermas also writes about the reasons that people acquire knowledge, and one of these reasons is related to emancipation. Habermas describes three types of knowledge: the technical, practical and emancipatory. He presents these interests as motivations for doing different types of inquiry, with the empirical-analytic sciences having a technical interest, the historical-hermeneutic sciences having a practical interest and the critically oriented sciences having an emancipatory interest (Habermas 1972). The technical interest creates objective knowledge and is interested in control, particularly that of the environment (Grundy 1987). The practical interest creates subjective knowledge and is concerned with understanding, in particular 'understanding the environment in order to interact with it' (Grundy 1987, p. 13). Finally, the emancipatory interest is concerned with empowerment, especially the ability to be autonomous and responsible (Grundy 1987). Emancipatory action requires the involvement of all parties, attempts to change structures which constrain freedom and promotes a reciprocal relationship between self-reflection and action. In this research I had an emancipatory interest, and I involved all parties by involving Aboriginal communities extensively in the research. These different types of interests provide a way to encourage those who may be familiar with only one way of acquiring knowledge to consider alternatives. For example, it is worth advocating for dietitians to move beyond the technical interest in order to challenge elements that may be influencing their practice. A benefit of using the emancipatory interest is that it is concerned with changing existing conditions, rather than just the pursuit of knowledge (McCarthy 1978). This is in line with a critical approach.

Of interest to this research is how White health professionals can engage with the emancipatory interest within the area of Aboriginal health. That is, how can they empower themselves to work with Aboriginal people, and empower the Aboriginal people they work with? Ultimately, such emancipation would require White health professionals to be freed from ideologies and situations that constrain them in their practice within the systems in which they work (organisation,

profession and individual). According to Habermas (1972), the key to this emancipation is self-reflection. For example: self-reflection is 'at once intuition and emancipation, comprehension and liberation from dogmatic dependence' (Habermas 1972, p. 208). The role of reflection in emancipation has also been discussed by other authors. Grundy (1987, p. 16) highlights the intimate relationship between the two: 'it is only in the act of self-reflection (that is, as the ego turns upon itself) that emancipation is possible'. Self-reflection for emancipation has been compared to self-reflection in psychotherapy:

> *…just as the 'self-reflection' of the patient in psychotherapy entails an insight into hidden sources of repression and at the same time a freeing from this repression, so too 'self-reflection' in the name of the interest in emancipation entails an insight into power structures and a practical freeing from them (Ottmann 1982, p. 82).*

Therefore, in this research, I consider how self-reflection can be used as a tool to emancipate White health professionals from any ideological and structural factors (rules and resources at the level of the organisation, profession and individual) that may influence their practice.

Benefits of using a critical approach in this research

In this research, using a critical approach enables me to acknowledge that people's experiences do not occur in isolation from wider structural and social determinants. Therefore, using a critical approach enables me to not only report on the experiences of White health professionals in Aboriginal health, but also to question why these experiences are as they are and consider potential ways to move forward. A critical approach ensures that I delve deeper, beyond those factors that are immediately obvious, in considering the roots of these experiences and how White health professionals' views are constructed, and ultimately how negative experiences may be altered and positive experience may be maximised. A critical approach also enables me to consider how health professionals might play a role in maintaining the structures that constrain their practice with Aboriginal people.

Using a critical approach reminds me to constantly be aware of my own viewpoints, assumptions and ideas about the world. It reminds me of the power that I have as a researcher working with the community, and encourages me to look for ways to reduce this power divide, for example by taking an approach to research whereby I am doing research *with* participants instead of *on* them.

I conducted this research and wrote this thesis from the viewpoint of a White person, and this is one reason why I use Whiteness theory as a theoretical perspective (Chapter 4). This is important because 'facts require an interpretation from within a framework of values, theory and meaning' (Neuman 2000, p. 80). A possible link between CT and Whiteness theory is the potential for Whiteness theory to be a tool through which emancipation of White people is explored. That is, how does an awareness of race, reflections on Whiteness, or an acquisition of a White Racial Identity, lead to emancipation of an individual from constraining structural factors and consequently better practice?

5.5. *Methodological Approaches*

In this section, I describe the two methodological tools used in this research – critical social research (Harvey 1990) and reflexivity (Etherington 2004).

5.5.1. Critical Social Research

Critical social research (CSR) is one way of undertaking research with a critical approach. I chose to use CSR as a methodology because it provides clear guidelines for how to apply a critical approach to research. It also promotes a gradual process through which a researcher comes to know and understand data; an approach that appealed to me. In this thesis I use CSR as it was described by Lee Harvey, an academic who has written in the areas of sociology and education (Harvey 1990).

Critical social research is concerned with locating key concepts, or phenomena, in wider social and historical structures. It is made up of nine elements: abstraction, essence, totality, structure, praxis, ideology, history and deconstruction and reconstruction (Harvey 1990). These nine elements provide guidelines about key concepts to investigate in a research project. Specifically, the process of deconstruction and reconstruction guides data analysis. I now explain the meaning of the nine elements and how they guided this research.

The first element, ***abstraction***, is the creation of conceptual categories or ideas. Critical social research is concerned with identifying underlying structures, that are often taken-for-granted, that influence understanding of these ideas. In contrast to the scientific approach which starts with factual observations and creates abstract concepts from them, CSR proposes that facts cannot

exist independently of a theoretical context. Therefore it starts with abstract generalisations and investigates them. The abstract generalisations I made as a new graduate dietitian working in rural and remote SA are an example of the use of abstraction in this research. Abstraction is related to the second element, ***essence***, which is the concept being explored. The essential concept that I explore in this research is the practice of White health professionals with Aboriginal people.

The third element, ***totality***, suggests that individual concepts do not exist in isolation, but are related to wider social structures. Totality highlights that social phenomena are interrelated and only have meaning when considered in a wider context. The fourth element, ***structure***, refers to the models that underpin the world, or a 'complex set of interrelated elements which are interdependent and which can only be adequately conceived in terms of the complete structure' (Harvey 1990, p. 25). In this research I acknowledge that the practice of White health professionals is dependent on many factors and does not occur in isolation. I investigate the structural factors that affect this practice.

Praxis, the fifth element, refers to the application of ideas, or the enactment of a theory, lesson or skill. Praxis enables a researcher to consider what needs to be done in order to alter the oppressive structures identified through research. In this thesis, I use reflexivity to bring about praxis in my own work and research. I also aim to disseminate the results of this research to raise awareness about changing practice within the N & D profession and OP area of practice/ research.

The sixth element, ***ideology***, refers to a set of ideas or ways of looking at things. There are often dominant ideologies in society. Harvey (1990) presents a view of ideology that suggests a change in ideology cannot occur without a change in societal structures. Therefore, ideology must be considered in conjunction with structure. In this research I consider how ideology affects practice of White health professionals. In Chapter 10, I present ideology as part of the structure that can enable or constrain White health professionals when they work in Aboriginal health.

The seventh element of CSR is ***history***. Critical researchers acknowledge that history is the result of active interpretation of available information and therefore is not necessarily '"factual". Therefore, CSR stresses the importance of relating history to wider social structures and contexts and acknowledging positions from which people interpret history. In Chapter 2, I presented the history of Aboriginal people in Australia since colonisation using Aboriginal and White accounts of history. In Chapter 7 I present my position as a dietitian-researcher, and acknowledge factors that may influence my interpretation of historical events and data.

The final two elements of CSR are ***deconstruction*** and ***reconstruction***. These are described as the fundamental action elements of CSR, or the processes that allow a critical social analysis of data.

Critical social research is not a discrete process because 'different elements are developed in parallel and all of the different aspects inform each other' (Harvey 1990, p. 29). It is an ongoing process that involves constant questioning, and there is constant movement back and forth between a number of elements, including: abstract concept and concrete data, social totalities and particular phenomena, current structures and historical development, surface appearances and essence, reflection and practice. A set of questions that can assist with deconstruction and reconstruction of data are presented (Chapter 6), however these are only a guide, and it is the approach to evidence (rather than the specific approach) that is most important when using CSR.

5.5.2. Reflexivity

Reflexivity is an important methodology and one that is commonly used as part of a critical approach. I chose to use reflexivity in this research for a number of reasons. First, it enables me to identify and address my viewpoints. It is important that any researcher using a critical approach identifies and reflects on their viewpoints when conducting research, as a researcher always begins with a viewpoint and any analyses are conducted with this viewpoint in mind (Neuman 2000). Second, reflexivity is a useful tool for exploring and learning from experiences, as I seek to do.

Kim Etherington, a professor, counsellor and occupational therapist, defines reflexivity as a process by which researchers notice their responses to people, events and the world around them and then use that knowledge to inform their actions, communications and understandings

(Etherington 2004). It has also been described as 'reflecting on the process of one's research and trying to understand how one's own values and views may influence findings' (Jootun, McGhee et al. 2009) (p. 42). Being reflexive encourages awareness of personal, social and cultural contexts in which we live and work and how those factors influence our interpretation of the world (Etherington 2004). Reflexivity also enables one to 'make explicit the conditions where data were being produced and to specify the ways in which the researchers' own identities and roles could have affected the data collected and the analysis' (Jootun, McGhee et al. 2009, p. 44). Ultimately, the reflexive researcher is able to acknowledge that any research findings are the product of the researcher's interpretation.

There are many writings about the uses of reflexivity in research (Marcus 1994; Dowling 2006). It is utilised in many fields of research including autoethnography, case study, grounded theory and participatory action research. As a methodology, reflexivity enables transparency and 'adds validity and rigour in research by providing information about the contexts in which data are located' (Etherington 2004, p. 37). It is commonly cited that reflexivity is a way to increase rigour or credibility in qualitative research (Koch and Harrington 1998; Dowling 2006; Jootun, McGhee et al. 2009; Pilnick and Swift 2011). While this can be one use, it is not the only use (Gouldner 1971; Furman 2004). In fact, some authors advocate for closing 'the door on a belief that distance between researcher and participant is paramount, and providing momentum for a move towards a position where boundaries between the two are surrendered' (Dowling 2006, p. 7). Acknowledging where you fit as a researcher in relation to the people whom you are researching is an important element of reflexivity.

Other uses of reflexivity in research have been discussed. Reflexivity is associated with a self-critique and opens the possibility for the research to incorporate many voices (Marcus 1994). In epistemological reflexivity, researchers are encouraged to reflect on the assumptions made about knowledge during the research, and how this affected what was found. Reflexivity from a critical standpoint is used to examine the political and social constructions that inform the research (Marcus 1994; Koch and Harrington 1998; Dowling 2006). Using reflexivity from a feminist standpoint encourages the reciprocal sharing of knowledge between the researcher and those being researched, so that the two become collaborators. The researcher is required to analyse themselves with the same lens through which they analyse participants. This type of reflexivity is

likely to be useful when sensitive issues are being explored (Dowling 2006). In this research, I draw on and use elements from these different types of reflexivity, which I demonstrate in Chapter 7.

Use of reflexivity in this research

By using a reflexive approach I aim to position myself within this research, (Etherington 2004) and consider the ways that I have influenced the research. I also consider my position as a dietitian-researcher and where I fit in relation to the White health professionals and Aboriginal workers I interviewed. Consistent with a critical approach, being reflexive encourages me to ask questions. For example, using reflexivity has allowed me to explore alternative ways of doing research and question the epistemological foundations on which my training as a dietitian was based. In this thesis I refer to "reflections" made in my Reflexive journal. I was reflexive in the sense that I took these reflections and altered my practice based on them. I provide examples of how I did this in Chapter 7.

Specifically, reflexivity enabled me to examine my own ideology, history and praxis; elements of CSR (Harvey 1990); develop an awareness of the context in which I conducted this research; alter my practice based on my growing awareness of this context; keep track of my development as a researcher, for example changing the ways I responded to certain situations; and identify why I had certain reactions to certain situations, for example feeling uncomfortable when I was the only White person with a group of Aboriginal people. Additionally, many of the questions I asked of participants put them in a state of vulnerability, for example according to Behar (1996, p. 273) 'we ask for revelations from others but we reveal little or nothing about ourselves, we make others vulnerable but we ourselves remain invulnerable'. By being reflexive, I aim to experience a similar level of vulnerability of my participants.

I also used reflexivity in the interview process. Reflexive interviewing is a process by which interviewers share their personal experience of the topic with interviewees during an interview (Etherington 2004). I used this technique as a way to (a) build rapport with participants, (b) clarify my thinking about a topic or how my experience related to a participant's and/ or to (c) encourage conversation about sensitive topics by sharing some of my own experiences.

Additionally, reflexivity fits with the epistemological, theoretical and other methodological approaches of this research. First, it is related to critical approaches to research. Reflexivity challenges researchers to be more conscious of their personal ideology, culture and politics, and that of their participants and research audience (Etherington 2004). Ideology is one of the important concepts for analysis in CSR (Harvey 1990). Praxis, another concept of CSR, is also related to reflexivity. Reflexivity is the way that I have engaged in praxis because it is how I identified what needed to be changed and how I went about making changes. Being reflexive enables the inclusion of a personal story with this research; this gives the reader the opportunity to judge the validity of the overall narrative and consider how my 'personal stories might impact on my opinions and analysis that are undoubtedly influenced by my history and culture' (Etherington 2004, p. 84), which is an element to a critical analysis. Second, it is related to social constructionism. As noted earlier, a social constructionist epistemology enables dominant discourses to be understood as social constructions, and these can be challenged through use of critical approaches to research. Reflexivity is integral to this process because it enables a researcher to become aware of the context in which these social constructions sit, which is necessary if they are to be challenged.

5.6. *Chapter Summary*

In this chapter, I described how I came to use the epistemological, theoretical and methodological approaches that underpin this research. I began by reviewing the affiliation to positivism in the discipline of N & D, and how this is often "silent". I conducted a review of the mainstream N & D literature to demonstrate that in this discipline, epistemological, theoretical and methodological standpoints are rarely acknowledged. I challenged this by acknowledging my standpoints in this research including an epistemological philosophy of social constructionism; a theoretical orientation of critical theory and methodological approaches of CSR (Harvey 1990) and reflexivity. I presented key theoretical concepts, including structuration theory and emancipation, that will be used in the interpretation of the results later in this thesis. Within this chapter, I identified how these elements are connected and what they add to this research. In this chapter I also highlighted the aspects of the significant paradigm shift I engaged in throughout this research and provided justification for why this was necessary and also difficult.

6. Methods

In this chapter I outline the methods used in this research, which are guided by the epistemological, theoretical and methodological approaches discussed in Chapter 5. Due to the use of reflexivity as a component of methodology, this chapter contains data from my reflexive journal to justify choices related to methods. In this chapter I also demonstrate the significant investment I put into working with Aboriginal people in Communities A and B to ensure the conduct of ethical research.

I begin by outlining the larger project within which part of this PhD is located, the *ewba* Community Programs. I highlight principles for doing ethical research with Aboriginal communities, and describe the importance of relationships in this research, including how I developed and maintained them. I then describe how two Aboriginal communities, Community A and Community B, were involved in this research; through a reference group, community consultation and dissemination of the results. I discuss the concept of reciprocity and how I used it as a key strategy for community engagement. I then describe the data collection process, including semi-structured interviews and use of a reflexive journal. I finish by outlining the process used for data analysis. In outlining how I conducted this research, I demonstrate my commitment to conducting ethical Aboriginal health research.

6.1. *Sample*

This research was located within a wider project, the *ewba* Community Programs. Due to the change in focus and paradigm shift during this research, *ewba* was not the only focus of the research; however this project is still important to describe.

6.1.1. Description of *ewba*

The primary goal of the *ewba* Community Programs was to contribute to the healthy weight of children and young people (aged 0-18) in two communities in SA, rural Community A and metropolitan Community B (Pettman, McAllister et al. 2010). A community-based, obesity prevention intervention (CBOPI), this program was repeatedly described by *ewba* staff as having a *'whole of community'* or *'whole of population'* approach (EWBA1; EWBA2; EWBA5; EWBA6; EWBA7)[12].

Characteristics of rural Community A and metropolitan Community B are provided (Table 6.1). These two communities were chosen as implementation sites for *ewba* by the SA Health department because of the presence of existing health system infrastructure, low socioeconomic status and the higher proportion of Aboriginal groups (Community A only). The percentage of the population in South Australia that identified as Aboriginal or Torres Strait Islander in the 2006 census was 1.2% (ABS 2006c). Socioeconomic status was measured by the Australian Bureau of Statistics using the Socioeconomic Index for Areas (SEIFA) index of relative disadvantage (IRSD) which focuses primarily on disadvantage and is derived from Census variables including low income, low level of education and unemployment (ABS 2008d). The SEIFA IRSD for Community A and B were lower than the average for country South Australia (IRSD=963) and metropolitan South Australia (IRSD=991) respectively. Importantly, Community B was a suburb, or a postcode area, within a wider council area while Community A was a rural town and three smaller, outer-lying towns in part of the local government area. Communities A and B were the sites for *ewba,* and as the PhD project was located within *ewba,* Communities A and B also became the primary sites for this PhD research.

Table 6.1: Characteristics of Community A and Community B; sites for the *eat well be active* Community Programs (ABS 2006c; Pettman, McAllister et al. 2010)

	Community A	**Community B**
Type	Rural town & outer-lying towns	Metropolitan suburb
Estimated population (2008)	19 101	23 724
SEIFA score (2006)	907	939
% Aboriginal population (2006)	4.2	1.1

[12] This represents information sourced from participant interviews. Further detail about how these quotes were obtained is presented in Section6.6.

Key messages, strategies and settings

The key messages, strategies and settings of *ewba* are shown in Figure 6.1. Indigenous agencies were one setting in which the program was implemented.

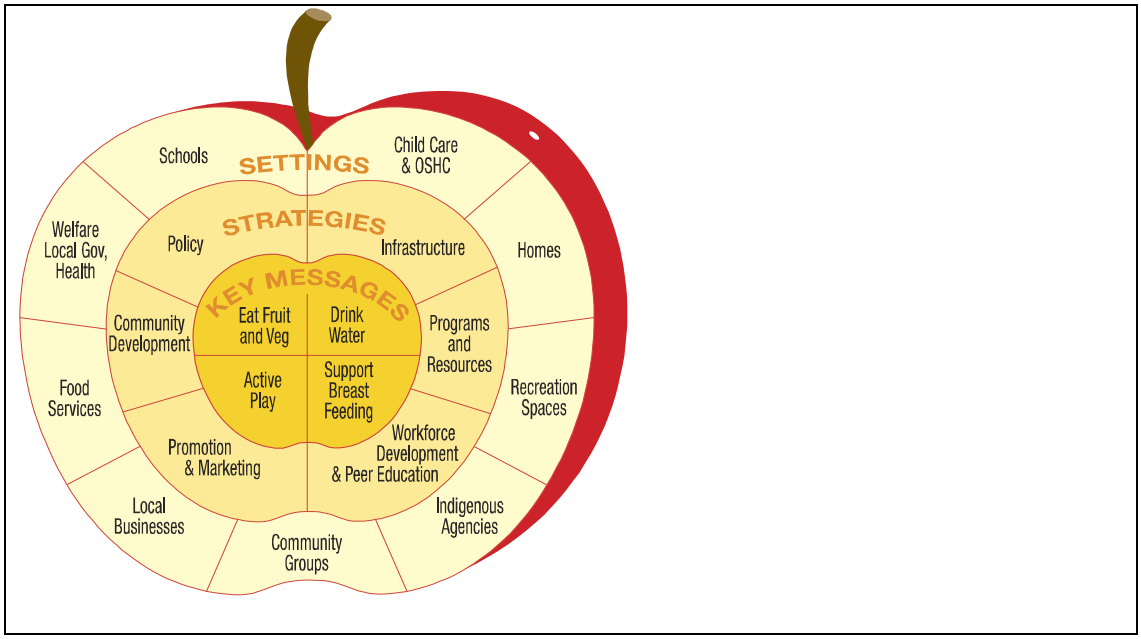

Figure 6.1: Key messages of the *eat well be active* Community Programs, strategies to implement key messages and settings for delivery of strategies (Jones, Magarey et al. 2008)

To address each strategy area demonstrated (Figure 6.1), *ewba* staff (project coordinators) delivered individual strategies across multiple settings in both Community A and B. The four main settings were under-fives, primary school, youth and community. *Ewba* staff worked in partnership with stakeholders to implement the program. There was one full time equivalent project officer in Community A and one in Community B. Individual strategies were developed through ongoing consultation with stakeholders through action groups and discussions, resulting in a plan to meet stakeholder needs. In practice, this meant finding the best fit implementation option for that stakeholder. This could have meant connecting stakeholders with another program or project, facilitating another organisation to provide training, modifying training or resources appropriately to meet their needs or developing new resources, training or programs. A small selection of individual strategies implemented in each strategy area are outlined in Table 6.2.

Table 6.2: Examples of individual strategies implemented in strategy areas for the *eat well be active* Community Programs

Strategy area	Individual strategy
Policy	Physical activity & nutrition policy
	Healthy fundraising
Infrastructure	Improvements to drinking water facilities
	Active play & healthy eating kits for family loan
Programs and resources	Foodcents budgeting program
	Talking with families about nutrition and active play
Workforce development and peer education	*ewba* Peer Education Leadership
	Mentoring for canteens
Promotion and marketing	Signage of key *ewba* messages
	Newsletter inserts
Community development	Local action groups
	Grant writing support
	Support for community events

Community A and Community B each had an Action Plan, developed in consultation with stakeholders, that summarised key objectives and strategies to be delivered in different settings. It was flexible and modified to meet changing needs of sites. The Action Plans sat alongside an Operational Plan, which was set up to clearly define the implementation strategies and measure progress. At the practice level, the Operational Plan set the agenda for the project coordinators' work and they were updated annually.

6.1.2. *Ewba* and Aboriginal communities

It is important to highlight that Aboriginal people were never intended to be the major group reached through *ewba*. Even though the higher proportion of Aboriginal people in Community A was a factor in its selection, *ewba* workers identified that the numbers of Aboriginal people in both communities would have been too low for them to be a major focus (EWBA6; EWBA7). However, it was still considered important to reach groups with high needs who were disadvantaged, and one worker commented *'we really wanted to make them [Aboriginal people] a smaller foci in a larger target group, so they are still a target group but not the primary target'* (EWBA6).

In the planning phase of *ewba* in 2004, SA Health provided a set of 'Guiding Principles' (Appendix 2) that represented the values of *ewba*, provided a framework and focus throughout the project and were based on key OP and primary healthcare documents (World Health Organisation 2000; Kumanyika, Jeffery et al. 2002; National Obesity Taskforce 2003; Swinburn, Gill et al. 2005). Two of the Guiding Principles that are relevant to this PhD research are:

1. 'inclusive and respectful of Aboriginal communities', and
2. 'equitable' (i.e. reaches all parts of the community where possible, especially the disadvantaged') (Pettman, McAllister et al. 2010),

These principles indicate that SA Health did place importance on the *ewba* project working well with the Aboriginal community, and focussing on equity. *Ewba* workers also indicated that it was an expectation within the two health services where *ewba* was based that the program would include and work well with the Aboriginal community (EWBA7). Equity has been defined as:

> *The absence of systematic disparities in health (or in the major social determinants of health) between groups with different levels of underlying social advantage/ disadvantage – that is, wealth, power or prestige. Inequities in health systematically put groups of people who are already socially disadvantaged (for example, by virtue of being poor, female, and/ or members of a disenfranchised racial, ethnic, or religious group) at further disadvantage with respect to their health...(Braveman and Gruskin 2003, p. 254)*

It is evident that *ewba* was a complex program with a multitude of aims and settings within which it was implemented. However, it is also clear that while *ewba* was a program with a whole of community approach, reaching the Aboriginal community was an important part of the project brief. Consequently, it is important to consider how well this was done and explore the context in which this occurred; one of the areas of inquiry in this research.

As previously described, I had concerns about determining the "effectiveness" of *ewba* in the Aboriginal communities of Community A and B, due to the association of this concept with measurement and the positivist paradigm. Consequently, as an alternative in considering the *ewba* Community Programs in the context of the Aboriginal communities of Community A and B, I qualitatively consider the following three elements of the program:

- Aboriginal workers' awareness of the program
- Perceived accessibility of the program by (a) Aboriginal workers and (b) *ewba* staff
- Perceived impact of the program in Aboriginal communities by (a) Aboriginal workers and (b) *ewba* staff.

Awareness of Aboriginal workers indicates how well known the program was amongst Aboriginal health staff; an important factor if the program was going to be translated to the Aboriginal community. Accessibility of the program indicates views on how easy the program was to access; also an important factor if the program was going to reach the community. Before impact is considered, it is important to consider awareness of Aboriginal health workers and perceived accessibility of the program. Perceived impact of the program by both Aboriginal and *ewba* staff allows a consideration of whether these viewpoints are similar/ different.

6.2. *Ethical research in Aboriginal communities*

There is a long history of research that has been conducted *on* Indigenous peoples around the world, *by* non-Indigenous peoples. To Indigenous people,

> *..."research" is probably one of the dirtiest words in the indigenous world's vocabulary...it stirs up silence, it conjures up bad memories, it raises a smile that is knowing and distrustful. (Smith 1999, p. 1). .*

Consequently, as a White researcher researching Aboriginal health, it was vital that I planned and conducted my research in an appropriate way that would do no harm.

Literature relating to ethical conduct of health research with Australian Aboriginal people indicates that a significant difference to Aboriginal health can only be made if Aboriginal peoples' voices, opinions and knowledge inform the research process (Sherwood and Edwards 2006). Working in partnership with Aboriginal people when conducting research is necessary (Smith 1999; Pyett, Waples-Crowe et al. 2008a). It is also important to consider *what* is researched. For example, Sherwood and Edwards (2006) suggest that the role of researchers in Aboriginal health is not to focus on disease causation and remedial measures, but rather to expose societal structures that are responsible for disadvantaging Aboriginal Australian people in respect to their culture and health status (Sherwood and Edwards 2006). This is consistent with using a critical theoretical approach for this research, which encourages an investigation into the role of structure.

6.2.1. NHMRC guidelines

The National Health and Medical Research Council (NHMRC) has produced guidelines for doing ethical research with Australian Aboriginal people (NHMRC 2003). An accompanying document has been produced to inform Aboriginal community members about what to expect from researchers (NHMRC 2006). Six elements to ensure ethical research have been suggested (NHMRC 2003) (Figure Figure 6.2).

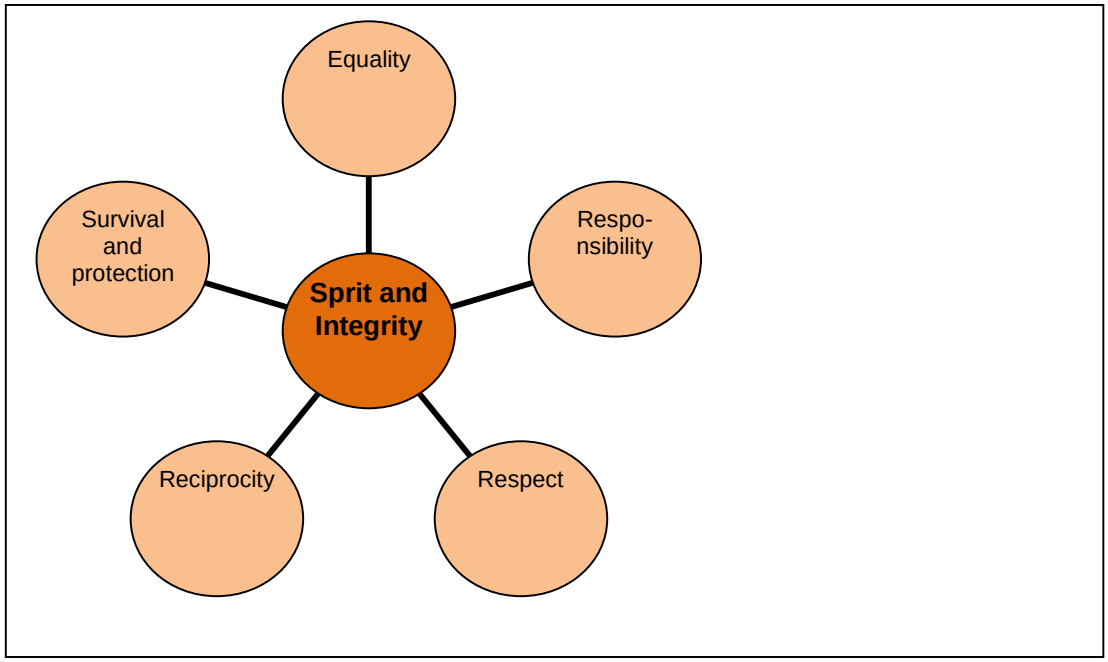

Figure 6.2: Elements of doing ethical research with Indigenous Australians (NHMRC 2003).

Upholding these ethical principles was paramount during this research. Some examples of how I upheld these values are provided (Table 6.3)

Table 6.3: Ways in which ethical principles for doing research with Aboriginal communities (NHMRC 2003) were upheld in this research

Ethical principle	Example of how it was upheld
Respect	Identifying protocols to engage with Aboriginal people and key people to engage with in Community A and B separately, and following these protocols
	Taking time to get to know key workers and community members
Responsibility	Reporting my results back to Aboriginal workers and community members who were involved in the research and asking for their comments
Equality	Working in partnership with Aboriginal workers and mentors
Reciprocity	Spending time with Aboriginal workers and community members in ways that they request
Survival and protection	Acknowledging the role of Aboriginal history in Australia, including colonisation, and adjusting my practice based on this
Spirit and integrity	Allowing time for Aboriginal people to tell their stories, and listening and learning from these stories as well as sharing my own

I now provide a detailed discussion of relationships and reciprocity, which were the two main ways I ensured that this research was ethical.

6.3. *Relationships*

Building and maintaining relationships was one of the main ways that I ensured ethical research (NHMRC 2003). This process ensured that Aboriginal workers and community members, in Community A and Community B, were involved in and had a chance to comment on all phases of the research. A detailed log of all the contact I had with Aboriginal communities, as well as others who provided assistance, is included (Appendix 3). This log is deidentified, except for those people who have agreed to be named, in order to maintain confidentiality. In this section, I briefly summarise this process and strategies used to build and maintain relationships.

6.3.1. Process

In 2008, I met with key organisations to identify who the key Aboriginal people were in Communities A and B. This included the Flinders Aboriginal Health Research Unit (FAHRU), the

Cooperative Research Centre for Aboriginal Health (CRCAH), both at Flinders University, and the Aboriginal Health Council of South Australia (AHCSA). These organisations had a good working knowledge of key Aboriginal people in communities within SA and suggested people to approach in Communities A and B. In early 2009, I had discussions with these people in the two communities and they gave me further ideas about where to start. Where possible, I also used connections that *ewba* had with the Aboriginal community; these were more developed in Community A.

The initial point of contact in both communities was the leader of the Aboriginal Health Teams. In rural Community A, the *ewba* project coordinator had good relationships with the Aboriginal Health staff and consequently introduced me. However, establishing relationships in both communities took time and persistence, although for different reasons. In metropolitan Community B, I had to persist and try a number of different approaches to discover the appropriate ways to access the community. Once I had this information, doors opened, and the opportunity to work with a women's group arose. In Community A, access to the appropriate people was quicker at the mainstream health service but a connection with the Aboriginal health service took longer. These experiences demonstrated the significance of "community gatekeepers" and the importance of forming relationships with these people first.

6.3.2. Strategies used to build and maintain relationships

Strategies used to build and maintain relationships included: spending time at community events, incidental contact; casual catch-ups (as opposed to formal meetings) and establishing a personal connection. Table 6.4 summarises the contact I had with key people over the course of the research. This contact is divided into phone, email, face to face meetings, events and groups and was collated by using information in the log (Appendix 3). The majority, but not all, of these people I had contact with were Aboriginal and the majority, but not all, were from Communities A and B. The others were key people in Aboriginal health in SA who were able to provide general advice. Phone calls and emails are underestimated here as it was logistically difficult to record all this correspondence. I have included information about the number of instances of contact and the number of instances of contacting different people, to highlight that in many cases, I contacted or met with the same people more than once. Table 6.4 demonstrates that the majority

of phone calls/ emails occurred in 2009 while I was trying to build relationships. This decreased in 2010 and 2011 because I spent more time cementing those relationships that I had developed.

Table 6.4: Details of key contact with key workers and community members during the research from 2008-2011, including phone calls, emails, meetings, attendance at community events and groups

	2008	2009	2010	2011
Phone				
No. phone calls	4	40	12	8
No. different people phoned	2	20	5	5
Email				
No. emails sent	12	21	5	16
No. different people emailed	11	18	2	9
Meetings				
No. meetings	8	65	24	7
No. different people met with	8	24	13	3
Events				
Total no. events attended	2	21	18	5
No. different events attended	2	9	9	2
Groups				
Total no. groups attended	1	13	18	2
No. different groups attended	1	4	4	2

I attended community events in Community A and B. Table 6.4 lists the number of events I attended in the years of this research. Examples of these events included community lunches, NAIDOC week events, FAHRU seminars, Reconciliation Week events, Sorry Day Events and Close the Gap Day events. At these events I spent time informally talking to Aboriginal community members and workers (sometimes about my research, other times just general discussion), and getting involved in whatever activities were being offered.

Attending these events enabled me to incidentally make contact with Aboriginal people, catch-up casually and have a chat. I was able to demonstrate that I was serious about working with the community through consistent attendance at these events. It was also a way to build my own confidence and learn about the community through observation, such as the dynamics between people and who the key people were. Many key people that I needed to talk to but who were difficult to contact by phone or email, were often present at these events so it was a good way to make contact.

At times it was difficult to attend these events; however I learnt to prioritise them. They were the best way to gain initial access to the community in an appropriate and respectful manner. As a PhD student I was in a position to make decisions about how I spent my time, hence I was able to dedicate time to attending these events. Unfortunately, as I demonstrate later in this thesis, practitioners are not always in a position to be able to make decisions in the same way.

I found that when I met Aboriginal people in an informal sense first, it led to a better and more productive relationship later on. Establishing an informal connection in the early days of the research meant when the time came to ask for something, they were more willing to give it. Chatting informally, or through a casual catch-up at a community event, also enabled me to establish a personal connection with someone. I found that if I shared a few details about myself, people remembered me more next time. Hence the informal setting was an ideal way to do this.

Many of the relationships I developed early on were also maintained through reciprocity, which will be described in Section 6.5.

6.4. *Community Involvement*

Through meeting with key Aboriginal people early on, and by reading ethical guidelines (NHMRC 2003), I learnt that when doing research, it is crucial to involve Aboriginal communities that you are researching in the research process (A Chong 2008, pers. comm., 10 November; S Perkins 2009, pers. comm., 4 March). This ensures that research is conducted in a culturally appropriate manner, communities have a say about the research and how it is done and that research does not reinforce principles of colonisation including dominance of non-Aboriginal people (Smith

1999; National Health & Medical Research Council 2003). Community involvement is also a sign of respect and is one way to ensure that ethical principles of doing research with Aboriginal communities are upheld (NHMRC 2003).

In Section 6.3, I briefly described how I built relationships in this research. This was a vital step because it enabled me to establish trust with key people. However, I wanted to ensure that the Aboriginal people in the research communities had an opportunity for more formal involvement. In this section, I describe how I undertook consultation and dissemination with the Aboriginal communities in Community A and Community B.

Initially, I was unsure about how to go about involving Aboriginal people in the research. Some of the questions I had included:

- Do I have a formal advisory committee or use more informal avenues?
- Do I want to talk to Aboriginal workers or community members, or both?
- Do I want to talk to Aboriginal people who are knowledgeable in the field N & D and OP, or does it not matter?
- Do I need to talk to people from both Community A and Community B?

Over time it became clear that there were no right answers to these questions. I learnt to identify what would best meet my needs and the needs of Communities A and B. I worked with each community in different ways. My first attempt to formally engage the communities was through a reference group.

6.4.1. Reference Group

In this section I describe the formation of a reference group for this research, including the initial way I tried to do this and the revised, more successful version.

Initial plan

Initially, I planned to form a new, separate group with Aboriginal people from Community A and B who could meet with me and have input into the research. I approached five people who were suggested to me by Alwin Chong from AHCSA (A Chong 2008, pers. comm., 10 November). However, four of the five people approached did not have the capacity to commit to this group

because they already sat on multiple reference groups and did not have the time or resources to sit on another group.

Questioning the initial plan

At the same time as attempting to form a reference group, I was spending significant time in the Aboriginal communities of Community A and B, both informally and through community events. Through these avenues, I was able to speak with a large number of Aboriginal people. This contact made me question the initial approach of forming a formalised reference group. I came to realise that the way I liaised with the community was less important; what mattered was that I did involve them. This was reinforced by an Aboriginal worker who told me that:

> *He said that the form this* (the advisory group) *takes doesn't really matter. That is, it might be very informal, I might meet with people separately. I might email or ring him informally, I might meet with him, I might have a teleconference with a few people at the same time – whatever works. (Reflexive Journal 25/2/2009, p. 17)*

Revised plan

Consequently, in May 2009 I re-thought the initial idea I had for a formal reference group. The idea of using whatever strategies worked for me and the people that I was working with fitted better with my practice and the ideas I was developing about working with Aboriginal people. Consequently, I developed an informal reference group with three separate parts: organisations, individual mentors and community members. The structure and roles of each part of this group are outlined (Figure 6.3). This structure enabled me to be more flexible in my practice. For example, I was able to speak to the people I needed to speak to, in ways and at times that suited them. I could alter my approach based on what worked best for different individuals and groups and there was no need for everyone to meet together. This approach met my needs, and did not add extra burden to Aboriginal community members and workers. Another benefit of this structure was that it allowed for consultation with groups that already had existing committees, such as Elders groups. This model considers sustainability because it avoids forming a new group that would inevitably dissolve once the project finished.

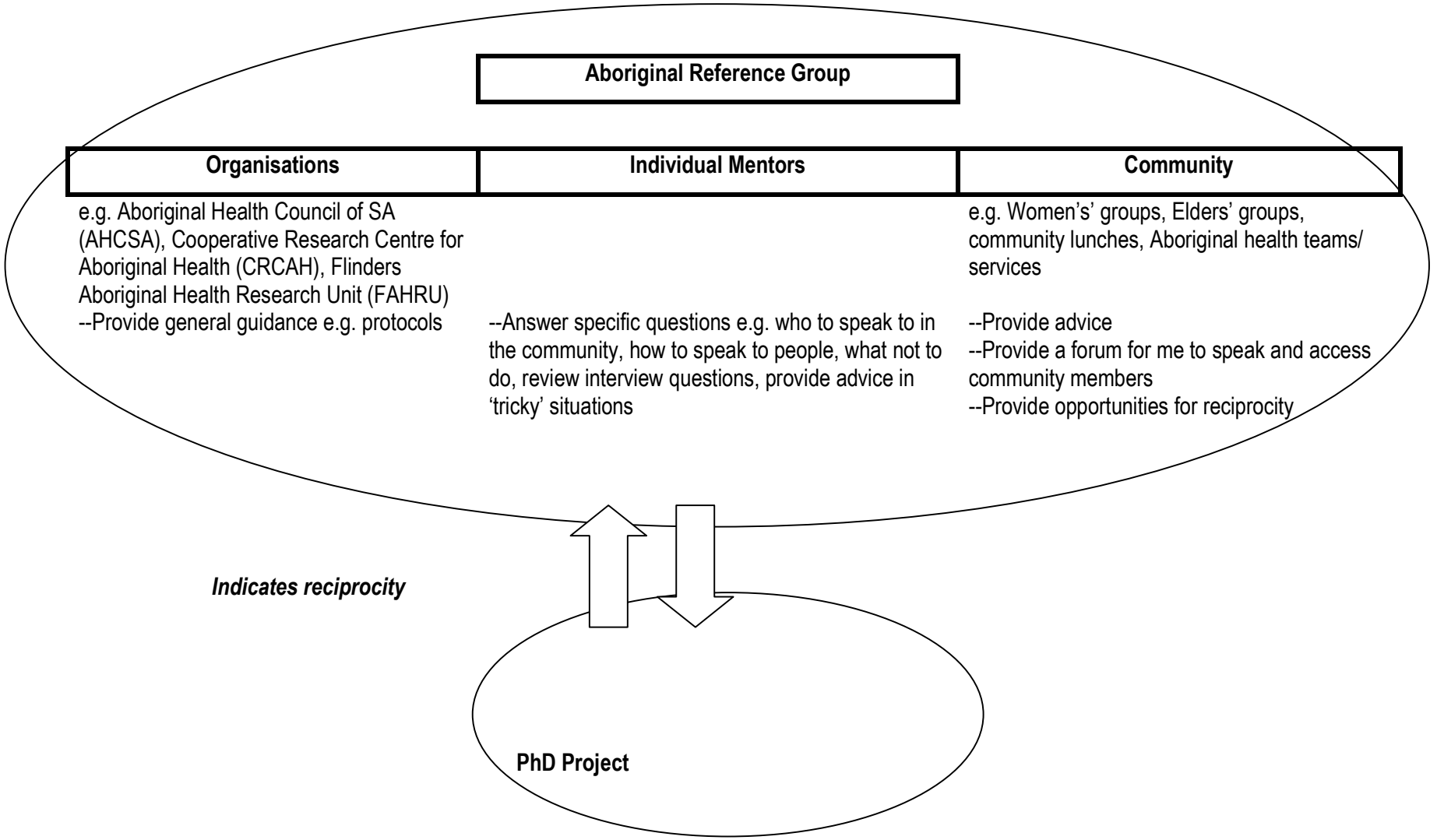

Figure 6.3: Structure of the revised Aboriginal Reference Group for the PhD project

Identifying people for the Reference Group

Organisations were relatively easy to identify because they were peak bodies concerned with Aboriginal health and/ or research in SA. I had three mentors for this research, two of whom I approached to sit on the initial reference group and who instead offered to be mentors. Kim O'Donnell and Mark Thompson provided me with support and guidance in the early phases of my project and were kept informed throughout. Luita Casey and I met at a women's group in Community B and she provided me with support in the middle to late phases of my project. My role and the roles of these mentors are outlined in a Terms of Reference (Appendix 4). Community members and groups were identified through suggestions from key Aboriginal workers, spending time at community events and through reciprocity (Section 6.5).

Activities with the Reference Group

In Table 6.5, I describe some of the different activities that I engaged in with the different parts of the reference group. This table demonstrates different ways the groups had input into this research.

Table 6.5: Activities undertaken with the three parts of the Reference Group for the PhD project: organisations, project mentors and community

Group	Activity	Timeframe
Organisations	Identification of key people to talk to	July 2008–June 2009
	Identification of relevant community protocols	July-Dec 2008
	Input into project design and interview questions	Jul 2008-June 2009
	Dissemination of results	May 2011
Project Mentors	Input into project question, methods, interview questions & lines of inquiry	Jan-Jul 2009
	Review of interview questions	July 2009
	Informal input into data analysis	Sep 2010
	Co-publication at conferences	April-May 2011
	Dissemination of results	May 2011
Community	Informal development and review of interview questions	Jan-Jul 2009
	Input for about project question, methods, interview questions & lines of enquiry	2009
	Increase relevance of the research to the community	2009
	Gain appreciation of Aboriginal life/ issues faced	Ongoing
	Dissemination of results	May 2011

In summary, the Reference Group provided a forum for communication between me and the community members in Community A and B. It ensured that the research process was open and transparent and enabled two-way learning to take place. I gained a greater understanding of community specific cultural protocols, processes for engagement with a certain Aboriginal community groups and life stories of Aboriginal people. This approach highlights the importance of flexibility when working with Aboriginal communities, and the importance of not adding extra burden.

6.4.2. *Community consultation*

In this section, I describe the community consultation undertaken in 2009 for this research.

Due to relationships I had developed prior to starting consultation, consultation was a formality where I provided workers and community members with more details about the research and a formal opportunity to comment.

What it looked like

Community consultation was a dynamic process that looked very different depending on the people consulted. It ranged from having a yarn with a community member over lunch to a formal consultation meeting. I was flexible with how I approached consultation and where possible, I utilised existing structures to avoid adding to people's workload. Through this process, I found that informal chats were a suitable approach for consultation when there was no established committee or formal avenue available:

> *I asked [project mentor] if informal chats were much more appropriate for Aboriginal people – he said yes – that his people have been yarning, literally, in the dirt for a very long time, and that that's what they are used to. Sitting down with a pen and paper doesn't really work for them. (Reflexive Journal 25/2/2009, p. 17)*

The relationships that I had built and the trust I had developed with Aboriginal people prior to consultation meant that consultation was quicker and more useful information was gleaned.

Process

The methods used to present the research question and during consultation were piloted at a women's group in Community B in June 2009. I made relevant changes to the methods based on

my reflections and comments from the women who attended the session. A crucial learning from this session was the need to make consultation relevant for the specific group that I was talking to. I did this by thinking about how my project might be relevant for that group of people and how what I was doing might benefit them in the long-term. For example in this pilot session I talked about how it is important that programs around healthy eating are as good as they can be with the Aboriginal community, because of the large number of kids who are overweight today.

Development of a Consultation Kit

Based on the results from the pilot session, I developed a "Consultation Kit" which I used at future consultations. This was a set of documents I used to talk about the research. I tailored the way I presented the information based on the group I was consulting. This kit included diagrams that outlined the project context and methods, as well as information about the Reference Group (Appendix 5).

Who was consulted?

Once the Kit was developed, key individuals and organisations/ groups/ individuals to consult were identified and contacted to make a time for a formal or informal meeting. The individuals and organisations that were consulted in Community A and Community B are listed in Table 6.6. The references to groups and individuals in this table are generic and do not provide specific names of groups/ positions of individuals to preserve anonymity. In some cases, consultation was planned with a group but did not eventuate, despite extensive persistence on my part. This appeared to be due to other priorities and cultural responsibilities of the group such as Sorry Business[13]. The two main examples where this happened was an Elders' group and a Men's group in one community. While some of the project mentors who were consulted did not work directly in community A or B, they had extensive knowledge of one or more of those communities due to previous work or personal experience.

[13] The time after the death of an Aboriginal person from a community. Includes the process of bereavement and mourning of the person who has passed away.

Table 6.6: Summary of individuals and groups from Aboriginal communities in Communities A and B consulted as part of the PhD research

Who consulted ***Type of consultation***	**Details**	**Community consulted**
Groups *Formal consultation*	Working together group	A
	Elders' Group	A
	Aboriginal Health Team	A & B
	Aboriginal Health Worker's Network	B
Groups *Informal consultation*	Staff involved in a cooking group with Aboriginal children	A
	Women's group	A & B
Individuals *Informal consultation*	Project Mentors	A & B
	Workers from Aboriginal Health Service (including head of Aboriginal health teams)	A & B

Therefore I conducted five formal consultations with groups, three informal consultations with groups and six individual consultations (four with mentors and one in each community with Aboriginal health team staff).

6.4.3. Dissemination

I disseminated the preliminary results of this research in order to share them and give people a chance to comment. I invited Aboriginal workers, community members and other White people who had been involved in this research to my final PhD seminar that was held at Flinders University on May 18 2011. Six of the Aboriginal people I worked with attended, three from each community. I also contacted all of the Aboriginal workers and groups in Community A and B who had had significant input into this research to determine the best way to share my results with them. This resulted in six separate dissemination events in May 2011 including Aboriginal health teams in both communities, women's groups in both communities, an Elder's group in one community and a working together group in one community. Dissemination resulted in useful comments from the Aboriginal people who had been involved. Most importantly, many identified that the information I presented was useful and they perceived it to be accurate. A summary of the research, as well as a thank you letter, was also sent to all participants and project mentors in November 2011. Project mentors were sent an additional letter that thanked them for their input into the research. Examples of these documents can be found in Appendix 6.

6.5. *Reciprocity*

I learnt early in this research that in order to gain something as a researcher, then I needed to give something back to the community. Of all of the ethical principles for doing research with Aboriginal communities (NHMRC 2003), I engaged most with reciprocity. Opportunities to enact reciprocity came out of the relationships I built and reciprocity helped me to maintain these.

My awareness of the importance of reciprocity developed through conversations with project mentors in early 2009, and the more I got to know members of the Aboriginal community, the more value I placed on it. One Aboriginal person (worker) advised:

> *You need to show that you exercise reciprocity – that you are giving something back to the community and that they are benefiting from it, i.e. what are the benefits to the community of using the data and how will the health and wellbeing of the community benefit?. (Reflexive Journal 23/2/2009, p. 13)*

6.5.1. Process

I used a three-step process when working with Aboriginal workers and community members through reciprocity. First, I focussed on building a relationship, second I asked if there was anything I could do for that person/ group and third I asked for input into the research. This meant that the people who were engaged in my project were generally those whom I could assist in some way.

Community-specific approaches

In Community B, the manager of the Aboriginal health team suggested I attend the weekly community lunches, where I could sit and talk to community. She also suggested specific parts of the community, where I might be able to offer services related to nutrition: for example if I wanted to talk to women or men then access was through the women's or men's groups respectively. If I wanted to talk to Elders there was an Elders group. In Community A, initially I became involved in the planning and delivery of a weekly cooking and nutrition education program for local Aboriginal primary school students.

Utilising my skills in nutrition

My expertise and skills in nutrition also represented a valuable opportunity for reciprocity,

especially considering the interest that a lot of people have in nutrition and healthy eating. I began to use these skills when trying to gain access to key community groups. For example, when trying to access a group I would explain why I wanted to get in touch and that I was a dietitian and could offer information about nutrition if they were interested. I found that people were more willing to speak to me when they heard this.

It also became clear that many of the Aboriginal community groups were driven by what members of these groups were interested in. Consequently, it was up to me to identify what the particular interest of the group was, and modify my approach accordingly. For example an Elders group may be interested in healthy eating for diabetes if they have diabetes, while a mothers group may be interested in how and when to introduce solids or healthy eating during pregnancy. One worker highlighted this when she said *'it is about what the community want, not what the workers want'*. (Reflexive Journal 14/5/2009, p. 57).

Advice on research was a long term goal

Although I began my quest for reciprocity as a way to ultimately speak to community members about my research, it became clear very quickly that this had to be a long term goal. Building trust with a group was about offering them something and meeting their needs first before meeting my own agenda. The groups were always aware of my agenda as I was honest about my reason for attending the groups and they knew I was doing research. This meant that I would spend time with a group doing whatever they were doing. If it was appropriate to bring up the research I would, but if not I would not. For example:

> *At the women's group today I helped them fold clothes that they had in these big garbags, because that's what they were all doing and the environment wasn't really conducive to talking (rustling bags etc). (Reflexive Journal 18/8/2009, p. 86)*

By spending time with groups participating in their activities, I was very privileged to listen to their stories and join in their conversations when appropriate. Over time I began to appreciate the value of this experience for providing a context for my research. I began to get some insight into the lives of these Aboriginal people, which was incredibly humbling and constantly made me question my approach and reasons for doing the research. Without these experiences that I gained through engaging in reciprocity, I would not have the same understanding of the lives of Aboriginal people,

which significantly influenced this research. For example, through these interactions I gained an appreciation of the struggles that some Aboriginal women face on a daily basis. I was more motivated to take a critical approach to research having seen the evidence of daily struggles because they were more real to me. Consequently, reciprocity became about more than me giving back – it was an opportunity for me to learn and reassess my own philosophical underpinnings.

6.5.2. What I did

The reciprocal activities I engaged in throughout this research were based on requests from Aboriginal workers and/ or community members. The main activities I engaged in are outlined in Tables 6.7, 6.8 and 6.9. Other avenues were explored but did not eventuate. It is interesting to note that most of the relationships described below were with women or women's groups. This is likely reflective of the clear distinction between men's and women's business in Aboriginal culture.

The majority of reciprocity I enacted was in 2009 and 2010. During this two-year period, I spent between half and one day per week on reciprocity, which represents a significant investment of my time. The amount of reciprocity I engaged in in 2011 was minimal; because of the time and space I needed to write up this research. However, the majority of people I was working with were aware of this before the time came to reduce the time I spent on reciprocity.

Table 6.7: Description of reciprocity enacted as part of this PhD project from 2008 until 2011 in Community A only

Opportunity for reciprocity	What it was	How the opportunity came about	What I did	Time commitment
Kids cooking group	Cooking and nutrition information sessions run with Year 6 students at 3 primary schools in Community A	*ewba* project coordinator was involved in the program, after she left I took over	• Member of planning committee • Contributed to & facilitated nutrition information sessions • Facilitated cooking sessions	From late 2008 to mid 2010 attended: • Eight 2-3 hour sessions • 4 planning meetings
Women's group	Group for women to yarn about cooking and food, prepare meals together and get some utensils/ cookbooks to take home	Request from worker at the Aboriginal Health Service for ideas & involvement in a healthy eating program for women	• Plan project & source funds on conjunction with 3 other organisations • Plan & deliver nutrition information during sessions • Assist with cooking • Conduct supermarket tours	From late 2009 to mid 2010 attended: • Eight sessions • Two planning meetings

Table 6.8: Description of reciprocity enacted as part of this PhD project from 2008 until 2011 in Community B only

Opportunity for reciprocity	What it was	How the opportunity came about	What I did	Time commitment
Women's group	Group for Aboriginal women to come together	Relationship with group coordinator through attending Community Lunch	• Yarned to the women about healthy eating & diabetes • Delivered healthy cooking sessions • Provided cookbooks • Attended group outings	From 2009 to 2010: • Assisted with 2 cooking sessions • Spoke about nutrition at 3 • Attended 3 group outings • Attended 3 other sessions as a guest
Mum's and Bub's group	Group for Aboriginal Mums and their babies	Group asked for some nutrition input through *ewba* project coordinator	Facilitated cooking, planned & delivered sessions about: • Healthy eating for babies & children • Introducing solids & feeding babies	Two sessions, 2 hours each

Table 6.9: Description of reciprocity enacted as part of this PhD project from 2008 until 2011 in Community A and Community B

Opportunity for reciprocity	What it was	How the opportunity came about	What I did	Time commitment
Aboriginal mentors	Aboriginal workers who were prepared to help me out informally with my project	Identified through relationship building phase of project	Provided advice and support when appropriate, including: • Suggestions for a healthy lifestyle program • Suggestions for cookbooks • Advice about research • Debrief	Ongoing 2009-2011
Aboriginal community events	Attendance at community events	Request for *ewba* support from Aboriginal health teams	• Helped facilitate and organise the provision of healthy catering and active activities • Provided resources • Healthy eating stall	Ongoing 2008-2010. Total events attended = 32
Resource person in community	Provision of occasional advice to Aboriginal workers and community members regarding healthy eating/ nutrition	My presence in community	• Advised an Aboriginal worker with the processes required to refer to dietitians • Provided dietary advice to an Aboriginal worker • Cookbook suggestions to Aboriginal community & workers	Ongoing 2008-2010

Being committed to reciprocity enabled me to maintain an ongoing connection with the community beyond consultation. While reciprocity represents a large time commitment on the part of the researcher, it is one way to ensure ethical research and build genuine, long-lasting relationships with Aboriginal workers and/ or community members. From these actions, I came to appreciate that working in partnership with Aboriginal people is a vital and necessary step if any improvements to Aboriginal health, either through practice or research, are going to be made by White people. Importantly, working with Aboriginal people through building relationships and reciprocity, I obtained first-hand experience as a White health professional in Aboriginal health. This experience was necessary because it provided me with crucial context for the research question, how White health professionals work in Aboriginal health. Hence an exploration of my own experience in so vital (Chapter 7).

6.6. *Data Collection*

In this section, I describe the data collection process including ethics approval, use of a reflexive journal and semi-structured interviews. The relevance of the data collection process to the relationships I developed with Aboriginal people in Communities A and B will also be highlighted.

6.6.1. Ethics Approval

Ethics approval was sought and received from the following committees: AHCSA, Flinders University Social and Behavioural Research Ethics Committee, SA Health Human Research Ethics Committee and the Ethics Committee of the Department of Education and Children's Services. Approval letters can be found in Appendix 7. Modifications were requested and approved as the project evolved. A template for a letter of support from key Aboriginal workers and community groups in Community A and B was created. Support was sought and received from five individuals in Community A and one in Community B, including three Aboriginal health Managers, two key Aboriginal workers and one Elder's Committee. These letters of support were included with all ethics applications. An example of this letter of support has been provided in Appendix 8. This example has been deidentified in order to maintain confidentiality in this thesis.

6.6.2. Reflexive journal

An important component of methodology; a reflexive journal was kept from the commencement of the PhD in 2008 until the end in 2011. This journal enabled me to keep detailed documentation

about what I was doing; reflect on and debrief from some of the challenges and difficult situations I experienced, develop a general awareness about the importance of self-reflection and how this can be used to alter practice and assess my own beliefs and biases and how they might influence the research.

I wrote in this journal every time I had contact with Aboriginal workers or community members. The journal reflected my needs as a researcher, which changed over time. 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) (Silverman 2005). 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.

When including excerpts from my reflexive journal in this thesis, I have referred to the date of the reflection and the page number of the journal it appeared on. When my reflections refer to direct quotes from a conversation I had with another person, I have checked with the person that my understanding of the conversation matched their understanding, and have sought permission to use the reflection. I have also sought permission to use all instances of personal communication in this thesis.

6.6.3. Interviews

Semi-structured interviews were chosen as the most appropriate method to allow in-depth exploration of the topic. They allowed me to cement the relationships that I built during the PhD and reinforce personal contact. Focus groups were not chosen as the standard technique because of the potentially sensitive nature of some of the questions. However, one focus group was conducted with a group of dietitians at a regional meeting because this was more time-effective and their preferred option.

Groups of workers interviewed

Four groups of workers were interviewed for this research: (1) *ewba* staff (project coordinators and managers) (2) Aboriginal workers from Community A and Community B that had some

connection to *ewba* (3) experienced White workers from Community A and Community B that also had some connection to *ewba* and (4) dietitians from around SA (no connection to *ewba*). These workers are related to each other through their focus on similar issues, including OP and/ or N & D. Most of the *ewba* staff and experienced white workers were also health professionals. The professions represented within these groups of workers were occupational therapists, dietitians, speech pathologists and professionals with expertise in women's health, men's health and/ or health promotion. While I do not seek to make comparisons across professional groups, it is important to highlight that the results relate to professional groups broader than just dietitians. When I wish to refer to *ewba* staff, experienced White workers and dietitians collectively in this thesis, I use the term "White health professionals".

Because this PhD was associated with the *ewba* Community Programs, the majority of interviews occurred with workers from Community A and B. However, for dietitians, the scope was widened to include dietitians working anywhere in SA because the number of dietitians solely working in Community A and B was small. The rationale for including the four groups of workers is outlined in Table 6.10.

Table 6.10: Rationale for including *eat well be active* staff, Aboriginal workers, experienced White workers and dietitians in the research

Group	Rationale
Ewba staff	Seek views of *ewba* staff how the project had worked with Aboriginal people Wide variety of experience working with Aboriginal people – explore if this affects practice Explore attitudes in-depth
Aboriginal workers (working in health in Community A or B)	Seek views of Aboriginal staff how *ewba* had worked with Aboriginal people Provide an Aboriginal perspective
Experienced White workers (working in health in Community A or B)	Explore how health professionals experienced in Aboriginal health work in this area, including practice and attitudes Provides a point of comparison for those with less experience
Dietitians (SA wide)	Relate research results to the dietetic profession (my interest as a dietitian) Attitudes and thoughts about dietetic practice in Aboriginal health Explore whether affects practice To put my own experiences, as a dietitian, into context

Inclusion & exclusion criteria

For *ewba* workers, all project coordinators who worked with the project in Community A and Community B from 2006 to 2010 were interviewed. One manager who was involved significantly in the *ewba* consultation phase was also interviewed as this was the quickest and most reliable way to collect information about this phase of the project. The manager and one *ewba* worker worked extensively across both Community A and B. The remaining *ewba* staff members worked mostly at the Community A or Community B site. For the other three groups of workers, a number of factors were used to determine inclusion and exclusion criteria (Table 6.11).

Table 6.11: Summary of inclusion and exclusion criteria for Aboriginal workers, experienced White workers and dietitians interviewed for this research

	Aboriginal worker	**White worker**	**Dietitian**
Time	Were working in Community A or B at the time of this research (2008-2011) OR Were a crucial ewba champion talked about clearly by project members (prior to 2008)		Working at the time of recruitment in early 2010
Geography	Working in Community A or Community B		Working in South Australia
Professional role	Government worker		Government worker in either community or clinical dietitians
My relationship to them	I had a relationship with them through my research and relationship building with community.		N/A, although most were aware who I was because of the small size of the profession
Knowledge of *ewba* needed?	Yes, working directly with *ewba*	Yes, some connection to *ewba*	No
Experience working with Aboriginal people	Yes	Extensive experience (15 years or more) OR currently working solely in Aboriginal health	Any level of experience

Recruitment

I used relationships I had built to recruit Aboriginal workers, experienced White workers and *ewba* staff. This significantly assisted my data collection process; recruitment was quicker because I knew who the key people were to talk to, and they were willing to talk to me because they trusted me. I could also conduct interviews in a more informal way, which often led to greater comfort of

the interviewee (particularly Aboriginal interviewees). E*wba*, Aboriginal and other White workers were recruited by approaching them in person, over the phone or via email and asking if they were interested in sharing their thoughts with me in an interview.

All dietitians who worked within SA at the time of recruitment for the study (2010) were invited to participate. The rationale for choosing SA was to limit the scope of the research. Three methods were used to recruit dietitians for this study. First, I attended a South Australian Nutrition Network (SANN) meeting where I spoke about my project and invited dietitians to participate, leaving them with a flyer. This flyer was also sent by email through the SANN distribution list. Second, I emailed the Heads of Department of the two major hospitals in Adelaide, asking them to forward an email and flyer to their staff asking for interested dietitians to contact me. This was to capture clinical dietitians who generally do not attend SANN meetings. I had planned to use the DAA-SA newsletter to do this, but this was not feasible due to cost. Third, I contacted specific dietitians, who I knew to have extensive experience in this area, and asked them if they were willing to participate.

Development of interview questions

In 2009, questions were developed based on areas of interest that emerged from my experiences spending time with Aboriginal communities in 2008 and 2009. Initial questions were designed through a brainstorm. Before interviews were conducted, draft questions were reviewed by a group of Aboriginal workers organised by one of the project mentors. Changes were made based on these comments and after Supervisor review. In 2010, the questions were modified again based on further experience and reflection that impacted on what I wanted to ask and how I went about asking it. The first interview for each of the four groups of workers was treated as a pilot and questions were then modified if necessary. These questions can be found in Appendix 9. Slightly different questions were used for the different groups of workers, meaning that not all four groups of workers commented on every question, which is important to keep in mind when reading the results.

Interviews were semi-structured and questions were used as a guide only. Techniques I used to assist in conversation and making interviewees comfortable, particularly with sensitive questions, included: summarising what I had found so far and reflecting this back to participants [reflexive interviewing (Etherington 2004)], reflecting my own experience and checking for understanding by paraphrasing what I thought the interviewee had said.

Conducting interviews

Interviews were conducted between January and June 2010. A time and location convenient for the interviewee was arranged. All participants were offered a copy of the interview questions prior to the interview. If they requested this, I emailed the questions approximately one week before the interview and I noted which participants requested copies. I informed the participants that I was asking them to participate in a formal interview. Interviews were audio recorded with participants' permission, or notes were taken if they preferred. One interview was conducted over the phone and notes were taken in this case rather than taking an audio recording.

All participants were provided with a Letter of Introduction and Information Sheet for the research. At the beginning of each interview I briefly summarised these and asked if they had any questions. They were asked to sign two identical consent forms, one for their records and one for mine (Appendix 10). I encouraged participants to be open in their responses and that I was interested in both positive and negative experiences. I stressed that the information they gave me would be deidentified. Interviews with Aboriginal workers and dietitians took between 20 and 45 minutes, while interviews with *ewba* workers and experienced White workers took between 45 and 90 minutes.

6.6.4. Data Management

All audio files from interviews were transcribed verbatim by a transcriber. I read all the transcripts and cross-checked anything that was unclear on the audio file. Participants were given the option to review their transcript and make any changes. For the one focus group with dietitians, the transcript was prepared to keep track of which dietitian said what. When notes were taken in place of an audio recording, participants were provided with a copy of the notes to check for accuracy.

6.6.5. Additional data sources from *ewba*

Ewba had a comprehensive evaluation strategy which is described elsewhere (Pettman, McAllister et al. 2010). Actions, interventions, reflections and evaluations were captured, some of which occurred prior to this PhD. Consequently, this information was used where appropriate and possible in this research.

Ewba workers were required to record all *ewba* interventions delivered, by entering them into a Microsoft Access Interventions Database. This database was also established by the Evaluation

Coordinator in 2005. Project coordinators entered their interventions using a coding system with regards to the site and type of activity. This data was exported in early March 2010, with interventions being entered up until January 2010. This information was used to identify what proportion of *ewba* interventions were delivered to the Aboriginal community and provided data against which I could cross-check project coordinator's and Aboriginal worker's reports of what implementation *ewba* did with the Aboriginal community.

Reflective journals kept by *ewba* staff, and other interviews with relevant people, conducted by the *ewba* Evaluation Coordinator as part of the larger *ewba* evaluation, were reviewed to see if they contained any relevant information for this research. Some of these interviews related directly to work that had been done by *ewba* with the Aboriginal community. No data was used from these sources because they lacked the depth needed to explore the issues specific to this PhD.

6.7. *Data Analysis*

Coding

Transcripts were imported into QSR NVivo 8.0 (QSR International, Doncaster, Victoria, 2008). Interviews were coded in groups in the following order: dietitians, *ewba* project coordinators and Managers, Aboriginal workers and experienced White workers. Prior to this I had done some coding of my reflexive journal, which helped to provide an idea of possible key themes. In presenting data from each group of workers in this thesis, I use the following coding system: EWBA for *ewba* staff, AW for Aboriginal workers, EWW for experienced White workers and DN for dietitians. Each individual is given a number along with this code, for example DN6 or EWW2.

The first time I coded the interviews with dietitians, I coded everything that I considered to be interesting. However, this resulted in a huge number of codes that were impractical to report. Consequently, I chose nine themes that kept recurring through the four sets of interviews: relationships, reciprocity, reflection[14], colonisation, race, construction of the self, construction of role, construction of the space and construction of Aboriginal people. Many of these themes were also emerging from my own reflections about working well in the area. I re-coded the dietitian data

[14] As described in Chapter 5, I used reflexivity as a methodology in this research. However, participants in interviews used the term "reflection" rather than "reflexivity" which is why I use it here. While I now acknowledge the difference between the two terms, at the time of conducting interviews, I was not confident enough in distinguishing the two to go into this with interview participants.

using these nine themes and also coded the rest of the sets of interviews in this way. This volume of data was much easier to manage. While it is possible that new, different themes may have emerged from other sets of interviews if they were coded in their entirety, some decision had to be made in order to manage the large volume of data. The fact that the chosen codes were supported through my reflections is a strength.

I have explored in more detail the meaning of each of the nine themes, and the sub-themes or "types" of data that I coded under each theme (Table 6.12). In some cases, minor themes were identified after I had already coded a portion of the other interviews. In this case, I performed a key word search/ went back and looked for that concept in transcripts I had already coded. In many cases, I was able to remember if this concept had been alluded to in an earlier interview because of the relatively small number of interviews.

Table 6.12: The nine major themes used to code the data in this research, and the sub-themes of types of data that was coded at each theme

Major theme	Meaning	Rationale for inclusion	Sub-theme
Reflection	• Do practitioners engage in reflection?	• Important element of my practice with communities, wanted to see whether others engaged in these practice techniques & how they used them	• Constructions/ understandings of reflection • Prompted reference • Unprompted reference
Reciprocity	• Do practitioners engage in reciprocity?		• Constructions/ understandings of reciprocity • Prompted reference • Unprompted reference
Relationships	• How important are relationships in this area of work and how are they built?		• Constructions/ understandings of relationships • Prompted reference • Unprompted reference
Race	• How do practitioners talk about/ think through race?	• Important element of my journey • Came up overtly in some interviews while was more covert in others	• Prompted reference • Unprompted reference • Racial identity/ race relations

Table 6.12 (continued)

Major theme	Meaning	Rationale for inclusion	Sub-theme
Colonisation	• How do practitioners understand and talk about colonisation?		• Constructions/ understandings of colonisation • Reflections on colonisation • Decolonising practice
Construction of the self	• How do practitioners see themselves and how they relate to their work?	• Came up in interviews	• Personal experience
Construction of role/ professional group	• How do practitioners see their role, especially in relation to the Aboriginal community?	• Came up in interviews	• Professional experience • Professional Group • Role
Construction of space	• What factors do practitioners think impact on the "space" in which they work with Aboriginal people?	• Came up in interviews	• General space • *ewba* space
Construction of Aboriginal people	• How do practitioners see Aboriginal people? • How do Aboriginal people see Aboriginal people?	• From my experience it appeared that people's perceptions of Aboriginal people (positive or negative) influenced how they worked with them • Came up in interviews	• Aboriginal Health Workers • Understandings of health
Practice	• What do practitioners do with the Aboriginal community? What do they perceive as ideal practice?	• Area of interest from beginning of the research	• Ideal practice (Aboriginal workers) • Ideal practice (White workers) • Whether or not to tailor mainstream programs

After coding transcripts from one group of workers into the nine themes, I began analysis on butcher's paper. From the codes from NVivo, I mind-mapped each of the nine key themes. Alongside the mind-maps I linked specific sections to quotes so that I was able to demonstrate each point on the mind-map with a quote. Once I had done that for all of the quotes for one theme, I thought about how different nodes on the mind-map fit together. I then wrote that information up into a draft results chapter, including quotes to demonstrate points. After I had written a draft results chapter for each of the four sets of interviews, I looked at how they were similar and different to come up with an integrated analysis. This resulted in an analysis of the practice of White workers, and the factors that affect this practice, as described in Chapters 8 to 11. This was essentially the process that allowed deconstruction and reconstruction of the data, as explained below.

Deconstruction and reconstruction

Data were analysed using the process of deconstruction and reconstruction; an element of CSR (Harvey 1990). This involves exploring the data by breaking it down into its individual elements and then putting it back together in a different way to expose deeper meaning. This was a step-wise and iterative process that occurred as a result of my increasing understandings of the data, much of which occurred through (a) conducting interviews and linking them across the four groups of interviewees and to my own experiences and (b) coding and re-coding data. As outlined in Chapter 5, Harvey (1990) poses a set of questions to aid with the process of deconstruction and reconstruction of data. In Table 6.13, I have outlined these questions, as well as the corresponding approach to address this question in my research methods.

Table 6.13: Steps involved in deconstruction and reconstruction of an area of enquiry in critical social research (Harvey 1990) and connection of each step to this research

Step	Question	Corresponding approach used
1	• Choice of area of enquiry (provoked by particular question)	• Aboriginal health in South Australia • Provoked by experiences as a new graduate dietitian
2	• Choose a central concept in the area of enquiry • This 'provides, at any point in the critical analysis, the best focus for deconstructing and reconstructing the phenomenon in its socio-historic context' (Harvey 1990, p. 30)	• Practice of White health professionals in South Australia
3	• Examine how the concept has been used	• Use interviews & reflexive journal • *General questions:* What do White health professionals working in Aboriginal health do? What does their practice look like? What are the enablers and barriers?
4	• What are the underlying assumptions that inform the usage of the concept?	• Practice of White workers affects how they work with Aboriginal workers and community, which impacts on health outcomes • Relationships between White and Aboriginal workers are vital to move forward in Aboriginal health
5	• How does the concept relate to the general area of enquiry (step 1)?	• Practice at the downstream level is a vital element of Aboriginal health in South Australia • Supporting practitioners to do this work is paramount
6	• What is the relationship between general abstractions and the concrete level? • I.e. what appears to be going on at the abstract level, and how is this manifested in concrete situations?	• There are a multitude of factors that affect the practice of White workers in Aboriginal health, some concrete and some abstract
7	• To what extent is there disjunction between the underlying presuppositions of the abstract concept and the nature of concrete reality?	• Structural factors are not the only factors that impact on practice of White workers with Aboriginal people

Table 6.13 (continued)

Step	Question	Corresponding approach used
8	• New conceptualisations are used to reconstruct an alternative perspective	• Consider the role of race in the context of Whiteness theory
9	• Relate the core concept to the social totality to see if it reveals further the nature of the workings of the totality	• Consider wider structural factors that impact on practice of workers including lack of racialised discourse in training and practice, support from professional associations
10	• Empirical data is used to elaborate the relationship and suggest further deconstructive stages	• Identify instances of racial discussion in data, and lack of racialised discourse
11	• The nature and manifestations of ideology are continually revealed	• As data is explored in more detail, the role of personal and professional ideology in influencing practice becomes clearer
12	• A new and radically different conceptualisation of the social processes and structural relations emerge	• Those factors influencing practice can be elicited in detail – concrete concepts including health system, management and organisation and abstract concepts including the self, personal and professional ideology and racial discourse

The points alluded to in the third column of Table 6.13 will be explored in more depth in Chapters 7 to 11.

6.8. *Chapter Summary*

In this chapter, I described the methods used in this research, including the location of the research in relation to *ewba,* how I formed and maintained relationships, how I involved the community, reciprocity I enacted, use of a reflexive journal and semi-structured interviews to collect data and the process of data analysis. My detailed description of the relationship building, community consultation, dissemination and reciprocity components demonstrate the strong commitment that I have to doing ethical research with Aboriginal communities.

The following five chapters present the results of this research. The first, Chapter 7, presents my journey and identifies my position as a reflexive dietitian-researcher, which is important to keep in mind when reading the remaining results chapters. In Chapter 8, I consider the practice of White health professionals. In Chapters 9 and 10, I explore the organisation, profession and individual as systems, each with structural factors that can constrain or enable the practice of White health professionals in Aboriginal health. In Chapter 11, I present a stage model for classifying White health professionals working in Aboriginal health, which may assist in moving practice forward. At the end of each results chapter, I present a summary which includes consideration of other literature which supports the results.

7. Reflexivity

In this chapter I present my journey, as a dietitian-researcher, throughout this PhD. Presenting my experiences and thinking is an integral part of this thesis, because these provided direction for further inquiry. In this chapter I elaborate on the issues, challenges and dilemmas I faced during this research, including the initial discomfort I experienced. I describe a number of aspects I learnt through engaging in reflexive processes, including developing my own identity as a White dietitian-researcher, and discovering the importance of relationships and reciprocity. This deep reflection enabled me to change my approach and my practice. As I come to the end of this PhD research, new questions that are paramount in my mind and are likely to influence my work in the future are also discussed. It is crucial to present this journey as it is an important rationale for the approach I took in this research. By documenting my journey, I am revealing the lens through which I conducted this research and analysed the data. This demonstrates my use of reflexivity, which provides a justification for many of the decisions I made. This chapter shows my experience, as a White health professional, working with Aboriginal people, demonstrating that I consider the practice of other White health professionals (participants) only after experiencing similar situations myself.

7.1. *Early challenges*

In this section, I discuss a number of challenges I experienced early in the research (mid 2008-mid 2009). These challenges were largely associated with setting up and defining the project. They paved the way for many of the learnings discussed in Section 7.3.

7.1.1. Feelings of uncertainty

I began this journey with many feelings of uncertainty. I felt that other White health professionals were suspicious and unsure of my intention of critiquing how well a project *(ewba)* had worked with Aboriginal communities when this was not the primary focus of the project (Reflexive Journal, 26/3/2009, p. 37). There was concern about how the results of this research would reflect on White health professionals who, despite good intentions of working with Aboriginal communities, did not always achieve positive outcomes due to a vast array of barriers. These concerns led me to conduct a detailed exploration of barriers to working in Aboriginal health as part of my interviews and ultimately address them through use of a critical theoretical approach.

I was worried about what Aboriginal people would think of the fact that I, a White person, had chosen to investigate this topic. I was uncomfortable referring to myself as a White person, mainly because I was concerned about what reactions it would evoke, from both Aboriginal and White people. While I had travelled overseas, grown up with people from different cultural backgrounds and had an interest in learning about other cultures, I had never explored my own Whiteness. I was aware that I was somewhat privileged, but held a philosophy that everyone should be equal and treated the same. I now recognise that while this intention was sound, it rarely occurs so simply. Individual differences, stories and experiences greatly impact on how people are placed in society. A trip to India at the end of 2008 was an important step in coming to acknowledge my Whiteness.

7.1.2. Angst within and between groups of people

It soon became obvious that a significant amount of angst[15] existed in the area of Aboriginal health, and that this angst worked in many directions between and within groups of White and Aboriginal people (Reflexive Journal 19/8/2009, p. 89). These issues became clearer as Aboriginal people began to openly discuss their challenges with White people in front of me (Reflexive Journal 16/2/2010, p. 146). Some of the issues that make up this angst are unresolved history between Aboriginal and White people, a lack of awareness by many White people about Aboriginal history and how it continues to impact today and a lack of a shared understanding about what can be done to address problems such as Aboriginal health. As I gained a greater understanding of this history and its continued impact, I saw the need to include it as a question in my interviews.

White people often referred to conflict they perceived to be ongoing in the Aboriginal community and they saw this as a barrier to their own work with this community (Reflexive Journal 26/3/2009, p. 38). It was clear that I had not picked an easy topic, and that the topic would always be fraught with this "backdrop" of angst that I would have to learn to deal with if I wanted to continue working in this area.

[15] I use this term to refer to the miscommunication, uncertainty, strained relationships, misunderstandings and lack of clarification of assumptions between and within groups of White health professionals and Aboriginal workers

7.1.3. Awareness of myself and my position

Initially I had a significant amount of concern, and at times fear, about how to work with Aboriginal communities in the "right" way. I did not want to upset anyone or be perceived as racist. Consequently I steered away from topics related to race and did not confidently acknowledge my position as a White person. I was very concerned about being a "typical White researcher" who comes into a community and takes a lot but does not give very much back. I felt that I would be perceived badly by the Aboriginal community for coming in as a White person trying to make a difference. I sought to show my good intentions by following appropriate processes to build relationships (Section 6.3.1) and uphold principles of ethical research with Aboriginal people (NHMRC 2003).

In the first year of working closely with Aboriginal people, I learnt what it feels like to be in the minority, with high levels of self-awareness, anxiety and discomfort:

> *I felt totally in the minority and I was always worried, thinking: 'what are they thinking about me?' 'Will they think I'm silly for being here?' 'Will they say something mean?' 'Will they single me out as the only White person?' Particularly when they were saying things about Whitefellas and what they think of Aboriginal people. I just wanted to say 'we don't all think like that' or 'yes I know we have done terrible things to you, but I want to help make it right'. (Reflexive Journal, 18/3/2009, pp. 30-31)*

Overcoming these daily experiences of feeling in the minority was challenging yet important in my attempts to build relationships with the Aboriginal communities of Communities A and B. Having experienced what it felt like to be in the minority meant that I was better able to relate to Aboriginal people who may experience this feeling regularly.

7.2. *A Paradigm shift*

As detailed in Section 5.2, I experienced a significant paradigm shift during this research. In this section, I reflect on this experience.

I began this research project with quantitative research in mind. However, once I got more into Aboriginal health research I was suddenly confronted with many issues including Indigenous ways of knowing, doing respectful research and the importance of developing relationships before data are collected. I could see that ideas I had for initial methods were not going to be appropriate. I

began to read about qualitative methods, epistemology, methodology, interpretive and critical paradigms, social constructionist and post-structural theories. I began to see limitations associated with the positivist paradigm, when applied to the Aboriginal health setting. I began to question the notion that there is one "right" answer or truth, and to see the value of communication and research through storytelling and discussions.

Questioning what I had always known and felt comfortable doing was confronting and I was somewhat hesitant at first. I wondered whether there were other dietitians who experienced similar frustrations. I felt confused and confronted by the reactions of colleagues who questioned whether the results from this research would be generalisable and therefore useful. As I ventured into concepts of social sciences and sociology, I occupied a lonely and uncertain space between disciplines and concepts.

Through wider reading and discussion I became more confident. I realised that I could share these new methods with others and that their initial reactions were sometimes related to not knowing about alternative approaches. In particular, utilising paradigms alternate to positivism has given me as a researcher permission to not have to find "the answer". These new ways of thinking have opened doors for me in my research and provided opportunities to research in a way I would not have before, and hence have produced new data. This has been exciting and somewhat liberating. Similarly, I have accepted the idea that it is okay not to know the answer or the "right" way to do something; the answer is contextual and dependent on an individual. I now recognise the desire to get things right as remnants from my professional training and also a personal characteristic.

The methods I have employed, being reflective and reflexive and entering into conversations with supportive colleagues, has enabled me to reach new understandings. Translating these into practice in Aboriginal health has reaffirmed my learning in this area.

7.3. *Learning to work despite the challenges*

Despite the early challenges discussed in Section 7.1, I kept persisting. Engaging in a paradigm shift, where I came to see my research through an alternate lens, assisted with this. However, I developed a number of other strategies to overcome these challenges and in doing so, experienced a number of learnings, which I discuss below. It is also important to highlight that

these learnings resulted in changes to my practice. This is what made me a reflexive researcher throughout this research – being able to act on my learnings and reflections through changing my practice. These learnings are described in three stages, from the start, middle and end of this PhD research as this highlights that my learning was cumulative and each learning led to further learning.

7.3.1. Early learnings (Mid 2008-Mid 2009)

Learnings in the early stage of this research were largely characterised by uncertainty, and my lack of confidence working in this area.

The importance of time

After my first attempts to build relationships and exercise reciprocity (Sections 6.3 and 6.5), I realised just how much time it takes to work successfully with Aboriginal communities. The challenges associated with identifying not only key people to talk to but also the appropriate ways in which to contact them highlighted that working with the Aboriginal community is a lengthy process. In hindsight, as described in Section 6.6.3, allowing adequate time during the initial stage and building trust made recruitment for interviews easier later on.

The most important step for me in acknowledging the role and importance of time was learning to readjust my own timelines, and not being too hard on myself when I had not achieved something that I thought I should have by that point in time. I dealt with this by looking instead at what I had achieved, and valuing things that I may not have placed so much importance on before. For example having lunch with the women's group in Community B and then being invited back to another session (Reflexive Journal 16/2/2010, p. 146). Using a reflexive journal to document these achievements was crucial to recognising them and not feeling pressured by time.

Persistence, frustration and motivation

When I reflected on the first six months in which I tried to build relationships, it was clear how important being persistent had been. I knew that persistence was important, for example when trying to get in contact with an Aboriginal worker I noted in my Reflexive Journal:

> *Persistence is necessary; I know from experience that I just need to persist.*
>
> *(Reflexive Journal, 5/11/2008, p. 8)*

Being persistent often required me to use multiple approaches to get in touch with a person, for example:

> *You have to be persistent – make it easy for them – keep ringing them back – different times, different numbers – with some people you might also try email or drop in in person. (Reflexive Journal, 21/4/200, p. 47)*

While some people were hard to get hold of, they were generally very happy to help me out when I did get hold of them. It became clear that the people I wanted to talk to were also being contacted by other people for their expertise, so their difficulty in being contacted was not about me or my project but simply a reflection of their lack of time. Learning not to take this personally and also developing the confidence to keep contacting people until I got an answer was a key learning (Reflexive Journal 30/11/2009, p. 102).

However, there was a fine line between being persistent and contacting someone too much. In one example I wanted to go and meet with an Aboriginal community group and I kept ringing the group leader. This person knew who I was and was very polite; however every time I rang I was informed that the group was busy. After five months of phone calls this person indicated that the group was not the best way to consult with those people (Reflexive Journal 22/4/2009, p. 48; Reflexive Journal 13/7/2009, p. 80) and suggested an alternative that met my needs. This situation demonstrates that persistence is important, but sometimes you need to question why an outcome is not obtained. It may be necessary to ask a different question, or frame your request in a different way in order to get a positive response.

While at times I found the need to be persistent very frustrating, as long as I was able to remind myself why making a connection with that person was important and how it contributed to the bigger picture then I found the motivation to continue.

7.3.2. Mid-way learnings (mid 2009 - mid 2010)

Many of my learnings about working with the Aboriginal community occurred mid-way through my PhD project when my anxiety and uncertainty decreased enough to enable me to focus more on the process. I began to understand more deeply the importance of relationships. In this section, I comment on my learnings related to relationships, approach, my changing role and perceptions and my growing awareness of race.

Relationships

A number of elements were important in relationship building in this research and they included avoiding tokenistic relationships, maintaining relationships, transparency, respect, trust and making connections.

Avoiding tokenistic relationships

Initially, I wanted to "engage the community" to ensure I had community input, which many White health professionals talk about as being important when working with Aboriginal communities. However, the longer I worked with communities, the more I realised that there was a difference between tokenistic community engagement, which makes the researcher look like they have done the right thing or "ticked the boxes", and actual community engagement where the community draws meaning from what you do. Working with diverse White staff, across a variety of settings, made me aware of a range of motivations that existed. While some people were genuinely committed, I perceived that some individuals worked with Aboriginal people because they "thought they should" or because it was the "thing to do" (Reflexive Journal, 15/12/09). I also learnt the importance of acting on feedback from Aboriginal community members received through consultation, to demonstrate the consultation was delivered to meet their needs rather than the researcher's.

Maintaining relationships

I came to see that establishing and building relationships is one task, but maintaining them is an entirely different issue and task altogether. Building a relationship in order to get your needs met (and maybe give something once-off in return) does not have the same impact or investment as maintaining a meaningful and committed two-way relationship over time. Until I entered this type of relationship with an Aboriginal colleague who became my cultural mentor, I did not truly appreciate the difference between a tokenistic relationship and one which is mutually beneficial for both parties over time.

Transparency

I was aware of the importance of transparency in my interactions with Aboriginal workers and community members about my true intentions right from the start of the project. One Aboriginal worker made this clear to me from the start when she highlighted the need to disclose that I was doing research to any community groups that I engaged with (Reflexive Journal, 1/4/2009, p. 44).

Transparency led me to say "this is what I am doing and this is why I am doing it, what do you think you could add/ would you like to be involved/ what do you have to say?" Being transparent led me to give potential participants all of the facts, and then letting them make up their mind if they wished to be involved and how they might contribute, rather than telling them what I was doing and what I wanted their involvement to be. This allowed me to avoid being paternalistic and give people the opportunity to develop their own interpretation of what I was doing. Being transparent was about sharing my agenda. By being transparent, I provided an opportunity for agendas to be discussed and negotiated.

Towards the end of my research I learnt the importance of the link between transparency and realistic boundaries, including the importance of being transparent about how long you can realistically spend in a community. This became a problem for me when I had the competing demands of continuing to work with Aboriginal people/ communities in order to give back (reciprocity) and write my thesis. Initially, I lacked understanding and appreciation of the time and space needed to write a thesis. Consequently in hindsight, I would have set boundaries around the time I spent doing reciprocity with Aboriginal people and communities from the start of this research. From now on I will think seriously about what I can and cannot offer to people and I will clearly articulate this. I will also feel less bad about what I cannot do.

Trust

Trust was, and remains, a crucial factor in building and maintaining relationships. Developing trust occurred through my actions such as spending time in community, through developing personal connections with people, and through the introductions of well-known and respected key people:

> *Being associated with [key worker] gives me credibility. If [key workers] trusts me then that is a good sign to the community members. (Reflexive Journal 9/9/2008, p. 5)*

Initially the signs that indicated that trust had been built were not always obvious to me. It took time to recognise the significance of being invited to a meeting in a worker's home, and the repeated invitation to join the women's groups to events including the movies and a trip to the zoo.

Trust building is a complicated business that works both ways. I came to understand that if an Aboriginal person trusts me and vouches for me and I go and do something wrong, then that not only makes me look bad but it makes the person who vouched for me look bad also. (Reflexive Journal 9/9/2008, p. 5) Initially this situation made me somewhat nervous because I felt like I had responsibility to maintain my end of the relationship and was concerned that I would do something wrong. This fear began to dissipate as my confidence grew.

It is interesting to note that trust was more prominent in certain places or certain situations. For example, I was only ever asked to do things by Aboriginal workers or community members when I was in their space. I was invited to women's group events through attending the community lunch. Another worker asked for my advice about a nutritional supplement when I dropped into her building, and first brought up her idea for a cooking program after an Aboriginal focussed meeting. This demonstrates the importance of having a presence in community and the importance of incidental contact. If I had not made the effort to attend these events and spent time in the space where Aboriginal people felt comfortable I do not believe I would have developed the trust and relationships that I did.

Respect

Being respectful is a crucial element in working with Aboriginal communities. Everything that I have discussed in this chapter is about working in a respectful way. It entails 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.

Making connections

I began to notice the way in which two Aboriginal people who may not have met before connected with each other. In one situation, an Aboriginal women's health project officer was speaking to a group of Aboriginal women and before any content was discussed, the group asked the worker where she was from and where she grew up. A discussion followed about the differences in the places that the women grew up in – for example the racism some women experienced while growing up (Reflexive Journal 9/6/2009, p. 67). This was crucial to the formation of trust between

the presenter and the women, and consequent success of the session. After this experience, I began to include more detail about my personal background when I met an Aboriginal person.

The importance of an interpersonal connection was reinforced to me at the same session where I came to appreciate the power of sharing stories:

> *It was amazing at how we all sat back and shared stories and we got so much more out of that. It made me realise the power of sharing stories. I don't think I'd truly appreciated before the strength and meaning of story sharing. (Reflexive Journal, 9/6/09, p. 67)*

I found that sharing cooking tips or recipes at cooking classes was also an effective strategy and I took this opportunity to learn from the women I was working with.

Further to this, I discovered that taking the time to get to know people, to share stories about myself and to be interested in their stories, led to increased trust. This was more challenging in formal settings such as meetings. However in these more formal settings, I adapted my approach by explaining my project, acknowledging their knowledge of the topic already and inviting them to assist me in improving mainstream worker knowledge.

Approach

My approach to working with Aboriginal people and community groups changed over time. Initially I brought a set agenda to each group session, but as my confidence and comfort level grew, I began to "go with the flow" and respond to the particular needs of participants at each session. This led to a more successful and less stressful encounter for both participants and myself:

> *If you go in with a set agenda then you will just get frustrated if you don't cover it, which often seems to happen. And because you get hung up on this, you don't appreciate the fantastic spontaneity that can occur if you just let the conversation wander. I have found that if I go in with a general idea what to talk about – e.g. today I know that we needed to cover the questions – but not too specific (e.g. a 'tick list' like I may have in the past) then I am a lot less stressed and consequently am much happier to just let the conversation flow. I think that you need to be in this state of mind to allow innovative, spontaneous ideas to come out. (Reflexive Journal, 31/7/2009, p. 85)*

I began to write down two or three points about nutrition for an education session, or key questions I wished to ask people in consultations and worked from there. More often than not, community members were interested and I got the information I sought. For example from a nutrition session I ran with a women's group:

> *I think that having the six strategies listed and then the pictures to refer to worked really well. Also giving them practical examples (e.g. "don't buy the marbled meat, buy meat where you can cut the fat off") and discussing practical, potentially limiting issues e.g. the cost of lean meat. Also talking about the food that we had that day, e.g. the extra light margarine and the lentils. (Reflexive Journal, 12/5/2009, p. 55)*

I found it important to not push my agenda straight away. Instead, I would structure the session like a sandwich – spending time talking to community members first, then weaving a few questions into conversations, and then ending with a general discussion.

> *Approach at a group – it's like a sandwich. You go in, warm up (which will often involve doing something like chopping vegies to cook or whatever), talk about whatever, then kind of comes the opportunity to ask the questions, and then you kind of lead that back to general chatting. So this is partly why it takes the time – you can't just launch in and get straight to business. (Reflexive Journal, 30/3/2010, p. 128)*

This research taught me that a "one size fits all" approach does not work with Aboriginal communities, because every Aboriginal community is different. This was evident in the different ways that I worked with Communities A and B to respond to their differing requests and challenges (Sections 6.3, 6.4 and 6.5).

My changing role and perceptions

As my approach and role developed, I began to move away from the idea of being an "expert" to a position of appreciating that I had just as much to learn from Aboriginal people, if not more, than they had to learn from me:

> *I think that making it clear that you are willing to learn is crucial and not making out like you know it all. (Reflexive Journal 24/11/2009, p. 99)*

When working with Aboriginal workers, I came to see that my role was to facilitate and advise, but not to make all the decisions. For example when working with an Aboriginal worker to plan a cooking program I used an approach where I sat back, advised, and was available to answer questions and discuss issues (Reflexive Journal 10/12/2009, p. 105). Sitting back and letting things evolve, rather than jumping in and trying to control the situation, led to better trust and rapport.

Comfort levels

As outlined in Section 7.1.3, initially when I was going to community events I was uncomfortable and felt very awkward. However over time, as I got to know people and became more confident in what I was doing, and why, I became more comfortable, until I reached the point of being able to walk into an event, and feel comfortable even if I did not know anyone there (Reflexive Journal 3/2/2010, p. 144; Reflexive Journal 16/2/2010, p. 146).

Initially, although I knew it was important to attend community events, prioritising them was difficult when I felt so uncomfortable and anxious. This anxiety was probably quite obvious to Aboriginal people; later when I was more comfortable and relaxed, I got a much better reception from people. An important strategy in moving though my discomfort involved remembering similar situations of uncomfortable initial interactions that had become positive. Persevering until I did feel comfortable and was able to consistently attend events was an important aspect of relationship building and maintenance.

> *I said hi to [worker] and it's like I can do that now, just acknowledge these people and they know who I am and they know why I'm there and they're not suspicious. (Reflexive Journal 3/2/2010, p. 110)*

This comment is one example of my change in comfort levels.

Redefining success

Another important step to working well with Aboriginal communities involved learning to redefine what I considered to be a "success." I came to see that major changes in nutritional habits would not occur by running a few sessions about healthy eating. Rather, by getting to know the community, and gaining their trust over time, people started to ask me for advice when they had a

nutrition issue. I began to appreciate that gaining people's trust was a major achievement that led to information exchange. Some examples of when I identified my success are presented:

> *I think that you know you are doing a good job when people start coming to you – for example when [worker] did today and when [another worker] asked for my details. (Reflexive Journal 6/5/2009, p. 54)*

As I came to redefine my notion of success, I also began to redefine what this PhD could actually achieve (Section 7.3.3).

A greater understanding of the impact of Aboriginal culture & past experience

It became clear through my work with Aboriginal people that culture and past experiences have a significant impact on how Aboriginal people live their lives and relate to the present. This was not obvious to me at first but over time I became more aware and began to pick up on cues. For example, while working with individual Aboriginal workers, I began to realise that some of the barriers that prevented them from doing some things in their professional role, such as working with certain organisations, were due to bad experiences in the past (Reflexive Journal 31/7/2009, p. 84). This was also evident when I attended community groups and guest speakers would come along from other Government organisations. The Aboriginal people in the room related what the workers said back to their own personal experiences, and because these were generally negative experiences, the present experience was tarnished by that negative experience (Reflexive Journal 4/5/2009, p. 53). This also extended to past experiences of family members and friends; which highlights the role and importance of family in the lives of Aboriginal people, and how a negative experience of one person can impact on health and service seeking behaviours of a much larger group.

Another thing I began to get an increased appreciation of over time was the connection of Aboriginal people to the land. This was made very clear to me at a Sorry Day lunch that was held at Community A in 2009. A DVD was shown about a particular Aboriginal group and the importance of water to this group, and the lowering water levels. I had underestimated the effect of reducing water levels on Aboriginal people; for example the DVD included comments like "when the water goes our spirit dies" and "there is so little left now compared to when our grandparents are young". Hearing Aboriginal people talk about this connection and the effect the water levels

had on them was confronting; it highlighted to me that there are a whole lot of cultural factors impacting on their lives that White people are not always aware of and/ or don't understand (Reflexive Journal 26/5/2009, p. 61).

Cultural hierarchies also became more obvious as I sat back and observed at events. For example in women's groups Elder women were listened to by all of the younger women; at a meeting the most senior Aboriginal worker was listened to by all of the others, and at a community lunch Elders were always served first (Reflexive Journal 12/5/2009, p. 55; Reflexive Journal 4/2/2010, p. 145).

Ensuring the work is meaningful for community members

The more I linked with community groups and workers the more I appreciated how important it is to ensure that the work is relevant, meaningful and understandable. For example, when I was doing community consultation and describing the *ewba* project, people were most interested when I described it as a program to prevent diabetes and overweight. The community members I spoke to were very aware of these issues and passionate about making it better for their children and/ or grandchildren (Reflexive Journal, 28/4/2009, p. 48). This was particularly the case for women because traditionally they have the role of looking after the family. Similarly, when inviting the women's group in Community B to become an informal part of the Reference Group, I explained how their input could make programs like *ewba* better for Aboriginal people in the future. One of the women paraphrased what I had said by saying 'so by helping you, we're really helping ourselves?' (Reflexive Journal 28/4/2009, p. 49). This re-interpretation led to her willing involvement.

A structured time & place for sharing

Developing a time and place where sharing can take place in a non-judgemental environment is important in cross cultural settings. In Community A, there is a structured group that meets monthly to provide an opportunity for non-Aboriginal and Aboriginal people to work together, to share and talk openly about any issues. This is a formalised meeting held during work time with a quorum of Aboriginal and non-Aboriginal staff. "Sharing" became a standing item on the agenda at the end of 2009 (Reflexive Journal 3/12/2009, p. 104). Since then, people have been encouraged to share their own personal stories and journeys. A similar, yet more informal meeting of

Aboriginal and White workers from across the wider region occurs over lunch in the Community B area.

Growing awareness of race

As I entered the second year of my PhD I started to become more familiar with the discourse of race by attending a Whiteness course, reading widely in the area and developing deeper relationships through which I had discussions with Aboriginal and White people about their experiences and understandings of the concept of race.

As I developed a deeper consciousness of race and related concepts, I was able to reflect on the initial feelings of discomfort I had felt. That is, the way I felt was not a result of my poor practice or something I had failed to do, but was rather reflective of a much larger issues, both at a health system level, and at a societal level, around Aboriginal and White people working together. Therefore in gaining a greater understanding of race, I gained more confidence in my practice.

When I attended the course about Race, Culture, Indigeneity and the Politics of Public Health at the University of Melbourne in June 2009 run by Emma Kowal and Yin Paradies, I was able to start a dialogue with myself and others about the impact of being a White researcher in Aboriginal communities and the realities of the barriers and possibilities within this work. I was able to begin to explore Whiteness and my own White privilege, to talk about White guilt and effective strategies for addressing it and to better understand perspectives of Aboriginal people working in White systems.

Being able to put a name to concepts including White privilege, White guilt and White Racial Identity (WRI) helped me to (a) clarify my thinking, (b) reassure me that the thoughts, feelings and experiences I had as a White person were valid and (c) identify these as issues but be able to put them aside so that while they impact on my work, they do not detract from it nor from my ability to do my work. This also highlighted to me the importance of recognising and acknowledging my position as a White person, and how this and my life experiences affect how I see the world. After this course I was much more willing to discuss my experiences and concerns in this area. In opening up, I discovered that some of my colleagues were also trying to work out where they “fit” as White people in the scheme of Aboriginal health. I spent time in discussion with these colleagues, who were also a source of support to me, and together, we questioned what we could

achieve in our work, what it means to be White and what to do with White guilt. This assisted in making me feel much less alone.

However, at this stage in my research I still had a lot of questions in my mind with regards to race, including how best to work with other White people at different stages of WRI and how to put into action my ideals of supporting an individual's power and agency.

7.3.3. End-stage learnings (Mid 2010-Mid 2011)

The learnings that I obtained towards the end of this research are characterised by an appreciation of the practicalities and realism associated with practice and research in Aboriginal health. Many of these learnings were reached when reflecting on the entire process and write-up phase of the thesis. These are essentially questions that I was left with towards the end of this research; the things I am beginning to understand, but do not have full responses to yet. They are aspects that I will continue to discuss and reflect on and may be areas for future research.

Reciprocity, deadlines and conflicting priorities

In mid-2010, I was spending one day per week with a women's group in Community A, and attending community lunches in Community B when I could. Towards the end of 2010, when I began seriously writing my thesis, I found it difficult to keep up with this level of commitment. By this time, I had provided almost two years of "reciprocity activities" to the community (Section 6.5). The only funds I received for these activities were through my standard PhD scholarship. Some months earlier, there had been discussion that my work with the women's group in Community A could become a paid position (Reflexive Journal, 13/5/2010, p. 134). However without this eventuating, and with the competing demands of writing my thesis, I decided to stop volunteering to help at this group. I was concerned about losing the relationships I had worked hard to make. However, the women and workers were all very understanding. In fact, when the women in the group found out that I had not been getting paid for the work I had been doing, they were shocked. In fact, this job did eventuate in mid 2011, after funds had been identified, highlighting that the process just took time, and was not affected at all when I ceased to volunteer. After deep reflection, I have realised that quarantining my time so that I can meet reasonable deadlines does not necessarily mean that I am less committed to Aboriginal health. What is important is to be up-front and transparent about my reasons for doing so.

Continuing my commitment to Aboriginal health

These experiences have prompted me to think about how I can continue to demonstrate a commitment to Aboriginal health and how best to take the learnings from this research and incorporate them into my practice. Four aspects are immediately obvious to me; (1) taking the time and space to find appropriate ways of working well with Aboriginal people in any new communities I enter, (2) continuing to acknowledge and challenge racism, (3) supporting Aboriginal colleagues to reach their goals, particularly those that are research related and (4) assisting White colleagues to acknowledge their Whiteness and develop a WRI. More aspects will become obvious over time.

Revisiting race by wrestling with Whiteness

My journey through this research has involved a deep struggle with the concepts of race and Whiteness. Engaging with Whiteness theory, and applying it to my own situation, is the main way that I came to understand race and how it related to me as a White dietitian-researcher. Initially, I was uncomfortable using the term "race" and felt guilty about my Whiteness. At this stage in my journey, I now feel comfortable with my Whiteness and no longer feel guilty, a fact I attribute to understanding my own commitment and actions toward improving Aboriginal health and cross-cultural relationships. I am now able to appreciate that race and Whiteness are issues that infiltrate the "space" of Aboriginal health and surrounding issues, sometimes consciously but often unconsciously.

As I progressed along my journey, over time I began to start recognising the progress I had made. For example, the self-awareness of my journey and learnings became more apparent as I worked with colleagues and spoke with research participants who were at different stages to me on their journey in developing a WRI and/ or awareness of race (Reflexive Journal 16/12/2009, p. 137). I saw them grappling with similar issues to those I had grappled with earlier. For example, one worker asked me if it was racist to use the term "White" (Reflexive Journal, 16/12/2009, p. 137). Through this comment I was reminded of my prior discomfort about using this term, and my current comfort as being able to identify as a member of the dominant racial culture. I also began to be approached by other people as a resource person about best approaches for working in Aboriginal communities, and by Aboriginal colleagues for requests to run programs. Reflecting on these events helped me to see the effectiveness of the work I was doing, and assisted in increasing my confidence to keep going using the approach I was using.

To highlight the significant changes in my thinking, and how I have come to new understandings about race and Whiteness, I have included some of the key thoughts and experiences I have had throughout this research that are related to race and Whiteness. Table 7.1 summarises my development of a WRI and I have linked my thoughts and experiences to the stages of WRI (Helms 1984; Helms 1985). I present this information as a means of clarifying my thinking and being a role model.

Table 7.1: Timeline that shows my development of a White racial identity (Helms 1984; Helms 1995) and processing of racial experiences during this research

Time	Thoughts at this time	Stage of White Racial Identity
Mid 2008	I am not an Aboriginal person, but I want to work with Aboriginal people to make things better for them, based on the practice dilemmas I have experienced	Disintegration
Early 2009	I still want to do this but it's hard. People don't always want to talk to me, some of them put up barriers. I don't understand why they won't talk to me because I just want to help. There are a lot of issues in this space that I wasn't aware of at first. For example: • I seem to be accountable for other White people • I feel guilty and I'm not sure why. Surely I'm not responsible for what happened in the past? • Some people judge me before they get to know me…I don't want to do anything wrong, I'm just trying to help White people judge me too….maybe it's because I'm doing stuff that they all tried to do but couldn't	Disintegration
Mid 2009	Perhaps I am not the only person experiencing these challenges. I find some Aboriginal people who are willing to work with me, which enables me to see that not all blackfellas seem to hate all Whitefellas. I question whether I should really be telling the Aboriginal people what I think they should know/ do? I realise the importance of asking people what they want, rather than telling them what I think they need.	Disintegration
Late 2009	I identify comfortably as a non-Aboriginal person. I no longer feel that I have to constantly seek Aboriginal people to talk to	Pseudo-independence
January 2010	I begin to understand the extent and effectiveness of my relationships, through working with colleagues and the ease with which I set up interviews for the research, with Aboriginal and White people. This gives me some confidence.	Immersion/ Emersion
February-March 2010	Listening and relating to participants in research interviews helps me to start processing ideas, thoughts and experiences I have had over the last 18 months.	Immersion/ Emersion

Table 7.1 (continued)

Time	Thoughts at this time	Stage of White Racial Identity
Late 2010	I am able to comfortably identify as a White person, who is a member of the dominant racial culture. I am more realistic about what I can achieve.	Autonomy
2011	I begin to appreciate the huge task that I have undertaken when I begin to seriously write it up I am able to make many links between my experience and the experiences of White participants from my interviews I begin to see the extent of the relationships I have built, especially in Community A, when I am approached for a part-time job as a dietitian with the Aboriginal community I begin to get nervous about the end of this journey and reflect that I could have been clearer at the start of this research about my boundaries, in particular when I would and would not be available. At the start I would have seen this as acting in a typically 'White' way, but now I appreciate the importance of articulating boundaries honestly I no longer feel that I need to apologise for my Whiteness. However I am left with many questions about where to from here. While I still may be held accountable for all that has happened since colonisation in some Aboriginal settings, due to my Whiteness, I no longer feel personally accountable. I am aware of my Whiteness and the privileges this confers upon me, and can enter discussions about Whiteness with both Aboriginal and White people. If I were to do this research again, I would do it differently. For example, I would have felt more comfortable in discussing race in interviews, so could have asked questions that were more directed to this topic I understand more deeply my own standpoint and where I am on my journey in Aboriginal health.	Autonomy

This table suggests that I spent a significant amount of time in the disintegration stage which is characterised by feelings of guilt, depression, disorientation, confusion and suppression of information (Helms 1984; Helms 1987). This is a difficult stage to be in and would explain why I found the early phases of my research so challenging and emotionally draining. After moving into the autonomy stage, I am secure in my racial identity and am more flexible in my responses to racial material and working in a racialised space, which makes me a more effective dietitian-researcher (Helms 1984; Helms 1987). I still acknowledge I may move between the stages and must work to maintain an autonomous WRI.

Some days, when I still struggle to communicate effectively with some Aboriginal people, I wonder if I can ever escape my Whiteness or not have it as an issue when working with Aboriginal people. Pragmatically, I don't think that this is possible at this stage in Australia. Race relations in Australia between Aboriginal and White people are still set against a backdrop of unresolved colonisation and a public failure to apologise for past wrongs. These factors continue to negatively impact on interactions between Aboriginal and White people. When I am having a bad day, I try to remember that there are many external factors impacting on my interactions, and only some of the impact is due to myself. Understanding that I acknowledge my Whiteness, at least to myself, helps. I also acknowledge that there are some spaces where it is inappropriate for me to be as a White person, and also that there is work that White people need to do to with other White people. I see that I can have a role in this area.

Redefining my role as a White dietitian-researcher?

Throughout this research, my perception of what I can and cannot achieve has changed. As discussed previously, I redefined my notions of success when working with Aboriginal communities. Similarly, I have begun to redefine my notions of my professional role as dietitian. The research process enabled me to have more flexibility. I attended community events and set aside my usual dietitian "headset". For example, when the catering for a community event was less than ideal (from a traditional dietetic viewpoint), and commenting on this would have jeopardised my relationships with key people, separating myself from my dietitian role helped me to justify not saying anything about this (Reflexive Journal 16/12/2009, p. 138).

Initially, my research goal was to become clear about 'this is 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 professional "expert" coming in with "the answers". Rather, using a critical theoretical approach, 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. We both work within systems that are often oppressive. As one individual I can only do so much; together we can do more.

I now appreciate that this research is not going to "solve" the "problems" in Aboriginal health. Rather I see value in engaging other White practitioners and researchers in N & D and OP about this work. I can start a dialogue with White workers involved in healthy eating and/ or healthy

weight about issues working in Aboriginal health, and encourage them to reflect about their position and practice. This leads to a wider question about how we can bring race into popular discourse, particularly in the area of dietetics; how to encourage people to discuss race and racial issues in popular discourse in non-threatening and useful ways? Sharing my story may prompt others to address some of the issues, but a more targeted and strategic approach is needed across training and professional updates. The Aboriginal cultural awareness training that is sporadically available to health professionals is often more focussed on Aboriginal culture than the position, role and responses of White professionals. I argue later in this thesis that White health professionals need to be aware of themselves and their position before they can move towards being culturally competent with Aboriginal people. Working in Aboriginal health is just as much about understanding Aboriginal culture as understanding White culture and how White culture is seen by Aboriginal people. In coming to these conclusions through my own reflexivity, I was able to explore these areas through semi-structured interviews.

As a White person in Australia who is aware of the issues surrounding Aboriginal health, I have a responsibility to name and challenge racism and inappropriate practices. I have taken this on board in my professional and personal life. For example, speaking up when a conference I was involved in planning was not going to include a Welcome to Country by a local Aboriginal Elder (Reflexive Journal, 28/2/2011, p. 116). It is important to think about how I challenge such practices in an appropriate way, particularly at a professional level, however I am committed to doing so.

7.4. *Chapter Summary*

At the beginning of this chapter, I outlined some of the challenges I faced when starting this research, including defining the research project, feeling uncertain, conflict between and within groups of Aboriginal and White people, and the lack of awareness I had about myself and my position.

Throughout this chapter, I described how I overcame these challenges. Primarily, this was through a deep self-reflection which enabled me to gain an understanding and greater appreciation about myself and my area of work. Specifically, I was able to reflect on the importance of time and persistence, the importance of relationships and how to develop and maintain them, suitable approaches to working in Aboriginal health, the importance and continued impact of Aboriginal history and my growing awareness of race. At the end of this research, I gained a much deeper

understanding of the impact of race and Whiteness on my work, in particular the impact of these issues, whether it be conscious or unconscious, on my practice with Aboriginal people. Through using reflexivity, I was able to improve my practice in these areas.

Similar to this research, a number of other studies have used reflexivity to add significantly to the research outcomes. Most of these studies lie outside the area of N & D and OP. However, within the field of dietetics, Gingras (2009) used reflexivity in a creative non-fiction, autoethnographic account of students and dietitians struggling with the dietetic profession. This text seeks to ask what counts as knowledge in dietetic practice, and 'during the research process, I (the author) learned of myself through the Other' (Gingras 2009, pp. 7-8). In the nursing field, in relation to her research in a spinal cord rehabilitation unit, Pellatt (2003) considered the effect she had on the research, the effect it had on her, and the resulting implications. For example, she identified that the 18 years of experience she had of working as a nurse in the same location as research was conducted, influenced how she understood the data and her role as an able-bodied researcher researching spinal cord injury (Pellatt 2003). She identified that being reflexive enabled transparency, which she hoped would bridge the gap between research and practice (Pellatt 2003). Similarly, a researcher used reflexivity to assess the impact of her status as both an insider (Indigenous cultural status) and outsider (middle class status) on her research with Indigenous people in working class areas of the Middle East (Bolak 1997). These examples demonstrate that reflexivity is a tool described in the literature and one that can be used in multiple ways, including gaining a greater understanding of the self, other and the experience of the research. However, there are a lack of examples from the areas of N & D and OP that use reflexivity, and therefore this research adds to that area.

Reflexivity has been beneficial in this research for a number of reasons; importantly it enables researchers to see what they are and what they are not when doing fieldwork (Reinharz 1997). For example, reflexivity assisted me to identify that my Whiteness meant that I would never be Aboriginal and consequently there were some things that were not appropriate for me to do or ask as a researcher. Research involves interactions with participants (Reinharz 1997) and therefore researchers need to have an understanding of their own attributes and what they might mean to the people being studied. For example, my growing awareness of my own Whiteness enabled me to think about what my Whiteness might mean or represent to the Aboriginal people I was working with. Therefore, reflexivity and engaging in reflexive writing enables researchers to not only

understand themselves, but also those they are researching (Ellis 2002). Similarly, having an awareness that not all White people are aware of their Whiteness, enabled me to "pitch" interview questions more appropriately. Ellis (2002) invites researchers to be reflexive, or look inwards, in order to bring about social change. For example, 'increased self-understanding may provide a quicker and more successful route to social change than changing laws or other macro-political structures' (Ellis 2002) (p. 402). She also highlights that 'engaging in the process of uncovering, going deeper inside yourself in the process of autoethnographic writing, can stimulate the beginning of recovery' (Ellis 2002, p. 401). Using reflexivity in this research has enabled me to reconcile many of the concerns I had throughout this journey.

In this chapter I demonstrated the large personal and professional journey that I have taken throughout this PhD. Importantly, my journey in Aboriginal health will continue beyond this thesis. I look forward to and welcome more challenges, learnings and deep self-reflection. By using myself as an example, I showed how White health professionals can use reflexivity to address practice dilemmas and move past the discomfort often experienced when working in Aboriginal health. The information I presented in this chapter is personal, which reinforces the depth of the personal self-reflection that is required to confront and move past challenges in this area. Later in this thesis, I argue that a personal reflection is necessary to ensure best-practice with Aboriginal communities. I demonstrate that the depth of a self-reflection, including consideration of race and Whiteness, impacts on the practice of White workers with Aboriginal people. Therefore, in later chapters, I draw on the information presented in the reflexive chapter to support other results.

8. Practice

In this chapter, I explore the practice of White health professionals, including *ewba* staff, experienced White workers and dietitians, with Aboriginal people. Consistent with the critical theoretical approach taken in this research, in Chapters 9 and 10 I consider factors found to enable and constrain this practice.

In the first part of this chapter, I present a detailed "case study" of the practice of one mainstream program, the *ewba* Community Programs, with Aboriginal people. To do this, I describe the actual practice of program staff during the consultation and intervention phases of the *ewba* project. First, I explore the process, results and barriers arising from the consultation. Second, I describe the intervention that occurred in Aboriginal communities from the perspectives of *ewba* staff and Aboriginal workers with some connection to *ewba*. Third, I discuss the extent to which Aboriginal workers were aware of *ewba,* how accessible it was to Aboriginal community members and the perceived impact of the project, from both the point of view of *ewba* workers and Aboriginal workers. In the second part of this chapter, I explore the concept of "ideal practice" with Aboriginal communities (practice perceived to be ideal by both White and Aboriginal workers). Consistent with my identification of them as important elements of practice (Chapters 6 and 7), this includes a discussion of relationships, reciprocity and reflexivity.

8.1. Participant characteristics

One focus group and forty one semi-structured interviews were conducted for the research. Details of participants interviewed are outlined in Table 8.1 and Table 8.2.

Table 8.1: Number of *ewba* staff, Aboriginal workers and experienced White workers interviewed, from Community A and Community B

Type of worker	Number from Community A	Number from Community B	Total
Ewba staff	3	4	7
Aboriginal workers with some connection to *ewba*	6	3	9
Experienced White workers	5	2	7

Table 8.2: Number of dietitians interviewed, from urban and rural locations

Type of worker	Urban location (n)	Rural location (n)	Total
Dietitians	7	14	21

The experience level of White health professionals interviewed varied. The majority of participants indicated how much experience they had working in Aboriginal health (number of years) during the interview. Based on this information I loosely classified experience level to include minimal or none (0-1 years), some (1-5 years), intermediate (5-15 years) and extensive (15 or more years). The number of White health professionals in each of these stages is summarised in Table 8.3.

Table 8.3: Experience level of White health professionals working in Aboriginal health

Type of worker	Minimal or no experience (0-1 years)	Some experience (1-5 years)	Intermediate experience (5-15 years)	Extensive experience (15+ years)
Ewba staff	1	6	0	0
Dietitians	7	5	7	2
Experienced White workers	0	2	0	5
Total	8	13	7	7

8.2. The case of the *eat well be active* Community programs

In this section, I use the *ewba* Community Programs to explore practice of White health professionals with Aboriginal people in one mainstream, CBOPI. This is important because it provides a specific, detailed example how a certain group of White health professionals have practiced in two Aboriginal communities.

8.2.1. Consultation

The purpose of the *ewba* consultation was '*to identify whatever the community's needs were but secondary and just as important was just using consultation as a first point of call to start building those relationships'* (EWBA7). These consultations identified barriers to healthy eating and physical activity for different community groups within Community A and B and helped to identify some potential strategies for action in conjunction with each community.

Separate consultations were held for different community groups, including Aboriginal community groups. It was *'immediately identified that we needed separate Aboriginal consultations, there was no doubt about that. There were no ifs or buts we just knew that we needed to do it, just as we separated pre-schools from local government and things like that'* (EWBA7). The difficulty came in determining how many Aboriginal consultations to have at each site and the team were guided by recommendations of the local Aboriginal Health Teams. In Community A, existing close working relationships between community members and Aboriginal workers meant that a single

consultation was possible with both groups of people commenting alongside each other. In contrast, in Community B a number of separate consultations were required.

It is important to note that this is not an exhaustive discussion of all consultation held by *ewba*, rather it highlights what consultation occurred with Aboriginal communities and how it was different in Community A and B.

Consultation process

The process for setting up consultations was similar in both sites. First, *ewba* workers identified and approached key Aboriginal health managers at each health service. These people suggested other key people in the community whom *ewba* could approach and in turn these people generally suggested another person (EWBA6). In both sites, *ewba* kept relevant Aboriginal staff informed of the progress of the consultations, an important part of maintaining relationships.

Community A

All appropriate service providers in the Aboriginal community were invited to a consultation, including health and education. A separate meeting with the local Elders' Group was also arranged to *'inform them of the project, seek some level of interest from them (and) to find out the best way to work with the Aboriginal Community'* (EWBA7).

While the structure of the consultations with the Aboriginal community was similar to consultations in other groups (for example primary school and under-fives), a different mode of delivery was used:

> *In Community A the Aboriginal manager essentially did our role for us in that consultation and we kind of sat back so we spoke to her about what we wanted and how we had gone about it with the other consultations, and she went ahead and stood up in front of the group and did it and when we broke up into small groups she had chosen and nominated to us some of her Aboriginal staff who would be good group leaders and group facilitators so we very much sat back and didn't really do anything; we "spectated" the whole time. (EWBA7)*

This is an example of *ewba* being flexible and responsive to the needs of this community.

Community B

Difficulties in identifying a specific Aboriginal community in urban Community B (Section 8.2.3) led to a wider and longer search for appropriate people with whom to consult. *Ewba* workers discussed with the local manager of Aboriginal education the possibility of consulting with Aboriginal students and parents or Aboriginal Education Workers[16] (AEWs) from nearby schools. Unfortunately the number of Aboriginal students attending these schools was very low and after a number of attempts, *ewba* found that logistically, they were unable to speak with students or AEWs.

Similarly, other organisations such as Families SA and a local Indigenous Kindergarten were contacted but these organisations did not have Aboriginal families specifically from the Community B postcode area. Attempts to consult with the local Elders' Group and the local Aboriginal Health Worker's Network did not eventuate.

> *I tried to get to the Elders as well and made contact with [name] who was involved with it at that time and I had to put a proposal of what I wanted to chat to them about to her and I had to keep chasing and chasing her and eventually she said oh, they're not interested. I don't know if she ended up speaking to them at all. (EWBA6)*

In the end, four very different consultations were undertaken in Community B. The first involved a visit to a local women's group and discussions during an arts and crafts session. The second was a visit to the local community lunch where the Aboriginal health manager introduced *ewba* staff who then casually chatted to community members who were having lunch, using a pre-prepared survey to guide discussion. Third, there was a youth consultation which involved casual discussion at a local youth centre with some pre-prepared discussion questions that had been sighted by the Aboriginal worker involved with youth. Finally, there was a combined community/ worker consultation, which again involved an introduction from the Aboriginal health manager and then discussion over morning tea, again using pre-prepared questions sighted by the Aboriginal health team.

[16] Positions in South Australian schools filled by Aboriginal people who address the needs of Aboriginal students and liaise with the Aboriginal community. Now known as Aboriginal community education officers (ACEOs)

Barriers to consultation

Ewba was faced with a number of barriers when planning and undertaking consultations with the Aboriginal community. Workers discussed that the Community A consultation had a *'really good feel'* and that the aims of the consultation were more easily met (EWBA7). Consultations in Community B, while ultimately resulting in useful information being gleaned, involved many barriers that needed to be addressed.

One worker identified that the time frame given to *ewba* by SA Health in which to complete the consultations was not conducive to building relationships prior to consultations. As indicated in Chapter 6, building relationships prior to consultation greatly assisted in this research. Some workers felt that a more ongoing consultation, without a timeframe, might have been more effective (EWBA6). In addition, a number of consultations with other groups had to be completed in the same time period, preventing a more focussed effort on developing effective Aboriginal community consultations:

> *…it takes time to build up that trust and relationships and I just didn't have that and because it was just one part of a whole lot of consultations I was doing I didn't have, I couldn't afford to spend the time that I really needed to and over the period of time to really find out a lot more and try and build up more trust to see if we could get a better sort of consultation process happening. (EWBA6)*

In addition, *ewba* workers found the consultations in Community B challenging and sometimes awkward. One *ewba* worker reflected that the consultation with workers involved conversation with *'one word answers'* (EWBA6) which she attributed this to lack of trust between herself and the Aboriginal workers. She felt the combined worker-community consultation was *'really stilted and awkward and very formal because no-one wanted to, it is intimidating, and no-one wanted to look me in the eye and really everyone was kind of looking at the floor a lot of the time'* (EWBA6). She also felt that the community lunch was not a useful site for consultation because '*people just wanted to eat'* and there *'was not a big turnout that particular day'* (EWBA6). The youth consultation was also difficult, perhaps because the group was fairly new. The most useful consultation was the informal discussion the *ewba* worker had with the women's group, reinforcing my learnings about the usefulness of an informal approach (Chapter 7):

> *…the best information I probably got was from the Aboriginal women's group because it wasn't an official consultation, really I was just joining in their craft and I was just sitting down chatting and just got chatting with a few women and I felt much more comfortable with that than the formal sessions and people were just kind of I mean when they're busy doing something they tend to be a bit freer because they are not sitting there with direct eye contact with a person which is fairly intimidating when you don't know someone. (EWBA6)*

Importantly, this experience made this worker reflect on the questions asked at the consultations:

> *I found it really hard to sort of target specific questions because I just kind of went where the conversation went and I just tried to kind of glean a bit of extra information because our questions were very clinical, for want of a better word, you know what barriers, what stops you and your family doing this and even that kind of things seemed to be a bit negative. (EWBA6)*

By following the conversation where it naturally went, the *ewba* worker was able to get *'a bit of a feel [for] what it is like for Aboriginal families in the community'* (EWBA6). This positive outcome demonstrates that in order to glean useful information from Aboriginal communities, White health professionals may need to take a step back and take a more informal approach. This may be challenging and uncomfortable for many White health professionals, for whom it is often not the usual approach.

There were marked differences in the levels of involvement of Aboriginal Health Workers in the consultations in rural Community A and urban Community B. In Community A, workers took the lead, but in Community B this did not occur, possibly due to differences in experience and confidence.

In addition, *ewba* workers felt that some groups were simply not interested in being part of the consultation, or had a different focus to *ewba* so it was not their core business:

> *They [group] weren't interested in being part of the consultation so I tried every possible avenue that I could that had been suggested and I did what I did with the best of what I had. (EWBA6)*

As indicated through my experience (Chapter 7), strategies to assist in obtaining this group's involvement could have included re-framing the goals of the *ewba* consultation so that it was considered part of the "core business" of this group, using reciprocity as a strategy or accessing these people through another avenue. However, this may not have been possible considering the tight time frame and competing demands of other *ewba* consultations.

At the time of the ewba consultations there was not an Aboriginal health worker[17] (AHW) for the target group of ewba (0-18 year olds and their families), apart from youth. *Ewba* staff felt that this was a barrier to doing useful consultation and that a subsequent relationship that has developed with a relevant, Aboriginal worker would have largely assisted with a successful consultation.

Finally, difficulties arose when *ewba* tried to identify an Aboriginal community specific to urban Community B. This made it unclear with whom to actually consult.

> *When we talked to the managers and staff they said 'oh well we've got an Aboriginal population at [council area] but we can't tell you how many families actually live in Community B', I mean you have ABS [Australian Bureau of Statistics] stats but they are so mobile. (EWBA7)*

One worker describes how she felt it was best to deal with this issue:

> *I kept reporting back to [manager] just basically saying we've just got to take Community B [suburb] out of the equation because everyone thinks regionally, and we've just got to keep in mind that Aboriginal Community, when we are talking about Aboriginal Community we are actually talking about the Aboriginal Community of the [whole region], not Community B. (EWBA6)*

This was a barrier throughout the *ewba* project and this issue is discussed further in Section 9.5.2.

The consultation experience highlighted two themes that continued throughout the *ewba* project; the difficulty in identifying and engaging the Community B Aboriginal community, and the large difference in the responses of Community A and Community B.

[17] Aboriginal health workers work at mainstream and Aboriginal community controlled health services and play a vital role in providing primary and clinical care to an Aboriginal community. They work with communities to assist them to live healthier lifestyles and are also involved in diagnosis and treatment of common medical conditions.

8.2.2. Intervention

The *ewba* interventions delivered to the Aboriginal communities in the two sites can be considered at a number of levels. First, in the ways that they were interpreted and remembered by the Aboriginal workers who were involved with *ewba*, recorded through participant interviews. Second, as they were described by the *ewba* project coordinators, also through participant interviews. Finally, the *ewba* Interventions Database, where all interventions that were delivered as part of *ewba* were recorded by the project coordinators, was used to quantify the extent of intervention in the Aboriginal communities. Each of these reports is described below.

Interventions as described by Aboriginal workers

Participants were asked to consider (a) how *ewba* had supported them in their work or what a specific *ewba* worker had done to assist them, (b) whether *ewba* had provided them with any new strategies and (c) what they perceived *ewba* to be.

Community A

Catering at local community events was the most common *ewba* activity reported by Aboriginal workers. Three of the six interviewees talked extensively and positively about how *ewba* had assisted them to implement healthy catering:

> *…we didn't really have to worry about the catering side of things like you guys did an absolutely fantastic job in working out that this was the healthy stuff and we could focus on the actual events and what we were doing and yet they also got this other information about healthy eating so that's been fantastic support for us. (AW6)*

Similarly, five interviewees talked about the input *ewba* had into a children's cooking program at the local schools and commented that the support provided in the form of money, planning and delivery of the sessions was valuable.

Other interventions mentioned included support for a women's cooking group, provision of culturally appropriate cookbooks, assistance with forming a strategic plan around healthy eating and physical activity for the Aboriginal health service as well as provision of planter tubs and pura taps, cooking demonstrations at community events, physical activity packs for children under the age of five and creation of a healthy active working group for health service staff.

Community B

Aboriginal interviewees from Community B referred to three things that *ewba* had assisted with – locating and applying for grants, provision of baby packs for new mums and a talk about healthy eating at the local "Mum's N Bub's" group.

Interventions as described by *ewba* project coordinators

Compared with Aboriginal workers, *ewba* staff provided a more extensive description of interventions delivered to the Aboriginal community. Interventions described by *ewba* staff in interviews are listed in Table 8.4 and Table 8.5. The four main *ewba* intervention settings have been used to classify the activities: under-fives, primary school, youth and community.

Table 8.4: *Ewba* interventions delivered in Community A as reported by Community A *ewba* staff

***Ewba* intervention area**	**Intervention delivered**
Under-fives	Work with local Aboriginal kindergarten
	Grants for Nunga Playgroup
	Assist Aboriginal crèche with health eating accreditation process
Primary School	Assist with planning and delivery of children's cooking program in local schools
Youth	N/A
Community	Collaborate with Aboriginal Health Team
	Plan and run training for Active Foodies
	Healthy catering
	Attendance at & support for community events e.g. Aboriginal Health Fair Day, Close the Gap Day, NAIDOC week, Reconciliation week
	Assist Aboriginal Health Team in development of healthy eating & physical activity strategic plan
	Assist in application for outdoor gym
	Assist in planning and delivery of women's group
	Installation of pura taps

Table 8.5: *Ewba* interventions delivered in Community B as reported by Community B *ewba* staff

***Ewba* intervention area**	**Intervention delivered**
Under -fives	Family Loan packs (Dads)
	Pura tap at local Indigenous kindergarten
	Create culturally appropriate flip chart for local Indigenous kindergarten
	Assist local Indigenous kindergarten with sourcing grants
	Culturally appropriate persona doll for local Indigenous kindergarten
	Baby packs for new Aboriginal mothers
	Sessions with Mum's N Bub's group
	Provision of hand held blenders, bibs and educational magnets to new Aboriginal mums
	Provision of active play kit to Mum's N Bub's group
Primary School	Active After Schools for Aboriginal students at local primary school
	Fit to Lead with Aboriginal students at local primary school
	Program for Aboriginal students run by local organisation
	Linking schools with local sporting office
Youth	Youth Group at Aboriginal community centre
	Mother and Daughter dance group at Aboriginal community centre
Community	Assist Aboriginal community centre in sourcing and applying for grants
	Aboriginal Health Team training in healthy eating and physical activity

Table **8.4** demonstrates that the majority of interventions targeting the Aboriginal community in Community A occurred at the community level. While there appear to be fewer total interventions than for Community B, this reflects the fact that activity focused on a few far-reaching (broad) strategies. In contrast, in Community B the majority of *ewba* interventions targeting the Aboriginal community were in the under-fives setting (Table 8.5).

Interventions as reported in the Interventions Database

A Microsoft Access Interventions Database was designed by the initial *ewba* Evaluation Coordinator to keep track of all interventions that were delivered. From 2006 until early 2010 *ewba* project coordinators systematically recorded the processes, outputs, and impacts of their work in this database which was set up so the site where the intervention was delivered, the type of intervention, the target group, the date and a description of the activity could be noted (Pettman et al 2011). It was intended that the database would provide quantification of how much intervention (dose) occurred, alongside a description of what strategies were undertaken in sites (e.g. policy or

program development; workforce or peer education and training; promotion and marketing; physical infrastructure). This Interventions Database was used to identify which *ewba* intervention activities were delivered to Aboriginal communities over the course of the project. In total, 74 instances of intervention with the Aboriginal communities (across 21 different settings) of Community A and B were identified, out of a total of 1074 instances of *ewba* intervention. That is, 6.9% of all interventions that were delivered as part of *ewba* were delivered to Aboriginal communities. The instances of intervention identified through this database were very similar to those provided by the *ewba* staff through their interviews (Table 8.4 and Table 8.5).

I now move on to discuss the awareness of Aboriginal workers about the *ewba* program, and the perceived accessibility and impact of the program from the point of view of Aboriginal workers and *ewba* staff using data from interviews.

8.2.3. Program awareness, accessibility & impact

Awareness of *ewba* by Aboriginal workers was considered (whether they knew about *ewba* and what they knew), as well as accessibility of the program (how easy it was to access) and perceived impact (who the program reached and how) to the Aboriginal people in both communities (from the point of view of Aboriginal workers and *ewba* staff).

Awareness (of Aboriginal workers)

Aboriginal health workers and other Aboriginal staff play a crucial role in reaching the Aboriginal community, whether that be in terms of health care or in delivery of a program like *ewba.* This will be highlighted in Section 8.3.1 of this chapter, and in later chapters. I also identified the importance of working with AHWs through my own work with Aboriginal communities, discussed in Section 7.3.2. Therefore, it can be said that unless the Aboriginal health workers are aware of a program, then it is unlikely that this program will be translated to the Aboriginal community. Consequently, it is important to consider whether Aboriginal workers, working in the Aboriginal health teams in Communities A and B, at the health services where *ewba* was located, were aware of the *ewba* program.

The extent to which Aboriginal workers involved with *ewba* were aware of the *ewba* program and its key principles/ messages was considered by reviewing their responses to specific questions in interviews. Only one of the nine workers interviewed (across both sites) was able to state that

ewba was about *'working with the local community about healthy lifestyles and healthy eating'* (AW6). Other participants' awareness of ewba was demonstrated in a myriad of ways as discussed below.

Identification through a key person

Aboriginal workers' awareness of *ewba* was mostly limited to the people they worked with (i.e. the *ewba* project coordinator or myself as PhD Candidate) or the interventions that they were directly involved in. It is important to note that this interview question was reframed midway through the interview process due to initial poor responses. I changed the question from "what can you tell me about *ewba"* to "tell me about your relationship with the *ewba* worker you had had the most contact with". This reinforced the importance of relationships identified in this research. Responses included:

> *….well the only way I know about it [ewba] is through you [referring to Annabelle, PhD Candidate]. (AW9)*

> *…people will say "oh they know you because you are involved with the program" but the program is eat well be active the same as with [ewba project coordinator] so they'll get to know you more than they'll know about the project but not make that connection. (AW1)*

On the other hand, some workers became confused with the question in the interview because they knew the *ewba* worker well, but did not necessarily associate them with any specific program (AW3). They had come to associate that particular person with healthy eating and physical activity in their community and associating them with the name of a project was of less relevance.

Know the name but not what it is

A number of Aboriginal workers interviewed had heard the term "eat well be active" but they did not know what it was.

> *I've heard about eat well be active but what does it mean? (AW1)*

Similarly, others had heard the term and understood the concept but they did not relate it specifically to the *ewba* Community Programs.

> *I'm just guessing that you know some fellas up there realised that we're getting fatter and more unhealthy and things acting on the health system and those sorts of things and they put a whole lot of money into this program so that it can filter through the community and get out there and find out what the needs are. (AW2)*

This is supported by one of the *ewba* workers who, in exploring how her role in assisting to implement healthy catering at a local community event would not have been attributed to *ewba* by the general community, said.

> *….there were lots and lots and lots of comments from people about how good the food was and how nice it was to have fresh Coorong mullet and stuff like that and how I guess it added to the enjoyment to the day but nobody would have had any idea that that was because I stood there and chopped salad for three hours. So I see that as indirect, I see that I had a primary role in bringing about that change to the catering but still indirect in that the community that accessed that would not know…[ ]…. They would just remember it as the year where they had the barbeque instead of hot dogs. It would not be attributed to anybody.(EWBA5)*

Others were aware that *ewba* was a project being run in their community but were not sure of the project aims or scope. There was also some confusion with similar programs being run in the same community. Confusion of the *ewba* Community Programs with other programs and other *eat well be active* South Australian healthy weight initiatives has been widely encountered and is not isolated to the Aboriginal community. The term "eat well be active" is used to describe a larger strategy in SA related to healthy weight, not just the *ewba* Community Programs. Therefore, when one worker was approached about the "eat well be active" training for Aboriginal Health Workers, she was not sure if this was the same as or different from the *ewba* Community Programs (AW5).

Accessibility (views of Aboriginal workers and *ewba* staff)

Similar to the importance of Aboriginal workers having awareness of a program, it is also vital to consider whether a program was accessible (was easily accessed by) to Aboriginal people in Community A and B. It is important to consider the view of both Aboriginal and *ewba* workers in this case. Three of the six Aboriginal workers from Community A commented that they felt that the *ewba* program had been accessible for the Aboriginal community in their location. Specifically, they felt that the way *ewba* workers worked in partnership with the Aboriginal Health Workers

assisted with this (AW6; AW7). However, it was suggested that the changeover of staff interfered with accessibility of *ewba* to this community as there were periods when there was no staff member (AW7).

Two *ewba* workers felt that *ewba* was accessible to everybody in the two sites (EWBA1; EWBA6). One worker felt that perhaps it was less accessible to the Aboriginal community in Community B compared with Community A (EWBA2).

Impact (views of Aboriginal workers and *ewba* staff)

To investigate the perceived impact (who the project reached and how) of *ewba* for Aboriginal people in the two sites by Aboriginal workers and *ewba* staff, I considered reports of who was impacted by *ewba* and how, factors which indicated it did have an impact and things which enabled it to have an impact. The majority of information reported here regarding the positive impact of *ewba* refers to Community A. The lack of similar positive impact in Community B will be discussed further in Sections 9.2.2, 9.2.9 and 9.5.2. I begin by outlining the impact from the point of view of Aboriginal workers, and then move on to the point of view of *ewba* staff.

Impact as perceived by Aboriginal workers

In general, Aboriginal workers felt that *ewba* was a positive program (AW3), had provided *'overwhelming support'* to the Aboriginal Health Team and responded to their needs (AW5). In Community A, Aboriginal workers felt that *ewba* could not have done anything more to make the program suitable (AW3; AW6). One worker described the impact of *ewba* to be:…

> *it's not so much in your face you do this, that sort of loony teaching I think it's been very subtly done and it has been moving along slowly to build up and I think that's the way people in the community like to learn. (AW7).*

How was the impact made?

In Community A, Aboriginal workers interviewed identified that *ewba* had a positive impact on primary school children (AW1, AW4, AW6), women (AW1), the community in general (AW6) and the community in general through primary school children (AW1, AW7). In Community B, workers reported that there was a positive impact on Aboriginal mothers and babies (AW2). In general, workers felt that impacts occurred in individuals and groups who participated in *ewba* programs or received *ewba* interventions, for example mothers and babies who received the packs in Community B, the children and women who participated in cooking programs in Community A.

However, some Aboriginal workers said that some of the impacts were achieved in a broader sense and extended beyond the immediate targets of *ewba*, for example, introducing healthy catering at community events in Community A and doing this consistently provided a subtle message to the wider Aboriginal community about what is healthy.

> *…the community has received that education process on what's healthy and what's not healthy. (AW6)*

> *I think one of the biggest examples of major change has been watching over the last few years events like we've run with fatty sausages and hamburgers. I think if it wasn't for eat well be active and the help with that I mean that has ripple effects like you wouldn't believe; like people are realising that they have got to start thinking of their diets…. (AW7)*

A number of workers also identified that *ewba* represented a great resource for Aboriginal Health Workers, for example *'it helped in helping Aboriginal Health Workers in better ways to send a message to community'* (AW7). The same worker felt that working with *ewba* enabled AHWs to increase their confidence that they were sending the right message to community. This led to greater role modelling; the importance of which was highlighted:

> *…it makes a big difference because they see [worker] sitting eating a hot dog, you know we're role models in the Community and a lot of it is about us not being saints or angels but trying to set the message across to these kids so it is not mixed messages. (AW7)*

Other workers felt comfortable in accessing *ewba* when they needed to, with one worker saying we could *'access you guys [ewba] if we have a question or if we want something presented to the [community group]'* (AW2). This comfort in accessing *ewba* meant that *ewba* messages were more likely to be conveyed to the Aboriginal community through the Aboriginal workers, who were likely to have a trusting relationship with community members.

Good working relationships

In Community A, an important impact of *ewba* was the development of good working relationships and trust between Aboriginal workers and *ewba* staff. For example:

> *…everybody is trusting of the eat well be active program now so you know, we don't hesitate about who to contact about healthy catering and healthy things and all that kind of stuff, we just go straight to you guys so it's fantastic (AW6).*

In Community A, this trust extended to and assisted in the building of positive relationships between community members and *ewba* workers:

> *I think that partnership has worked really well and the community have found that, have seen that partnership and they have been more open and they have let the eat well be active program in and you can see that from the changes and what's happening at our actual events…[ ]…a lot of the community and the school kids they know your face now and they see you and they can come up to you and ask a question without feeling, you know it is just that they are comfortable with the workers….(AW6)*

The good working relationship between *ewba* and the Aboriginal community in Community A was demonstrated at the 'Close the Gap' Day in 2010 when *ewba* and the women's group prepared food together for the community members attending. Consequently, the positive relationship between Aboriginal and *ewba* workers was perceived to have contributed to the impact of *ewba* in this site. Importantly, much of the connection between *ewba* and the Aboriginal communities after 2008 was facilitated by myself as PhD Candidate, due to my constant contact with both areas. This is important to consider when interpreting the results. This is also important to consider in the context of my paradigm shift. In the positivist paradigm, such an engagement in intervention, considering my role as a researcher, would have been considered a "contamination" of the results and therefore a weakness of this research. This would not have enabled me to develop the relationships and understandings I did by working closely with the Aboriginal communities I was also researching. However, in the critical paradigm, I see my engagement with these communities as a strength of this research, as it greatly added to my understanding of these communities and relationships with them, which enhanced my ability to do the research and broadened the perspective I used in analysis.

Potential reasons for impact in Community A (views of Aboriginal workers)

Specific to Community A, Aboriginal workers provided a number of reasons why *ewba* had a positive impact in their community. First, the approach taken by *ewba* workers in Community A was to seek out the relevant Aboriginal workers and what they could help with, rather than saying

'this is what we do' (AW6, AW7). According to one Aboriginal worker, this is not the usual approach of White health professionals (AW6). Second, focussing on the local community and their needs rather than assuming that the needs of all Aboriginal communities are the same:

> *…actually coming to us who work within the Community and sitting down and talking to us here locally about how we see that, you know, programs are going to work…[ ]...actually coming to us as the Health Workers that work in the community and finding out what we need, it's been a really, really good thing…(AW6)*

Working in a way that is culturally appropriate was also considered something that *ewba* had achieved in Community A. One worker felt that the close working relationship between *ewba* workers and Aboriginal Health Workers, as well as the commitment to identifying local issues, demonstrated cultural appropriateness (AW6). Another worker suggested that asking who the key stakeholders are is another way to ensure this, however she did acknowledge that defining what is 'culturally appropriate' can be complex (AW7). Transparency was also seen as an important characteristic of workers, *'the way you [ewba] have been honest about well you know we don't know where we are and don't know how long we'll be able to, how long we are going to be funded'* (EWBA7).

Similarly, some of the Aboriginal workers interviewed commented specifically on the *ewba* project coordinators. In general, Aboriginal workers in both sites felt that *ewba* workers worked well with the Aboriginal community in a culturally appropriate way. However, Aboriginal workers from Community A provided much more specific comments about the skills and abilities of the *ewba* workers and spoke extensively about their positive work. In particular, several Aboriginal workers commented that some *ewba* workers demonstrated a commendable passion for working well with the Aboriginal community which assisted them in their work:

> *I think that the workers had that real passion and commitment to work with Aboriginal Community and they searched it out and they found it, they made it [ewba] accessible. (AW7)*

Other skills *ewba* Community A workers demonstrated that were seen as favourable by Aboriginal workers included being a good communicator, energetic and informative (AW4), working with Aboriginal health workers (AW6), using a suitable approach for the local area (AW6), consulting

the community (AW3), asking questions (AW3) and wanting to work with the Aboriginal community (AW7). These are important lessons for practice for White health professionals working with Aboriginal communities.

Impact as perceived by ewba staff

Overall, *ewba* project coordinators indicated that *ewba* had a positive impact (EWBA4) in the Aboriginal community, however this impact was small (EWBA6), localised (EWBA6) and generally, indirect (EWBA5). One worker questioned her impact:

> *I think I've had an indirect impact. I think that I've had a small, indirect impact. No, perhaps I've had a small indirect potential impact because it's still, a lot of it is still in the potential stage. (EWBA5)*

Ewba staff tended to perceive a greater impact in the Aboriginal community in Community A compared to Community B. In Community B, the most impact was thought to have occurred in the latter stages of the project (EWBA6) to specific groups who received interventions i.e. Aboriginal mothers and their babies. This supports the opinions of Aboriginal workers in Community B about where the impact was. *Ewba* staff indicated that impacts in Community B were the direct result of interventions and a relationship with one Aboriginal Health Worker. The *ewba* worker involved in this process outlined that the many, informal conversations she had with the key Aboriginal worker contributed to this impact because the worker would approach her informally about nutrition issues (EWBA6). On the other hand, another *ewba* worker interviewed did not think that *ewba* had an impact on the lives of Aboriginal people in Community B because of the lack of extensive relationships with members of the Aboriginal Health Team (EWBA3).

There were a number of specific groups in Community A that *ewba* workers felt were impacted by *ewba*. First, in the early stages of the project, Aboriginal families who had children attending the local Aboriginal kindergarten, were affected, partly due to a committed staff member at this site who was passionate about healthy eating (EWBA1). This kindergarten provided a "backdoor" or point of entry to the Aboriginal community in Community A for *ewba* in the initial stages of the project (EWBA1). Second, in the middle and latter stages of the project, primary school students were positively affected through the cooking program at schools and the wider community through healthy catering at community events (EWBA5; EWW8). These students tried new foods at home

(EWBA5; EWW1) and community members asked for and enjoyed healthy food at community events (EWBA4). Third, it was felt that Aboriginal workers benefited from the support of *ewba* in Community A (EWW1). Similar positive impacts across all of these areas were not observed in Community B. In line with a critical theoretical approach, potential reasons for differences in *ewba* in Community A compared with Community B will be considered in Sections 9.2.2, 9.2.9 and 9.5.2..

8.3. *Ideal Practice*

In the preceding section of this chapter, I considered how the practice of *ewba* staff "looked" in the *ewba* program. This enabled exploration of one example of practice by specific White health professionals with two Aboriginal communities in one specific program. In the remainder of this chapter, I consider practice more broadly by reporting on what *ewba* staff, dietitians and experienced White workers think they should do in their practice. I describe this as "ideal" practice and am referring to the ideal practice of White health professionals with Aboriginal people. I also consider comments from Aboriginal workers about what makes the practice of White health professionals ideal. In particular, views of Aboriginal workers provide ideal situations to aim for in practice.

Identifying ideal practice is important because it is then possible, using a critical theoretical approach, to identify what might constrain or enable workers from engaging in such practice, and then address these issues. In Chapters 9 and 10, I consider why ideal practice is not always possible and I provide a detailed analysis of factors that constrain and enable practice of White workers in three systems: the organisation, profession and the individual. Much of the interview data about what makes practice ideal supports my own experiences presented in Chapter 7.

In this section, I present views of Aboriginal workers, experienced White workers, dietitians and *ewba* staff about what constitutes ideal practice. Due to the similarity of views between the different groups of workers, I present these views concurrently. Table 8.6 summarises the elements of ideal practice identified by participants in interviews. Due to the way that interview questions were structured, not all workers raised all points. With the exception of dietitians, who were asked specifically about the importance of reciprocity and reflection, participants were asked to comment generally about what they believed to be important qualities for White health

professionals working in Aboriginal health. Therefore Table 8.6 also summarises which groups of workers raised which points.

Table 8.6: Elements of ideal practice and which groups of worker/s (Aboriginal health workers, eat well be active (ewba) staff, dietitians and experienced White workers) identified them as ideal

Element of ideal practice	Aboriginal workers	*Ewba* staff	Dietitians	Experienced White workers
Working with Aboriginal health workers	√	√	√	√
Using appropriate processes	√	√		√
Building relationships	√	√	√	√
Relinquishing control	√	√		√
Awareness of Aboriginal history	√	√	√	√
Communication	√	√	√	√
Commitment	√			
Cultural awareness	√	√	√	√
Flexibility	√	√		√
Humility		√		√
Honesty		√		√
Persistence		√		√
Reciprocity	√	√	√	
Reflection			√	√

8.3.1. Working with Aboriginal Health Workers

The importance of working with and supporting AHWs was identified by Aboriginal workers, dietitians, *ewba* staff and experienced White workers (AW3; AW6; AW7; DN1: DN3; DN5; DN7; DN8; DN9; DN14; DN20; EWBA1; EWBA2; EWBA4; EWW5). Aboriginal workers identified themselves as the people who know what is going on in the community (AW2) and the right people to speak to (AW3).

One *ewba* worker felt that being a non-Aboriginal person, it is more effective to work with AHWs than on your own because they help get things happening on the ground (EWBA2). Another experienced White worker described her view on the importance of working with AHWs:

> *They're in a good position for that; I mean we couldn't work with the Aboriginal community if we didn't have our Aboriginal workers. Well I suppose we could but it is just that link into the community. You still have to develop the relationships between ourselves and the community but it is that worker who can supply the links into there. If that worker respects us and we respect them well they'll say "oh she's all right, she knows what she's talking about, we can invite her in, this is okay". (EWW2)*

Another experienced White worker stated: *'you can't just walk in knowing everything, you've got to work with the community and get their ideas and work with them on achieving it'* (EWW6).

Other ways to work with Aboriginal people discussed included finding a champion or key person in the community (EWBA1) who can advocate for you (EWBA3), often a key community leader (EWBA4; EWW6); or an Aboriginal mentor (EWBA4; DN9; DN14).

8.3.2. Using appropriate processes

Aboriginal and White workers identified the importance of using appropriate processes when working with the Aboriginal community. Aboriginal workers highlighted the need to *'work with the right people'* (AW3) and *'go through the right channels and consult with the right people'* (AW6). Two Aboriginal workers highlighted the importance of consulting the local Elder's Committee (AW3; AW6) and another two discussed the importance of accessing Aboriginal people through existing groups (AW2; AW8). These groups facilitate processes (e.g. community consultation),

and in addition, being invited to a group assumes a level of trust between you and the Aboriginal workers which assists with the overall process:

> *…if we bring people into our groups we then know them and trust them and we would feel that they are appropriate to deliver the information to our clients, like my clients trust that I will bring people to the group that they are going to like and that they are going to respect them and treat them nicely and all of that, whereas if I get a worker that I know is just not going to, I just wouldn't even invite them, do you know what I mean? (AW2)*

This was reiterated by *ewba* staff and experienced White workers who suggested the importance of finding out who the appropriate people are to consult (EWBA1; EWBA5), consulting the Elders (EWW5) and utilising existing groups, for example:

> *At [working together group in Community A], it's natural for Aboriginal and White workers to come together and discuss things, it's a very open forum so that is a very natural and non-intrusive and welcoming way to meet people' (EWBA5).*

8.3.3. Building relationships

Building relationships was a key aspect of ideal practice identified by Aboriginal workers and all types of White workers. One way to build relationships is through involvement in community events and being *'prepared to actually do rather than just direct'* (EWBA5). White workers felt that this type of involvement is a crucial part of building trust and relationships (EWBA5) and in showing support for the Aboriginal community (EWW2). One *ewba* worker learnt, through her involvement in a community event, *'that in order to build effective relationships with Aboriginal community and workers you really have to spend a lot of time building trust and being involved rather than just preaching to people about what they should do'* (EWBA5). Participating in a community event means that you have something to offer to the community *'other than just your agenda of trying to get people to eat healthy and be physically active'* (EWBA5) and can be a form of reciprocity. This is important because *'Aboriginal people have had a lot taken from them over the years so it doesn't hurt to be able to offer something'* (EWBA5).

Relationships were seen as an initial, key step when working in Aboriginal health. For example, one *ewba* worker described the "order" in which she approaches Aboriginal health: *'it went from me introducing myself, to building a relationship, to now having a professional relationship'* (EWBA3). This worker felt that relationship building and building trust was important and should be done first:

> *…creating those relationships, attending the lunch program, having lunch with community, just chatting and then being involved. That kind of just shows the order of what is most important to Aboriginal community. (EWBA3)*

This allows people time to get to know you and what you are doing, in contrast to telling the community what your project is about and asking them if they would like to be involved straight away (EWBA3). This was reiterated by another *ewba* worker who stated that *'meeting Aboriginal workers without an agenda was really important to setting up the relationship'* (EWBA5).

Relationship building may be an informal process; *ewba* staff stressed the importance of informal strategies to engage in relationship building. One worker said that her work in the Aboriginal community happened *'in a kind of more informal way'* and it was *'more about making connections and things'* (EWBA6). Similarly, other workers stressed the importance of meeting people informally (EWBA3; EWBA5; DN10), whether that be through community events or *'taking the opportunity, if you have something that you need to give somebody, instead of sending it through the mail, if it's not too much of an issue, just drop it off, like make yourself known but not in an assertive way'* (EWBA5) and getting to know people informally through *'social conversation about what was happening on the weekend'* (EWBA5). The importance of relationships was reiterated by one worker who felt that *'you cannot evaluate the significance of a relationship with Aboriginal community'* (EWBA3).

With regards to dietitians interviewed, most of them had an appreciation of the importance of relationships when working with Aboriginal people; even those with minimal experience in the area were able to state relationship building as an essential skill. While some were aware of this only in theory, others had learnt through successes and mistakes, the importance of having good relationships with the appropriate Aboriginal people before working with the community. It was acknowledged that without good relationships, very little could be achieved. This supported my own experiences of relationships with Aboriginal communities, as presented in Chapter 7.

Some of the benefits of good relationships noted by dietitians were the ability to get things done, the opportunity relationships provided to learn and the credibility they received from the person they had a relationship with, which then increased their chances to work well with the community.

> *…if you build a relationship with those key people and they get to know you then they talk about you to the community and they will say oh yes, [name], she's actually all right. (DN14)*

Dietitians also discussed the challenges they had experienced when building relationships. There was general acknowledgement that it takes time to build effective relationships with an Aboriginal community. Those with more experience discussed just how long it had taken to build specific relationships. One dietitian, who had worked in a community for approximately twenty years, felt that she had gained a lot of trust over that time but was only really starting to make progress with nutrition messages in the last few years (DN1). Those with minimal experience had some awareness of the time taken to build relationships and this was a barrier when people were unable to think about their work long-term.

Some dietitians discussed the difficulty in measuring relationship building and knowing *'when [you are] not being productive and when to get out and do something else'* (DN3). One dietitian, who had developed very productive relationships with Aboriginal people in his area, highlighted the need for White people to let go of negative beliefs and judgements if they are to have good relationships with Aboriginal people. In his case, his desire for personal privacy was something he needed to work through as it initially held him back in forming relationships as some level of disclosure was required (DN20).

In summary, dietitians were aware of the importance of relationship building. However, those with less experience did not portray confidence in their ability to build successful relationships. While the concept of relationship building may be simple, it requires, experience and confidence and *'in reality it takes time to build relationships, it doesn't happen like it happens in the text book'* (DN14). These results highlight the need for dietitians to be given practical advice about the "how" of relationship building, including examples of where it has worked and where it has not, some strategies to get started, and reiterate the time that it takes. Such information would also be useful to workers in programs like *ewba.*

8.3.4. Relinquishing control

Aboriginal workers reported the importance of White workers relinquishing control when working with Aboriginal workers and community members. This entails working alongside Aboriginal staff rather than leading the process (AW7) and not coming across as the only expert (AW7). Similarly, it is important for Aboriginal people to have control, especially with regards to nutrition information (AW8). These strategies avoid practising in a way that reinforces colonisation. For example, instead of telling people what to eat, providing choices based on what people are already eating (AW8), or working with a community in terms of what they value and what they want rather than pushing your ideals or the ideals of a program onto the community (AW8).

As well as not taking the lead and not imposing on Aboriginal people (EWBA1; EWBA5) *ewba* staff and experienced White workers suggested other ways for White workers to relinquish control. These included acknowledging things about yourself such as admitting what you don't know, acknowledging that you need training and not being scared (EWBA4), not expecting immediate change and understanding the limitations of your work (EWBA1; EWBA2; EWW5). Acknowledging that White people do not have all the answers and not assuming that their ideas are the best way to solve *'what we see as Aboriginal problems'* (EWBA5) were also reported as important strategies.

8.3.5. Awareness of Aboriginal history

The next important aspect of ideal practice was an awareness of Aboriginal history. A number of Aboriginal workers felt it was beneficial if White health professionals had an awareness and understanding of Aboriginal history as well as Aboriginal culture and lifestyle (AW2; AW4).

> *I think they just need to have an understanding of where we're from, of where we've come from and you know it is not just about an Aboriginal person anyway it is about understanding what their lifestyle's like, what their history is, and the family. (AW4)*

Aboriginal workers felt that if White health professionals had this awareness, then they would have a better approach and probably be more successful in their work with Aboriginal people (AW4).

White health professionals also identified the importance of being aware of Aboriginal history (EWBA2; EWBA5; EWW2; EWW7; DN6; DN9; DN14; DN21). One worker felt that White health professionals cannot expect Aboriginal people to tell them everything and therefore it is important

for White workers to *'take a bit of initiative to learn about it for yourself so that you're armed with that knowledge so that when people are telling you things you are hearing it within the context that it's being said'* (EWBA5).

8.3.6. Communication

Approaches to communication, reported as elements of ideal practice by Aboriginal workers, included treating Aboriginal people like people, smiling and saying good morning, being civil, respectful and treating them how you would like to be treated:

> *…when someone walks in the door, you smile and say good morning and make them feel welcome because that's what we're here for and if you can't do that well you shouldn't be working here (AW1).*

Using appropriate communication, such as sitting and yarning, because *'an Aboriginal person would rather sit under a tree and have a good yarn with you on the ground'* (AW2), was seen as beneficial. Not looking at your watch is important when doing this (AW1). Asking Aboriginal people what they want and asking questions when you do not know something (AW3) are also important aspects of good communication and good practice.

Other approaches to communication that were cited as ideal by both Aboriginal and White workers included being clear when explaining things (AW5), using visuals (AW5; EWBA4; DN1), teaching kids who pass the messages onto their families (AW 3; AW7), asking questions (EWBA1; EWBA4; EWW1; EWW4) and taking time to explain why things are important.

> *…I got told for years and years and years, you know we get told you need to do this and we've accepted that and we've done it but we've never knew why or how and that's just about food in general…[ ]…They were White people and then, you know, years and years go by and we get told what to do all the time, what we have to do and I think we need to inform, particularly when it is non-Aboriginal people informing Aboriginal people about things, they need to know why. Why are you bringing this program to us? (AW4)*

Consequently, explaining why things are important is one element of ideal practice.

8.3.7. Commitment

Being committed was a quality reported by Aboriginal workers as important for ideal practice with Aboriginal people. In particular, Aboriginal workers highlighted commitment as an important quality for White health professionals. This included wanting to work with Aboriginal

people (AW7) and persisting with clients who may be difficult to contact (AW2). One way to demonstrate commitment is to follow through with what you say and offer (AW1). A commitment to building relationships with Aboriginal people is needed (AW7) with an underlying understanding of the importance of relationship building in this line of work, for *example 'the biggest thing that you could do is build your relationship with them [Aboriginal people]'* (AW1).

8.3.8. Cultural awareness

Cultural awareness and its importance in ideal practice of White health professionals was discussed by both Aboriginal and White workers. One Aboriginal worker talked about the importance of upskilling White health professionals and making the space more conducive for them to work with Aboriginal people:

> *…I think unless we've got something to give our workers who've never had experience or an opportunity to meet with Nungas we have to have something in there to support them in doing what they want to do and sometimes that hasn't been the case and I don't think that's fair to non-Aboriginal staff so I'd like to see something, like we've built in here with our three streams of – we call it essential training. (AW7)*

This worker felt that the need for cultural support extended to non-Aboriginal managers who may be managing Aboriginal staff, highlighting the need for cultural training across all levels of workers:

> *I've had a lot of managers say to me 'I've never met an Aboriginal person; I've never had the opportunity'. Now they are managing three Aboriginal staff. It's a culture shock for both sides. (AW7)*

Ewba staff, experienced White workers and dietitians also thought that some form of cultural training was important (EWBA4, EWW2; DN9; DN10). However, one *ewba* worker highlighted that relying too much on this training may be a hindrance because making training a prerequisite before working with the Aboriginal community may stop people from starting in the first place.

> *Well sometimes there's a thing that I need to go through two days cultural training, I need to have an Aboriginal mentor, I need to do this and do that before I can even approach someone. Do I do that to approach the next person, a non-Aboriginal person, you know?...[ ]…I am not saying no training but you don't need that to make that initial contact all the time. (EWBA4)*

Ewba staff and experienced White workers also discussed the concept of "cultural appropriateness". The meaning of this term was a little unclear; some workers referred to "cultural appropriateness" as an important quality but did not define what they meant by it (EWBA1). Others talked generally about culture and how they felt it was important; for example, to keep cultural rules and issues in mind (EWW6), *'having an understanding of the value of culture and what it has to offer us'* (EWW3), understanding and valuing Aboriginal culture (EWBA1; EWBA4; EWW3; EWW5), being aware of cultural differences (EWW4) being aware that you are working with a different cultural group (EWBA4) and thinking about changes you might need to make to take account of this (EWBA3). While some workers referred to certain "rules" for working with Aboriginal people such as not using direct eye contact (EWBA6; DN8), experienced White workers made the point that workers need to be careful because such rules were *'not helpful'* (EWW3) because not all "rules" will apply to all groups of Aboriginal people (EWW4).

8.3.9. Flexibility

Flexibility was seen as a key quality in terms of making the most of situations and being aware that when working in Aboriginal health, things don't always happen the way they were planned in your diary (AW2).

> *It is a different way of working…[ ]…[but] whatever you do for anyone else you need to do that with Aboriginal people (AW1)*

This highlights that while there is an element of difference to practice with Aboriginal people, many aspects of practice are similar to what would be done for anyone and it is still important for a health professional to do everything that they would usually do.

Flexibility was commonly mentioned by White health professionals, with ten dietitians recognising its importance. Flexibility was also mentioned by one *ewba* worker who stated the importance of *'framing your agenda with whoever you want to work with, the workers, the community or whatever and getting them to see how your agenda could benefit them'* (EWBA4). That is, it is the skill of the worker to *'frame your agenda, making your agenda fit in with the situation'* (EWBA4). Consequently this worker highlighted that while you approach work with Aboriginal communities the same as any other group of people (seeing what you have that may benefit them and thinking about how) the work will look different on the ground because every group of people has different needs (EWBA4). Other *ewba* workers identified flexibility as being willing to adopt new strategies if initial plans do not work or do not suit the community (EWBA1), being willing to take indirect

routes into the community (EWBA1; EWBA6), accepting that you may not have all of your results when you want them (EWW5) and acknowledging that things happen in people's lives that require flexibility (EWW1).

Flexibility when delivering programs, such as linking a program's key messages to something else relevant for a community, was also reported as important:

> *…even though it's a very important part of life, being active and eating healthy, it needs to be tied into something that is seen as more important or delivered in a way that is not seen as a healthy eating and physical activity programme...[ ]…So you can cook healthy food and talk about healthy food but it's because you've gone out and you've gone bushwalking and you've established that connection with land and then you've identified bush foods and then you've used things like mushrooms or wattle seed or whatever in the food that you're preparing and then you can have the conversation about well this is healthy because, so it's seeing the bigger context…(EWBA5)*

This type of approach acknowledges that healthy eating and physical activity are not a priority for everyone and connecting these to other things that are a priority for people is important.

8.3.10. Humility, honesty and persistence

Humility was seen as important by White health professionals and it was described as acknowledging that you can learn from Aboriginal people (EWBA5) and not assuming that you know anything that they do not know already (EWW5). Part of being humble is accepting that it is okay to make mistakes (EWBA5; EWW1), being *'prepared to be told off sometimes'* (EWW3) and then getting on with it again afterwards (EWW5). Similarly, showing you are serious and genuine about working in Aboriginal health was perceived to be important (EWBA4). For example, one worker commented that, *'most Aboriginal people in my experience can very quickly tell if somebody is genuine and interested in understanding them'* (EWW4).

Honesty and persistence were also considered elements of ideal practice by *ewba* staff and experienced White workers (EWBA5; EWW1). Honesty was described as being upfront about what you can achieve (EWBA2), being open and honest in general (EWBA4; EWBA5; EWW2), being honest about not understanding things (EWW4) and not making promises that you cannot keep, to ensure that you can deliver on what you say you will (EWW7).

8.3.11. Reciprocity

Participating in two-way learning, or reciprocity, was seen as important to Aboriginal workers:

> *…it is just constant with these sorts of things [being asked to do things e.g. survey] and you don't ever hear anything back, do you know what I mean? Like you think I did my part there but you don't even get anything back. (AW2)*

This was reiterated by some of the White workers who acknowledged that Aboriginal Health Workers *'sometimes feel a little bit overused and it is really about giving something back and being able to show benefit for the workers in the communities'* (EWBA2).

Additionally, most dietitians demonstrated an understanding of reciprocity. It was understood generally as a process that enables two-way, or both ways, learning. It was seen by dietitians as something that was mutually beneficial to both parties involved (in this case the dietitian and the Aboriginal clients/ community) and demonstrated working in partnership.

> *…there's learning on both sides so they give you something and then you give them something. (DN8)*

Dietitians with more experience understood reciprocity to be more about ensuring that as a practitioner, one provides the community what they want in the way that they want, and only then does one expect to get anything back. However, some dietitians, generally those with less experience, felt that by imparting dietetic knowledge as part of their job, they were doing enough in terms of reciprocity. Consequently they saw reciprocity as a process by which they could learn from Aboriginal people without doing anything extra. Some participants asked me to provide a definition of reciprocity, in which case I gave an example from my research or referred to one of the common ways it is described such as "two-way learning" or "giving back in return for getting something such as knowledge".

Without being prompted to discuss reciprocity, some dietitians raised instances in their practice where reciprocity had been an important component, demonstrating the importance of this concept to their work. However, they did not refer to the concept as "reciprocity"; rather they referred to actions which I understood to represent reciprocity. One dietitian talked about how she opened up her home regularly for a community get-together when the community health centre was not seen as a safe place by the Aboriginal community for these get-togethers (DN1). Another

discussed the benefits of aligning yourself with an Aboriginal health worker because they *'generally are quite established in their community and have a good understanding of where things are at'* and as a dietitian you can *'support them as well in their own quest for general information'* (DN6). One dietitian talked about sharing things about herself, that she would not normally share with clients, before expecting Aboriginal people to share things about themselves (DN4). Another dietitian talked about two-way learning in relation to learning about Aboriginal history in order to demonstrate her willingness to learn (DN14).

When prompted to discuss reciprocity, some other examples of its use were shared. These included putting on a lunch in return for Aboriginal people coming to their nutrition event (DN15), spending time at a local community event to help out even though it was not directly related to nutrition (DN19), taking up opportunities, when invited, to share something about herself or be involved in an event (DN6), helping with tasks such as collecting bush tucker (DN1), co-presenting at a conference with an Aboriginal Community Education Officer[18] (ACEO) (DN1) and working with a community group to build up their skills in an area they have an interest so that when you leave, you have left something behind that the community can use (DN9).

8.3.12. Reflection

Reflection was not addressed extensively by White workers. However, dietitians with extensive experience and experienced White workers spoke of the usefulness of reflection as a strategy without being prompted (DN 9; DN 6; DN 20; EWW2; EWW3; EWW5). They identified that reflection enabled review of work practices, and sharing of information with other professionals, which made their job easier. Two dietitians (DN6 & DN9) specifically mentioned the role of debriefing, as a useful strategy that they have used or would like to use more often. Dietitians with less experience did not make any comment about reflection. Despite referring to it as reflection, some dietitians highlighted that they actually engaged in reflexivity through discussing examples of how they had altered their practice based on a reflection.

[18] New name for Aboriginal Education Workers (AEWs), previously defined

8.4. *Chapter Summary*

In this chapter, I described the *ewba* Community Programs as an example of how a mainstream CBOPI has engaged with two Aboriginal communities. In doing so, I provided a detailed discussion about the consultation and intervention elements of the program. I also considered the awareness of *ewba* of Aboriginal staff and the perceived accessibility and impact from the point of view of Aboriginal workers and *ewba* staff. Data from interviews about the case of *ewba* suggested that the following were important when delivering CBOPI to Aboriginal communities: relationships, organisational ethos, target group not limited, respectful of Aboriginal concepts of family and community and the community can be relatively easily identified.

As previously identified, there is a lack of evidence about best practice for community-based OP in Aboriginal communities in Australia and overseas. A number of strategies used by similar programs with Aboriginal communities were identified in Section 3.4 and Table 3.5. For example, working in partnership with communities and Elders, (Caballero, Clay et al. 2003; Paradis, Levesque et al. 2005; LaRowe, Wubben et al. 2007), integrating Aboriginal ways of learning or knowing (Daniel, Green et al. 1999; Caballero, Clay et al. 2003; Paradis, Levesque et al. 2005; Saksvig, Gittelsohn et al. 2005; LaRowe, Wubben et al. 2007), developing and using culturally specific tools (Caballero, Clay et al. 2003), differential funding, employment of Indigenous staff and consideration of the cultural safety of participants (Trindall and Bell 2008). Such information may be used by future programs in South Australia looking to reach Aboriginal communities, or other CBOPIs.

Ewba did not engage in the majority of strategies used by these programs to be regardful of Aboriginal peoples' and communities' needs and preferences. In all fairness, *ewba* was not designed specifically for Aboriginal participants. However, this research encourages consideration of whether it is (a) worthwhile and (b) ethical to deliver a program where Aboriginal people are part of the target group, without developing specific strategies to ensure the needs and preferences of Aboriginal peoples and communities are regarded. While *ewba* appeared to have an impact and was well received in Community A, this was largely due to the characteristics and approaches of individual *ewba* workers who happened to have the skills and abilities to work well with this group and who naturally engaged in some of the strategies reviewed that consider Aboriginal peoples' needs and preferences. This demonstrates the importance of employing White health professionals with good skills and approaches to Aboriginal health. Therefore it would

follow that to ensure a program is suitable for Aboriginal participants, specific strategies are developed to ensure the program is regardful of Aboriginal peoples' and communities' needs, or employment of workers with a good understanding of these strategies. Similarly, the factors that ensure ethical research with Aboriginal communities are outlined in Section 6.2. These include the NHMRC principles of reciprocity, respect, equality, responsibility, survival and protection and spirit and integrity (NHMRC 2003). It would seem that at a minimum, programs in Australia working with Aboriginal communities should be required to demonstrate how their program meets these principles.

In this chapter, I also presented ideas from Aboriginal and White workers about what makes "ideal practice" when White health professionals work in Aboriginal health. Elements of ideal practice identified included: working with AHWs, using appropriate processes, relinquishing control, having an awareness of Aboriginal history, communication, commitment, cultural awareness, flexibility, humility, honesty and persistence, reciprocity and reflexivity. These findings support previous research into the practice of health professionals with Aboriginal communities. For example, working in partnership with Aboriginal people has been stressed by multiple authors (Watts and Carlson 2002; Read 2006; Blackman 2009; Macaulay 2009; Smith 2010; Bennett, Zubrzycki et al. 2011; Stedman and Thomas 2011), as has flexibility (Thomas, Gray et al. 2011). The importance of getting to know an Aboriginal person first before direct questioning or "getting down to business" was also identified in the literature (Watts and Carlson 2002; Bennett, Zubrzycki et al. 2011) as was the importance of considering a person's context when working with them (Stedman and Thomas 2011). Valuing and incorporating Aboriginal expertise has been previously cited as a beneficial strategy (Smith 2010; Bennett, Zubrzycki et al. 2011).

The importance of relationships cannot be stressed enough. This was identified by the majority of workers interviewed (Aboriginal and White) and was also crucial to the success of my own research (Chapter 7). Relationship building is cited as a fundamental element of working in Aboriginal health (Bennett, Zubrzycki et al. 2011; Thomas, Gray et al. 2011). Similarly, reciprocity was crucial to the success of my research and enabled me to develop trust, maintain relationships and gain a greater understanding of Aboriginal people and issues. It also enabled me to undertake ethical research by giving back to the communities I was working with. Few of the dietitians and experienced White workers interviewed identified reciprocity as important to practice, suggesting it is not a well-known strategy, especially amongst those with less

experience. However, reciprocity has been identified as an effective strategy for working with Aboriginal communities in other literature (Bennett, Zubrzycki et al. 2011; Thomas, Gray et al. 2011).

As demonstrated in Chapter 7, reflexivity was crucial to the development of my skills as a dietitian-researcher in Aboriginal health. Like reciprocity, reflection and/ or reflexivity were mentioned only by experienced dietitians and workers, suggesting that those with less experience are not aware of its usefulness or do not feel confident to use it. Self-reflection has been reported in the literature as an important tool for practitioners working in Aboriginal health (Bennett, Zubrzycki et al. 2011; Stedman and Thomas 2011). Considering the benefits of reciprocity and reflexivity demonstrated through this research and supported by other research, it is important that White health professionals are educated and trained in the benefits of these two techniques, especially when working in Aboriginal health.

Ideas about ideal practice with Aboriginal communities were greater in White health professionals who were exposed more to Aboriginal people. For example, *ewba* workers in Community A compared with those in Community B. This suggests the importance of exposure to the area of Aboriginal health in order to increase understanding and develop strategies to work in it. In general, it is acknowledged that skills required to work in this area are 'not radically different from those generally required for practice' (Weaver 1999, p. 221). For example, communication skills, problem solving skills, the ability to listen and tolerate silence, patience (Weaver 1999) and the need to avoid trying to 'do good', unless this 'good' is defined in Aboriginal people's terms (Henry, Houston et al. 2004). However, it is clear that an understanding of the importance of these skills follows from exposure to the area.

There are other guidelines for best practice that exist and are relevant to this research. Strategies for dietitians to address racial and ethnic health disparities have been identified (American Dietetic Association 2011) while practice guidelines for working with Aboriginal people exist (Smylie 2000). For example, dietitians are encouraged to become knowledgeable about different food patterns, perform a cultural assessment, include participation from the target population, collaborate with community partners and work with health workers to assist clients in navigating the health and social services (American Dietetic Association 2011). Similarly, Smylie (2000) encourages health professionals to work proactively with Aboriginal people to address gaps in health care and deliver

care that is culturally appropriate, work with staff who can advocate for Aboriginal people, recognise the importance of family and community to Aboriginal people and respect traditional Aboriginal knowledge and approaches to health care. Some of these suggestions about best practice in Aboriginal health were identified by participants in this research, such as the importance of working in partnership with Aboriginal people.

9. Aboriginal Health as a System Part 1: The Organisation

The previous chapter identified that the majority of White health professionals interviewed have ideas about what constitutes ideal practice in Aboriginal health. Most of the time, these ideas were supported by Aboriginal workers' views of ideal practice. However, it is clear from the example of *ewba,* and participant interviews, that White health professionals do not always engage in ideal practice. If they theoretically have the agency to do so, then why is this ideal practice rarely achieved? This question is considered in the next three chapters.

As defined in Chapter 5, Giddens describes systems as activities of human agents situated in various contexts that are reproduced across time and space. Importantly, systems consist of relations between agents, meaning that agents are vital parts of systems. For the purposes of this research, "Aboriginal health in South Australia" can be considered a system. (described in Section 5.4.2). This research identified that within this larger system of Aboriginal health, there are smaller systems including the organisation, profession and individual (Section 5.4.2) (Figure 9.1).

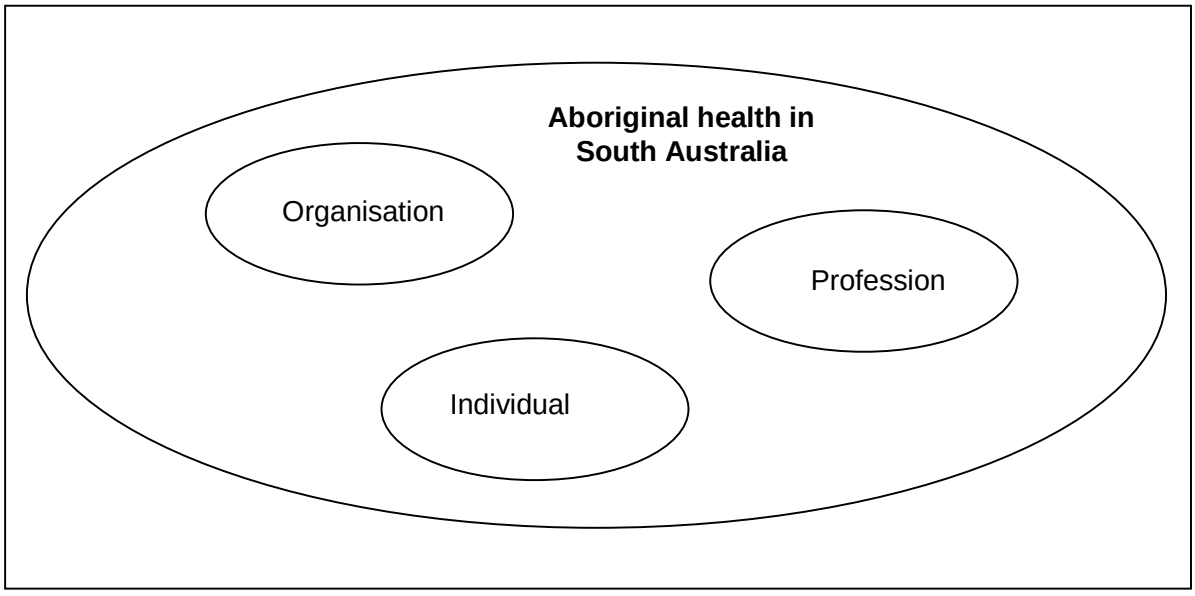

Figure 9.1: Aboriginal health as a system in South Australia, and the three systems that exist within it identified from this research

Figure 9.1 demonstrates that the individual, profession within which an individual sits, and the organisation in which they work are systems within this larger system of Aboriginal health. The

individual, profession and organisation can each be considered independent systems because I identified from interviews that in each of these areas, rules and resources exist that can either help or hinder wider action, in this case practice of White health professionals with Aboriginal people. As described in Chapter 5, rules and resources are structures within systems that can either constrain or enable the actions of agents. Therefore, by identifying the organisation, profession and individual as systems within this research, I am able to explore, within each system, factors that constrain or enable agent's action (practice), as well as how within those systems, agents contribute to, and maintain/ perpetuate the system. Therefore, this chapter and the next explore those systems which sit within the larger system of Aboriginal health – the organisation, the profession and the individual.

In this chapter, I present elements at the organisational level identified through semi-structured interviews with Aboriginal workers, *ewba* staff, dietitians and experienced White workers to enable or constrain the practice of White health professionals in Aboriginal health. In the next chapter, I consider elements at the professional and individual level that do the same. This is in line with a critical theoretical approach which advocates for identifying and challenging oppressive structures (including factors which may constrain good practice).

In this and the next chapter, I commonly present results from different groups interviewed (*ewba* staff, dietitians and experienced White workers) simultaneously. When this occurs, the group I am referring to is usually evident through the identifier in brackets – for example (DN6). If not clearly evident, I explicitly state which group I am referring to. Where relevant, I also consider the views of Aboriginal workers interviewed. Aboriginal workers provide unique insights into the barriers and enablers for working in Aboriginal health and therefore this data are used to provide insight, which invariably contributed to a greater understanding.

9.1. *Summary of organisational factors*

A summary of the factors within the organisation as a system identified to influence the practice of White workers (dietitians, *ewba* staff and experienced White workers), either by enabling or constraining it, is presented in Table 9.1. The four main areas identified were organisational culture, organisational support, accessibility of health services and higher level decisions. These are rules and resources because they are things agents draw on when acting (doing their job) within the particular system of the organisation. They also have the potential to constrain or

enable practice, as identified in this chapter. Table 9.1 also identifies which groups of workers identified each factor as important. Similar to Chapter 8, not all groups of workers commented on all issues. In this case, that was because participants were asked an open question about what constrained and what enabled their practice in Aboriginal health.

Table 9.1: Summary of factors within the organisation as a system that influence the practice of White health professionals with Aboriginal people, and which groups of participants identified these factors in interviews

Organisational factor	Aboriginal workers	*Ewba* staff	Dietitians	Experienced White workers
1. Organisational culture				
Expectation that Aboriginal and White staff would work together		√	√	√
Unforeseen events		√		
Cultural training for staff		√		√
Aboriginal specific positions		√		√
Support for Aboriginal staff	√			√
Operate in silos	√			
Higher level coordination			√	
Tokenism	√	√	√	√
Staff turnover	√	√	√	
2. Organisational support				
Management support		√	√	√
3. Accessibility of health services				
Flexibility of health services	√	√	√	√
Welcoming to Aboriginal people	√		√	√
4. The wider mainstream health system				
Statistics/ reporting			√	
The impact of higher level decisions		√		

9.2. *Organisational culture*

Organisational culture refers to those resources and/ or attitudes within organisations that enable or constrain White workers to work well with Aboriginal people. The elements of organisational culture identified by participants are presented in Table 9.1, and expanded upon below.

9.2.1. An expectation that Aboriginal and White staff would work together

Experienced White workers felt enabled to work with Aboriginal people when their organisation had an ethos or an expectation that they would work with Aboriginal people (EWW2). This included having spaces or groups where Aboriginal and White people could come together, work together and share stories with each other (EWW3; EWW5; EWW7), such as the working together group in Community A. Similarly, one dietitian highlighted that unless an organisation is committed to addressing Aboriginal health, then committed individuals who work within those organisations will find it difficult (DN5).

Specific experiences from ewba

The importance of providing an organisational culture where Aboriginal and White staff work together was also demonstrated within *ewba.* As reported by *ewba* workers, health services in Community A and B had different expectations about Aboriginal and White staff working together. Those who had worked in Community A identified that working more closely with the Aboriginal community was a natural part of working at the health service that surrounded it:

> *…obviously being in the [Community A Health Service] there's a very strong, good Aboriginal Health Team there, you know it is very public in its….[ ]…commitment towards working with Aboriginal people. When you walk in there's those posters about invasion and that sort of stuff and there's groups like [working together group] so it is very obvious that you need to be working with the Aboriginal Community when you are in Community A (EWBA4)*

The very nature of Community A (rural, high Aboriginal population) meant that '*it was a given that at some point in time there would be some liaison with the Aboriginal community'* (EWBA1). The Aboriginal community was relatively easily identified, and it would be very difficult to avoid working with them (EWBA5). However in Community B, the Aboriginal community were more hidden and *'it [would not] be as noticeable if you didn't access Aboriginal people'* (EWBA5).

Workers reported that in Community B, a culture of Aboriginal and White people working together was less present than in Community A. These workers were able to make comparisons across the two sites because they had worked in both of them. One worker identified that *'personality issues and a wariness towards the project in Community B'* (EWBA2) contributed to this, while another described:

> *[In Community A there is] not that stigma about working alongside White people, it is encouraged and, you know, there is integration (EWBA6).*

Overall, *ewba* workers thought that the greater culture of working together in Community A contributed to the more extensive relationships that developed there between White *ewba* staff and Aboriginal workers, which supports data from other White workers about the importance of working together as an element of organisational culture.

9.2.2. Unforeseen Events

Following on from organisational culture, *ewba* workers in Community B identified that unforeseen events at local organisations inhibited the formation of relationships between Aboriginal and White people. *Ewba* workers felt that there were a number of set-backs and a *'series of unfortunate events'* (EWBA1) in Community B that prevented them from working well with Aboriginal people in that community. The loss of a key Aboriginal worker and the closing of the Aboriginal Community Centre occurred at the beginning of *ewba* at the start of 2006. Many of the *ewba* interventions with the Aboriginal community were planned around this community centre. When the key worker left, *'there was no-one to take over the centre…[ ]…and everything that was kind of linked with it fell apart'* (EWBA6). The *ewba* staff identified that with the loss of this centre came the loss of the structures and the mechanisms needed to *'make things work'* (EWBA6; EWBA7).

While some *ewba* staff focussed in-depth on these unfortunate events as reason for challenges experienced in Community B, another worker reflected on the relationship between *ewba* and the Aboriginal health team:

….unfortunately we haven't been able to create any professional or personal relationships with Aboriginal Health Team. In my opinion, to get to the community you have to go through the team, the Health Team because they have access to the community and if you don't have a working relationship with the team you're not going to access the community. (EWBA3)

These points highlight how events can influence relationships, and lack of relationships can impact on program delivery.

9.2.3. Cultural training for staff

Experienced White workers and *ewba* staff highlighted the importance of cultural awareness training which helps to create awareness and challenge some of the myths about Aboriginal people in popular culture (EWBA2; EWW7). Conversely, not providing cultural awareness training was seen to constrain good practice with the Aboriginal community (EWW3; EWW5). One worker explained why this training is important and worth fighting for:

…non-Aboriginal people think that Aboriginal people are a problem and they kind of pathologise it as if Aboriginality in itself is going to give you worse health and they blame Aboriginal people for that and say things like "well, if only they'd come in here" or "if only they'd stop smoking" or "if only they'd eat properly." And it's with such judgement that it's frightening and that's one of the reasons why I will do everything I can to make sure that cultural awareness training, including an understanding of White privilege and dominant culture, is undertaken by every staff member on the health site. That's what I want and that's what I've been working towards for some years. It is very, very hard to accomplish that but I'm not going to stop trying because I don't think people can fundamentally change, I don't think non-Aboriginal people can change, until they're given the information. (EWW5)

Aboriginal workers expressed similar ideas about the importance of cultural training for non-Aboriginal staff (Section 8.3.8).

9.2.4. Aboriginal specific positions

The existence of Aboriginal specific health promotion positions was seen as beneficial by experienced White workers. At one organisation in Community A, one such position enabled a number of strategies to be developed and actioned by a group of Aboriginal and non-Aboriginal people working together (EWW5). One White worker discussed how it was not appropriate for her

to do some activities, such as chair a committee to organise National Aborigines and Islanders Day Observance Committee (NAIDOC) week activities, as she is not Aboriginal (EWW5). Aboriginal specific positions were also thought to enable the practice of White health professionals by providing a key contact person within an Aboriginal health team whose business is primary health care (EWBA2; EWW6) which creates more opportunity to work in partnership (EWW5).

9.2.5. Support for Aboriginal staff

Experienced White workers identified that providing support for Aboriginal workers is important. For example *'it is actually really hard work as a[n Aboriginal] worker to stay in that environment so we have to create a system in which we support workers to make sense of what's happening to them'* (EWW3). Similarly, one Aboriginal worker discussed that organisations could enhance their ability to work well with the Aboriginal community by first ensuring that their Aboriginal staff were happy and in a position to support each other (AW8).

9.2.6. Operate in silos

Aboriginal workers reported that mainstream organisations encourage people to work in defined work roles, which can lead to a tendency to operate in "silos" which can inhibit relationship building and working in partnership (AW7). This can lead to Aboriginal health being perceived only as Aboriginal health team business, leading to Aboriginal Health Workers becoming inundated with work (AW7). This may constrain effective relationships and action between Aboriginal and White workers.

9.2.7. Lack of higher level coordination

Dietitians identified a lack of coordination of services at the higher health system level despite the Close the Gap initiative (Section 2.2.6) (DN6). This lack of coordination has similar effects to working in silos, whereby programs are repeated and prominent, visible Aboriginal people in the community (such as Aboriginal health teams) are approached by multiple people with multiple requests, including for consultation. A number of dietitians suggested that to overcome this, there needs to be *'a focus of working with Aboriginal people as core business in all settings'* (DN8) in *'health related disciplines and education and finance and right across the board'* (DN6).

9.2.8. Tokenism

White and Aboriginal workers discussed several levels of tokenism they perceived to exist within mainstream organisations and how this impacted negatively on their capacity or the organisation's

capacity to work well with Aboriginal people. Tokenism was mentioned in terms of policy, management and meeting procedure.

With regards to policy, one experienced worker identified tokenism when organisational policies for cultural respect and accountability exist but are not reflected in practice (EWW4). An Aboriginal worker identified that policy may also be considered tokenistic if it says what needs to be achieved in Aboriginal health but does not say how this is to be achieved (AW7). Similarly, while organisations may have policies regarding participation in cultural awareness training, one worker identified that this training may be perceived as tokenistic if delivered in isolation. For example, this training is *'only a small part of the picture'* (EWW4). Policies in mainstream may not adequately address the cultural needs of Aboriginal employees, making it difficult for Aboriginal people to continue working and meet their cultural obligations. For example bereavement leave arrangements, where

> *...we [Aboriginal workers] have got no rights per se in the HR [human resources] manual around leaving or working with community at sorry times' and 'policy says you can only take bereavement leave or compassionate leave if it is direct kin like brother, sister, mother, father (AW7).*

At the level of management, *ewba* staff and dietitians highlighted that management input was often perceived as tokenistic, particularly by the Aboriginal community:

> *At [community event], for example, this doesn't involve me but the [Aboriginal health] manager there was quite critical that they saw that it was tokenistic because the director [of the health service] only rocked up for like 45 minutes and they are very vocal usually about the fact that Aboriginal health is so important at [location] but they were only there for 45 minutes for a whole day event, missed the whole Welcome to Country and stuff which is very important to them. (EWBA4)*

Dietitians reported that some managers appeared to be '*very pro, 'let's put Aboriginal health first, let's make it a priority'* (DN17) on the surface, but they tended to have very a limited understanding of the practicalities of working in Aboriginal health or the time and long-term commitment needed to do it well. This lack of understanding from managers resulted in pressure on dietitians who were expected to produce outcomes more quickly.

Some actions in meetings were also perceived to be tokenistic by dietitians, such as acknowledging Aboriginal land at the start of a meeting or in meeting minutes, in a manner that portrayed apparent lack of passion or true organisational commitment (DN7; DN14; DN17). This highlights the importance of acknowledging the core values and messages represented by these gestures, but that to ensure their intended purpose and to demonstrate respect they need to be delivered with feeling.

9.2.9. Staff turnover

Dietitians reported that staff turnover was a barrier to good practice in Aboriginal health, particularly in rural and remote areas where high staff turnover is common, because it creates a sense of mistrust and resistance between the health service and Aboriginal workers/ community.

> *Aboriginal Communities have had different non-indigenous people coming in over the years and not trusting what they are actually about and having no time to build that trust. (DN14)*

A high turnover of Aboriginal health staff was also identified as difficult for White health professionals because it can disrupt established relationships between workers (DN3; EWBA6).

Staff turnover issues specific to ewba

The issue of staff turnover was explored in-depth by *ewba* staff and Aboriginal workers involved in *ewba*. Aboriginal workers in Community A stressed the importance of continuity of staff and programs. They reported that the large changeover of *ewba* staff that occurred in Community A was confusing for the community (AW7). This was acknowledged by *ewba* workers who reported that staff turnover was '*an impediment along the way with developing relationships',* particularly with the Aboriginal community (EWBA2).

Ewba workers became frustrated when they built a good relationship with a key Aboriginal worker whom they described as a *'champion'* (EWBA1; EWBA6) and then this person moved on. In the early stages of *ewba* in Community A, there were *'a lot of changes in leadership and a lot of movement of staff at that time and that lack of stability really restricted us in terms of what we could do with the Aboriginal Health Team'* (EWBA1). Similarly in Community B, all the *ewba* workers commented that turnover of staff within the Aboriginal Health Team, specifically loss of those *'key staff who were really interested in engaging with the project'* (EWBA2), impacted

significantly on their work. One worker reflected on the loss of a worker she had built a relationship with:

> *…when she left it [the work] kind of fell apart and so because I didn't have a relationship with any of the other health workers I wasn't able to work with the community through the health centre…[ ]…I was unable to make any progress with the Aboriginal Health Team once that particular worker had gone…(EWBA3)*

Similarly, there was the loss of another worker early on in the project who was involved with Aboriginal youth in Community B. From *ewba's* point of view, the loss of this worker meant that *'we no longer had access to Aboriginal youth'* (EWBA6; EWBA7). These particular scenarios highlight the value of working with multiple workers within an Aboriginal Health Team and the need to be prepared to look elsewhere to engage new workers in novel ways.

9.3. *Organisational support*

Organisational support refers to the support that is or is not available within organisations for White health professionals to work with Aboriginal people.

9.3.1. Higher level and management support

All types of White workers interviewed identified the importance of support from managers and higher level health service staff. For example, having an Executive Director of Aboriginal Health was seen as an enabling factor because it demonstrated a real commitment to Aboriginal health (EWW3). Similarly, a supportive manager, in particular one who would lead by example, was seen as an enabler (EWBA3; EWBA4; EWW2). This idea was explored in greater detail by dietitians, who consistently referred to their organisation and management as crucial elements in determining whether or not they were successful in working with Aboriginal people. It was acknowledged by dietitians that unless they had a supportive manager who was aware of the issues and challenges of working with Aboriginal communities, they would struggle to do the work. For example, one dietitian talked about her manager who was very supportive, and encouraged the use of a community development approach (DN5). This manager was aware that relationship building was a necessary precursor to achieving health outcomes.

In contrast to the reports of supportive managers, there were also reports of non-supportive managers. For example, one dietitian talked about her manager who she did not see was

supportive of her work in Aboriginal health. This dietitian was required to visit Aboriginal people in a bus that acted as a *'mobile health clinic'* (DN10). This is still a somewhat clinical approach and she highlighted that *'there will be days when you go and you will see two people'*. Instead of supporting the development of alternative strategies, this approach continued to be advocated by the manager. However, it is important to highlight that often managers are constrained by organisations which impose specific approaches. What is evident from this and the discussion about supportive organisational culture (Section 9.2) is that within the restraints of the common mainstream culture, there are supportive managers and there are organisations that consider alternative approaches.

9.4. *Accessibility of health services*

Accessibility of health services refers to how easy it is for Aboriginal people to access health services. The elements of accessibility of health services identified by participants are presented in Table 9.1, and expanded upon below.

9.4.1. Welcoming to Aboriginal people

Having physical spaces that were welcoming to Aboriginal people was seen as an enabler to good practice by all types of White workers interviewed. One participant talked about how the health service in a rural area was not utilised by Aboriginal people because they did not feel comfortable using it (DN1). At one stage there were no AHWs but over time changes have been made, for example planting Indigenous plants in the garden, and it is now a positive place for Aboriginal people (DN1). This was reiterated by another dietitian, working in an Aboriginal community controlled health service who stated that this health service had '*designated resources and space for the Aboriginal community, for the Aboriginal community to have a sense of community ownership over the services run largely by Aboriginal people completely for Aboriginal people'* (DN6). Another worker highlighted the importance of an organisation providing welcoming spaces for Aboriginal people (EWW1), including appropriate spaces for health workers and community members (EWW3), which demonstrates that an organisation values its Aboriginal workers and community members (EWW3).

These points were reiterated by Aboriginal workers, who identified that mainstream services are often not Aboriginal friendly, which can deter Aboriginal people from accessing them. For example, services might be highly clinical, and there *'are no Aboriginal faces in the organisations'*

(AW2). Previous experiences Aboriginal people have had with racism within a service may also deter access:

> *…there are still services that we don't use and ones that we will send people to and ones that we won't because of our own experiences there or we've heard things about racism and things like that, you know. (AW2)*

These factors demonstrate the importance of an organisation being Aboriginal friendly.

9.4.2. Flexibility of health services

Dietitians who had worked in both Aboriginal community controlled services and mainstream services highlighted the differences between, and opportunities within, both settings. One dietitian felt that community controlled services had more *'fluid boundaries'* (DN6) which makes them easier for Aboriginal people to access, such as the organisation being willing to treat Aboriginal people even if they are from another geographical area.

Similarly, Aboriginal workers identified the structured nature of mainstream health services, such as *'strict appointment times [where] if you don't turn up right on time, if you're five or ten minutes late well you have to reschedule'* (AW2), as a barrier. Such structure does not acknowledge the fact that Aboriginal people may struggle to make appointments for many reasons, including a lack of transport or other, cultural priorities and commitments such as funerals (AW2). Such reasons for cancellations of appointments are not reflected in health service statistics which just mark an incidence of non-attendance as "did not attend" (DN19).

Frustration with this inflexible structure was reiterated by *ewba* staff and experienced White workers who identified difficulties in working with Aboriginal people when the health system is set up around *'non-Indigenous work rules'* such as *'schedules and working to schedules and [statistics] and that sort of stuff*' (EWW1). Within this health system there are *'objectives that we need to meet'* (EWBA4) and in general, systems and programs are set up to target and reach the dominant culture because they are the easiest to access and the most likely to take up the messages and therefore show a positive outcome (EWBA5). This was demonstrated by one dietitian:

> *Our health system isn't almost set up to be able to have that flexibility with Aboriginal health in general….we're trying to get them to fit into our world, we're not adjusting to fit into their world…(DN8)*

Furthermore, dietitians reported that generally, Aboriginal health teams and services had different expectations and approaches to mainstream organisations, which made it difficult to work together. For example one dietitian was directed to provide one-to-one consultations with Aboriginal people, by a mainstream organisation, but she was used to working from a more comprehensive primary health care approach when working with Aboriginal people (DN9).

9.5. *The wider mainstream health system*

It is important to indicate that organisations are part of the wider health system. Therefore, policies and practices that occur in this wider system are likely to have an impact at the level of the organisation. In this section, I refer to factors at the level of the wider health system, identified by participants in interviews to directly impact at the organisational level and ultimately on their practice as White health professionals. The elements of the wider mainstream health system identified by participants are presented in Table 9.1, and expanded upon below.

9.5.1. Statistics/ reporting

Many dietitians were concerned about statistics being the measure against which their practice is assessed. It was acknowledged that much of the effort and time required to work well with Aboriginal people, such as building relationships, is not reflected or recordable in current statistical accounts, which are used to measure services provided within Government health services. Therefore they identified the importance of having a manager who values these activities and can see past the fact that initially when working with Aboriginal people, very little will be reflected in statistics. One dietitian who had worked in a management role suggested the following approach:

> *I think that if you're starting something new you'd really want to be upfront in negotiating with your manager and saying well you want to do this but it is going be done developmentally, you are not going to see next month that the Aboriginal people in the stats, that's not going to happen and give me a time line of at least a year before you are asking for major things to have happened. (DN3)*

Being able to record activities like relationship building in statistical accounts would likely assist in identifying the importance of such activities and consequently White health professionals incorporating them into their practice.

9.5.2. The impact of higher level decisions

The following discussion demonstrates how the geographical site of Community B, selected as one site for delivery of *ewba,* did not provide a meaningful boundary for the purposes of identifying and working with the surrounding Aboriginal community. *Ewba* workers perceived this as a significant factor in constraining their practice with Aboriginal people in Community B. This example of *ewba* is important in demonstrating that decisions made at a higher level, with regards to selecting sites for programs, can seriously affect the practice of White workers with Aboriginal people.

The intervention site of Community B was a suburb within a larger local government area in metropolitan Adelaide. The Aboriginal community was not defined by the chosen suburb but encompassed a much larger suburban area. In particular, the choice of Community B posed a challenge for implementation of the *ewba* program, suggesting that choice of site is an important factor when considering what level of contact with the Aboriginal community is desired. For example, it was difficult for *ewba* to engage with the local Aboriginal health team because this team had a mandate to serve an area much wider than the suburb of Community B. In fact, during the initial consultation this team told ewba that *'the program was not suitable for the Aboriginal community if it was only going to be for the Community B area'* (AW5). However, the communities had already been chosen and higher level management had not foreseen this as a difficulty when planning the project. This situation highlights the need to consult Aboriginal communities before crucial decisions such as site selection are made.

In addition, *ewba* workers found it difficult to engage and work with a range of other agencies who, like the Aboriginal health team, served a wider target group than Community B. As stated by one *ewba* worker:

> *…the issue here is our identification of Community B and this has come up quite a bit in terms of our project having borders around Community B and Aboriginal Community here not having those borders…[ ]…It's also been an issue with other agencies and families with that sort of Community B area just because nobody really identifies us as a Community B service…[ ]…There are all sorts of reasons why Community B was chosen but it just hasn't quite matched up as well with the Community. (EWBA2)*

Finally, the number of Aboriginal people living in Community B appeared to be very small and Aboriginal people were difficult to identify and contact. *Ewba* workers talked about how they went to other agencies *'in search'* of Aboriginal families from Community B with whom to work, such as Families SA who *'looked through all of their records [but] did not have a single Aboriginal family from Community B'* (EWBA6). According to another worker,

> *the Aboriginal community was really hard just to find…[ ]…the Community B Aboriginal community, according to ABS, was very, very small, according to the Aboriginal staff here at the health service, even smaller…[ ]…they were impossible to find let alone work with, it was just like 'well who are we going to work with? We want to work with the Aboriginal community but who are they and where do we find them? (EWBA7)*

Such experiences meant that *ewba* workers tended to be disheartened about working with the Aboriginal community before they even started. Due to the difficulties experienced in locating Aboriginal community members in Community B, *ewba* staff involved stressed the importance of ensuring that any work done through schools, community groups and under-fives sites needed to be *'respectful of Aboriginal communities because that was our most likely way to catch them because they were just going to be part of the existing school system because we couldn't think how to identify them otherwise'* (EWBA7).

However, when interviewed in 2010, *ewba* workers reported that over time they began to broaden the area within which they targeted Aboriginal people in Community B. That is, they took a more regional approach rather than just focussing on the one suburb. They reported this was because *'we soon realised that we were never going to be able to target only [the Aboriginal] Community B' (EWBA7).* For example, the catchment area was broadened to include an Indigenous kindergarten that was in a nearby suburb.

> *…it [kindergarten] wasn't in Community B but we knew that any families living in Community B would be accessing that service so we worked really, really closely with them and they were one of our target groups (EWBA7).*

While workers reported that in the early stages of the project *'the pressure to try and stay within those boundaries was much higher'* (EWBA7), flexibility was granted by SA Health who were content as long as the project team and the Evaluation Academic Team were happy with any

decisions that were made (EWBA7). However, the decision to move outside Community B was not considered ideal, especially for evaluation purposes as the local Indigenous kindergarten was in a suburb that was acting as an evaluation comparison site for *ewba*. From interviews, informal discussions with *ewba* staff, and my own observations it appears that discussions about broadening the boundaries of Community B began soon after difficulties with engaging the Aboriginal community were experienced. However, the actual decision to broaden the area appeared to occur sometime in late 2008, after this PhD research began.

A similar but less significant situation occurred in Community A. E*wba* was limited to the rural city of Community A which included the main town and three outer-lying towns. This criteria for Community A meant that a key (outlying) Aboriginal community was excluded (EWBA5). Similarly, the 0-18 year old target group meant that key Aboriginal organisations working with a different age group could not be a site for intervention, such as an organisation that worked with Elder Aboriginal people in Community A (EWBA5).

9.6. *Chapter Summary*

In this chapter, I identified that the organisation is a system, within the larger system of Aboriginal health, that has a number of structures (rules and resources). White health professionals draw on these structures in their practice, and they can be both enabling and constraining to ideal practice with Aboriginal people. The four main areas identified to enable or constrain the practice of White health professionals within the organisation were organisational culture, organisational support, accessibility of health services and higher level decisions.

The role of the organisation, including the health system and management, in Aboriginal health practice is supported by other literature. Barriers within an organisation have been shown to constrain and influence the scope of practice of primary health care workers (Lloyd, Wise et al. 2008; Allan 2010) while organisational capacity was also shown to affect the delivery of interventions related to smoking, nutrition, alcohol and physical activity to Aboriginal clients within an Aboriginal community controlled health service (Panaretto, Coutts et al. 2010). Staff turnover was one of these organisational barriers, which was found to erode trust between health services and Aboriginal community members, prevent the development of trusting relationships between Aboriginal and White workers and impact on the delivery of interventions (Lloyd, Wise et al. 2008;

Panaretto, Coutts et al. 2010). Finally, the support of health service managers is seen to be paramount to the delivery of successful health care to Aboriginal clients (Lloyd, Wise et al. 2008).

Providing a space for Aboriginal and White people to work together in partnership at the organisational and individual level, was identified as important in this research and commonly reported in the literature as an enabling factor. Areas and examples where Indigenous and non-Indigenous people have worked in collaboration include research (Dance, Brown et al. 2004; Pyett, Waples-Crowe et al. 2008a) and program delivery (Preuss and Brown 2006; Read 2006). These partnerships were shown to enable high quality information to be accessed (Dance, Brown et al. 2004), contribute to a successful intervention to stop petrol sniffing (Preuss and Brown 2006) and contribute to securing the future of Australia as a 'healed and healthy nation' (McKean, Adams et al. 2008, p. 555). Partnerships also allow Aboriginal people to contribute to the healthcare of Aboriginal people. For example, it is common for 'discourses that shape the medical care of people of colour are occurring without the input of those directly impacted' (Burton 2007, p. 12), and partnerships between Aboriginal and White workers is one way to avoid this from happening.

Cultural training of staff was a factor at the organisational level identified in this research to constrain and/ or enable practice and these findings are supported in the literature. In creating a culturally aware workforce it is vital to consider how students, who are future practitioners, may become culturally aware. University training has been found to influence individuals in the workforce, for example Atkins and Gingras (2009) found that undergraduate dietetic education contributed to the professional identity of dietitians including their relationships with others. Recommendation 29 in the "Health is Life: Report on the Inquiry into Indigenous Health" report (Commonwealth of Australia 2000, p. xxiii) stated that:

> *Within two years, all undergraduate and post-graduate health science courses should include an effective cross cultural awareness component, as well as dealing in detail with the current health status of Indigenous Australians and the factors which have contributed to their ongoing social and cultural disadvantage. All continuing medical education courses should also expand on these matters and continue to expose health professionals to cross-cultural learning.*

While health courses at universities do tend to have objectives about cultural competence and/ or training, students generally do not get the opportunity to apply theoretical concepts in an

environment where cultural issues will impact on delivery of these concepts (Cunningham and Wollin 1997). This was identified in this research by the lack of White interviewees who had the opportunity for practical placement that exposed them to Aboriginal health. Providing clinical placement/s training to student nurses in Aboriginal communities was shown to assist in the development of cross-cultural skills, increase students' awareness of Aboriginal health status, socio-cultural and historical influences and the nurse's role in Aboriginal health (Cunningham and Wollin 1997).

It is recognised that there are many complex areas that need to be covered in university courses, and that the curriculum of many courses is already overcrowded (Cunningham and Wollin 1997; Commonwealth of Australia 2000). Similarly, depending on the setting of a health service, there may be multiple groups with high needs, including Aboriginal people and/ or refugees, CALD people, people of low socioeconomic status, disabled people and others who are marginalised. Therefore it may be difficult for a health service to prioritise Aboriginal health when there are multiple groups that need attention. However, in the words of one of my participants,

> *I know that there are competing factors in the curriculum and things but if there has to be anything, any sort of specific information shared, it should be around, I believe our Indigenous community. (DN6)*

This is reinforced in the literature, by an Aboriginal author:

> *...if Indigenous health issues were of major concern and Indigenous people were considered of worth, training and education would be provided and curricula would be changed to reflect content that is seriously attempting to address Indigenous health issues. Indigenous people would be included in curriculum development and education in ways in which Indigenous people could participate fully and be valued (Fredericks 2006, p. 94).*

Aboriginal people are the First Peoples of this country and including specific information about working with this group is a sign of respect and a way to avoid perpetuating colonising practice.

10. Aboriginal health as a system Part 2: The profession and the individual

In this chapter, I present the profession and individual as systems within the larger system of Aboriginal health (Figure 9.1). I consider the rules and resources (structures) within these systems that constrain or enable the practice of White health professionals with Aboriginal people. These elements were identified through semi-structured interviews with Aboriginal workers, *ewba* staff, dietitians and experienced White workers.

10.1. *Summary of professional and individual factors*

A summary of the factors within the profession and individuals as systems identified to influence the practice of White workers (dietitians, *ewba* staff and experienced White workers), either by enabling or constraining it, are presented in Table 10.1 and Table 10.2. For professional factors, the two main areas identified were White workers' perception of their role in Aboriginal health and issues specific to dietitians as a professional group. For individual factors, the two main areas identified were personal ideology and colonisation. Personal ideology and colonisation can be considered rules and resources because they are things agents draw on when acting (doing their job) within the particular systems of the profession and individual. They also have the potential to constrain or enable practice, as identified in this chapter. Table 10.1 and Table 10.2 also identify which groups of workers identified each factor as important. As for organisational elements (Chapter 9), not all groups of workers commented on all issues. In this case, that was because participants were asked an open question about what constrained and what enabled their practice in Aboriginal health.

Table 10.1: Summary of factors within the profession as a system that influence the practice of White health professionals with Aboriginal people, and which groups of participants identified these factors in interviews

Profession factor	Aboriginal workers	*Ewba* staff	Dietitians	Experienced White workers
1. Perception of role				
Choice to focus on Aboriginal people			√	√
Broader view of role			√	√
Part of a wider mandate		√	√	
2. Dietitians as a professional group				
Characteristics			√	
The Dietitians Association of Australia			√	

Table 10.2: Summary of factors within the individual as a system that influence the practice of White health professionals with Aboriginal people, and which groups of participants identified these factors in interviews

Individual factor	Aboriginal workers	*Ewba* staff	Dietitians	Experienced White workers
1. Personal ideology				
Past experience		√	√	√
Passion & commitment				√
Awareness of limitations of knowledge		√		√
Awareness of the "reality"		√		√
Awareness of position		√		√
Confidence		√	√	
Fear			√	
2. Colonisation				
Understanding of colonisation		√	√	√
Understanding of continued impact of colonisation		√	√	√
Address colonisation through practice		√	√	√

10.2. *Professional factors*

In this section I explore ideas that White health professionals have about their professional role in Aboriginal health, and how this may enable or constrain their practice. I also explore professional factors as they relate specifically to dietitians, including characteristics of dietitians and consideration of the Dietitians Association of Australia as it relates to Aboriginal health.

10.2.1. Perception of role

The White workers interviewed had different ideas about what their role in Aboriginal health looked like. Of all of the interviewees (*ewba* staff, dietitians and experienced White workers) only one worked solely with Aboriginal people. The rest had differing levels of engagement with Aboriginal people, and one factor that affected that level of engagement was how the White worker perceived their role. The different ways that White health professionals perceived their professional roles in Aboriginal health are presented in Table 10.1, and expanded upon below.

Purposefully focussing on Aboriginal health

Some experienced White health professionals actively chose to work in Aboriginal health and went beyond the minimum or required role. Some chose to work at the strategic level as advocates to improve the state of the health system for Aboriginal people. For example, while one worker's position was to work across the whole of community, she was *'able to develop the position [and choose] to put a lot of [her] energy into progressing Aboriginal health'* (EWW5). Within her position, she worked at the broader level to attempt to make health services more Aboriginal friendly, *'advocating with people in higher positions than I am to continue to support cultural training and to prove to them the benefits of it and keep it going'* (EWW5). Similarly, another worker who worked clinically with Aboriginal clients also worked hard at the strategic level to *'ensure that our services are prioritised for Aboriginal children and their families and that there are culturally appropriate and inclusive practices for Aboriginal people and that we work really hard to reach out to Aboriginal Community members rather than saying "oh they're welcome to come in of course"'* (EWW3). Only one dietitian highlighted how she made extra effort to reach Aboriginal people through her work:

> *…even though I had a big workload I was going to make extra time and appointments to see the Aboriginal people who were on dialysis to try to do that extra bit because that's my way of trying to be part of the big picture. (DN8)*

Consequently, these workers went beyond what was required in their role to address issues of Aboriginal health at a higher level, where there was potential for a larger impact to be made, highlighting that some White workers see a need for extra effort in Aboriginal health.

Broader view of role

Experienced White workers and dietitians identified that having a broader view of their role as a professional, when working with the Aboriginal community, was useful. For example, as a dietitian, being aware that *'it is not just good enough to know about nutrition, you've got to actually understand how nutrition is relevant to the setting that you are in'* (DN2). This was reiterated by other dietitians; one reported that being a dietitian is context specific, for example *'being a dietitian at the [hospital] is going to be different to what you are if you are working in diabetes in the community'* (DN3). Another stressed the importance of tailoring what you talk about to the specific person and their situation (DN21) and this view was supported by others (DN10; DN11; DN13).

Working from a strengths-based approach and seeing yourself as a facilitator was also discussed by dietitians and experienced White workers as a suitable role (DN2; DN3; DN5; EWW2; EWW5; EWW7). For example, one worker described her role as to work with the AHWs in her team, supporting them as they saw fit and being advised by that person what she might do (EWW2). This worker saw Aboriginal workers as the *'conduit between our [Non-Aboriginal people's] expertise and the Aboriginal community'* (EWW2). Similarly, another worker saw his role as *'supporting the community with ideas that they have'* and to *'encourage them with that and connect them with other people who might be able to assist'* and to '*facilitate that process and offer some ways forward'* (EWW7). Therefore having broader ideas about the role of the health professional with Aboriginal communities is likely to enable practice.

Perception of role: part of a wider mandate

In contrast to those who actively sought to work in Aboriginal health regardless of their role, others understood their work with Aboriginal people to be part of a wider mandate to work with all people in the community. Most of the *ewba* staff described their work with Aboriginal people to be the result of a larger mandate (EWBA1; EWBA3; EWBA4; EWBA6; EWBA7). For example, one worker said that she worked with Aboriginal people because *'my role is to work with people with diabetes or at risk of developing diabetes and diabetes is such a huge problem within the Aboriginal population'* (EWBA1). Similarly, another worker was required to work with the whole

community in her position, and said that *'my work encompasses Aboriginal people because they're part of the community'* (EWBA6). *Ewba* workers saw their role to entail increasing healthy eating and physical activity within the target group of 0-18 years, and if Aboriginal people fell within this target, then so be it (EWBA1; EWBA3). This approach could be constraining in the sense that Aboriginal people were seen as another part of the wider community, rather than as a group that may have required an alternative approach or additional resources, which is a common approach when considering equity.

Similarly, one worker felt that the decision to work with Aboriginal people was not something that she was in control of. For example:

> *I work in a clinical setting where I don't see a lot of Aboriginal patients. It is not that I don't want to they just don't come through my ward. (DN15)*

This could be reflective of working in a clinical setting and in a facility servicing a population with a low proportion of Aboriginal people.

10.2.2. Dietitians as a professional group

Considering the nature of the profession as a system, and my connection to the dietetic profession, I was interested in specifically exploring dietetics as a profession. Characteristics of dietitians thought to constrain practice in Aboriginal health were commonly raised by dietitians in interviews. To add to this information, I also considered the peak professional body for dietitians in Australia, Dietitians Association of Australia (DAA), and how it might enable or constrain the practice of dietitians in Aboriginal health.

Characteristics of dietitians

Dietitians raised that as a professional group, there are certain characteristics that are common that might constrain their work with Aboriginal people. Participants felt that dietitians were, in general, high achievers, which could sometimes be a problem when working with Aboriginal people. For example, having a vision of things working in a particular way and then for whatever reason they do not (DN19). Or, in the case of a new graduate dietitian, having a set "'agenda" to cover in a session that is non-negotiable and if they do not cover everything by the end of it then they are a failure (DN3; DN21), or having the idea that there is one "right" way to do things (DN8). Working in Aboriginal health may also be challenging for dietitians who have certain ideas about what they should be doing in a day, for example:

> *So because we are normally used to being so efficient and getting this done and that done or whatever, it [working in Aboriginal health] often looks like you're not doing anything and you know, what can you say you are doing? (DN5)*

Some dietitians identified that these ideas and approaches will not result in successful work with the Aboriginal community as the dietitian needs to be flexible and re-evaluate what is delivered based on the situation (DN10, DN14).

It was acknowledged that it takes time to work well with the Aboriginal community. One dietitian reported that it took three years for her to build relationships (DN1). Due to this time required, it was identified that working with Aboriginal communities may *'seem a waste of time by really efficient workers who struggle with the concept of sitting there doing nothing while waiting'* (DN10) and that often, dietitians *'expect to have impact in a much shorter time frame'* (DN1). Some suggested that dietitians need to take a step back when working with Aboriginal communities and re-evaluate what counts as success (DN5, DN4), as well as be committed to the cause:

> *…it is kind of like, okay, everything that you learnt as a dietitian around programs and like you know getting stuff done and being assertive and you know speaking up and stuff, stop and actually like take a step back and just get to know who you are working with and then revisit some of that stuff. (DN21)*

This approach, however, requires dietitians to "let go" of many of the things they may consider important and integral to them being a "good" dietitian, and therefore involves a re-evaluation of what makes a "good" dietitian. This poses the questions: what does it mean to be a "good" dietitian in general, what does it mean to be a "good" dietitian in Aboriginal health and are the two different?

Some dietitians, with more experience in the area, questioned the notion of what it means to be "professional" in the dietetic sense. The notion of what some dietitians perceive as professional was described by one dietitian as being "removed":

> *…that slightly removed thing where I am just giving you the information that you need to get and I am not going to relate to you as a person. (DN3)*

This type of approach was not seen as useful when working with the Aboriginal community and the same dietitian went on to explore that being professional is about *'getting high quality*

outcomes with the people you want in a respectful way' rather than having a *'particular persona'* or behaving in a particular way (DN3).

Dietitians Association of Australia

It is important to consider DAA in any analysis of the dietetic profession in Australia. As outlined in Section 3.1.2, DAA is a professional membership organisation designed to support its members and the peak body representing dietitians in Australia.

Considering the role of the profession as a system, what DAA does in relation to Aboriginal health has the potential to influence the work of dietitians with Aboriginal people. Importantly, the professional environment of individual organisations, including policies, will contribute to the professional environment that individual dietitians are exposed to. Not all dietitians are members of DAA. However, the majority of dietitians will be exposed to DAA through N & D university courses (for which DAA sets entry-level standards), gaining and maintaining the APD credential, for the purposes of continuing professional development (CPD) and events such as the annual National Conference. Therefore DAA does, to some extent, influence what is and what is not available (easily) to dietitians. DAA has the potential to impact widely across the dietetic profession and any dynamic within DAA potentially reflects the wider dynamic amongst dietitians. From a review of the DAA website, and my own experience with DAA as a dietitian, I identified four ways in which DAA advocates for Aboriginal health (Table 10.3).

Table 10.3: Ways in which DAA supports Indigenous health and nutrition, which can contribute to dietitians' professional environments: identified through review of the DAA website and my own experience as a dietitian

Area identified	Contribution to professional environment
National Competency Standards for Entry Level Dietitians in Australia	• Provide direction to accredit university courses, assess dietitians from overseas and contribute to continuing professional development of dietitians. • Of 51 elements, one relates to cultural competency, for which there are three performance criteria relating to ATSI and culturally and linguistically diverse peoples
Indigenous Interest Group	• Opportunity for DAA members to: discuss key issues related to Indigenous nutrition, network, investigate peer support opportunities and collaborate and advocate for action on nutrition issues in Indigenous communities.
Mutual recognition with New Zealand	• Before New Zealand dietitians can practice in Australia they are required to complete a short program and quiz about Australian Aboriginal people. • Unclear what the rules are for those in other countries.
Joint Policy with the Public Health Association of Australia (PHAA) about Indigenous food security	• Written in January 2009, this policy considers the current situation of food security of Indigenous people in Australia, and what action DAA and PHAA plan to undertake to address the issue. • Ten recommendations for action were made.

I also gave DAA an opportunity to comment on the ways in which they support Aboriginal health and nutrition, which ultimately contribute to the professional environment dietitians are exposed to. I did this by contacting Claire Hewat, Chief Executive Officer of DAA in February 2011. Further ways that DAA supports Aboriginal health, identified by Clare Hewat, are outlined in Table 10.4.

Table 10.4: Ways in which DAA supports Indigenous health and nutrition, which can contribute to dietitians' professional environments: identified by Claire Hewat, DAA Chief Executive Officer, on 16 February 2011

Area identified	Details
Training of Australian dietitians	Understanding of indigenous nutrition/health issues as part of entry level competency but this cannot be at high level
Overseas dietitians seeking to work in Australia	A requirement for overseas trained dietitians to pass a cultural competency self study and quiz program
Continuing professional development (CPD) for dietitians	Members undertaking higher level training, CPD in this area can count it as part of their CPD hours
	Providing access to other CPD and resources for members where we can
Interest group	Supporting an Indigenous Interest Group
Conferences	Ensuring DAA always has at least one Indigenous nutrition workshop at the National Conference
	Embedding an indigenous health stream in the International Congress of Dietetics (to be held in Sydney in 2012) scientific program
	Having a special rate for Indigenous health workers to attend the national conference, advertised through the conference website and Indigenous interest group
Linking with other organisations	Though our membership of Allied health Professions Australia, auspicing the formation of the Indigenous Allied Health Association
	Working with the Public Health Association of Australia (PHAA) to develop an indigenous food security statement which got very good coverage in the media
	Supporting the Batchelor Institute of Indigenous education (Northern Territory) in developing their degree course in nutrition and ensuring their graduates can become associate members of DAA
Advocacy	Advocating for more emphasis on nutrition in the "Closing the Gap" initiative and generally advocating for better indigenous nutrition
	Advocating for more nutrition workforce in aboriginal communities either ourselves or with "mates" like PHAA and Red Cross
	Ensuring indigenous issues are highlighted in any relevant submissions around health reform in general

This represents a relatively large number of ways in a variety of areas that DAA supports Aboriginal health and is more than I identified. Increasing DAA members' awareness of these multiple strategies may increase their exposure to Aboriginal health within the dietetics profession. These strategies might not always be clear to members, for example I was unable to find advertisement of the discounted rate for Aboriginal health workers to attend the National

Conference on the conference website and in the registration documents. In addition, at the 2011 National Conference there was one workshop concerned specifically with Aboriginal health, two posters but no concurrent sessions. The workshop and one of the posters were from myself. This is likely to reflect the low numbers of dietitians working in Aboriginal health and therefore the low numbers of conference abstracts submitted in this area. An important consideration is how to support those dietitians who are working in Aboriginal health to present at National Conferences in order to create a greater "presence" of Aboriginal health at these conferences.

Importantly, DAA highlights that:

> *All this is being done whilst we are undertaking similar activities around refugees, CALD communities, the elderly, children, disadvantaged groups in general, those with disabilities and mental illness, the hospitalised, the malnourished...which is always our challenge. The profession and its interests and work areas are very diverse and because we are here to support our members our focus is broad. (C. Hewat 2011, pers. comm., 16 February)*

In support of this comment is the fact that the number of dietitians working exclusively in Aboriginal health is very low (less than five in South Australia) and considering other needs as highlighted by Clare above, focussing largely on Aboriginal health at the level of DAA may well be impractical.

Furthermore, Clare Hewat also indicated on 16 February 2011 that:

> *The workplaces where people encounter a lot of Aboriginal people are the best placed to provide the necessary education/orientation in context with the local community. DAA cannot do that but we can ensure that our graduates/members are open to those experiences and possibilities and have the basics under their belt. Once they are there we put the professional support structures around them to support their work and we advocate for them and the job they are trying to do.*

Importantly, there are a very small number of Aboriginal dietitians in Australia (less than five in early 2011). Some other allied health associations have specific Indigenous associations which can only be joined by Indigenous members of the profession, for example social work and psychology. Others also have specific Indigenous committees, for example the Australian

Physiotherapy Association has an Indigenous Health Committee. Therefore, it may be useful to have a similar committee through the DAA and attempt to increase the number of Aboriginal dietitians.

It is my view that there is great potential for DAA to contribute to a positive professional environment for dietitians working in Aboriginal health. While only a small number of dietitians do work exclusively in Aboriginal health, most, if not all dietitians have the potential to work with Aboriginal people as part of their work with the wider community. The more equipped they are to do so, and the more positive they feel about this, the more likely that such work will eventuate. Having greater discourse amongst dietitians about Aboriginal health, challenges of working in Aboriginal health, race and the position of White people in the dominant race culture are important and could contribute to positive attitudes amongst the profession about working in Aboriginal health. One way that these could be facilitated on a widespread level is through DAA.

10.3. *Individual factors*

In this section I explore the personal ideology of White workers, and how this may enable or constrain their practice in Aboriginal health. I also explore ideas that White workers have about colonisation, and how these can also affect their practice.

10.3.1. Personal ideology

As outlined in Chapter 5, Harvey (1990) refers to ideology as a set of ideas or way of looking at things. I have extended this idea of ideology to "personal ideology" which refers to personal sets of ideas or ways of looking at things. The elements of personal ideology found to enable and constrain practice are presented in Table 10.2, and expanded upon below.

Past experience

Participants referred to a number of past experiences that had contributed in some way to their current ability to work more positively with Aboriginal people. These experiences were not necessarily all positive at the time. However, they had a positive outcome because they generally encouraged the worker to reflect on an event or an issue and then move forward. For example, one dietitian talked about growing up in a town in the Northern Territory. She was constantly around Aboriginal people, and this made it easier for her to work in Aboriginal health because it was *'not that foreign'* (DN4). Similarly, dietitians and *ewba* staff discussed opportunities to work

with Aboriginal people through university placements or prior work experience. Only three dietitians interviewed had had the opportunity to do a university placement in an Aboriginal community, and they all reported it as a positive and enabling experience (DN4; DN15; DN18). Two *ewba* workers described the impact of visiting an Aboriginal mission (EWBA2; EWBA4) and how prior experiences working with Aboriginal communities helped to provide *'an idea about what you are able to do within the program and understand a bit more about the culture and the history'* (EWBA2).

Two dietitians and one *ewba* worker identified as coming from non-dominant cultural backgrounds and having experienced hardship in their home countries. This enhanced their ability to empathise with Aboriginal people in their practice (DN4; DN16; EWBA3). One worker talked about how this affected her work:

> *Do you know what, I think for me it's slightly different because I'm a migrant. In my eyes Aboriginal people are the true owners of this land so the way I see things is so different to how White people see things but I can only talk from my own personal perspective…[ ]…I believe that being Brown has actually been an advantage for me working with Aboriginal community because I'm not of a dominant culture, I have a huge respect for Aboriginal community because they have been through a lot. This is their land, I'm a visitor in their land and so I respect them, I respect their culture. (EWBA3)*

This worker reflected that these views meant that *'the way I interact with the Aboriginal community may be different to the way the White people interact with the community'* and that she picks up on racism more easily because she has experienced it herself (EWBA3).

On the other hand, dietitians also referred to negative experiences they had with Aboriginal people as factors that constrained their practice. Two dietitians talked about growing up in rural SA and being exposed to negative beliefs about Aboriginal people, which left them with a sense of fear about working in this area (DN17; DN21). Others reflected on negative experiences they had had with AHWs who cancelled their involvement in a program or event at very late notice (DN8). Additionally, a number of participants felt that AHWs did not have the level of clinical and/ or nutrition knowledge that they were often assumed to have by White workers (DN3; DN6). For example, *'a lot of health workers themselves have limited nutrition knowledge and skills'* (DN6).

One experienced White worker described how the fear she held as a child towards the Aboriginal community sometimes resurfaced:

> *I grew up, and can tell a personal story, in Darwin, and in walking to school I would walk past members of the Aboriginal community who were inebriated and would ask me for money and harass me if I didn't have it and I was fearful. As an adult, more recently I experienced a group of Aboriginal people in Coober Pedy [remote community] and I was fearful again. Even all the thinking that I've done, I can still flip into feeling frightened and then the kind of shame that went along with that, how easy it is to feel unsafe in relationships and how vulnerable we are as people (EWW3).*

Being aware and working through any negative experiences with Aboriginal people is important if White health professionals are to overcome them and continue to work in this area.

A lack of past experience with entering a different cultural space was also identified as a constraining factor to the practice of dietitians. As a professional group, it was perceived that dietitians tend to have *'that general awareness of different cultures and people of different backgrounds whether it is based on income, education or culture'* (DN14) and *'a reasonable understanding of social issues and things like that'* (DN9). However, due to the lack of opportunity to undertake university placements with Aboriginal communities identified by dietitians, whether or not a dietitian has entered another cultural space is likely to be dependent on personal experience. Entering another cultural space generally means that the person has experienced what it feels like to be in the minority; something that most Aboriginal people in Australia face every day. Being able to acknowledge that this is how many Aboriginal people feel is an important step to relating to Aboriginal people in an effective way, as demonstrated by my own experience (Chapter 7). Entering another cultural space involves taking a risk, where a dietitian is required to step out of their comfort zone (DN20, DN8), work in a situation where they do not feel confident and be in a physical place where they are likely to be in their minority (DN20). The extent to which a dietitian is able to do this may depend on their experience of other cultural spaces in their life (DN20). This is particularly the case for the majority of dietitians who come from White, middle class backgrounds. Another dietitian saw her different cultural background as a barrier to working in this area; as she had not been in Australia for long, she had not had the opportunity to meet many Aboriginal people (DN16).

Passion and commitment

Experienced White workers talked extensively about the passion and commitment they had for work in Aboriginal health (EWW1; EWW2; EWW3; EWW5; EWW6). These workers were well aware of the difficulties of this work but reported that their passion and commitment kept them going. This was explored in-depth by one worker who stated that work in Aboriginal health is *'sometimes a burden'* but giving up is not something she would do (EWW5). This worker spoke of strategies such as keeping going by *'holding onto hope and trust and that some of what I do, whether it's chatting with you [interview] or something else that I do today, will make a modicum of difference to somebody out there and that's what keeps me driven'* (EWW5). She highlighted that in this area of work, being cynical is destructive and corrosive and when it all feels like it is too hard, she has *'to say no to cynicism'* (EWW5).

Acknowledge limitations of knowledge

It was evident that most experienced White workers had engaged in deep self-reflection about their work in Aboriginal health (EWW1; EWW2; EWW3; EWW4; EWW5; EWW7). One thing that emerged from such reflections was awareness that they still had a lot more to learn. One worker described this as:

> *It's a Johari's Window, you know that thing about you know what you know and then there is this part where you can't know what you don't know, but sometimes you intuitively sense it and you think "I am not getting this quite right" and sometimes, if you're lucky, you'll have somebody or people to work with who will say "if you'd done that in that order" or "what you forgot to do was that", it moves me along. (EWW5)*

This awareness of having more to learn was clearly evident in interviews because these workers were careful to highlight that theirs was just one perspective, and that they did not have all of the answers.

One *ewba* staff member also referred to the limitations of his knowledge and how this helped him in working with the Aboriginal community:

> *...firstly you have to admit that you don't know. That's one thing I think I've done quite well. I have been quite open that I didn't have as much experience, I have been quite open that I haven't known a lot, I was quite vocal about that...[ ]... I think community leaders and people who've worked a lot with Aboriginal people appreciate that, they don't like to see someone sort of bluffing their way through it and if you're open and honest and say, "look, I'm interested, I'm genuine, committed but I don't know a lot and I'm on a learning curve" they will appreciate that and they will run with that but you've got to make sure – the bottom line is honesty. (EWBA4)*

For this worker, acknowledging the limitations of his knowledge was an effective strategy for working with the Aboriginal community.

Awareness of the "reality"

Some experienced White workers and *ewba* staff identified some of the "realities", or daily struggles, of working in Aboriginal health. For example, a level of discomfort associated with working in this area was acknowledged by two workers (EWBA4; EWW3). One stated that because of this discomfort, even though he enjoyed working in Aboriginal health, '*you've got to push yourself every day to do it'* (EWBA4). Similarly, one experienced worker posed the question *'how do you remain hopeful in the face of so much chaos and despair?'* (EWW3). Experienced White workers and *ewba* staff had an appreciation of the difficulties faced by AHWs who live and work in the same community. They acknowledged how different it is for themselves as White workers when they can physically leave and disengage from work at five o'clock (EWW3; EWW4; EWW5; EWBA5).

Three experienced White workers demonstrated an awareness of racism, discrimination and how the need for cultural safety influenced the lives of Aboriginal people. These workers saw racism as a daily reality that Aboriginal people face. This awareness was an enabling factor to their practice because they were able to adjust the way they worked accordingly. One worker described her understanding of these issues:

> *I think that getting up every morning and knowing that you might face racism today - I think that deeply affects your health and knocks your health whenever you come up against it, whenever you feel racism it knocks you…[ ]...The other thing that I think is a great difference in an Aboriginal person's health is their cultural safety and that sense of – people from the dominant culture have a sense of that we have a right, we have an unalienable right to go wherever we like to do pretty much whatever we like within the [White] law, that we have a blessing to move freely and to receive services equally with everyone else. I think that for Aboriginal people, and there are other people to whom this applies too, don't necessarily feel that they're going to get equal treatment, fair treatment, social justice wherever they move, so whether you're dealing with the local deli or dealing with trying to get housing or whether you're trying to set up a business and want to borrow some money from a bank, it's not the same. (EWW5)*

An awareness of the realities of working in Aboriginal health was enabling - workers were still willing to continue working in Aboriginal health despite them and were more realistic about what they could and could not achieve because they had greater understanding about the factors influencing their work.

Awareness of position

The majority of experienced White workers had developed an awareness of their position as White health professionals. This was demonstrated in interviews through a discussion of dominant culture (EWW5), individual Whiteness (EWW3; EWW4; EWW5; EWW7) and White privilege (EWW5). These concepts were only briefly mentioned by one *ewba* worker (EWBA3).

Several workers explored how working in Aboriginal health has enabled them to learn a lot about what it means to be White (EWW3; EWW4; EWW5). For one worker, this realisation encouraged her to think about herself and where she fits, and what she brings to relationships with Aboriginal people, including a naivety (EWW3). Another worker, who grew up with Aboriginal people, identified that:

> *I am aware of my Whiteness but then a lot of the time I just feel like I'm part of the [Aboriginal] community as well (EWW4).*

This had a number of implications for this worker, including a blurring between work life and community life and challenges of working in non-Aboriginal culture having the life experience with Aboriginal people that he does (EWW4).

Another worker highlighted the role that partnerships with Aboriginal people had in developing her awareness of her Whiteness and White privilege:

> *I couldn't have moved in that direction and understood more about White privilege and culture without that partnership. (EWW5)*

Another worker reflected on his life and described it as a *'very White existence'* (EWW7). Because of this, he made extra effort to *'listen to the stories, whether that's dreamtime stories or just recent stories, recent history'*. He felt that by doing this he was able to *'start to see the world in a different light'* (EWW7). This illustrates how a worker's self-reflection influenced his practice which in turn altered his thinking.

These workers were not only able to acknowledge their own characteristics and own positions, but were also aware that not everyone had the same points of view and experiences as them. One worker talked about her experience and how this may be different for an Aboriginal person:

> *I enter the world thinking that people are going to like me whereas actually, this will seem a silly thing to say, but it was shocking to me to discover and to know that there are many people who when they meet someone for the very first time don't think "oh this is going to be great, this person's going to like me, you know, we'll get along well." They actually think "oh, I'm not sure about what this will be like" and there are other people who actually think "this is going to be awful in some way" and it's the people who have been the most disadvantaged who have had the most experience of relationships that have been destructive, negative and unhelpful. (EWW3)*

Clearly, having an awareness of these issues enabled these experienced White workers to reflect on and adjust their practice with Aboriginal people.

The importance of having an awareness of position was explained by one experienced White worker:

> *...we need to have an understanding of their culture, an understanding of White privilege, we need to understand that we carry that to the table when we're meeting with our Aboriginal colleagues or the community generally and we need to understand that they know that and they know, they understand dominant culture; they have to understand dominant culture and they have to understand White privilege and they know we've got it but if you don't understand White privilege and dominant culture and how that sits alongside Aboriginal experience I think it is very, very hard to work with Aboriginal people. (EWW5)*

A discussion about the importance of acknowledging position when working in Aboriginal health will be extended in Chapter 11.

Confidence

A lack of confidence in working in the area of Aboriginal health was commonly reported by dietitians. The reasons dietitians did not feel confident included feelings of frustration, a lack of training, being overwhelmed and having a sense of not knowing what they do not know.

Two dietitians reported feeling confident when they started working in this area. One described initially approaching his work with Aboriginal people with *'this dietitian missionary zeal wanting to save the world'* (DN20). However, this did not last long, and as described by another dietitian *'when you start out you have optimism and you think you know it all and then the more you work in the area you find out that you don't know anything'* (DN9), demonstrating that over-confidence quickly makes way for a lack of confidence. For some dietitians, a lack of confidence eventually led to an acceptance that they were never going to get things totally "right" when working with Aboriginal communities (DN1; DN6; DN20).

Other dietitians discussed never having felt confident about working in Aboriginal health (DN4; DN7; DN13; DN17). Some dietitians were quick to report that they did not have the skills and knowledge needed to work in this area (DN5; DN16) which diminished their confidence. Confidence levels changed over time; even those with more experience reported going through periods and stages when they questioned their work and their abilities to work in this area (DN20). This reflects the fact that work with Aboriginal communities ebbs and flows, for example

something that worked really well last year might not work well this year (DN20). This "ebb and flow" often also exists when trying to build relationships:

> *One minute I feel like yes I'm accepted and in favour and ready to work with me now and then all of a sudden, 'no' and it might be two months later and a new opportunity comes up (DN17)*

This research has identified that this "ebb and flow" is a normal part of working with Aboriginal communities, at all stages, and that it is not necessarily a reflection of the work of the dietitian.

Fear

There was considerable discussion regarding fear amongst dietitians when working with Aboriginal people. Some people talked about this fear in relation to themselves, others talked about it in general, some discussed it directly, others indirectly. Overall, working with Aboriginal people was seen as complicated (DN6) and very difficult, almost too difficult in some cases (DN3). Working with Aboriginal people was seen as stepping into unknown territory.

One *ewba* worker questioned where this fear comes from. In his interview he indicated that this fear *'is more from the practitioner than it is from the community'* or that *'sometimes the system, the bureaucracy, the organisation can install a sense of fear or try to tell you that you don't know enough* (EWBA4).

This can become quite disabling, as this worker describes:

> *Well sometimes all the evidence is like "you've got to do this and you've got to do that" and you almost get absorbed in that and start believing in that. You forget that "hey it is just another person" and they just want you to be genuine and they just want you to be considerate and you just want to work together. You just get hung up on these things and then become hesitant about approaching them and the whole almost becomes a barrier for you to reverse that. (EWBA4)*

There was also a large fear of doing something wrong. For some, this was related to a fear of not fully understanding Aboriginal culture.

> *[There is the belief amongst dietitians that]….there are a lot of cultural norms and cultural nuances that you are sort of never going to get right so again there is that stigma attached, "well it's all too hard because I don't want to sort of go offending anybody or go making any wrong moves or inappropriate gestures or inappropriate language". (DN6)*

Others lacked confidence in their understanding of what Aboriginal people ate:

> *...you don't know if they [Aboriginal people] still do eat bush tucker or if they do their shopping locally (DN15)*

For others, it was just an intense underlying fear of doing something wrong whenever they worked with Aboriginal people. Whenever they did not get the response they wanted or expected from an Aboriginal person, they made the assumption it was because they did something wrong. Those with moderate and extensive experience were much better at recognising that outcomes were not always related to things they had done:

> *…having that understanding that if you have that feeling of doing something wrong, just having that awareness that there's a lot that goes on in Aboriginal Communities that we don't understand and we don't know about and that we might never understand it very well. (DN14)*

Additionally, there seemed to be the perception amongst those with minimal experience that there are certain skills or knowledge you "have to know" to start working in this area. Again, this was a barrier to getting started. Those with more experience were able to acknowledge that *'there is a lot of on the job learning'* (DN1) and we all do make mistakes, but we learn from them (DN1; DN3; DN6; DN20).

Clearly, there are multiple factors at the level of individual workers that can either enable or constrain the practice of these workers in Aboriginal health.

10.3.2. Colonisation

My personal understanding of the importance of colonisation was increased through this research (Chapter 7).Through interviews, I explored how an understanding of and attitudes towards colonisation might affect practice. The elements associated with colonisation found to enable and constrain practice are presented in Table 10.2, and expanded upon below.

Understanding of colonisation

The ways in which White workers demonstrated their understanding of colonisation varied. Experienced White workers were more likely to talk about it directly, while dietitians and *ewba* staff tended to talk about it more indirectly. That is, rather than referring to the event itself, participants discussed their perception of Aboriginal peoples' experiences with the effects of colonisation and what they perceived the effects of colonisation to be. I interpreted participants' understandings of colonisation from a direct interview question, or from comment elsewhere in the interview. The indirect ways in which individuals expressed their understanding of colonisation were through a personal connection, by talking to Aboriginal people or hearing about history and the Stolen Generation.

A number of dietitians related their understanding of colonisation back to a story or a personal connection (DN1; DN4; DN9; DN10; DN13; DN16 DN20; DN21) with an Aboriginal person they had worked with or something that had happened in their childhood. Hearing a personal story from an Aboriginal person appeared to have a significant impact on the participants, who may not have heard these types of stories before, for example:

> *Some people I work with at the health service now – they were living on the outskirts of town before the 1967 Referendum – when there were not equal rights for Aboriginal people. They had to go back to where they lived at 6pm, they had to get cheaper cuts of meat from the butcher and the fruit and veg that was going to be thrown out, they were living in tin shanty houses that would be flooded in winter. (DN20)*

Similarly, *ewba* staff and experienced White workers reported hearing personal stories from colleagues who had grown up on missions after being taken away from their families (EWBA4) and working with AHWs or community members who had been part of the Stolen Generation (EWBA6; EWW6).

Personal stories reiterated to White health professionals how recent the events of colonisation are, and the associated loss and trauma. This was reinforced by an experienced White worker who highlighted how she always thought it was something that was in the past, but through her experiences working in Aboriginal health she has come to see

> *...that the Aboriginal Community are living with the impacts of that every day still today and that when we talk about things like the Stolen Generation that's not people who are dead and gone many years ago those are people I work with today (EWW3).*

These examples demonstrate that talking with Aboriginal people is one way that White people can gain a greater understanding of colonisation. The extent to which an Aboriginal person is willing to share their experiences will vary greatly and is likely to depend on the relationship.

In contrast to those workers who did demonstrate an understanding of colonisation in direct or indirect ways, some workers lacked a basic understanding. For example, two dietitians required clarification of the question, including an explanation of what I meant by the term "colonisation" (DN8; DN15). After providing this definition, their response demonstrated a lack of understanding of the word "colonisation" rather than the concept. Other dietitians understood the question and acknowledged that colonisation must still have some impact on the lives of Aboriginal people today and felt somewhat overwhelmed by, for example *'all the history out there that you can't get your head around'* (DN10). Others tried to relate it to their practice but could not see how it fit with their practice:

> *…I suppose that there are actually quite some tensions [in the workforce] at the moment I think and I don't know how that sort of fits into colonisation. (DN2)*

One *ewba* worker was quick to point out that he felt he did not understand the issue of colonisation:

> *I'd be absolutely lying if I thought I understood it [colonisation] because the longer I work there the longer I realise I don't know…[ ]…I haven't worked in the area long enough to understand but it is definitely an issue, it's huge…[ ]…I am not an expert and I'm probably too uncomfortable to comment on it but all I know now is that I have more questions. (EWBA4)*

However, he was clearly interested and willing to find out more. This suggests that some further clarification and education about this issue for White health professionals may be useful.

Understanding of continued impact of colonisation

All of the White health professionals interviewed indicated that colonisation still impacts on the lives of Aboriginal people today. However, the depth of their feeling and their understanding of this continued impact differed. Some workers acknowledged they were uncertain of the continued impact of colonisation on the lives of Aboriginal people today. For example, one experienced worker stated that:

> *...we are still only a couple of generations down the line from, I think it's not colonisation but the impacts of colonisation and they are still living with it today. I don't know exactly how that affects or impacts on their everyday life, but I am sure it would have some sort of impact. (EWW6)*

Similarly, while all dietitians felt that colonisation would still have an impact on the lives of Aboriginal people, some were unsure how. Some effects that were reported included trauma and negative experience (DN6; DN4), disempowerment (DN3), and generational grief (DN1).

> *I didn't understand about the missing generations. For example, there are lots of grandparents raising grandchildren (which is quite stressful), and there are all sorts of issues it creates including money stress. There's a generation in the middle that's either in jail or dead or dysfunctional. (DN1)*

It was also reported by both dietitians and *ewba* workers that while colonisation still continues to impact on Aboriginal people today, this impact might be at an unconscious level (DN14; EWBA2).

Experienced White workers provided a different perspective by referring to the general lack of knowledge that White people have about history and the fact that this is not taught (EWW5; EWW7).

One worker described how a lack of knowledge of history means that people do not appreciate why the past needs to continue to be acknowledged.

> *Basically we are not very good about knowing our own history. Aboriginal people know theirs extremely well. You know, [people ask] "why did we have to say sorry, why do they keep going on about it?" And whilst we acknowledge we need to move forward, we can't forget the past. I've got a heap of mates who are always sort of on about that, you know, and so there is just that lack of understanding. So people need to hear the stories and stuff to understand the big things that impact on communities, that's crucial. (EWW7)*

Another worker expanded on this idea by acknowledging that some people try and deny that colonisation occurred or think that it was a good thing, and to do so is to undervalue or devalue Aboriginal culture and what existed in Australia prior to colonisation, including *'Aboriginal parliaments or Aboriginal social structures and complex science and knowledge'* (EWW5). A lack of understanding of issues such as these could seriously impact on a White worker's ability to work with an Aboriginal client in an appropriate and effective way.

In contrast to those who were uncertain, some White health professionals clearly identified ways in which colonisation continues to impact on the lives of Aboriginal people today, and these included through the Stolen Generation, the practice of White workers, storytelling, intergenerational effects, health issues, responses of Aboriginal people and continued racism.

Stolen Generation

It was very common for dietitians to talk about colonisation in terms of the Stolen Generation. In particular, to refer to the Stolen Generation as something (resulting from colonisation) that still affects Aboriginal people today. When asked if she felt that colonisation still impacts on the lives of Aboriginal people today, one dietitian responded:

> *I think it does because I have worked with people from the Stolen Generation and that has an impact on where their life has gone (DN8).*

Similarly, another dietitian talked about colonisation in terms of National Sorry Day[19], and felt that the importance of this day to Aboriginal people demonstrated the importance and impact that colonisation still has today for Aboriginal people.

[19] An annual event to mark the anniversary of the Apology to the Stolen Generations on February 13 2008

> *I think it [colonisation] does [still impact] because otherwise all of that National Sorry Day wouldn't have obviously meant a lot to as many people as it did (DN5).*

The Stolen Generation is one effect of colonisation that is generally quite widely known in everyday Australian discourse, particularly after Kevin Rudd's Apology in 2008 and appearance in popular films such as Baz Luhrmann's "Australia". Participants may have felt more comfortable discussing colonisation, an event they may not know much about, in terms of something that has been widely discussed in the Australian public relatively recently. Referring to the Stolen Generation or a related event allowed the participant to say by default that they thought colonisation was important. That is, by default it must be important because these things happened (such as the Stolen Generation) or these events occur in aid of it (National Sorry Day).

Perpetuated through practice of White workers

It was acknowledged that White workers could perpetuate colonisation through their practice if they were not careful. Examples of how this could happen included: using a paternalistic approach and appearing to have all the answers when working with an Aboriginal person (DN3; DN2); or through a lack of recognition of history and the hardships faced by Aboriginal people (DN9).

Storytelling

One *ewba* worker identified that the culture of storytelling in Aboriginal culture facilitated a connection with history which allowed the impact of colonisation and events of the past to continue to be perpetuated:

> *I think that colonisation does significantly, and has significantly and will continue significantly to have an impact while that culture of storytelling is occurring because it is constantly being perpetuated. And is not a bad thing because it's important to their culture but it is important for us to be aware of where that sits within their culture. (EWBA1)*

Similarly, some dietitians perceived that the older generation would experience the greatest effect today from colonisation, because they were likely to be more affected by the past than the younger generation (DN3; DN5; DN10; DN16).

> *…particularly the older generations it might mean that they still harbour some, I don't know what the word is, not resentment but yes, they still feel we are like maybe the enemy and you know don't want to be taking advice from someone they don't feel is on their side. I think that for (the younger generation), I mean, they are probably younger and realise that the people who are around now are not the same people who were necessarily responsible for all of that. (DN5)*

The idea that perhaps negative experiences were passed down from the older generations to the younger generations was presented.

Intergenerational Effects

Three experienced White workers reflected on the idea that the impacts of colonisation and associated events are intergenerational. One worker described this:

> *I don't think we could overestimate how much colonisation, invasion, disrespect, illegal acts, it's immeasurable how much damage that's done and if you damage my grandmother, if you damage my mother you damage me, you know. It is like that damage, that hurt, you carry through. (EWW5)*

Another talked about the fact that Aboriginal people living on missions were not allowed to make decisions about their lives, and how this is passed from one generation to the next and consequently impacts on Aboriginal people today (EWW1). A third discussed the impact of these intergenerational effects, for example carrying around grief that is part of the individual part of their history, which complicates things in everyday life such as work (EWW4).

Relationship to health issues today

Experienced White workers and *ewba* staff related colonisation and other historical events to health issues of Aboriginal people today. For example disadvantage and poor health outcomes (EWBA2), and violence which may be the end result of experiencing trauma (EWW3). One worker used an analogy of an iceberg to explain his understanding of how colonisation continues to effect Aboriginal people today.

> *…the analogy of an iceberg, 90% under the water and unseen, so often when I'm working with Aboriginal men I'll draw this iceberg on a Whiteboard and we'll talk about the presenting issues and what people see, especially the White community, you know, violence, grog, drugs, family breakdown, mental illness and that is often the problem story. But what often people don't see is like an iceberg, under the waterline and so we can follow back – and this is some context for what's happening in people's lives – so we can go back to colonisation or invasion and all the losses that went with that – loss of land and language and ceremony and culture and identity – all the murder, rape, slavery all that stuff that is often not talked about, abuse of power by a White dominant culture and then Aboriginal men involved in all major wars, all that historical stuff. (EWW4)*

This worker reflected on his experiences talking to some Aboriginal men and how he came to see the feelings of helplessness felt by some individuals, and how this led to anger which could then lead to *'violence, drinking and gambling and the poor housing and those sorts of things'* (EWBA4).

Understanding Aboriginal people's responses today

Dietitians explored how Aboriginal people's responses to certain situations today, which could be explained by colonisation or events resulting from colonisation, impacted on how they as non-Aboriginal people acted in certain situations. For example, in the non-Aboriginal community it may be common for people to go up to other people's babies and say "what a nice baby" and try and touch the baby, whereas one dietitian pointed out this could instil fear in an Aboriginal person that the non-Aboriginal person is trying to take the baby away (DN19). Similarly, another dietitian talked about a meeting where a group of non-Aboriginal and Aboriginal people were discussing tobacco and *'some of the Aboriginal people in the meeting got very, very upset and cross because they said well it was YOU who gave us tobacco in the first place'* (DN2). This highlights the need

to be aware of colonisation and associated events to help understand the reactions of Aboriginal people in such situations.

Continued Racism

It was acknowledged by experienced White workers, dietitians and *ewba* staff that while practices of the past were no longer (technically) in existence today, the racism resulting from those past practices is still present.

> *In the lifetime of many of the people at Point Pearce[20] the Aboriginal babies weren't allowed to be born at Maitland Hospital, they had to have their babies at Wallaroo Hospital which is much further away and there is still that racism today within Point Pearce which is 15 or 20 minutes from Maitland, whereas Wallaroo is an hour from Point Pearce. (DN14)*

Similarly, the idea that Aboriginal people were different to White people was taught throughout childhood for some of the participants, who were brought up to believe that *'you just didn't mix together'* (DN21). This created fear when they were forced to mix together, for example for sport:

> *I was brought up in and around [area] and it was very much in existence when we had football and netball teams like from childhood, no-one wanted to play against [Aboriginal team] and everyone was scared. (DN21)*

One worker highlighted how racism still exists at the institutional level, which he felt could impact on Aboriginal workers

> *I think there's actually still quite a bit of institutionalised racism; it's subtle so while we have most organisations that have Aboriginal workers in them and service Aboriginal clients, often those Aboriginal workers feel as though they are treated a bit differently – there's a bit of tokenism about their position, sometimes they hear the talk but they don't see it in practice about being culturally respectful or culturally accountable. (EWW4)*

Similarly, an individual worker may not overtly demonstrate racism, but a sense of angst or ill-feeling may be displayed which may influence decisions at an organisational level such as whether or not to provide a work space for Aboriginal workers, as described below:

[20] Site in South Australia which used to be an Aboriginal mission

> *I think people are very [politically correct] you know I haven't really experienced any White colleagues say anything negative but I have felt – I can give an example [Aboriginal Health Team] wanted an office at a particular site so it is a big organisation and they've got lots of sites and I was in a meeting, it was all White people except for myself and the team leader said that the Aboriginal Health Team would like this space and this site and the White workers were very unhappy about it because, according to them, the Aboriginal Health Team were not committed to using the space, they weren't going to be there every day so why should they have their own space, they need to come up and see the site and show that they're committed to using the space before they could have the space so while nobody actually said anything incorrect, you could sense that people were not happy. (EWBA3)*

These examples demonstrate the impact that racism can have at multiple levels of the space in which people work. This also demonstrates how racism can adversely affect White people in addition to Aboriginal people; for example having such experiences and beliefs in childhood could make it challenging for White people to work with Aboriginal people as adults.

In summary, while some White workers did not have an extensive understanding of how colonisation continues for some Aboriginal people today, others were able to explore this issue in detail.

Address colonisation through practice

Interviewees were asked whether, in light of their awareness about the continued impact of colonisation today, they would alter their practice with Aboriginal people. The responses to this question varied, with 17 of 35 White interviewees clearly stating that they would alter their practice to take account of colonisation and were able to explain how. Five White interviewees stated that they would alter their practice to take account of colonisation but they did not know how they would, four stated that they would not alter their practice while two said they would only address it if it was raised by the Aboriginal person. For the interviewees that answered in this way, there was little discussion because they did not demonstrate the same level of understanding of the question as those who answered that they would change their practice and knew how they would do so. Clearly, these workers lacked an understanding of how colonisation could be both perpetuated and addressed through practice. This is not surprising as this is a complex issue to grasp. Therefore, this represents an area for future ongoing discussion and education. The responses of

the 17 workers who indicated they would change their practice and who could describe how have been classified into four areas: approach, communication, organisational level and things individuals can do.

Approach

Dietitians and *ewba* staff discussed flexible and responsive approaches to practice that did not reinforce colonisation. One worker talked about sitting back, waiting, going slowly and waiting for Aboriginal people to come to you (EWBA1). Being flexible in your approach and *'making room for behaviour that others might find inappropriate'*, for example *'if an Aboriginal person behaves in a way that dominant culture perceives as being inappropriate like missing an appointment, being an hour late, I let it go'* (EWBA3). This may involve being flexible with people who have had *'a really rough time'* (DN4) such as difficult family circumstances or meeting Aboriginal people half-way:

> *…rather than making them do things our way you've got to ring this number and then you've got to wait three weeks and then you have to do xyz, we'll try and meet you at least half-way. (DN3)*

Additionally, being flexible with your agenda and considering colonisation when tailoring your approach to a group of Aboriginal people, and consequently considering how relevant your agenda is to them (EWBA4).

Communication

In terms of communication, one experienced worker highlighted the importance of asking where people are from, showing interest and sharing stories as an important part of working with Aboriginal people, particularly when you first meet them (EWW7). These are important aspects of relationship building. Having discussions about issues such as *'the impact of multiple policies such as the removal from land'* is an important way to learn about and appreciate issues Aboriginal people have faced (EWW3).

Giving Aboriginal people time and space to tell their stories was seen as an effective way of working by dietitians (DN8; DN20; DN21). It was acknowledged that each Aboriginal person has their own, individual story to tell. Some also mentioned sharing stories about themselves:

> *One day they might ask me about my story and background and that's when you know that things are a little bit easier. (DN21)*

In this case, this dietitian felt that being asked to share her story would indicate that her work was going well.

Organisational level

At the level of the organisation, experienced White workers felt that making access to health services as easy as possible for Aboriginal people was one way to acknowledge the effects of colonisation on Aboriginal people (EWW2) and *'support[ing] Aboriginal Health Workers in doing their job in whatever way that might be'* (EWW2). Another way to address colonisation at the organisational level is to acknowledge the impact of colonisation and its continued effects through a formal organisational document in order to *'make that really clear that we know that is a fact'* (EWW3).

Individual level

Experienced White workers, dietitians and *ewba* staff indicated that there were a number of things that they could do at the individual level. Being aware of Aboriginal history and making an active effort to learn about it was seen as important (EWBA2). This was reiterated by another worker who stressed the importance of understanding the past so that when designing programs today, issues can be accounted for (EWBA5). A number of dietitians talked about the importance of showing an interest in and learning about the history of the local Aboriginal people they worked with (DN1; DN2; DN14; DN18; DN9, DN20). The value of learning a bit about culture, and also being aware of issues facing contemporary Aboriginal people was stressed (DN20). Strategies included: watching films and television programs about contemporary Aboriginal issues (DN20), visiting Aboriginal camps (DN1), learning local language and using it (DN1) and learning from Aboriginal people (DN14). Avoiding judgement, not getting offended when Aboriginal people don't initially want to work with you and avoiding personal blame were strategies suggested by another worker (EWBA3). Finally, being open to learning from Aboriginal people (EWBA5) and acknowledging the impact that colonisation has had on the lives of Aboriginal people were seen to be important (EWW2).

10.4. *Chapter Summary*

In this chapter I have identified that the profession and the individual are systems within the larger system of Aboriginal health in SA. Each of these systems has rules and resources (structures) that can both enable and constrain the ideal practice of White health professionals with Aboriginal people. Within the system of the profession, the two main structures found to constrain or enable practice were perception of role and dietitians as a professional group, while for the individual, these were personal ideology and colonisation.

There is some discussion in the literature about elements within the individual affecting the practice of White health professionals in Aboriginal health. The importance of health professionals evaluating themselves and increasing their self-awareness has been acknowledged. Specifically, this includes a critique of their own practice (Pyett, Waples-Crowe et al. 2008b), reflection on their beliefs, attitudes, values and worldviews (Weaver 1998; Foster 2006; Nguyen 2008; Bennett, Zubrzycki et al. 2011), awareness of assumptions (Foster 2006), knowledge of one's limitations (McLaren 1995), preconceived ideas and stereotypes (Weaver 1999; Williams 1999), personal cultural situatedness (Nelson 2007) and motivation to work with Indigenous peoples (Bennett, Zubrzycki et al. 2011). An understanding of one's own cultural background is also important (Cunningham and Wollin 1997) because many White health professionals lack understanding of the impact of their own culture on the way that they provide health care (Lloyd and Wise 2011). Weaver (1998) states that self-awareness begins with self-reflection, an important element of practice identified in Chapter 7. In the area of health promotion and public health, there has been a call from Maori academic and Public Health Physician Dr Papaarangi Reid for non-Aboriginal people to challenge themselves and critique their own practice, and consider whether the ways that they work in health promotion challenge or reinforce the values that have led to Indigenous disadvantage (Pyett, Waples-Crowe et al. 2008b).

Furthermore, attitudes and values of White workers are identified in the literature as important when working in Aboriginal health (Bennett, Zubrzycki et al. 2011). There is some evidence that attitudes affect practice in Aboriginal health, for example physician's attitudes towards Aboriginal people affected the care they provided for sexually transmitted infections in this group of people (Khan, Plummer et al. 2008). Negative attitudes amongst nurses have also been observed, and these may be due to lack of knowledge and understanding about cultural differences which may be due to, in part, the relatively little contact that student nurses were found to have had with

Aboriginal people in their lives (Cunningham and Wollin 1997). One way to counteract negative attitudes is to demonstrate compassion and understanding towards Indigenous peoples (Henry, Houston et al. 2004), which may be achieved through a greater understanding of history and hardships these people have, and continue to, face.

In support of the importance of an understanding of colonisation identified in this research, having an awareness of and knowledge about Aboriginal history and culture has also been identified in the literature as important (Weaver 1999; Henry, Houston et al. 2004; Foster 2006; Fredericks 2006; Macaulay 2009). It is important to understand how historical events impact on relationships between practitioners and Aboriginal communities in Australia in the present day (Hunter 1997). Similarly, the importance of history in relation to nutrition is highlighted, stating that 'the impact of past policies and practices and the "introduced diet" are reflected in the poor health outcomes' of Aboriginal people (Shannon 2002, p. S576). This extends to an awareness of and knowledge about contemporary issues including health statistics (Fredericks 2006) and the structure of communities and reservations (North American Indians) (Weaver 1999).

In this research, only experienced White workers talked about colonisation at length and were able to identify that it still has an impact for Aboriginal people today. Those workers with less experience may lack understanding of or have a general discomfort with the issue, as there is clearly a lack of exposure to colonisation within the dominant culture in Australia. This could be addressed by addressing these issues in greater detail at university. Colonisation and governmental control over Aboriginal people has been institutionalised in the policies and practices of organisations and within worldviews, education and training of health professionals (Jones 2000 in Lloyd & Wise 2011) and even the language of health promotion has been described as 'the language of the colonisers' (Pyett et al 2008b, p. 181). However not all White participants in this research identified this. Experienced White workers were able to identify the need to avoid a colonialistic and paternalistic approach in their practice. However, the majority of White health professionals would benefit from exploring the importance of colonisation in the lives of Aboriginal people, and how it relates to their work.

As identified in this research, the literature supports the notion of the importance of recognising the belief systems, values and worldviews inherent in a particular model of theory used within a particular area of health care or profession (Weaver 1998). Identified by dietitians in this research;

occupational therapists (OTs) in the literature have also identified that 'at times, the role of the occupational therapist interferes with the ability to respond to the clients' expressed needs' (Steadman and Thomas 2011, pp. 46-47). These authors also highlight how working well in Aboriginal health often requires OTs to reorient their expectations about what they can and cannot achieve in certain timeframes. Therefore to work well in Aboriginal health, it may be necessary for health professionals to "let go" of some of the preconceived ideas they have about their roles.

11. Characteristics of White health professionals

In the previous two chapters, I identified that the organisation, profession and the individual are smaller systems within the larger system of Aboriginal health. These smaller systems contain structures that enable and constrain the practice of White health professionals working in the Aboriginal health, which these workers can also perpetuate through their practice. In this chapter I elaborate on the role of individuals in doing this and I present a tool to enable White health professionals to move forward with their practice. This tool takes many of the lessons and learnings presented in this research and enables them to be utilised in a practical sense, by White health professionals working in Aboriginal health.

In this chapter I demonstrate the variety of characteristics of White health professionals interviewed (experienced White workers, dietitians and *ewba* staff) and how this relates to their practice with Aboriginal people. White workers interviewed have been classified into four stages based on their characteristics. This stage model enables greater understanding about where White workers are "at" in their journey in Aboriginal health. As such, this model provides potential for ways forward and for devising strategies to work with workers in the different stages.

In this chapter I also consider how this model might apply to systems other than the individual – specifically to organisations and to professions.

11.1. *Four stages of health professionals*

White health professionals interviewed were classified into four stages: *Don't Know How, Too Scared, Too Hard* and *Barrier Breaker* (Figure 11.1). The fourth stage, *Barrier Breaker*, was further divided into two stages, Stage 1 and Stage 2.

My contact with stage theories initially came from reading Helms' work on White Racial Identity (WRI) (Section 4.2.3). When analysing the data from this research, stages were clearly evident in the White health professionals interviewed. However these stages were not just related to their White Racial Identity (WRI). If they had been, then I could have solely used Helms' theory as a tool for analysis. In addition to stages in the awareness of their Whiteness, I also identified stages in the workers' approach to practice, their willingness to work in Aboriginal health, their awareness of Aboriginal history and other factors, which I expand upon in this chapter. The benefit of the

stages of workers I present here is that this tool is designed to be based on and related to practice, so that it is directly relevant to and can be used by White health professionals.

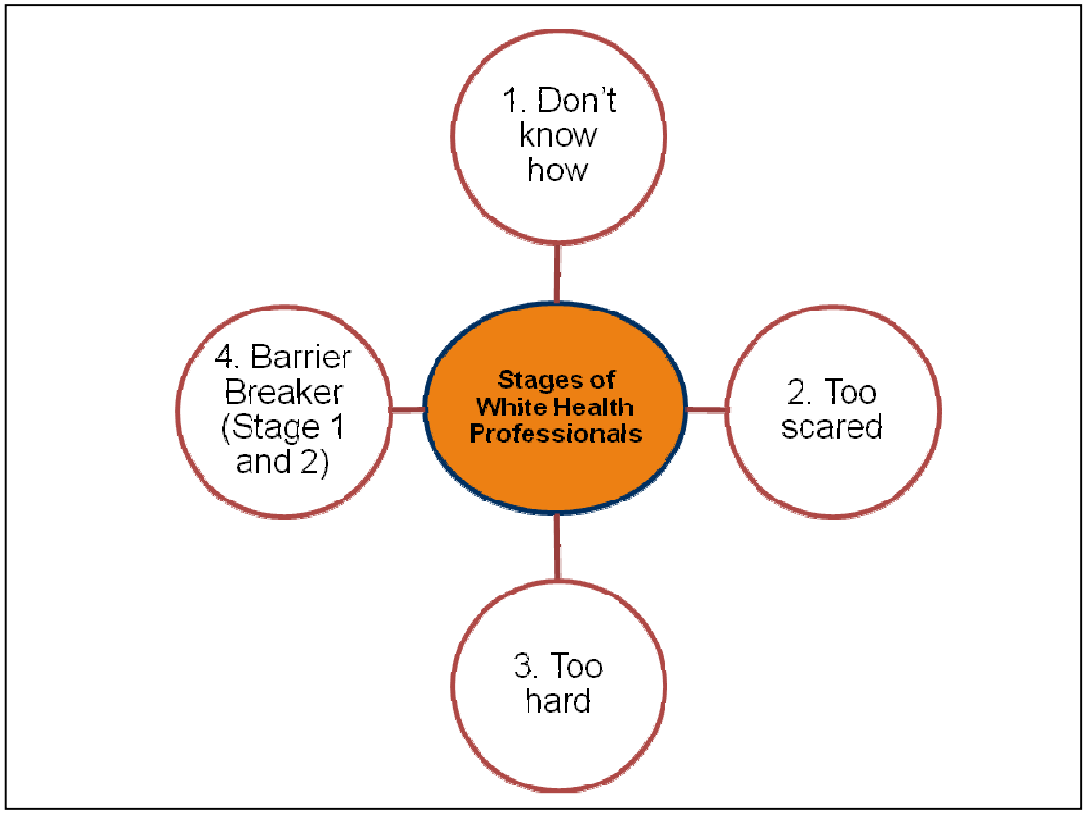

Figure 11.1: The four stages of White health professionals identified in this research

I classified the White workers interviewed (dietitians, *ewba* staff and experienced White workers) into the stage that appeared to describe them the most. This was done qualitatively, based on quotes from interviews. A summary of the number of workers in each stage is presented (Table 11.1). Importantly, these stages are not fixed. For example, workers may move back and forth between the stages based on events that happen or experiences they have. In the discussion below, quotes from the same person may appear in more than one stage. This is because discussion from most interviewees indicated that they had previously been in different stages.

Table 11.1: Number of dietitians, *ewba* staff and experienced White workers in the four stages: Don't Know How, Too Scared, Too Hard and Barrier Breaker (Stages 1 and 2)

Stage	Don't Know How	Too Scared	Too Hard	Barrier Breaker – Stage 1	Barrier Breaker – Stage 2
Dietitians	4	6	3	7	1
Ewba staff	0	1	4	2	0
Experienced White workers	0	0	0	3	4
Total	4	7	8	11	5

For each stage of worker, I present characteristics of workers in that group and problems and benefits of being in each stage. Any exceptions are also considered.

11.2. *Defining the four stages of workers*

In this section I highlight the characteristics that define the four stages of workers: *Don't Know How, Too Scared, Too Hard* and *Barrier Breaker* (Stage 1 and 2).

11.2.1. Don't Know How

The defining characteristic of workers in the *Don't Know How* stage was that they did not know how to work in Aboriginal health. They lacked strategies to do so. This was clearly demonstrated by one dietitian:

> *....before I started work with Aboriginal Communities I was kind of like 'geez how am I going to do this? Like, I know nothing basically, and that's when I went in feeling like I know nothing and yeah I was very worried about it. (DN4)*

Another dietitian did not know how to go about identifying the Aboriginal community in the rural town in which she worked. This was a barrier to her working with the Aboriginal community:

> *I just don't see Aboriginal people within the township of [town]…[ ]…I just don't know where they are…[ ]…. I am at a loss to know what could improve or help because I can't see the group and I'm not sure whether I need someone to come along and say 'okay, [name], let's go and meet the Aboriginal Community', I just don't know what could help. (DN7)*

As these workers had not worked in Aboriginal health, they were not aware of the intricate complexities of working in this area. Therefore, in contrast to those in the *Too Scared* stage, a benefit for workers being in the *Don't Know How* stage was that they were not constrained by an understanding, and consequent fear of, these complexities. Because of this they were still relatively willing to work in Aboriginal health. However, the result of not knowing how to work in Aboriginal health was that they did not work in Aboriginal health, leading to no work with or improvement in health outcomes for Aboriginal people.

11.2.2. Too Scared

The defining characteristic of workers in the *Too Scared* stage was that they were too scared to work in Aboriginal health. This fear stemmed from two main areas –a fear of being racist and a fear of getting things wrong. The underlying assumption here was that there is a "right" way to work in Aboriginal health. The extent to which a fear of being racist impacted on a dietitian's practice is demonstrated below:

> *I didn't care if I spent all my time talking to my clients about the weather…[ ]...of course I feel differently now but [before] I wasn't so outcomes and relationship focussed. I hoped people thought I wasn't being racist, (whispered) that was what I was so scared of. (DN4)*

Workers in this category had some experience of working in Aboriginal health. It appeared that after workers moved beyond the *Don't Know How* stage and got on with their work regardless, they became more aware of issues such as racism. This adversely impacted on their work because they did not know how to address these issues through their practice. Consequently, they were too scared to work in the area. Similar to the *Don't Know How* stage, the result for the *Too Scared* stage was that they did not work, or worked minimally, in Aboriginal health. One worker described how her fear influenced what she did and did not do:

> *So I come into it with this background fear, you know I'm in a place now where I really want to engage and I really want to be involved and start doing things and it has been a little bit like two steps forward and one step back and you know, you do something and then all of a sudden you think "oh, I did that wrong, I don't know what it was, I feel like we can't discuss it, I'll go away for awhile until the next window of opportunity comes up and then I'll have another go". So I think with me personally there's this underlying fear of I'm gonna do something wrong. (DN17)*

However, there was one exception to this. One *ewba* staff member was clearly scared about working in Aboriginal health. However, this fear did not become immobilising and he continued to work in the area and learn new things every day. Because he worked in *ewba* Community A where he was strongly encouraged to work with Aboriginal people, working in Aboriginal health was not really a choice. He was mentored by Aboriginal workers who he could talk to about issues such as being too scared, and who introduced him to key people in the community. He commented on this mentoring relationship:

> *…identifying the right people to talk to and taking the lead from them [mentors] and generally they are the ones who put you on to the best next steps to take. (EWBA4)*

This exception demonstrates that if a worker can work collaboratively with Aboriginal people in a supportive way, then fear in the *Too Scared* stage appears to be less of an issue.

11.2.3. Too Hard

Workers in the *Too Hard* stage perceived working in Aboriginal Health to be too hard. They had more practical experience than those in the first two stages, and this increased their awareness of the external barriers that exist in Aboriginal health. External barriers are barriers that exist outside of the individual health professional as a system. For example, those in the *Too Hard* stage focussed on external barriers that can make it hard for Aboriginal people to eat healthy food and be physically active. A description of these barriers is presented:

> *A lot of Aboriginal populations are living in quite low socio-economic and quite bad conditions…it could be quite difficult when people have got all these other things that seem like much higher priorities, so more immediate concerns like "we don't have enough money to pay the bills" and those types of things mean that nutrition can sort of seem like something that can go on a back burner. (DN5)*

In addition to acknowledging the barriers, those in the *Too Hard* group were the most likely to indicate that a health professional could only do so much if an Aboriginal person "did not want help". For example:

> *I think that if you can make things accessible to the Aboriginal Community, you can make information, you can make services accessible to them but they have got to want to access them and it is not because they don't understand or they don't see it as valuable it is because there seems to be a barrier there that stops them from accessing, so you can do as much as you like and provide as much as you like but if they don't necessarily want to access that, they won't. It is about valuing, I've made some notes, it is about valuing the program and for it being a priority so it may not be a priority and it's not. For a lot of the communities it is not a priority, the priority is domestic violence, the priority is all those issues that we talk about all the time with disadvantaged communities; there's a whole lot of reasons that they won't necessarily want to access the services and resources that are provided. (EWBA1)*

These were also external barriers that were perceived as being out of the worker's control; therefore they did not seek to address them in their practice. Therefore, these barriers were seen as something that individual workers could not get past and consequently, similar to those in the *Don't Know How* and *Too Scared* categories, these workers did very little in Aboriginal health.

Those in the *Too Hard* stage tended not to state in their interview that they found working in Aboriginal health too hard. Instead, they focussed extensively on the external barriers they perceived to prevent them from achieving outcomes with the Aboriginal community, justifying why they had not done or achieved more. This was unlike workers in the *Don't Know How, Too Scared and Barrier Breaker* stages who identified that they had a role in the lack of outcomes achieved with the Aboriginal community. For example:

> *I am not sure that I managed to make the patient aware of the importance of the dietetic changes. And the reason why might be partly because of myself. (DN16)*

Those in the *Too Hard* stage attributed the lack of an outcome, or the challenges, to external barriers. This was particularly the case with *ewba* in Community B. For example:

I think I'd say that I have always felt I want to do more, that there's a lot more I could do for Aboriginal Community but I am working within, I am not trying to make excuses, I'm working within a situation that's presented to me, and we've certainly had really good intentions all the way along but we've had some really big setbacks when things were actually working quite well and you know if [community centre] had remained in place who knows what our interventions would look like now perhaps bigger and brighter than what it is now which is quite small but I feel really positive about what we've done. (EWBA6)

The excessive focus on external barriers by those in the *Too Hard* group meant that these barriers really did constrain their practice and ultimately positive health outcomes in Aboriginal people.

11.2.4. Barrier Breaker

The defining characteristic of workers in the *Barrier Breaker* group was that they were aware of the many barriers in Aboriginal health but continued to work in the area regardless. The presence of barriers did not prevent them from working in the area. This is summarised by one experienced worker:

If something doesn't work then you find another way to make it happen. If something wasn't going to work or isn't working then you wouldn't just walk away because you'd find another way around it, so I don't think there would be anything that would stop me from working with the whole Aboriginal community. (EWW6)

This was reiterated by another worker:

... it's sometimes a burden when things get really, really hard...there's been a lot of hope and laughter but there have been a lot of tears as well, mine. It is sometimes really hard and it's a real struggle and you feel as though you're not getting anywhere, that you haven't made any difference at all and that's frustrating and it hurts, but you just have to get back on the horse and get along and do some more and not ever give up because giving up is not an option. (EWW5)

Barrier Breakers had a good understanding of external barriers, and barriers that might exist within them as individuals, and how these might influence their work. Therefore, they were able to take account of them in their practice. For example, one dietitian reported that cultural differences between Aboriginal and White people might be a barrier to practice for some dietitians. His suggestion for how to avoid this as a barrier was to take the following approach:

> *…okay you need some stuff from us and we've got some stuff so let's just work together and we're happy to work with you, you know, value you in your way of learning and your way of doing things and your family and that sort of stuff and we'll work with you…(DN3)*

Barrier breakers can be divided into two sub-categories, Stage 1 and Stage 2. *Barrier Breakers* in both stages had the characteristics presented to this point. However, *Barrier Breakers* in Stage 2 had an additional characteristic that was unique. They identified as members of the dominant (White) racial culture and were aware of the advantages that this conferred, for example:

> *...the colour of your skin is significant and my Whiteness is a passport to some privileges that my Aboriginal colleagues may not have. (EWW5)*

The defining characteristics of the *Barrier Breakers* in Stage 2 will be explored in more detail in Section 11.3.4. This clear difference between *Barrier Breakers* in Stage 2 and all of the other stages of workers is significant and represents an area for intervention with White workers. This idea will be discussed in more detail in Chapter 12.

11.3. *Characteristics of White health professionals in the four stages*

In this section I present a number of characteristics and consider where each stage of health professionals fits in relation to each of these characteristics. I present these characteristics as a qualitative, visual continuum from most to least. The place of each stage along the continuum represents my interpretation of where each stage fits, based on qualitative data from interviews.

11.3.1. Willingness to work in Aboriginal health

The willingness of the White workers in the different stages to work in Aboriginal health is visually represented in Figure 11.2.

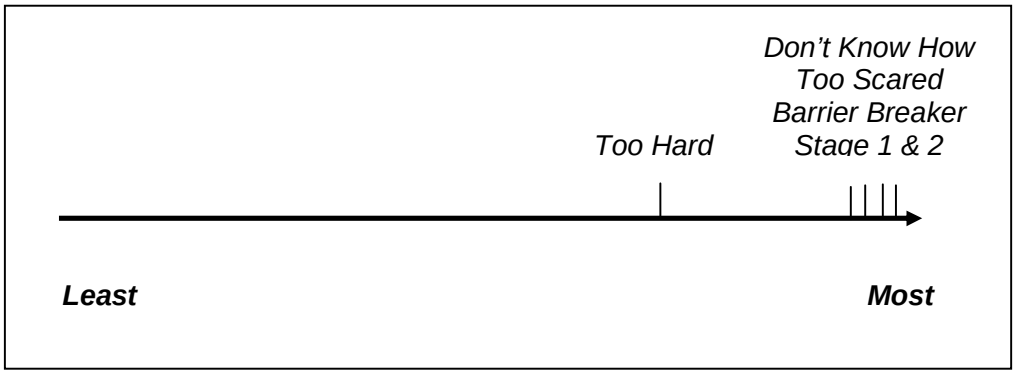

Figure 11.2: Willingness of White health professionals in the four stages (Don't Know How, Too Scared, Too Hard and Barrier Breaker) to work in Aboriginal health

Workers in the *Don't Know How, Too Scared* and *Barrier Breaker* (Stage 1 and Stage 2) categories were the most willing to work in Aboriginal health. Those in the *Too Hard* group were generally still willing, just not to quite the same extent. This is because they were the group that perceived external barriers as the greatest problem, and therefore working in the area (amongst these barriers) was less appealing.

The willingness of the majority of White health professionals to work in Aboriginal health was summarised by one dietitian:

> *...I'd say most dietitians go in, or they start work with the understanding that the Indigenous population is a high priority area and they all want to work there...[ ]... it is a matter of really wanting to be involved but actually not knowing how to go about being involved...(DN10)*

It is a positive finding that the majority of workers were willing to work in Aboriginal health. This suggests that energies need to be focussed not so much in encouraging White health professionals to work in Aboriginal health, but rather in helping them to do so.

11.3.2. Practice in Aboriginal health

The differing levels of engagement in practice with Aboriginal people in the different stages of workers are demonstrated in Figure 11.3.

Figure 11.3: White health professionals' levels of engagement in practice with Aboriginal people in the four stages (Don't Know How, Too Scared, Too Hard and Barrier Breaker)

Practice varied between the four stages. *Barrier Breakers* (Stage 1 and 2) were able to talk in more detail about the practice that they had done with Aboriginal people. They appeared more confident in talking about what they had done. There was no sense that they were worried about whether what they had done was "right".

It is likely that *Barrier Breakers* had more to say about their practice simply because they were at that stage where they were able to engage in practice more freely, without fear or feeling constrained by barriers. That is, they had had more experience and therefore had more practice opportunities to reflect on.

Some workers provided examples of how they had changed their practice with Aboriginal people, based on their growing experience in the field. Three *Barrier Breakers* reflected on changing their practice based on learning from Aboriginal co-workers (DN20; EWW2; EWW5); one example is provided:

> *….some of the smaller things [I've learnt] have been that we non-Aboriginal people, we'd push a bit, you know, when we're working with each other, we push a bit more and what I've learnt from working with Aboriginal co-workers is not to do that. Like don't keep pushing because, okay, just leave it alone. (EWW2)*

Another *Barrier Breaker* identified the value Aboriginal people place on knowing where someone is from and altered her practice to take account of this by stating where she was from when she introduced herself to an Aboriginal person:

> *I have changed some things in my own practice. When I introduce myself to Aboriginal families and Community I introduce myself as a woman who comes from the Whyalla region and Adelaide region and who is the mother of two children so I kind of talk about the things that I do really value about myself rather than going into the Speech Pathologist der-da-der. (EWW3)*

While more common in the *Barrier Breaker* group, some workers in other stages still reflected on their practice. For example, one dietitian in the *Too Scared* group reflected on how since working in Aboriginal health, she had altered her approach and re-evaluated what she counted as success:

> *...potentially before I started I would have had a lot more expectations in terms of time lines and when I wanted to get things finished and when I wanted to start working with people and I guess like a notion that I wasn't doing anything if I was sitting yarning whereas now I really understand the importance of that and the flow-on benefits and recognising success in different ways. (DN4)*

These examples demonstrate the importance of self-reflection when working in Aboriginal health, and that engaging in reflexivity can be a tool to improve practice.

Some workers also questioned what they could do to address Aboriginal issues when they were not at work. One *ewba* worker identified that

> *...as a human being living in Australia I can just try and participate in things like Sorry Day, be genuine in my approach to them [Aboriginal people], take time to get to know them (EWBA4).*

Workers also reported that challenging racism in social situations, while not directly related to their professional role in Aboriginal health, was important to them (EWBA4; EWW4; EWW5; EWW7):

> *…if all you are doing at a barbecue is speaking up if someone's being racist, if that's all you're doing I think that if everyone did that we'd all be in a better place. (EWBA4)*

These workers were able to use actions like this one to make them feel that they were contributing to addressing Aboriginal issues, especially when their practice at a professional level was slow.

11.3.3. Awareness of Aboriginal history

White health professionals in the different stages had different levels of awareness of Aboriginal history (Figure 11.4).

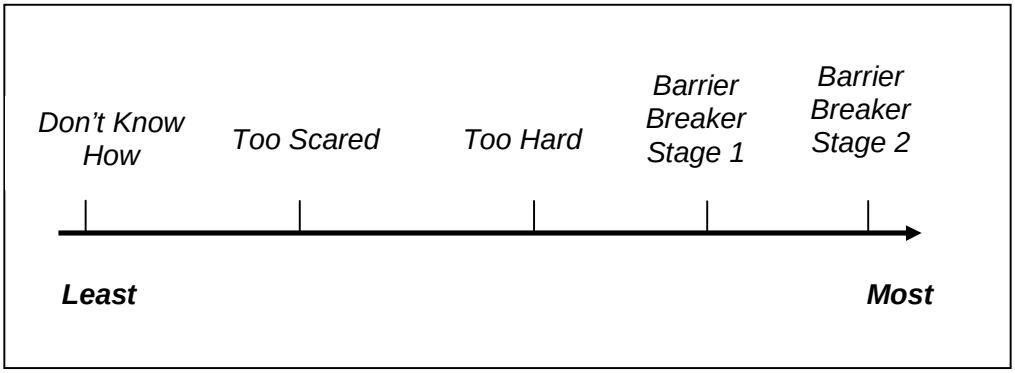

Figure 11.4: Awareness of Aboriginal history in White health professionals at the different stages (Don't Know How, Too Scared, Too Hard and Barrier Breaker Stages 1 and 2)

Awareness of Aboriginal history followed a slightly different pattern to the previous characteristics presented. That is, awareness of Aboriginal history increased across the stages.

Workers in the *Don't Know How* and *Too Scared* stages did not yet know enough about Aboriginal history for it to constrain their work. On the other hand, those in the *Too Hard* group had a reasonable understanding of some of the atrocities committed towards Aboriginal people in Australia since colonisation. However, they had not yet developed strategies to deal with knowledge of this history and the guilt associated with an awareness of these atrocities was immobilising. Therefore this was one of the factors contributing to working in Aboriginal health being too hard. It was highlighted that knowing a little bit, without any follow-up, could be more detrimental than beneficial, for example:

It [2 day cultural awareness training] also puts you in a spot where if you're worried about doing the wrong thing you can sometimes come out the end of the cultural respect workshop going "Oh, my God, I am going to do the wrong thing", which can almost make it worse in some sense. You're really like, well for them to do a workshop of two days and then have nothing to follow that up with it does leave you feeling like "I am going to do something wrong" and so you've either got to decide "okay I am going to keep expanding my cultural awareness, it is actually going to become part and parcel of my allocated time and I am going to work my way through it" otherwise you will just, yeah, you almost feel a bit lost, I think. (DN17)

In contrast to those in the *Too Hard* group, *Barrier Breakers* in Stage 1 had reconciled their feelings about Aboriginal history; they were able to acknowledge past atrocities and talk about them. The difference between the *Barrier Breakers* in Stage 1 and 2 was the depth of understanding of Aboriginal history and its continued impact today. *Barrier Breakers* in Stage 2 provided detailed examples that demonstrated this depth of understanding. They also looked at how they could use that deep understanding in their practice to avoid perpetuating colonisation (Section 10.3.2).

11.3.4. Awareness of one's Whiteness

The level of awareness of the different stages of White health professionals regarding their Whiteness is represented in Figure 11.5.

Figure 11.5: Awareness of one's Whiteness in White health professionals at the different stages (Don't Know How, Too Scared, Too Hard and Barrier Breaker Stages 1 and 2)

As highlighted, *Barrier Breakers* (Stage 2) were set apart by their awareness of their Whiteness. Workers in the other stages were not aware of this or did not discuss it openly. As demonstrated through my own experience, it is possible to be aware of your Whiteness but not be able to discuss it openly (Table 7.1). I was not able to do so until I began conducting interviews and realised that other White workers had similar experiences and concerns to me. Being aware of and identifying with their Whiteness was one way that *Barrier Breakers* in Stage 2 addressed internal barriers to practice in Aboriginal health.

For example, *Barrier Breakers* in Stage 2 clearly stated their position:

> *I see myself as of the dominant culture, I'm English, I'm a migrant and have been a migrant twice to this country and I'm White. (EWW5)*
>
> *….open to working with me as a privileged White woman. I suppose I've also learnt a lot about what it means to be White and a comfortable middle class White girl and have explored more what I bring. (EWW3)*

Having an awareness of this position was clearly advantageous to White health professionals when working with the Aboriginal community. By acknowledging and reflecting on their own Whiteness, *Barrier Breakers* in Stage 2 altered their practice to take account of this. For example, it was clear from one worker's discussion that knowing what you are, and what you are not, gives you a greater appreciation for what is and is not appropriate for you to do as a White worker:

> *...there are things that [Aboriginal Health Worker] can do that I simply couldn't do. I'm not Aboriginal and it is not appropriate for me to try and do some of those things...[ ]...there are often a lot of things happening that are not appropriate for me to know about...(EWW5)*
>
> *I know there's a whole undercurrent of tension that I don't understand...(EWW3)*

Through being comfortable with their Whiteness, these workers were able to accept that as White people, there were just some things that they could not do or could not know about. Rather than perceiving these as barriers, they just got on with their job regardless and focussed on what they could do. Having an awareness of the concepts of dominant racial culture and Whiteness enabled them to understand these situations in a different light to someone who has no concept of

dominant racial culture, who may interpret these situations as Aboriginal people trying to exclude White people.

Having an awareness of themselves and what they have, meant that conversely, these workers had a greater awareness of what Aboriginal people do not have, for example:

> *...probably for me the understanding of my own Whiteness has been part of that journey as well, so that thing about being a Whitefella and being part of a dominant culture and what that means because I think most White people would never have to think about who they are in their own community because they just are, so they never have to struggle with the same sort of issues that Aboriginal people have to, such as whether I'll be accepted here or whether I'll be judged or looked down on there. (EWW4)*

Being aware of what Aboriginal people don't have, a result of being consciously aware of what they themselves do have, enabled workers to be more empathetic towards Aboriginal people and/ or react differently to those White people who did not have this understanding.

11.3.5. Comfort in discussing racial issues

Figure 11.6 demonstrates the differing levels of comfort in discussing racial issues between workers in the different stages.

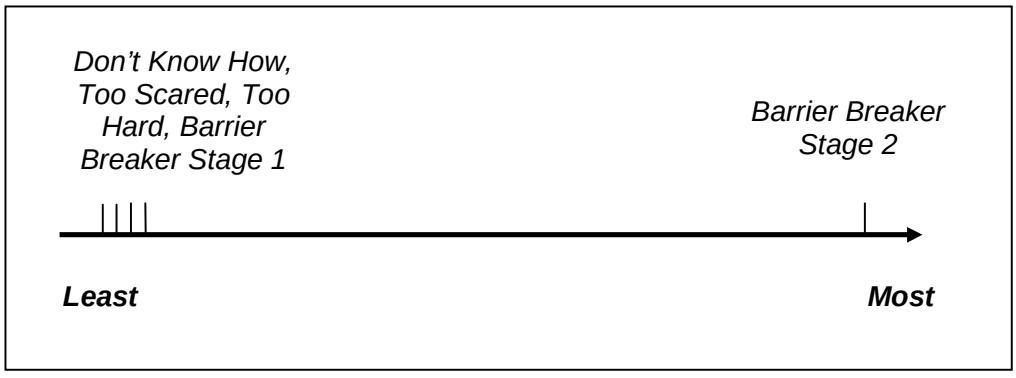

Figure 11.6: Level of comfort in discussing racial issues between White health professionals in the different stages (Don't Know How, Too Scared, Too hard and Barrier Breaker Stage 1 and 2

It is evident from Figure 11.6 that the level of comfort workers had in discussing racial issues follows a similar pattern to their awareness of their Whiteness. This is

not surprising as to openly discuss their Whiteness, it was necessary for workers to acknowledge and talk about race.

This suggests that increasing comfort in discussing race – or bringing race into popular discourse so it is just something that people talk about – is a way to get White health professionals identifying and talking about their position and therefore improving their practice.

Importantly, an increased comfort in discussing racial issues and awareness of one's Whiteness was also accompanied by an increased engagement in reflexivity. Reflexivity was one of the main tools that *Barrier Breakers* in Stage 2 used to discuss racial issues and their awareness of their position. It was through reflexivity that these workers were able to describe situations they had experienced, how they were related to race or Whiteness and how they had changed their practice and/ or learnt from the situation.

11.3.6. White Racial Identity

Figure 11.7 shows the relationship between the stages of workers presented and WRI theory (Helms 1984; Helms 1995). A discussion of WRI theory is in Section 4.2.3 of this thesis.

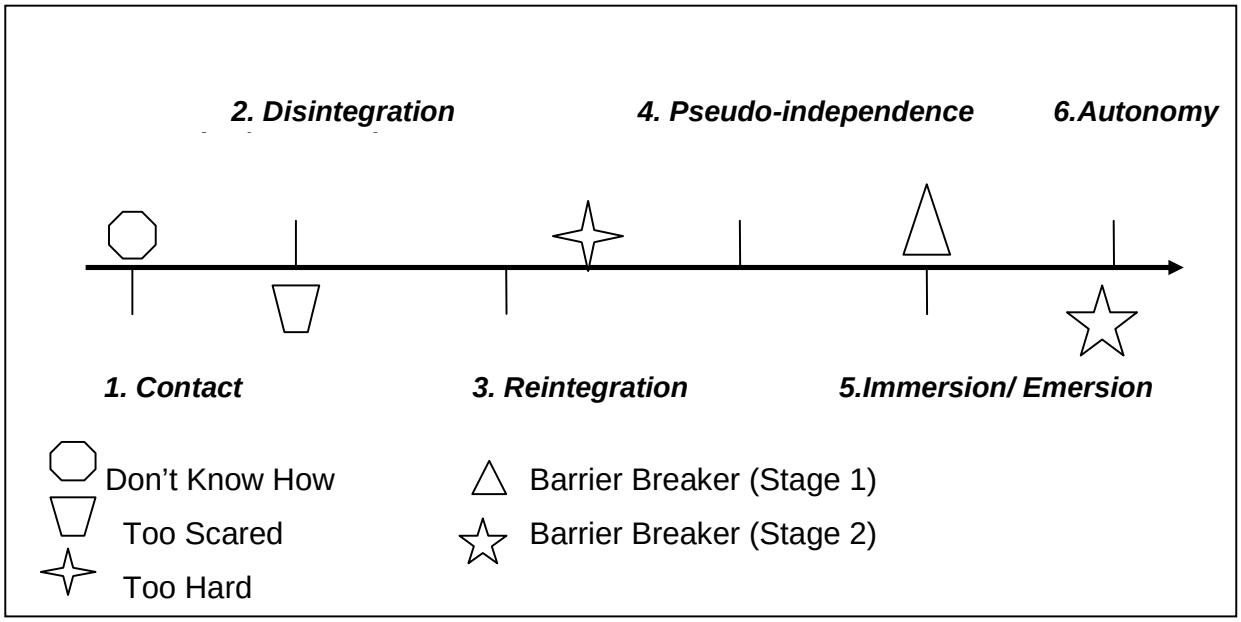

Figure 11.7: Relationship between stages of White health professionals (Don't Know How, Too Scared, Too Hard and Barrier Breaker Stages 1 and 2) and White racial identity theory (Helms 1984; Helms 1995)

Workers in the *Don't Know How* group were primarily in the contact phase of WRI. They consistently made comment about how they treated everyone the same.

> *You can't treat anyone differently, you've just got to treat them as you would anyone else (DN15)*
>
> *People are people and that belief - sometimes there's a perception that you've got to change things too much and I don't think you do generally, on most occasions you don't... (EWBA4)*

Those in the *Too Scared* group were in the disintegration phase. They were aware of the existence of racism and somewhat confused about what to do about it. This phase is characterised by disorientation, confusion and suppression of information (Helms 1984; Helms 1995). This confusion is part of what contributed to their fear.

> *...because you're like, sorry. There's nothing I personally can do about it and then it is heaps difficult because [you think] "well what can I do about this"?...[ ]... it is really hard to maintain sort of a balance, it is hard not to feel bad, it really is and I reckon you sort of do feel it a bit even so and it is just like how to manage that constructively instead of just doing things that aren't maybe so helpful because you feel bad. (DN4)*

Those in the *Too Hard* group were between phases of reintegration and pseudo-independence. Some of these workers were angry; a characteristic of the reintegration phase. In particular they were angry about their perceived lack of ability to help Aboriginal people, or their perceived idea that Aboriginal people would not help themselves.

Others in the *Too Hard* group actively sought to engage with Aboriginal people when it suited them. A characteristic of those in the pseudo-independent group is to engage with Aboriginal people who may be seen as "special" or similar to White people.

Barrier Breakers in Stage 1 were generally in the immersion/ emersion stage. They were beginning to acknowledge and think about how racism affected them as workers, for example

> *...we know there are huge amounts of discrimination and racism and all sorts. It is also reversed, so we all kind of feel that...(DN10)*

In contrast to *Barrier Breakers* in Stage 2, they were not yet at the autonomous stage. Autonomy is characterised by being secure in a racial identity, being able to relinquish the privileges of racism and actively seek cross-racial interaction (Helms 1984; Helms 1985). *Barrier Breakers* in Stage 2 demonstrated that they were flexible in their response to racial material and that they were secure in their racial identity by openly discussing concepts of race, White privilege and Whiteness. *Barrier Breakers* in Stage 2 were also aware of the importance of difference:

> *I heard someone say recently how tiring it is not to have your difference known and that really stuck in my mind as part of what respect is. It is actually knowing that you're different, we are all different, each one of us is different, but not to have your difference known and recognised and respected is a difficult thing. So, to actually acknowledge where someone is, somebody's identity and actually acknowledging that, and respecting that and being mindful of that...[ ]...so it is not when you are working with people, it is not always about seeing only that facet of it, but it is also about respecting who they are. (EWW5)*

Therefore *Barrier Breakers* in Stage 2 identified the importance of having a useful reaction to difference. That is, '*acknowledging that difference but not prefacing everything you do and say by acknowledging that difference' (EWW5)*.

11.4. *Reflection on where I fit*

Considering the emphasis I have placed on White health professionals being aware of their position when working in Aboriginal health, and the use of reflexivity in this research, it is pertinent that I provide some comment about how I see this model relating to my own practice.

As a new graduate dietitian working in rural and remote South Australia, I was very much in the *Don't Know How* stage. I did not know how to go about working with Aboriginal people, lacked confidence to do so and thought that there must be a "right way" out there to "find". After the end of my one year of practice I had some experience working with Aboriginal people, and this, along with the challenges I experienced during that year, put me in the *Too Scared* stage. For a long time I was too fearful to do anything, which is perhaps why when I began this PhD, I did not begin to engage with the Aboriginal communities of Community A and B until about six months into the research. The only thing that alleviated this fear was going out and spending time with communities. Over time, as I built relationships and learnt that it was not always so scary, I gradually moved out of this stage. However, based on my experiences since starting this PhD, I

can see that I have moved in and out of the *Too Scared* stage. At times, when my contact with someone was less, or I was focusing on different parts of the research, I was fearful about making contact again. Would I be perceived as the White researcher who just contacts people when they want something? However, while I was somewhat fearful, I was not so fearful that it completely inhibited my practice, it just slowed it down.

There were times, especially in the relationship building and consultation phases of this research, that I did think it was maybe all just *Too Hard.* As I grappled with the reality of Aboriginal history in Australia, and began to grapple with my own Whiteness, I struggled to see the way forward. It was easy to focus on the external barriers that make it difficult to work in Aboriginal health and attribute my lack of action to them.

However, through all of these challenges I kept going. I kept talking to Aboriginal and White people, and kept reflecting on my practice. I addressed the uncomfortable issues that arose using reflexivity. This is what enabled me to continue with my practice and move into the *Barrier Breaker* stage. While I acknowledge that I do not have as much experience as many of those I interviewed in the *Barrier Breaker* Stage 2 category, and that I do move back and forth between the stages, I now have many characteristics of the *Barrier Breaker* Stage 2 category. For example, I am comfortable in discussing racial issues, I have immersed myself in learning about Aboriginal history and I have an autonomous White Racial Identity. I am aware of my status as part of the dominant racial culture and I continue to practice in Aboriginal health as a dietitian. However, I acknowledge that it requires work to stay in this category, including continued exposure to Aboriginal health, active relationships with Aboriginal people and a critical mindset where I am constantly reflecting on my practice, my experiences and my Whiteness.

11.5. *Applying the stages to other systems*

It is evident from data and experiences from this research that while the stages presented in this chapter were designed for individual health professionals, they also may relate to other systems, including professions and organisations. That is, it is worth considering where an organisation and/ or a profession is at in terms of its experience in working in Aboriginal health, and what it has in place to support workers.

The case of *ewba* provides a good example of this in terms of the organisation. As previously mentioned, the health service at Community A had a greater ethos about working with Aboriginal people, compared to Community B. The regular and compulsory cultural awareness training for all staff, the presence of the working together group, the posters about Aboriginal history and culture in the foyer, the experienced staff and the general awareness about working with the Aboriginal community all contributed to this ethos. While some of these factors were present at the health service in Community B, they were not present to the same extent. This environment, which could be likened to the *Barrier Breaker* stage for individuals, assisted in fast-tracking staff through the stages presented in this chapter. For example, workers who had little experience working with Aboriginal communities quickly gained skills and blossomed in this environment (EWBA4). In contrast, dietitians who had worked in the same health service for a number of years, which did not go out of its way to support work with the Aboriginal community, had not progressed from the *Don't Know How* stage (DN7; DN13). However, the interaction between the two (individual and organisation) is also clearly important, as not all individuals who worked at organisations like Community A had reached the *Barrier Breaker* stage. Therefore, when working in Aboriginal health, it is important to consider the stage that an organisation, profession and individual are at when planning for action. For example, an individual in the *Barrier Breaker* Stage 2 phase might be limited in what they can do when working in an organisation that is at the *Don't Know How* stage, while an individual in the *Don't Know How* or *Too Scared* stage would benefit from being in a *Barrier Breaker* organisation. Exploring the relationship between the stage of workers, organisations and professions warrants further research.

11.6. *Chapter Summary*

In this chapter, I presented a model to help understand the stages that White health professionals go through when working in Aboriginal health. I demonstrated how White dietitians, *ewba* staff and experienced White workers can be classified into these stages based on their characteristics, including approach and attitudes to practice, willingness to working in Aboriginal health, awareness of Aboriginal history, awareness of position in the dominant (White) culture and comfort in discussing racial issues. This model is also strengthened as it can be related to WRI theory (Helms 1984; Helms 1995). The stages of White health professionals act as a model to bring the findings of this research together. To create this model, I have synthesised information from all of the results presented in this research. This model is a quick and straightforward tool that practitioners can relate to and use to address their practice in Aboriginal health. Importantly, the model is not static; workers may move back and forth between the stages based on events and experiences.

The model is primarily about improving practice of White health professionals in Aboriginal health. It reiterates that all White health professionals are at different stages in their journey in Aboriginal health. For example, there was a tendency for those in the *Too Hard* group to focus on the constraining nature of many external barriers. Those in the *Barrier Breaker* group had accepted that they were unable to change many external factors and instead focussed on factors they could address within themselves, such as identifying their Whiteness. Therefore this model has two purposes; first it is a tool to acknowledge and validate that working in Aboriginal health is a journey, and second it provides some insight into how workers may move into the next stage and therefore move forward in their practice.

The identification of the four stages of workers highlights a number of points about the work that White health professionals do in Aboriginal health. Identification of the *Don't Know How* group suggests that health professionals do not necessarily have a general awareness about how to work in Aboriginal health. The *Too Scared* group demonstrates the large amount of fear that surrounds working in Aboriginal health. The fear associated with getting practice "right" and the fear of being racist immobilised the practice of health professionals in the *Too Scared* stage. This fear has also been identified in non-Aboriginal people working in other professions, such as social work (Bennett, Zubrzycki et al. 2011).

The *Too Hard* group, with their focus on external barriers to practice, demonstrates the power of these barriers in constraining practice. Like those in the *Don't Know How* and *Too Scared* stages, the outcome for this group of health professionals was that they took little or no action in Aboriginal health. In contrast, *Barrier Breakers* had moved to a new level of understanding and consequently were able to deliver outcomes in Aboriginal health. Importantly, *Barrier Breakers* had shifted their focus for action from external barriers to themselves as individuals. They identified that addressing individual factors was a way to improve their practice.

For many White health professionals, identifying external barriers to good practice in Aboriginal health was "safe". That is, health professionals did not have to take personal responsibility for anything that went wrong. It was only the *Barrier Breakers* who were able to comment and reflect on themselves in detail. The tendency to refer to external barriers but not themselves was indicative that the worker did not have a good understanding of their role in Aboriginal health. This can be related to my own journey - at the start of this research, I was reluctant to consider and discuss myself; I was afraid of this and the associated discomfort.

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12. Discussion and Conclusions

This research explored the role of White health professionals in addressing Aboriginal health. Through use of a social constructionist epistemology, critical and Whiteness theoretical approaches and reflexivity and CSR methodologies, I explored: my journey as a reflexive dietitian-researcher, the practice of White health professionals including ideal practice, structural elements of systems that can constrain or enable practice and stages that White workers can move through when working in Aboriginal health. In line with a Whiteness theoretical perspective, this work clearly demonstrates that the White health professional has a vital role in addressing Aboriginal health – whether that be through being reflexive in their practice, addressing themselves as an individual or identifying which stage they are at (Chapter 11) and consciously trying to move forward.

As outlined in Chapter 5, in his theory of structuration, Giddens describes systems as consisting of actions of agents when these actions are situated within a specific context and reproduced across time and space. In acting within systems, individuals draw on and use structures (rules and resources) which can either constrain or enable their practice. In using these rules and resources, agents unknowingly reproduce them through their actions. Therefore, the theory of structuration purports that systems and structures are created and maintained through a process of structuration, through the actions of agents. This is summarised in Figure 12.1.

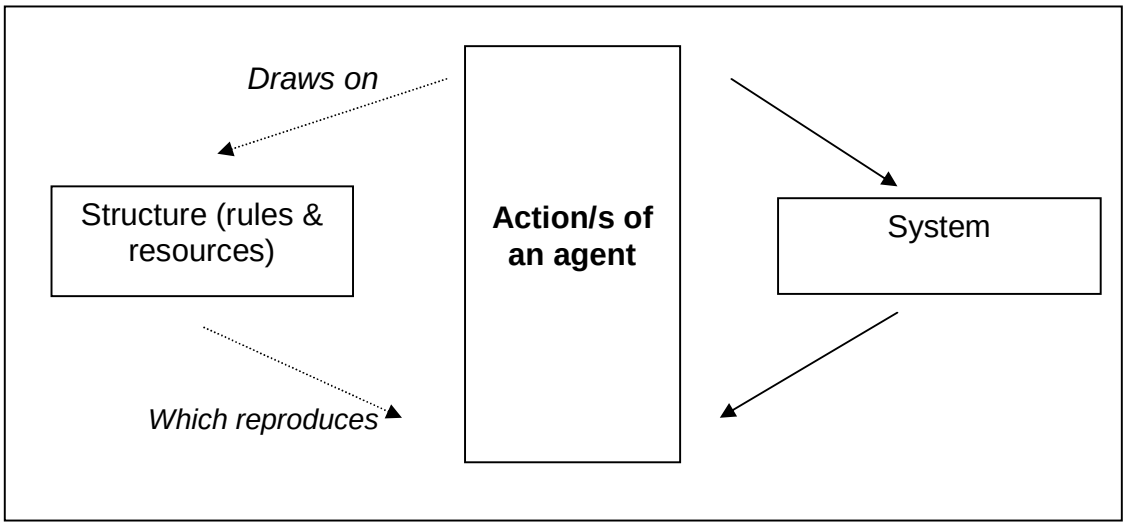


Figure 12.1: The relationship between the actions of agents, structure (rules and resources) and systems in the process of structuration

As identified in Chapter 5, the area of exploration in this thesis is Aboriginal health in SA which can be considered to be a system because it is produced and reproduced through the actions of agents over a specific time and in a specific place. In Chapters 9 and 10, I identified three smaller systems within this larger system of Aboriginal health in SA: the organisation, profession and individual (White health professional). These three areas can be considered systems because not only do they consist of actions of agents in a specific context and are reproduced across time and space, but also there are many rules and resources in these three areas on which White health professionals draw to practice in Aboriginal health, within the wider system of Aboriginal health.

It is therefore pertinent to discuss the key themes of this research in three areas: the organisation, the profession and the individual, which I do in the first part of this chapter. In doing so, I highlight how structuration theory (and other relevant literature and/ or theoretical perspectives such as Whiteness theory) can contribute to an understanding of the key themes of the research. After discussing the key issues and themes, I reflect on the research process including a consideration of the strengths and limitations of this work. I then present recommendations for practice in order to maximise the relevance of this research to practitioners. I finish this chapter and thesis by presenting a final conclusion.

12.1. *Key Themes and Issues*

In this section I discuss the key themes and issues arising from this research. This discussion is presented in three parts. First, I discuss key issues and themes related to the practice of White health professionals. While it is essentially an individual health professional that engages in practice, issues related to practice are relevant at the level of the organisation, profession and individual. As will be consistently highlighted throughout this discussion, an individual practices within a larger context and unless they have the support of their organisation then they may be limited in what they can achieve. Second, I discuss key issues that are relevant specifically to the organisation and the profession. Third, I discuss issues that are most relevant at the individual level.

12.1.1. Practice in Aboriginal health

In this section I discuss key themes and issues related to practice in Aboriginal health. These key themes and issues have been identified to be relevant across the three systems identified in this research: the organisation, profession and the individual.

Relationship building is vital to any practice done with an Aboriginal community

Relationship building is a crucial prerequisite for any work that is done with an Aboriginal community. This was identified consistently by most participants in interviews, and clearly demonstrated through my own experience. Relationships need to be maintained once they are initiated. In this research, I initiated and maintained relationships through informal catch-ups, regular attendance at community events, being a resource person in the community and working with mentors. It is important that managers and organisations support health professionals to build relationships with the Aboriginal community and appreciate the time required to do so. The relationships I built in this research and the processes I used to do so can be a model for practitioners and researchers working in N & D, OP and other areas. Some examples of the references to the importance of relationship building in the literature were discussed in Section 8.4.

Embed reciprocity into any practice that is done with an Aboriginal community

Reciprocity is a key activity for building and maintaining relationships, building trust and rapport with a community and for "giving back" something of value to an Aboriginal community. This was identified by some participants in interviews and demonstrated through my own experience. Reciprocity enables two-way learning and ultimately greater understanding of issues faced by some Aboriginal people, which can enable better practice. It is cited as one of the principles for doing ethical research with Aboriginal communities (NHMRC 2003) and consequently should be incorporated into any program or practice with Aboriginal people. Furthermore, reciprocity is one way to demonstrate respect for Aboriginal people by demonstrating that you value their time and expertise, and are therefore willing to give something back for it. As for relationship building, the processes I used for reciprocity in this research can be used as a model for others. As described in Section 8.4, reciprocity has also been identified as important in other literature.

Engage in reflexivity as part of practice when working with an Aboriginal community

Reflexive practice is an important element of practice for all White health professionals. It is especially relevant when working with Aboriginal communities because it is a strategy through which individuals are able to critique their practice, themselves and their position, and make changes accordingly. However, this research suggested that reflexivity is not widely used by

White health professionals as it was only mentioned as a useful strategy for practice by a small number of (experienced) participants. Therefore, incorporating reflexivity into practice and research represents an opportunity for White health professionals, including dietitians. The use of reflexivity is advocated for in the critical dietetics movement, for example, in order to move dietetics forward (generally or in a specific area such as Aboriginal health), dietitians will need to be inventive, ask "why" questions, challenge the status quo, be willing to make mistakes and take risks (Berenbaum 2005). Similarly, we need to ask questions about "why" and "how" instead of "what" (Buchanan 2004). Meaningful responses to these questions will require the use of reflexivity. Some other uses of reflexivity in the literature were presented in Section 7.4.

The use of reflexivity in this research provides an example to others in the fields of N & D and OP. It clearly demonstrated the benefits of asking questions of oneself during research. Being reflexive enabled me to ask "why" questions in this research and to use my own experience as a prompt to explore the experiences of others. For example, when I felt uncomfortable being in the minority around Aboriginal people, I asked myself why, and through deep self-reflection I found that not being comfortable in identifying as a White person to the Aboriginal people I was working with was a contributing factor. I then sought to identify whether this was also an experience for other White health professionals in interviews. Similarly, being reflexive gave me the courage to challenge the dominant ways of doing research in my profession, and to step outside my comfort zone and take risks when working with Aboriginal people. 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. It is clear that using reflexivity has been vital to this research and added a deeper level of understanding. Consequently, using reflexivity as a research tool is likely to add significant value to research within N & D and OP.

Critically consider strategies for "ideal" practice when working in Aboriginal health

In terms of the practice of White health professionals, this research supports previous evidence about strategies for good practice of health professionals in Aboriginal communities, as demonstrated in Section 8.4. Strategies identified as elements of "ideal" practice in this research include working with AHWs, using appropriate processes, relinquishing control, having an awareness of Aboriginal history, communication, commitment, cultural awareness, flexibility, humility, honesty and persistence. Information about best practice with Aboriginal communities

has not previously been published in the area of N & D in Australia and is minimal in the area of OP; therefore this research is new in that it contributes to these areas.

However, in presenting these strategies as "best" or "ideal" or "good" practice, it is important to provide some clarification. In considering my initial and revised methods for this research, I highlighted that concepts such as "effectiveness" are not necessarily the same for everyone and cannot necessarily be measured. For example, I highlighted the importance of White health professionals and researchers identifying their position, and acknowledging that Aboriginal people may have a different position to them. My growing awareness of different positions, and the implications of this for understandings of key concepts such as "effectiveness", was part of the rationale for the paradigm shift I underwent during this research. I apply the same reasoning to the concept of "ideal" practice here, in that different people will have different views of what this means and what kind of practice is "ideal". However, I continue to name these elements as "ideal" practice in this thesis for a number of reasons. First, while these strategies for practice were commonly reported amongst White health professionals, many of them were also supported by the Aboriginal people I interviewed. Second, I acknowledge that many of the practitioners and researchers reading this research will be looking for a quick guide to working with Aboriginal people. While I have clearly demonstrated in this research that there is no one way to work with Aboriginal communities, I also consider it important to provide some form of guidance to this group of people. Therefore, I present these elements of "ideal" practice with the important caveat that it is important to use a critical approach to consider strategies such as these in the context of the community you are working with and what may and may not be appropriate for that group of people. Therefore this research adds to the body of knowledge about good practice in Aboriginal communities in the areas of N & D and OP and other, related areas.

Be regardful of Aboriginal peoples' and communities' needs and preferences when delivering a mainstream program to an Aboriginal community

This research identified factors to consider when delivering mainstream, CBOPI to Aboriginal communities. This research supports the small body of evidence previously published in this area (Section 3.4), however it also adds new information and is new in the sense that it relates specifically to CBOPI and to Australian Aboriginal people. As for strategies for "ideal" practice presented above, it is important to critically consider the strategies presented here in the context of the specific program and the Aboriginal community being worked with. While these strategies

have been devised with CBOPI in mind, they are also likely to be relevant for mainstream OP programs (not necessarily those that are community-based), other programs or individual health professionals working with Aboriginal communities.

It was clearly evident from this research that programs and health professionals need to be regardful of Aboriginal peoples' and communities' needs and preference when running programs or working with clients. That is, an approach that seeks to address all people within a community without consideration of their different situations (including their race) is unlikely to be appropriate or equitable. This was evident in this research through the detailed interviews and literature reviews which clearly identified, for example, the differing levels of race privilege experienced by White and Aboriginal people and the daily challenges faced by Aboriginal people. Therefore, it is vital that within mainstream programs, strategies are developed that enable programs to be regardful of the needs and preferences of Aboriginal people and communities. However, as identified by a number of participants, it is important to acknowledge difference but not have it the only thing that is focussed on. Using the case of *ewba,* the following were identified as important to consider when being regardful of Aboriginal peoples' and communities' needs and preferences: program planning, timeframe, approach, target group and setting.

Program planning

Mainstream programs wishing to reach Aboriginal people require careful and targeted plans and guidelines based on best practice principles or evidence around working with Aboriginal communities. These need to be developed in conjunction with the Aboriginal communities in question as the needs of every community will differ. "Evidence" includes not only peer reviewed publications and reports, but also most importantly, input from local community members.

Timeframe

To deliver a program successfully with the Aboriginal community, it is likely that more time will be needed. Timeframes need to be responsive and take into account additional time that may be needed for crucial activities, such as building and maintaining relationships.

Approach

This research identified the need for less focus on project brand and more focus on the individual health professionals who are the "face" of the project. A strengths-based approach that avoids colonising, paternalistic practice is important. Working with AHWs is crucial; they link projects with

community members and suggest the most effective approach for each community. Listening to key Aboriginal community members, who can provide guidance about what is and is not appropriate, is the first step. Most importantly, projects must have the flexibility to address and incorporate this feedback and input into their project plan.

Target group

If Aboriginal people are to be involved in a program, an approach that focuses on all ages (i.e. birth to Elders) rather than a single age group should be utilised to meet Aboriginal concepts of family. This acknowledges the important roles of extended family members, including grandparents, aunts and uncles. The concept of "target group" is also relevant when considering where the program will be located. A geographical location that enables involvement of an entire Aboriginal community, rather than just one part of it, is necessary.

Setting

The setting within which the program is located, and that setting's ethos and prior connections to the Aboriginal community, will influence the program. Therefore choice of setting in which to locate the program is important. Ideally, this setting will have an ethos of Aboriginal and White staff working together and extensive cultural training for White staff. Ideally they will also be trusted by the Aboriginal community who feel that that location is a "safe" space and are willing to access it.

12.1.2. The organisation and the profession

In this section I discuss key themes and issues directly relevant to the organisation and the profession as systems within the larger system of Aboriginal health in SA.

Ensure a consistent approach to Aboriginal health across multiple levels

The need for continuity in practice/ approach at levels within the health system was identified in this research and in the literature. In this research, White participants identified that it was difficult to work well in Aboriginal health unless the approach of a manager, organisation and health system were consistent. This was reiterated in the literature, for example, Aboriginal health policy on its own 'is not sufficient to bring about the changes required to improve the health of Aboriginal people when the system through which it is to be implemented is ill-prepared to deliver the policy as intended' (Lloyd and Wise 2011). Similarly, another study found that the knowledge and skills

of individual workers are important but that they are not the only factors that determine the success of policy, for example:

> *The capacity of the health professionals working in a complex health system to change their goals, the focus and the methods of their work, and to build the knowledge and skills they need is limited, unless there is a significant investment by the health sector at the time of releasing a new policy (Lloyd, Wise et al. 2008).*

Continuity across the health system, organisation, management and individual worker, with respect to commitment to Aboriginal health, is important if practitioners are to feel supported and there is to be any real change. Totality; or the need to change at all levels, is important because each is dependent on the other.

Provide and support opportunities for collaboration between Aboriginal and White staff

An expectation at the organisational level that Aboriginal and White staff will work together, and structures that are put in place to enable this collaboration, were identified to assist in good practice. Such collaboration between Aboriginal and White workers also needs to be supported at an organisational and management level. This was evident from the organisational structures in place in Community A that facilitated this sharing.

Provide training and continuous opportunities for White health professionals to reflect on: Whiteness, White privilege and Aboriginal history

It is important that staff receive regular cultural training with continuous opportunities to discuss and reflect on this training, however it is vital that cultural awareness training be accompanied by discussion of concepts including Whiteness theory, White privilege, Aboriginal history and colonisation. This was supported in the literature, where the importance of going beyond cultural awareness training was identified. A number of terms were identified in the literature including cultural awareness, cultural sensitivity, cultural competence and cultural safety. Cultural competence is defined as something that should exist across the workforce at the level of systems, organisations, professions and individuals (Nguyen 2008), starting with managers who would ideally ensure cultural competency of programs and policies of the organisation (Foster 2006). In this research, many of the participants referred to the need for cultural awareness training. However, cultural awareness is only the very first step and can perpetuate stereotyping of

specific cultural groups (Nguyen 2008); as identified in the *Too Hard* stage of workers presented in this research which showed that on its own, cultural awareness training can be a barrier to further practice. Similarly, cultural sensitivity, which is one step beyond cultural awareness and gets people to start thinking about their own beliefs and attitudes (Nguyen 2008), is not enough because 'alone it does not address the effects of colonialism and the power dynamics between health professionals and their clients, nor is it working towards changing the life chances of Maori people' (Jungersen 1992) (p. 746). Cultural safety, which was first discussed by Maori Nurse Irihapeti Ramsden (Ramsden 2002) means that there is no assault on a person's identity (Ramsden 2002). It reorients the idea of effective practice from something that the White worker is in control of to something that the Aboriginal person they are working with defines. Cultural safety provides a framework for how White people can engage with Aboriginal people, once they have identified their own prejudice and attitudes (Nguyen 2008). Furthermore, any type of cultural training should include anti-racism training and a discussion of issues of White privilege, hence taking the focus off racism being an Indigenous problem (Fredericks 2006).

How this might be done, especially with a group of workers who generally do not have a lot of exposure to concepts like Whiteness and White privilege, needs to be considered. The model I present in Chapter 11 provides a good entry point into discussing these concepts. It provides White health professionals with an opportunity to look at themselves and critique their own practice in a non-confronting way. It provides an opportunity to move into a discussion about Whiteness, by considering the characteristics of *Barrier Breakers* in Stage 2 and how others may reach that stage. Providing opportunities for health professionals to receive training about Whiteness gives White health professionals an opportunity to develop the knowledge and skills required to name White as a race. Therefore, this represents an opportunity for White health professionals to draw on a rule/ resource (Whiteness training) that could stop the perpetuation of White being thought of as a "neutral" race, and therefore gain an understanding of the importance of addressing race when working in Aboriginal health.

Increase discourse and dialogue about Aboriginal health, race, Whiteness and fear about working in Aboriginal health

It is clear from the model of stages that workers go through presented in Chapter 11 that greater engagement with racialised discourse was observed in those White workers who had a greater

engagement with practice in Aboriginal health. This racialised discourse included awareness of Aboriginal history, an individual's awareness of their Whiteness, dominant racial culture and racial issues. It was also evident that there was a significant amount of fear associated with discussing racial issues amongst the majority of White health professionals.

One way to alleviate this fear associated with Aboriginal health and race is by bringing these concepts into popular N & D and OP discourse. This is also likely to progress workers through the stages of the model. Organisations, workplaces, universities and professional associations (including DAA) have a responsibility to create an ongoing space to discuss such issues and aid in bringing race into popular discourse in N & D and OP. Some examples of how this may be done are presented in Table 12.1.

Table 12.1: Strategies to bring race into popular discourse at the level of the organisation, profession and individual

System	Strategies
Organisation	Cultural awareness training to cover Whiteness
	Continuous opportunities to reflect on and discuss racial issues & challenges
	Formal and informal opportunities for Aboriginal and White staff to work together
Profession	Opportunities to reflect & discuss issues of race as students & dietitians
	Exposure to racialised discourse e.g. texts
	Exposure to eating styles, food habits and health beliefs of different racial groups
	Use and discussion of racial terminology during dietetic training
	Professional bodies (e.g. DAA) to identify and support racial difference, both in terms of professionals and clients. Look for ways to increase the number of dietitians from different racial backgrounds, including Aboriginal people
Individual	Consider Whiteness
	Consider own beliefs, attitudes and awareness about race and people from different racial groups

Support workers to move into Barrier Breaker stages

The model presented in this research is a practical tool that can be used by White health professionals to reflect on their practice and ideally move forward. On May 26 2011, in conjunction

with three dietitians experienced in Aboriginal health, I conducted a workshop at the DAA National Conference based on this model. This workshop gave participants an opportunity to discuss barriers to practice in Aboriginal health and consider what stage of the model they most identified with. They were invited to discuss the following with other dietitians at the same stage: what is hard about being at that stage, their experiences from being in that stage and potential ways to move forward. Fifty people registered for this workshop and over 40 attended. Since the conference time, I have had requests from other organisations to run the workshop again or assist them in developing similar tools specific to their organisation.

This workshop was very well received by participants. They were comfortably able to identify which group they most identified with, and there was a relatively even distribution with approximately ten individuals in each group, suggesting the model is relevant to dietitians beyond those interviewed in this study. Additionally, this model enabled open conversation between dietitians at this workshop about their work in Aboriginal health; they openly spoke about being too scared or not knowing how to practice. This was an encouraging outcome because in this research I identified that practitioners often do not talk about such issues. This experience suggests that the model could be used to start dialogue among practitioners. An additional positive outcome was the identification by some participants of ways to move through the stages. I have included a summary of the discussion from this workshop, including ideas from participants about potential ways forward, in Appendix 11. This workshop strengthens this research because it suggests that this research, in particular the model, applies to White health professionals beyond those interviewed in this study.

The model presented in this research is also useful because it suggests potential ways forward. The stage-wise nature of the model implies that the ultimate goal is for White health professionals to reach and stay at the *Barrier Breaker* stage. A key consideration is how workers in each stage might be supported to move towards this goal

Those in the *Don't Know How* stage are likely to benefit from practical guidelines, strategies and resources for working in Aboriginal health. Being exposed to the area will help them to move forward. Exposure to the area enables health professionals to reassess any assumptions that may have about working in Aboriginal health. Talking to other White health professionals who work in the area, perhaps in a mentoring role, could assist them in identifying strategies for working in the

area. Documents and guidelines, such "Values and Ethics: Guidelines for ethical conduct in Aboriginal and Torres Strait Islander research" (NHMRC 2003) would also be useful to provide practical tips. Many organisations also release guidelines about working in Aboriginal communities, such as "Working with Aboriginal people and communities: a practical resource" (New South Wales Department of Community Services 2009) and a "Toolkit for Indigenous service provision" (Department of Families, Housing, Community Services and Indigenous Affairs 2010). Making students and less experienced White health professionals aware of resources such as these will be useful. While this may seem obvious, it does not always occur. For example, it is identified that while there is a mandate for OTs to work in Aboriginal health, there is little guidance about how to do this (Thomas, Gray et al. 2011).

Alleviating the fear associated with Aboriginal health is vital for those in the *Too Scared* stage to move forward. One way to do this is to start talking about the issues that people are afraid of, including bringing race into popular discourse. This includes dispelling the myth that there is one "right" way to work in Aboriginal health, and discussing racism. Until race and racism become part of the popular discourse that health professionals are exposed to, it will be difficult to address these issues. Ways in which race can be brought into popular discourse were suggested in Table 12.1. However, the opportunity to discuss and reflect on these issues needs to be ongoing and needs to occur within the individual's specific work and personal contexts. It also needs to be acknowledged that being fearful is a normal part of working in Aboriginal health, and that past failures or bad experiences do not have to be reasons not to try again.

Those in the *Too Hard* group need to be encouraged to look past external factors as barriers to their practice. One way to do this is to introduce the idea of focussing on themselves as individuals (such as their position in the dominant racial culture) and to encourage reflection in this area, including personal ideology, and awareness of Aboriginal history. Ultimately, by increasing their self-awareness and addressing these individual factors, workers in the *Too Hard* group will be able to see past external structural barriers and think about alternative ways to engage with Aboriginal communities, as *Barrier Breakers* have done. They will still be aware of external barriers, but will be able to consider what they can do regardless of them. That is, by acknowledging that individual factors also play a role, it becomes easier to stop attributing all difficulties in Aboriginal health to external barriers.

To move from *Barrier Breaker* Stage 1 to *Barrier Breaker* Stage 2, workers can reflect deeply on their position in the dominant (or other) racial culture and how this influences their work with Aboriginal people. This requires a deep self-reflection and enables one to develop "ownership" of or greater agency towards their role in Aboriginal health, including an understanding of what they contribute; directly and indirectly, consciously and unconsciously. This is a slow process and requires acquisition of an autonomous WRI (Helms 1985; Helms 1995). *Barrier Breakers* in both stages would make good mentors to health professionals in the first three stages. For *Barrier Breakers* to maintain their effective work in Aboriginal health and to remain at this stage, it is important that they are able to debrief with one another and continue to engage in reflexivity.

The model I have developed about stages that White health professionals go through has not been related to Aboriginal people in this research. This is partly because I used a Whiteness lens and took the approach that it is White people who need to address their practice to move Aboriginal health forward. While I did interview Aboriginal workers about how they thought White health professionals should work with them, I did not ask them about how they work with White health professionals. This was due to where I was at in my journey at the time I did interviews. At that time, I would not have felt comfortable questioning Aboriginal peoples' practice with White people because I would not have wanted to seem like I was judging their work.

However, Kim O'Donnell, Aboriginal mentor for this research, identified that this model could be used by Aboriginal people in their work to analyse where White people are "at" in their understanding of Aboriginal health. With this understanding in mind, Aboriginal people could try different approaches to working with White people to enable White people to move closer to becoming Barrier Breakers. However, Aboriginal people must also be reflective of their practice and the ways they interact with White people. This model will assist Kim to place a White person's reaction or comment in the context of these stages first and adjust her practice accordingly, rather than to attribute comments immediately to racism (K O'Donnell 2011, pers. comm., 11 November).

Relating the model to Aboriginal people as well as White people makes it more inclusive. It also provides potential to think about how Aboriginal and White people, at different stages in the model, might interact. Different "combinations" of stages could be explored for more effective ways to work together. A similar thing was explored by Helms (1984) when she looked at how

White people and Black people at different stages of White and Black identity, respectively, work together. This represents an avenue for future research.

Clearly, the model is useful not only for identifying where a White health professional is "at" in their thinking in Aboriginal health, but also for providing a way forward to achieve better practice. This represents an important contribution to research and practice in the areas of N & D and OP.

12.1.3. The individual

In this section I discuss key themes and issues directly relevant to the individual as a system within the larger system of Aboriginal health in SA.

The individual is an important element for action in this research. The individual was identified as one system, containing structural factors (rules and resources) that can either enable or constrain practice in Aboriginal health. An individual has the capacity to address these structural factors that sit within them as an individual. According to Giddens' structuration theory, it is the actions of individual agents that create and maintain systems. Therefore, with respect to the organisation and profession that were also identified as systems, individuals have some agency to address the structural factors within these systems that enable or constrain their practice.

An important part of a critical approach is identifying oppressive forces in society and how groups can be emancipated from these forces. While not an oppressed group in terms of privilege, clearly White health professionals experience some form of oppression, whether it be perceived or real, with regards to barriers that constrain their work in Aboriginal health. In light of this, and the discussion presented in Section 5.4.2 about Habermas' ideas regarding emancipation from structural factors, it is important to consider how White health professionals may be emancipated from these constraints, and therefore improve their practice in Aboriginal health.

Recognise the importance of personal factors (personal ideology) and address any that may constrain practice

Personal ideology refers to personal sets of ideas or ways of looking at things. Elements of personal ideology to affect the practice of White health professionals in Aboriginal health included past experience, passion and commitment, awareness of the limitations of one's knowledge,

awareness of the reality, awareness of one's position, confidence and fear. These factors are supported by existing literature (Section 9.6). The first step in addressing these factors is identifying them as issues and recognising their importance to a White health professional's practice in Aboriginal health. Only after these factors are acknowledged can they be addressed. Using the model presented in Chapter 11 is one way to start talking about some of these issues. Advocating for the recognition of personal ideology is consistent with a social constructionist epistemology because it highlights that practice in Aboriginal health, like knowledge, is not neutral, but rather is shaped by personal ideological factors.

Identify and work through their Whiteness

This research identified that those White professionals who acknowledged and had worked through their Whiteness were better placed to work in Aboriginal health. The different levels of awareness of their Whiteness, and development of a WRI, can be considered in terms of the stages of workers presented in this research. This is important to consider, because a greater understanding of elements related to Whiteness theories may enable movement into this stage.

Don't Know How and Too Scared

Those in the *Don't Know How* and *Too Scared* stages did not see the racialised nature of working in Aboriginal health. These participants can be described as "colour blind" (Frankenberg 1994) because they saw people as people regardless of their racial background. These individuals did not see themselves as White because their Whiteness was invisible to them; they are racially "neutral" (Frankenberg 1994; Moreton-Robinson 2000). These are characteristics of individuals in the contact (first) stage of WRI (Helms 1984) and hence workers at the *Don't Know How* and *Too Scared* stages have the greatest potential to progress in terms of their WRI. The idea that Aboriginal people should be treated the same as White people was a common view held by these participants, and is somewhat similar to that held by Pauline Hanson and John Howard that Aboriginal people should be treated as "ordinary Australians" (Stratton 1998). This approach was also been identified in OTs who did not like to differentiate between different types of clients, including Aboriginal and White (Stedman and Thomas 2011). These approaches demonstrate a lack of understanding of the diversity of Aboriginal peoples and their general desire to be regarded as racially distinct (Stratton 1998). It suggests an approach that focuses on equality (treating people the same) rather than equity (reallocating resources and treating people differently based on what they do and do not have). When considered in the context of structuration theory, this action/ approach perpetuates not naming race which perpetuates an unnamed inequity in race

privilege between Aboriginal people and White health professionals within the system of Aboriginal health, which is unidentified by the majority of people engaging in the action.

Similarly, seeing difference is perceived to be "bad" and workers at the *Don't Know How* and *Too Scared* stages tended to put any differences between Aboriginal and White people down to "culture". Naming culture instead of race is a 'selective attention to difference' 'by means of a partial description (or) euphemism' (Frankenberg 1994, p. 156) which denies the effect of race in Aboriginal people's lives and at the same time continues to allow the worker to feel good about themselves because they have not used a term that makes them feel uncomfortable. Saying that it is about culture has the resulting implication that it is not about race (Stratton 1998). This highlights the lack of discussion about race, and the discomfort associated with it, amongst workers at the *Don't Know How* and *Too Hard* stages.

Moving from Too Scared to Too Hard

Workers in the *Too Scared* and *Too Hard* stage were comfortable in talking about race by referring to racism. This is indicative of being in the disintegration (second out of six) stage of WRI (Helms 1984) which does not suggest a well-developed WRI. By being able to choose how they talk about race, this highlights the power that White workers have in the health system with respect to how they perceive and respond to Aboriginal people. White people have the privilege of deciding what they do and do not talk about when it comes to race (McIntosh 1986; Helms 1993) and therefore they assist in creating the discourses that exist about Aboriginal people. If this discourse is created by a majority of people who are colour-blind, then this power and structural culture of colour evasion will continue to be perpetuated (Frankenberg 1994). In the *Too Hard* group, there was a significant amount of stereotyping of Aboriginal people. This tendency to stereotype is a characteristic of the reintegration (third of six) stage of WRI (Helms 1984).

The excessive focus on external factors by those in the *Too Hard* group has been reported elsewhere in the literature. For example, participants in a workshop about race and culture were more likely to attribute Indigenous ill-health to structural factors than to the agency of Indigenous people (Kowal and Paradies 2005). The authors refer to this as 'overstructuration' of Indigenous ill-health, 'where Indigenous agency is inherently problematic and must always be deemphasised' (Kowal and Paradies 2005, p. 1352).

Feelings of guilt were also evident in some workers at the *Too Scared* stage; one of these participants demonstrated feelings of guilt about what had happened to Aboriginal people in the past and with regards to what she could do in the community, which she felt was not enough. These are very similar to the feelings I experienced when working as a dietitian and at the start of this research. Feelings of guilt tend to accompany acknowledgement of Whiteness and are indicative of being in the disintegration stage of WRI (Helms 1984). This stage can provide some angst because it is the first point at which individuals stop seeing the world as racially neutral (contact stage) and often don't know how to respond to this change in perception (Helms 1984). The role of guilt in the responses of White people to Aboriginal people has been explored elsewhere, with an acknowledgement that attitudes towards Indigenous people are influenced by feelings of guilt (Pedersen, Beven et al. 2004), and the potential for guilt to be a stimulus for White people to find out more about Aboriginal people (Selby 2004).

Barrier Breakers - Stage 1 and 2

Barrier Breakers in Stage 1 had a greater awareness of the role of race in the health system in which they worked, however they were yet to recognise themselves as racialised. Most of these participants acknowledged in some form or other that accessing the health system or organisations was difficult for Aboriginal people because of the way that it is set up. In doing so, they demonstrated some understanding of the effect of racial issues in the health system; such as the "White system" that made it more difficult for Aboriginal people to access health services.

In contrast, *Barrier Breakers* in Stage 2 identified that race was an important factor not only in the lives of Aboriginal people, but also in their own lives. Therefore they saw themselves as racialised. Making racial issues personal is necessary in order to acknowledge and challenge White privilege and the role it has in the lives of White health professionals (Walter, Taylor et al. 2011). *Barrier Breakers* in Stage 2 can be described as race cognisant because they were able to identify the impact of race on the lives of Aboriginal people, identify that race shapes contemporary Australian society, questioned their own role and were generally committed to making change (Frankenberg 1994). Some of the ways in which participants demonstrated they were race cognisant included acknowledging their Whiteness, discussing the impact of their Whiteness on their work and personal life, discussing their White privilege and ways in which they addressed issues of racism and making changes in Aboriginal people's lives. *Barrier Breakers* in Stage 2 were also much less likely to stereotype Aboriginal people and it was common for these individuals to constantly

preface an answer to a question with a statement that they did not want to generalise about Aboriginal people, or to highlight the heterogeneity of Aboriginal people. The acknowledgment of their position as White people is important because it demonstrates that these people are aware of racial difference. This is in contrast to White people who do not feel the need to identify their subject position, because they see their Whiteness as the norm (Moreton-Robinson 2000). In general, people in this group can be described as having an autonomous racial identity (Helms 1984). That is, they were clearly comfortable in their own racial identity because they were able to talk about it, they recognised the heterogeneity of Aboriginal people despite the racial group and they sought opportunities for cross-racial collaborations and approached them is a respectful way.

By examining the difference between *Barrier Breakers* in Stage 2 and those in earlier stages, it was clear that working with Aboriginal people is a stimulus for examining one's self, but that this only emerges over time. This is supported by writers in Whiteness theory who state that to recognise the importance of the self, one has to be exposed to another race (Baldwin 1964; Morrison 1992). This is supported by my own journey, where feelings of discomfort I experienced when working with the Aboriginal community was a stimulus for examining myself. This was also evident in two participants who had recently started working in Aboriginal health and had started this journey in response to challenges and experiences they had recently had. This supports the idea that White dietitians and health professionals could be exposed to Aboriginal people through their university courses to at least start this journey.

As highlighted in the preceding discussion, racial identity can be thought of as a stage-wise process. This is important because this suggests that workers who are not yet very developed in their racial identity can progress. Providing the stimulus for them to do so is something that can be done. Clearly, it is advantageous to be in an autonomous stage of racial identity when working in Aboriginal health as in this research, these individuals were the most comfortable in their position, had good relationships with the Aboriginal community and were the most active in their practice. Different stages of WRI (Helms 1984; Helms 1995) might help to explain the differences observed in those who were aware of themselves as racialised but had different modes of practice. For example, those in the autonomous stage had worked through the guilt and angst often raised in the disintegration stage, meaning that they were freer to focus on their practice without the distraction of such feelings. From my own journey in this research, I can clearly see the development of my WRI. When I immersed myself in Aboriginal communities, I was forced to

acknowledge my Whiteness and this was associated with significant guilt for me (disintegration stage) and the idea that I had to "make up" for something and over time I felt anger about this (reintegration stage). I actively sought contact with Aboriginal people because of this. Over time, and through contact with Aboriginal people, I gradually lost this feeling of guilt and that I had something to make up for. I still spent time with Aboriginal people but it just tended to happen, I didn't have to try too hard (pseudo independent stage). Towards the end of my research I became much more secure in my racial identity and entered the autonomous stage where I was able to work with Aboriginal people as individual people and be aware of racial difference, but not feel that I had something to make up for through this practice.

This discussion highlights how discussing Whiteness theories in the areas of N & D and OP, and focusing on developing White racial identities, is likely to move White health professionals further toward the *Barrier Breaker* category which is likely to be beneficial for their practice in Aboriginal health. Clearly, unless a White health professional recognises their Whiteness and takes this awareness into their practice, they continue to perpetuate a system where race is invisible and is therefore not addressed when working with Aboriginal people. When using a theoretical lens based on structuration theory, one can see the power of an individual recognising their Whiteness. In recognising their Whiteness and drawing on it as a rule or resource in practice, this has the potential to alter individual action and therefore the wider system (for example Aboriginal health in SA). If for no other reason, such action names White as a race which goes a long way to demonstrate an individual will not be complicit in not identifying the unnamed privilege that is given with Whiteness, and they recognise the importance of race in their practice in Aboriginal health.

This highlights the importance of White health professionals identifying their Whiteness, and developing strategies to manage this, in their work with Aboriginal people. This view is supported by research done in the social work profession:

> *...the predominant Whiteness of Australian social work is a crucial issue for the profession and practitioners to engage with to progress our practice with Indigenous people and communities. (Walter, Taylor et al. 2011, p. 6)*

Therefore, this research adds to this body of evidence about the importance of White health professionals identifying their position and provides evidence specific to the areas of N & D and OP.

Reorient thinking away from external barriers

In this research, it was evident from my own personal experiences as a dietitian and researcher, and from interviews, that within the system of Aboriginal health, many White health professionals perceive they have lost their agency. This is evident through the extensive focus on structure (rules and resources), particularly external structure (for example elements within the organisation) as constrainers or enablers of action during participant interviews. Only those in the *Barrier Breaker* group were able to identify their agency, and their role in addressing or perpetuating these structures. They were the group who were able to engage in the most practice in Aboriginal health, suggesting that reorienting thinking away from external barriers, towards the acquisition of agency, is a positive step to improving the practice of White health professionals in Aboriginal health.

This view is supported by structuration theory. It is through a process of structuration that Aboriginal health, as a social system, has come to look like it does. If White health professionals were able to perceive the process of structuration (development and maintenance of a system) as something that their actions were involved in, then perhaps they could think a little more about what they could do to change the structures that they perceive to be constraining them. This is likely to be especially useful for those in the *Too Hard* phase. Therefore, I am suggesting that White health professionals, who are struggling to work in Aboriginal health, re-evaluate their perception of how systems and structures are created and maintained, to be more in line with that proposed by Giddens. That is, health professionals obtain an understanding of structures as something that they draw upon whenever they act within a system and that through using these structures, they reinforce them. In reinforcing these structures, they also reinforce the systems which hold these structures They then have the option to think about whether they continue to draw on the structures they are using or not. The ideas that would need to be presented in order to get dietitians and other White health professionals thinking in this way are outlined in Figure 12.2.

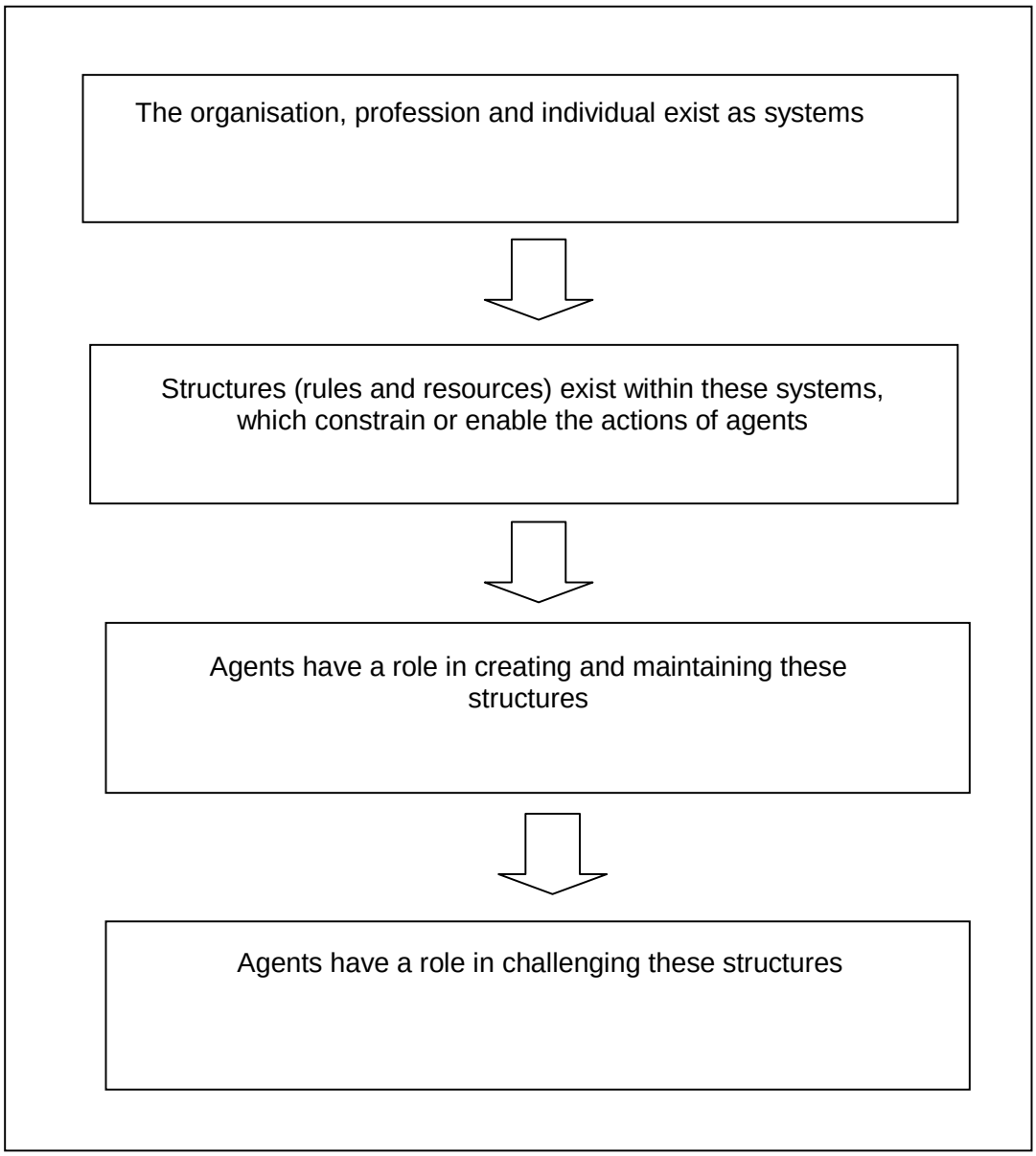


Figure 12.2: Ideas needed to get White health professionals thinking about their role in addressing structures

Figure 12.2 demonstrates that a movement away from focussing on external factors as constraining practice requires an understanding of the idea of the organisation, profession and individual as systems, the existence of structure as the rules and resources within these systems, the role of agents in creating and maintaining these structures and systems and therefore the implication that they have the ability to address them.

It is important to consider what types of structures White health professionals might address, and how. Some of the constraining structures identified in this research, and some suggestions for how to overcome them, are presented in Table 12.2.

Table 12.2: Constraining structures identified within specific systems in this research, and some suggestions for how to overcome them

System	Constraining structure	Ways that individuals could challenge it
Organisation	Tokensim (Section 9.2)	• Identify and challenge instances of tokenism
	Operate in silos (Section 9.2)	• Management to provide opportunities for staff to work together • Actively seek opportunities to work with others
Profession	Perception of role (Section 10.2.1)	• Advocate that Aboriginal health is everybody's business
Individual	Lack of understanding of colonisation (Section 10.3.2)	• Seek opportunities to learn about it • *Barrier Breakers* to advocate importance of learning about it

Importantly, identifying structures that constrain practice can be difficult for an individual to do and requires a certain amount of insight. For example, not all workers identified that having a view of their professional role where they actively try to work with Aboriginal people is enabling to practice. This highlights the advocacy role of *Barrier Breakers* within organisations to get individuals in earlier stages recognising the importance of these issues. Furthermore, as identified in Table 12.2, the main way to overcome structural barriers as an individual health professional is by identifying those things that make practice difficult and acknowledging and actively challenging them, rather than just going along with them. I recognise the challenge inherent in such action and acknowledge that not all White health professionals would have the inclination to do so. Therefore, training White health professionals to have the confidence to be active rather than passive in their practice is an important part of ultimately being able to address structure and ultimately change practice. Reflexivity is one way to encourage health professionals to be active rather than passive because it requires agents to critically assess their actions.

The key to being able to address structure and engage in action rather than being passive lies in engagement with the emancipatory interest (Habermas 1972). As stated in Section 5.4.2, the emancipatory interest is concerned with empowerment, especially the ability to be autonomous and responsible (Grundy 1987). This is in contrast to the technical interest which creates objective knowledge and is interested in control (Grundy 1987). The technical interest is often associated with the empirical-analytic sciences, on which a large part of traditional N & D and OP training is based. The ability to be autonomous and responsible, and change conditions which constrain freedom, are all aspects of the emancipatory interest and are all actions which would assist White health professionals to challenge constraining structures. Therefore a key question is how can White health professionals engage more with the emancipatory interest? In this research, it was only *Barrier Breakers,* especially those in Stage 2, who had engaged with the emancipatory interest, demonstrated by the way that they continued to work in Aboriginal health regardless of the surrounding challenges. They generally did this through the use of reflexivity. Habermas (1972) states that the key to emancipation is self-reflection. I extend this to advocate for the use of reflexivity because it promotes the translation of self-reflections into action. Engagement with the emancipatory interest gave health professionals in this research the ability to engage with and critique their Whiteness, because they looked beyond objective knowledge for ways to improve their practice. Therefore, whether they intended to or not, these health professionals had engaged with a social constructionist epistemology because by engaging with an emancipatory interest, they actively recognised that there is more than one type of knowledge and way of knowing.

However, engaging fully with an emancipatory interest, which in turn may give White health professionals more of an inclination to address structures in their practice, lies much deeper. There are two ways that I see this being possible and sustainable, and I use the example of dietetics to explore these. The first is through university training. Training dietitians to question rather than accept the status quo, to identify what is unspoken and acknowledge this, to incorporate reflexivity into their practice and to have a critical approach, is vital. This is the type of approach that is advocated for in the critical dietetics movement (Aphramor, Asada et al. 2009), suggesting that by training critical dietitians, we are training dietitians who are better placed to identify and challenge oppression. The second is through considering and challenging the dominant foundations on which the dietetics profession is based. Unless dietitians recognise the affiliation that the profession has to the technical interest and the empirical-analytic sciences, then they are unlikely to be able to challenge the ideas associated with such foundations, such as the

idea that there is a “right” way to do something. In this research, I had to challenge these ideas, before I was able to engage with the emancipatory interest and consider how to address issues around dietetic practice in Aboriginal health. Therefore, for White health professionals to engage fully with the ideas of structuration theory, and to see their role in creating and maintaining structure, they need to engage with the emancipatory interest. Reflexivity is an important part of this, but training critical dietitians, and questioning the dominant foundations on which our profession is based, are required for any sustainable change. I demonstrate this visually in Figure 12.3 by expanding on the previous figure, Figure 12.2.

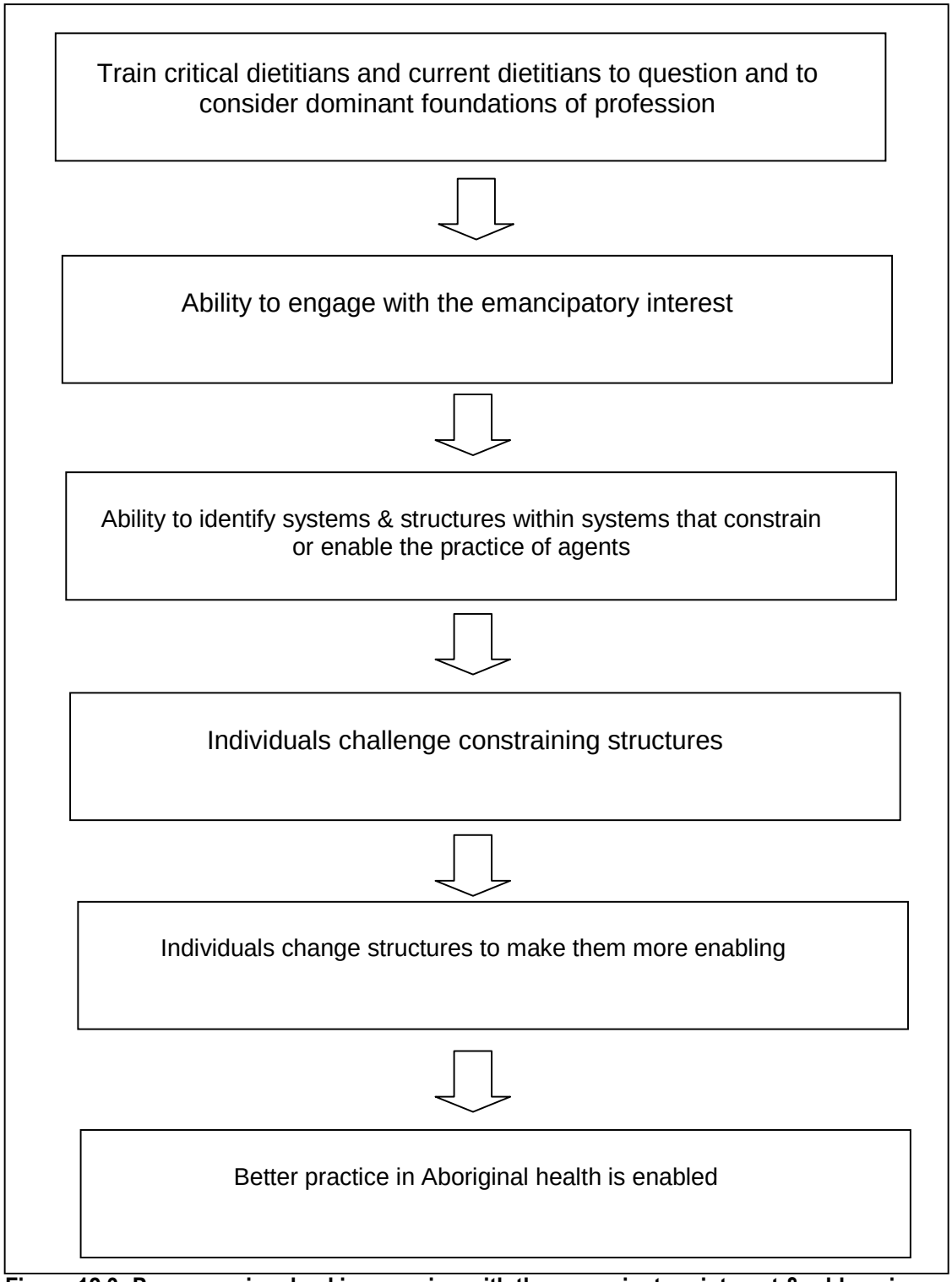


Figure 12.3: Processes involved in engaging with the emancipatory interest & addressing constraining structures to lead to better practice by White health professionals in Aboriginal health

Addressing uncomfortable issues

This research has clearly identified that in order to move forward in Aboriginal health, White health professionals, need to address uncomfortable issues. For example, addressing oppressive structures requires, in many cases, challenging the status quo, while learning to acknowledge one's Whiteness can be confronting.

There are parallels that can be drawn between the uncomfortable issues raised in this research. For example, Whiteness theory can be linked to structuration theory. Structuration theory identifies the role of individuals in creating and maintaining structure, and therefore emphasises the agency individuals have to address these issues. As demonstrated in this research, individuals rarely take responsibility for these issues – it is easier to name external factors as constraining action. Similarly, White individuals rarely see their role in race. Their Whiteness generally remains unmarked and unnamed (Frankenberg 1993). However like structuration theory highlights the role that individuals do have in structure, Whiteness theory highlights the role that White individuals do have in addressing race. If White individuals continue to not name themselves as White, then through a process of structuration, they perpetuate a system that does not acknowledge the importance of race on the lives of both Aboriginal and White people, for example through race discrimination and race privilege respectively. Putting the responsibility to change on White health professionals requires them to acknowledge the privilege granted through their Whiteness and actively address this. In doing so, this helps to re-orient the unequal distribution of power between White health professionals and Aboriginal people. Therefore use of these theories reinforces the role of White health professionals in addressing issues, many of which are uncomfortable, in order to move forward in Aboriginal health.

Similarly, this thesis has been an opportunity for me to address uncomfortable issues, not only in terms of race and Whiteness, but also in terms of challenging the predominant medical, positivist model that is common in dietetics. Power (2011, p. 13) highlights the role of individuals, like myself prior to this research, in perpetuating the positivist, medical model:

> *Some social theorists assume that when a group of people are in positions of relatively less power, they are more likely to support others in less powerful positions. This is not the case. Unless people in less powerful positions challenge the nature and "rules" of the game of power, they are likely to support "the game", to try harder to achieve power by the rules of the game, and to use whatever power they have to support hierarchical relations. This is what dietitians have done by embracing the positivist, reductionist model of medical knowledge and by setting ourselves up as "nutrition experts" against the embodied food knowledge of our patients and clients.*

This is also related to structuration theory; that by continuing to work in a positivist way, dietitians reinforce the system, or contribute to the dominance of positivism and privileging of medical knowledge. Critical dietetics provides an opportunity to challenge this structure, and individuals who engage with this movement are exercising their agency to do so.

Furthermore, I am able to draw parallels between two of the issues raised in this thesis – the invisibility of race in the lives of White people, and the invisibility of positivism in dietetics. Aphramor (2011, p. 2) states that positivism is 'a particular stance that seeks objectivity, so the type of science that wants neutrality is not itself neutral but reflects one philosophical viewpoint'. This highlights that positivist philosophies are one way, not the only way, and that they are not perhaps as "objective" and "neutral" as people think. This raises the question, can we ever truly be neutral when working as White health professionals in Aboriginal health? I do not think so; trying to uphold neutrality just reinforces the ideas that many less experienced workers have about the need to treat everyone the same. And, as I was reminded by one of the Aboriginal participants in this research, *'there is nothing more unequal than the equal treatment of unequals'* (AW8). This is why Whiteness theory is so vital. It shouts that as Whites, 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. Critical dietetics is one approach that invites us to do so.

12.2. *Reflecting on the research process*

12.2.1. Strengths and limitations

Using reflexivity and including my journey in this thesis is a strength. In this research I advocate for White health professionals to identify their own positions, attitudes and values and to work through their Whiteness. I do not feel it would be appropriate for me to suggest such things if I had not performed them myself. Having a deep awareness and understanding of my own journey, particularly in relation to race, enabled me to devise suitable interview questions. It also enabled me to analyse the participant data with the lens of someone who had been through similar experiences.

My position as a PhD Candidate, or a dietitian-researcher, was a strength of this research. Being a researcher dedicated to one research project gave me the time and space to build relationships and enact reciprocity. While I advocate that these strategies should be employed at all costs, it may be more challenging for researchers working on multiple projects or practitioners who have multiple commitments. Throughout this research my role was somewhat fluid in that I moved from holding the role of a dietitian to researcher to mentor to student. This was advantageous because I could use my judgement as to which was the best role for the different situations I was in. For example when attending Aboriginal community events as a PhD Candidate, I was not fully engaged with my dietitian role and therefore I did not spend a lot of time assessing whether the food provided was not in line with healthy eating guidelines.

In this study, I collected all of the data and did all of the analyses which ensured consistency. The relationships that I had built with the majority of the participants prior to interviews meant that they were more likely to give me honest answers. This was especially the case for the Aboriginal participants, with whom I had engaged in reciprocity. In terms of dietitians, while I did not have a well-developed relationship with the interviewees, they knew who I was and saw me as a colleague. However, for all of the interviews there is still the risk that participants were telling me what they thought I wanted to hear, especially in light of the fear of racism that was identified.

While this research will not necessarily apply to all contexts, this is not a weakness because I did not seek to produce generalisable research. Similarly, the majority of data was collected from *ewba* communities; two defined geographical regions. While one was urban and the other rural,

this does not include data from a remote context, which is where many issues around Aboriginal health and nutrition exist in Australia. Despite these factors, it is likely that the learnings from this research will benefit practitioners in other geographical areas. The potential for transferability was reinforced by the relevance of the model to the 40 dietitians who attended the DAA workshop.

I interviewed White health professionals with varied experience, ranging from zero to over 20 years experience. In doing so, I was able to capture issues that may affect health professionals with different amounts of experience. This potentially makes the research relevant to a wider audience. It was important to interview some people who had no, or a small amount, of experience working with Aboriginal people, because this is relatively common, especially amongst dietitians. However, White dietitians who had been working in Aboriginal health, or had some interest in the area, were more likely to respond to my recruitment request. It would be of interest to talk to dietitians and other White health professionals who have no interest working in Aboriginal health and to identify why. However, this would likely be a sensitive topic, considering the political nature of Aboriginal health.

This research does not consider higher level issues such as infrastructure and food supply that are commonly perceived to influence the practice of health professionals with Aboriginal communities. However, this was not the purpose of this work. I am not discounting the importance of these factors by not addressing them. I am simply arguing that there is some redistribution of focus so that White health professionals are better prepared to work in Aboriginal health, and they are supported by a professional and organisational ethos that allows them to do so. In the long run, this focus is likely to contribute positively towards addressing higher level issues.

This research takes the view that it is the responsibility of the White health professional to move forward in Aboriginal health. In taking this view, I am not discounting the importance of the role of Aboriginal people in addressing Aboriginal health. As acknowledged in Chapter 2, Aboriginal people are the ones who are best placed to develop solutions for Aboriginal people (Mattingley and Hampton 1988). Other writers have advocated that non-Aboriginal people have a minimal role in activities such as Aboriginal health research (Humphrey 2001). However, I take the position that through working in partnership with Aboriginal people, and focussing on relationships, White health professionals can take responsibility for moving forward in Aboriginal health, while at the same time acknowledging the vital role of Aboriginal people in developing solutions.

The use of race and Whiteness theories as a lens to interpret data in this research contributes new knowledge in the areas of N & D and OP. It uses these theories in a way so that issues related to race and Whiteness theory can be understood by people without an extensive background knowledge of this area. It has been acknowledged that the majority of literature about 'postcolonial race relations in Australia...[ ]...are generally not accessible to those without prior exposure to critical disciplines' (Kowal and Paradies 2005, p. 1348). This research seeks to contribute to filling this gap.

While I have experienced a significant paradigm shift in order to undertake this research, I also maintain a connection to my initial epistemology and that which is predominant in N & D and OP, positivism. This puts me in a good position to speak with dietitians and other White health professionals who still work from a positivist philosophy. Maintaining this connection will maximise my chances of conveying this research to practitioners and researchers in N & D and OP. I am not a sociologist, nor do I have an interest in operating from a purely positivist orientation. I see myself as a translator because my skills lie in interpreting work located in sociology or social sciences, and presenting them in a way that dietitians operating from a positivist foundation can understand and use. However, I also see it as important to educate others about new ways of thinking and doing research. This is in line with theories of cultural change which identify the need to maintain some connection to the status quo, but to depart enough to make your work and ideas stand out:

> *If the leader comes on too strong, then the culture will rebel. If the leader is overly respectful of the existing culture, he or she will become absorbed into the status quo. (Fullan 2010)*

Therefore, working out how I can maintain a connection to positivism while still working in an alternative paradigm is a question at the forefront of my mind as I complete this research.

12.2.2. Where I am now

I have struggled, particularly in the latter phases of this research, in writing up this thesis. As I near the end of this PhD, my thinking and approach has changed again. My understanding about the use of theories, specifically critical and Whiteness theories, has improved by writing this thesis. Therefore I experienced a dilemma, in that what I had written was indicative of my understanding of my data at one point in time. To some extent, I have been able to expand on my initial analysis in the final version of this thesis. However, I also feel that, given my more

developed skills in the use of qualitative research methods, theory in general, critical theory, and Whiteness theory, I would conduct the research somewhat differently now. For example, I would use Whiteness theory in greater depth to inform the development of interview questions for White health professionals. Despite this, I recognise that this is unavoidable in the process of doing a PhD, and am content to acknowledge that while I would do a lot of this research differently now if I were to do it again, I do not discount my previous decisions and experiences, because at the time I was only acting in the best way that I saw fit. This is one reason that I have sought to include reflection and reflexivity consistently throughout this thesis; to demonstrate how my thinking and approach has changed.

In saying this, I do welcome opportunities for future research, where I can extend this work about race, Whiteness and Aboriginal health, especially in the context of the dietetic profession. I am excited by the prospect of using the skills I have developed during this PhD to undertake such research. I am comforted by the fact that while any new research would still pose a challenge, it is unlikely that I will have to depart from familiarity to the same extent that I did in this research. It is my vision that eventually, concepts of epistemology, qualitative research, critical approaches and social theories will be a usual part of a dietitian's skill set, that such a significant departing from familiarity will not be necessary for anyone.

In reflecting on the extent to which I departed from familiarity in this research, I was drawn to a quote cited by Anderson (2011) in a paper about what critical dietetics means to her. She presents a quote by Schon (1998):

> *Am I going to continue to do the thing I was trained for, on which I base my claims to technical rigor and academic respectability? Or am I going to work on the problems - ill-formed, vague and messy that I have discovered to be real around here?*

Undertaking this research and presenting this thesis was my way of beginning to challenge the systems which can constrain the practice of dietitians – in Aboriginal health and in general. As challenging as this journey has been, it was never an option for me to keep working as I was trained, without addressing the "messy" and "real" problems I identified through my practice as a new graduate dietitian.

12.3. *Recommendations*

In Section 12.1 of this chapter, I discussed the key themes and issues arising from this research. Importantly, I see it as vital that this research is accessible to others, in particular practitioners. The key themes and issues identified in Section 12.1 are those things, based on the evidence from this research and previous research, that would ideally change at the level of the organisation, profession and individual to improve the practice of White health professionals in Aboriginal health. Therefore, I also present these key issues and themes as a series of recommendations for the organisation, profession and individual health professionals. These recommendations are summarised in Table 12.3. These recommendations are likely to be useful for individual White health professionals, their managers and directors of organisations and professional associations. While I have clearly extensively discussed strategies to engage in each of these activities in Section 12.1, I provide one example of how the recommendation could be implemented in practice (Table 12.3). I highlight the level at which this example implementation strategy is likely to be relevant by highlighting the relevant party in bold (for example an individual health professional, manager, profession or organisation). In presenting these recommendations for practice I also acknowledge that different health professionals will be at different stages in their practice in Aboriginal health. These recommendations simply aim to provide a starting point.

Importantly, the epistemological position of this thesis, social constructionism, recognises, values and gives equal voice to multiple discourses. This research is consistent with this epistemological position in that I have not provided judgement about certain discourses being more correct than others. However, this research goes one step further and considers equity when presenting voices, in line with critical and Whiteness theories. Critical and Whiteness theories seek to give voice to the oppressed, which I have done in this thesis, for example by highlighting the privilege White people experience and how this can affect the practice of White health professionals in Aboriginal health. Furthermore, in engaging with a critical theoretical approach, in particular theories of emancipation, it is appropriate and necessary to provide some indication for action, rather than just describing the problem. This provides further justification for the presentation of recommendations from this research.

Table 12.3: Recommendations arising from this research in the areas of practice, organisation & profession and individual

Area	Recommendation	Example of implementation
Practice	Relationship building is vital to any practice done with an Aboriginal community	**Health professionals** can attend Aboriginal community events and their **managers** can support them to do so in work time
	Embed reciprocity into any practice that is done with an Aboriginal community	**Health professionals** can ask Aboriginal people what they can do for them, and temporarily put their own agenda on hold. **Managers** can support them to do so
	Engage in reflexivity as part of practice when working with an Aboriginal community	**Health professionals** can ask "why" questions and seek to change their practice based on answers to these questions and observations
	Critically consider strategies for "ideal" practice when working in Aboriginal health	**Health professionals** can consider what strategies are relevant for the community they are working with by talking to that community
	Be regardful of Aboriginal peoples' and communities' needs and preferences when delivering any mainstream program to an Aboriginal community	**Organisations** and **funding bodies** can insist that programs outline how they will reach Aboriginal communities, and be regardful of their needs and preferences
Organisation & profession	Ensure a consistent approach to Aboriginal health across multiple levels	An **organisation, manager** and **health professional** need to have a consistent approach to Aboriginal health, and value the same things, such as the importance of developing good relationships and the time taken to do so
	Provide and support opportunities for collaboration between Aboriginal and White staff	An **organisation** can provide a structured time and place for sharing between Aboriginal and White staff and **managers** can attend themselves and support **health professionals** to attend

Table 12.3 (continued)

Area	Recommendation	Example of implementation
Organisation & profession continued	Provide training and continuous opportunities for White health professionals to reflect on: Whiteness, White privilege and Aboriginal history	An **organisation** and a **profession** can provide cultural awareness training that includes information and discussion about Whiteness. This can be followed up by regular opportunities for discussion through face-to-face meetings or through the telephone and/ or internet
	Increase discourse and dialogue about Aboriginal health, race, Whiteness and fear about working in Aboriginal health	**Professional associations** can ensure Aboriginal health forms a significant part of university curriculums which includes discussions about race and Whiteness. Such discussions can also be facilitated through the **profession** and **organisations** through discussion.
	Support workers to move into Barrier Breaker stages	**Professional associations, organisations** and managers can direct **health professionals** to resources about how to work in Aboriginal health, provide opportunities to discuss fear associated with the area, highlight the agency that individual **health professionals** do have and provide opportunities for continuous reflexivity and mentoring
Individual	Recognise the importance of personal factors (personal ideology) and address any that may constrain practice	**Health professionals** and **managers** can assess their own personal ideology including confidence, beliefs, attitudes towards and prior experience with Aboriginal people, identify any of these factors that might be constraining their practice, and address them through reflexivity or open discussion
	Reorient thinking away from external barriers	**Health professionals** and **managers** can recognise the role that they play in creating and maintaining structures and systems and therefore regain some agency for addressing Aboriginal health
	Identify and work through Whiteness	**Health professionals** and **managers** can think of themselves as White, work towards developing a White racial identity and avoid perpetuating the invisibility of White as a race

12.4. *Conclusion*

This research presents a new way of looking at Aboriginal health by identifying that White health professionals have a role in addressing Aboriginal health and moving it forward. This research is new and novel in the sense that it has brought new methodologies and approaches into research in the areas of N & D and OP, most notably reflexivity, a critical theoretical approach, social constructionist epistemology and race and Whiteness theories. It is my goal that this research will not only assist White health professionals to move forward in their practice with Aboriginal people, but also contribute to dialogue about alternative ways of knowing, thinking and doing research in N & D and OP.

This research identified the common focus on external barriers that mean many White health professionals find it *Too Hard* to work in Aboriginal health. This research presents the organisation, profession and individual as systems within the larger system of Aboriginal health, which each have structures that can enable or constrain practice. In doing so, and using structuration theory to explore the role of the individual in creating and maintaining these structures, this research provides an opportunity for White health professionals to reorient how they see Aboriginal health. It encourages White health professionals to recognise the agency they do have in addressing barriers, whether that be at the level of the organisation, profession or, in particular, the individual. In doing so, and through engagement with reflexivity and race and Whiteness theories, White health professionals will ultimately obtain emancipation from the external factors that many perceive to constrain their practice, and have an impact on the larger system of Aboriginal health.

In consideration of my initial goals for this research, I have not identified the “right” way to work in Aboriginal health. In contrast, I have identified that there is not one right “way” to work in Aboriginal health. As a White dietitian-researcher, I consciously choose to continue working in Aboriginal health in spite of knowing this fact. I recognise that in order to move forward in Aboriginal health, White health professionals need to address uncomfortable issues. In presenting this thesis, this is the challenge I pose.

APPENDICES

Appendix 1: Review of qualitative literature in N & D

Appendix 1A: Review 1: review of studies from major international nutrition journals with key word "qualitative", 10% selected for review

Reference (setting)	Key words	Epistemology No/ yes (type)	Theory/ framework No/ yes (type)	Methodology No/ yes (type)	Methods No/ yes (type)	Analysis No/ yes (type)	Qual/ quant/ mixed methods	Markers of quality
Bai et al 2009 J Human Nut Diet (Indiana, USA)	Psychosocial factors, mother's decision, exclusive breastfeeding	No	Theory of planned behaviour	No	Open-ended questionnaire (self-administered)	Content analysis – rank & frequency of responses considered (Ajzen & Fishbein 1980)	Qual	Purposive sampling
Bove et al (2003) Appetite (New York, USA)	Food choices, newly married couples	No	No	No	In-depth, semi-structured interviews	Constant comparative method (Glaser & Strauss 1967, Strauss & Corbin 1990)	Qual Excellent study, development of a theory	Interview notes, field notes, transcripts verified using audiotapes by interviewer, prolonged engagement, member checking, team approach to analysis, quotes provided, themes put into 'convergence patterns' (i.e. development of a theory)
Briley et al 1994 JADA (Texas, USA)	Menu, child care centre, grounded theory	No	No	Grounded theory	Interviews, observation	Open & axial coding	Mixed methods	Sampling described, saturation (all centres within certain distance included) but 'saturation' as a word not mentioned

Appendix 1A (continued)

Reference (setting)	Key words	Epistemology No/ yes (type)	Theory/ framework No/ yes (type)	Methodology No/ yes (type)	Methods No/ yes (type)	Analysis No/ yes (type)	Qual/ quant/ mixed methods	Markers of quality
Brotherton & Abbott 2009 J Human Nut Diet (Preston, UK)	Clinical decision making, PEG feeding, patients & carers' perceptions	No	No	No	Semi-structured interviews	Thematic analysis (Carter 2004)	Qual	Purposive sampling; field notes; reflexivity; interview questions provided ; rigorous transcription; written informed consent; relevance/ implications for practice considered
Brown & Miller 2002, Journal of Nutrition Education & Behaviour (Pennsylvania, USA)	Gender role, family food preferences	No	No	No	All completed a gender role preference questionnaire, then some couples were interviewed (semi-structured)	Thematic content analysis, constant comparison, and consensus	Qualitative	Advertising and snowball sampling, couples stratified using questionnaire, questions finalised in 5 pilot interviews, two coders,
Burgess-Champoux, Marquart et al 2006, Journal of Nutrition Education & Behaviour (Minnesota, USA)	Perception, children, parents, teachers, whole-grain foods, school-based intervention	No	Questions based on social cognitive theory	No	Focus groups: 7 with children, 3 with parents, 2 with teachers	Qualitative data analysis procedures to develop common themes from encoded transcripts	Qual	Consent, same moderator for all focus groups, assistant took notes, two independent coders

Appendix 1A (continued)

Reference (setting)	Key words	Epistemology No/ yes (type)	Theory/ framework No/ yes (type)	Methodology No/ yes (type)	Methods No/ yes (type)	Analysis No/ yes (type)	Qual/ quant/ mixed methods	Markers of quality
Carels, Harper et al 2006 Appetite	Perceptions, caloric estimations, healthy & unhealthy foods, weight loss participants	No	No	No	Food healthfulness questionnaire	Coding of open-ended questions (type not specified)	Mixed methods. Qual in this case refers to qualitatively classifying foods	Coding checked for inter-rater reliability, clinical implications considered
Connell, Lofton et al 2005 Journal of Nutrition (Mississippi, USA)	Children, food insecurity, well-being	No	Mentions social learning theory but only in the discussion – used as context for results	No	Semi-structured, in-depth interviews	Constant comparative method (Glaser & Strauss 1967), including frequency of themes mentioned	Qual	Questions included, two interviewers, debriefing after each interview to check similarity of themes emerging, purposeful sampling, saturation reached, quotes included
Derrickson, Sakai et al 2001 Journal of Nutrition Education	Interpretations, balanced meal, food security	No	No	No	77 telephone interviews	Responses categorised into common themes; constant comparative analysis	Qual	70% of data coded by two researchers to check for agreement, remaining 30% consensus ensured
Devine, Jastran et al 2004 JADA (New York State, USA)	Satisfaction, challenges, dietetics & nutrition professionals	No	Ecological model of practice emerged from data	Grounded theory	In-depth interviews	Constant comparative method (Glaser & Strauss 1967; Strauss & Corbin 1998)	Qual	Purposive sampling (Lincoln & Guba 1985), recruitment until saturation reached, informed consent obtained, peer debriefing, member checking, quotes included

Appendix 1A (continued)

Reference (setting)	Key words	Epistemology No/ yes (type)	Theory/ framework No/ yes (type)	Methodology No/ yes (type)	Methods No/ yes (type)	Analysis No/ yes (type)	Qual/ quant/ mixed methods	Markers of quality
Felton, Nickols-Richardson et al 2008 JADA	African-American students, perceptions, professions	No	No	No	Demographic questionnaire with elicitation interviews or focus groups	Phenomenological analysis (Colaizzi 1973)	Qual	Written informed consent obtained, standard methods used for focus groups, same interviewer for all interviews, second person sat in on all interviews & took notes, brief quotes included
Germov & Williams 1996 Appetite (Newcastle, Australia)	Dieting women, sociological approach, food & nutrition	Yes to a paradigmatic discussion – but paper is not research so context is different	Yes to a theoretical discussion – but paper is not research so context is different	N/A	N/A	N/A	N/A	
Griffiths & Bentley 2005 EJCN	Socioeconomic status, overweight, India	No	No	No	In-depth interviews, focus groups	Content analysis (assisted development of a coding scheme)	Mixed methods	Snowball sampling, interview guide pilot tested
Harrison & Jackson 2009 Canadian Journal of Dietetic Practice & Research (Halifax, Canada)	Meanings, youth, unhealthy food, healthy food	Yes (social constructivism)	No	No	Yes (semi-structured interviews)	Yes (thematic analysis)	Qual	Recruitment described, member checking of interview transcripts, peer reviews of interviews

Appendix 1A (continued)

Reference (setting)	Key words	Epistemology No/ yes (type)	Theory/ framework No/ yes (type)	Methodology No/ yes (type)	Methods No/ yes (type)	Analysis No/ yes (type)	Qual/ quant/ mixed methods	Markers of quality
Hart, Herriot et al 2003 J Human Nut & Diet (Surrey & Merseyside, UK)	Healthy diet, exercise patterns, children, parental perspectives	No	No	'qualitative methodology'	Focus groups	Standard qualitative analysis (Krueger 2000) – themes identified	Qual	Judgemental sampling to get a range of SES, discussion schedule provided, quotes included
Holdsworth, Delpeuch et al 2009 J Human Nut & Diet (France & UK)	Acceptability, stakeholders, mandatory nutritional labelling	No	? if relevant - used multi criteria mapping – decision analysis tool	No	Interviews	Criteria clustered into issues	Mixed methods	Snowball sampling, quotes included
Jastran, Bisogni et al 2008 Appetite (Ithaca, USA)	Eating routines	No	No	No	Demographic questionnaire, FFQ, 9 interviews (7 x 24-hour recalls, 1 x eating situations & 1 x summary)	Constant comparative method (Strauss & Corbin 1998)	Qual	Purposive sampling, rapport developed over 9 interviews, interviewer checked transcripts, filed notes taken, consent form signed, data reviewed by all team members, quotes included
Kerschner & Pegues 1998 JADA (Kerschner and Pegues 1998)	Not research							

Appendix 1A (continued)

Reference (setting)	Key words	Epistemology No/ yes (type)	Theory/ framework No/ yes (type)	Methodology No/ yes (type)	Methods No/ yes (type)	Analysis No/ yes (type)	Qual/ quant/ mixed methods	Markers of quality
Kristensen, Holm et al 2002 Appetite (Denmark)	Satiety, social contexts, qualitative interpretations	No	No	No	Semi-structured, in-depth interviews	Not specified, but themes were identified	Qual but part of a larger study that included quant components	Sampling – aimed to cover relevant features& wide variation in social & individual conditions of participants Included quotes
Montagne, Piel et al 2004 Nutrition Reviews								Not relevant – 'qualitative composition' of endogenous protein components
Nelson, Kocos et al 2009 Journal Nutrition Education & Behavior (Minnesota, USA)	Understanding, perceived determinants, weight-related behaviours, qualitative analysis	No	Social cognitive theory used to develop questions	No	6 x focus groups & 10 x one-on-one interviews	Specific thematic analysis (Miles & Hubermann)	Qual	Questions provided, written informed consent obtained, same person for all interviews, two researchers did data analysis & compared
Novotny, Rumpler et al 2001 JADA (Minneapolis USA)	Diet interviews, subject pairs, recall, eating same foods	No – study purpose is to compare qualitative descriptions of food items eaten	No	No	2 x interviews (24-hour recalls)	Quantitative	While food descriptions are qualitative, the analysis is quantitative (mean, median, range etc)	Random selection from database of participants of other studies, written consent obtained

Appendix 1A (continued)

Reference (setting)	Key words	Epistemology No/ yes (type)	Theory/ framework No/ yes (type)	Methodology No/ yes (type)	Methods No/ yes (type)	Analysis No/ yes (type)	Qual/ quant/ mixed methods	Markers of quality
Paisley, Beanlands et al 2008 Journal Nutrition Education & Behavior (Toronto, Canada)	Dietary change, roles, responses, significant others	No	Refers to theory of behaviour change	Constant comparison approach	Semi-structured interviews	Yes – Nudist software & manual coding	Qual	Stratified purposive sampling method, interview guides pre-tested in 4 interviews, consent obtained before & after interview, coding done by 2 researchers, data collection until saturation
Pelletier, McCullum et al 2003 Journal of Nutrition (NY state, USA)	Participation, power, beliefs, food& nutrition policy	No	No	No	Group discussions		Mixed methods	
Piwoz & Bentley 2005 Journal of Nutrition (Asia & Africa)	Women, voices, choices, nutrition, HIV/AIDS	Not relevant – not a research study						
Prattala & Roos 1999 Appetite (Finland)	Review of research on meals	No Review study – not really relevant			3 studies: qualitative interview, health-behaviour questionnaire & dietary survey			

Appendix 1A (continued)

Reference (setting)	Key words	Epistemology No/ yes (type)	Theory/ framework No/ yes (type)	Methodology No/ yes (type)	Methods No/ yes (type)	Analysis No/ yes (type)	Qual/ quant/ mixed methods	Markers of quality
Quandt, Shoaf et al 2006 Journal of Nutrition (North Carolina, USA)	Experiences, Latino immigrant families, food insecurity, hunger	No	No	?ethnographic research	In-depth, open-ended interviews	Codes defined (Arcury & Quandt 1998)	Mixed methods	Informed consent collected, codes discussed between interviewers, quotes included
Quintiliani & Carbone 2005, Journal of Nutrition Education & Behavior (North Carolina, USA)	Impact, cancer prevention messages, cognitive & affective arguments, message characteristics, stage of change, self-efficacy	No	Communicating arguments – affective & cognitive information	No	Telephone and in-person surveys and cognitive response interviews	Statistical (one-way analysis of variance) analysis. Some minor review of qualitative data to supplement quantitative data	Mixed methods	
Rasheed, Frongillo et al 2009 Journal of Nutrition (Matlab, Bangladesh)	Maternal, infant & household factors, breastfeeding trajectories, first 6 months of life	No Quant study informed by qual ***– not relevant***	No	No			Quantitative – appears to use a previous qual study to inform this study	
Rowe 2002 Journal of Nutrition (Washington DC, USA)	Communicating, science-based, nutrition information	***Not relevant*** – not research						'highlights qual and quant data to illustrate consumer confusion (etc) toward nut science and health info'

Appendix 1A (continued)

Reference (setting)	Key words	Epistemology No/ yes (type)	Theory/ framework No/ yes (type)	Methodology No/ yes (type)	Methods No/ yes (type)	Analysis No/ yes (type)	Qual/ quant/ mixed methods	Markers of quality
Scarpello, Poland et al 2009 Journal of Human Nutrition & Dietetics (Norfolk, UK)	Qualitative study, food-related experiences, rural village shop customers	Refer to interpretive approach for analysis but not related to epistemology	Refer to the work of structuralist theorists but do not describe in detail	No	In-depth, semi-structured interviews	Interpretative phenomenological approach (Smith et al 1999; Dibsdall 2002; Daborn 2005)	Qual	Purposive sampling, all four authors involved in analysis, saturation, voice tone & expression considered, researchers discussed results & came to a consensus, quotes included
Sellaeg & Chapman 2008 Appetite (Vancouver, Canada)	Masculinity, food ideals, men who live alone	No	Constructionist approach (Lincoln & Guba 2000) **Refers to 3 additional papers that also use this approach	Not specified (although they say 'we used a qualitative research approach')	Food journals, semi-structured interviews	Constant comparative method (Glaser & Strauss 1967; Miles & Huberman 1994)	Qual	Recruitment through community notices, snowball & purposive sampling, data collection continued until saturation, peer debriefing, rapport established with participants, analysis occurred simultaneously with data collection, quotes included
Shepherd, Neumark-Sztanier et al 2006 JADA (Minnesota, USA)	Weight, calories, obesity prevention, perspectives, adolescent girls	No	No	No	Semi-structured, open-ended interviews	Content analysis & development of coding template (Morse & Field 1995)	Qual	Inter-rater reliability for two coders assessed

Appendix 1A (continued)

Reference (setting)	Key words	Epistemology No/ yes (type)	Theory/ framework No/ yes (type)	Methodology No/ yes (type)	Methods No/ yes (type)	Analysis No/ yes (type)	Qual/ quant/ mixed methods	Markers of quality
Stotts Krall & Lohse 2009, JADA (Pennsylvania, USA)	Low-income, eating competence	No	No	No	Semi-structured interviews	Content analysis & comparative analysis (Bazeley 2003)	Mixed methods	Convenience sampling, notes taken during interview, interview script pilot tested prior to use
Witt Strain et al 1992 JADA (New York, USA)	Food intake, obese persons	No	No	No	Self-reported food record	Not qualitative	Mixed methods	Probably N/A
Woods & Hegsted 1979 Journal of Nutrition (Boston, USA)								***Not relevant*** – 'quant and qual changes in phospholipid in the intestine of the gerbil'

Appendix 1B: Review 2: review of Australian studies with key word 'qualitative', 10% selected for review

Reference (setting)	Key words	Epistemology No/ yes (type)	Theory/ framework No/ yes (type)	Methodology No/ yes (type)	Methods No/ yes (type)	Analysis No/ yes (type)	Qual/ quant/ mixed methods	Markers of quality
Adams, Bowie et al 2008 Nutrition & Dietetics (Melbourne, Australia)	Recognition, medical & nursing professionals, malnutrition, elderly hospitalised patients	No	No	No	Written questionnaire to assess health professional knowledge MNA to assess malnutrition	Number of responses to questionnaire items	Mixed methods	
Hughes & Desbrow 2005 Nutrition & Dietetics (Gold Coast, Australia) (Hughes and Desbrow 2005)	Students, awareness, motivations, expectations, career, dietetics	No	No	No	Open-ended, semi-structured interviews	Qualitative content analysis by both researchers, counts used to identify frequency of themes	Qual	Informed consent given at interview, list of questions provided with inquiry logic (rationale for question), interviews recorded in abbreviated form by two researchers , two researchers compared analysis

Appendix 1B (continued)

Reference (setting)	Key words	Epistemology No/ yes (type)	Theory/ framework No/ yes (type)	Methodology No/ yes (type)	Methods No/ yes (type)	Analysis No/ yes (type)	Qual/ quant/ mixed methods	Markers of quality
Ip, Mehta et al 2007 Nutrition & Dietetics (Adelaide, Australia)	Parent's perceptions, television food advertising, children	No	No	No (but detailed description of focus group method & rationale for qualitative research)	Focus groups with a semi-structured interview schedule	Described but not referenced – essentially identification of themes		Transcripts verified by research supervisors, coding audited, researcher triangulation, same researcher conducted all focus groups with another researcher observing & recording details, interview schedule included & pilot tested, participants sent letter outlining key themes, written consent obtained from participants, quotes included
Irsenring, Bauer et al 2005 Nutrition & Dietetics	Constipation assessment scale, effective tool, bowel function, patients receiving radiotherapy	No (validation of a tool – MCAS – Modified Constipation Assessment Scale)	No	No	Qualitative diet history interview was used to validate some of the information in the MCAS including bowel function and dietary habits	N/A	Mixed methods	

Appendix 1B (continued)

Reference (setting)	Key words	Epistemology No/ yes (type)	Theory/ framework No/ yes (type)	Methodology No/ yes (type)	Methods No/ yes (type)	Analysis No/ yes (type)	Qual/ quant/ mixed methods	Markers of quality
Maubach & Hoek 2010 Nutrition & Dietetics	Qualitative study, parents' views, front-of-pack nutrition labels	No	No	No	Semi-structured depth interviews	Iterative thematic analysis (Braun & Clark 2006)	Qual	Recruitment via-health centres & snowball sampling ceased when saturation reached, interview protocol provided, written informed consent received, option for participants to review transcripts, interviewer checked accuracy of transcripts, quotes included
O'Kane, Craig et al 2008 Nutrition & Dietetics (Rural NSW, Australia)	Rural men, attitudes, health & body image	No	No but some discussion around the cultural constructs of masculinity	No	Focus groups (Hawe et al 1992)	Identification of themes (Hawe et al 1992) & summaries of data (Morgan 1997)	Qual	Focus group questions provided in Appendix, convenience sampling, two facilitators & two research assistants took notes during focus groups, quotes included
Sirikulchayanonta, Idesee et al 2010 Nutrition & Dietetics (Bangkok, Thailand)	Food experience, multimedia, fruit & vegetable consumption, kindergarten children	No	Implementation based on social learning theory (quasi-experimental study)	No	Questionnaires	Scores from questionnaire	Quant	

Appendix 1B (continued)

Reference (setting)	Key words	Epistemology No/ yes (type)	Theory/ framework No/ yes (type)	Methodology No/ yes (type)	Methods No/ yes (type)	Analysis No/ yes (type)	Qual/ quant/ mixed methods	Markers of quality
Temple 2006 Nutrition & Dietetics	Household factors, older Australians, purchasing a varied diet	No	No	No	National cross-sectional survey (ABS) (food purchasing behaviour)	Quant	Quant	
Yeatman, Player et al 2010 Nutrition & Dietetics (Wollongong, NSW)	Women, perceptions, mandatory iodine fortification	No	No	No	Focus groups (justification of their use)	Analysis for recurring words, phrases & themes (Reed & Playton 1997; Elo & Kyngas 2008)	Qual	Convenience sample, schedule (questions) predetermined, one facilitator, quotes provided,

Appendix 2: *ewba* Guiding Principles

Taken from Pettman, McAllister et al 2010

- Sustainability
- Intersectoral action
- Community development approach (i.e. strengthens the community through supporting community participation, building community capacity and strengthening social capital)
- Equitable (i.e. reaches all parts of the community where possible, especially the disadvantaged)
- Inclusive and respectful of Aboriginal communities
- Positive approaches that reduce stigmatisation and victim blaming
- Feasible (i.e. ease of implementation within resource and timeframe context)
- Focus on preventative strategies and those addressing environmental factors in a range of settings with sufficient overall intensity/dose
- Based on best available evidence
- Builds on existing initiatives where appropriate, or identifies opportunities to trial an innovative approach, and adds to evidence base of effective practice in contributing to healthy weight
- Consistent with existing national and state nutrition and physical activity guidelines.

Appendix 3: Log of contact with Aboriginal workers and community members

Appendix 3: Log of contact with Aboriginal workers and community members during this research

Date	Action	Community
March-April 2008	Decided on Aboriginal focus for PhD project	N/A
March-April 2008	Discovered Flinders Aboriginal Health Unit (FAHRU) on the internet	N/A
25.6.08	Attended FAHRU seminar – engaging Aboriginal Communities in Research	N/A
16.7.08	Met with 2 workers from FAHRU	N/A
14.7.08	Michelle reported on my behalf that I was interested in talking to the *ewba* project coordinators about their work with Aboriginal communities at the *ewba* team meeting	N/A
12.8.08	I emailed Community A *ewba* project coordinator and asked if I could meet with her before team meeting to talk about her links with the Aboriginal community in Community A	A
5.8.08	Met with *ewba* manager and first discussed the idea of an Aboriginal Advisory Committee. She provided some advice about who to speak to in Communities A and B	Both
7.8.08	Project Management Committee (PMC) Meeting – spoke with Community A *ewba* project coordinator about who to speak to in the Community A Aboriginal community	A
8.8.08	South Australian Nutrition Network professional development session - working with Aboriginal communities. *Ewba* project coordinator from Community A was there and she introduced me to two key Aboriginal people from Community A who were also there.	N/A

Appendix 3 (continued)

Date	Action	Community
12.8.08	*Ewba* project coordinator (Community A) mentioned she had cultural awareness training the next week and *ewba* manager said she would try and fit me in	A
19-20.8.08	Two day cultural awareness training in Community A. I spoke to the facilitator and asked if I could meet with her at another time to get her thoughts about an Aboriginal Advisory Group for my PhD project.	A
26.8.08	Visited the school cooking program in Community A Met with three key Aboriginal people in Community A to outline my project	A
28-29.8.08	Tried to phone (facilitator of cultural awareness training) to organise meeting time	N/A
1.9.08	(Facilitator of cultural awareness training) phoned me back, meeting organised	N/A
8.9.08	Met the team leader of Aboriginal health in Community A	A
9.9.08	Met with (facilitator of cultural awareness training) at Pt Adelaide	N/A

Appendix 3 (continued)

Date	Action	Community
Sept-Oct 2008	Michelle Jones tried to get in touch with an Aboriginal academic from UniSA who she used to work with	N/A
Oct 13 2008	Annabelle and Michelle met with (Aboriginal academic) at Uni SA. Spoke about my project, what I am hoping to do and also possibilities for co-supervision. She suggested another Aboriginal academic at UniSA to speak to who asked me to email him information about my work.	N/A
14.10.08	Emailed my PhD project info. Suggestions were made about who I could talk to.	N/A
22.10.08	Emailed a non-Aboriginal academic at Flinders University for some advice about working with Aboriginal communities.	N/A
27.10.08	Emailed Aboriginal academics from Yunggorendi (Aboriginal unit) at Flinders University seeking assistance	N/A
4.11.08	Email reply from non-Aboriginal academic at Flinders University about working with Aboriginal people. She invited me to contact her further if I had any specific questions.	N/A
5.11.08	Phoned Aboriginal Health Council to speak with key Aboriginal research contact. He wasn't there so I sent him a brief email requesting a time to chat	N/A
10.11.08	Met with key contact at the Aboriginal Health Council.	N/A
15.11.08	Attended the Aboriginal Health Fair Day at Community A	A
23.1.09	Sent emails to six Aboriginal people in Communities A and B asking if they would sit on an Advisory Committee for my project	Both

Appendix 3 (continued)

Date	Action	Community
23.1.09	Sent emails to a number of internet based interest groups (e.g. Dietitians Association of Australia Indigenous Interest Group) requesting advice	N/A
27.1.09	Phoned the Cooperative Research Centre for Aboriginal Health (CRCAH) based at Flinders University and asked how they could assist me with my work.	N/A
In the week beginning 27.1.09	Received lots of useful responses from the emails sent to internet interest groups	N/A
In the week beginning 27.1.09	Received emails from three of the Aboriginal people I approached to be on the Advisory Group.	Both
30.1.09	Met with one of the Aboriginal people about the Advisory Group.	B
4.2.09	Followed up the other four Aboriginal people who had not yet replied about the Advisory group via phone	Both
12.2.09	Followed up two Aboriginal people who still had not replied, by phone	Both
13.2.09	Met with two people from the CRCAH	N/A
13.2.09	Went to a lunch in Community B for Aboriginal and non-Aboriginal workers to come together	B

Appendix 3 (continued)

Date	Action	Community
16.2.09	Got in touch with a non-Aboriginal worker from the Aboriginal Health Department in SA Health (CRCAH recommended I speak with her)	N/A
23.2.09	Spoke with an academic working in Melbourne with experience in Aboriginal health (CRCAH recommended I speak with her)	N/A
23.2.09	Arranged a meeting with one of the Aboriginal people I contacted about the Advisory Group	B
24.2.09	Contacted two other people by email, recommended by the CRCAH	N/A
25.2.09	Met with Aboriginal person spoke with on 23.2 (Mark Thompson). He agreed to be a mentor to me for this research.	B
26.2.09	Phoned an Aboriginal community member suggested by Mark Thompson.	B
2.3.09	Tried to phone another Aboriginal person initially approached about Advisory group (Kim O'Donnell)	B
4.3.09	Went to Working Together group	A
4.3.09	Met with Aboriginal health leader	A
5.3.09	Spoke with leader of Aboriginal health team– she gave me some contacts and also some info about the community lunches	B
6.3.09	Met with Kim O'Donnell at Flinders	B
10.3.09	Emailed Janet Kelly	N/A
10.3.09	Emailed key education contact	B

Appendix 3 (continued)

Date	Action	Community
11.3.09	Spoke with another contact at the Aboriginal Health Department (SA Health)	N/A
	Went to community lunch– for the first time	B
13.3.09	Spoke to key education contact	B
18.3.09	Attended community lunch and DVDs about Alzheimer's and drug use by the Grannies Group	B
20.3.09	Phoned leader of the local Aboriginal Health Worker's Network – asked to speak to the next meeting. Worker said she would get back to me.	B
20.3.09	Phoned Janet Kelly to make a time to meet	N/A
20.3.09	Attended ethics seminar at Flinders University, worker from Yunggorendi was speaking and I spoke with him afterwards. He suggested some for people for me to talk to.	N/A
23.3.09	Phoned Janet Kelly – meeting set for 25.3.09 at 4pm	N/A
23.3.09	Phoned leader of the Elders group in Community B. Not there so I left a message	B
23.3.09	Spoke with Kim O'Donnell – who is also happy to be a mentor for this research.	B
24.3.09	Went to women's group	B
24.3.09	Went to meeting with Aboriginal Community Education Officers (ACEOs)	B
25.3.09	Met with Janet Kelly for the first time – chatted about PhD issues	N/A
25.3.09	Went to community lunch.	B
26.3.09	Presented to the Dietitians in the region about my project	N/A

Appendix 3 (continued)

Date	Action	Community
26.3.09	Went to lunch where Aboriginal and non-Aboriginal people come together.	B
27.3.09	Phoned the CRCAH – they are organising some people working in Aboriginal health to review my proposed project methods.	N/A
30.3.09	Phoned leader of the Elders group again. Left another message.	B
31.3.09	Met with five others about plans for the school cooking program.	A
1.4.09	Went to community lunch	B
2.4.09	Went to Close the Gap day. I was on the *ewba* stall.	A
21.4.09	Second planning meeting for school cooking program	A
21.4.09	Phoned and spoke to Mark Thompson; set up a meeting for Wed 29th April	B
21.4.09	Phoned and spoke to leader of the Elders group. She is going to talk to the Elders group this week and get back to me – possibly something for next Thursday 30th April	B
22.4.09	Emailed key contact about attending the Elders group. Key contact phoned me back and put me on the next agenda.	A
29.4.09	Met with Mark Thompson	B
4.5.09	Presented at Elders Advisory Committee Meeting	A

Appendix 3 (continued)

Date	Action	Community
5.5.09	Planning meeting for school cooking program and first project session Visited Aboriginal worker at the local Aboriginal gym	A
6.5.09	Attended community Lunch Phoned leader of the Elders group twice – she was in a meeting so left a message for her to return my call	B
12.5.09	Went to women's group– cooked soup and scones	B
14.5.09	Met with Luita Casey	B
15.5.09	Met with Kim O'Donnell	B
19.5.09	Second project session for school cooking program. Brief meeting after with workers	A
26.5.09	Second cooking session for school cooking program	A
27.5.09	Attended the Reconciliation Day Event and movie at local theatre	B
28.5.09	Met with Ngala Cox at Inner Southern. She is happy to be involved in my research.	B
29.5.09	Attended the Reconciliation Day Event	A
2.6.09.09	School cooking program	A
3.6.09.09	Attended community lunch	B
9.6.09	Went to women's group	B
12.6.09	Met with Mark Thompson and two others who had reviewed my proposed interview questions.	B

Appendix 3 (continued)

Date	Action	Community
16.6.09	Met with Luita Casey – general discussion about research and other issues.	B
16.6.09	Spoke to leader of the Elders group and emailed her the diagrams I would like to talk to the elders about. She said she would get back to me. The email address she gave me bounced but luckily I had hers from another source.	B
17.6.09 – 19.6.09	Attended course in Melbourne: Race, Culture, Indigeneity and the Politics of Public Health.	N/A
23.6.09	Attended school cooking program	A
26.6.09	Phoned key contact at local primary school to see if I would be able to work with Aboriginal students. Left a message.	B
30.6.09	Final school cooking session for this term	A
2.7.09	Met with Luita	B
6.7.09	Attended NAIDOC event	B
7.7.09	Phoned Luita to set up another meeting	B
13.7.09	Phoned leader of the Elders group - She received my email but hasn't had a chance to get to it yet due to NAIDOC week. Issues around having guest speakers at social events for the elders.	B
17.7.09	Met with Luita Casey Discussed Terms of Reference and the document I had written about formation of my reference group and interview questions	B
29.7.09	Met with Aboriginal Maternal and Infant Care workers	B

Appendix 3 (continued)

Date	Action	Community
29.7.09	Attended community lunch	B
31.7.09	Met with Luita Casey. Discussion around her uni stuff and also our 'tool' for interviews	B
3.8.09	Talked at Mums and Bubs group with Aboriginal Maternal and Infant Care worker	B
18.8.09	Went to women's group	B
19.8.09	Attended community lunch	B
19.8.09	Met with Luita	B
24.8.09	Met with Luita at her house	B
25.8.09	Went to zoo with the women's group	B
31.8.09	Met with Luita at her house	B
2.09.09	Attended 'working together' meeting	A
7.09.09	Attended Elders meeting	A
9.09.09	Attended community lunch	B
9.09.09	Met with Luita before the lunch	B
11.09.09	Attended Aboriginal Health Workers Network meeting. Shared my plans for my PhD project and got feedback.	B
18.09.09	Meet with Luita, meeting cancelled.	B
22.09.09	Meeting with Luita, meeting cancelled.	B
28.09.09	Met with Luita	B

Appendix 3 (continued)

Date	Action	Community
7.10.09	Working together group	A
20.10.09	Casual visit to Aboriginal workers	A
23.10.09	Meeting with *ewba* project coordinator and Aboriginal worker	A
30.10.09	Met with Luita	B
4.11.09	Working together meeting	A
6.11.09	Spoke with Luita over the phone	B
11.11.09	Met with Luita	B
16.11.09	Attended community lunch	B
24.11.09	Met with Aboriginal workers	A
	Met with *ewba* project coordinator about planning for the future – Aboriginal community	A
26.11.09	Attended Aboriginal health Fair Day	A
30.11.09	Attended community lunch	B
	Planning meeting for women's cooking program	A
3.12.09	Working together group	A
	School cooking program	A
7.12.09	Was meeting with Luita but meeting cancelled	B

Appendix 3 (continued)

Date	Action	Community
10.12.09	Spoke to *ewba* project coordinator and Aboriginal workers about women's cooking program	A
16.12.09	First women's cooking session	A
	Planning for next year with Aboriginal worker and *ewba* project coordinator	A
18.1.10	Met with Luita	B
1.2.10	Attended Elders meeting	A
3.2.10	Attended community lunch	B
4.2.10	Women's cooking group planning session	A
15.2.10	Women's cooking session	A
19.2.10	Met with Luita	B
23.2.10	Went to the movies with the women's group	B
25.2.10	Met with worker	A
1.3.10	Elders meeting	A
	Women's cooking session	A
2.3.10	Women's group	B
3.3.10	Working together meeting	A
15.3.10	Women's cooking session	A

Appendix 3 (continued)

Date	Action	Community
16.3.10	Women's group	B
24.3.10	Attended community lunch	B
25.3.10	Attended Close the Gap Day	A
29.4.10	Women's cooking session	A
30.4.10	Women's group	B
7.4.10	Met with Aboriginal worker	A
12.4.10	Women's cooking session	A
19.4.10	Women's cooking group – supermarket tour	A
20.4.10	Women's craft group	B
22.4.10	Met with Luita at her house	B
28.4.10	Went to community lunch	B
3.5.10	Women's cooking group	A
4.5.10	Women's group	B
7.5.10	Met with Aboriginal Maternal and Infant Care worker	B
12.5.10	Attended community lunch	B
13.5.10	School cooking program	A

Appendix 3 (continued)

Date	Action	Community
17.5.10	Presented at Mums and Bubs group	B
18.5.10	Phoned Luita	B
26.5.10	Attended Sorry Day event	A
27.5.10	Attended Reconciliation Event	B
31.5.10	Phoned Luita	B
10.6.11	Women's cooking, final session	A
1.7.10	Attended public lecture by Aileen Moreton-Robinson	N/A
5.7.10	Attended NAIDOC week event – I had a healthy eating stall	B
14.7.10	Attended community lunch	B
20.7.10	Women's group	B
4.8.10	Working together group	A
11.8.10	Attended community lunch	B
12.8.10	Women's cooking session	A
19.8.10	Women's cooking session	A
20.8.10	Met with Luita	B
25.8.10	Attended community lunch	B
26.8.10	Women's cooking session	A

Appendix 3 (continued)

Date	Action	Community
2.9.10	Women's cooking session	A
9.9.10	Women's cooking session	A
23.9.10	Women's cooking session	A
24.9.10	Met with Luita	B
27.10.10	Attended community lunch	B
4.11.10	Met with Luita	B
8.12.10	Attended community lunch and opening of new Aboriginal health team building	B
20.12.10	Met with Luita	B
13.1.11	Spoke with Aboriginal worker about potential paid work	A
18.1.11	Spoke with Luita	B
4.1.11	Met with Luita	B
17.2.11	Met with Luita, Kim and Janet to brainstorm for presentation (Australian Health Promotion Association conference)	N/A
28.2.11	Spoke with Aboriginal worker about potential paid work – looking to start in May	A
1.3.11	Phoned Luita	N/A
29.3.11	Practice with Luita, Kim and Janet at Flinders University, for Australian Health Promotion Association conference presentation	N/A

Appendix 3 (continued)

Date	Action	Community
12.4.11	Luita and I co-presented at the Australian Health Promotion Association conference in Cairns	N/A
2.5.11	Shared PhD findings with Elders group	A
	Shared PhD findings with Aboriginal workers	A
4.5.11	Shared PhD findings with Working Together group	A
13.5.11	Shared findings with Aboriginal workers & organised a time to share findings with women's group in August	B
18.5.11	PhD final seminar at Flinders University	N/A
26.5.11	DAA conference workshop	N/A
2.6.11	Began paid work in Community A – one day/ week	A

Appendix 4: Terms of Reference for work with Aboriginal Reference Group

The overall purposes of the Reference Group (RG) are as listed:

- To provide a forum for communication between the researcher and the people who are being researched.
- To ensure the research process is open and transparent
- To enable two-way learning to take place: from the point of view of the researcher learning may include cultural protocols or information, correct processes for engagement with a certain Aboriginal community etc; while from the point of view of the RG this may include learnings from the research, or anything else that the researcher can offer from their expertise (e.g. nutrition and dietetic or research information).

Table 1 explains the general roles of the different components of the RG

Table 1: Outline of the roles of the different components of the Reference Group

Organisations	• Provide general guidance e.g. protocols
Mentors	• Answer specific questions e.g. who to speak to in the community, how to speak to people, what not to do, review interview questions or other necessary documents, provide advice in 'tricky' situations • Advice around interpretation of the data
Cultural facilitator	All of the above listed for Mentors, as well as: • Facilitates access to the community i.e. aids with recruitment where possible and appropriate • Available to discuss a wide range of issues related to Aboriginal culture • Co-publication • Assistance with collection of data where possible
Community	• Provide approval • Provide a forum to speak to and access community members • Provide opportunities for reciprocity

Relationship between the Mentors and the PhD Candidate

The relationship between the mentors and the PhD Candidate is such that informal contact occurs between the two on a needs basis. This may occur via email, telephone or face to face contact. The PhD Candidate will make contact with each mentor separately.

The PhD Candidate may ask of the mentor:

- Contact the mentor informally and discuss issues that arise
- Meet with the mentor at a suitable pre-arranged time at a location convenient for the mentor
- Review of pieces of work that are to be used directly with community e.g. questions for interviews, information sheets
- Assistance in interpreting data
- Advice around cultural issues
- Opportunities for co-publication (mainly Cultural Facilitator)

The mentor may ask of the PhD Candidate:

- Advice/ assistance in areas relevant to the PhD Candidate's expertise e.g. dietetics/ nutrition, research
- Highlight areas of interest for co-publication

Relationship between Community and PhD Candidate

Depending on the role of the community group in the Reference Group/ PhD project, the level of contact with community groups will differ. In some cases it is ongoing (on a weekly or fortnightly basis), other times it is more opportunistic and sometimes there will be one off contact. This method was designed due to the different nature and structure of many Aboriginal community groups (for example, some are more formal than others, some meet regularly, others do not). Contact usually happens face to face. Please note that the term 'community' is used here to encompass not only members of the community who are consulted in a non-professional sense, but also Aboriginal workers who are part of that community and may be consulted through a professional setting (for example an Aboriginal Health Worker's network) rather than through a community group. These people still identify themselves as 'community members'.

The PhD Candidate may ask of the community:

- To comment on proposed aspects of the project, for example the project methods. This will occur as part of the consultation process.
    - The consultation process involves showing and discussing all of the elements of the Project Consultation Kit to community members. These elements are outlined in Table 2

Table 2: Elements of the project consultation kit for formal community consultation

Element of Kit	Purpose/ Rationale for inclusion
Project context diagram	To explain the PhD question visually and place the project in context of important areas including Aboriginal health and being healthy. Comments requested.
Project methods diagram	To explain the PhD methods visually and show the inter-relationships between the separate methods. Comments requested.
Structure of Reference Group diagram	To visually represent the Reference Group. Comments requested.
Roles and responsibilities of PhD Candidate and members of the RG (Terms of Reference)	Important to outline roles so that everyone is clear and knows what to expect Ask people what degree of involvement they would like to have and explore opportunities for reciprocity.
Letters of support	For RG members to sign to indicate their support to the ethics committees (these will be forwarded to the committees)

- Their opinions around the issues of the PhD project – for example healthy eating and the Aboriginal community

The Community may ask of the PhD Candidate:

- For input in areas of the Candidate's expertise for example a nutrition session with their community group
- For the research to be reported back/ presented to the community in a certain way
- Suggestions for how the research may be used on completion of the project

Appendix 5: Documents used for consultation (Consultation Kit)

An investigation into Aboriginal peoples' experiences with a mainstream healthy eating and physical activity program

Annabelle Wilson

PhD Candidate

Flinders Uni/ *eat well be active* Community Programs

Phone: 8384 9259 / 0403 899 193

Email: annabelle.wilson@flinders.edu.au; annabelle.wilson@health.sa.gov.au

Thank you for giving me the opportunity to talk at the (insert meeting/ group).

I am here today to:

- Talk to you about a project I am doing that you may be interested in
- Give you a chance to make any comments about this project

This Information Pack contains:

Introduction	Introduces the project, myself and my reasons for doing the project
Project context diagram	Shows how I see the PhD project relating to other areas, including Aboriginal health and being healthy.
Project methods diagram	Shows the methods I will use for the PhD
Structure of Reference Group diagram	Shows the structure of the Reference Group I have been using for the PhD

Annabelle Wilson, PhD Candidate
Brief PhD project summary

I am doing my PhD with the *eat well be active (ewba) Community* Programs, a community-based, childhood OP program. This program encourages children aged 0-18 years and their families to eat well and be active. *ewba* has been run since 2005 and is delivered to the communities of Community A and Community B.

Before starting with *eat well be active* I worked as a dietitian based in a rural area. It was through this work that I developed a strong interest in Aboriginal Health.

In 2008, I decided to combine my interests in Aboriginal health and research and begin a PhD with *ewba*, focusing on how effective *ewba* has been in the Aboriginal communities of Community A and Community B.

My PhD will use *ewba* as an example of a mainstream healthy eating and physical activity program. This research will be a case study, where I investigate what elements of *ewba* were and were not successful in the Aboriginal communities of Community A and Community B, and why and why not.

To answer this question I will be interviewing people from the following groups:

- Aboriginal children and their parents who have been involved in *ewba*
- Workers in Aboriginal organisations who have been involved in *ewba*
- *ewba* project coordinators

I will be talking to these people about:

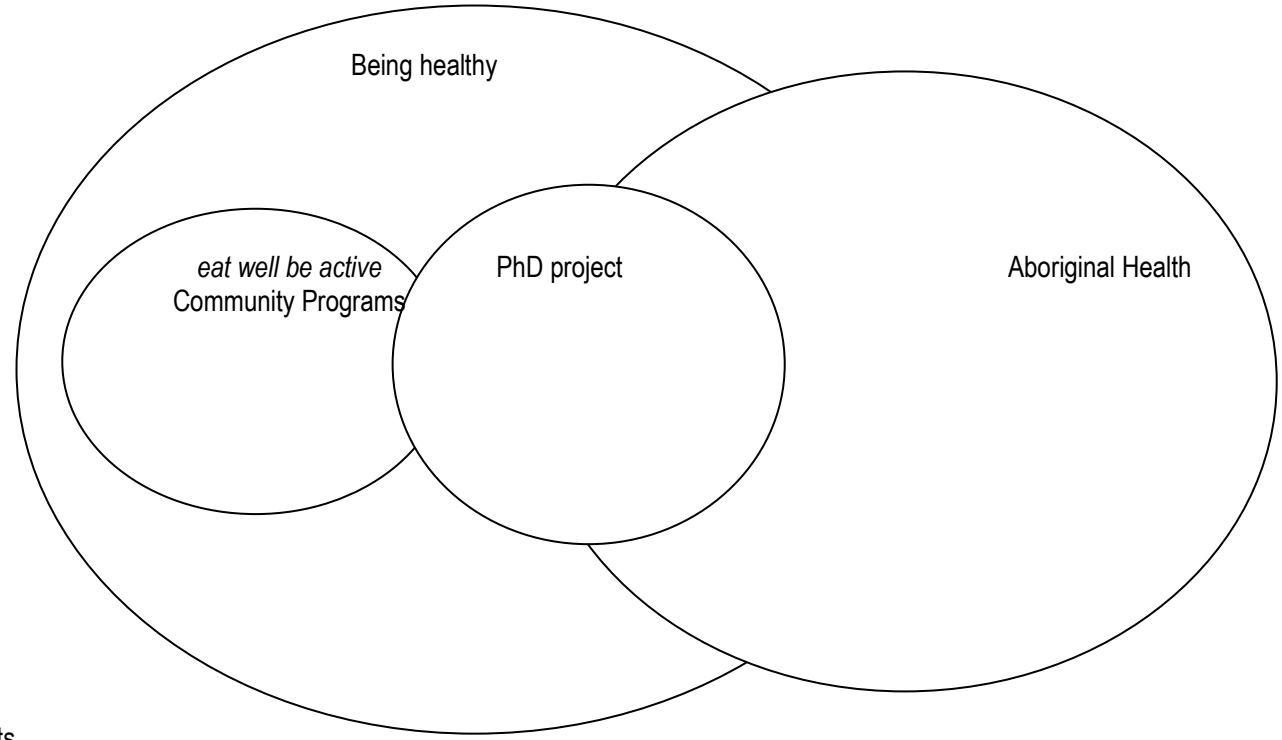
- How they were involved in *ewba*
- What was good about *ewba* and what could have been improved
- Their understanding of the *ewba* key messages
- Understandings of and attitudes towards health in the Aboriginal communities of Community A and Community B
- Working relationships between Aboriginal and non-Aboriginal people involved in *ewba*

I will also be using information obtained from surveys completed by school students in years 5-7 in 2006 and 2009, as well as height, weight and waist circumference, to answer the question.

I have spent a lot of time talking with the Aboriginal communities in Community A and Community B, who have had a considerable input into this project.

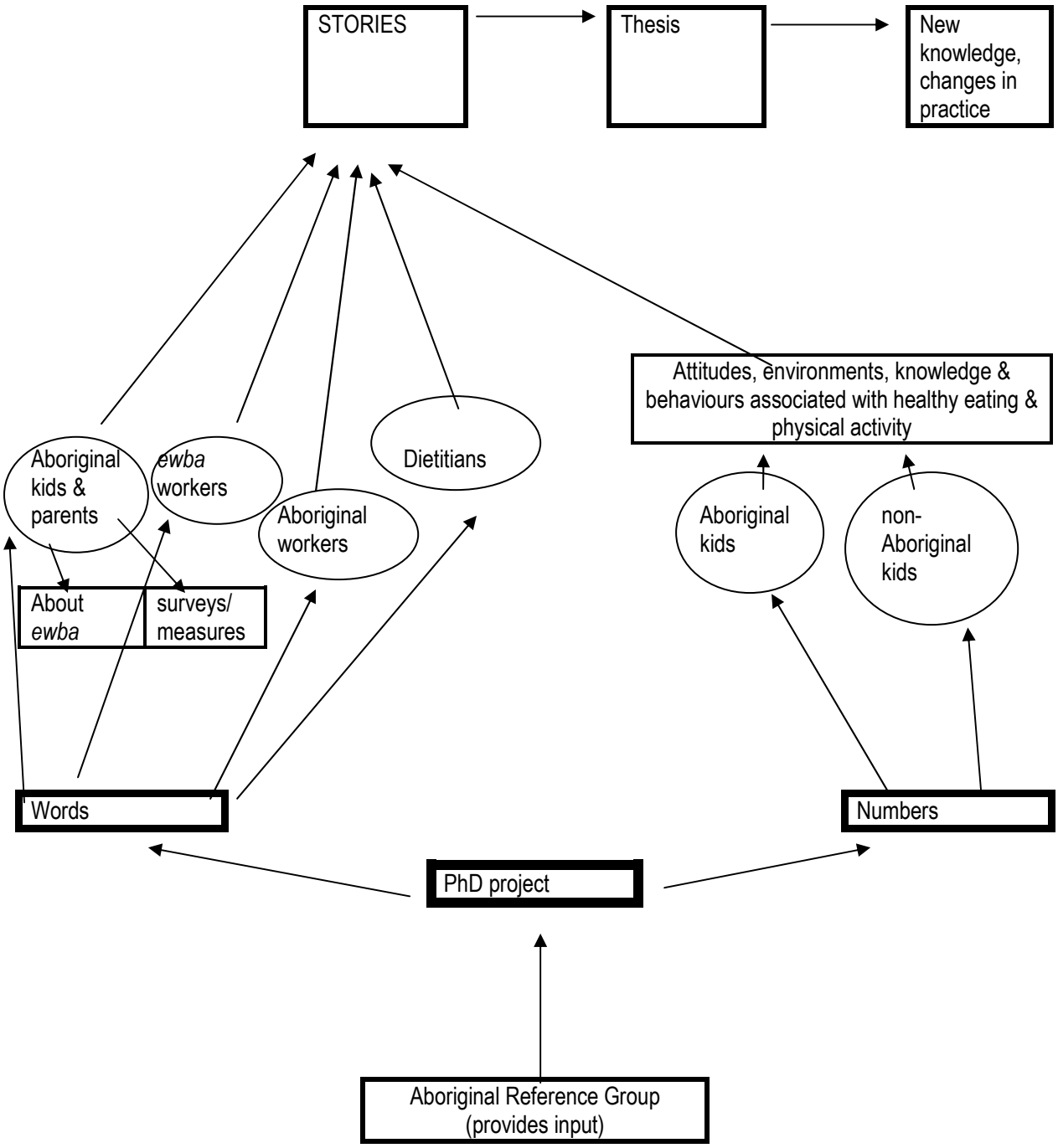
It is my aim that my PhD will create evidence about the experiences of Aboriginal community members and workers with mainstream healthy eating and physical activity programs, and that this information can then be used to recommend how similar programs might be run with the Aboriginal community in the future.

My PhD project in the context of other areas
Annabelle Wilson 2009



Comments
This diagram shows that *ewba* and my PhD project both occur within the context of being healthy (overall this is what they are concerned with). The diagram shows that there is overlap between *ewba* and my project, but that they are not the same thing.
When Aboriginal health is brought into it, part of Aboriginal health overlaps with 'being healthy' as defined by programs like *ewba,* but part of the definition of 'being healthy' is different.
I explain how my project as being like a bridge, it is trying to find a better medium so that there can be some overlap between programs like *ewba* and the Aboriginal health arena, in a more effective way. I talk about the potential for programs like *ewba* to shift more to the right, i.e. to have at least some part rooted in the Aboriginal health arena.

Outline of PhD project methods
Annabelle Wilson 2009

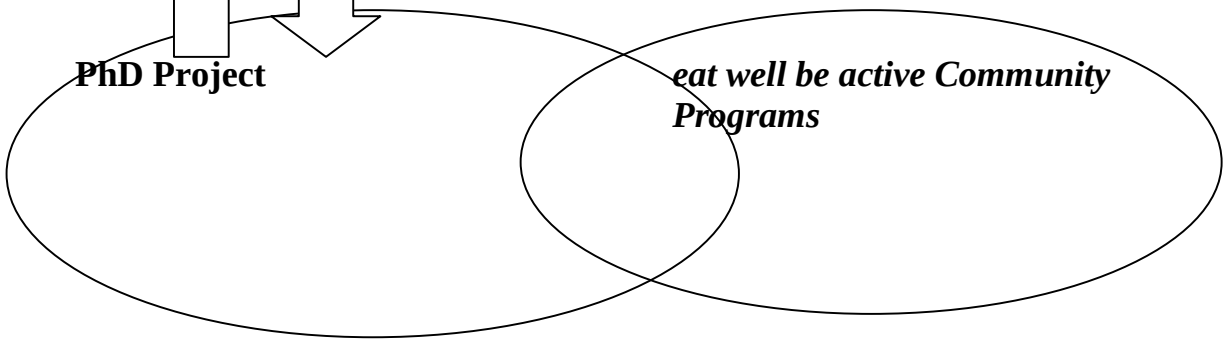


Comments
In this diagram I talk about the two different types of information I am collecting: words and numbers. I explain how each part of the information (data) will contribute a story and that the stories will all be pulled together to write the thesis and (ideally) lead to some new knowledge or change in practice. I also highlight the input of the Reference Group into the project.

Structure of Aboriginal Reference Group
Annabelle Wilson 2009

Aboriginal Reference Group

Organisations	Individual Mentors	Community
e.g. Aboriginal Health Council of SA (AHCSA), Cooperative Research Centre for Aboriginal Health (CRCAH) --Provide general guidance e.g. protocols	--Answer specific questions e.g. who to speak to in the community, how to speak to people, what not to do, review interview questions, provide advice in 'tricky' situations	e.g. Women's' groups, Elders' groups, community lunches, Aboriginal health teams/ services --Provide approval --Provide a forum for me to speak and access community members --Provide opportunities for reciprocity



Appendix 6: Documents used for dissemination of results

Flinders
UNIVERSITY

Annabelle Wilson
B. Nut. Diet. (Hons)
School of Medicine

Rm 7E-102, Level 7, Flinders Medical Centre
GPO Box 2100
Adelaide SA 5001
Telephone +61 8 8204 4715
annabelle.wilson@flinders.edu.au
Facsimile +61 8 8204 6406
www.flinders.edu.au/medicine/sites/nutrition-and-dietetics/

17 November 2011

Name
Position
Address Line 1
Address Line 2
Address Line 3

Dear (participant name)

Thank you for participating in an interview in 2010, as part of my PhD research looking at how White health professionals work in Aboriginal health.

This research is now completed, and I am contacting you to share the findings.

Please see attached a summary of the research including the main findings and some recommendations for future practice.

If you would like any more information or if you would like to discuss any of the findings and/ or recommendations further, please contact me by phone on (phone number) or by email at (email address).

Yours sincerely,

AMWilson

Annabelle Wilson

inspiring
achievement

Annabelle Wilson
B. Nut. Diet. (Hons)
School of Medicine

Rm 7E-102, Level 7, Flinders Medical Centre
GPO Box 2100
Adelaide SA 5001
Telephone +61 8 8204 4715
annabelle.wilson@flinders.edu.au
Facsimile +61 8 8204 6406
www.flinders.edu.au/medicine/sites/nutrition-and-dietetics/

17 November 2011

Name
Position
Address Line 1
Address Line 2
Address Line 3

Dear (project mentor name)

I am writing to formerly thank you for your contribution to my PhD research. As a mentor, you provided me with guidance around planning and undertaking this research in Aboriginal communities, and analysing data and reporting on the research. Your support and expertise was invaluable and again I thank you for your input.

Please see attached a summary of the research including the main findings and some recommendations for future practice, for your information.

If you would like any more information or if you would like to discuss any of the findings and/ or recommendations further, please contact me by phone on (phone number) or by email at (email address).

Yours sincerely,

AM Wilson

Annabelle Wilson

inspiring
achievement

Addressing Uncomfortable Issues: The role of White health professionals in Aboriginal health. Summary of PhD Research.

Annabelle Wilson, PhD Candidate, Flinders University of South Australia
Supervisors: Associate Professor Anthea Magarey, Dr Michelle Jones, Dr Janet Kelly

Background

Australian Aboriginal people experience nutrition related diseases such as kidney disease and diabetes at higher rates than non-Aboriginal Australians. Therefore, health professionals working with Aboriginal people in these areas, including dietitians and diabetes educators, can potentially have a large impact on the health of Aboriginal Australians. While this fact is recognised by many health professionals who are generally willing to work in the area, many consider Aboriginal health to be a complex area of practice. It is therefore pertinent to consider how health professionals might work most effectively in Aboriginal health.

This research investigated the role of White health professionals in addressing Aboriginal health in South Australia. Specifically, it explored the practice of White health professionals working in the areas of obesity prevention and nutrition and dietetics from the point of view of Aboriginal and White workers.

This research arose from practice dilemmas I experienced as a dietitian working in rural and remote South Australia. Willing and interested to work in Aboriginal health, as a new graduate dietitian I lacked the confidence to do so. Hence, I embarked on this research in order to explore the challenges involved in working in Aboriginal health in greater depth, with the view of suggesting some ways forward for myself and other White health professionals working in this area.

Methods

The setting for this research was the *eat well be active* Community Programs, a community-based, childhood obesity prevention program run in South Australia from 2005-2010. Located in one rural and one urban community, I sought to explore how this program was delivered to the Aboriginal communities within the larger rural and urban communities. Throughout the course of the research, I broadened the focus to include dietitians across South Australia, in order to assess the wider context in which White health professionals work in Aboriginal health. This research used a social constructionist epistemology (way of knowing) and critical theoretical approach. Whiteness theories were used as a lens for data analysis of White health professionals' experiences of working in Aboriginal health.

The four main methods used in this research were relationships, reciprocity, reflexivity and semi-structured interviews. These were informed by documents outlining guidelines for ethical research in Aboriginal health (NHMRC 2003; NHMRC 2006). These methods provide examples of ethical research and practice in Aboriginal health and are likely to be useful to practitioners and researchers.

Relationships

In order to conduct ethical research, I worked closely with Aboriginal community members and workers in both *eat well be active* communities, through building and maintaining relationships. This involved attending community events, working closely with Aboriginal mentors, informal catch-ups with local Aboriginal workers and community members and spending time in the community.

Reciprocity

Reciprocity involved giving something back to the communities I was working with, in exchange for information and experiences shared with me. My skills in nutrition represented a valuable opportunity for reciprocity. All activities of reciprocity were based on requests from Aboriginal workers or community members and I tailored my approach based on the interests of a specific group. Examples included assisting with community cooking groups and community events. Over a two-year period, I spent between half and one day per week on activities of reciprocity.

Reflexivity

Reflexivity is the process by which researchers notice their responses to people, events and the world around them and then use that knowledge to inform their actions, communications and understandings (Etherington 2004). I kept a reflexive journal throughout this research which enabled me to consider the ways that I influenced the research, my position as a White dietitian-researcher and the attitudes and values I brought to the research.

Semi-structured interviews

Forty-one semi-structured interviews and one focus group were conducted for this research. This included 21 dietitians, 7 staff members from the *eat well be active* Community Programs, 7 White health professionals with extensive experience in Aboriginal health (more than 15 years) and 9 Aboriginal workers.

Results

This research identified some strategies that are important for White health professionals to engage in when practising in Aboriginal health (Table 1). These were identified by both Aboriginal and White workers interviewed.

Table 1: Important strategies for practice for White health professionals working in Aboriginal health

Awareness of Aboriginal history	Humility
Awareness of one's Whiteness	Persistence
Building relationships	Reciprocity
Commitment	Reflexivity
Communication	Relinquishing control
Cultural awareness	Using appropriate processes
Flexibility	Working with Aboriginal health staff
Honesty	

However, White health professionals were not always able to engage in these strategies as part of their work in Aboriginal health. Elements within an organisation, profession and individual were identified to either enable or constrain such practice. These factors are summarised in Table 2.

Table 2: Factors identified to enable or constrain the practice of White health professionals with Aboriginal people, at the level of the organisation, profession and individual

Level	Enabling Factor	Constraining Factor
Organisation	An expectation that Aboriginal and White staff would work together	Operate in silos
	Cultural training for staff	Tokenism
	Aboriginal specific positions	Staff turnover
	Support for Aboriginal staff	Statistics/ reporting
	Management support	
	Health services are flexible	
	Health services are welcoming to Aboriginal people	
Profession	Perception of role – chose to focus on Aboriginal health	Perception of role – position description stipulates work in Aboriginal health
	Characteristics of health professionals in certain professions (e.g. dietitians) and professional associations may be both enabling and constraining	
Individual	Past experience with Aboriginal people	Fear
	Passion & commitment	Lack of confidence
	Awareness of limitations of knowledge	
	Awareness of the "reality" of working in Aboriginal health	
	Awareness of position (Whiteness)	
	Confidence	
	Understanding of colonisation, its continued impact & how to address this through practice	

Furthermore, at the individual level, White health professionals were identified to pass through four stages in their practice in Aboriginal health, as demonstrated in Figure 1. These stages include Don't Know How (not knowing how to work in Aboriginal health), Too Scared (being too scared to work in Aboriginal health), Too Hard (feeling like working in Aboriginal health is too hard) and Barrier Breaker (working in Aboriginal health regardless of the challenges). Within these stages, health professionals had different levels of confidence, past experience working with Aboriginal people, awareness of Aboriginal history and their own Whiteness, attitudes and beliefs.

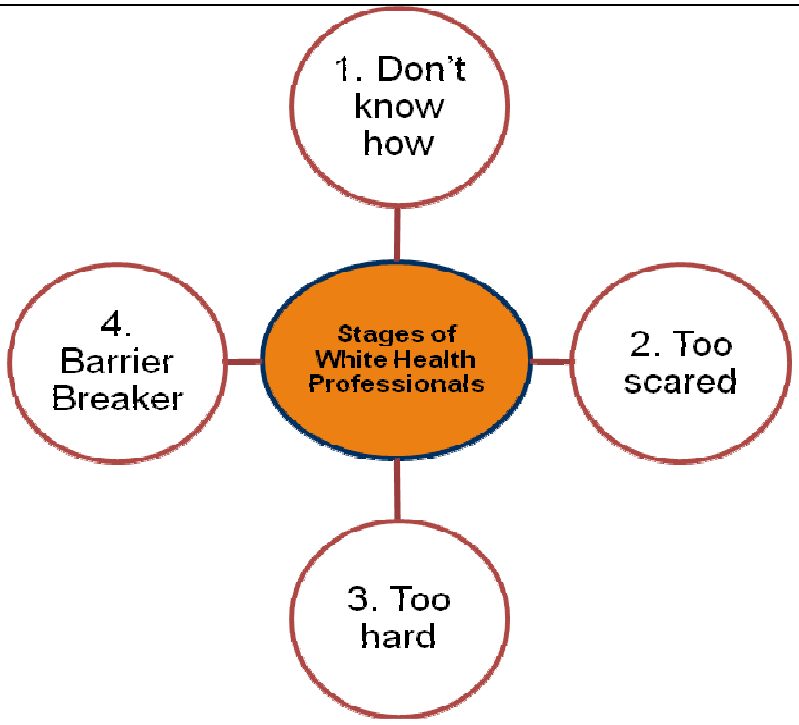


Figure 1: The four stages of White health professionals identified in this research

Therefore, this research identified the importance of addressing elements within an organisation, profession and individual in order to address the practice of White health professionals in Aboriginal health. In particular, it demonstrated the role of individual White health professionals in addressing Aboriginal health through looking at themselves, which generally requires them to address uncomfortable issues.

Recommendations made from this research are presented in Table 3. The recommendations are presented for practice in Aboriginal health, as well as at the level of the organisation, profession and individual, highlighting the importance of change in all of these areas. These recommendations highlight that even when large-scale change may not possible, something can still be addressed. For example, individuals can consider personal factors (such as attitudes and beliefs) and how these might influence their practice in Aboriginal health.

Table 3: Recommendations arising from this research in the areas of practice, organisation & profession and individual

Area	Recommendation
Practice	Relationship building is vital to any practice done with an Aboriginal community
	Embed reciprocity into any practice that is done with an Aboriginal community
	Engage in reflexivity as part of practice when working with an Aboriginal community
	Critically consider strategies for "ideal" practice when working in Aboriginal health
	Be regardful of Aboriginal peoples' and communities' needs and preferences when delivering any mainstream program to an Aboriginal community
Organisation & profession	Ensure a consistent approach to Aboriginal health across multiple levels
	Provide and support opportunities for collaboration between Aboriginal and White staff
	Provide training and continuous opportunities for White health professionals to reflect on: Whiteness, White privilege and Aboriginal history
	Increase discourse and dialogue about Aboriginal health, race, Whiteness and fear about working in Aboriginal health
	Support workers to move into Barrier Breaker stages
Individual	Recognise the importance of personal factors and address any that may constrain practice
	Reorient thinking away from external barriers
	Identify and work through Whiteness

Please contact Annabelle Wilson (email address) if you would like any more information about anything reported in this summary.

Appendix 7: Ethics approval letters

Flinders University and Southern Adelaide Health Service

SOCIAL AND BEHAVIOURAL RESEARCH ETHICS COMMITTEE

Room B1, Union Building, Flinders University,
GPO Box 2100, ADELAIDE SA 5001
Phone: (08) 8201 3116
Email: human.researchethics@flinders.edu.au

FINAL APPROVAL NOTICE

Principal Researcher:	Ms Annabelle Wilson
Address:	Southern Primary Heatlh PO Box 437 Noarlunga Centre, SA, 5168
Project Title:	Transferability of a mainstream community-based childhood obesity prevention program to Aboriginal people
Project No.:	**4455**
Approval Expiry Date:	**31 December 2011**

The above proposed project has been **approved** on the basis of the information contained in the application, its attachments and the information subsequently provided.

In accordance with the undertaking you provided in your application for ethics approval for the project, please inform the Social and Behavioural Research Ethics Committee, giving reasons, if the research project is discontinued before the expected date of completion.

You are also required to report anything which might warrant review of ethical approval of the protocol. Such matters include:

- serious or unexpected adverse effects on participants;
- proposed changes in the protocol; and
- unforeseen events that might affect continued ethical acceptability of the project.

In order to comply with monitoring requirements of the *National Statement on Ethical Conduct in Human Research (March 2007)* an annual progress and/or final report must be submitted. A copy of the pro forma is available from http://www.flinders.edu.au/research/info-for-researchers/ethics/committees/social-behavioural.cfm. Your first report is due on **9 June 2010** or on completion of the project, whichever is the earliest. *Please retain this notice for reference when completing annual progress or final reports.*

Andrea Jacobs
Acting Secretary
Social and Behavioural Research Ethics Committee
11 June 2009

cc: Dr Anthea Magarey, Nutrition and Dietetics
Dr Michelle Jones, Southern Primary Health, PO Box 437, Noarlunga Centre SA 5168

NB: ***If you are a scholarship holder and you receive funding for your research through the National Health & Medical Research Council please forward a copy of this letter to the Head, Higher Degree Administration and Scholarships Office, for forwarding to the NHMRC.***

AHREC

ABORIGINAL HEALTH
RESEARCH ETHICS COMMITTEE

12th May 2009

Ms Annabelle Wilson
Eat Well Be Active Community Programs
Department of Nutrition and Dietetics
Southern Primary Health
GPO Box 437
Noarlunga SA
5168

Reference No: **04-09-285**

Dear Annabelle

Thank you for submitting your research project, *Transferability of a mainstream community-based childhood obesity prevention program to Aboriginal people*, on the 15th April 2009 for ethical consideration.

At our last meeting your application was assessed and I am pleased to inform you that this proposal has met with support and that the committee has decided that your application be recommended.

In accordance with the NH&MRC guidelines, *National Statement on Ethical Conduct in Research Involving Humans*, we require at regular periods, at least annually, reports from principle researchers.

If you require any further information please do not hesitate to contact the Executive Officer or myself.

We wish you well with the project and look forward to receiving a copy of your report.

Sincerely yours
Lot Evans

MS LUCY EVANS
ACTING CHAIRPERSON
Ref: Proposal/Approval/12May2009

Aboriginal Health Council
of South Australia Inc.

AHREC is a sub-committee of AHCSA

78 Fullarton Road Norwood SA 5067 PO Box 787 Kent Town SA 5067
Tel: (08) 8132 6700 Fax: (08) 8132 6799 Email: alwin.chong@ahcsa.org.au Website: www.ahcsa.org.au

Government of South Australia
SA Health

Human Research Ethics Committee

ABN 97 643 356 590

Level 10, CitiCentre
11 Hindmarsh Square
Adelaide SA 5000

PO Box 287
Rundle Mall
Adelaide 5000
Telephone (08) 8226 6064
Facsimile (08) 8226 7088

Ms Annabelle Wilson
PhD Candidate
Eat well be active Community Programs
PO Box 437
NOARLUNGA CENTRE SA 5168

Dear Ms Wilson,

Re: Transferability of a mainstream community-based childhood obesity prevention program to Aboriginal people.

HREC PROTOCOL NO: 293/05/2012

Thank you for responding to the issues raised by the Department of Health Human Research Ethics Committee in relation to the above project. The Committee considered your response out-of-session.

I am pleased to advise that ethics approval has been granted to this project, subject to the following conditions:

- The research being conducted in accordance with the 'National Statement on Ethical Conduct in Human Research.'
- Provision of a final report when the project is completed.
- Immediate notification to HREC of any complaints by or adverse events involving participants.
- Immediate notification of any unforeseen events that might affect continued ethical acceptability of the project.
- Submission of any significant changes to the original proposal. Such changes should be approved by the HREC before they are implemented.
- Immediate advice, giving reasons, if the project is discontinued before its completion.

Approval is given for a period of three (3) years only, and if the research is more prolonged than this, a new submission will be required.

Should you have any questions or concerns, please contact Sarah Lawson, Executive Officer of the HREC, Tel 8226 6367 or E-mail hrec@health.sa.gov.au

We wish you well with your project.

Yours sincerely,

Andrew Stanley
CHAIRPERSON
HUMAN RESEARCH ETHICS COMMITTEE

23/07/2009

Government of South Australia
Department of Education and Children's Services

Policy Directorate
Education Centre
Level 8/31 Flinders Street
Adelaide 5000
South Australia

Tel: 8226 2154
Fax: 8226 7839

DECS CS/06/0116-2.7

24 June 2009

Ms Annabelle Wilson
Flinders University
GPO Box 2100
ADELAIDE SA 5001

Dear Ms Wilson

Re: Amendment to Research Project Titled "Evaluation of the eat well be active Community Programs."

Thank you for providing information about the amendments made to your approved proposal.

I am pleased to inform you that the amendments were assessed and hereby grant approval for the research to proceed. This approval applies to the following amendments:

- *ewba* surveys to be used for follow up quantitative data collection.
- methods that will be used in the PhD project associated with *ewba*.

Please supply the department with an electronic copy of the final report, which will be circulated to interested staff and then made available to DECS educators for future reference.

I wish you well with your project.

Lois Mirdam
for

Liz Furler
EXECUTIVE DIRECTOR
POLICY DIRECTORATE

Appendix 8: Letters of support from Aboriginal communities to ethics committees

Flinders UNIVERSITY

Department of Nutrition and Dietetics
Flinders University
GPO Box 2100
Adelaide SA 5001
Tel: 08 8204 4715
Fax: 08 8204 6306
annabelle.wilson@flinders.edu.au
www.flinders.edu.au
CRICOS Provider No. 00114A

LETTER OF SUPPORT TO ETHICS COMMITTEES

Regarding the project: Transferability of a mainstream community-based childhood obesity prevention program (the *eat well be active* Community Programs) to Aboriginal people

eat well be active.
Community Programs

This letter is designed to indicate support of the above PhD project by key Aboriginal organisations/ groups. It will be used as a letter of support when applying to Ethics Committees for ethical approval of this PhD project.

I (name) ..... (position) Aboriginal Services Manager ..... of

(organisation/ group) CHSA .....

have met with Annabelle Wilson (PhD Student), have received verbal and/ or written information about the PhD project and support this project to take place through my organization/ group.

Signed: ..... Date: 31/3/09 .....

For more information please contact:
Annabelle Wilson
PhD Candidate
Phone: 8384 9259
Email: annabelle.wilson@flinders.edu.au

ABN 65 524 596 200 CRICOS Provider No. 00114A

Appendix 9: Interview questions

Interview questions – Aboriginal workers

Thank you for agreeing to take part in a formal interview for my PhD. In this interview I would like to talk to you about a number of themes. We will start by talking about health in general, then move on to your experiences with *ewba* and then talk more in general about Aboriginal health and mainstream programs and approaches.

Consent form and Information Sheet.

I would like to invite you to share both positive and negative experiences. Please be honest during this interview and feel free to talk about any bad experiences that you may have had. What you say will be deidentified which means that no-one will know who said what in my Thesis (report). If you say something that you feel will identify you and you do not wish for me to use it then please let me know. You will have the opportunity to review the transcript (typed up) version of this interview. While I have been involved with *ewba,* my personal commitment is about improving the way that healthcare is delivered for Aboriginal people.

Health

1. What do you think makes an Aboriginal person healthy? Is this different to what makes a (non-Aboriginal) person healthy? How is it the same or different? Why?

2. What stops or helps Aboriginal people to eat healthy food and be active?

eat well be active

3. What do you know about the *eat well be active* Community Programs?

- *Prompt: role of project, project aims, who does the project work with?*

4. How has *eat well be active supported* you/ your organisation in your work?

- *What could eat well be active have offered you/ supported you with that would have been useful to you/ the Aboriginal community?*
- *Did you feel that you could ask for such things?*

6. *eat well be active* aimed to target the Aboriginal community in Community B and Community A, however the Aboriginal community was not the **main** target of the program.
    - Has *ewba* been as accessible for Aboriginal community members in Community A/ Community B than for non-Aboriginal community members? *If not why not and what could be done differently? If yes, what made it accessible?*

- Has *ewba* had an impact on the lives of Aboriginal people in Community B/ Community A? *If not why not and what could be done differently? If yes, what had an impact?*

7. Think about the contact that you had with the staff from ewba (if any)
    - *What contact have you had?*

- *What process did ewba staff go through to engage with you? Was this appropriate? Why or why not? How could it be better?*

- *Was this contact positive or negative? Why or why not? How did they work with you – was it culturally appropriate?*

General questions about mainstream programs

8. What things should non-Aboriginal staff know and do when working with Aboriginal staff?

10. Thinking about mainstream health programs in general….
    - Can they meet the needs of Aboriginal people? *If yes, how? If no, what would you suggest as an alternative?*
    - What can mainstream health programs/ services do to better engage (a) Aboriginal workers and (b) Aboriginal community?

Finishing up

11. Is there anything else you would like to add or thought I would ask but have not?

Interview questions – dietitians

Thank you for agreeing to take part in a formal interview for my PhD. Today I would like to get your thoughts and experiences about working with the Aboriginal community. You do not have to have lots of experience working with Aboriginal people.

The interview is organised into a number of themes: we will start by talking about health in general and move onto talking about working with Aboriginal people.

Consent form and Information Sheet.

I would like to invite you to share both positive and negative experiences. Please be honest during this interview and feel free to talk about any bad experiences that you may have had. What you say will be deidentified which means that no-one will know who said what in my Thesis (report). If you say something that you feel will identify you and you do not wish for me to use it then please let me know. You will have the opportunity to review the transcript (typed up) version of this interview.

1. How experienced would you say that you are working as a dietitian in Aboriginal health?

2. What do you think are some of the beliefs dietitians hold about working with Aboriginal people/ communities? How do you think this impacts on their work?

3. In your experience are new graduate dietitians equipped to work with Aboriginal people? *Why or why not?*

4. In your opinion, what skills and qualities make a dietitian be able to effectively work with Aboriginal people?

5. As a dietitian, what stops you or helps you to work with Aboriginal people?

6. What do you see as the challenges in delivering nutrition information to Aboriginal people and communities? Are these the same or different to challenges involved in delivering information to non-Aboriginal people?

7. Some of the literature discussed the importance of concepts such as reciprocity (giving back), respect, working in a way that does not continue colonisation, flexibility etc……Could you tell me whether these are important aspects of your work with Aboriginal people? And how do you address such issues in your work?

8. Do you have any other comments or is there something you thought I would ask that I have not?

Interview questions – *ewba* staff

Thank you for agreeing to take part in a formal interview for my PhD.
Today I would like to get your thoughts and experiences about working with the Aboriginal community as part of the *ewba* Community Programs. The interview is organised into a number of themes, including your work as a project coordinator for *ewba,* working with the Aboriginal community in general and health in general.

Consent form and Information Sheet.

As you know working with Aboriginal communities was not a primary target of *ewba.* However like *ewba,* there are multiple mainstream programs that do not primarily target Aboriginal people, but they still aim to reach them. It is the goal of my PhD to investigate whether such an approach is effective, using *ewba* as an example (case study).

I would like to invite you to share both positive and negative experiences. Please be honest during this interview and feel free to talk about any bad experiences that you may have had. What you say will be deidentified which means that no-one will know who said what in my Thesis (report). If you say something that you feel will identify you and you do not wish for me to use it then please let me know. You will have the opportunity to review the transcript (typed up) version of this interview.

Yourself as a Project Coordinator for *eat well be active*

How long have you worked for *eat well be active* as a project coordinator?
- At what stage of the project?

I would like to talk now about your role as project coordinator for *ewba*, and any experiences you have had with the Aboriginal community through that role.
- What do you see your role, as project coordinator, to entail in terms of working with the Aboriginal community?
- During your time as project coordinator, did you attempt to work with the Aboriginal community? *If no – why not? If yes – explore:*
    1. Process of engagement/ contact
    2. Intervention delivered
    3. Any outcomes
    4. Barriers/ enablers
- What learnings have come out of your work with the Aboriginal community?
- What do non-Aboriginal people need to know when working with Aboriginal people?

As you know *ewba* aimed to target the Aboriginal community in Community B and Community A, however the Aboriginal community was not the **main** target of the program.
    - Has *ewba* been equally accessible for Aboriginal community members in Community A/ Community B than for non-Aboriginal community members? *If not why not and what could be done differently? If yes, what made it accessible?*
- Has *ewba* had an impact on the lives of Aboriginal people in Community B/ Community A? *If not why not and what could be done differently? If yes, what had an impact?*

Working with Aboriginal people in general

As a non-Aboriginal person working on a project like *ewba*, what stops you or helps you to work with the Aboriginal community?

What are some of the beliefs that non-Aboriginal people hold about working with Aboriginal communities? How do you think that this impacts on their work?

Do you think that colonisation still impacts on the lives of Aboriginal people? Would you address this in the way that you work with Aboriginal people?

Health

What makes an Aboriginal person healthy? Is this different to what makes a (non-Aboriginal) person healthy? How is it the same or different? Why?

What stops or helps Aboriginal people to eat healthy food or be active? How is this different to non-Aboriginal people?

- *Do you think that this impact on the success of programs like ewba in the Aboriginal community? If yes, how can this be addressed?*

Finishing up

Is there anything else you would like to add or thought I would ask but have not?

Interview questions – experienced White workers

Thank you for agreeing to take part in a formal interview for my PhD. Today I would like to get your thoughts and experiences about working with the Aboriginal community. The interview is organised into a number of themes: we will start by talking about health in general and move onto talking about working with Aboriginal people.

Consent form and Information Sheet.

I would like to invite you to share both positive and negative experiences. Please be honest during this interview and feel free to talk about any bad experiences that you may have had. What you say will be deidentified which means that no-one will know who said what in my Thesis (report). If you say something that you feel will identify you and you do not wish for me to use it then please let me know. You will have the opportunity to review the transcript (typed up) version of this interview.

Health

1. What makes an Aboriginal person healthy? Is this different to what makes a (non-Aboriginal) person healthy? How is it the same or different? Why?
2. What stops or helps Aboriginal people to eat healthy food or be active? How is this different to non-Aboriginal people?
    - *Do you think that this impacts on how successful attempts to work with the Aboriginal community are around healthy eating and being active?*

Working with Aboriginal people in general

3. I would like to talk now about your role as …… at …….., and any experiences you have had with the Aboriginal community through that role.

- What do you see your role, as ……, to entail in terms of working with the Aboriginal community?
- During your time as …….., did you attempt to work with the Aboriginal community? *If no – why not? If yes – explore:*
    1. Process of engagement/ contact
    2. Intervention delivered
    3. Any outcomes
    4. Barriers/ enablers
- What learnings have come out of your work with the Aboriginal community?
- What do non-Aboriginal people need to know when working with Aboriginal people?

4. How do you demonstrate a commitment to Aboriginal health through your work?

5. As a non-Aboriginal person working …….., what stops you or helps you to work with the Aboriginal community?

6. What are some of the beliefs that non-Aboriginal people hold about working with Aboriginal communities? How do you think that this impacts on their work?

7. Do you think that colonisation still impacts on the lives of Aboriginal people? Would you address this in the way that you work with Aboriginal people?

Finishing up

8. Do you have any other comments or is there something you thought I would ask that I have not?

Appendix 10: Information Sheets and Consent Forms

Information sheet & consent form – interviews with Aboriginal workers

INFORMATION SHEET

Title: 'Semi-structured interviews with Stakeholders from Aboriginal Organisations/ Groups'
Effectiveness and impact of the *eat well be active* Community Programs in Aboriginal people

Investigators:
Annabelle Wilson
PhD Student
eat well be active/ Flinders University
Ph 08 8384 9259

Dr Michelle Jones
Evaluation Coordinator
eat well be active
Ph 08 8384 9704

Purpose of the study:
This study is an evaluation of the *eat well be active* Community Programs. Evaluation means to find out the value and outcomes of a program. This part of the evaluation aims to find out if the *eat well be active* Community Programs has been effective in Aboriginal children and their families. We want to hear about your experiences with the *eat well be active* project and whether or not you think this project has engaged the Aboriginal community that you work with.

What will I be asked to do?
You are invited to attend a semi-structured interview with the Investigator, Annabelle Wilson. Annabelle will chat to you informally about your experiences with *eat well be active*. This chat will last for about 30 to 45 minutes and you will have a chance to give your opinions. This chat will be recorded using a digital voice recorder and the information will be typed up and saved as a file on a computer.

What benefit will I gain from being involved in this study?
You will have the knowledge that your involvement in the evaluation will provide critical information and feedback about the success and challenges of providing mainstream community based childhood obesity prevention programs that also attempt to target the Aboriginal community. It will allow the sharing of your experiences and improve the planning and delivery of future mainstream programs which also aim to reach Aboriginal groups.

Will I be identifiable by being involved in this study?
No. Unless you wish to be identified, all information that identifies specific people or places (e.g. names) will be changed or removed from the file. Any comments made by individuals that are used in the final thesis will not be identifiable, unless by request of the person being interviewed.
Once the interview has been typed-up and saved as a file, the voice file will be destroyed. Identifying information will be changed or removed and the typed up file will be stored on a password protected computer that only the evaluation coordinator will have access to.

Are there any risks or discomforts if I am involved?
Other group members may be able to identify your contributions in the report even though they will not be directly attributed to you.

The investigators anticipate few risks from your involvement in this study. If you have any concerns regarding anticipated or actual risks or discomforts, please raise them with the investigators.

How do I agree to participate?
Participation in this study is voluntary. You may answer 'no comment' or refuse to answer any questions and you are free to withdraw from the focus group at any time without effect or consequence. A consent form accompanies this information sheet. If you agree to participate please read and sign the form. Please keep a copy of the consent form for your personal records.

How will I receive feedback?
You will receive a copy of the executive summary of the final thesis and can have access to the full version of the thesis if requested.

Has this study been approved by an ethics committee?
This study has received ethics approval from: the Flinders University Social and Behavioural Research Ethics Committee, SA Health, the Aboriginal Health Council of South Australia and the Department of Education and Children's Services (DECS).

Where can I get further information?
For further information about this project or the *eat well be active* Community Programs, please contact Annabelle Wilson or Dr Michelle Jones (details above).

Thank you for taking the time to read this information sheet and we hope that you will accept our invitation to be involved.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee. For more information regarding ethical approval of the project the Secretary of the Committee can be contacted by telephone on 8201 5962, by fax on 8201 2035 or by email sandy.huxtable@flinders.edu.au.

eat well be active.

Community Programs

CONSENT FORM

Title of Project: 'Interviews with Stakeholders in Aboriginal Organisations' Effectiveness and impact of the *eat well be active* Community Programs in Aboriginal people

1. I have read and understood the 'Information Sheet' for this study.
2. The nature and possible effects of the study have been explained to me.
3. I understand that the study involves a semi-structured interview that will take about 30 minutes.
4. I understand that the interview will be recorded using a digital voice recorder.
5. I understand that participation involves the risk(s) that my information may be used in a published report but that my name will be changed to ensure confidentiality.
6. I understand that all research data will be securely stored on the Noarlunga Health Services Department of Health premises and will then be destroyed when no longer required.
7. Any questions that I have asked have been answered to my satisfaction.
8. I understand that any information I supply to the investigator(s) will be used only for the purposes of the study.
9. I agree to participate in this interview and understand that I may withdraw at any time without any effect.

Name of Participant:

Signature: Date:

Statement by Investigator

☐ I have explained the project & the implications of participation in it to this volunteer and I believe that the consent is informed and that he/she understands the implications of participation

If the Investigator has not had an opportunity to talk to participants prior to them participating, the following must be ticked.

☐ The participant has received the Information Sheet where my details have been provided so participants have the opportunity to contact me prior to consenting to participate in this project.

Name of Investigator

Signature of Investigator:

Date:

Information sheet & consent form – interviews with *ewba* staff

INFORMATION SHEET

Title: 'Semi-structured interviews with EWBA project coordinators'
Effectiveness and impact of the *eat well be active* Community Programs in Aboriginal people

Investigators:
Annabelle Wilson
PhD Student
eat well be active/ Flinders University
Ph 08 8384 9259

Dr Michelle Jones
Evaluation Coordinator
eat well be active
Ph 08 8384 9704

Purpose of the study:
This study is an evaluation of the *eat well be active* Community Programs. Evaluation means to find out the value and outcomes of a program. This part of the evaluation aims to find out if the *eat well be active* Community Programs has been effective in Aboriginal children and their families. We want to hear about your experiences with working with Aboriginal Organisations/ Stakeholders during the course of the *eat well be active* Community Programs.

What will I be asked to do?
You are invited to attend a semi-structured interview with the Investigator, Annabelle Wilson. Annabelle will chat to you informally about your experiences with working with Aboriginal organisations/ groups. This chat will last for about 30-45 minutes and you will have a chance to give your opinions. This chat will be recorded using a digital voice recorder and the information will be typed up and saved as a file on a computer.

What benefit will I gain from being involved in this study?
You will have the knowledge that your involvement in the evaluation will provide critical information and feedback about the success and challenges of providing mainstream community based childhood obesity prevention programs that also attempt to target the Aboriginal community. It will allow the sharing of your experiences and improve the planning and delivery of future mainstream programs which also aim to reach Aboriginal groups.

Will I be identifiable by being involved in this study?
No. Unless you wish to be identified, all information that identifies specific people or places (e.g. names) will be changed or removed from the file. Any comments made by individuals that are used in the final thesis will not be identifiable, unless by request of the person being interviewed.
Once the interview has been typed-up and saved as a file, the voice file will be destroyed. Identifying information will be changed or removed and the typed up file will be stored on a password protected computer that only the evaluation coordinator will have access to.

Are there any risks or discomforts if I am involved?
Other group members may be able to identify your contributions in the report even though they will not be directly attributed to you.
The investigators anticipate few risks from your involvement in this study. If you have any concerns regarding anticipated or actual risks or discomforts, please raise them with the investigators.

How do I agree to participate?

Participation in this study is voluntary. You may answer 'no comment' or refuse to answer any questions and you are free to withdraw from the focus group at any time without effect or consequence. A consent form accompanies this information sheet. If you agree to participate please read and sign the form. Please keep a copy of the consent form for your personal records.

How will I receive feedback?
You will receive a copy of the executive summary of the final thesis and can have access to the full version of the thesis if requested.

Has this study been approved by an ethics committee?
This study has received ethics approval from: the Flinders University Social and Behavioural Research Ethics Committee, SA Health, the Aboriginal Health Council of South Australia and the Department of Education and Children's Services (DECS).

Where can I get further information?
For further information about this project or the *eat well be active* Community Programs, please contact Annabelle Wilson or Dr Michelle Jones (details above).

Thank you for taking the time to read this information sheet and we hope that you will accept our invitation to be involved.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee. For more information regarding ethical approval of the project the Secretary of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.research@flinders.edu.au.

eat well be active.

Community Programs

CONSENT FORM

Title of Project: Evaluation of *eat well be active* Community Programs
Effectiveness and impact of the *eat well be active* Community Programs in Aboriginal people

1. I have read and understood the 'Information Sheet' for this study.
2. The nature and possible effects of the study have been explained to me.
3. I understand that the study involves a semi-structured interview that will take about 30-45 minutes.
4. I understand that the interview will be recorded using a digital voice recorder.
5. I understand that participation involves the risk(s) that my information may be used in a published report but that my name will be changed to ensure confidentiality
6. I understand that all research data will be securely stored on the Noarlunga Health Services Department of Health premises and will then be destroyed when no longer required.
7. Any questions that I have asked have been answered to my satisfaction.
8. I understand that any information I supply to the investigator(s) will be used only for the purposes of the study.
9. I agree to participate in this interview and understand that I may withdraw at any time without any effect, and if I so wish, may request that any data I have supplied will be withdrawn from the research as long as this request is made before the final report has been prepared.

Name of Participant:

Signature: Date:

Statement by Investigator

☐ I have explained the project & the implications of participation in it to this volunteer and I believe that the consent is informed and that he/she understands the implications of participation

If the Investigator has not had an opportunity to talk to participants prior to them participating, the following must be ticked.

☐ The participant has received the Information Sheet where my details have been provided so participants have the opportunity to contact me prior to consenting to participate in this project.

Name of Investigator

Signature of Investigator:

Date:

Information sheet & consent form – interviews with dietitians and experienced White workers

INFORMATION SHEET

Title: 'Semi-structured interviews with workers'
Effectiveness and impact of the *eat well be active* Community Programs in Aboriginal people

Investigators:
Annabelle Wilson
PhD Student
eat well be active/ Flinders University
Ph 08 8384 9259

Dr Michelle Jones
Evaluation Coordinator
eat well be active
Ph 08 8384 9704

Purpose of the study:
This study is an evaluation of the *eat well be active* Community Programs. Evaluation means to find out the value and outcomes of a program. This part of the evaluation aims to find out if the *eat well be active* Community Programs has been effective in Aboriginal children and their families. We want to hear about your experiences with working with Aboriginal Organisations/ Stakeholders during the course of the *eat well be active* Community Programs.

What will I be asked to do?
You are invited to attend a semi-structured interview with the Investigator, Annabelle Wilson. Annabelle will chat to you informally about your experiences with working with Aboriginal organisations/ groups. This chat will last for about 30-45 minutes and you will have a chance to give your opinions. This chat will be recorded using a digital voice recorder and the information will be typed up and saved as a file on a computer.

What benefit will I gain from being involved in this study?
You will have the knowledge that your involvement in the evaluation will provide critical information and feedback about the success and challenges of providing mainstream community based childhood obesity prevention programs that also attempt to target the Aboriginal community. It will allow the sharing of your experiences and improve the planning and delivery of future mainstream programs which also aim to reach Aboriginal groups.

Will I be identifiable by being involved in this study?
No. Unless you wish to be identified, all information that identifies specific people or places (e.g. names) will be changed or removed from the file. Any comments made by individuals that are used in the final thesis will not be identifiable, unless by request of the person being interviewed.
Once the interview has been typed-up and saved as a file, the voice file will be destroyed. Identifying information will be changed or removed and the typed up file will be stored on a password protected computer that only the evaluation coordinator will have access to.

Are there any risks or discomforts if I am involved?
Other group members may be able to identify your contributions in the report even though they will not be directly attributed to you.
The investigators anticipate few risks from your involvement in this study. If you have any concerns regarding anticipated or actual risks or discomforts, please raise them with the investigators.

How do I agree to participate?
Participation in this study is voluntary. You may answer 'no comment' or refuse to answer any questions and you are free to withdraw from the focus group at any time without effect or consequence. A consent form accompanies this information sheet. If you agree to participate please read and sign the form. Please keep a copy of the consent form for your personal records.

How will I receive feedback?
You will receive a copy of the executive summary of the final thesis and can have access to the full version of the thesis if requested.

Has this study been approved by an ethics committee?
This study has received ethics approval from: the Flinders University Social and Behavioural Research Ethics Committee, SA Health, the Aboriginal Health Council of South Australia and the Department of Education and Children's Services (DECS).

Where can I get further information?
For further information about this project or the *eat well be active* Community Programs, please contact Annabelle Wilson or Dr Michelle Jones (details above).

Thank you for taking the time to read this information sheet and we hope that you will accept our invitation to be involved.

This research project has been approved by the Flinders University Social and Behavioural Research Ethics Committee. For more information regarding ethical approval of the project the Secretary of the Committee can be contacted by telephone on 8201 3116, by fax on 8201 2035 or by email human.research@flinders.edu.au.

eat well be active.

Community Programs

CONSENT FORM

Title of Project: Evaluation of *eat well be active* Community Programs
Effectiveness of the *eat well be active* Community Programs in Aboriginal people

1. I have read and understood the 'Information Sheet' for this study.
2. The nature and possible effects of the study have been explained to me.
3. I understand that the study involves a semi-structured interview that will take about 30-45 minutes.
4. I understand that the interview will be recorded using a digital voice recorder.
5. I understand that participation involves the risk(s) that my information may be used in a published report but that my name will be changed to ensure confidentiality
6. I understand that all research data will be securely stored on the Noarlunga Health Services Department of Health premises and will then be destroyed when no longer required.
7. Any questions that I have asked have been answered to my satisfaction.
8. I understand that any information I supply to the investigator(s) will be used only for the purposes of the study.
9. I agree to participate in this interview and understand that I may withdraw at any time without any effect, and if I so wish, may request that any data I have supplied will be withdrawn from the research as long as this request is made before the final report has been prepared.

Name of Participant:

Signature: Date:

Statement by Investigator

☐ I have explained the project & the implications of participation in it to this volunteer and I believe that the consent is informed and that he/she understands the implications of participation

If the Investigator has not had an opportunity to talk to participants prior to them participating, the following must be ticked.

☐ The participant has received the Information Sheet where my details have been provided so participants have the opportunity to contact me prior to consenting to participate in this project.

Name of Investigator

Signature of Investigator:

Date:

Appendix 11: 2011 National DAA workshop

DAA Workshop: From evidence to practice in Aboriginal health: challenges and potential solutions for dietitians

DAA National Conference, May 26 2011

Participants were asked to break into the group for the 'stage' of worker they most identified with and discuss:

1. What makes it hard to be at that stage?
2. What are some experiences you have of being at that stage?
3. How might you move forward?

The following is a summary of participants' notes from the workshop.

Don't Know How

What makes it hard being at that stage?

- Ignorance – what are the problems (from UK)
- Not knowing where to get useful information
- Having no experience – overwhelmed by study topics
- Not knowing where to start or what makes a difference
- Fear of not targeting the right areas
- Lack of cultural understanding
- Lack of confidence
- Not knowing what to prioritise
- Intrinsic issues
- Who to approach in order to tackle issues
- Little experience – especially if from another country
- Daunting
- Don't how where to start or what to do
- Have a gap in knowledge

How might you move forward?

- Get ideas from other people
- Mentors in Aboriginal health
- Cultural competency training
- Gain local area information Organisations like SARRAH (Services for Australian Rural and Remote Allied Health: http://www.sarrah.org.au/)
- Link with Aboriginal Health Workers
- Identify where you are
- Be aware of gaps in knowledge
- Be a genuine person
- Join in Aboriginal celebrations
- Take an interest in language e.g. learn words
- Go on bush tucker walks
- Increase connection and get education from Aboriginal people
- Build trust through conversation about your own story

- Indigenous Health InfoNet: http://www.healthinfonet.ecu.edu.au/

Too Scared

What makes it hard being at that stage?

- Hard to get started
- Scared to fail – in your own eyes and in the eyes of the health service (in terms of delivering an outcome)
- Not wanting to contribute to the failure of the system
- Scared to get the cultural awareness 'right' – i.e. scared to say or do the wrong thing
- Scared of not being accepted
- Lack of confidence – don't know the right way to go about it (there is a lack of evidence) and don't want to repeat a failed program or method
- Is what you are doing actually adding to the bigger picture or really helping
- Hard to keep going when you've given it a go but haven't got the feedback you wanted – therefore hesitant to try again/ move forward
- Limited by extrinsic factors e.g. food service systems in hospitals

How might you move forward?

- Not having an agenda, just being there and starting to build relationships
- Start talking about family as a way to initiate relationship building
- Having a mentor (non-Aboriginal Barrier Breaker)
- Talking to management to negotiate time to spend with community building relationships
- Keep information simple and straightforward – i.e. one message at a time

Too Hard

What makes it hard being at that stage?

- You have a good understanding of Aboriginal health but the barriers affect your work e.g. through outreach where you see a patient once or twice (clinical setting) and can't necessarily refer them on
- Feel like an outsider to the Aboriginal Health Team
- Not enough time – e.g. only one day/ week in Aboriginal health – there was a feeling amongst the group that it got easier the more days you spent working in Aboriginal health
- Dietitians are high achievers
- You lose your confidence
- It is frustrating
- You want to 'chuck it in'
- You have high expectations about what you should be doing and achieving (from other jobs, targets and KPIs etc) – when you don't reach these, this can lead to decreased job satisfaction

How might you move forward?

- Work more in Aboriginal health – this can lead to a change in motivation and a change in mindset
- Reorient expectations – your own, but also those of other health professionals who might think you should be achieving more
- Keep an open mind
- Build rapport – this often happens through making mistakes

- Use humour
- Talk with Aboriginal Health Teams
- Be aware that success is slow
- It is okay not to talk about nutrition the first time
- Be a person before a dietitian
- Accept that there are some barriers that you can't change but some that you can – focus on the ones that you can
- Be creative with solutions
- Have mentors
- Know where you can refer patients/ clients

Barrier Breaker

What makes it hard being at that stage?

- The barriers never go away
- Priorities
- There are still issues, including transport and cultural behaviours
- Still need to be accountable – e.g. work to schedules and deadlines
- Take it personally
- Working based on evidence based practice but this does not always happen
- Cultural awareness/ sensitivity – concerns about offending clients or doing/ saying the right thing
- Adult learning principles – using life skills and being practical
- Time
- Being the last priority (as a dietitian) in a multidisciplinary setting (i.e. compared with podiatry, diabetes educator)
- Western ways of health care

How might you move forward?

- Empowering Aboriginal Health Workers and other professionals to assist dietitians
- Capacity building
- Marketing – promote the service using ideas that people can relate to
- Communication – understanding levels of health literacy
- Tapping into existing services/ programs
- New ideas, do something different and evaluate it
- Practice leads to evidence
- Being a chameleon
- Starting anyway – running traditional cooking classes and not going well resulting in the clients involving themselves

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