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Historical and current perspectives on the health of Aboriginal and Torres Strait Islander people

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With acknowledgement
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LEARNING OBJECTIVES

This chapter will help you to understand:

- Why the health of Aboriginal and Torres Strait Islander people is the business of every health professional in Australia
- The key events in Australian history that have influenced the health of Aboriginal and Torres Strait Islander people
- The continuing effects of colonial policies on the health and wellbeing of Aboriginal and Torres Strait Islander people
- Factors promoting best practice in developing policy, programs and service delivery for Aboriginal and Torres Strait Islander communities
- The current policy environment relevant to the health of Aboriginal and Torres Strait Islander people
- The role of nurses as change agents in the field of Indigenous health.

KEY WORDS

Closing the Gap
health gap
social justice
worldview

Introduction

The health of Australia's First Peoples – Aboriginal and Torres Strait Islander peoples – is critically poor and requires urgent and informed attention at both state and national levels. The early days of contact between colonial forces and First Peoples saw the onset of the health catastrophe that continues to engulf Australia's Aboriginal and Torres Strait Islander peoples. This is a catastrophe of death, disease and entrenched social disadvantage. This crisis is real. It is a crisis complicated by our history and the many factors that shape Australia today.

Prior to 1788, there were at least 500 language groups living as autonomous nations across the land that we now call Australia. Australia is now recognised to be the home of the oldest living and surviving cultural groups in the world. They traded with each other and maintained social and educational systems. Archaeological evidence confirms at least 120,000 years of permanent residence in Australia (Broome, 2002). Prior to colonisation, each nation lived separately, each with their own language and cultural traditions. But with invasion and subsequent colonisation, the origins of the First Peoples and their names for themselves were dismissed as irrelevant (Smith, 1999). Culturally specific, self-assigned names were replaced with the global terms 'Aboriginal' or 'Indigenous', which were from the Western tradition. Colonising forces named the country and named the people who lived there (Smith, 1999).

This chapter provides a perspective on the current health issues facing First Peoples in Australia, placed within their historical context. It explores some of the historical factors that underpin the gap between the health of Indigenous and non-Indigenous Australians. It describes the policy environment that established the Closing the Gap campaign, and challenges nurses to consider their personal responsibility for closing the health gap.

We, the authors of this chapter, are Aboriginal women who work(ed) as nurses and midwives. We specialise in Aboriginal and Torres Strait Islander health and have been privileged to gain and develop our knowledge and expertise in various sectors of Aboriginal and Torres Strait Islander health. We have used our nursing skills and cultural knowledge to advocate for better and more appropriate health services for Australia's First Peoples. We are interested in a range of health care environments, from community health clinics to hospitals.

We argue that Aboriginal and Torres Strait Islander health is the business of every health professional in Australia. We believe that health professionals need to be familiar with the history of Australia's Aboriginal and Torres Strait Islander peoples. Understanding of the historical context helps to put current health needs into perspective. Understanding something about the Country on which you are working and the custodians who care for it is a critical step in working with Aboriginal and Torres Strait Islander people towards a healthier Australia.

The narrative about Aboriginal and Torres Strait Islander health

The dominant public story of Aboriginal and Torres Strait Islander health status is a 'bad news story', or 'a problem to be solved' (Saggers & Gray, 1991). Media stories portray examples of appalling health, social breakdown, housing crises and wasted money. The dominant story is based on its Western truth, so governments continue to make the same decisions in developing policy, programs and services for Australia's First Peoples and their communities, and health improvements often do not occur.

The dominant Western story has resulted from a lack of balance in presenting the story of the experiences of Australia's Indigenous peoples since invasion. Many health professionals have had little opportunity to gain access to this knowledge because until very recently it has not been taught in schools or universities. They also have little opportunity to learn and understand the different worldviews and cultures of Aboriginal and Torres Strait Islander peoples.

Policy decisions about Aboriginal and Torres Strait Islander peoples' health continue to be made without community partnership. Geia (2012) argues that her community commonly sees governments undergoing a repeated process of policy and program development, but presenting it as though it were new:

New ways of government 'doing consultation' with Aboriginal communities still appear as interventions for purely political ends that are at most culturally inappropriate and inaccessible for Aboriginal families and bearing little sense of ownership by the Aboriginal people because their participation in policy development is at best given lip service. Again it is policy done to Aboriginal people and not genuine partnerships with Aboriginal people. (p. 20)

Government policy makers and many health professionals fail to appreciate that by continuing the same old policy practices and program development there will be little gained. It is time that health professionals listened to their clients informing them about their health needs and responded appropriately. The prospect of progress and being effective in improving the lives of the people in communities remains, at best, a pipe dream (Geia, 2012, p. 20). The same outcomes continue to be seen, and the burden of ill health experienced by Aboriginal and Torres Strait Islander people continues to grow.

The stories that health practitioners learn about Aboriginal and Torres Strait Islander peoples' health – whether through the media, or through school, families or connection to communities – influence the ways in which they work with Aboriginal and Torres Strait Islander clients. At the level of patient care, the ways in which nurses think about, talk about and deliver care to Aboriginal and Torres Strait Islander people will depend on the narrative being played in their heads. Is that story positive or negative? Is it one of hope or hopelessness?

Nurses make value judgements about their clients – whether they intend to or not – and these judgements invariably influence the ways in which they deliver patient care. This means that entrenched stories of deficit (those ubiquitous 'bad news stories') can cause significant negative changes in the lives of Aboriginal and Torres Strait Islander peoples and can influence the care they receive. Conversely, good news stories can bring about significant positive changes in both Indigenous and non-Indigenous communities.

Knowing the ancient story

Aboriginal Australians believe they did not travel to this continent, but originated from their distinct Country. Archaeological evidence suggests that Aboriginal peoples have lived on and cared for the Australian continent for between 60,000 and 120,000 years – a land tenure that outdates any other civilisation in the world (Sherwood, 2013).

Prior to the British invasion, occupation and settlement of Australia, Aboriginal Australians lived a lifestyle that enhanced their physical, mental, emotional and spiritual wellbeing (Gammage, 2012). Records suggest that Australia's First Peoples enjoyed excellent

health and wellbeing. Prior to 1788, the First Peoples were self-determined, with each nation group in control of their lives and sovereignty of their Country. They were economically independent and practised a lifestyle focused upon sustainability and balance. Law was intrinsically connected to Country and recognised the value of all living and non-living beings and matter. The laws facilitated reciprocal, sharing relationships.

Prior to the British invasion, food was hunted and gathered, with some farming (Gammage, 2012). The nutritional content of food was rich. Varied food sources, seasonal farming practices and trade enabled a wide-ranging diet (Reid & Lupton, 1991). Early writings of people on the First Fleet to Australia reported that the First Peoples appeared to be very healthy and strong looking (Saggers & Gray, 1991). This was a reference to the First Peoples of the Eora, Tharawal and Darug Nations, who were and continue to be the traditional custodians and owners of what is now known as Sydney.

The history that most Australians have not been told

In 1770, Lieutenant James Cook claimed the eastern side of Australia as a British possession. In 1788, British settlers and convicts arrived on the First Fleet under the command of Captain Arthur Phillip. ‘Invasion’ and ‘settlement’ are the terms that best describe what occurred once Phillip and the British Army arrived (Connor, 2003, p. xi).

26th January 1788 the colony of New South Wales was established and thereafter other parts of Australia were declared colonies, eventually six in all. Aboriginal societies and their territories were overrun by settlers, and in many parts of the continent and its islands, if they survived at all, they did so in much-reduced and horrible circumstances.

(Langton, 2010, p. xvi)

The British claimed Australia under *terra nullius* (land belonging to no one) (Behrendt, 2012) and immediately commenced their dispossession of the First Peoples from their land. British colonial policy handed over to settlers and pardoned convicts land that had been Country to countless generations of Aboriginal peoples. In many circumstances, these were violent colonial acts, undertaken without the consent of Aboriginal Australians. To this day, Aboriginal people continue to state that sovereignty of Aboriginal land was never ceded to the British forces. Invasion was followed by frontier warfare over land, which erupted between the British and the Aboriginal people. This lasted until 1838, although massacres of large groups of Aboriginal people persisted until the 1930s (Connor, 2003).

Dispossession and ongoing warfare took its toll on the population of Aboriginal people. They were also hit hard by diseases that were previously unknown to them. Since they had had no exposure to these diseases prior to invasion, their immune systems were highly susceptible; infections and disease resulted in the deaths of many. At the same time, the significant disruption in access to traditional foods, Country and traditional practices (such as their ability to undertake vital societal, legal and religious obligations) played heavily upon the First Peoples’ health and wellbeing (Dudgeon, Wright et al., 2014).

As a direct result of the stress of invasion, many Aboriginal Australians died – due to diseases, starvation, poisoning, torture or warfare (Franklin & White, 1991; Reynolds, 1987; Saggers & Gray, 1991). Behrendt (2012) noted that historians ‘have estimated that in Queensland alone the Aboriginal population was reduced from 120,000 to 20,000, with

accusations that the expansion of the pastoral industry in the state accounted for at least 10,000 direct killings' (Behrendt, 2012, p. 117).

It may be stated broadly that the advance of settlement has, upon the frontier at least, been marked by a line of blood. The actual conflict of the two races has varied in intensity and in duration, as the various native tribes have themselves in mental and physical character ... But the tide of settlement has advanced along an ever widening line, breaking the tribes with its first waves and overwhelming their wreck with its flood.

(Fison & Howitt, 1880 cited in Reynolds, 1987, p. 4)

Colonial policy and practice continued to influence the health and wellbeing of Aboriginal and Torres Strait Islander people. Since 1788, Aboriginal and Torres Strait Islander Australians have been described as a 'problem' requiring a Western solution (Geia, 2012; Geia, Hayes & Usher, 2011; Sherwood, 2010). Colonisation is universally recognised as a critical determinant of the health and wellbeing of Indigenous peoples (Durie, 2003).

Acknowledging colonisation as a determinant of health requires an appreciation that it is not a 'finished project' (Czyzewski, 2011, p. 10). Data describing the health of Australia's Indigenous people demonstrate that there has been and continues to be inequity in health care (Holland, 2016). Colonisation has left an unrelenting legacy upon Aboriginal and Torres Strait Islander people through the continuing economic, social, political and educational marginalisation of them and its profound effect on their health and wellbeing and that of their communities (Zubrick et al., 2010).

Protectionism and the 'doomed race'

Implementation of colonial policies that targeted Aboriginal and Torres Strait Islander peoples resulted in significant physical, emotional and spiritual ill health and the death of many people. On hearing of the maltreatment of Aboriginal people in the early years of Australian settlement, in 1838 the British Parliament passed a Bill to protect the Aboriginal people who were being slaughtered by settlers. Aboriginal Protection Boards were created to oversee the treatment of Aboriginal people under the Aboriginal Protection Policy. However, the Bill and its policy failed to be implemented in the manner intended by the British government. Instead, the policy became a notorious outcome of colonialism, which 'mandated total control over Aboriginal peoples' (Sherwood, 2010, p. 45). The policy controlled where Aboriginal people could live and enforced restrictions on mobility, employment, marriage, education and nutrition (Sherwood, 2010).

Reserves and missions established under the Aboriginal Protection Policy became the enforced new homes of Indigenous Australians. They were placed in over-crowded, poor housing, and diseases flourished. Food rations were provided to some people, and generally consisted of flour, sugar and tea. This was a very different from their traditional diet of 'bush food' (Sherwood, 2010).

Health research from this era promoted a 'doomed race theory'. In 1928, Tropical Health Specialist Dr Bruce Cleland claimed that all full-blood Aboriginal people would become extinct (Mitchell, 2007). Government underfunding of missions and reserves ensured malnutrition and high rates of infant mortality. Individuals who were observed to be suffering from smallpox, leprosy or syphilis were regarded as threatening the health of non-Indigenous Australians. They were chained by their necks and limbs, then forced to walk great distances to lock hospitals, where they were left to die (Grant & Wronski, 2008, pp. 1–28). (Lock hospitals are discussed in Chapter 2.)

A hint of a turn in the road

In 1938, Aboriginal activists William Ferguson and John Patten paved the way for a pivotal change in the way that Aboriginal and Torres Strait Islander people engaged with the wider Australian population. Ferguson and Patten gave voice to the silent cries of Aboriginal and Torres Strait Islander people by challenging the notion that Australia Day should be celebrated. They declared that Aboriginal Australians would not rejoice on 26 January 1938. Rather, they announced it a day of mourning:

These are hard words, but we ask you to face the truth of our accusation. If you openly admit that the purpose of your Aborigines legislation has been, and now is, to exterminate the Aborigines completely so that not a trace of them or their descendants remains, we could describe you as brutal, but honest. But you dare not admit openly that your hope and wish is for our death! You hypocritically claim that you are trying to ‘protect’ us; but your modern policy of ‘protection’ (so-called) is killing us off just as surely as the pioneer policy of giving us poisoned damper and shooting us like dingoes ... The arbitrary treatment which we receive from the Aborigines Protection Board reduces our standards of living below life-preservation point, which suggests that the intention is to exterminate us. In such circumstances, it is impossible to maintain normal health. So the members of our community grow weak and apathetic, lose desire for education, become ill and die while still young.

(Ferguson & Patten, 1938, pp. 54–6)

Forced removal: The Stolen Generations

The workings of colonisation and the implementation of the Aboriginal Protection Policy produced overwhelming trauma in Aboriginal and Torres Strait Islander families and their communities. It was a devastating betrayal of Aboriginal protection. The forced removal of children is perhaps the most critical betrayal of all.

New South Wales records show that, from 1814, Aboriginal children were taken from their families under the guise of being ‘civilised’. Children were kidnapped and ‘exploited as slaves and guides’ for settlers (Ella et al., 1998, p. 29). In 1890, the NSW Protection Board authorised the removal of children so that they could be apprenticed and trained in state-run institutions. The *Aborigines Protection Act, 1909* (NSW) enabled the Aboriginal Protection Board to remove any Aboriginal child from her or his family and place the child in an institution. In 1937, the Aboriginal Protectors from Western Australia, South Australia and the Northern Territory decided that it was their duty to remove Aboriginal children from their families if they believed the children were the offspring of Aboriginal and non-Aboriginal parents. They justified these removals on the basis of neglect. Recent estimates suggest that between 20,000 and 25,000 children were removed from their families under this policy (Australian Human Rights Commission (AHRC), 2012).

Removed children were often placed in state-run homes. Historian and scholar Dr Rosalind Kidd describes these homes as generally uncaring institutions where many hundreds of children died due to physical abuse, starvation and psychological neglect (Kidd, 2000). The *Bringing Them Home* report (Human Rights and Equal Opportunity Commission (HREOC), 1997) provides detailed narratives of people’s experiences of removal and life after their removal. Some of these stories describe the children’s treatment at the hands of the Aboriginal Protector. Many of the Stolen Generation survivors reported to the Inquiry

that they had been forbidden to speak their own language, were told that their parents did not want them, experienced neglect and abuse (physical, emotional and sexual), received little or no education, and were refused contact with their families (HREOC, 1997).

Separating Aboriginal and Torres Strait Islander children from their parents and communities has been demonstrated to have serious long-term impacts on their safety, well-being, mental health, cultural identity and development. In many cases, the forced removal of members of the ‘Stolen Generations’ from their families and communities has prevented them from acquiring language, culture and the ability to carry out traditional responsibilities. It has also made it difficult for these individuals to establish their genealogical links. Most forcibly removed children were denied the experience of being parented or at least cared for by a person to whom they were attached; for many, this was the most significant of all the major consequences of the removal policies. Forcible removal also had long term impacts on the physical and mental health of people removed, and long term problems with substance abuse and imprisonment. In 2008, of those who had experienced removal from their natural family, 35% assessed their health as fair or poor and 39% experienced high or very high levels of psychological distress, compared with 21% and 30% of those not removed. The *Bringing Them Home* report details the intergenerational consequences and effects of removal. Many members of the ‘Stolen Generations’ still have not been reunited with their families. The legacy of forcible removal remains in the lives of Aboriginal and Torres Strait Islander individuals and communities today and contributes to their continued disadvantage. The *Bringing Them Home* report recommended that reparations be made in response to the gross violations of human rights that occurred as a result of the forcible removals. In addition to acknowledgement and an Apology, the Report recommended that reparations should include guarantees against repetition, restitution, rehabilitation and monetary compensation.

(AHRC, 2012, 1.13)

Creating the health gap

The stories described in this chapter provide a very brief overview of the government policies and practices that have influenced the health of Indigenous Australians. From the time of colonisation, Indigenous Australians have not enjoyed the health and social equity that many non-Indigenous Australians have had. This situation continues today. Government policies and practices over the past 200 years, including specific policies targeting Aboriginal and Torres Strait Islander peoples, have contributed greatly to what is now known as the ‘health gap’.

In their correspondence to the Secretary General of the United Nations in 1970, The Aborigines Advancement League wrote:

This is an urgent plea of several hundred thousand so-called ‘Aborigines’ of Australia that the United Nations uses its legal and moral powers for the vindication of our rights to the lands which we have traditionally occupied. We make this plea under the Item 55 of the General Assembly, which deals with the elimination of all racial discrimination for it’s only racial discrimination which can explain the refusal of the Government to grant us, and us alone, our rights ...

health gap – the disparity in health outcomes experienced by different groups in society. In Australia, there are significant health and life-expectancy gaps between Aboriginal and Torres Strait Islander people and other Australians.

We must emphasise: FROM THE TIME OF THE FIRST SETTLEMENT IN 1788 TO DATE THE CROWN HAS NEVER USED EVEN ITS CLAIMED POWER TO TAKE OUR LAND, EITHER BY TREATY OR BY PURCHASE. THE CROWN HAS BLATANTLY TAKEN OUR LAND WITHOUT TREATY, WITHOUT PURCHASE, AND WITHOUT COMPENSATION OF ANY KIND.

We, the Aborigines of Australia whom the invaders have not yet succeeded in wiping off the face of the earth, are the owners of the land of Australia in equity, in the eye of any system of civilised law and in justice and yet we have no share in the great mineral, agricultural and pastoral wealth of our country.

(cited in Reynolds, 1989, p. 87)

Aboriginal historian Professor Marcia Langton offered a personal perspective of Australian history:

History was for me a terrible burden because it was in this class that I learnt that people like me were hated, and that the only stories told about us provided a steady stock of evidence about our supposedly shockingly violent tendencies, savagery and, most importantly, our innate tendency to steal and pilfer.

(Langton, 2010, pp. ix–x)

The current health story

Aboriginal and Torres Strait Islander health today is a story informed by history, policies, warfare, Western medicine and press bias. It is important to recognise that the poor health status experienced by Indigenous Australians did not simply just occur; it is the result of past events. We believe that it is vital that all health professionals gain a deep appreciation of the current health status of Aboriginal and Torres Strait Islander Australians. Health professionals need to recognise that the appalling health outcomes experienced by Indigenous peoples are the direct result of colonisation (not only in Australia, but also experienced by Indigenous peoples worldwide) (Commission on Social Determinants of Health, 2007; Czyzewski, 2011; Giroux & Giroux, 2008).

At the end of June 2011, the Australian population of Aboriginal and Torres Strait Islander people was estimated to be 669,736 (MacRae et al., 2013). New South Wales has the largest population of Indigenous people, with about 31 per cent of the total Aboriginal and Torres Strait Islander population living in the state. The Northern Territory has the highest percentage of Indigenous people, with 30 per cent of the population being Aboriginal or Torres Strait Islander (MacRae et al., 2013).

Recent health data indicate that there is a significant difference in morbidity and mortality between Indigenous Australians and the general Australian population (Australian Institute of Health and Welfare, 2015). Australia is considered a developed nation, therefore Indigenous health must be seen as a social justice issue (Commission on Social Determinants of Health, 2008). As Adelson (2005) noted, disparities in health are markers of a disproportionate suffering of disease within a population.

From 2006 through to 2010, the leading causes of death of Aboriginal and Torres Strait Islander people were cardiovascular disease, neoplasms (almost entirely cancers) and injury (MacRae et al., 2013). Importantly, the category of injury also includes death by suicide (intentional self-harm); in 2010, injury was 2.4 times more frequent among Indigenous

Australians than non-Indigenous Australians (MacRae et al., 2013). On a more positive note, between 1991 and 2010, both Indigenous and non-Indigenous infant mortality saw a noteworthy reduction in the Northern Territory, South Australia and Western Australia (MacRae et al., 2013).

There is some evidence that the overall story about Aboriginal and Torres Strait Islander people's health may not be entirely accurate. Despite improvements in data collection specifically focused upon Indigenous peoples across Australia, there continues to be a deficit in the reporting of deaths, cancers and disease (MacRae et al., 2013). It is important that we capture health data effectively, so that an accurate story can inform policy for health service providers. This is something that has not been done well in Australia. The Australian Bureau of Statistics and the Australian Institute of Health and Welfare often warn health planners that the data they report are not entirely valid due to poor documentation of Indigenous status by professionals across the nation.

CASE STUDY

Making assumptions about health

Lorri is a 34-year-old woman with three children. The eldest is 12, the second is 8 and her third is just 2 years old. Lorri has just started back at university to complete her studies after a break having her last child. She arrives at accident and emergency at 10 p.m. She presents with a headache and slightly slurred speech, unsteady on her feet. Because her husband was working, Lorri had to wake up her children to bring them with her to the hospital and as a result they are tired and cranky and the baby is crying.

The triage nurse is about to finish her shift and is not happy about this late arrival. The nurse assumes the slurred speech is a result of Lorri being drunk and so does not bother to triage her, leaving her for the next shift to delegate. The nurse details this assumption in her handover to the next triage nurse starting her shift. As a consequence, Lorri has been left in the waiting room for four hours without any observations being taken. The children have settled, sleeping on their mother.

The children are woken when Lorri falls to the floor. The nurse says 'typical – she's just come in to sleep this one off'. The children scream with worry as their mother is now unconscious and the eldest demands that their mother be seen by a doctor, and, because they are terrified, the children do make a lot of noise until this happens.

The doctor and nursing staff bring the mother and children into the A&E triage rooms and commence emergency treatment. The doctor smells her breath and immediately recognises that she is a diabetic and not drunk. Lorri is in fact suffering from a hypoglycaemic event.

Lorri had been suffering from undiagnosed diabetes since her third pregnancy. She was told she was diabetic when she was pregnant and that it would be all okay once she had the baby. However, it was only 18 months after Lorri had her baby that she started to have symptoms such as headaches and tiredness, which she put down as simply being a mum and studying again.

Lorri was seriously injured in her fall, and – worse – could have died as a result of the delay in her treatment. Her case was taken up by a human rights lawyer, and the A&E

and the nursing staff were found to be negligent. The hospital had to pay a considerable amount in compensation to Lorri and her traumatised children.

Questions for reflection

- Lorri's situation is not uncommon: a mother with children requiring emergency health care. What should the triage nurse on duty have done?
- It was obvious that Lorri was an Aboriginal woman. Why do you think the staff failed to diagnose her diabetic status?
- Why do you think it was assumed that Lorri would be a drinker?
- How differently would you manage this case?

Indigenous ways of knowing about health

Aboriginal and Torres Strait Islanders view health from a **worldview** that is significantly different from the biomedical model. Understanding and appreciating this different way of viewing health and life is fundamental to providing health care for Aboriginal and Torres Strait Islander people. Worldviews are important, because:

Each culture's worldview is self-contained and adequate in the sense that it provides a coherent view of reality as *perceived and experienced* by the cultural group under consideration ... Thus – allowing for the principles of modification in each culture, and varying degrees of openness to change – each culture's worldview is adequate for *that culture* and thus valid *in its own terms*.

(Jenkins, 2006 cited in Ranzijn, McConnochie & Nolan, 2009, p. 17)

The National Aboriginal Health Strategy Working Party (NAHSWP) describes the health worldview of Aboriginal people in this way:

Health is not just the physical well-being of the individual, but the social, emotional and cultural well-being of the whole community. This is a whole of life view and it also includes the cycle of life–death–life.

(NAHSWP, 1989, p. ix)

The definition provides health professionals with a valuable tool with which to approach Indigenous health. The following definition is also helpful:

[The] Aboriginal concept of health is holistic, encompassing mental health and physical, cultural and spiritual health. Land is central to wellbeing. This holistic concept does not merely refer to the 'whole body' but in fact is steeped in the harmonised interrelations which constitute cultural wellbeing. These inter-relating factors can be categorised largely as spiritual, environmental, ideological, political, social, economic, mental and physical. Crucially it must be understood that when the harmony of these inter-relations is disrupted, Aboriginal ill-health will persist.

(Swan & Raphael, 1995, part 1, p. 13, cited in Taylor & Guerin, 2010, p. 90)

worldview – the paradigms that guide and determine the ways in which people see the world. Worldviews influence how people make sense of their world through their systems of knowledge. They describe what can be known and the systems of knowing that relate people to their environment, cultures and experiences.