

How Children Grow: Indigenous and Health Professional Perceptions



An interim report for health service
providers in the Northern Territory

Principal authors

Danielle Smith, Lisa Mununggurr,
Dorothy Bamundurruwuy and Karen Edmond

Co-authors

Paul Wunungmurra and Helen Nyomba

May 2001



First published in 2003 by
The Cooperative Research Centre for Aboriginal & Tropical Health (CRCATH)

© Copyright Cooperative Research Centre for Aboriginal and Tropical Health This work is copyright. Apart from any use as permitted under the Copyright Act 1968, no part may be reproduced without prior written permission of the author.

Smith, D., Mununggurr, L., Bamundurruwuy, D., Edmond, K., Wunungmurra, P. and Nyomba, H., 2003, *How Children Grow: Indigenous and Health Professional Perceptions*, Cooperative Research Centre for Aboriginal and Tropical Health, Darwin.

The ideas and opinions presented in this report do not necessarily reflect the ideas and opinions of the Cooperative Research Centre for Aboriginal and Tropical Health (CRCATH).

General inquiries about this publication should be directed to:

Cooperative Research Centre for Aboriginal and Tropical Health
PO Box 41096
Casuarina
NT 0811

ISBN 1 876 831 61 8

Design and layout by Sarah Walton, CRCATH
Edited by Michael Duffy, CRCATH

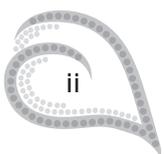


Table of Contents

Acknowledgments	v
Preface	v
Executive Summary	vi
Chronology	viii
1. Introduction	1
2. Study design	3
2.1 <i>Research paradigm and methods</i>	3
2.2 <i>Preparation for data collection</i>	3
2.3 <i>Study population</i>	4
2.3 <i>Realities of doing research in a remote Aboriginal community</i>	6
2.5 <i>Ethical issues</i>	9
2.6 <i>Interpreting the findings</i>	9
3. Yolngu stories	11
3.1 <i>Yolngu stories about why children grow well</i>	11
3.1.1 <i>Food</i>	11
3.1.2 <i>Sickness</i>	18
3.1.3 <i>Looking after kids</i>	19
3.2 <i>How Yolngu know if a child is growing</i>	25
3.3 <i>The clinic story</i>	25
3.4 <i>Ideas for growth promotion action</i>	28
4. Clinic staff stories about child growth	31
4.1 <i>Clinic staff stories about why children grow</i>	31
4.1.1 <i>Food</i>	31
4.1.2 <i>Sickness</i>	34
4.1.3 <i>Looking after kids</i>	35
4.2 <i>How clinic staff know if a child is growing</i>	38
4.3 <i>The Growth Assessment and Action Program</i>	40
4.4 <i>The Clinic's work</i>	41
4.5 <i>The Yolngu story about child growth</i>	45
4.6 <i>Ideas for action</i>	47

5. Comparison of Yolü and clinic staff stories	49
5.1 <i>Factors affecting child growth.....</i>	<i>49</i>
5.2 <i>How people know whether a child is growing.....</i>	<i>51</i>
5.3 <i>Clinic staff knowledge and perceptions of the GAA program.....</i>	<i>52</i>
5.4 <i>Knowledge and perceptions of the other group's story</i>	<i>52</i>
5.5 <i>Ideas</i>	<i>53</i>
6. Stakeholder feedback.....	55
6.1 <i>Clinic staff comments</i>	<i>55</i>
6.2 <i>Project team response.....</i>	<i>57</i>
7. Project team observations	59
8. Conclusion	63
References.....	65

Acknowledgments

We would like to thank the Cooperative Research Centre for Aboriginal and Tropical Health for funding this project and the Department of Health and Community Services (DHCS, previously Territory Health Services or THS) for implementing it. Thanks to the Community Council, Gapuwiyak Community Incorporated, which has given a lot of time to this project, and for its ongoing support. Also, thanks to the Strong Women¹ workers in the community who have been very helpful and supportive. We particularly want to thank all the project participants who have been involved in this project in many different ways. Thanks also to the health service providers who participated in the workshops to develop recommendations, which will be included in the final project report. Also to Alan Ruben who has been acting as project leader since Karen Edmond's departure, and who has greatly assisted in getting this report finalised. Finally, Jeannie Devitt and Colin MacDougall provided many valuable comments on draft copies of this report, which we are greatly appreciative of.

Preface

This report offers insights into the perceptions of child growth held by a limited number of Aboriginal people and clinic staff in a particular remote Aboriginal community at a particular point in time. A period of cross-cultural communication over child growth between a limited number of individual Aboriginal community members, clinic staff and a research team comprising Aboriginal and non-Aboriginal researchers is documented. This report does not offer a concerted 'understanding' of Yolngu and clinic staff perspectives in relation to child growth.² Nor does it give a unified 'community' or 'clinic' perspective. While there are common themes, there are also contradictory views that reflect the ways different people make sense of child growth in a period of rapid change in the community.

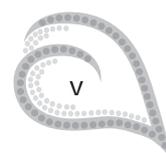
This research has not been an attempt to document 'traditional' Yolngu knowledge about child growth and to seek solutions to the current problem of child growth based on the way things were done 'before'. People have complex and changing views that reflect their attempts to reconcile traditional views with new information and issues. The focus has been on how people make sense of child growth today and on solutions relevant to the current situation.

A limitation of this research is that the documentation of Yolngu and clinic views represents only a partial account of their social realities at a particular point in time. The stories in this report were given at that particular point and reflect the context in which questions were asked. The fact that the community interviews were undertaken in a cross-cultural context using a number of languages with disempowered people increases the potential for misinterpreting the data. It also means it is more likely that there is a significant gap between the views given to the researchers (one being a relative stranger) and a lived social reality. The insights in this report on Yolngu and clinic staff perspectives on child growth must be considered in the context of this limitation.

Further, this report describes and analyses data from a case study in one Aboriginal community. Care must therefore be taken in generalising findings to other Aboriginal communities.

1. Strong Women, Strong Babies, Strong Culture is a THS program, which employs local women to work in culturally appropriate ways with pregnant women to increase birth weights and child growth.

2. Yolngu refers to the Indigenous people who live in North East Arnhem Land



Executive Summary

This report demonstrates that there is a significant difference between the way Yolngu and health service providers understand child growth. It has been written for Northern Territory (NT) health service providers. The information in this report has been collected as part of the “Djamarrkuji’ Manyak Nguthanawuy Djäma” or *Improving Child Growth in the NT* Project. This is a two and a half year participatory action research project currently being carried out in a remote Aboriginal community in the Top End of the NT by the Department of Health and Community Services (previously Territory Health Services) with funding from the Cooperative Research Centre for Aboriginal and Tropical Health (CRCATH).

The aim of the project is to improve the growth of Indigenous children in the NT. This report addresses two objectives of the overall project:

- (1) to document social and cultural issues impacting on the growth of young Indigenous children; and
- (2) to use this study to improve the Growth Assessment and Action program across the NT.

It has been produced as a stand-alone report due to its potential value to health service providers in the NT in their work around child growth. A final report will be written describing all aspects of the project, including specific recommendations to improve the GAA program.

This report involves an analysis of data from interviews and participant observation around child growth. A team of Yolngu researchers and a non-Aboriginal researcher (DS), who spent 12 months living in the community, collected this data between June and August 2000. The team interviewed forty-three Yolngu community members in the following categories: young men and women with no children; new parents; parents with two or more children; and grandparents. Thirteen clinic staff, including Aboriginal Health Workers, nurses and doctors, were interviewed. This report documents each group’s perceptions and knowledge of child growth and their ideas for growth promotion action. The data from the Yolngu group and the Clinic group are also compared and contrasted. Observations made by the project team based on this analysis are also included. It is hoped that the information in this report will contribute to an understanding of the issues surrounding Indigenous child growth by health service providers in the NT, and that the information in this report be used by DHCS to make improvements to its GAA Program and lead to an improvement in child growth.

Key similarities and differences between Yolngu and Clinic staff stories

Food and the introduction of solids

- ‘Good food’ was one of the most common responses given by both groups to the question ‘Why **do** children grow well?’
- ‘Bush food’ was the most common Yolngu response to this question, but it was also noted that some kids did not want to eat it these days
- ‘Eating enough food’ was the most common clinic staff response, while very few Yolngu mentioned this
- There was a significant difference between the perceptions of Clinic staff and Yolngu of the appropriate time to introduce solid foods to babies. Clinic staff said children should start eating solid food when they are 4 months old, while Yolngu said children should not eat food until they start crawling, sitting up and walking.

Caring for children

- There was a significant difference between the way Yolngu and clinic staff perceive 'caring for children' to promote child growth. Yolngu generally have a broad understanding of caring for children to ensure they grow well that includes attending to the social and emotional well being of the child. Clinic staff generally described discrete health actions relating to nutrition and hygiene when they talked about how people should care for children.
- Families not looking after children was a major concern for many Yolngu.
- There was some difference in who the two groups perceived as being responsible for caring for children. Most Yolngu described it as the job of 'families' and in particular 'parents', while some clinic staff said 'families', some said 'women' and the Aboriginal Health Workers said 'mother and fathers'.
- Some Yolngu thought the clinic should make sure the children grow well.

Illness

- The impact of illness on child growth was another key area of difference between the two groups.
- Clinic staff most commonly offered illnesses like worms, skin sores and weak blood in response to the question 'Why **don't** children grow well?'
- Only one Yolngu in the community group mentioned illness as a reason for poor child growth.

The GAA program

- Clinic staff undertake regular growth monitoring and do well with the children who are 'at risk'.
- The clinic does not have time, money or staff to help all the children keep growing well all the time.

Knowledge of the other group's story

- Generally Yolngu did not have a good understanding of the clinic's story about child growth, but they appeared to know more about the clinic story than clinic staff knew about the Yolngu story.
- Most Yolngu have seen growth charts and know about 'the line going up', while some respondents said they wanted to know more about weighing children and growth charts.
- While some clinic staff wanted to learn more about the Yolngu story, others described it as being a 'traditional' story which suggests they see it as having little contemporary relevance.

Ideas for growth promotion action

- Both groups had many ideas for growth promotion action, a number of which were similar.
- Yolngu and clinic staff, however, did not agree on the best way to promote child growth, which reflects the difference in the way the two groups understand the key causes of poor child growth.

The differences between Yolngu and Clinic staff perspectives on child growth discussed in this report are considerable. This does not suggest that either group's story is of more value than the other's. Rather it suggests the need for the two groups to share their stories more, so that a common understanding of the causes of child growth and appropriate growth promotion strategies can be developed.

Chronology

1998

Prior to 1998	Identification by DHCS of deficiencies with its GAA Program
Mid 1998	Community members discuss concern about child growth with visiting health service provider and interest in being involved in a child growth project
December	Concept proposal for an "Improving Child Growth" Project submitted to the Cooperative Research Centre for Aboriginal and Tropical Health (CRCATH)

1999

January	Concept proposal approved by CRCATH
Strong	Six trips to community by project leader (KE) and four by PhD student (DS) to consult with Community Council, Community Health Committee, two Women workers, community clinic and community members about being involved in a child growth project
August	Full project proposal submitted to the Cooperative Research Centre for Aboriginal and Tropical Health
November	Project proposal approved by CRCATH

2000

February	DS moved to community for 12 months fieldwork
February-March	Project adviser and co-workers recruited, project information sheet translated, project team visits to all households to inform community members about the project and introduce DS
April-May	Interview themes developed, project team discussion about interviewing, interviewing practice
June-August	Interviews and preliminary data analysis completed
September-Dec	Community reports based on content analysis completed and process of community decision making on growth promotion activities supported
December	12 months intensive fieldwork completed by DS

2001

February-March	In-depth thematic data analysis and draft copy of this report completed. Draft copy provided to stakeholders. Project visit to community by KE and DS to discuss report with Community Council, project committee and Clinic staff, and invite feedback.
April	Clinic staff feedback received and incorporated into report
November	DHCS and CRCATH approval of report

1. Introduction

The “*Djamarrkuli*” *Manymak Nguthanawuy Djäma*” or ‘Improving Child Growth in the NT Project’ is a two-year participatory action research project currently being carried out in a remote Indigenous community in the Top End of the NT. The study community has characteristics common to other remote Indigenous Top End communities: high infant mortality rate; high hospitalisation rates for young children due to gastroenteritis, respiratory and other infections; low employment, income and education levels; and overcrowding (d’Espaignet et al, 1998).

The project was developed in response to community members expressing concern about poor child growth to a visiting health service provider in 1998. Child growth statistics for the community are comparable to other Aboriginal communities in the Top End, which show that 15 per cent of children aged 0-5 are underweight, compared to three per cent Australia-wide (DHCS, 2000).

Growth monitoring has been part of routine practice in the NT for over 30 years. In 1998 DHCS implemented a new growth monitoring program, the Growth Assessment and Action (GAA) Program, to improve the growth of children aged between 0 and 5 years of age in the NT. The GAA Program includes reviewed guidelines for growth monitoring, new growth charts including weight for age and length/height for age, and an increased emphasis on growth promotion action. The program has three main components: monitoring the growth of individual children, instigating early action if growth falters and undertaking growth surveillance at a community level on a six-monthly basis.

DHCS has subsequently identified four deficiencies in the implementation of the GAA program in the Top End. These are: insufficient involvement of families and communities; poor understanding of social and cultural issues impacting on Indigenous children’s growth by service providers³; inadequate understanding of growth monitoring and promotion by families and service providers; and the absence of guidelines for promoting effective community action. This project was also designed to address these deficiencies.

The aim of the project is to improve the growth of Indigenous children in the NT. The objectives of the project are:

Local

- To increase family and community involvement in child growth promotion
- To improve the GAA program in the community according to the following indicators:
 - increased understanding of specific socio-cultural factors influencing child growth by service providers
 - increased understanding of growth monitoring and promotion by service providers and families
 - increased community action to promote child growth
- To improve the growth of children in the community

3. This includes Indigenous knowledge and perceptions of child growth.

More broadly

- To document the process of improving community involvement in child growth promotion
- To document social and cultural issues impacting on the growth of young Indigenous children
- To document specific community action strategies that can be used to help with growth action in other communities
- To use this study to improve the GAA program across the NT

This report addresses two objectives of the overall project:

- (1) to document social and cultural issues impacting on the growth of young Indigenous children; and
- (2) to use this study to improve the GAA program across the NT.

It has been produced as a stand-alone report due to its potential value to health service providers in the NT in their work around child growth. A final report will be written describing all aspects of the project, including specific recommendations to improve the GAA program.

In order to meet these objectives a large part of this project has involved documenting Yolngu and Balanda stories about child growth.⁴ A Strong Women worker involved in the consultation for this project said at the outset that she wanted to teach Balandas more about how Yolngu think about child growth. She also wanted to know more about the weighing and measuring of babies. DHCS also identified the limited understanding service providers have of social and cultural issues impacting on Indigenous children's growth and the confusion of Indigenous families and health service providers surrounding growth monitoring and promotion as issues.

In this study we sought two sets of perceptions;

- Yolngu community members' knowledge and attitudes towards child growth in order to find out about the Yolngu story; and
- health service providers' knowledge and attitudes in order to document the clinic story.

We also sought to discover what each group knew of the other group's story and suggestions from both for child growth promotion strategies. The project team asserted that if Yolngu and Balanda shared their stories and worked together to promote child growth, this may lead to an improvement in child growth in the community.

4. 'Balanda' is used in Arnhem Land to describe non-Aboriginal people. In this report we have referred to the 'Yolngu' (indigenous people of North-East Arnhem Land) or 'community' story and the 'Clinic' or 'Balanda' story. We recognise that the geographical community includes the white service providers living there, but for the purposes of this report it refers to the Yolngu community. This is the way the term had been used by the project team and Yolngu community members. At the same time, while there are Yolngu working in the Clinic, it is generally associated with Balanda. 'Clinic stories' has been used interchangeably with 'Balanda stories'.

2. Study design

2.1 Research paradigm and methods

This research was undertaken within the critical theory paradigm, where the objective is not simply to understand, but to use that understanding to bring about change (Baum, 1998). This study attempts to document different groups' perceptions and attitudes and use these to stimulate community-driven growth promotion action and empowerment. It is based on a participatory action research framework where the emphasis has been as much on the participatory process as the product of the research (Wallerstein, 1999).

The study design included the use of qualitative research methods such as semi-structured interviews, focus group discussions and participant observation. Exploring themes in semi-structured interviews and focus group discussions was thought to be useful due to the documented difficulties of questioning in the context of research in indigenous cultures (von Sturmer, 1981; Devitt and McMasters, 1998). Participant observation seeks to uncover, make accessible and reveal the meanings people use to make sense of their daily lives and at the same time is non-interventionist (Jorgensen, 1989; Adler and Adler, 1994).

2.2 Preparation for data collection

The project commenced in February 2000 when a non-Indigenous PhD student, Danielle Smith, started a one-year period of fieldwork in the community. DS had visited the community four times to get to know people, negotiate a research agreement and seek approval for the project. It was decided, however, that the collection of child growth stories would not commence for several months. This was on the basis that DS was essentially an unknown quantity in the community and the value of any data collected before DS had gained the trust of people would be questionable. This position was validated by comments made by community members who had been upset by past research carried out in their community, as they did not know 'who these people were or what they were doing'.

A senior community project adviser (Dorothy Bamundurruwuy) was appointed and three co-workers (Lisa Mununggurr, Joyce Malakuya and Paul Wunungmurra) were recruited to work on the project team. In preparation for data collection, informed consent sheets and project information sheets were translated into Yolngu-matha. We then visited people in their houses to talk about the project and give people an opportunity to meet DS and ask questions. A tape recording in Yolngu-matha of the project information sheet assisted this process.

A set of themes to be used in interviews and focus group discussions with both Yolngu and clinic staff was developed out of a session involving the project team, Strong Women workers and Women's Centre staff. They were:

- the reasons children grow well
- food
- caring for children
- ways of knowing whether a child is growing well
- knowledge of the GAA program
- knowledge of the other group's story
- ideas for growth promotion action.

The project team then discussed how Yolngu and Balanda 'find out about things'. When doing research in the cross-cultural context it is necessary to be highly sensitive to what is culturally appropriate. Yolngu team members came up with the following list as important things to remember when collecting stories from Yolngu:

- takes a while, you have to go slowly
- sit there first and have a chat for a while (this will encourage them to talk) and then tell them why you are there
- must tell them why you are asking their story
- people talk around the thing you want to know about and eventually they get to what you asked about
- do not stop people from talking, always listen to what they have to say, and it doesn't matter how long they talk for
- they have feelings and if you do not let them tell you their story they will not talk to you any more and may walk away
- afterwards they need to see something happening with their story, they need to see that it is being used to take action
- make sure you don't have someone interviewing their poison cousin⁵

The project team also discussed how Balanda find out about things. Semi-structured interviews, themes, informed consent, neutrality, respect and confidentiality were discussed. Practice interviews using the tape recorder were also done.

2.3 Study population

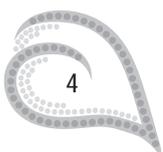
Community group

We planned to interview up to 100 community members and 10 family groups. This was divided into even numbers of men and women in four different groups. These were: young people with no kids; new mothers and fathers; people with two or more kids; and grandparents.

Yolngu members of the project team approached potential respondents. This method of sampling for the community group was thought to be the most appropriate as the co-workers are members of the community with established family and personal relationships. Given people's experience of past research as being a negative activity of outsiders, it was necessary to do as much as possible to assure people that we were operating differently. One way of showing this difference was for team members to approach family and conduct interviews and focus groups. We also put signs up around the community inviting people who wanted to tell their story to let the project team know. No one approached us. DS also suggested approaching various prominent community people, such as the Town Clerk, who she thought would be willing to talk to us.

Table 1 shows the number of community members interviewed or involved in a focus group during data collection between April and August 2000. Family group interviews are discussed in the next section. All interviews were done by at least one co-worker and DS. While the majority were done in Yolngu-matha, some respondents chose to be interviewed in English.

5. 'Poison cousins' have an avoidance relationship and, among other things, may not speak to each other.



Ultimately we only interviewed 43 people from a target of 100. This was mainly because of difficulties in recruiting and the amount of time it took to set up, conduct, and translate and transcribe each interview/focus group discussion. This was exacerbated by our male co-worker leaving the team, frequent funerals, community disruptions, the heat and DS' ill health during this period. We also felt we were reaching the point of saturation. As time went on interviews provided us with much less new information and we started to hear many of the same things we had heard in previous interviews. We also decided it was important to move on to the action stage of the project so we stopped interviewing despite the low numbers.

Table 1: Community members interviewed/involved in focus group according to demographic group

Demographic group	Number
Young women with no children	2
Young men with no children	7
New mothers	4
New fathers	3
Mothers with 2 or more children	7
Fathers with 2 or more children	6
Grandmothers	10
Grandfathers	4
Total	43

There are several sampling issues with the community group. One is that the sample may be biased towards the families of the Yolngu team members. The community is made up of four camps: Top Camp, Middle Camp, Bottom Camp and Wharf Camp. The project adviser and a co-worker both live in Middle Camp and often recruited respondents from this area and nearby Bottom Camp. Using a community map DS tried to ensure participants were recruited from all areas of town, but co-workers generally showed a preference for interviewing members of their own extended kin networks. One of the camps in particular is socially and geographically isolated and on some occasions was said to be too far to walk to in the heat.

Apart from selecting family members, one Yolngu co-worker tended to recruit women as she clearly found them easier to talk to than men and because this was more culturally appropriate. Because the project team was predominantly female it was very difficult to recruit men to the study, particularly young men, who had little desire to discuss babies and children with a young Yolngu woman and a Balanda woman. The project team had hoped having a male co-worker working with us would address this issue but he left the project around the time we started interviewing. Further, in general we found it difficult to recruit young people, as they were very shy.

It is also difficult to be precise about the number of people who declined to be interviewed, due to the nature of doing research in an Aboriginal community with Aboriginal co-workers. Many interviews were set up by Yolngu team members outside of working hours. Co-workers would tell the team that someone had agreed to be interviewed, but not about the process that had led to this decision, nor whether others had refused. Also, we often approached family groups in their houses. Some people would agree to be interviewed while other people would walk away, or leave during the interview. There were no cases of no-one agreeing to be interviewed when we approached a family group. Two people who participated in a hunting/interviewing trip agreed to be interviewed but did not return in time to join the group interview and were subsequently not interviewed.

Clinic group

To find out clinic staff perceptions we planned to interview all health service providers working in the community health clinic during the period of interviewing. This included doctors, nurses, Aboriginal Health Workers (AHWs) and the visiting paediatrician.

Table 2: Health service providers interviewed/involved in focus group according to profession

Profession	Number
Doctor	1
Nurse	5
Aboriginal Health Worker	6
Visiting Child Health Service Provider	1
Total	13

Table 2 shows that we interviewed 13 health service providers, including all clinic staff and the visiting paediatrician. Several Aboriginal Health Workers were not interviewed as they had only recently commenced their training at Institute of Indigenous Tertiary Education and were absent from the community for extended periods during data collection. All clinic staff agreed to be interviewed.

DS recruited the majority of the Balanda clinic staff, while Yolngu staff were recruited by LM and DS. DS and LM did most of the interviews with Balanda staff, although some were done by DS alone. The interviews with Yolngu staff were done by LM and DS in Yolngu-matha. Most of the interviews with clinic staff were done in the clinic, while one was done outside the Women's Centre and one was done in the respondent's home.

2.4 Realities of doing research in a remote Aboriginal community

Undertaking this research highlighted the tenuous relationship between the description of qualitative research methods often found in theory books and the realities of conducting research in an Aboriginal community with Aboriginal co-researchers.

One of the methodological issues was whether we were conducting semi-structured interviews or focus group discussions. *Semi-structured interviews* are guided one-on-one discussions to collect information for subsequent analysis that usually provide richer and more complex data than questionnaires (Baum, 1998). *Focus groups* involve open-ended interviews with between five and ten people on a particular focused issue (Baum, 1998). Among their strengths, they:

- save on interviewer time
- yield lively interaction between participants, leading to discussion and debate that may not occur in an interview
- allow participants to formulate their opinions in the group (Baum, 1998).

While we planned to do both, we often ended up doing something in between the two. We quickly discovered that interviews were generally effective with older community members but not with young people, who were usually too shy to speak to the research team on their own. We decided to take groups of young people out hunting and then run focus group discussions while we ate our catch. We hoped that they would be more relaxed talking about child growth outside of the community and away from the gaze of passing community members. In most cases the mothers, grandmothers or other older relatives of these young people accompanied us on these trips. It would have been culturally inappropriate to ask them not to come, particularly given the shortage of vehicles in the community to go hunting in. In some cases this resulted in the older people leading the discussions and the younger people being reluctant to give their view. These trips also highlighted the reality that most people were more interested in fishing than participating in the kind of activities we had in mind.

In other cases during focus group discussions the researchers attempted to elicit the views of participants on a topic that someone had already discussed. Generally this was met with the response that this respondent's story was the 'same' as the one already told. Some of the difficulties we experienced in doing focus group discussions are evident in the following account from DS' journal of a hunting trip.

Lisa and I went and got the car, tape recording equipment and some food from the shop. We spoke beforehand about what food we would buy. We decided on oranges, bread, tea, sugar, milk and steak for bait.

We then picked up two very old ladies (60s?), one old lady (45-55), my adopted mother (45-55), one younger lady (25-35) and a child. It was good to have my mother there as she was able to help to get the interviewing going when it finally did. I think it would have been much harder had it been only Lisa and I. I'm wondering whether this means we need our project adviser to come along with us to run the show.

We went out to Baralmana and started off by going fishing. I didn't really think about how long we would do this for but it ended up being a lot longer than I guessed at. Lisa and I fished together and the other women sat in spots along the bank. We didn't catch anything, so I guess after a while it got a bit boring. At around 1pm Lisa and I decided it was time to start heading back to the car for some food and a cup of tea. We both called out for the women to come. Lisa was calling my mother so that she could tell the women to come - I assume as she is my mother and therefore in a position to tell the women to do this.

The three of us went back, but the others didn't come for ages. We started interviewing at about 2.45 with two of the women. Initially my mother who was there was not joining in the discussion, but encouraging the other women to talk. One of the old ladies turned up half way through and the other turned up just before we finally left.

The group interview didn't really seem to work. It was a lot more stilted than the recent interviews we have done. Only one person would answer each question and then it seemed to be considered finished. Other people did not seem to see it as necessary to add their own thoughts. When one woman had finished responding to one question I asked the old lady what she thought, and she said hers was the same story, and so was everyone's. She didn't seem to see the point in adding to the answer.

I think that the interview was made more difficult by the fact that everyone was tired and hungry by then. I suggested to Lisa that we needed to think of a way to prevent this happening again. We did get some stories but one of the women didn't speak at all and two others barely said anything. So it's fine to go hunting for hours but we need to make sure we at least get some good stories from the people who go. (DS' field notes 4/7/00)

It was also difficult to elicit the views of all people present during group discussions because some people came and went during the discussion. Generally they were conducted with a family group in their house. Many of these group discussions therefore ended up being interviews with several people at the same time.

On the basis that often we were doing something between interviews and focus group discussions, from now on this report will refer to 'respondents'. This should be taken to include all discussions where data was collected, regardless of whether they were one-on-one, with several people or with a family group.

There were also other difficulties in doing interviews with Yolngu in both the community and clinic group. As mentioned in the methodology section, direct questioning is not a communication style that Yolngu people seem comfortable with. Our decision to use semi-structured interviews did not completely alleviate this problem, due to the Yolngu co-workers' use of the interview themes as a set of questions in the initial interviews. This reflected their discomfort with conducting interviews. Consequently, some respondents tended not to be relaxed and it was difficult to get some interviews to flow (see Devitt and McMasters, 1998).

Having a Balanda on the research team made it difficult to establish rapport with some people. In one instance, when we were visiting houses just to tell people about the project, a woman screamed at the team as she thought DS was from 'Welfare' and she was trying to take her grandchildren away.⁶ On others some people may have felt they had to speak to us on the basis that there was a Balanda asking them to. It was also difficult to establish a 'conversational' style due to DS' limited Yolngu-matha and the limited English of many respondents. On many occasions the co-workers, preferring to believe that DS understood what people were saying, tended to withdraw themselves from interviews. This seemed to be associated with their general awkwardness in the role of 'interviewer'. This resulted in reluctance on the co-workers' part to interpret and consequently an inability on DS' part to probe further on various topics.

Interviewer neutrality was considered by the Balanda team members to be another methodological issue. Although we had discussed the importance of this in preparing to start our interviews, it was not possible in practice. As the co-researchers were both members of the community and family to many of the respondents, it was impossible for them to remain neutral when they perceived the stories we were being told as also being theirs. This resulted on occasion in the co-researchers adding things to and qualifying people's responses. Further, as time went by and the co-workers got used to hearing people's responses they would at times volunteer what they deemed to be appropriate responses to people who were having trouble answering their questions.

Our interviewing was also at times made stressful and difficult by other events going on in the community. For example, there were occasions when drinkers were involved in disruptive behaviour in and around our interviewing activities.

6. 'Welfare' was taken by the project team to refer the Family and Children's Services Program funded by the Commonwealth and Northern Territory Governments.

2.5 Ethical issues

A key ethical issue was informed consent. It is an extremely complex matter to gain informed consent in a way that is culturally appropriate. It appeared to be even more difficult when Yolngu team members were required to get written informed consent from their own family members. In some cases both the Yolngu interviewers and respondents appeared to see this as an unnecessary burden as both parties trusted that the project team was acting in good faith. If anything, discussions about protecting respondents and their stories seemed to create stress for some respondents as this implied we might not do the right thing. To address this issue the project team discussed the ethical requirement that we get informed consent from all project participants.

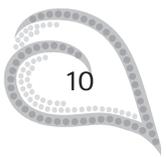
Further stress was created by the requirement of *written* (as opposed to verbal) informed consent. Many of the respondents were not literate and therefore were both stressed and in some cases embarrassed when asked to sign the form. Others had had bad experiences in the past in signing 'bits of paper'. Respondents expressed concern about potentially having their name 'put up on the wall at a conference' or 'being taken to court' as a consequence of signing a form.

The project team discussed getting verbal informed consent on a tape recorder. The project adviser felt that if respondents had to give informed consent, they should sign the form, and she therefore rejected this idea. This may have been related to the embarrassment she herself would have experienced if we had told the ethics committee that some Aboriginal people in her community could not sign a form. She insisted that respondents *should* sign the form, even while acknowledging the stress this was creating. She then made a tape recording in the vernacular explaining the informed consent sheet in detail and we got informed written consent from all project participants.

2.6 Interpreting the findings

Commentary from Aboriginal community members and clinic staff makes up the greatest part of the data. Taped interviews in Yolngu-matha were translated and the main points were transcribed in English by the project team. This was due mainly to time limitations but also to the inexperience of the team in doing comprehensive translation and transcription. The quality of the data from these interviews may suffer as a consequence. A partial data analysis was done during the interviewing so preliminary findings could be used to stimulate discussion around growth action once the interviewing was completed. A content analysis was then done by the project team around the specific themes that were used in the interviews. For example, one of the themes used in the interviews was 'food'. We fed back to the community information such as how many respondents mentioned 'when the baby starts crawling' as being the right time to introduce food. These reports have been given to Council, community members and clinic staff.

The analysis in this report is a more in-depth thematic analysis, which highlights significant issues and draws out implications, particularly those that emerge from a comparison of the two groups' stories. Draft copies of this report have been provided to project stakeholders and their feedback is included in Section 6 of this report.



3. Yolngu stories

This Section includes a thematic analysis of the data from the Yolngu interviews. The themes discussed are: stories about why children grow; how Yolngu know if a child is growing; the clinic story; and ideas for growth promotion action. Within each theme numerous sub themes are also set out.

3.1 Yolngu stories about why children grow well

3.1.1 Food

Kids grow tall from bush food

The most frequent response to the question ‘What are the reasons for good child growth?’ was ‘bush food’. One grandmother said *“When you feed kids bush food they don’t get sick and don’t go to the clinic, no check-up”*. All bush food was said to be good for children. Fish, yams, kangaroo, turtle, turtle eggs, oysters and crabs were mentioned in many of the interviews.

Among the positive qualities of bush food, respondents said that it was fresh and free - *“you can go and get bush food when you run out of money”* (Grandmother). One young woman said that bush food protects the body from the harmful affects of shop food. She said, *“when you feed them shop food kids don’t get sick because bush food is already inside their body”* (Young woman). Respondents mentioned ‘exercise’ as a positive spin-off of hunting for bush food. According to one father, *“you don’t get exercise like when you go hunting, only hunt in the shop”*. Bush food was often associated with outstations where it is generally more readily available and consequently outstations were also given as a reason for good child growth.

The Yolngu perception of bush food as being the best food to make children grow well does not correspond with it being the food children eat most often. This is evident in the interview data where respondents spoke about the type of foods they see children eating and in observations made by the research team over the year. Children’s limited access to bush food partly explains this. Issues such as people not knowing about bush food and how to hunt, the lack of a car to go hunting, the distance from the community to the creeks and the sea, and people being too ‘busy’ doing ‘other things’ or too ‘lazy’ were mentioned.

On the other hand a number of respondents talked about the fact that some children these days do not want to eat bush food. According to one grandmother:

The kids don’t know that bush food now. Now they say, ‘I’m not eating this fish its bad, I don’t know it’. Kids cry and say ‘I’m not eating this, bush food is rubbish food’.

Bush food makes them grow, shop food doesn’t

While respondents generally talked about the importance of mixing Balanda (shop) and bush food, four of the 43 Yolngu community members interviewed said that all shop food is bad for children. Two of these respondents were older grandmothers who said that shop food was very bad for babies. The third was a father with several children who said *“don’t be embarrassed, but Balanda food is poison”*. Another father said *“all Balanda food will kill you”*.

Some Balanda food is good, some bad

These days it's the modern days and there's two types of food. One from the store and one we get out bush. Traditional food I will give to my kids and self. All the time it is fresh food. In this hand I'll have to choose and think more carefully which is good food because I'll have to pay with money. I'll have to see which food is good for my body and the child. On the other hand I can get whatever I want.
(Grandmother)

... new one food these days. Some Balanda food is good, some bad. Makes kids sick and weak and they have to go to hospital everyday, little kids and big kids.
(Grandmother)

While bush food was the main reason respondents gave for good growth, 'good' or 'healthy' shop food was also a key theme in the Yolngu interviews. On the other hand, 'bad' or 'wrong' shop food was one of the main explanations given for children not growing well. So, while some respondents did not distinguish between shop food, categorising it all as 'poison', the majority of respondents interviewed grouped shop foods into 'good' and 'bad' categories. One respondent said they did not know what was 'good' shop food to make children grow well.

The majority of respondents grouped shop foods into 'good' and 'bad' categories. Generally this grouping was similar to the way a health service provider would categorise foods. The following tables show the main 'good' and 'bad' foods mentioned according to how many respondents spoke about them.

Table 3. 'Good' foods for children.

Type of food	Number of respondents
Fruit	17
Vegetables	13
Meat	10
Weet-Bix	9
Damper	9
Baby food	8
Water	6
Eggs	5
Fruit juice	5
Chicken	4

Table 4. 'Bad' foods for children

Type of food	Number of respondents
Sweet food	13
Coke/soft drink	7
Junk food	5
All shop food	3
Bubble gum	3
Tea	3
Greasy food	2
Sugar	2
Chicken	2
Damper	2

At the same time some foods, such as lollies, Coke, soft drinks, golden syrup and cordial were each described by one respondent as being 'good' food for kids. The following excerpt from a group discussion shows that the meaning of 'good' and 'bad' are not self-evident.

Interviewer: *What Balanda food is good for kids?*

New mother: *Coke and soft drink.*

Interviewer: *Is that good food?*

Mother: *I don't know, maybe. It's their favourite food... Coke and other soft drink are bad.*

New mother: *Lollies is another one kids want.*

In this case, Coke and soft drink are thought to be good for children on the basis that they are their 'favourite'. The soft drink was not being judged on its nutritional content, but on the value children attribute to it and the fact that this is what they want. This suggests that some respondents consider children's preferences as relevant to what they eat. This may also reflect the well-documented holistic understanding of health that many Indigenous people have (Nathan

and Japanangka, 1983; National Aboriginal Health Strategy Working Party, 1989). At the same time the second respondent, having explained why these drinks are 'good', goes on to say that they are 'bad'. It appears she is unsure of the value of these foods, but is aware that there is a different view to that of Yolngu children.

'Dry damper' and 'dry food' were mentioned as 'bad' foods in several interviews. This was said to apply both to bush food and shop food. One father explained that "*with bush food like kangaroo, eat it half cooked, not dry one*". When we asked what was wrong with it being too cooked he said it was dry with no fluid and "*dry food is bad, very bad*". LM explained this further during the transcription of the interview. She said when you eat dry food the fluid can't go into the body for energy and then you get 'weak blood'. On many occasions the team observed people complaining about the new style of food being cooked by the Women's Centre. Unlike the soupy stews they used to make, the new curries were 'too dry' and consequently often smothered in tomato sauce before being eaten.

While many respondents spoke about the 'bad' foods available in the shop, only four respondents were critical of the shop itself. These respondents, who were all men, noted that: it is difficult to get vegetables in the shop and when the food arrives in the shop it is 'rotten and bad'; it's hard to know whether the food in the shop is over date and the shop employees don't care because they are 'only thinking about money'; and the take-away had been selling 'bad' food for a long time.

'Junk food, lollies, soft drinks, chewing gum, bubble gum and only a little bit of food'

While the majority of respondents could list foods that are 'good' for children, they described them eating 'bad' foods as a reason for poor growth. Coke, soft drink and lollies were the foods most often mentioned in response to the question 'What foods do most kids in the community eat?' Some respondents spoke about these items as not being food and said that children eat a lot of lollies but only '*a little bit of food*' (Young man). There were several different explanations for this.

'Lollies are their favourite'

Children *wanting* to eat 'bad' food was one of the main reasons given for them doing so. Many respondents talked about kids '*doing their own thing*' and '*eating their own way*'. This relates to children making their own decisions about what they eat, as well as the importance placed on children being happy.

Interviewer: *What about your other child?*

New father: *... too much eating lollies.*

I: *How old is that child?*

F: *Three or five. Small.*

I: *When he says 'I want lollies' what do you say?*

F: *I say, 'lollies aren't good for you. Not good for you. Too much eating lollies is not good for you'. He cries, 'lolly, lolly, lolly'.*

I: *And then you give it to him?*

F: *Yes.*

An interview with another father:

- I: *Do you tell your kids not to eat lollies?*
- R: *Yes, that's the main word, but they don't know what it really means, "don't eat lollie". If I'm talking to adults I can explain it more, but kids don't understand.*
- I: *So what happens when you tell your kids not to?*
- R: *(They say) 'why giving me in the first place and now stopping me?' They might feel, they can't talk, but they might have that feeling...*

While parents generally know these foods are not good for children and tell them so, they do not prevent them from eating them. In addition to a holistic approach to health, which places importance on children being happy, this also reflects the importance accorded to an individual's autonomy, including a child's autonomy. Hamilton, writing about Aboriginal people in Central Arnhem Land, observed that importance is accorded to individual autonomy and permissive child-rearing practices are employed in relation to the foods children eat (1981). This seems to apply equally in this study community in North East Arnhem Land, as evidenced by the following excerpt from a discussion with a young man about the children in his family.

- I: *What do you say when they want lollies?*
- R: *Just leave it, its up to them.*
- I: *Is it up to them what they eat?*
- R: *Yes. If you tell them not to eat lollies they cry.*

Another young man was unique in viewing children as being responsible for the impact of eating 'bad' food on their health. He asserted that when a child gets a 'weak body' it is the 'baby's fault for eating too many lollies'.

It was also observed in this research that when a child cries or throws a tantrum over lollies it shows the people with the money how much they want them. Adults who are concerned for the happiness of the children they care for usually give them what they want to stop them crying. LM told the following story about a young boy from her family.

He woke up having a dream that he was eating lollies. He wanted some lollies so he started crying for money. Everyone laughed and said it was Sunday and the shop wasn't open. He kept crying for lollies until someone gave him \$20. The next morning he was waiting outside the shop at 9 o'clock for it to open to that he could buy lollies.

Hamilton also made the observation in relation to the foods children eat that 'wants sufficiently deeply felt will be satisfied by others' (1981: p.151).

On another occasion DS sat in on an informal session outside the Women's Centre, organised by the Strong Women workers and involving a visiting DHCS nutritionist. The four-year old daughter of one of the Strong Women workers started crying for lollies. For some time her mother ignored her and listened to the 'healthy food' story being told by the nutritionist. Eventually she gave in and went off to the shop with her crying daughter. They returned soon after with a family size block of chocolate. After helping herself to a good portion, she told her daughter to sit quietly and eat it while she listened to the rest of the 'healthy food' story.

Only two respondents, one father and one grandmother, suggested that parents should be 'strict' and 'show tough love' (stop them eating 'bad' food) when it came to what kids could eat, by not acceding to their requests. Both of these respondents had very good English and a lot of experience outside of the community. Further, one had been an AHW while the other had been involved in health education and research. This suggests that they may have observed other child rearing practices and see them as making it easier to ensure children eat 'good' foods than the permissive Yolngu approach does.

Eating bad food is a habit

Another common explanation for children eating 'bad' foods was that this is a 'habit' for 'everyone' in the community. It was explained that adults got 'the habit' from 'mission time', when there was only sugar and flour on the shelves of the shops. Kids form the habit when they are young and then when parents tell them not to eat 'bad' food they think, "why (you) giving me in the first place and now stopping me" (Father with lots of kids). According to this man:

I don't know whether we are eating right food or not, because we've got this habit of eating food. Sometimes when we're desperate for that food we just go to eat that junky food for that habit. The best thing I'll have to learn too, as a parent, is what's the really good food for the kids and myself. Then it will give me a good picture to get good food from the shop.

In other words, people, not just children, like 'junky food' and do not find it easy to resist. This father indicated that he does not know whether he is eating the right food. He then referred to 'that food' and 'junky food'. This suggests that he has some understanding of what is generally considered to be healthy food and what is considered not to be healthy food. He went on to say:

I know some way of living, but I don't use it. I live like other people live. Because I like junk food see? Because of the taste. Chicken, fatty foods, lollies, Coke.

Parents don't know what is good food for kids

While many respondents were able to list 'bad' foods for children this did not prevent them eating them themselves or from feeding them to their children. The degree of understanding they have of unhealthy foods is likely to influence this behaviour. Listing items is not equivalent to having a comprehensive understanding of healthy and unhealthy foods. Most respondents interviewed were able to reel off a list of 'good' and 'bad' foods, but few respondents were able to explain in any detail why they were categorised as such. Some respondents said when kids eat lollies and junk foods they get (each item scored in brackets by number of times mentioned): sores on the skin (5); sick (3); weak blood (2); sick when adults (2); boils (1); and bad teeth (1). One respondent spoke about the effect that mothers eating 'bad' foods had on their breast milk and consequently the growth of their child.

Descriptions of the effect of eating lollies on children as depending on their age is further evidence that some Yolngu may not have a comprehensive understanding of these foods: "... later they can get into lollies, when they get stronger they can get into lollies" (Father). Another father also spoke about lollies being okay for older children. One father talked about lollies and 'junky food' being good for kids when they are young, but when they get older they might start to get sicker. Discussions with the project team also revealed that cold Coke is generally thought to be good for you but hot Coke is bad for your lungs. These different stories about 'bad' foods show that while people can recite a list of them, they do not always have a comprehensive understanding of why they may be 'bad'.

Junk food is lazy food

Mother and father encourage them to eat so many bad foods as only have a little bit of money and it's a quicker way to get them full. They are too lazy to feed them good food. Easy way is to feed them junk food and put them in the street.
(Grandmother)

Two respondents said that parents gave their children junk food because it is easy and they are careless. Another reason given for children eating 'bad' food was parents not knowing how to cook.

It's hard to find food

Three respondents mentioned children not eating enough food as a reason for poor growth. Some respondents talked about this in terms of the general availability of food in the community.

I go and look for a little bit of food. It's hard to find food. There's too much going on outside, cards. Not thinking of kids. This happens in my family all the time... starving for sugar, tealeaf and damper all the time.
(Young man)

While the shortage of food in the community was not a key theme in the interviews, it was observed by the project team on a daily basis. It was a key issue for many people and finding food regularly occupied a lot of their time. The fact that there is 'too much going on' also suggests that kids may not be able to get access to food if they come home and parents have locked the fridge and cupboard and are not there. The project team observed this occurring on several occasions. Council only issues one set of keys with each house and it often meant people had to find the person with the key to their fridge or go hungry. This man continued, saying, "if they don't lock up the food, the kids will finish all the food and other Yolngu will steal it. They get food from other people when theirs is locked up". He also said

Before, just one word for kids to come home for food and they would go. But now lots of things happening. Kids too busy playing all the time. Too much happening outside for kids and parents.

Another reason given for children not eating enough was that families were not sharing food and helping each other as they did in the past. One mother said "we don't get food from our family, they don't share, we look for food". A father talked about how things were changing and families were not sharing food, "instead people are starting to think we need to live by ourselves, have own food, and just look after immediate family." This reflects the social change that is occurring in the community: social relations and norms are changing to adapt to the different ways people are living.

Only one respondent said that the problem was that people do not have enough money for food. In preparation for a community feedback day, this was included in a list of reasons children do not grow well. Interestingly, our project adviser became very agitated about this point and said it was not the case. She believed that everyone has money but they used it on items other than food.

The interview data supports that view. Many respondents spoke about the problem of money being spent on things other than food. These generally included cards, kava and cigarettes, while alcohol and marijuana were also mentioned, but less often. A grandmother who was the primary carer of her grandchildren complained that "on payday their mothers get money, go to cards and kava and don't give her food. Then the money is finished".

On the other hand, one new father said that sometimes cards can provide money for food.

One man said it was not good for kids to eat too much. *“It’s good for kids to only eat a little bit because if you eat more then you feel hungry and then have to eat more”.*

Breast milk, smoking ceremonies, weaning practices and growth stages

Breast milk and smoking ceremonies were also described as reasons for good child growth. Smoking ceremonies are performed for new mothers for several reasons.

Olden times, when mother first had baby, they had smoking ceremony. That’s traditional way. It’s talking discipline and also to protect the baby from diseases, make mother and baby healthy, make a lot of breast milk come and also make baby not cry much and have a lot of sleep. I’m not sure if a lot of people are using that or not. That’s really important in my family. That is where it’s really important.
(Grandmother)

According to another grandmother, *“no ceremony, no breast milk and bad growth”*. Another grandmother said that if the mother gave the baby breast milk before the ceremony, the baby would be skinny as this was the wrong way. Grandmothers were the only ones to talk about the importance of smoking ceremonies and breast milk, with the exception of one young mother. This suggests that the younger generation may not value a practice that some older ladies see as being central to child growth. This reflects a more general theme throughout the interviews that times are changing and things are being done differently. Generally the old times were talked about as being better days when children were healthy and grew well.

In the interviews we also asked respondents about the best/proper time to start giving babies solid food (Table 5). The appropriate weaning time for babies according to most Yolngu interviewed is a lot later than the four to six months that health service deliverers suggest. Only one young mother out of 29 respondents said that four months was the right time. A grandmother, on the other hand, said that four months old was okay for Balanda babies to start eating food, but not Yolngu babies. This suggests that respondents are aware of the ‘appropriate weaning time’ message being given out by the health clinic, but that this is not necessarily seen as appropriate for their babies.

Table 5: When to start giving babies food

When to start food	Number of respondents
Crawling	10
Sitting up	4
Walking	4
1 year old	3
Get teeth	2
Reach out hand to food	2
4 months old	1
Tired of breast milk	1
Tall	1
Try to stand up	1

While we did not ask respondents what were the best weaning foods for children, the following foods were mentioned by some respondents (each item scored in brackets by number of times mentioned): baby food (7), fish (5), meat (2), turtle (2), damper (1), djipi (1), oysters (1), porridge (1), vegetables (1) and Weet-bix (1).⁷

⁷ ‘Djipi’ is a porridge made from damper and powdered milk.

Yolngu child growth stages were also described to the research team in informal discussions. These are listed below in the order they are said to occur as a child develops:

1. Yuta or yalgi yothu - newborn
2. Biliyunamirr yothu - baby that is turning over
3. Nhinanhamirr yothu - baby that is sitting
4. Galyunamirr yothu - baby that is crawling
5. Dharranhamirr yothu - baby that is trying to stand up
6. Djandjantmirr yothu - baby that is taking 5 or 6 steps
7. Marrtjinyamirr yothu - baby that is walking
8. Wandinyamirr yothu - baby that is running

Children are said to get diarrhoea when they move from one stage to the next. Some people therefore see intermittent bouts of diarrhoea as an integral part of a child developing.

Two other stages were described, but it was unclear to the project team where they fitted in with the other stages. One was 'ganan lukanhamirr yothu', described as a 'baby touching food by own hand'; the other was 'wanganhamirr yothu', described as 'baby that is trying to talk and say kinship names'.

3.1.2 Sickness

Sickness was not a key theme in the Yolngu commentary and was only described by one Yolngu respondent as a reason for poor growth:

... (you) also have to look at the health side, like the household. It is very hard for children when the house is crowded, lots of germs and sickness...
(Grandmother)

While sickness was not generally described in relation to the causes of good and bad growth, some respondents discussed it in relation to child growth. For example, some respondents talked about looking for signs of 'sickness', including signs of asthma or fever and children having 'a runny nose or ears', to establish how well a child is growing. Other respondents noted that children in Gapuwiyak are sicker now than they were in the past, due to them eating less bush food 'these days'.

It has to link up with food we ate before, they were strong and healthy in the old days.
(Grandfather)

Sickness was also described as a consequence of Yolngu not 'looking after' their children well. Children getting 'sick' was often described as the consequences of inadequate care, rather than them not growing well physically. Finally a limited number of ideas for action aimed to prevent children getting 'sick'.

3.1.3 Looking after kids

If you don't care for that baby, that baby won't grow healthy

... maybe I have to make myself, have to help my child. So that's the main thing that mother has to understand, understand in your mind and in your heart. So if you don't care for that baby, that baby won't grow healthy. That baby will have a lot of problems.

(Grandmother)

When mother and father don't look after kid then get skinny, weak one.

(Grandmother)

I don't see other people caring for kids. Kids walk around, no clothes and eating lollies... sit at cards.

(Father)

While bush food was the main reason given for children growing well, people not looking after their children was given as the main one for them *not* growing well. Sixteen Yolngu mentioned this in the community interviews and in many cases it seemed that children not being cared for well was a greater concern to respondents than whether or not they were growing. Respondents spoke at length and with passion about this as being a major problem in the community. The concern about this is reflected in the community's decision to start a family centre as a growth promotion action and its focus on being a place for children to be looked after and mothers to be educated in how to do this.

How Yolngu look after kids

A range of actions were described by Yolngu respondents as constituting 'looking after' children. Ensuring children are not 'left alone' was described as a key aspect of 'looking after' them. Children who are 'left alone' to wander in the streets are at risk of accidents and getting sick:

Some mothers and fathers look after their kids, and some don't. Their kids get sick quickly. Parents should get kids from trees and water and bring them home.

(Mother)

(The reason children grow well is) märi, momu, mother giving a good hand for that child and caring well. If baby crawls away from mother, mother goes and gets it doesn't leave it. Don't let the snake or insect get on it when crawling. Don't let them walk away from home. They might have an accident with the feet, they might get burnt in the fire. Lots of things mother has to be careful for, don't be careless for that baby, then the baby will grow well and not get sick.⁸

(Grandfather)

Conversely, family members spending time with children is an important aspect of 'looking after' them well. One young woman was asked whether her son's father helps to look after him and replied:

R: *Yep, he looks after him. He takes him for a walk.*

I: *Does he do any other looking after?*

R: *No, only visiting and taking him around.*

'Looking after' children also includes performing health actions such as: washing children and their clothes and sheets; having a clean house; getting bush food for children and giving them food.

8. Your 'märi' is your maternal grandmother and 'momu' is your paternal grandmother Zorc, R. (1986). Yolngu-Matha Dictionary. Batchelor, Darwin Institute of Technology..

Give them a bath, clean the house, wash them. Always listen to what they have to say to me. If they're crying for a banana or something, give that to them.

(Father)

Food is important, water, make sure you wash them, shower them morning, lunch and afternoon.

(Father)

Disciplining children is another aspect of looking after them and one that was primarily noted by men. In a number of interviews discipline was described as including telling children not to swear, steal, or smoke cigarettes and marijuana. It also relates to teaching them law and culture. When one father was asked, 'how do you look after that child to make sure he grows well', he responded, "*I taught him to make a spear, then go to fresh water and spear barramundi*".

A mother also described the way her sister looks after her children by teaching them how to get 'bush food'. A father described telling his sisters to look after their children well:

... but I keep yelling at them, 'this is the right track and this is the right way to look after your kids. Make sure the kids come first before everything else. You need your kids to grow up healthy, strong and to know ceremony and singing, so when you pass away the little ones can take over for the future'.

While a grandfather said, "every day check up the child, then the child will grow well, then the child will grow tall and learn good *rom* and not get sick."⁹ These actions suggest that 'looking after' children relates to ensuring their overall development, rather than just their physical growth.

They are the ones supposed to look after that child

'Looking after' after children being 'family' business was a key theme in the Yolngu data. Most respondents described parents, grandparents, aunts and uncles and the 'whole family' as being responsible for 'looking after' children. Respondents also described caring for children as a 'team' effort that involves 'everyone'. Some of the comments that reflect this include:

I help to look after my sister's child because she has two other children to care for, my mother and father also look after the kids. (Young woman)

The grandmother and grandfather look after well, father and mother and the whole family. (New mother)

*Help each other, *märi*, *waku*, *ngandi* and *bapa*... all the family helps, back and forth giving money, clothes and food.¹⁰ (Mother)*

*Mother, *märi* and family should all help look after kids... (Grandmother)*

Me and my brothers work together for the children as a team. (Grandmother)

*It's good to take kids to the bush and feed them bush food... mother, *märi*, *nathi*, *momu*, *ngapipi*, extended family (should hunt for food).¹¹ (Young man)*

We help each other, my mothers, sisters and grandmother. (Young father)

*Everyone (should look after kids). Father, mother, *märi'mu*, *momu* and second father.¹² (Grandfather)*

9. Zorc *Ibid.* defines 'rom' as, 'culture, behaviour, law, rule, custom, tradition, habit, way of life or doing things'.

10. Your 'ngandi' is your mother and her sisters and your 'bapa' is your father and his brothers *Ibid.*

11. Your 'ngapipi' is your mother's brother *Ibid.*

12. Your 'märi'mu' is your paternal grandfather and his sisters *Ibid.*

While parents were not described as solely responsible for ‘looking after’ children, the key role of parents was emphasised in many interviews.

It's especially mother and father's job. Before auntie or märi or märi'mu. Specially mother and father. They are the ones supposed to look after the child. (Father)

It's mother and father's job mainly. (Father)

So too was the view that parents ‘these days’ are not fulfilling their responsibilities, which means that the job of caring for children is falling to other family members. This view was expressed in all the demographic groups.

Some mothers and fathers look after their children and some don't. (Mother)

I look after my grandkids because my children don't. (Grandmother)

Some parents just go and play games and don't think about the baby. (New father)

Some kids get really sick because mother and father don't look after them properly. (Father)

Although this view applied to both ‘mothers’ and ‘fathers’, there was slightly more emphasis on ‘mothers’ not looking after their children. Further one father suggested that “*these days it is mostly fathers who are looking after kids, mothers are playing cards, spending money.*” Several female respondents held the conflicting view that only ‘mothers’ are caring for children these days and fathers are not doing their job:

Some fathers are good, some just watch and don't do anything. Some fathers just think 'ok mother you look after our kids, I have to do whatever I want', some fathers are like that. (Mother)

A minor theme in terms of who is responsible for ‘looking after’ children was the separation of roles between parents and grandparents. Only grandparents described this view. One grandmother said parents have to look after children and ‘märi and momu’ are responsible for the ‘health side’. Another grandmother noted mothers and fathers should look after newborns while grandmothers look after older children, and a grandfather said,

Grandmothers and grandfathers are supposed to look after, especially for (their) daughters' kids. It's the mother's job when the baby is small, then when they start walking they can go to the grandparents.

Some grandparents appeared happy to be doing the majority of the caring of their grandchildren, although grandparents being displeased with this situation was a more common theme in the interviews. The following discussion with a grandmother, whose daughter also participated in the interview, shows that she falls into the former category:

Grandmother: I look after my daughter's kids. She thinks too much of cards. The father always drinks kava. Mother and father don't look after the kids. Cooking food, washing clothes and the caring is done by me. I wake up and feed food to the kids, shower them and then go to school. School finishes and they come home and then I feed them food in the afternoon and night. Mother and father don't care. Mother playing cards and father is drinking big kava.

Interviewer: You're saying that she doesn't look after them?

Grandmother: Yes, she doesn't look after them, I do.

Interviewer: She (the respondent's daughter) is laughing.

Grandmother: Yes, she's thinking about how she doesn't look after her kids. Father drinks kava all night and sleeps long time and doesn't help Märi in the morning. Even mother doesn't help märi, only märi looking after.

Interviewer: *Is that good for you to look after them doing that big work?*

Grandmother: *Yes, good, nothing. It's good for me to look after the kids.*

The daughter then pointed out that that when her children were younger she cared for them and if they have to go to hospital in Gove, Darwin or Adelaide she takes them.

Other grandparents were less than happy to be doing this 'big work'. One grandmother complained that she always looks after her daughter's children while they go to cards and drink kava. She wonders why they do not look after them and said, "*they've got no mothers, its like they've passed away*". Another grandmother said,

Before mother went to get yams and märi or momu cared for the baby. If baby cried they called out for mother to come, they came running. These days you call out and mother doesn't come.

This comment highlights another common theme in the interviews, that parents not fulfilling their child care responsibilities is a new issue. This reflects a changing social trend, and one that is not very popular with some sections of the community.

Grandparents not doing their share of looking after children was also a theme in the data, although a minor one. Grandmothers primarily expressed this view. A grandmother described the 'old days' when '*nathi*' would sing the baby to sleep and said, "*now its different, new one (different) Yolngu. 'Momu', 'märi' and 'ngathi' don't look after*".¹³ One young man also noted that grandparents are not doing their job:

... some grandparents are looking after kids, some are not. Kids going in the street and some grandparents (are) not bringing them home.

Most of the commentary on Yolngu not 'looking after' children related to other people's behaviour and very few respondents described themselves as not caring for children. One grandfather said that kids grow well "*when you have a decent mother... like me and her, we know how to handle our kids*". Another father said, "*my family care for kids, I don't see other people caring for kids*". The few respondents who did describe themselves as not 'looking after' after their children were generally not self-critical. For example, a mother said that she used to look after her children but when they 'grew tall' she started drinking kava and now her sisters look after her children. Only one man was critical of his own behaviour in not caring for his children. Some respondents were reluctant to comment on the behaviour of others in relation to child care.

Why some people aren't looking after kids

People are busy doing other things

There were a number of explanations as to why Yolngu are not 'looking after' after their children. The most common was that parents are 'busy' doing 'other things', which primarily referred to gambling at cards and drinking kava. Some respondents also described the problem of fathers being 'busy' at ganga, alcohol and fighting.¹⁴ Grandmothers being 'busy' at cards was also mentioned, although less frequently.

13. Your '*ngathi*' is your maternal grandfather and his brothers *Ibid*.

14. '*Ganga*' is the term used in the community for marijuana.

While many respondents attributed poor growth to the fact that so many people are 'busy' doing these 'other things', such activities were not necessarily looked on as being negative in themselves. The use of the word 'busy' tends to suggest these are seen as legitimate activities to be involved in, particularly if they do not adversely affect the care children receive. Some respondents talked about how they themselves play cards or drink kava once they have bought food for their kids. A new father said, "I look after my kids and know how to play cards, but don't drink kava. My wife goes to the cards too but doesn't drink kava." Another father said that first he and his wife buy food and in the night-time they drink kava.

Spending money on these 'other things' was also seen as a sign that people were not caring for children. While most respondents said this was because this leaves no money for food, some commented that there was no money for clothes for kids and one grandfather said the house could not be kept to a 'reasonable standard' if there was no 'household budgeting'. According to one father:

Maybe my priority as a parent is cards and kava, instead of kids, just because of that habit. I like to win money because it will satisfy my want and maybe when I win money I will turn and see my kids, and if I lose, that's bad luck.
(Father with lots of kids)

While some respondents were critical of people spending money on 'other things', others did not see it as problematic if they also bought food for their children. In a discussion about money being spent on cards a grandmother said,

Yes, it's a big problem. Like good, like card playing is a habit, life habit or lifestyle. But other things to help that child, parents will think to put most of the money to food. We get small amount for playing cards, or kava, or whatever we want. Just small amount. It's up to that person, that father, mother or family... But Balanda like that too. Hey? Yes. Some spend money to cards and some I keep for myself.

None of the nineteen ideas that were given for growth promotion action addressed the issue of parents being 'busy' doing these 'other things'. In the above quote, 'it's up to that person, that father, mother or family' suggests the value accorded to the autonomy of the individual means it is their right to do what they want with their time and money. We asked a father why he thought kava and cards come first for a lot of people. He answered, "Don't know. I don't look to other people with my ideas about what they think".

Young people don't know the story about growing children

Some young mums are learning how to care. They don't know how to wash the baby... adults and old people were having babies in the old days. These days 12 or 13 years old and they don't know school. They only go half way and then go out. How will they bath the baby? Care for the baby?... father is same age as young mum.
(Young man no kids)

The people who were interviewed attributed the lack of knowledge among today's parents about looking after their children to their relative youth. One respondent said young parents were not learning how to care for kids at school because they 'only go half way and then go out'.

Others said the young parents' lack of knowledge was because they were supposed to be taught by their parents how to care for the baby but this was not happening. One grandfather said it is the grandparents' job to help the young people because they did not know the story about growing children, but these younger mothers and fathers were not listening to their parents. While a grandmother said,

I talk to my daughters about looking after the kids, they don't listen... I ask where the money is. They go and tell people I'm telling them what to do all the time.

Two respondents said the young age of mothers also contributes to them not looking after their children because they are too shy. One father said that young mothers were embarrassed because they may be considered by others to be too young to be parents and so they leave their babies with their mothers.

Problems between parents

Several respondents said that when parents were not married they didn't look after their kids. One father said that if they were not married the mother and baby stayed on their own and the father lived in another camp. In this case the father would not help to look after the kids and this was a problem. A grandmother agreed that fathers weren't looking after their kids like they used to because they were not married to the mother. She said this was because women did not want to get married, because when they do all the money goes into the 'father's hand'. By choosing not to get married, these women did not get help from the father in caring for their kids, but they did have the option of spending their own money on their kids.

A 'bad relationship' between parents was also given as a reason for them not looking after their children. In this case, social disruption is impacting on the care children receive and subsequently their growth. One father said sometimes the mother deliberately left the baby if the father was giving her a hard time or if he didn't support them. A grandfather explained that, "if the husband has another girlfriend then the mother gets upset and doesn't care for the kids. Just pretends to look after the kids at money time... get money and don't care for kids". Another father with several children, when asked whether people go to cards and forget their children because they think someone else will look after them, said:

Maybe, most people do, yes. Especially me. Father has no respect for women. Like women are more important. If I don't have that respect towards my woman then it's not going to work. If I've got that full respect for my woman it's going to balance my lifestyle.

One thing that was not mentioned in the formal interviews was the issue of women having children with different men. In informal discussions, however, this was talked about as a problem in the community. Young women having babies to different men meant that the fathers would not help to look after any of these children, or support them financially.

Mothers are lazy

It's hard for the mother... not hard. It's good for the mother and father to chase them around bring them home. Good. But probably the mother and father are too lazy to get up and chase those kids and bring them home for lunch or shower or maybe breakfast.
(Father)

Three respondents said that some mothers were too lazy to look after their children. Only one respondent said that fathers were also lazy. A grandmother explained this laziness in the following way. This quote also suggests that new mothers may be bored in their role of child rearing, as they are no longer able to engage in activities such as 'drinking' or 'smoking'.

Maybe for young mother, maybe they had a health problem before they became a mother. Maybe drinking lots of alcohol or smoking, that sort of problem. And when you become a mother you're restless. That's my understanding.

Other explanations

There were several other explanations for why some Yolngu are not looking after children. One was that sometimes parents have a preference for one child and so they look after that one well, but leave other children that they like less for grandmother to look after. Another was that maybe people didn't think children are important. Finally, one grandfather said the parents weren't capable of looking after their kids because the mother couldn't read and write and 'understand Balanda (language)'.

3.2 How Yolngu know if a child is growing

Yolngu say the main way to tell whether a child is growing well or not is to look at the body. This includes looking at their eyes. If their eyes are dry it means the child needs more water. If they are pale on the eyelids or under the eyes they have weak blood or no blood. If the eyes are going in it means the child is getting skinny or has diarrhoea. A running nose or ears is also a sign that a child is not growing well.

Respondents also described looking for signs of sickness to determine whether a child was growing well or not. Several respondents said that if a child was not sick they were growing well. In response to being asked how she knew if her child was growing well, one grandmother said 'no sign of asthma and no sign of any fever'. Other respondents said that if a child looked happy and was playing well, they knew they were growing well. If a child was not visibly sick then it was assumed it was growing well.

Yolngu also know whether a child is growing well based on how well it is looked after. Seven respondents said that if you care for a child well then you know it will grow well.

I know by looking after them well. If you look after them well then they grow well. If you don't look after them they get sick, weak. I see other kids like this. Other kids grow well.
(Grandfather)

Yes, I know (he's growing well) because from birth we fed him.
(Father)

Four respondents said they knew whether a child was growing by taking them to the clinic for weighing and a check-up. Three respondents talked about holding babies to see how they were growing.

Sometimes we know that he grows because when we cuddle him he goes like fat, sometimes we feel him. Like every time when we feel him and he's got heavy we say 'looks like he's put on weight'.
(New mother)

Long time ago mother used to understand for that child. When they used to lift that child, it's too light. So they know that that child is not growing well and needs lots of food.
(Grandmother)

3.3 The clinic story

In the interviews we asked respondents what they knew of the clinic story about child growth. In our initial interviews most respondents said they did not know the clinic story. We then started showing respondents a blank Road to Health growth chart and asking them to tell us about it. This was a more effective way of facilitating discussion around respondent's knowledge of the clinic story and perceptions of the clinic's work.

Lose weight paper

Thirteen respondents, mostly men, said that they did not know what the growth chart was or that they hadn't seen it. This may be because they have never taken a child to the clinic for weighing. The chart was variously described as 'lose weight paper', 'levels, hard one' and 'statistics work'. One father, who used to be a health worker, said, "I know that one. If the line goes up, proper healthy boy. If goes down there then in trouble, means he's not being looked after well." One father, who did not know the growth chart, thought men should learn about them.

Father should understand this and it will give him more knowledge to understand kids. If I'm relying on my wife to take them to the clinic how would I know if my kids are healthy or not?

Female respondents had mostly seen a chart and generally explained it by saying that the line going up was good and down was bad or 'one line goes up and one line goes down'. Some respondents said that the top line was the good one and that it was best for kids to be kept on it. Two respondents talked about the 'red line, white, green line', and one respondent mentioned the 'orange line', which suggests some people may not be aware of the change to the new Road to Health chart. This may be partly because there are some old charts still in use.

It also emerged from our interviews that the English term 'weight' was itself not necessarily clearly understood. We asked the respondents who described the line going up as good and down as bad to tell us what 'weight' was. Seven respondents described 'weight' as being to do with how heavy something is and seven respondents did not know what 'weight' is.

One young father explained the process of weighing children as, "every time you take the child to the clinic and put them on that thing and see if they're eating less or more food". A man talking about his 14-year old son said "He's skinny now, but weight and everything is good". Other explanations related 'weight' to whether a child was healthy or not. According to one young man weighing is to "check up body, whether it's good or bad... for sickness". This is a very likely source of confusion, as a child may not look sick to the carer, yet clinic staff may find the child is either not gaining or is losing weight. Further, the fact that some respondents don't know what 'weight' is suggests confusion about the meaning of a process where the clinic staff get a number from the scales, which they then use to determine the direction of the line on the chart.

Some respondents said they did not understand growth charts and the weighing of children because clinic staff had not explained it to them. The following comments reflect this:

When you take children to the clinic the nurses don't explain.

(Grandmother)

Sometimes the clinic staff show the growth chart, but other times they don't.

(Young woman)

(Growth charts) are in the hospital, but they don't tell me the results... clinic staff show the chart, but they don't tell the story. They say if he's growing or not but don't tell the straight story, what really happened.

(Grandmother)

Sometimes health workers are up at the clinic all the time. They advise parents about good food and to look after kids well. But they never go out and visit houses and tell the true story. We need a man and a woman to do that work. Sometimes that clinic mob are just in the clinic, no time to go and sit and tell the story. They do their job well, but we need someone in the community to do that other work.

(Father)

This suggests that some respondents want to know more of the clinic story about weighing children and growth charts. For some respondents it is not enough simply being told whether their child is well or not, or that their line is going up or not. If the clinic staff fail to explain the whole story about their child's growth, Yolngu may perceive that they aren't being told the 'true story'. The perception is that clinic staff know more about what is happening with their child's growth, but they are keeping this story from the parents or family.

The clinic is for sick kids

When you feed them bush food kids don't get sick and don't go to the clinic, no check-up.
(Grandmother)

A perception that came through in many of the interviews is that the clinic is a place for sick people, not for routine check-ups. Some respondents said that their children were healthy and therefore did not go to the 'hospital'.¹⁵ One young woman said that you only go to the clinic if your child is sick. This may explain why many parents do not take their children for weighing on a regular basis. Reasons Yolngu may give, such as mothers are 'too tired to walk to the clinic for weighing' are better understood in this context.

The clinic is responsible for child growth

During an interview a project co-worker said that the clinic staff were 'lazy' because they didn't drive around and take mothers and babies for weighing. The young woman being interviewed added, 'like at Elcho, they always drive to get the people and the baby and take them to weighing'. Another young woman said she only goes to the clinic if the van picks her up. This suggests some respondents see clinic staff as having responsibility for children being weighed.

When they are monitoring growth, clinic staff may appear to assume some responsibility for child growth because they are not perceived to be telling parents the 'true story'. The same appears to occur when a child is diagnosed as not growing well. Respondents said that the clinic checks for illnesses, gives medicine and sends children to the hospital in Gove and Darwin. It is the clinic and other non-Aboriginal organisations, such as 'Welfare', that appear to address the issue and solve the problem. Therefore some respondents may have come to see child growth as being the responsibility of the clinic and other Balanda organisations.

For example in our interviewing, and more generally over the course of doing this project, there were many references to 'Welfare'. In particular respondents talked about 'Welfare' taking away children if they are not growing well.

Sometimes I explain to my sisters, 'if you don't look after the baby the Welfare will come and take the baby'. I tell them that, 'if you don't look after properly'. If you are shy it's hard to find that baby, you'll end up in court. I used to tell my sisters because they don't understand English very well. That's what I tell them can happen against kids. Because Welfare comes into the family, it's going to be a real hard day.
(Father)

15. The term 'hospital' was often used to refer to the community clinic, particularly by older respondents.

When we asked a mother and father about growth charts they told the following story about when their son 'lost weight a long time ago'.

Interviewer: *Why did he lose weight?*

Mother: *Don't know.*

Father: *Jesus knows.*

Interviewer: *And now?*

Mother: *Good, we look after him, him and I.*

Interviewer: *Before when your child was skinny what story did the clinic mob tell you?*

Mother: *Same. Not eating food. Thinking he was a refugee, now he's good.*

Interviewer: *Before, did the clinic talk strong to you?*

Mother: *Nothing. The Welfare woman shopped for food and brought it here from Gove and Darwin.*

Father: *The Welfare lady was worried about that skinny baby.*

In this case it is the 'Welfare lady' who was worried about the children and not the parents who didn't know why their baby wasn't growing. Further, it was the 'Welfare lady' that appeared to attempt to solve the problem of the child having lost weight, not the parents.

3.4 Ideas for growth promotion action

In the interviews there were 19 different ideas for growth promotion action. The number of respondents who suggested each idea is included in brackets.

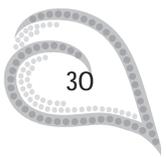
- Have a meeting and talk about looking after kids (6)
- Ask ALPA (the shop run by the Arnhem Land Progress Association) to sell healthy food (5)
- Get the Women's Centre to cook bush food for kids (4)
- Make guidelines about the shop and health (4)
- Train two Yolngu to teach people to live in modern day houses (3)
- Build a child care centre where teach parents how to make food and look after children (3)
- Feed the children like the Meals on Wheels Program (3)
- Help each other with strong talk and good food (3)
- Give children medicine (2)
- Teach teenagers to look after children (2)
- Ask parents to help with their children (2)
- Don't give children food from the take away (1)
- Get money from parents and cook food for the children (1)
- Give kids good food (1)

- Clinic have meeting with family when child not growing well (1)
- Cook healthy food for children and mothers (1)
- Scientists check food and only send healthy food to the shop (1)
- Send the children to outstations (1)
- Ask Council to clean up the rubbish (1)

While we did not ask how individuals could act to improve child growth, some respondents answered the question about community action with ideas such as bathing children, feeding them and asking family to help to look after them. When respondents gave these ideas we asked whether they had others that everyone could work on together. Some respondents said no, they had already given their ideas. This suggests that taking action at a community level to deal with child growth may not be perceived as the best way to address the issue by some Yolngu.

While respondents suggested talking about looking after kids, asking parents to look after their kids and teaching teenagers to look after kids, most of the ideas did not focus on change in the behaviour of parents and carers. The main reasons given for children not growing well were parents not looking after them and too much cards, kava, and marijuana. None of the ideas addressed these in terms of people doing more of the former and less of the latter, however. It seems likely that this is related to the value accorded to the autonomy of the individual and therefore the reluctance of Yolngu to tell others how to behave. When asked why he thinks kava and cards come first a father replied, *“I don’t know, hard to tell. I don’t look to other people with my ideas about what they think.”* Another father talked about money being spent on ‘other things’ due to people not budgeting. He said, *“we should have a big workshop on budgeting. Some people don’t like this as it feels like school. But that’s how to do it.”* The reference to school suggests people do not like education when they perceive that someone else is deciding what they need to learn.

Many of the ideas that were suggested to deal with the problem of children not being cared for focussed on setting up some kind of care program. One father suggested parents give \$20 of their wages to the project team who could then cook lunch for their children. He said, *“I’ll speak to them. I’ll just tell them ‘if you are tired of looking after them you can just chuck in \$20, they cook in the Women’s Centre, send them there’”*. Other suggestions included building a child care centre and starting a Meals on Wheels program for children.



4. Clinic staff stories about child growth

This section includes a thematic analysis of the data from the clinic staff interviews. The themes discussed are:

- stories about why children grow;
- how clinic staff know if a child is growing;
- the GAA Program;
- the clinic's work;
- the Yolngu story;
- and ideas for growth promotion action.

Within each theme numerous sub-themes are also set out.

4.1 Clinic staff stories about why children grow

4.1.1 Food

Kids don't grow because they don't eat

But nine times out of ten if the kid's not growing, the reason is simply that they're not being fed.

(Doctor)

The main reason given for children growing well by clinic respondents was children being 'fed enough food' and 'often enough'. According to clinic staff, children should be fed: small meals all day long, three times a day and any time they feel hungry.

The main factor thought to affect the regularity and amount of food consumed by children was that Yolngu didn't have enough money for food. While some clinic staff simply said that Yolngu did not have the money in the first place, others related this to the fact that money was being spent on other things like cards and kava. The fact that Yolngu had nowhere to store food was mentioned. Respondents also observed that when people do buy a lot of food, other people in the family will eat it. The lack of storage of food was seen as a key issue given that the shop is closed from Saturday lunchtime until Monday morning. Parents not teaching children how to eat, and children consequently not knowing how to eat, was also mentioned.

One clinic staff member said that mothers only feed their babies when they themselves are hungry. Mothers drinking kava was said to make this more of an issue as it suppresses their appetite and means they are less likely to feed their kids. Another respondent thought some children may have been suffering from anorexia, resulting from not eating enough in the past, and therefore did not feel hungry and didn't want to eat.

What kids should eat

Children eating 'proper' foods or having a 'balanced diet' was given as another main reason for children growing well. Most clinic staff would describe fresh fruit, vegetables, meat and fish, and not much fat and sugar as the basis of a good balanced diet. Baby food, bush food, Weet-bix and breast milk were also said to be important.

.. a lot of the time it's to do with what mum and dad, or the family who are looking after the child, are nurturing the child with. So for babies who grow well they're fed fresh fruit and vegies and they're fed good meat, and fish and good milk and not much sugar, not so much fat.

(Nurse)

What kids do eat

The 'clinic story' closely related poor growth to children eating too much of the 'wrong thing'. Foods that were mentioned as 'bad' for children included sugar, lollies, chips, bubble gum, junk food, Coke and greasy foods.

So all the chocolate, bubble gum, chip, that's all yaka manymak (no good) except occasionally because everyone can have some of that and it can do them no harm. But for their bubble gum to be their breakfast, and their chips to be their lunch and their bubble gum to be their evening meal, that will make them grow badly, because they don't have what we call a balanced diet.

(Nurse)

Why kids eat what they eat

Respondents explained why children eat these 'bad' foods in different ways. Some clinic staff said it is because parents didn't know what were 'good' foods for children.

... I think there's a difficulty with us saying, 'if you feed the baby this they'll grow well'. I don't know whether some of the parents don't understand this food will make them grow well. I'm not sure that they understand everything we're telling them. Even when the (Aboriginal) Health Workers explain it to them, I think they're a bit confused when they leave here.

(Nurse)

Another respondent partially attributed this to the educational materials used in the clinic.

... I know that young mums I've seen given very complex charts about what foods to feed your kids when they're at different developmental stages, and young mums have been given pictures of food groups and all that sort of stuff... it confuses me, it's got to confuse them sometimes.

(Doctor)

Other staff said that Yolngu did 'know' what 'good' food was. A number of staff said that often when they asked a mother what she had been feeding her baby she said exactly the same thing.

... I'm always interested when I ask women what they're feeding their babies. They always say exactly the same thing, you know, meat, fish, eggs, vegetables, in the same order. So it's obviously an answer they've learned to tell me because they think that's what I want to hear. It's often not true of course. So I think they have an idea of what they think we want to hear.

(Doctor)

The following quote from an Aboriginal Health Worker suggests that an important issue is not whether parents know what 'good' food is, but whether they feed it to their kids.

When kids get sick mum and dad just standing and thinking. Then they take them to the clinic and get the story from the nutritionist. The first time they get the story and mum and dad try their best to give good food. How many days or weeks for? After one or two weeks they start to forget about it, back to style, same way. Hear a new story and line goes up, then after a few weeks forget and line goes down.

(AHW)

According to this AHW, even when there was an improvement in their child's growth from feeding them 'good' food, parents often did not maintain their changed behaviour. This suggests that some parents do not have a comprehensive understanding of health and unhealthy foods and that they do not equate their child's health with eating these 'good' foods. Some of the reasons given for parents not feeding their kids 'good' foods, even when they know what they are, included: parents did not stop kids from eating 'bad' foods; parents were too lazy to cook them proper foods so gave them junk food instead; kids preferred take-away; and kids ate lollies because of peer pressure.

That 'good' food is expensive and often not available in the shop were also mentioned as reasons why parents did not give their kids these foods, even though they appeared to know what they were.

... the food is already a week old when it gets there, the green fruit and vegetables that were green when they left Darwin often are brown by the time they get there. So there's limited choice for parents to make on what food that they can feed their children. And then if you try to feed a kid a rotten apple it's going to say 'thankyou very much, but no thankyou, I prefer the bubble gum'.

(Nurse)

Some clinic staff observed that the take-away did not sell healthy food and was open longer than the shop, which is another way in which parent's access to healthy food was limited. Several staff thought that Yolngu knew what 'good' foods were from the clinic telling them, but that Yolngu did not know why the foods were 'good'. One respondent said, "I do believe that parents know it's not good, but they don't know why... I don't think they understand that concept."

Bush food and outstations

Six of the thirteen clinic staff interviewed said that bush food contributed to child growth. They said they encouraged mothers to feed their kids bush food, as it was all good for them. Most of the Balanda respondents assumed that kids ate a lot of bush food, particularly those who live at outstations. One respondent said that the most of the food consumed by people on Aboriginal communities was from the shop and that it was hard to get bush food unless you lived at an outstation and had a reliable car. An Aboriginal Health Worker said that before people ate a lot of bush food but now they eat from the shop.

Outstations were also thought by some respondents to be a contributing factor to good child growth. Apart from the availability of bush food, some outstations are by the sea so children were thought to do a lot of swimming in the salt water, which is good for their skin. One respondent drew a positive relationship between outstations and families that were functional, happy and stable. These families were thought to look after their children better and to have fewer growth problems.

Breast milk, weaning practices, teaching kids to eat

Breast milk was the second most common response to the question 'What are the reasons children grow well?'. Some respondents said the clinic had no problem encouraging mothers to feed their babies breast milk, but often mothers fed them only breast milk for too long. The failure of mothers to start their babies on solids at what clinic staff thought was an appropriate time was one of the reasons cited for children not growing well from 6 months onwards.

Babies are allowed to go (without solids) and then it's too late by the time they've lost weight, they're failing to thrive, they're malnourished, they're sick and you're trying to catch up and you don't catch up.

(Nurse)

While one clinic staff member observed a delay in weaning that they thought might be related to cultural practices, others thought mothers sometimes forgot and needed to be reminded. Another possibility was that mothers may be confused as to when was the right time to introduce solids. Clinic responses to the question 'When should babies start eating solids?' ranged from four to nine months. Some of the AHW responses were, 'when walking on own', 'if the weight goes well then start food', 'when they grow give them food' and 'when the baby cries for food'.

The following comment from one respondent supports the notion that Yolngu may be being given various and sometimes inconsistent information.

I don't really know what sort of message the clinics have been putting out. My impression is that the clinics have not been putting out a consensus statement, but a message from one of the nurses who had a particular interest in that area.
(Paediatrician)

Once children are weaned clinic staff talked about the problems of children not being taught how to eat by their carers and food not being prepared appropriately for them. One respondent said,

There's no example set for Yolngu children to see other children in the family eating. Its sort of like a dysfunctional home... it seems to be disjointed eating, the way they eat, they don't eat like we do, sit down and have an evening meal... they don't see that mum and dad are eating, well why should they eat?
(Nurse)

Others said that food was not mashed up enough so that baby could digest it easily. This was attributed to the fact that mothers did not know how to do this.

One respondent said that the weight of babies at birth determined how well they grow.

So the children from the start, it's from the time the mother's pregnant right throughout their ante-natal period they have to take care of themselves and eat well. So that the baby has an optimal opportunity when it's born.
(Nurse)

4.1.2 Sickness

Illness or sickness was the most common response given by clinic staff to the question 'What are the reasons children do *not* grow well?'. Worms, anaemia, skin sores, parasites, colds, pussy ears and anorexia were all mentioned. Worms and skin disease were related to overcrowded housing, where children carry a much higher disease load, and poor hygiene. Sickness was also said to come from children playing in the water and not washing their hands. Anaemia was linked to diet and worm infestations.

Illness was discussed in different ways by different staff. Some staff talked about illness as a key reason for children not growing well.

Food... Um, well I guess the things that... Then you've got look at the things that they don't grow well with and infections can stop growth, but that's not answering your question directly. But infections can stop or reduce child growth. Also worm infestations, especially hookworm infestations, strongyloides, parasites.
(Nurse)

If the child doesn't hear the mother telling them not to go to the water, they get sick... get children out of the puddles, take them home or they'll get sick.
(AHW)

Children get diarrhoea and lose weight.
(AHW)

Hookworms, if they have an infestation they will be infected every three months, even if we treat them. That causes anaemia and lethargy and failure to thrive. Cold and ear infections make them feel unwell, every child has an ear infection, so they don't eat properly and they lose weight.
(Nurse)

Immunisation is also important. Hygiene is a vital factor because opportunistic infections occur purely because of poor hygiene.
(Nurse)

Anaemia, hookworm and urinary tract infections cause failure to thrive, and other infections.

(Nurse)

I think they need adequate food number one, it's a pretty silly thing to say. Number two they need an appetite. Two things affect their appetite. One is chronic ill health. If you feel sick you don't feel hungry. There's a high disease load. The other, I don't know if it applies to these kids, is anorexia.

(Paediatrician)

One nurse discussed illness as resulting from the failure of parents to introduce food, which then resulted in poor child growth: “they get ill, they've got no resistance so they quickly lose weight”. Other staff talked about checking for underlying medical problems when children presented in the clinic with poor child growth. The following quotes suggest that illness was seen as a key reason for poor child growth.

You have to eliminate first that there's no underlying medical problem as to why the child is failing to thrive. So there's a series of tests that are done: blood tests, urine, check the child to make sure there's no sores, there's no really underlying medical problem.

(Nurse)

... if the child's not growing well we have to check them for any medical reason. Any disease that's preventing them from growing. So we check them for urinary infections. We check them for evidence of worm infestation, pussy ears skin sores, all this stuff can interfere with their growth.

(Doctor)

4.1.3 Looking after kids

‘Looking after’ or ‘caring for’ children was not as strong a theme in the clinic as the Yolngu interviews, with less than a quarter of the clinic staff describing it as a factor affecting child growth. The three clinic respondents who described people not ‘looking after’ children as a reason for poor growth were all Yolngu. The following comments were made during interviews with two AHWs:

I: *What are the reasons for good growth?*

AHW: *Looking after the child well, washing everyday, feeding...*

I: *What are the reasons for bad growth?*

Respondent: *Mother doesn't look after well or talk well.*

Another AHW:

I: *What are the reasons for good growth?*

Respondent: *Looking after well, how they sit with food, mother and father look after...*

While Balanda clinic respondents referred to the way different mothers look after children, it was not listed as a reason for good or bad growth. The importance placed on children being well cared for in order for them to grow well reveals a substantial difference between the perceptions of Yolngu in both groups and Balanda clinic staff perceptions.

How to look after children

There was also a difference between the actions described by respondents in each group as constituting ‘looking after’ children. Clinic staff generally described health actions when they talked about how to ‘look after’ children, such as: washing children, cooking food for them, keeping the house clean, washing clothes and changing bed sheets.

Bath and feed them, cook food and give them food to take to school. Feed them three times a day, then they will be strong and healthy all the time.

(AHW)

While respondents in the Yolngu group also described a number of these actions, they also emphasised the social dimension of caring as being central to good growth. Including not leaving them alone and teaching them discipline, law and culture. Some of the AHWs also described not leaving children 'alone' and teaching them law and culture as aspects of caring for children well.

... before (parents) looked after them, no cards and kava, going in family groups hunting everyday.

(AHW)

Who should look after children

'Families being responsible for 'looking after' children was a key theme in the clinic interviews, although the emphasis on the role of women was stronger than in the Yolngu interviews. This is evident in the following comments:

Anybody in the house. The mother primarily for the first couple of months as she can breastfeed. But anybody can care for children. You have extended families here, which can give mothers a rest.

(Nurse)

Certainly what I see here- different from Balanda culture- is that raising babies is very much 'women's business'. And sometimes you see men getting involved, but it's usually, you know, the mother and the aunties and the grandmother that look after the babies. It's usually not the men.

(CMO)

It's a family thing, and it's usually the older ladies and the aunties in the family group, not so much the mother. They all seem to have second mothers that seem to be the ones that make sure that the baby is growing... it's the women's business to look after the children. Its women's work.

(Nurse)

In this community, Aboriginal communities, very different to my community. Whoever's caring for the child, whether that's grandmother, auntie, but family. Whoever takes responsibility for that child, its their responsibility... in general the world over, mothers, aunties, in my family and everyone's family, look after children the most. But I do see, we do get men in here. But yeah, I do think that because the clinic is separate we don't see as much. But still women do most of the caring. (It's) no different to anywhere else I've worked.

(Nurse)

Depends on the family. Mainly the mothers, but in some cases the grandmothers, sometimes the aunties or the second mothers or it's a shared thing. Some men do, but not that many.

(Nurse)

The Balanda view may have been informed by their observation that it is generally women who bring children to the clinic. It may also reflect their narrower view of the actions that constitute caring for children, unlike the Yolngu perspective which incorporates a range of actions, some of which may be more often performed by men.

While the Balanda clinic respondents saw looking after children as being ‘family’ but primarily ‘women’s’ business, the Aboriginal Health Workers (AHWs) all said that ‘parents’ are responsible for looking after children. One male AHW noted that ‘fathers’ should not be forgotten and should be spoken to about the issue of child growth: “*keep an eye out for men and start to talk about this to them, father one*”. This is similar to the view in the Yolngu interviews that both ‘mothers’ and ‘fathers’ are responsible and highlights a difference between Yolngu and Balanda respondent perceptions.

Why people don’t look after children

Several Balanda clinic staff identified factors that they considered lead a family to look after their children well including: functional families where people are ‘in control of their lives’; parents being employed; parents who are able to speak, read and write English; mothers being well educated and able to communicate with clinic staff; and family elders teaching young mothers.

The kinds of things that we see, the characteristics of kids that grow well, firstly they usually come from a functional family. They usually have a family where people are kind of in control of their lives. I know that’s a bit nebulous but it’s the best I can think of at the moment. There’s usually people with jobs, people who speak English, people who can read and write.

(Doctor)

A number of these factors relate to the capacity of the family to operate in the Balanda world. This compares with only one Yolngu respondent saying that mothers need to be able to read and write English to care for their children well.

The factors identified that prevent families from looking after kids well included: problems in the home; too much kava, cards and alcohol; fathers not supporting mothers; and, older women in the family not supporting mothers.

While these factors were also described in numerous Yolngu interviews, they were talked about differently. For example both Yolngu and clinic respondents described parents spending time and money on cards and kava as a reason for children not receiving adequate care. While Yolngu respondents did not describe these activities as being necessarily negative in themselves, Balanda respondents tended to perceive people playing cards and drinking kava as evidence that families are ‘dysfunctional’ and not in ‘control’. While Balanda not generally discern between how many resources people used on them and whether they affected the care of children, one respondent did:

... young mother that play a lot of cards are more likely to have babies with growth problems. However, some very good mothers play cards and some people manage to play cards and its not a problem and they look after their kids really well, but certainly playing cards is an association. Drinking kava is an association...

(Doctor).

Further, while respondents in both groups described the problem of grandparents not teaching young people, the view that young people don’t listen to their elders ‘these days’ was only expressed in the Yolngu interviews. This suggests Balanda respondents may not be aware that Yolngu knowledge systems have been affected by the ‘changing times’.

4.2 How clinic staff know if a child is growing

Growth charts

Most of the clinic staff said they used growth charts to work out whether a child was growing or not. Some respondents placed emphasis on the line going up or the curve following the right pattern. Others talked more about the three lines on the chart and whether the child was in the right section of the chart. Despite the introduction of the New Road to Health Charts, which are not coloured, five respondents talked about the green line being good and the red line being 'bad'. Again, this may be related to the ongoing use of these charts with older children.

If they're following a growth curve for development according to their age and what they're expected weight is of an average of the population.

(Nurse)

See how he's staying down here? And he was in the green bit, going towards the green bit, and now he's staying in the orange bit, which is okay and he's healthy and he's not going to be a big problem, but he should be up here.

(Nurse)

The white line and green line are good. Between the orange and white line they're not growing well.

(AHW)

Looking at them

One respondent said that you could not tell whether a child was growing well or not by looking at them as sometimes they looked fine but they may not be putting on weight.

You won't see it immediately when the child walks in. The child might look good and healthy, which is why it's very confusing for parents and things because they think the kids is healthy, eating okay, doesn't look sick. But when we measure it and do its weight we find that it's much littler than what it should be at that age.

(Nurse)

Others said that while growth charts were the most accurate measure of whether a child was growing, you could also get an idea of growth by looking at the child. One respondent said they looked to see if the child looked skinny, and had pussy ears and sores. Another looked to see if the child was 'starving, tired, sick, unhappy or sleepy' and whether the child's eyes were white, which meant it was starving.

While most respondents relied on the growth charts and looked at children to back this up, one nurse said that the Road to Health charts were not right for Aboriginal children and the best way to know if they were growing was to look at them.

You only have to look at a child to see if the child's healthy or unwell. And a mother and an auntie and a grandmother know more about that child than any of us know. But we love to make assumptions and say 'if this child isn't this big, and that fat, and that tall, it must be a problem', well no, that's not necessarily so, but everyone will argue that point. What I think is one of the big problems is that we use, we use charts the same for Balanda babies, Aboriginal babies, Chinese babies, we all use the same chart, but its not right. Our build, our natural size is very different... So for me, is a child playing? Is the child learning? Is the child reaching its milestones? Does the child look happy and healthy?

(Nurse)

This view that Aboriginal babies are naturally smaller than Balanda babies underlies a likely difference in messages being given to Yolngu about child growth by the clinic. This respondent did not consider poor child growth to be a serious health issue in the community and this view is likely to have been expressed to community members.

At the same time, this respondent still weighs children to check if they are 'following the line', despite perceiving that the charts are not right. It should also be noted here that, when a Yolngu respondent made an assessment of whether a child is growing or not by looking at them, the respondent weighed the child to check this.

They will come to you with a concern... someone said the other day, 'this child's a skinny one, you have to weigh him'. At the child's putting on loads of weight and he had grown taller, but his weight was fine and he's gaining weight every time he's been weighed in the last month. I said, 'no, no, no, he's fine, he's just getting tall that's all'.

(Nurse)

A number of the AHWs also said they worked out if a child was growing by looking to see if they were 'healthy', 'strong' and 'playing' and did not mention weighing them. One respondent said that they knew whether a child is growing well by giving them a lot of food. The suggestion here is that providing the child with enough food ensures their good growth.

Growth and growth charts are very difficult

In the clinic interviews we asked staff whether they explained growth charts to Yolngu mothers and used them as an educational tool. All clinic staff said that they showed the charts to people. The majority of respondents said that they taught people that the line has to keep going up. Many of them felt that people had an understanding that the line had to go up, but did not know much other than this.

The charts are a tool that anyone can understand. There's no particular medical 'mahoogamy' about them and certainly I always show the chart to mum and will talk about the chart because it's a nice graphical way of showing how the kid's doing. But explaining the whole concept of a graph, with an x axis and a y axis, and how the line is really a representation of the kid's weight over time, it's just a concept that a lot of the young mums have just never come across before. So sometimes I wonder what it really does mean to them. Because they always nod and say, 'yes I understand', you know, and that's not always the case".

(Doctor)

At the same time this respondent suspects that some Yolngu did not think that growth charts had anything to do with child health.

Amongst some people there has been a lot of scepticism about the growth charts and I strongly suspect that some people think the growth charts are a bit of Balanda conjuring tricks. You know, that they really don't have anything to do with the health of their babies.

(Doctor)

There were different explanations as to why most Yolngu only knew that the line had to go up. In the above quote there is the suggestion that the concept of a graph to monitor weight over time was very difficult to explain. This respondent went on to say that growth charts could be used as an educational tool as much as a diagnostic tool, but the time you spent educating depends on how busy you were. Another respondent related limited understanding of growth charts among Yolngu to the fact that they do not speak English.

Growth and growth charts, very difficult. Yes, we do try to teach them, but as you know a lot of Yolngu don't speak English, let alone read English. So these ones (growth charts) with this format, its better, and its getting better. Because everyone's starting to know these ones now... So mums are actually looking at them and going 'I get the thing of what it should be doing'.
(Nurse)

One respondent said the mothers did not need to know more than whether the line was going up or not.

They get very confused. But all I teach them is that it should go up. I just explain to the mothers that "the baby has to do this, it has to go up, you follow the dots, the dots have to go up. The dots go across, the dots go down, it's bad. The dots have to go up to make it strong". And they understand that... What they understand is that the baby has to put weight on. I say that babies have to get fat everyday until they're adults. That's when we stop needing to put weight on. So every time I weigh this baby when it comes to the clinic it should be heavier. And that means it's a healthy baby. Until it's grown up and doesn't need to come to the clinic any more. And they understand that... That dot is a good baby getting strong, or a baby getting weak. If it goes up its strong, if it goes down its weak. If it goes across, not so good either. So I don't know if they need to understand any more than that. I mean most European women probably wouldn't understand much more than that in all honesty.
(Nurse)

This idea was supported by another clinic staff member who said,

... growth charts are one thing, they're great, but they're for us to worry about because we're the medical people who need to worry about whether they're under weight or over weight or whatever.
(Nurse)

The Aboriginal Health Workers generally said that they showed growth charts to mothers and then advised them. They talked less about educating mothers about the charts and more about telling them what to do to get the child to come back to the line, as well as telling them that it was the carers' responsibility to get the children to grow. One health worker said that people don't listen when they talk about weighing; *"the story goes in one ear and out the other"*.

4.3 Growth Assessment and Action Program

In the interviews we asked clinic staff to tell us what they knew about the GAA Program. Five staff did not know what it was. The other respondents said it was about weighing and measuring children every three to six months and checking their blood. Two respondents mentioned action plans as being part of the GAA program. One of these two said that if the monitoring showed a child was not maintaining a growth pattern for age, then you worked out an action plan with the mother. When asked whether they used action plans very often, one said,

Action plans should be used more often but when you work in this situation they're not always practical. Otherwise we'd only get through a fifth of our work if we kept running around looking at everything.
(Nurse)

The second respondent said they had done an action plan and enjoyed it and thought it might achieve a positive outcome. However, they had forgotten to complete it by filling out what happened as they said the plans involved *'too much paper work'*.

When asked about action plans, another respondent said they were too time consuming and required a lot of paper work. Further, this respondent said that the medical check up in the action plan was too thorough to be done once a month so they preferred to use an abbreviated form the clinic had developed. Another respondent, when asked about action plans, said they had not been required since they started work in the community.

... in the last 2 months that I've been here we really haven't had any child we've needed to be concerned with. We have been concerned, but there haven't been any children that have required planning, putting a plan together.
(Nurse)

Two staff members mentioned the six-monthly GAA reports. One said that they couldn't remember whether the GAA report was helpful but that there were 'heaps of graphs' in it (Nurse). Another said that the time lapse between the collection of data and the arrival of the report in the community was a problem. Reports currently arrived in communities up to six months after the data had been collected. They are therefore not always seen as relevant as there may have been major changes in child growth patterns over that period.

4.4 The clinic's work

The clinic's good and not so good work

Clinic staff were asked 'What does the clinic do well and not so well in relation to child growth?'. The main aspect of the 'good' work identified in interviews was regularly seeing 'at risk' children in the clinic.

We do well with babies that are yaka manymak (no good). Babies that are bad, we do fairly well with them because we have to... We see them all the time, make sure they come to the clinic, and if we don't we go and pick them up and bring them in.
(Nurse)

We always check the baby first who is the sickest.
(AHW)

...(We) concentrate on babies who plateau on their weights, growDHCS and their heights or anyone who's sick, then concentrate on those and do constant reviews.
(Nurse)

I keep a register of 'at risk' kids. I have a spreadsheet with all the names of all the kids that we're worried about, and every month I have to write something about each kid. So we see all these kids at least every month... and if the child's not growing well we have to check them for medical reasons... maintaining the 'at risk' register is a success'.
(Doctor)

While maintaining the register was seen as a success, one respondent also said that the clinic should be seeing these kids more often, but that this is difficult when 'we don't have any health workers' (Doctor). This respondent is suggesting that although there are a number of AHWs employed at the clinic, at times there are none present in the clinic.

The routine weighing and measuring of children was also mentioned as a positive feature of the clinic's child growth work. Children are weighed on a regular basis, regardless of whether or not they are sick. Respondents also mentioned doing 'Well Baby' checks every three months, telling parents what foods to give their children and giving children immunisations.

On the other hand, some clinic staff said the clinic was not very good at dealing with the 'not so good children'. This was related to a lack of resources and to parents not bringing in the children because they are not worried about them.

The ones we probably don't do so well at are these ones, these ones that aren't yaka manyak (no good), they're not down here, really bad, but they're not as good as they should be either... the ones that aren't really sick but they aren't doing very well either, they're the ones that we probably don't do well in the clinic. Because we haven't got time and we haven't got the staff and mum and dad don't bring them in because they haven't got the time.

(Nurse)

Others talked about the clinic not doing enough growth promotion work.¹⁶

What we do is treat it (poor growth) when kids do come. Do Well Baby checks every 3 months. I think that's very good, but I don't think we do enough health promotion, primary health care. There should be mothers' groups from the clinic to tell them about baby care and (they) should start with ante-natals... We need to have a well baby clinic and not just be seeing kids when they're sick.

(Nurse)

The main reason given for this was limited resources.

We don't have enough staff to give every kid blue ribbon growth promotion treatment.

... I'm concerned that we may well have 30 kids or more that we need to deal with at any one point in time and don't have the resources to do an action plan on every one of those kids. So that's a concern.

... So there's all sorts of problems. The bottom line is that there's really not enough resources. Maybe in the future there will be.

(Doctor)

If you had more man hours and more people to help with the education programs and the idea of running programs... And if you can get out there, on the ground and educate them and show them this really does work. But you have to work at it. Its not a fly-by-night talk every 3 months because that's what the program says.

(Nurse)

The high number of relief staff working in the clinic was also said to impact on what the clinic did not do well. One respondent thought the staff themselves had an influence on how much work was done in growth promotion.

Over the years there have been a number of nurses who want to talk to you about wanting to do this and that. And then things change and there's a nurse who hates the place.

(Paediatrician)

The limited amount of growth promotion work being done may also be partly related to some clinic staff not seeing it as being as important as growth monitoring. In many of the interviews growth monitoring was discussed as being the way in which the clinic works to promote growth. According to one respondent:

But the way that we make sure that kids are growing well, and continuing to grow well in this community, is to continue to weigh and to continue to measure them.

(Nurse)

16. A definition of growth 'promotion' was not requested or provided in the interviews, however we realise it means different things to different people.

Another respondent suggested that one way to promote child growth would be to build a shelter in each camp and weigh the children there. This idea, which was supported by another respondent, suggests some clinic staff equate growth promotion with growth monitoring.

Several staff said they would like to do more growth promotion work. Three respondents said they want to start a 'Well Baby' clinic. This would involve setting a regular time for mothers to come to the clinic with their babies. Apart from weighing and measuring the babies, this could involve educating the mothers about food and hygiene, demonstrations of how to prepare foods for babies and finding out from the mothers how they were going and what help they needed. Other respondents talked about doing more education with people, particularly on the kinds of shop food that were healthy. One respondent said the clinic should start a program of going out from the clinic and spending time with Yolngu carers, even if the child did not need to be weighed.

The Aboriginal Health Workers were generally very reluctant to criticise any of the clinic's work and found this a difficult question to answer.

Clinic responsibility for child growth

One clinic staff member said that it was the clinic's responsibility to ensure children grew well.

We're the medical people who need to worry about whether they're underweight or over weight or whatever.
(Nurse)

Others said that it was not the clinic's job, but the responsibility of the child's parents and family.

It's the parents' job to look after kids. We talk to mothers that it is their responsibility, we only do checking and other stuff.
(AHW)

Whoever takes responsibility for that child, it's their responsibility. Not the clinic. It's definitely not the clinic's when the children get sick and people are too lazy or you know, don't bring children back when we've asked them to. Then full stop, I don't care who that is in the family. Whoever takes responsibility for that child.
(Nurse)

In the second quote, while the respondent says it was not the clinic's responsibility, there is the suggestion that people were doing the wrong thing when they didn't comply with the clinic and bring the 'children back when we've asked them to'. This suggests that the respondent sees parents as being responsible for child growth as well as having a responsibility to the clinic to follow their instruction to bring the child back.

The respondent went on to say,

We talk to the mothers about 'what are you feeding your child? Is there a problem with money? Where does the child live? Is he going from home to home and no ones got any money? Is there a problem?'... And I talk to (the doctor) and say 'are you worried about this child? What do you think?' And he's very reasonable and often we'll say, 'all right, we'll give you one month'.
(Nurse)

This further suggests that while the respondent said the clinic was not responsible for child growth, this was not evidenced in some of its actions. One respondent discussed the way Balandas generally, and the clinic in particular, took responsibility away from Yolngu.

It's a Balanda fault, giving things to people and taking away responsibility, empower them and give them responsibility, not take it away. And we see it all the time in Health from picking people up for the plane that they can walk up the hill to the clinic... I'm not being mean by saying 'no I won't pick you up', you try not to disempower them.
(Nurse)

The clinic taking some responsibility for child growth may partially explain why carers may mislead staff about the foods they were feeding their children. Several respondents noted that mothers often recited exactly the same list of good foods when asked what they have been giving their children. The doctor said “*it's obviously an answer they've learned to tell me because they think that's what I want to hear*”. If parents felt more responsible for the growth of their children they may not feel the need to mislead clinic staff. At the same time, misleading clinic staff is also likely to be related to the unequal power relations between new young mothers and health ‘experts’. They may also have given a false response because of the shame involved in admitting that they had not done as the clinic staff advised.

The lack of consensus between the clinic staff on their roles and responsibilities around child growth suggests some confusion on this issue. Some staff saw the clinic as being entirely responsible, while others claimed no responsibility at all. The DHCS position lies somewhere in between, with the clinic being responsible for the medical aspects and having an awareness of the social issues impacting on child growth.

As far as I can see the majority of kids are doing well

Some of the respondents commented on the significance of child growth as a health issue in the community. Almost all of them did not think that child growth was a major problem.

They do tend to know what is good for their kids. This is reflected in most kids: blood is strong, weight is good, teeth are bad... As far as I can see the majority of kids are doing well. If there is a failure to thrive at one stage, if you treat them and explain about what foods they need, they do try and they gain weight, their anaemia gets better.
(Nurse)

Two respondents talked about child growth now in comparison to ‘before’.

Before there was bad growth, sores and diarrhoea. This time different. Good because we have lots of female health workers.
(AHW)

I have noticed an improvement in health over the 5 years that I've been here. (I) used to see lots of infected scabies... I asked the health workers and they're not seeing it as much... not seeing as much anaemia.
(Nurse)

Different staff explained this improvement in child health in different ways.

I truly haven't seen many skinny, unhappy, miserable looking children... there's been a vast improvement with intervention due to (the doctor) and the previous nurses and now I'm reaping the benefits. What I'm seeing are the benefits of the result of it all.
(Nurse)

... there doesn't seem to be as many admissions purely for failure to thrive. And that's, you know, probably due to the three things I mentioned: the Health Workers, the resident doctor and Strong Women, Strong Babies.
(Nurse)

Another respondent talked about a general improvement in health in the community during the time they had been there as well as in child health.

What I was saying about the babies is, you just, I haven't seen the extent of pussy sores on the babies. Just over the last, it's not just recently, it's over the last couple of years, maybe three. And I asked the health workers and they said 'no'. they're definitely not seeing anything like they used to. I mean people still do get sores and that. I just wonder if it is all that one-on-one education finally starting to get through.
(Nurse)

The doctor noted that community members have commented on the reduction of children going to hospital now, compared to two years ago and went on to say,

The admission rate has gone down dramatically and I've been given some of the credit for that, whether I deserve that or not is up for debate. You know, I think the Strong Women probably deserve more (credit) than I do. But, I think people have perceived getting their first full time doctor with an improvement in infant health.
(Doctor)

One respondent, while acknowledging that child growth was a concern in health, said it was not a major problem in this community, compared to other Aboriginal communities.

... certainly not as bad as quite a few communities I've been before, so I'm using that as a comparison I suppose... I don't think it's a major problem. I think if we compare the children to the scales that we discussed before that, yes, there's quite a few children that fall under the 5th percentile, but they aren't sick children... I've seen very few children that have concerned me here... it's still an issue that we need to be aware of and we need to address it as it arises. And we need to do well baby programs... but it's not a major problem.

... Yes compared to non-Aboriginal communities, yes, but when I'm comparing it from Aboriginal community to Aboriginal community, which I think is a fairer comparison and guide, no, I don't think it's a major problem.
(Nurse)

On the other hand, one respondent felt that children had started plateauing on their growth charts earlier than they used to and therefore that growth still was a key issue. They said it used to be nine or ten months before babies started plateauing, now it was more like four or five months. This respondent was not sure why this was the case but suggested mothers may not be feeding babies as much, or feeding them the wrong foods.

4.5 The Yolngu story about child growth

Clinic staff were asked what they know about the 'Yolngu' story about growth. The responses we got from the AHWs were: 'nothing, don't know'; 'good food'; and 'mother and father have to listen to the story from Strong Women'. Asking the Aboriginal Health Workers this question was slightly confusing as they themselves were Yolngu and they had been educated in the clinic story. What this did seem to reveal was that they were more comfortable talking about the clinic story than the Yolngu story. The reluctance to talk about the Yolngu story may have been because most of these interviews were conducted in the clinic setting. It may have also been due to some of the female AHWs not having any children. According to one of the Balanda staff members,

Two or three of our health workers don't have any kids and I don't know that they feel that they have a lot of authority to talk about traditional stuff about child rearing. And they don't much, they more function as interpreters during the conversations.
(Doctor)

This respondent, who had been in the community for two years, was the only one who seemed to have some knowledge of the Yolngu story about child growth. The doctor noted:

- Yolngu have a strong traditional sense of what is the correct food to give kids at certain stages and ways of working out how well babies are growing;
- when babies stopped growing it was a sign that the mother was pregnant;
- some Aboriginal groups considered diarrhoea a normal developmental thing; and
- Yolngu have a 'reasonable' understanding about what's bad shop food and what's good shop food.

The respondent learnt these things through talking to the Strong Women and going on hunting trips with the old ladies. This respondent went on to say that the '*clinic is not a good place to discuss with young mums as they find it intimidating being here*'.

Clinic staff made the following comments on what they knew about how Yolngu understand child growth. The amount of time they have worked in the community is included in brackets after each response.

I know very little about the Yolngu story except that it's different to our story. (Nurse- 1 year)

Nothing I'm afraid, I'm sorry. (Nurse- 2 weeks)

Well I've got no idea. I'll be honest, I have no idea. (Nurse- 3 months)

No, nothing. Nothing. They always seem to agree with what our concerns are, I've never heard anything otherwise. So, if they wish to enlighten me that's fine... Um I actually think their perception is the same as ours. I'm not saying that it is. My perception of it is that the women want their children to grow the same way that I want them to grow. Of course there's interpretation differences, and then cultural beliefs that it would be different... (Nurse- 6 weeks)

I'm not sure what you mean. But obviously things are a lot different now than they used to be. There's a lot of different things that come into play. You know the whole living conditions, food, social circumstances, they're all different than they were in the old days... (Nurse- 5 years)¹⁷

Nothing, I usually rely on the nurse to do the translation. I don't have time to sit down and have a chat. (Visiting paediatrician for 13 years)

The period of time clinic staff had spent in the community and related nearby communities was likely to have influenced the amount of knowledge they had. High staff turnover is therefore likely to reduce the capacity of Balanda health service providers to learn much about how Yolngu understand child growth. At the same time, some respondents who had worked in the community for up to a year had the same level of understanding of the Yolngu story as those who had worked there for two weeks.

Another factor that may influence the amount of knowledge of the Yolngu story people have is their willingness to accept that Yolngu people *do* have their own story and that it *is* as valid as the Balanda story. One respondent said Yolngu always agreed with the clinic's concerns and they had never heard anything otherwise, "*I think we always seem to agree, I don't think there's a great discrepancy*" (Nurse). We went on to explain that in our community interviews we had heard things like moist damper with flavour and tea was good for kids. The response was,

17. Having read a draft of this report, this person said that she does have an understanding of the Yolngu story about child growth, she just did not understand the question being asked.

Oh yeah, by all means, what they think are good growing foods and what we know are good growing foods, yes of course there is a big discrepancy, yes there is.
(Nurse)

Another respondent, having said they knew nothing about the Yolngu story went on to say,

... but Balanda story comes from here (shows growth chart), and Balanda story comes from many, many years of research on children and why they don't grow well. So we've had many, many, many years.
(Nurse)

Another factor may be that Yolngu people don't voluntarily communicate their story to clinic staff. A nurse explained, *"but their story I wouldn't know because no one's ever told me their story, they don't tell"*. Another said, *"I've never heard anything otherwise, so if they wish to enlighten me that's fine"* (Nurse). And,

People might tell you what they want you to hear. Sometimes you just don't even find out... I would love to know what's going on in their heads.
(Nurse)

This may be due to the unequal power relationship between clinic staff and Yolngu and the intimidation some people experience when visiting the clinic. Finally, the fact that people *'don't have time to sit down and have a chat'* must impact on their capacity to gain an understanding of how Yolngu people think about child growth.

It is important to note that in several clinic interviews respondents assumed that the question was relating to the 'traditional' Yolngu story about child growth. This suggests that while some respondents accept there is a 'traditional' story, they may not consider that this story bears any relation to the contemporary child rearing patterns in the community. It is likely these clinic staff would see little point in learning about a story they do not consider relevant to contemporary life.

4.6 Ideas for action

There were 24 ideas for action mentioned in the clinic interviews. These included:

- Show people what shop food is healthy (4)
- Ask ALPA to sell healthy food (4)
- Women's Centre cook food for skinny kids with parents' money (4)
- Have a well baby clinic (3)
- Take all lollies out of the shop (2)
- Give a copy of growth charts to family (2)
- Educate school kids about food, health and kids (2)
- Teach people bush food is good (1)
- Teach people to eat less junk food (1)
- Get parents to discipline kids and don't give them bad food (1)
- Get everyone to work together (shop, Council, Clinic, Strong Women and parents) (1)
- Help Yolngu to use own system to grow kids (1)
- Review 'at-risk' kids more often (1)

- Get old women to work with families (1)
- Get a full-time infant health worker (1)
- Ask the Government to make shop food cheaper and tell the shop to sell good food (1)
- Teach parents about lifestyle and diet (1)
- Less kava, cards and alcohol (1)
- Get a vehicle to go hunting for bush food (1)
- Work together in the Clinic more (1)
- Have a community meeting (1)
- Build a shelter in each camp for weighing and feeding (1)
- Open the shop on Sunday and lower prices (1)
- Give children medicine to make them feel hungry (1)

The focus of many of the clinic staff ideas was on children eating ‘good’ food. Some ideas related to educating parents and children about good foods, while others focused on changes to the price and type of food available in the shop and opening hours. Education was also a major theme in many of the ideas. The clinic doing education was the main emphasis, while one respondent suggested there would not be an improvement in health generally until children went to school and learned English. Another respondent said the old ladies should educate the young ladies according to ‘traditional’ Yolngu knowledge about child rearing.

The AHWs primarily supported the community idea of a feeding program in the Women’s Centre. One Balanda supported this idea. On the other hand, several Balanda clinic staff believed this was the ‘*worst thing*’ that could be done to promote child growth. These staff said a feeding program would only ‘*increase dependency*’ and take away further the responsibility of parents to look after their children. This suggestion was said to reflect that fact that “*parents aren’t dealing with the issue.*” (Nurse)¹⁸

There were also a number of ideas that focused on the clinic’s work to promote child growth. These included things like having a Well Baby clinic, employing a full-time infant health worker, reviewing ‘at risk’ kids more often and working together in the clinic more.

18. In subsequent discussion and a draft letter to Council, clinic staff have spelt out a more detailed position on the Family Centre idea. This is included in Section 6.

5. Comparison of Yolngu and clinic staff stories

This section of the report involves a comparison of the Yolngu and clinic staff stories. The themes discussed in Section 3 and 4 are used to draw out some of the similarities and differences between the Yolngu and clinic staff stories. The themes are:

- stories about why children grow;
- how you know if a child is growing;
- knowledge of the other group's story; and
- ideas for growth promotion action.

Comparing and contrasting these themes in the two groups' stories highlights insights and implications for the GAA Program and DHCS. Stories about the GAA Program are not compared, as Yolngu were not specifically asked about it. Rather, we include observations that may be useful in improving the GAA Program that are based on clinic staff comments about the program.

5.1 Factors affecting child growth

Food

There were some similarities in the way Yolngu and Clinic staff explained the reasons for child growth. Food and families caring for children, for example, were main points in each of the groups' explanations. The emphasis they were given, however, and the ways in which they explained the importance of these factors, differed.

In considering food as a factor, Yolngu highlighted bush food as being the main reason children grow well. Clinic staff focused on children eating enough food and eating often enough. Clinic staff also listed bush food as a reason for child growth, but their perception of the extent of its use in the community differed from that of some Yolngu. A number of Yolngu noted that children did not eat bush food very often, even though it was the best food for children. Further, some Yolngu said that children these days did not like bush food and therefore refused to eat it. Clinic staff on the other hand generally thought that children did eat a lot of bush food and that they preferred it to shop food.

Only three community respondents out of 43 mentioned children not 'eating enough' and 'often enough' as factors, compared with seven out of 13 clinic staff. This has implications for the clinic's message to parents about how much and how often they should be feeding their children, particularly given the comment of one man, who said that it was not good to eat too much, as then you felt hungry and needed to eat more.

The explanations as to why children did not eat enough were also quite different. Clinic staff mentioned factors such as lack of money, money being spent on other things, lack of storage, parents not teaching children how to eat, feeding them only when they are hungry and anorexia. Only one Yolngu explained the lack of food as the result of not having enough money. As mentioned in Section 3.1.1.5, this explanation irritated the project adviser who said that everyone had money, they just spent it on 'other things'. This perception was backed up in the interview data.

Most Yolngu attributed children not eating enough food to difficulties in 'finding' it. 'Finding' food generally relates to getting it from other family members, who these days are less inclined to share. While clinic staff discussed *lack of storage* as being a problem, some Yolngu mentioned *overly secure food storage* as a factor. Many people now have cupboards and fridges but as they are often locked when parents are out, children cannot get food from them. Locking away food was observed by the project team to be a common practice, due to many people sharing the one house and having '*too much family*'. This suggests that the problem of food storage may only be partially solved by the shop opening on a Sunday, as one clinic respondent suggested.

Children eating 'good' food was emphasised by both Yolngu and clinic respondents as being a key reason for good growth. In the Yolngu interviews, in explaining the reasons children eat 'bad' foods, the emphasis was on them being children's 'favourite'. Further, both children and adults are thought to eat junk food and lollies because it is a habit and it is what they like. Yolngu talked about children as being able to eat these foods if that is what they want, and if they cry hard enough. A number of Yolngu respondents and clinic staff, who said they are powerless to influence what was in the store, suggested that DHCS or Government lobby ALPA to remove 'bad' food from the store. Further, in the interviews and in informal discussions, a number of Yolngu said that removing these 'bad' foods from the store was the best thing to do.

Clinic staff on the other hand emphasised parents not 'knowing' what are 'good' foods to feed children as being the reason for children eating 'bad' foods. There was some difference of opinion among clinic staff on this issue. Some staff think parents don't 'know', and others think they 'know', to the extent that they can recite lists of 'good' foods for children, but don't know why they are 'good'. This second position is supported by data from the Yolngu interviews.

It seems that while many people are aware of what are 'good' foods according to the clinic, they do not have an in-depth understanding of why this is the case, nor of the potentially detrimental health effects of eating 'bad' food. At the same time, as parents recognise the right of the child to decide what they eat and are concerned for their mental health, children may be more likely to continue to eat 'bad' foods while they were available in the shop.

Late introduction of solids was also cited as a key reason in the clinic stories for poor growth, but was not mentioned by Yolngu. This appears to be directly related to differing perceptions about the right time to wean children. While clinic respondents ranged from four to nine months, the majority of Yolngu said when the child is crawling, sitting up and walking. This applies both to Yolngu in the community and the clinic group. Clinic staff said Yolngu waited too long; Yolngu said it was okay for Balanda babies to start early, but not Yolngu. Yolngu had a clear view of the right time to start weaning their children. It is unlikely that they simply forget to start giving their babies food, as clinic respondent suggested.

Looking after children

Both groups talked about the importance of looking after children in order for them to grow well. However, Yolngu respondents placed a lot more emphasis on this than clinic staff and spoke about it at great length. As has been mentioned, this may reflect the fact that Yolngu are more concerned about the problem of people not looking after their children than they are about the problem of children not growing physically well. This in turn reflects the perception that health is acquired through social, as well as physical material and therefore that when a child is happy they are healthy.

There were some differences within and between the two groups over who was thought to be responsible for caring for children. While the Balanda clinic staff tended to see it as families', and in particular '**women's business**', the AHWs and other Yolngu talked about the role of families and parents. The perception of the Balandas in the clinic may be related to the fact that fathers rarely come to the clinic with their children, which may be because there is a separate men's clinic.

Generally both groups explained in similar terms some of the reasons for some families not looking after children. In addition, Balanda clinic staff talked about the need for people to be educated, able to communicate with clinic staff, able to speak, read and write English and in control of their lives. They therefore largely equated looking after children well with Yolngu being able to operate effectively in the Balanda world.

At the same time, however, clinic staff also talked about the need for family elders to teach young mothers how to look after their children. Yolngu also talked about young people learning from grandmothers and grandfathers, but said that these days young people did not listen to the old people. In this period of rapid change it is likely that some young people no longer look to the old people to teach them. Yet this is happening in a cross-cultural context in which the Balanda system of delivering education both in clinics and schools in Yolngu communities is currently not very effective. In a recent review of Indigenous education in the NT it was concluded that there is evidence of deteriorating outcomes for Aboriginal students from an already unacceptably low base. (See Collins, Northern Territory Department of Education, 1999). It is therefore not surprising that some young parents these days did not know either story about looking after children.

Illness

Illness was the most common reason given by clinic staff for children not growing well. They particularly mentioned worms, anaemia, skin sores, parasites, colds, 'pussy' ears. Only respondent in the community group mentioned illnesses as contributing to poor child growth. This suggests a fundamental difference between the way Yolngu and clinic staff understand child growth and how illness itself impacts on growth. This also raises the question of whether Yolngu see things such as worms, colds and pussy ears as 'illness'.

5.2 How people know whether a child is growing

Overall there was a difference between the way the two groups determined whether a child was growing well. The majority of Yolngu said they knew by looking at the child. The majority of clinic staff said they knew by weighing them and plotting their growth on a chart, but could also get an idea by looking at them. The fact that most Yolngu knew by looking (and only four Yolngu said they knew by taking the child to the clinic for weighing) sheds some light on why some parents do not take their children to the clinic on a regular basis for weighing. Seven Yolngu also said that if you cared for a child well then you knew it would grow well. This highlights the broad understanding Yolngu have of health. It also tells us that Yolngu do not necessarily relate poor growth to factors such as illness.

The use of these other methods to work out whether a child is growing also suggests that some Yolngu may not have been convinced of the usefulness of the clinic's method of weighing children. This has implications for children who suffer from long-term malnutrition, which can result in stunting and early acute growth problems. In these cases it is hard to work out whether a child is growing properly simply by looking at them.

The fact that one clinic staff member said that the current growth charts were not useful in assessing whether Aboriginal children are growing well or not is also significant. Clinic staff ambivalence about growth charts will almost certainly be picked up on by community members.

5.3 Clinic staff knowledge and perceptions of the GAA program

The two stories have not been compared here, as Yolngu were not asked about their perceptions and knowledge of the GAA program. This section includes observations from the Clinic interviews that may be useful in improving the GAA program.

Generally Clinic staff have a good understanding of the growth monitoring aspects of the program. This reflects the focus of the clinic's work on growth monitoring and following up 'at risk' kids. Only one clinic staff member said that the current growth charts are not helpful in assessing how children are growing.

Some staff mentioned action plans but only one had been developed and this had not been completed. Not having enough time, '*foreign*' paper work, and '*not being concerned enough to need to do a plan*' were cited as reasons for not using action plans. Only two people referred to the GAA reports.

The importance of growth promotion as a key feature of the GAA program was not recognised by some clinic staff. Several respondents saw growth monitoring as being a method of growth promotion on its own. Others talked about the need to do growth promotion activities like 'Well Baby clinics' in addition to growth monitoring. Their capacity to do these activities is currently being constrained by a lack of time, staff and money. This may also reflect DHCS' current focus on early detection in the GAA program and may change as it shifts to prevention and growth promotion.

5.4 Knowledge and perceptions of the other group's story

It seems from the interview data that Yolngu have more knowledge of the 'clinic's' story about growth than clinic staff have of the 'Yolngu' story. Looking at what Yolngu know about the clinic story, however, it seems that their understanding is not very comprehensive. For example, while Yolngu are familiar with growth charts and the process of weighing children, few understood more than that the line on the chart has to go up. While clinic staff generally thought Yolngu did not need to know more than this, a number of Yolngu said they want to know more about growth charts.

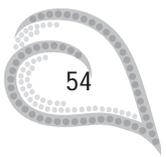
Some of the perceptions Yolngu have of the clinic and its role in relation to child growth are at odds with clinic staff perceptions. For example, Yolngu generally see the clinic as being a place for sick people and not for routine check-ups. On the other hand, clinic staff are frustrated with parents who do not bring their children for weighing regularly. A greater focus on primary health care and health promotion may address the current perception held by many Yolngu. Some Yolngu also see the clinic as being responsible for child growth, while most clinic staff say it is definitely *not* their responsibility.

Clinic staff knowledge of how Yolngu understand child growth is limited. Only one of the seven Balanda clinic staff appeared to have an understanding of Yolngu perceptions and knowledge of child growth. Some others gave the impression that regardless of how Yolngu understand child growth, the Balanda story was the right story as it was based on research. This was compounded by a general Clinic perception of Yolngu not understanding a lot of things, such as what is 'good' food for children.

5.5 Ideas

Both groups had similar ideas for actions to promote child growth. Clinic staff also suggested ideas to improve their growth promotion work in the clinic. The focus of many of the Clinic's suggestions was on educating Yolngu parents and carers about child growth. Yolngu, on the other hand, focused more on programs for children, like a feeding program in the Women's Centre or regularly taking the children out for bush food. This focus became more evident in the next stage of the project, which involved the community deciding which action/s to implement. Following community meetings, project committee meetings involving clinic staff and discussions with clan leaders over a three-month period, a family centre (initially named a child care centre) was selected by the community as a growth promotion action. Pending funding being secured, the family centre will include a feeding program, childcare and education for new parents on looking after children.

A number of clinic staff did not see this as being an effective way to promote child growth. This may reflect the difference in the ways the two groups see the problem. While some clinic staff were concerned about child growth, Yolngu seemed to be more concerned about children receiving proper care and about teaching new parents how to look after them. This reflects their understanding that if children are well cared for they will grow well. Some clinic staff also thought it may lead to families being less responsible for child growth and more disempowered. The Yolngu committee working on the family centre idea is aware of the clinic's concerns and is currently developing a model that will encourage families to be involved in the centre.



6. Stakeholder feedback

An important aspect of the participatory action research spiral is to feed findings back to study participants. The Community Council, project committee and clinic staff have all been provided with draft copies of this report for comment. The executive summary of this report has been discussed with the Yolngu Town Clerk, who also offered to discuss it with the Council Chairman (who was not available at the time to participate in the discussion) and the full Council at their next meeting. It has also been discussed with the Yolngu project committee and clinic staff.¹⁹ In addition, community reports providing feedback on the findings discussed in this report have previously been given to project participants and the Council of the community where this research was conducted. These were in a format that allowed greater access to the information for project participants with lower levels of English literacy.

As was anticipated, given the different world views and perspectives of the various stakeholders, and the fact that views change over time, there have been varying responses to the report from these groups. We respect and value the views of these groups and therefore set out in this section the feedback we have had from stakeholders and our response to them.

The Town Clerk, the Community Council and the project committee (all Yolngu) gave verbal feedback on the draft report in discussions of the report's executive summary. No concerns were expressed or amendments requested. Three clinic staff have expressed concerns and given extensive verbal feedback. These clinic staff disagree considerably with the project team's interpretation of the data. Some of their comments have been taken on board and changes have been made. Other comments have not been accepted and the original interpretation remains. The main points of contention made in their verbal feedback are outlined below.

Clinic staff were also invited to submit a written response setting out their views on this report to be included as an appendix in the final version of the report. Two e-mails were received from one clinic staff member. These comments summarised the verbal comments she had already provided and she did not want these e-mails included as appendices to this report. Her comments are incorporated in Section 6.1.

6.1 Clinic staff comments

This section has been separated into two parts. Section 6.1.1 includes comments received but not responded to or incorporated in the report. We did not respond to comments where we had no reply or on the basis that they were recommendations. Section 6.1.2 includes clinic staff comments to which we made a response. The project team response to the comments in Section 6.1.2 is set out in section 6.2.

Comments not responded to by the project team

- Child growth was a community concern before it was expressed to the project team in 1998
- Danielle Smith does not have a health background and may not have understood some of the comments
- The report could be made easier to read by editing the repetitions and correcting the contradictions

19. Only three of the Balanda clinic staff who were interviewed are still working in the clinic. Findings were discussed with them and two of the Aboriginal Health workers interviewed (others were not present).

- Clinic staff experience difficulties in communication due to cultural and language differences
- Clinic staff feel professional and legal pressures to take responsibility for child health but work hard to empower people to be responsible
- A high proportion of people start babies on solids around four months of age and not at the later stages suggested by many Yolngu interviewed
- More people are bringing their children to the clinic for check-ups than in the past
- Clinic staff do think that growth promotion is important and baby clinics have been run on and off over the past few years
- Clinic staff see some of the potential risks and negative effects of a Family Centre as being:
 - Yolngu might not have the correct qualifications so Balandas could end up controlling the centre
 - Possible high money costs to Yolngu in the future if the Government subsidies are withdrawn
 - The poorest mothers might not be able to afford it if the subsidies are withdrawn, while they are more likely to have children who are not growing well
 - It may send a message to Yolngu women that looking after their children is not their responsibility, when they should be taking more responsibility
 - Mothers might leave their children at the Centre and go and play cards or drink kava
 - It would be cheaper for older Yolngu women to teach the younger women in their own homes, and they may not do this in the Centre if they are not doing it already
 - Risk of transmission of infectious diseases with a Child Care Centre
- Clinic staff need training in cultural awareness and orientation when arriving in an Aboriginal community
- There is a lack of educational resources for young mothers
- DHCS should provide formalised language training to clinic staff
- Clinic staff should be meeting people half way but there are too many demands on their time and not enough resources
- The Clinic needs more resources

Comments responded to by the project team

1. The sample size in the Yolngu group is not big enough to make generalisations
2. Some of the quotations appear to be taken out of context and not what staff meant to say at the time
3. Unclear whether quotations are condensed or edited as the grammar appears to be incorrect
4. Clinic staff do not think illness is the main reason for poor child growth
5. Clinic staff do not think caring for children is 'women's business'
6. Clinic staff do not think having a separate men's clinic means less men bring their children to the clinic
7. Not enough emphasis on the lack of clinic resources, DHCS support and time
8. The report made us look lazy and does not reflect all the hard work we have done and the fact that there have been marked and continued improvements in child health
9. Concern that the report depicted the staff and clinic in a negative way in being insensitive and not understanding Yolngu well

6.2 Project team response

1. Limited sample size and generalisations

Sample size is acknowledged as a limitation in the preface of this report. As discussed in the preface, this report does not attempt to offer either a Yolngu or Clinic staff 'understanding' of child growth. Insights are discussed, rather than generalisations being made.

2. Quotations out of context and not reflecting what staff meant to say at the time

Interview transcripts were not given to Yolngu respondents due to some respondents having lower levels of English literacy. As we wanted to treat both groups in the same way, we did not return them to Balanda respondents either. As some clinic staff have questioned the interpretation of their original comments these transcripts have now been provided to the clinic staff who have commented on this report. This should address their concerns that they have been quoted out of context. In hindsight it may have been useful to allow clinic staff and Yolngu to have a copy of their transcripts and change anything they wanted to before the data was analysed.

3. Condensed or edited quotations

Some quotations have been condensed in an attempt to limit the length of this report. More complete quotations have since been included in some instances to address the comment about quotations being taken out of context.

4. Illness is not the main reason for poor growth

There are three key issues where clinic staff feel their meaning has been misinterpreted. One is that they did not mean to say that illness was one of the main reasons for poor child growth, rather they have to rule out any medical problems when a child presents with poor growth. This has now been qualified to say 'Illness was the most common response given by clinic staff to the question 'what are the reasons children do not grow well''. Numerous quotes have also been added to support the assertion that this was a common theme in the interviews.

5. Caring for children is not ‘women’s business’

Some Clinic staff have also said that they did not mean to say that looking after children is ‘women’s business’, rather that they observe that females do most of the caring. This is contrary to comments originally made in some clinic staff interviews. Quotations have been added to demonstrate that some clinic staff did refer to women as being primarily responsible for child growth, while others talked about observing women doing the majority of caring.

6. The separate men’s clinic does not mean fewer men bring their children to the clinic

This is contrary to comments originally made in some interviews. We do agree that respondents reflecting on this may have given a different emphasis to it from the one given in the interviews.

7. Not enough emphasis on the lack of clinic resources, DHCS support and time

Some clinic staff believe that more resources being directed to the clinic would help address many of the issues that emerge in the report. They also feel that there is a lack of educational resources for young mothers. This was not a major theme in the clinic staff interviews. However, where respondents did mention the lack of resources it has been included in this report. The need for additional resources is included in the recommendations section of this report.

8. The report made us look lazy and does not reflect all the hard work we have done

Some clinic staff think that they were made to look lazy in the report. They feel that the real issue is that they are under-resourced. (See comment on previous concern).

9. The report depicted the clinic in a negative way: insensitive and not understanding Yolngu well

Clinic staff say they are interested in learning about Yolngu stories but they do not have the time to do so because they are under-resourced. This report has not attempted to depict either group in any particular light. The interpretations in it are based on taped interview transcriptions and reflect the comments made in these interviews.

7. Project team observations

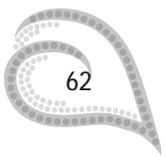
This section includes project team observations based on the analysis of the data. Issues that the project team considers are significant are drawn out and discussed. We refer to them as 'observations' as they are based on our interpretation of the data, rather than conclusive evidence.

1. Many Yolngu seem to have a limited understanding of how to eat well from the shop. Knowledge of 'good' and 'bad' food appears to be limited to identifying food items as falling into either of these two categories. Education that provides Yolngu with a more in-depth understanding of the potential effects of eating 'good' and 'bad' food on the body is needed. At the same time, it should be recognised that nutritional value is only one of many influences on food preferences and can be outweighed by habit, enjoyment, convenience and cost (Santich, 1995). The importance placed on individual autonomy, including child autonomy, raises questions about the extent to which nutrition education delivered to carers will result in a change in the foods Yolngu children eat, as long as 'bad' foods are convenient and readily available.
2. 'Good' foods, such as fresh fruit and vegetables, must be available in the shop and healthy meals available in the take-away. Due to the time taken to transport food to remote communities it can be difficult to ensure the quality of the food on arrival. However, while 'good' foods that are 'rotten', 'old' and 'off' continue to be sold it is unlikely there will be any significant change in the way most people eat from the shop. Further, as many people regularly eat from the take-away it is important that healthy meals are available there in addition to standard take-away fare.
3. While only one Yolngu respondent said that food is 'too expensive', studies have documented the high cost of food in remote Aboriginal community stores in the NT. While a family dependent on social welfare pays 23 per cent of their income for a typical basket of food in a capital city, it would take 35 per cent of their income to buy the same basket in an Aboriginal community store in the NT (Price and McComb, 1998).

In addition to this, the majority of Aboriginal families living in rural and remote regions of the NT have low levels of income. In 1996, around 65 per cent of the NT Aboriginal population had a weekly income of less than \$200, while around 35 per cent of Australians overall had a similarly low income (Devitt, Hall and Tsey, 2001). Further, while the number of Aboriginal adults in the labour force is much lower than that of non-Aboriginal Territorians, the number of dependents they support is higher. Only 40 per cent of Aboriginal adults are in the labour force compared with nearly 75 per cent of non-Aboriginal Territorians. In 1996, 18 per cent of Indigenous families in the NT had four or more children, compared with 4.3 per cent of other families (ABS, 1997). The current high cost of food, low income levels and high levels of unemployment need to be addressed before food intake of Aboriginal children is likely to increase.

4. The ways in which the two groups explained the reasons for good and bad growth differed considerably. In many of the Yolngu interviews the importance of caring for children was emphasised and discussed at length as being central to child growth. While clinic staff also talked about the importance of caring for children, it was not given the same emphasis or discussed in the same way. Clinic staff generally referred to health actions relating to nutrition and hygiene when they talked about how people should care for children. The fact that most Yolngu did not mention the role of environmental factors such as hygiene in determining child health and growth is significant. It suggests that either environmental health education has not been delivered effectively to Yolngu respondents or that Yolngu have not accepted the level of importance in determining health outcomes placed on it by health service deliverers. In relation to caring for children Yolngu generally described a broader approach which includes attending to the social and emotional well being of the child, as well as to their physical needs.
5. Further, while only one Yolngu in the community group mentioned illness as a cause of poor child growth, it was the most common response from clinic staff. This suggests that the two groups understand the causes of poor child growth very differently. It is therefore not surprising that there was a difference of opinion between the two groups on how best to promote child growth. Yolngu community members have decided on a family centre, with an emphasis on childcare and teaching parents how to care for children. This reflects the importance they place on children being cared for. The Aboriginal Health Workers have also supported this idea. Balanda clinic staff, on the other hand, raised concerns about this idea and question whether it is the most effective way of promoting child growth. This suggests there is a need for the two groups to spend time sharing their stories and developing a new story that incorporates the perspectives of both Yolngu and health service providers. This is consistent with conclusions of both the 'Sharing the True Stories' project at Nightcliff Renal Unit, with the findings of the 'Forgetting Compliance' project and with other projects investigating ways and means of crossing the cultural gap.
6. The majority of clinic staff did not see child growth as being a significant health issue in the community. It is likely that this level of concern about child growth, in comparison to other health issues, would be picked up on by Yolngu community members. Child growth statistics for the community are comparable to those for other Aboriginal communities in the Top End, which show that 15 per cent of children aged 0-5 are underweight, compared to 3 per cent Australia-wide (DHCS, 2000). These statistics, combined with the documented impact of poor child growth on adult health, suggest child growth is a major health issue in the community.
7. There was a significant difference between how much Yolngu want to know about the clinic story and how much clinic staff think they *need* to know. This indicates a good opportunity for clinic staff to provide more comprehensive information to community members, particularly on things like growth charts and growth monitoring.

8. References by some clinic staff to the Yolngu story as being 'traditional' suggest that this story is not seen as being relevant to the contemporary context. Yolngu knowledge, attitudes and practices are perceived by some as being of the past and belonging to the past. To the contrary, Yolngu, like any group, are constantly developing their knowledge, attitude and practices in relation to the change that is occurring both within and outside the community. This is reflected in numerous comments about 'changing times. There is a need to recognise that, like the clinic story, which changes with each new scientific discovery, Yolngu people are constantly developing their story to take into account the 'changing times'.
9. There is evidence of different views amongst the clinic staff on the value of time spent doing this kind of research. Clinic staff said they wanted to know more about the Yolngu story about child growth, but they did not have time. A number of the research findings, which came out of the project team having time to talk, were questioned by some clinic staff who did not believe that Yolngu respondents thought these things. Further, the lack of 'outcomes' that resulted from DS spending 12 months in the community were noted by one clinic staff member. While clinic staff said they would learn more about the Yolngu story if they had time, allocating time for this may be made difficult while DHCS' focus is on tangible short-term outcomes.



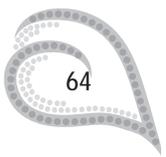
8. Conclusion

This report offers insights into perceptions of child growth held by Indigenous community members and health service providers in a remote Indigenous community of the NT. As stated in the Preface, it does not seek to offer a concerted 'understanding' of Yolngu and clinic staff perspectives in relation to child growth. Nor does it give a unified 'community' or 'clinic' perspective. While there are common themes, there are also contradictory views that reflect the ways different people make sense of child growth in a period of rapid change in the community.

The key findings in this report are:

- there is a significant difference between the ways Yolngu and clinic staff understand child growth, with many Yolngu having a broad understanding of child growth that includes the social, emotional and physical development of the child, and clinic staff generally referring to health actions relating to nutrition and hygiene when they talked about how people should care for children;
- where both Yolngu and clinic staff talked about the same factors influencing child growth, such as caring, they were often given different meaning and emphasis;
- the difference in the way the two groups understand the causes of growth has led to differences in opinion about appropriate child growth promotion strategies;
- many Yolngu have a limited understanding of how to eat well from the foods available at the shop;
- the capacity of Yolngu to make healthy food choices is limited by the availability and price of 'good' foods in the shop;
- the value placed on individual autonomy means that children often decide what food they eat, therefore nutrition education for carers may be less effective than reducing the amount of 'unhealthy' food available in the shop;
- many Yolngu have a limited understanding of the role of illness and environmental health factors in determining child growth;
- there is some difference in opinion over who is responsible for caring for children and ensuring children grow well;
- neither group has a good understanding of the other group's story, but Yolngu generally seem to know more about the clinic story than vice versa; and,
- while some Yolngu want to learn more about the 'clinic' story, a number of clinic staff see the Yolngu story as being 'traditional', which suggests they may perceive it as having little relevance to their work.

It is anticipated by the project team that the information in this report will be of use to health service deliverers in the NT involved in working with child growth. We also hope that this information will be of use to DHCS in improving its GAA Program. Specific recommendations on the GAA program have not been included in this report. This report addresses only one aspect of the Improving Growth Promotion in the NT Project. A set of recommendations will be developed based on all components of the project on its completion in June 2002. These will be included in the final project report.



References

Australian Bureau of Statistics (1997) *Census of Population and Housing: Selected Social and Housing Characteristics*, cat no 2015.0, ABS, Canberra.

ABS (1997). 1996 *Census of Population and Housing: Aboriginal and Torres Strait Islander People*, cat no 2034.7, ABS, Canberra.

Adler, P. and Adler, P. (1994). *Observational Techniques. Handbook of Qualitative Research*. N.K. Denzin and Y.S. Lincoln, Sage, Thousand Oaks: 377-92.

Baum, F. (1998). *The New Public Health: An Australian Perspective*. Oxford University Press, Melbourne.

Collins, B. (1999) *Learning Lessons: An independent review of Indigenous education in the Northern Territory*, Northern Territory Department of Education, Darwin.

Condon JR, Warman G, Arnold L (editors) (2001). *The Health and Welfare of Territorians, Epidemiology Branch*, Territory Health Services, Darwin.

Devitt, J. and McMasters, A. (1998). *Living on Medicine- A Cultural Study of End-stage Renal Disease among Aboriginal People*, Central Australian Aboriginal Congress, Alice Springs.

Freire, P. (1972). *Pedagogy of the Oppressed*. Penguin, Harmondsworth.

Hamilton, A. (1981). *Nature and Nurture - Aboriginal Child-Rearing in North-Central Arnhem Land*, Australian Institute of Aboriginal Studies, Canberra.

Jorgensen, D.I. (1989). *Participant Observation*. Newbury Park, California, Sage.

Nathan, P. and Japanangka, D. (1983) *Health Business*, Heinemann Educational Australia, Melbourne.

National Aboriginal Health Strategy Working Party (1989) *The National Aboriginal Health Strategy*, (no publisher) Canberra.

Northern Territory Department of Education (1999) *Learning Lessons: An independent review of Indigenous education in the Northern Territory*, Northern Territory Education Department, Darwin.

Santich, B. (1995) *What the Doctors Ordered- 150 years of dietary advice in Australia*, Hyland House Publishing, Melbourne.

D'Espaignet, ET, Kennedy, K, Paterson, BA and Measey, ML , (1998) *From Infancy to Young Adulthood - Health Status in the Northern Territory 1998*, Territory Health Services, Darwin.

Territory Health Services, (2000) *Growth Assessment and Action Nutritional Surveillance System*, Darwin.

Von Sturmer, J. (1981). 'Talking with Aborigines', *Australian Institute of Aboriginal Studies Newsletter* 15, pp. 13-33.

Wallerstein, N. (1999) 'Power between evaluator and community: research relationships within New Mexico's healthier communities', *Social Science and Medicine*, v.49, pp. 39-53.

