Policy influences affecting the food practices of Indigenous Australians since colonisation

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Abstract: Aboriginal Australians face a range of health challenges, which can be linked to dietary-related factors. A higher prevalence of dietary-related illness, such as cardiovascular disease, diabetes and renal disease, exists among Aboriginal people. This paper examines factors affecting the food practices of Aboriginal Australians since colonisation and contrasts these with the sustainable food practices of Aboriginal people prior to permanent European occupation. Significant shifts in policy and other factors affecting food and eating practices in Australia have occurred over the past 200 years. Influential overlapping historical epochs identified include the pre-colonial, colonial, protection and assimilation periods, as well as the influence of the industrialisation of food production. The literature review draws on historical sources and policies that highlight the impact of the changing food identities of Aboriginal people that affect dietary-related illness. The paper concludes with some implications for food and nutrition policies. Evidence drawn from these findings indicates that further progress is required to inform the development of culturally appropriate food policies to address the dietary-related health issues of Aboriginal people.

Introduction
This is an interpretive inquiry that, first, seeks to understand the food practices of Australian Aboriginal people in a historical, cultural and political framework and, second, to identify and examine the impact of each major policy epoch on Aboriginal food practices and identities. These insights are then used to understand the contemporary pattern of Aboriginal Australian food and eating practices and implications for contemporary food policy. The significance of this analysis is first established in an examination of the current health crisis affecting Aboriginal communities and links to food practices. The paper demonstrates that the food practices of Aboriginal people are subject to privileging of dominant food practices, colonial control and power. Drawing from a postcolonial theoretical perspective, we identify that the high prevalence of dietary-related illness among Aboriginal people is linked to the historical legacy of the colonial struggle and the consequences of continuous postcolonial policies. This research could be used to develop culturally relevant food and nutrition programs and policies.

Life expectancy of Indigenous Australians
The gap in the life expectancy between Aboriginal and non-Aboriginal Australians is a continuing...
source of national concern. Life expectancy at birth for Aboriginal and Torres Strait Islander males is estimated to be 67.2 years, 11.5 years less than life expectancy for non-Indigenous males (78.7 years) (ABS 2011). Life expectancy for Aboriginal and Torres Strait Islander females is estimated to be 72.9 years, 9.7 years less than life expectancy for non-Indigenous females (82.6 years) (ABS 2011). Table 1 provides a summary of the life expectancy status of Aboriginal and Torres Strait Islander people.

Estimated life expectancy differs across states and territories. For Indigenous males, life expectancy is highest in New South Wales (69.9 years) and lowest in the Northern Territory (61.5 years). A similar pattern exists for Aboriginal and Torres Strait Islander females, with the highest life expectancy in New South Wales (75.0 years) and the lowest in the Northern Territory (69.2 years) (ABS 2011). Differences in estimates of life expectancy between non-Indigenous and Indigenous Australians are greatest in the Northern Territory (14.2 years for males and 11.9 years for females) and Western Australia (14.0 years for males and 12.5 years for females) (ABS 2011).

The death rate for some Aboriginal and Torres Strait Islander groups is up to 46 times higher than that of the non-Indigenous population (ABS and AIHW 2008). Patterns of disease, injury and suicide rates are often examined in order to understand the disparity between the average life expectancy of Aboriginal and Torres Strait Islanders and non-Indigenous Australians.

Table 1: Life expectancy and Aboriginal and Torres Strait Islander status — 2005–07 (ABS 2009)

<table>
<thead>
<tr>
<th>Life expectancy at birth</th>
<th>Indigenous</th>
<th>Non-Indigenous</th>
<th>Total</th>
<th>Difference between non-indigenous and Aboriginal and Torres Strait Islander life expectancy at birth</th>
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<tr>
<td></td>
<td>years</td>
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<td>Males</td>
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<tr>
<td>NSW</td>
<td>69.9</td>
<td>78.7</td>
<td>78.5</td>
<td>8.8</td>
</tr>
<tr>
<td>Qld</td>
<td>68.3</td>
<td>78.6</td>
<td>78.4</td>
<td>10.4</td>
</tr>
<tr>
<td>WA</td>
<td>65.0</td>
<td>79.0</td>
<td>78.7</td>
<td>14.0</td>
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<tr>
<td>NT</td>
<td>61.5</td>
<td>75.7</td>
<td>72.0</td>
<td>14.2</td>
</tr>
<tr>
<td>Aust.</td>
<td>67.2</td>
<td>78.7</td>
<td>78.5</td>
<td>11.5</td>
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<tr>
<td>Females</td>
<td></td>
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<tr>
<td>NSW</td>
<td>75.0</td>
<td>82.5</td>
<td>82.4</td>
<td>7.5</td>
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<tr>
<td>Qld</td>
<td>73.6</td>
<td>82.5</td>
<td>82.3</td>
<td>8.9</td>
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<tr>
<td>WA</td>
<td>70.4</td>
<td>82.9</td>
<td>82.5</td>
<td>12.5</td>
</tr>
<tr>
<td>NT</td>
<td>69.2</td>
<td>81.2</td>
<td>77.6</td>
<td>11.9</td>
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<tr>
<td>Aust.</td>
<td>72.9</td>
<td>82.6</td>
<td>82.4</td>
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<table>
<thead>
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<th>Difference between males and females</th>
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<tbody>
<tr>
<td>NSW</td>
<td>−5.1</td>
<td>−3.9</td>
<td>−3.9</td>
</tr>
<tr>
<td>Qld</td>
<td>−5.3</td>
<td>−3.9</td>
<td>−4.0</td>
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<tr>
<td>WA</td>
<td>−5.4</td>
<td>−3.8</td>
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<td>NT</td>
<td>−7.7</td>
<td>−5.4</td>
<td>−5.6</td>
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<tr>
<td>Aust.</td>
<td>−5.6</td>
<td>−3.8</td>
<td>−3.9</td>
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</table>
Diseases contributing to death rates
Rates of ill health, injury, disability, suicide and so-called lifestyle conditions, such as obesity, are much higher among the Indigenous population in Australia (Vos et al. 2009). Non-communicable diseases account for 70% of the health gap. Cardiovascular disease (24%) is the leading cause of disease, followed by diabetes (12%). Chronic respiratory disease accounts for 9% of the health gap. Collectively, cardiovascular disease, Type 2 diabetes and other tobacco-related conditions, such as chronic respiratory disease and lung disease, account for half of the Indigenous health gap. Lifestyle risk factors implicated in these conditions include high body mass, physical inactivity, raised blood pressure and high blood cholesterol levels (Vos et al. 2009). As reported by Vos et al. (2009), 60% of Aboriginal and Torres Strait Islander adults in the north of Western Australia have diabetes. While these health conditions largely affect older Aboriginal and Torres Strait Islander people, younger age groups also reflect unacceptably high incidence rates. Aboriginal children up to 17 years of age in Western Australia are 18 times more likely than their non-Indigenous counterparts to have Type 2 diabetes. Linked to the incidence of diabetes, End Stage Renal Disease (ESRD) now occurs among Aboriginal and Torres Strait Islander people at eight times the rate of non-Indigenous people. The rates of hospitalisation for diabetes and ESRD are increasing for Indigenous people (Cass et al. 2004).

Suicide
In 2008 Indigenous suicide accounted for 4.2% of Indigenous deaths (103); 74 were males and 29 were females (ABS 2008a). The increase in Aboriginal suicide has coexisted with the struggles of Aboriginal people at political, individual and community levels to deal with the ongoing effects of colonisation, alienation and feelings of hopelessness (Tatz 2001). Hassan (2000:203) states that evidence from Australian studies shows that social disadvantages — such as relational problems (family/relationship/marital problems, shame and guilt), instrumental problems (financial, limited educational opportunity and unemployment issues) and health problems — are primary circumstances preceding suicide. Individual social disadvantage results in dependence on others or the social security system for basic necessities such as food, shelter and clothing. This contributes to ‘anger, hopelessness, lack of purpose, ennui and pessimism’ (Tatz 2001:102).

Other conditions
Infectious diseases and neonatal conditions account for 14% of the health gap. Rheumatic heart disease is one of the major health differentials between Indigenous and non-Indigenous women (Gracey and King 2009). Mental disorders account for 10% of the health gap between Indigenous and non-Indigenous Australians. This includes substance abuse disorders (6%) (Vos et al. 2009). Overall, the mortality gap between Indigenous and non-Indigenous people in Australia is worse than any other member country in the Organisation for Economic Co-operation and Development. Understanding the causal pathways that explain a mortality gap of this extent requires a deeper exploration. It is not only in the area of suicide and mental health and substance abuse disorders that the ongoing impact of colonisation on health is clear.

Social determinants of health
The poor health of Indigenous people around the globe is linked to poverty, malnutrition, unemployment, poor and inadequate housing, low levels of educational attainment, overcrowding, poor hygiene, environmental contamination and prevalent infection, inadequate clinical care, and poor access to programs of disease prevention and management (Gracey and King 2009; Marmot 2004, 2007; Marmot and Wilkinson 2006). For example, as mentioned above, rheumatic heart disease is much more prevalent among Indigenous women. Untreated streptococcal throat infection, typically spread by droplet infection, can lead to the development of rheumatic heart disease. Prevention of rheumatic heart disease involves hand washing before meals and meal preparation and not sharing food or drink, as well as adequate medical diagnosis and the timely prescription and completion of a full course of antibiotics for streptococcal throat infections. Although not identified as ‘lifestyle diseases’, inadequate and overcrowded housing, lack of clean water, poor
sanitation facilities and lack of access to medical services are major contributors to the spread of this disease. Crowded sleeping arrangements due to inadequate housing have also been associated with the presence of streptococcal skin infection, which is linked to the incidence of ESRD (Cass et al. 2004). High unemployment, low income and low educational attainment, smoking and maternal malnutrition have also been linked to the incidence of ESRD (Cass et al. 2004). Remote communities have little access to programs that would prevent the progression to ESRD, despite the high incidence of known precursors to ESRD such as albuminuria (Cass et al. 2004).

Having control is an important aspect of cardiovascular health (Kritharides et al. 2010) and has been correlated with exercise levels and vegetable intake (Daniel et al. 2006). In northern Arnhem Land unemployment, low income levels, remoteness, deprivation and environmental factors have been shown to increase risk of cardiovascular disease.

The social determinants of health identified in the Ottawa Charter for Health Promotion (World Health Organization 1986), including income, education, employment, living conditions, social support and access to health services, are all sources of inequity for Indigenous people in Australia. In Australia, Aboriginal and Torres Strait Islander people are much more likely than non-Indigenous Australians to experience environmental conditions that promote ill health. Action on the underlying economic and educational determinants of health among Aboriginal and Torres Strait Islander people has been limited (Anderson cited in Walsh 2001).

The colonisation of Indigenous nations underpins the factors affecting the health of Aboriginal and Torres Strait Islander people (King, Smith and Gracey 2009). This includes the impact of the loss of land, language and social fabric and the destruction of the environment. There are also enduring health effects linked to pervasive institutional and interpersonal racism, environmental deprivation, spiritual, emotional and mental disconnectedness, and the legacies of assimilation policies, such as the abduction and institutionalisation of children (HREOC 1997). Any of these factors may be exacerbated by intergenerational trauma combined with the disregard and ignorance of policy makers regarding Aboriginal and Torres Strait Islander understandings of wellbeing (Trudgen 2000).

To understand and address these health issues it is essential to consider the processes and the impact of colonisation on Aboriginal people. Colonisation has not only affected rates of infectious diseases, suicide and mental health but has also had a pervasive impact on the prevalence of so-called ‘lifestyle diseases’. The mechanisms of this impact highlight the way in which policy continues to affect health beyond the assumed relationship between poverty and disease. This paper examines one of the major risk factors for ill health in the epidemic of lifestyle diseases linked to dietary and food practices. It examines the diet and food practices of Indigenous Australians before and after European colonisation of Australia and the impact of Aboriginal policy on food practices, as well as contemporary changes in food manufacture and supply.

This discussion and analysis is based on a literature review of contemporary scholarship and historical documents. In order to undertake this analysis, a variety of relevant literature, including journal articles, textbooks, policies and frameworks, were identified. To locate this literature, key word searches of academic databases and library catalogue systems were undertaken. These included Australian Aboriginal, Australian or Indigenous food practices and/or eating habits. In addition, manual search strategies were employed at all relevant catalogue locations in order to capture those items not directly indexed or poorly indexed. Seminal texts were also identified in the reference lists used in articles. Library requests were made to locate these early reference materials and policy documents. The literature was analysed in order to identify key historical policy themes. These themes were further reviewed in discussion with academic mentors and colleagues in the areas of health, nutrition and food practices in order to identify the implications for contem-
Sebastian and Donelly

Policy influences affecting the food practices

History of Aboriginal food practices and eating habits

Pre-colonial food and eating practices
A study conducted in the 1970s of 200 nomadic Australian Aboriginal men described them as ‘slimly built, sinewy featherweights’ (Elphinstone 1971 cited in Gracey 1996:198). Though this representation cannot be generalised to the entire Aboriginal population of the pre-colonial era because of the diverse geography, climatic conditions and food variety, it is evident that most people were fit and slim. The sketches and paintings of first contact, for example, attest to this. Types and availability of food and eating habits were regulated according to seasons, rainfall, food availability and geography of place/country (Gracey 2000). For example, people who lived along the Murray River in Victoria, built eel farms and stone houses on the rich volcanic soils (McCalman et al. 2009:254). It is also known that before colonisation, Aboriginal Australians enjoyed a great variety in their diet. They ate local and seasonal food depending on availability. They acquired food using a variety of measures which were developed to preserve plant and animal species (McCalman et al. 2009).

Australian Aboriginal food practices date back 60,000 years in a continuous food culture, with little external cultural influence until 1788. These food practices were passed down through Dreaming stories using an oral communicative tradition in which the landscape was and remains sacred for Aboriginal people. According to this tradition, the land is thought to be created by the journeys of ancestral spirits and is identified as the source of life. The land therefore nourishes, supports and teaches (Rose 1996:54). The survival of Australian Aboriginal peoples depended on knowledge of food sources, waterholes, plants and animal anatomy. The detailed knowledge of different species of flora and fauna, and their seasonal distribution in the ecosystem, was essential for survival. Australian Aboriginal clans respected and tended the land through various food practices. These practices were developed and maintained through experiential learning, ceremonies and rituals (Rose 1996:54). Aboriginal Australians used food resources without exhausting them. Hunting and gathering were collective activities designed to ensure that all members of Aboriginal society were included in the process and adequately fed. Aboriginal people practised ‘fire stick farming’, which encouraged food plants to be regenerated by helping seeds to sprout (Jones 1969: 224–8). Early white explorers reported finding long strips of burned grass along rivers, creeks and waterholes. This practice, in turn, encouraged migration and the breeding of birds from the northern hemisphere, and attracted game to particular spots (Bowman 1995). The land was skilfully and systematically managed through the continuous and creative use of fire. There was careful consideration of many variables, such as seasonal conditions, humidity, degree of fire resistance and a range of other properties of various plant communities (Reynold 1990).

Regrowth of plants was achieved by returning roots, such as tubers and rhizomes, to the ground, ensuring that there was always food for the future. The use of ash nourished the soil and plants without the use of chemicals, fertilisers and pesticides. Vegetables, fish and meat were prepared by drying, leaching, fermenting, roasting and smoking. Food was not transported over large distances, which meant that fresh vegetables and meat were included as part of the daily diet. Through intergenerational learning about food processing, Aboriginal Australians were able to remove harmful toxins from food. This prevented food poisoning and related illnesses. Tools such as the mortar and pestle were used to pound food. Sharp shells and bones were used to scrape and cut roots, seeds and meat. Nardoo, lily, acacia and cycad seeds were collected and ground into flour (Isaacs 2002). The flour obtained was baked into bread, similar to unleavened bread.

Ground ovens were used for cooking. The four major cooking techniques used were baking, roasting, steaming and grilling. Large, smooth,
red hot stones were used to cook and the food was wrapped in paper bark and leaves (Isaacs 2002). Aboriginal people used ground ovens to cook intact animals so as to retain the nutrients, keeping the cooked meat moist.

Fruits and some vegetables were eaten raw. Eggs were sometimes eaten raw and sometimes baked (Isaacs 2002). Table 2 provides a summary of a wide variety of foods Aboriginal men, women and children hunted and gathered.

Food practices vary among the different nations of Aboriginal Australia. These food practices and food identities are based on the wide variety of social kinship structures, traditional practices and beliefs, such as totems. Food obtained from traditional food systems is linked to sharing, spirituality and country; it is the key to the survival, health, skills and the cultural identity of Aboriginal people.

Gracey (1996:187), an Australian medical scholar, describes Australian Aborigines as ‘one of the world’s largest and most successful hunter-gathering societies and in some remote regions, particularly in northern and central Australia where traditional customs have endured, these original methods of obtaining and preparing food are still used, although to a small extent in most places’. He argues that food-related illnesses, such as obesity, diabetes and heart disease, are non-existent in hunter-gatherer communities around the world. Food has been a significant feature of Aboriginal people’s history (Wahlqvist 1997).

The colonisation of Australia by Europeans led to the loss of Aboriginal peoples’ food knowledge, individual identity and culture. The colonisers had little knowledge and value for local plant and food culture in terms of their own survival and health. Colonisation and industrialisation of food have significantly disrupted the food gathering and preparation practices of Indigenous food communities.

**Colonial days**

The First Fleet brought animals, seeds, rice, flour, salted meat, alcohol, and the eighteenth-century food preferences and practices of Great Britain. In 1788 the First Fleet landed with animals which included ‘one stallion, three mares, three colts,'

<table>
<thead>
<tr>
<th>Gathered</th>
<th>Hunted</th>
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</thead>
<tbody>
<tr>
<td>Vegetables: leaves and stalk: lily, spinach, grass</td>
<td>Marine food: freshwater and salt water fish, oyster, abalone, shell fish, crabs, eel, dolphins, sting ray, whales</td>
</tr>
<tr>
<td>Tree, fern, palm heart, mangrove, carrots, native beans and peas</td>
<td>Reptiles: turtles, goannas, snakes</td>
</tr>
<tr>
<td>Tubers: yam, lily, potatoes</td>
<td>Rodents</td>
</tr>
<tr>
<td>Corms</td>
<td>Monotremes</td>
</tr>
<tr>
<td>Seeds: millet, nardoo, wild rice, wattle, Lily</td>
<td>Birds, more than 30 different species: game goose, turkey</td>
</tr>
<tr>
<td>Bulbs and rhizomes: onions, native ginger</td>
<td>Marsupials: flying foxes</td>
</tr>
<tr>
<td>Fungi</td>
<td>Land animals: kangaroos, wallabies, euros, emus, possums, bandicoots, echidnas</td>
</tr>
<tr>
<td>Fruits: quandongs, guava, berries, wild figs, pandanas, bread fruit, tomatoes, wild peaches, desert bananas, orange</td>
<td></td>
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<tr>
<td>Nuts: macadamia, cycad, almond, walnut, bunya nut</td>
<td></td>
</tr>
<tr>
<td>Insects: caterpillars, witchetty grubs, ants, moths</td>
<td></td>
</tr>
<tr>
<td>Birds eggs</td>
<td></td>
</tr>
<tr>
<td>Nectars</td>
<td></td>
</tr>
<tr>
<td>Banksia and flowering gum</td>
<td></td>
</tr>
<tr>
<td>Honey</td>
<td></td>
</tr>
<tr>
<td>Gums</td>
<td></td>
</tr>
<tr>
<td>Wattles</td>
<td></td>
</tr>
<tr>
<td>Beverage: water (from waterholes, soaks, dew, pandanas trees, wells, roots, distended frogs), sweetened drinks, fermented drinks</td>
<td></td>
</tr>
</tbody>
</table>

Table 2: Traditional Aboriginal foods and beverages (adapted from Hodgson and Wahlqvist 1993:44; Isaacs 2002:216–29)
four cows, twenty-nine sheep, nineteen goats, forty-nine hogs, twenty-five pigs, five rabbits, eighteen turkeys, twenty-nine geese, thirty-five ducks, one hundred and thirty fowls and eighty-seven chickens’ (Wood 1977:33).

In the first few years the colonisers’ food was based on rations of food brought from Europe and supplemented by fish and other meagre amounts of foods produced in the fledgling colony. These food types remained the basic diet of the European colonisers for the first 50 years. A letter written by a bushman before his death stated that he became sick because his diet consisted of damper only (Gollan 1978:18). Such events were common despite the availability of nutritious food such as wild yams, berries, fruits and nuts that Indigenous Australians ate in large quantities. The ignorance of European settlers about the plentiful fresh bush food that initially surrounded them led to the ‘hungry year period’ of 1788–92 (Davey, MacPherson and Clements 1977:33).

Areas of immediate occupation by the colonists were cleared, and food and water sources were depleted or made inaccessible to Aboriginal people. Indigenous people sampled rations according to the impulse of soldiers and officers. The colonisers introduced damper, tea and stew. Food shortages among convicts and soldiers led to strict rationing and to pressure for immediate agricultural expansion. Some Aboriginal clans were cut off from their seasonal food sources (Hetzel 2000:158). Instructions from Governor Phillip that ‘natives should not be offended or molested on any account’ were soon rescinded. A pandemic of European diseases, such as chicken pox and smallpox, decimated the Aboriginal population.

Competition for scarce resources and crops intensified, leading to the active extermination of Aboriginal people (Paterson 2005:287). This was a pattern repeated all over the frontier and continued into the twentieth century in some states, including the Northern Territory and Western Australia.

In 1901 Ella Simon, an Aboriginal woman born in the Manning Valley, Queensland, commented, ‘as settlement spread and fences went up, they [Aboriginal people] couldn’t get their food without going into paddocks. They were always being punished for stealing but if they didn’t “steal”, they’d starve’ (Simon 1978:24). Traditional food sources disappeared as farms were established and land fenced off, securing it by force. Transactions between white and Aboriginal Australians undermined moral claims:

While the whiteman kills and hunts his (Aboriginal person’s) kangaroos and emus, he is debarred, in turn from hunting and killing the white man’s cattle. Occasionally the native will indulge in a cattle hunt, but the result is usually disastrous to himself and, on the whole, he succumbs quietly to his fate, realising the impossibility of attempting to defend what he certainly regards as his own property. (Spencer cited in Rowse 1998:14)

Aboriginal people were criminalised simply for attempting to avoid starvation. Armed resistance in the Sydney region was quashed in the wake of the decimation of the population. All land became occupied and defended by the Crown and/or settlers. Periods of martial law on the advancing frontier included the slaughter of old people, women and children and the widespread abduction and sexual assault of women. Fire farming and other traditional food practices were obliterated by war waged between Aboriginal clans and colonisers.

Policies of protection and impact on food practices

Between 1869 and 1910 every state and territory introduced an Aboriginal Protection Act. This also signalled the widespread introduction of government-sanctioned food rationing for Aboriginal people. These control measures regulated every aspect of Aboriginal people’s lives, including where they could live, work, whom they could marry, where their children could live, and any rations or payments they would receive.
As Aboriginal people were expected to die out, they were ‘buried’ through paternalistic policies that assigned them to strictly controlled pastoral stations, missions and reserves (Rowse 1998; Kidd 2006). People from different language groups and Aboriginal nations were removed from their ancestral lands and forced to live on missions and reserves (Kidd 2006). These sites were typically situated on the poorest agricultural land. Local bush foods could not sustain such a static population. People became substantially or fully dependent on rations (Rowse 1998).

The pastoral industry, in the harshness of the Australian climate, could only be economically and technologically sustained by unpaid or poorly paid Aboriginal servants and labourers (Kidd 2006). European pastoralists required Aboriginal knowledge, which was fundamental to the development of the pastoral economy (Paterson 2005:282). This knowledge included an understanding of the local environment and access to waterholes for the herd. Aboriginal women, meanwhile, were involved in domestic labour as cooks and household servants. While working as servants, Aboriginal women learned about Anglo-Irish colonial food, cooking and eating practices (Kidd 1997). These women usually worked in the morning at stations (for example, cooking and cleaning) and spent their afternoons searching for bush foods. There was wide variation in access to bush foods based on geography, farming practices and soil degradation. For their own food preparation, women used a combination of Anglo-Irish and Aboriginal traditional methods (McArthur, McCarthy and Specht 2000).

Food rations were distributed to Aboriginal people who were attached to cattle stations, police stations, government reserves and missions (Rowse 1998). Rations for a single adult in the early twentieth century in New South Wales were eight pounds of flour, two pounds of sugar and a quarter pound of tea, occasionally supplemented by rice, tea, jam and canned goods (Behrendt cited in Harrison 1991). Each dependent child received half this amount. It was a monotonous diet low in fat and deficient in protein and vitamins A and C, and inferior to the settler’s food both in quality and quantity. Money was deducted from wages to cover the cost of rations whenever a person joined the workforce. Up to 80% of the wages of Aboriginal people were withheld by the government (Kidd 1997). People had little access to money to purchase food beyond the allocated rations or the limited available bush foods (Kidd 2006).

Policies and impacts of assimilation

Between 1930 and 1970 assimilation policies were introduced to extinguish all Aboriginal cultural practices and to ensure that Aboriginal people were absorbed into colonial culture: promoting changes in Aboriginal diets and eating habits was an important factor in achieving their [Aboriginal] assimilation…adoption of European eating habits should make the Aboriginal people more acceptable to the community generally…Communal feeding was introduced to ensure that all residents in the settlements would be adequately fed, [also] as a means of inculcating European tastes in food, and as a means of training people…in the use of European eating utensils. (National Territory Administration cited in Harrison 1991:133).

Along with many other aspects of people’s lives, such as the right to raise children in a family, traditional food practices were tightly controlled and frequently destroyed. Working in various industries restricted hunting and food gathering (Rowse 1998). The official ration in the 1930s was not enough to give Aboriginal people a full meal once a day but was just sufficient to keep Aboriginal people close to the ration depots (Gray 2007:163). The outdoor kitchen shifted to the use of an internal cooking fireplace, in effect ‘to privatize cooking and eating patterns by removing them [Aboriginal people] from public sites of collective consumption’ (Morris 1989:81).

Inadequate diet and under-nourishment led to poor health, malnutrition, infant mortality and poor reproductive power among Aboriginal Australians. Forced child removal was also linked directly to food and malnutrition (Tonkin and Landon 1999). A non-Indigenous man, Daryl Tonkin, who lived with Aboriginal people in the Gippsland area of Victoria in the 1920s and 1930s, reported:
I’ve seen the Welfare myself walk into a person’s house and go through the cupboards looking for food, then making note of what they did or did not find. It was these notes that gave them the right to walk in another day and take the children away. This made the people keep whitefella food always in the cupboards, even if they never ate it. In fact, they only had cupboards to keep the whitefella food in. (Tonkin and Landon 1999:216–17)

The separation and removal of children from pastoral stations, missions and reserves meant that the development of intergenerational knowledge and skills in the collection and gathering of bush foods was no longer possible (Wahlqvist 2011:46). Institutional food farming and cooking practices were used to train girls to become domestic servants and boys as farm labourers. Institutions for Aboriginal children were typically operated on half the budget of institutions for non-Aboriginal children. Rowse (1998:17) argues that ‘the rationing relationship was an historic achievement’, which turned Aboriginal people into paupers and robbed them of their own knowledge about food, culture and agency. Food was also withheld as punishment (Rowse 1998).

In response to high infant mortality rates and malnutrition in the mid-1950s, some missions and reserves introduced communal feeding. This practice replaced food rations, with three prepared meals a day, seven days a week, ostensibly to improve Aboriginal health (Rowse 1998). Such institutional and instrumental feeding of Aboriginal people was one of the most effective ways to ensure people were kept compliant and dependent (Rowse 1998:13–24).

As award wages became available, attendance at meals declined and communal feeding was phased out. With each change in food policy for Aboriginal people, their agency was diminished. Stoler (1995:150) observes that ‘racialised Others’ are often compared and equated with children, a representation that conveniently provided a moral justification for imperial policies of tutelage, discipline and specific paternalistic and maternalistic strategies of custodial control of Aboriginal people.

The introduced diet of rations lacked fresh foods from the bush, sea and rivers and established patterns of eating that imposed significant nutritional deficiency that is still evident in Aboriginal communities today (Brimblecombe and O’Dea 2009). With legislative changes in the 1960s, Aboriginal people received wages and more equitable access to social security payments. Aboriginal people were able to purchase foods that were affordable to people on low incomes (Kouris-Blazos and Wahlqvist 2000). In the 1970s, as a result of newly introduced policies of self-determination, some people in remote areas moved from missions to homeland outstations. However, this was only possible for people where resettlement during the assimilation era was close to unalienated ancestral land (Rowse 1998). Nutritional levels of people living at outstations improved compared with people living in missions and settlements because of the greater opportunity to collect bush foods to supplement deliveries of non-perishable food stores. The food practices and habits introduced by the dominant culture slowly validated themselves and were transferred to the everyday life of Aboriginal Australians, thus reinforcing, shaping and changing their identities.

**Industrialisation of food practices**

The widespread industrialisation of food production and distribution has contributed to many social and political changes in Australia, including changes to the diet of Aboriginal people (McArthur, McCarthy and Specht 2000; Hodgson and Wahlqvist 1993). Urbanisation, loss of traditional food practices, increasingly sedentary lifestyles, access to transportation, changing socio-economic status and cooking technologies, and storage facilities have contributed to changes in food practices (Kouris-Blazos and Wahlqvist 2000:225). While major technological changes have occurred in the preservation of foods, mechanisation of production, retailing and transport, the impact of these changes on the diets of Aboriginal people is complex. For example, canning and freezing to preserve foods were significant innovations in storage techniques (Goody 1997:343). However, the greater cost of canned foods and prohibitive cost of white goods, as well as transportation costs, may have delayed their adoption by people living in remote communities (Kouris-Blazos and Wahlqvist 2000:226).
For the early colonial household cooking was done using a wood stove; in 1875 gas cookers arrived and by 1904 Sydney had its first public electric power supply. Domestic refrigeration arrived in 1912. Despite technological advancements, urban Aboriginal households had limited access to food storage equipment, such as refrigerators, and lacked preparation and cooking facilities. Aboriginal people still only had two main sources of food (Kidd 1997), distributed food rations and restricted access to bush food. The shift from free-range food sources and subsistence agriculture to ‘factory model’ industrial food rations changed the way Aboriginal Australians ate. The industrialisation of food production introduced modern food habits and foods such as white sugar, flour, bread, processed canned meat, white damper (water/flour mixture fried in oil or cooked in ashes), fried eggs, stewed lamb chops, powdered milk, condensed milk, and small amounts of margarine, jam and sugar (Kouris-Blazos and Wahlqvist 2000:227). The adulterated industrial diet, reinforced by commercial food values, contributed to further health deterioration; as George Orwell (1976[1937]:88) said, ‘We may find in the long run that tinned food is a deadlier weapon than the machine-gun’. Orwell’s observation about the eating habits of the poor in the 1930s can easily be applied to many Aboriginal people’s food practices and diet since invasion (Orwell 1976[1937]:86):

Would it not be better if they spent more money on wholesome things like oranges and wholemeal bread or even saved on fuel and ate their carrots raw?...the peculiar evil is that the less money you have the less inclined you feel to spend it on wholesome food. A millionaire may enjoy breakfasting on orange juice and Ryvita biscuits; an unemployed man doesn’t. When you are unemployed, which is to say when you are underfed, harassed, bored and miserable, you don’t want to eat dull wholesome food.

Today, industrialised food corporations dominate many aspects of food supply and food practices in Australia (Scrinis 2007). This has had profound effects on lifestyles, including diet and the level of activity associated with the production and preparation of food.

Caloric imbalances endemic to ‘fast food’ culture have contributed to the emergence of an obesity epidemic (Popkin 2006). New diet-related conditions are also emerging among Aboriginal Australians. While the threat of malnutrition, which plagued Aboriginal Australians since colonisation, has been reduced, the modern diet has increased the incidence of obesity, diabetes, ESRD and other diet-related illnesses. The National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan 2000–2010 (Bussey 2012; National Aboriginal and Torres Strait Islander Nutrition Working Party 2001) recognises that poor nutrition is central to poor health and dietary-related chronic diseases among Aboriginal people.

Other changes to food practices have been influenced by the rise of mass media, and urbanisation combined with capitalism has formed a greater divide between the rich and the poor through economic and social exploitation. People of low socio-economic status suffer more ill health due to the high cost of healthy and quality food (Lang and Heasman 2004). Nestle (2007) argues that supermarkets provide easy-to-access cheap, energy dense, high-calorie food which is affordable for families who are on the lower income end.

Sustained economic disadvantage means that many Aboriginal people cannot always afford to make healthy food choices (ABS 2008b). In Aboriginal communities there are individuals and families who have attained a high, stable income and a better and healthier lifestyle (Saggers and Gray 2007:8); however, the majority of Aboriginal people are economically disadvantaged in obtaining quality food. In 2010 only an estimated 46% (166,100) of Indigenous people aged 15 years and over were classified as employed (ABS 2010). A large proportion of Aboriginal people fall in the low-income, low socio-economic status range, which exacerbates dietary-related problems.

Inadequate cooking facilities and lack of cool storage and vermin-safe food storage for perishables can create ongoing nutritional problems for Aboriginal people in both urban and remote areas (Torzillo, Rainow and Pholeras 1993). The socio-economic status of Aboriginal people creates difficulties in paying electricity and gas bills in urban and rural areas. If the electricity and gas supply is turned off, refrigerators and stoves are
unavailable. This increases the risk of food spoilage and limits dietary choices. In many instances, this may mean purchasing takeaway foods prepared away from the home. Supermarkets stock as many as 20,000 different food items; however, in 2004–05, 18% of Aboriginal and Torres Strait Islander people aged over 15 years ran out of food in a pay period in New South Wales compared to only 4% of non-Indigenous Australians.

Rural/remote food practices

Increased reliance on supermarkets and small community food stores has further reduced the consumption of bush foods (Kouris-Blazos and Wahlqvist 2000:228). In rural and regional areas, the small community store might be the only source of food within a large geographical radius. Due to the lack of transportation and storage facilities, perishable items such as fresh milk, cheese, fruits and vegetables are regularly in short supply (Harrison 1991). Remoteness also results in higher food prices, hence access to food for Aboriginal people is reduced by income and inadequate transport. In 2008, 69% of Aboriginal households in remote areas and 47% in very remote areas had a registered motor vehicle (Australian Health Ministers’ Advisory Council 2011) in comparison with more than 90% of non-Indigenous households in these areas. The distances involved in accessing food stores may make access prohibitively expensive and so people are more likely forced to rely on a single and often expensive local supplier.

Aboriginal people in the Northern Territory and rural areas consume more sugar, white flour and carbonated soft drinks than the national average. A study conducted by Lee, Bonson and Powers (1996) on the effect of retail store managers on Aboriginal diet in remote communities concluded that individual store keepers were more responsible for determining the nutrient density of food than the community itself. However, the study failed to look at the individual family and community food practices and eating habits in Aboriginal peoples’ homes. Store food may also be supplemented by traditional hunter-gatherer food practices.

Aboriginal food Identities

Food is central to individual and collective Aboriginal identity. Fischler (1988:275) argues that the ‘way any given human group eats helps assert its diversity, hierarchy and organization and at the same time both its oneness and the otherness of whoever eats differently’. Aboriginal people are diverse, and in pre-colonial days they were differentiated according to languages, geography, kinship and clans. Aboriginal people shared and ate their meals with their families and clans. Clans shared food resources and performed economic, customary, religious and cultural ceremonies involving food (Wood 1977).

Traditional Aboriginal society was based around clans. Clans mainly consisted of related families and extended families. A number of clans in a group formed a community. The relationship between individuals in a clan was defined by rules for sharing food. Aboriginal people were an ‘eating community’ (Falk 1997:21). Food played a symbolic role in the community and it was shared among the young and the old, women and men, according to the customary rules of sharing. There was very little wastage. For example, Elders, pregnant women and children were prioritised. In modern times these groups are often food insecure.

A formal system of sharing meant that no one went hungry (Lupton 1998:20). Food totems and food taboos had a social function. Food taboos were also related to age, sex, initiation ceremonies and pregnancy and were a tangible sign of the kinship bonds between each person in the family and community, as well as their ability to rely on each other (Walker 1993). Through particular food practices, people shared and strengthened their spiritual bonds and sustained their sources of meaning.

Contemporary identities are complex. Traditional identities are interwoven with contemporary food practices and the evolving and resilient Australian Aboriginal culture. Some Aboriginal Australians have actively maintained and adapted their culinary heritage, including the development of new foods in the wider Australian cuisine. Contemporary food practices have also created a sense of loss of culinary tradition and identity for many Aboriginal Australians.
Policy influences affecting the food practices  
Sebastian and Donelly

(Gallegos 2011). Aboriginal people are sometimes lost between the two realities, trying to preserve their traditional culinary heritage and culture and at the same time trying to adopt new food practices and eating habits. It has been argued that bush food has nutritional advantages. It is an excellent source of fibre, complex carbohydrates, calcium and magnesium, antioxidants and phyto-chemicals (Brand-Miller and Holt 1998). Many urban and regional Aboriginal people do not consume bush food, and some have no desire to consume bush food due to a lack of cultural knowledge or a desire to leave behind what they perceive as cultural stereotypes and experiences of vilification and abuse mixed up with cultural identity and/or specific food practices (Gallegos 2011:48).

Current research

Contemporary food practice is often guided by information about nutrient content and medical benefits, which arouses anxiety and concern about inappropriate diets and food contamination. Lupton (1998:27) argues that moral and medical discourses currently guide individuals in how best to use food for individual benefit rather than for the collective good. There is little recognition or investigation of food as a traditional site of kinship or the impact of social and cultural beliefs and values on the food practices and eating habits of Aboriginal people. Adam’s (2009) interpretive research challenges the impact of the ongoing policies of the dominant culture on food and nutrition of Aboriginal people. Reilly et al. (2011) and Thompson, Gifford and Thorpe (2000) considered the meaning of food and factors such as participants’ complex social environment, Indigenous knowledge, culture and social systems, and connections, as well as the micronutrient content of food.

Implications for food and nutrition policies

Food policy is how policy making shapes who eats what, when and how and whether people eat at all and with what consequences. It is also about how food is produced, grown, distributed and consumed (Lang, Barling and Carahe 2009). Analysis of the historical experiences of Aboriginal people has shown that major policies have directly targeted the food practices of Aboriginal people in a variety of ways and continue to do so (Adam 2009). Poverty and hunger has been a persistent theme for Aboriginal health and nutrition policies and statements (Caraher and Coveney 2003). Nutrition and malnutrition have played a big part in the design of food policy. Aboriginal households experience unacceptable levels of food insecurity, where household members do not have access at all times to enough food for an active healthy life for all household members. A typical approach to food policy in this context is to take a ‘top down’ view through state control of food production and supply; for example, the recent changes to the licensing of Aboriginal community stores by the Department of Families, Housing, Community Services and Indigenous Affairs (2010) were ostensibly to improve food security. As described above, state control of food planning for Aboriginal people has been a powerful tool in the extermination, extinction and exclusion of Aboriginal people. In this context, state control could further undermine the agency and control of Aboriginal communities in responding to the diverse factors affecting the health of community members. For example, despite the benefits of homelands in improving access to bush foods and health outcomes, services, including food services to homeland communities, are currently being reduced (Amnesty International 2011). It is argued that this is an attempt to encourage Aboriginal people to move to larger communities and therefore gain access to better services.

However, the privatisation of Aboriginal community stores in larger communities has not delivered changes in health status. Power and control of resources in communities has typically been concentrated in the hands of white corporate employees (Bockman 2006). Nutritional problems associated with mal-consumption, such as obesity, cardiovascular disease and diabetes, environmental concerns and the thousands of years of lost Aboriginal life expectancy, are the hidden costs in corporate balance sheets. The market place has been unable to adequately address the health and wellbeing of Aboriginal people. The epidemic of diabetes, cardiovascular disease and ESRD among Aboriginal people demonstrates the failure of the marketplace to deliver adequate health outcomes. Technical solutions, such as the addition of folate to staple foods to reduce the
risk of neural tube defects in new-born infants, tend to be expert-led top-down approaches and are unlikely to be able to address more pervasive health issues.

A more tantalising prospect is the emergence of food democracy whereby food systems are held accountable from the bottom up. Typically, at the moment, civil organisations representing food interests have raised concerns about the impacts of food supply and safety and the methods used in production. This is consistent with ongoing resistance by Aboriginal people to food control and the long struggle for living wages (for example, among Aboriginal pastoral workers) and the use of traditional food practices which protected the nutritional status of children and older people.

Mainstream public food standards and dietary policies treat people as food consumers by ignoring cultural and social factors influencing their relationship with food. Aboriginal people are affected by mainstream food policies, which show a direct link to dietary diseases among socio-economically disadvantaged groups. Mainstream food suppliers of processed and cheap food influence policy and law relating to food labelling and food composition (Lawrence 2010). However, the main goal of the Australian and New Zealand Food Authority in setting food policy and food standards is purported to be ‘the protection of public health and safety’ (Office of Legislative Drafting and Publishing 2013:17). Aboriginal health and nutrition policy analysts could challenge and critique the food policies and food standards that contribute to ill health and chronic illnesses among socially and economically disadvantaged Aboriginal communities (Lawrence 2010:162) and call for a new approach to food policy.

It is not that families in poverty are unaware of long-term health issues of food practices but they have the more immediate concern of filling their stomachs as cheaply as possible (Lang, Barling and Caraheer 2009). Because the implementation of policy involves so many stakeholders, there are many opportunities for policy to be distorted, especially in the layers of vested interests between the grassroots community, dominant entities in the food supply chain and government decision makers. This issue has undermined many aspects of policy for Aboriginal people. More opportunities for grassroots initiatives and local control would address some aspects of this policy issue.

Very little attention is placed on the relationship between Aboriginal health and the food policy agenda. Other pressing issues affecting Aboriginal health and associated with employment, income levels, violence, housing and alcohol take precedence. However, the growth in lifestyle diseases will have an impact on these priorities. Each of these factors is intimately connected to food practices. As the International Diabetes Federation (2006) notes, ‘whenever poverty and lack of sanitation drive families to low cost per calorie foods and packaged drinks, Type 2 Diabetes thrives’. Social determinants of nutrient intake should be the focus of food policy. Improving the income, employment and housing of Aboriginal people is a major platform for changing diet but only in the context of control of policy initiatives by Aboriginal community members themselves.

Another aspect of food policy is the manipulation of access to foods through the regulation of price. Do policy makers have the right to take a moral stance in regulating behaviour through fiscal measures for Aboriginal people? Raising funds to address the economic impact of disease due to dietary factors seems like a reasonable justification. However, this is exactly the kind of reasoning that was behind paternalistic policies which controlled every aspect of the lives of Indigenous people. This can only be a decision that is made by grassroots Aboriginal communities for themselves.

Historical discourse on the dietary practice of Aboriginal people is demeaning and paternalistic and has traditionally focused on the so-called poor practices of Aboriginal people. This does not reflect the resilience of Aboriginal people and their survival or their influence on the food practices of all Australians. Food policy cannot continue to create and extend a paternalistic deficits approach to Aboriginal food practices (Adam 2009). A new discourse of Indigenous resilience and Indigenous knowledge is needed to underpin food policy.

As this inquiry has shown, while nutritional factors affect health, social factors affect dietary practice. Food does not merely comprise biochemical components but has a social function. This paper has attempted to analyse the complex and
disempowering control and abuse of food and access to food which has occurred since colonisation and to contrast that with the well-integrated, complex and sustainable food practices of Aboriginal people prior to permanent European occupation. What people think about food and how they approach daily existence is highly relevant. Various Aboriginal cultural groups have different rules of engagement with norms and expectations of what is real food and the significance of food in their everyday lives. Too much thinking about food policy is shaped by dominant political and corporate interests. Policy makers accept ‘deficit’ or ‘empty vessel’ models of people and their food cultures — waiting to be filled with better or correct knowledge; once this is achieved they will change their attitudes to human behaviour and means of operation in the light of superior logic. The failure of food policy is due in part to cultural insensitivity. Food behaviour is subject to a range of influences which are part of decisions about foods, including taste, culture, preferences, income and food availability, convenience, education, time, familiarity — and the historical experience of colonisation. Effective food policy making includes a commitment to understand and engage with the meanings that people bring to the table.

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