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Understanding Diabetes in a Rural Aboriginal Community

A thesis in partial fulfillment of the requirements
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Abstract

This thesis explores the way seven Aboriginal peoples from Yidiyi, who dwell in a remote region of the Northern Territory Australia, understand and treat their diabetes. In 1935, Aboriginal clan groups who dwelled in their own totemic land, mixing only in times of ceremony, migrated into the town of Yidiyi to live as a community. These people have, for the last eighty years, been adjusting to living with and integrating certain aspects of Western culture. With diabetes statistics rising for Australian Aboriginal peoples, my participants negotiate how they deal with and treat their diabetes. For Aboriginal peoples, health and wellbeing is holistic and interconnected with all aspects of life. To maintain health is to maintain positive interactions with all human and non-human entities. This thesis contributes to the literature that argues for the following: an understanding of Australian Aboriginal culture in Western settings; an integration of local Aboriginal healing methods within Western clinical environments; and continuous efforts that work to improve bicultural relationships.

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Chapter One

Introduction/Background

Introduction

At the end of my undergraduate degree in December 2012, my partner suggested that we move to Yidiyi (pseudonym used)¹. Recommended by a friend, Matt had signed up to apply for a job to work in a Catholic school in this Aboriginal² community in the Northern Territory.

I decided to do my Honours year here in 2013, extramurally, through Massey University, and was excited about the possibility of working with the local people. My research agenda changed once I realised I needed to become well-informed about local Aboriginal culture and how to study here ethically before undertaking a project with Aboriginals in the town. After living here and studying Indigenous ethics and methodologies here for a year, I felt prepared to work with the local people. I will discuss this experience in more depth in my Methodology chapter.

After meetings with my supervisors and local people, it was decided that my research aim, in the broad sense, was to understand diabetes from my participants' perspective. Initially, I had hoped to use action research and gain community involvement, however, once I began asking questions, I realised that people with diabetes often ignore the symptoms and do not wish to talk about them. Throughout the research process I utilised Indigenous methodologies as a guiding framework which assisted in personal critical reflection.

¹ Throughout the thesis pseudonym's are applied for any place, person or any local language term to secure the anonymity and privacy of the community and residents. Names were chosen by participants, all other pseudonym's were discussed with Sister Annie (my cultural advisor from my Honours dissertation) to ensure they were culturally appropriate.

² Following the convention used by World Council of Indigenous Peoples, capitals are used for nationality, ethnic groups and religions. The words, indigenous and aboriginal are not capitalised when they mean 'native to'; however, I have capitalised these words when referring to Indigenous peoples.

After reading a wide range of literature, I felt that I had an understanding of two cultural (Western and Aboriginal) perceptions of the body and health care. Using Indigenous methodologies allowed me to reflect on my understanding of health. I realised that I objectify my body and think about health care as a matter of healing the physical. My reflection led me to read the works of certain anthropologists, particularly Tim Ingold, which added to an appreciation of the local understanding of health and how Aboriginal peoples connect cosmologies, land, and human and non-human entities. I also learnt very early on that an individual's experience in their society, and their emotions, influence their perception of diabetes.

I found through my conversations with my participants that their perception of their diabetes and treatment for it were all unique. After reading the literature, I was expecting my participants to give me negative feedback about their experiences at the local clinic, which worked with a biomedical model of health. I was not expecting to listen to a variety of personal ways to heal diabetes. Ultimately, I found that healing is personal and is performed to improve a holistic sense of self within the local community of Yidiyi. My participants' diverse healing methods for diabetes illustrated that the health of the body is connected to everything around them and to improve the health of the body and overall sense of wellbeing, engaging with certain areas of life, such as culture, family and land, is needed. This is why my participants chose to use a range of techniques to help them reconnect with what they think may be lacking in their lives.

As I had lived in Yidiyi for a year before I began this thesis and now for a total of just over two years, I was able to continually reflect on local social issues that may contribute to the cause of diabetes. I found that local social life in Yidiyi is always changing and is negotiated with aspects of Western culture. However, although local people wish to integrate elements of Western culture in a personal sense into their day-to-day living, there is a strong desire to maintain Aboriginal culture. At times I felt as though the local Western institutions and non-Indigenous culture found it difficult to embrace and grasp

local Aboriginal culture in order to seek ways to benefit the whole community (as heterogeneous as it is).

Overall, I found that in order to improve Aboriginal health and decrease the rise in diabetes, an improvement in bicultural relationships needs to be focussed upon. To be effective, Aboriginal health services should be holistic and integrate a wide range of community involvement, and Aboriginal healing methods need to be integrated in the clinical environment. In addition, knowledge of Aboriginal culture is required to be included in Western biomedical training in Australia in order for relationships to develop. This advice has been given for decades, yet the lack of funding to carry out this kind of integrated health in rural Aboriginal communities continues, meaning there has been little or no progress in this area. This thesis is a contribution to the literature that reiterates and contextualises these points in terms of one indigenous community.

Organisation of thesis

This thesis is a contribution to the field of indigenous studies that presents how some Aboriginal peoples perceive and heal diabetes. Firstly, in the background section of this chapter, I provide an overview of the field's history, from my experiences and from the literature. This section is useful in understanding diabetes in Yidiyi, as are the data analysis chapters that follow, as this thesis has a strong focus on the social factors that contribute to diabetes. Chapter Two is a review of relevant literature. In this chapter, I cover a broad range of literature that begins by discussing the biomedical understanding of the body. Ultimately, I found that the Western objectification of the body has led to the way mainstream clinics treat patients. In comparison, the Aboriginal perception of the body is connected to the environment and includes all human and non-human entities. Following this, the Methodology Chapter complements the literature review as I establish the perspective of this thesis within indigenous studies and explain how and why the research is informed by Indigenous methodologies.

Chapter Four is where my data analysis begins. This chapter discusses the variety of different healing methods my participants use and highlights the point that healing is holistic while also ascertaining that Yidiyi locals require longer consultation times that focus on personalised healing practices that are suited to each particular person. Chapter Five demonstrates the complexities of fieldwork. I found that, specifically, Aboriginal healers and bush medicine in Yidiyi was spoken about differently from the way they are addressed in the literature. My research also substantiated the point that it is essential that community resolutions arise from community control to ensure meaning and effectiveness. Chapter Six leads on to discuss bicultural social factors that contribute to the cause and treatment of diabetes in Yidiyi. It was clear that participants seek to find a locally applicable way for people with diabetes to understand and treat their diabetes, while also working towards improving bicultural relationships.

Personal experience

When I first arrived in Yidiyi and was being driven down the main street to my new home, I was dismayed. There was rubbish, malnourished dogs and graffiti everywhere. My new home had barbed wire above a high fence surrounding it and a padlocked gate. Visually, the high wired fence differentiated the local and non-local houses. House colour also did this: Non-local houses are all cream, while the local houses are bright greens, purples, pinks, blues and yellows. I was also told that, as a female, I was unable to exercise alone away from the main street. This was initially hard as I enjoy running by myself.

However, my own experiences of being chased by dogs, the comfort of knowing my gate is locked at night when fighting occurs, and the knowledge that there are men who have attacked women in broad daylight, makes me realise that safety precautions are necessary.

In saying that, I have had no experiences that have ever made me feel negatively about Yidiyi. I enjoy my time living out here: it is filled with blissful moments of community life and Aboriginal culture I know I will appreciate forever. For example, I love working with local people in my part-time employment in adult education. We share many laughs, mostly involving cross-cultural differences. As my time in Yidiyi has increased, my

relationships with local people have developed and I enjoy talking with adults and children while at the local store or out walking. My most cherished memories is the process of being welcomed on to a person's "country"³ and having the opportunity to learn about a person's knowledge and relationship they have with their land, ancestors, and family.

Geographical context

To understand health in this locality the social context and cultural landscape needs to be appreciated. Yidiyi is one town in the *Yamurr* region. Outside of the town there are 20 rural outstations where the 20 patrilineal clans belonging to the area once resided. The 20 clans are segregated into three ceremonial groups⁴. These different groups are locally referred to as a person's "culture". There are social, political and economic alliances between these groups and also between different families and clans within and beyond the *Yamurr* region. People's living arrangements are roughly organised into separate areas with members of traditional family coalitions living close to each another.

The town

The 300 km journey to the closest established city makes the town isolated. The road to this city is closed during the wet season, from November through to April. Over this period, flying is the only way out; however, return flights are a costly \$600 return for the 45 minute trip. There is one main street in town where all services can be found. There is a school; a childcare centre; a library; a museum; a small grocery store; a post office; a police station; a general store (which sells a few clothing items and household items such as stereos and cots); a takeaway store; a butcher; a women's centre (which employs local women to screen-print their art to sell); a safe house (for women); a recreational hall (where local bands occasionally play and can be used for sporting activities); a Centrelink

³ A person's country is the local term that refers to the land to which they belong and their place of Dreaming.

⁴ People lived day-to-day in family groups and meet in times of ceremony. I often hear local people say that a person in another ceremonial group is a different culture. I will not disclose the names of these groups due to ethical and privacy reasons.

(which is a branch of the Department of Human Services delivered by the Australian government, aimed at supporting people with payments and services in times of crisis); an aged care centre; a church; and a bank. There are also two councils in the area: the Regional Council and the *Yamurr* Council. The former is run for the interests of the wider region of the Northern Territory, while the latter is more concerned with local activities involving the 20 clans.

The general store sells all basic food items. Their stock is delivered by barge once a week. My partner Matt and I, and most of the staff at the school, order groceries online through a supermarket website. A credit card is needed to order groceries. No locals that I know of have a credit card and purchase all their food at the local store. I prefer not to shop at the store as I find the prices high. Most food items are between \$1-3: more than what I would purchase them for via the online supermarket website. Most local people do not own fridges or freezers and need to purchase meals daily.

Local colonial history

The next section is based on my local knowledge having lived in Yidiyi for two years, in addition to drawing on two anthropologists who have lived with a similar number of Aboriginal clan groups who also migrated from outstations to dwell in a town center: William Stanner (1930s-70s) and Bill Ivory (2000-today).

Aboriginal clans at the top end of the Northern Territory were not isolated from outside visitors once colonisation began. Visitors who frequented the area prior to the 1890s, were fishermen from Malaysia and Indonesia, and explorers (Ivory, 2009, p. 101). As visitors increased, the Aboriginal peoples in remote areas of the Northern Territory developed a reputation for violence and occasionally murder. Locals explain that the reason for violence was that they were trespassing. These acts in the Northern Territory prompted the Commonwealth government to invite missionaries from the Catholic Church to set up missions (Ivory, 2005, p. 3). It was due to the missionaries influence that the 20 clans moved from their totemic land into what is now the community of Yidiyi.

The local Aboriginal peoples welcomed the missionaries because of Minji's vision. Minji was a local sorcerer with a violent reputation in the area who became very sick. On his deathbed, he described being taken to heaven by a brown hawk and saw images of angels, Jesus, and the Virgin Mary. The angels gave him a song to return to earth with to describe his experience. When the missionaries arrived 10 years later, his kinsmen saw a picture of the Virgin Mary and realised that she was connected to Minji's vision (Furlan, 2005, p. 76-78). This story and song is owned and told by the family today who still live in Yidiyi and it has a strong influence on local politics.

A number of cattle farms were established across the region and provided work for local Aboriginal peoples. In 1968 there was a change in government policy from assimilation towards what is known as the "self-determination era" and award wages became the compulsory form of payment, which meant Aboriginal peoples were entitled to be paid the same as non-Indigenous people. This resulted in many Aboriginal peoples losing their job because employers preferred non-Indigenous employees to Aboriginal peoples as they were considered to have a better work ethic and spoke English (Taylor, 2004, p. 4). During the change in policy, those employees who lost their jobs moved to the township of Yidiyi. The movement, contributed to the rise in the population of the town. It was also during the self-determination era that residents were able to access cash without work through social security payments, known locally as "sit down money". Those wanting to work were limited in their employment opportunities due to the population increase (ibid).

During the self-determination era in the 1970s, Aboriginal communities began to call for councils designed to bring together local leaders to discuss the issues relevant to their community (Mowbray, 2005, p. 7). In Yidiyi, this developed through the formation of a locally-lead council in 1978. By 1994, however, it lost its traditional validity as it was being solely run by the local Indigenous landowners (Senior, 2012, p. 30). By 1999, local people were eager to establish a governing arrangement that was structured around traditional governing practice. As a result of this decision, the *Yamurr* Council was

formed. Decisions should be made through group meetings consisting of one member per clan group. The decisions can take a long time to be made, nonetheless, they are mostly community-made. However, the daily running of the council is operated by non-local people.

Within the *Yamurr* Council, the decision making process over community concerns took a long time to be processed by the Northern Territory Government's standard. As a result, in 2007, the Northern Territory Government implemented numerous councils across the region to function as the major source of community decision making processes. Under the John Howard administration, 2007 was the same year the Australian federal government enforced the Northern Territory National Emergency Response, otherwise referred as "the intervention"⁵. This policy was motivated by increasing reports of child sexual abuse and neglect in the Northern Territory. It included a number of administration changes: monitoring welfare payments (50 per cent of payments was required to be spent on food. This was to discourage money being spent on alcohol⁶); suspension of the Racial Discrimination Act⁷ (RDA); expecting Aboriginal people to lease property to the government in return for basic services; subjecting Aboriginal children to mandatory health checks without consulting their parents, and against the oath of doctors. The establishment of the council in the community made the implementation of the intervention possible.

Contemporary organisation of tribal groups

Ivory recognised in his research, that before the Aboriginal peoples he worked with migrated into the town center, the environment influenced the size of clans and leadership patterns and styles (Ivory, 2009, p. 82). Similar to Yidiyi, each clan in the region Ivory

⁵ In June 2007, the federal government staged an intervention in the Northern Territory aiming to "protect Aboriginal children" from sexual abuse. Without consultation, Aboriginal peoples' lives were heavily regulated, and many felt ashamed and angry.

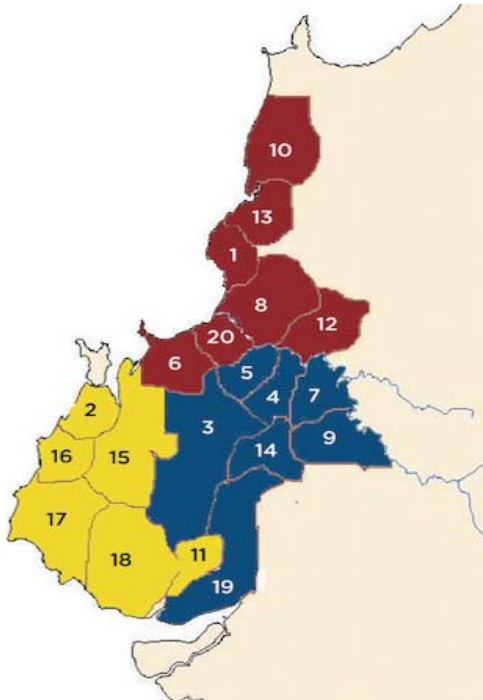
⁶ Decreasing money being spent on costs such as alcohol was implemented by dispersing the BasicsCard. The card can be used to buy living expenses, such as food, clothing and hygiene products at a variety of approved stores and businesses. Money cannot be taken from an ATM machine.

⁷ The Racial Discrimination Act 1975 makes it against the law to treat you unfairly because of your race, colour, descent, national or ethnic origin or immigrant status.

worked in varies in size. One clan may have as many as 150 people, while another may have as few as 13 (ibid). As Nicolas Peterson (1986) did before him, Ivory claimed that the variation in the size of the clans was due to the type of terrain the clan inhabited and what it could provide for them as a group (Ivory, 2009, p. 62; Peterson, 1986, p. 59).

Within the clans, there are three different ceremonial groups. Below, I have used the map Ivory used in his research which is similar to the way clans in Yidiyi are segregated on their land and connected through ceremonial groups. Clans living on land in a similar region would share the same ceremonial group, although sometimes clans of different ceremonial groups share the same land border. A ceremonial group has a minimum of one spoken language and a maximum of five. For example, Yidiyindi is now the most commonly used language in Yidiyi and traditionally spoken by six clans (see yellow section in table below. Number 15, for example, is named Yidiyi, where all clans now reside). They also share the same ceremonial group. There are another seven clan groups who share the same ceremonial group, and speak five different languages (blue section). The same is similar for the remaining seven clans, sharing the same ceremonial group, while four clans speak a different language to the other two (red section) (ibid).

Table 1: Clan groups in the Port Keats region



(Ivory, 2009, p. 79) Colour added for clarity.

During a conversation with a local leader, Ivory was told that knowledge that connects a person to other clans or people has been lost (2009, p. 83). Awareness of moiety⁸ or subsection name is not known, particularly by young and middle-aged people. Ivory was told that knowing this information could be useful for those wanting to maintain “a wide network of relationships” which would socially categorise a person and enable them to “engage with [people] or request favours and assistance” (ibid). During my fieldwork, I too found this. Some locals told me that they did not speak their traditional language anymore and chose to speak Yidiyindi. Some people told me they had lost knowledge on how to conduct women’s ceremony also known as women’s business, and on occasion, some older children could not tell me their totem, however, the latter may have been due to a language barrier. In relation to my own conversations, I feel that some knowledge of moieties is increasingly being lost.

⁸ Moiety is a unit which a tribe or community is divided into on the basis of unilineal descent.

In Ivory's experience, cultural loss is due to migration to the local town: "the contemporary social construct of the region in general is complex and interconnected to ethno-historical influences and changes in the social and physical environment" (2009, p. 72). Yidiyi's moiety sections formed gangs in the 1960s, referred to locally as "tribes". Since then, more gangs have emerged with approximately eight established gangs in total. Ivory's interview data with young men in a Northern Territory prison tells us that older "tribes", or gangs, were more focussed on cultural values than the newer gangs are. One ex "tribal" gang member was of the opinion that the newer gang members initiated fights within the community to avoid certain aspects of their cultural responsibility, such as the men's ceremony, and were formed in resistance to the decisions local tribal leaders were making for the community (Ivory, 2013, p. 4). However, locals have told me that, at times, a young gang member has, later on, become a member of the *Yamurr* council board (which I will discuss shortly). From conversations, I have noticed that most men over 40 years old have 'grown out of' participating in gang culture. Elders suggested to Ivory that, in order to minimise gang violence, rather than disassembling the gangs, the energy of the members should be harnessed towards activities that involve spending more time in their country and to becoming knowledgeable about maintaining their responsibilities to their land (ibid). Elder's suggestion to Ivory to use gang involvement as a positive for the community would be one way that could give individuals power and autonomy over choices and behaviour.

Local governmentality

Yamurr is the local form of governmentality as well as a local word which can describe the area. I came to understand the word to mean a connection of many different aspects of life. Older local people I spoke to described *yamurr* as "our way of life". It is inclusive of social, economic, educational and family relationships. Similar forms of governmentality can be found in other Aboriginal communities, Ivory describes the form of governmentality in the community he worked in as a practical and traditional way to move ahead and involves "interaction, cooperation, and respect between individual families, clans and tribal groups" (Ivory, 2005, p. 4).

Much of the local cultural knowledge is accessible for local Indigenous peoples, while some knowledge is reserved for elders. For example, the men's ceremony involves all dance groups and could be described as *yamurr*. This is because all men come together to share their clan knowledge and to pass it down to designated young men. Nowadays, the school sports carnival organised by the school is also referred to as *yamurr*, because it is a time of coming together as one. Through my conversations, I came to understand that it does not mean the *act* of interacting ideas or knowledge with one another; rather, it is more the importance of peaceful and democratic *interaction*. *Yamurr* is foundational to the cultural construct and world-view of local people.

Stanner was working in the Northern Territory when the missionaries arrived in Yidiyi in 1935. He discusses the similarities in forms of governance within Australian Aboriginal culture across the Northern Territory. There is certain knowledge sacred to males and females, known in the English language as “women's business” or “men's business”. Although all peoples are considered interconnected and that women hold roles of power, it is more likely that males are in positions of community leadership. The older dominate the younger; the men dominate the women (Stanner, 1956, p. 314). Power, authority, influence, age, status and knowledge all align together. The men of power, influence, and knowledge, are mature men. The greater the secret knowledge and authority (relevant to their clan land), the higher the status. The young men do not acquire full knowledge until they are well advanced in years (approximately 60 years old). There is no delegated leader as such, however, there are leaders in the sense of men with unique skill, initiative and force, and they are given great respect; and may even attract a following (*ibid*). In saying this, people are not forced to follow the group consensus if they disagree.

All people have responsibility for their land. It is physically and symbolically expressed through clearing and maintaining their totemic land and occurs at the beginning of the dry season by burning the grass. Landowners alone have the right to burn their own land. The act signifies cleansing, rejuvenation and ownership (Ivory, 2009, p. 80). The act of burning grass in one's own country is also a signifier to other clans that the land is being tenured, people are active on it, and that responsibilities are being maintained (*ibid*). If an

individual or group, local or non-local, wishes to spend time on a clan's country, permission must be sought, usually from a respected elder who has connections with the land.

Marl

Marl is the local term for “Dreaming”, “Dreamtime” and “Ancestral Time”. Dreamtime refers to a period of creation made by pre-existing ancestral spirits (Dean, 1996, p. 3). During this process, Aboriginal people's ancestors established a set of irreversible structures that were set to be followed eternally, such as life, law and moral codes (ibid). The ancestral spirits transformed into different elements of the environment, such as plants, animals and land. This period gave meaning to everything. In other words, the land itself was a sacred place. Richard Bawden discusses the lengths to which the Australian Aboriginal culture went to, to share their culture and beliefs. For an ethnic group consisting of over 200 languages, it is surprising that the ontology of all Aboriginal peoples share so many similarities (Bawden, 1998, p. 13). The sharing of knowledge between kin groups, which occurred through ceremonies and rituals, accounts for the many similar ontological elements of Indigenous culture between Aboriginal groups (Dean, 1996, p. 2). Stanner, who carried out extensive research on Dreaming in a number of Aboriginal communities, never identified the time in history in which the Dreamtime occurred, nor the Aboriginal term for ‘time’ (1956, p. 354). Stanner stated that, “the past was, in a sense, still part of the present” (1956, p. 305). In his experience, a person may refer to their totems as their Dreaming or the existence of a custom due to the Dreaming, such as avoidance relationships. For example, not speaking to your mother-in-law or father-in-law or your brother or sister, if they are of the opposite sex.

A *Marl* story is owned by a clan and its members and can explain the creation of life. For example, one *Marl* story Eve (my cultural advisor) told me depicted the evolution of the goose, which took place on her land during the *Marl*. In a sacred area on rocks there are footprints of an ancestor changing into a goose's webbed foot tracks. The markings depict the transformation of the ancestor into a goose and confirm that geese are a totem to that particular site and Eve's clan. As this event took place on her land, Eve has an

association and responsibility to this particular site of significance, referred to in Yidiyindi language as *mingki*. By having a connection with this religious site, Eve and other members of her clan, are granted with *Marl*, which in this context means, spirituality. *Marl* is extremely important to my participants as it contributes to their identity.

There can be a number of *Marl* belonging to that land and when a child is born they usually inherit two totems belonging to their father's country. They can still visit their mother's land and treat it like their own but are related totemically to their father's country. A person from Eve's clan then has, for example, goose *Marl*. This then intimately connects a person with their ancestors from the *Marl*, making no distinction between the spirit and human world. A person in this community has both an English name and an Aboriginal name. A person's Aboriginal name is often their personal totem in their spoken language or an area in their country. A name then, is a meaningful part of the body because it connects the person to their land or totem (Stanner, 1956, p. 305). In his experience, Stanner found that an Aboriginal person's name, spirit, and shadow are all part of a person's identity: Humans, society, nature, past, present and future are at one together within a unitary system and are so entwined "that ontology cannot illuminate the minds under too much influence of humanism, rationalism and science" (Stanner, 1956, p. 306).

Particular inherited *Marl* can also heal people. For example, a person can also have, headache *Marl* or abscess *Marl*. This type of *Marl* is also inherited patrilineally and gives that person the ability to heal a person from their discomfort. A non-Aboriginal co-worker of mine experienced abscess *Marl*. She had an abscess and a local friend said to her that she had abscess *Marl* and could heal her by wiping her sweat on her abscess. She declined the offer and went to the clinic to get antibiotics to relieve the pain. A week later the abscess was still there and still as painful. Her friend offered again to relieve her. This time she accepted, and her friend wiped her abscess with her armpit sweat and instructed her not to get it wet for 24 hours. The following day her abscess had begun to heal and eventually went away. When I spoke with the mother of the woman who treated her, she

said that locals quite often visit them to receive abscess *Marl*. Healing diabetes and ill health in general through body sweat is a significant topic in this thesis.

The clinic

For the most part, Indigenous and non-Indigenous community members visit the local clinic when they are experiencing ill health. It was built in the 1950s by the Northern Territory government in the main street of Yidiyi. The clinic provided basic Western medical amenities. In 2010, it was refitted as a result of receiving \$7.6 million, under the Howard government intervention policy, to refurbish the existing complex and construct a new building. The money contributed towards building clinical consultation rooms, an emergency room, a public and staff training room, baby treatment rooms, and consulting rooms for visiting specialists. There is also a new reception area, improved staff amenities and a safe drug storage and dispensing area, as well as an area specifically used for dental services, with its own waiting room. The following community programs have since been established through the clinic: Well Women's and Well Men's screening; Antenatal and Postnatal Care; Healthy under 5s; Healthy School Aged Kids program; Childhood and Adult Immunisation Program; Preventable Chronic Disease Management Program and Infectious and Communicable Disease Prevention and Control. Part of the \$7.6 million went towards a new emergency room service and specified digital equipment, which means local and non-local residents no longer have to travel to the nearest city for things such as X-ray assessments.

I am also aware that the Yidiyi clinic was architecturally-designed to be culturally sensitive, with one side for men and the other for women. Both have their own separate entrances, with children treated in the middle. This was to respect the cultural protocol of separating men's and women's business. This may have been the case when it first opened, however, my experiences at the clinic are very different. When entering the clinic there are two entrances (as above). However, once inside, there is a large reception area with one bench facing the reception desk for all patients to wait on. When I visit the clinic, all males and females are received together. There is a wall that might have created

privacy for the two sexes but it is only slightly wider than the bench that runs parallel to the reception desk. It is as high as the ceiling, however, if I was sitting on one side of the bench and leaned forward, I could easily see who was sitting on the other side.

Conclusion

Researching the local context for this background chapter has contributed to my understandings of community dynamics, specifically between local and non-local people and the effects of a top down approach to medical care and to general local and national governance. Firstly, it has become clear to me that local people live in a community that is still essentially run by “whitefellas”⁹. For example, although there is the *Yamurr* Council, the presence of the Regional Council and the daily reality of the BasicsCard introduced by the 2007 Intervention is symbolic of an overarching neo-colonial colonisation which controls the day-to-day experience for local people. High gates and barbed wire fences symbolise and reinforce the spacial and political segregation between locals and non-locals. I have found that this dichotomy seeps into the clinical environment where local protocols are acknowledged but do not appear to be carried out. The literature and my experiences told me that local people have a strong connection to each other and to non-human entities such as land, animals and ancestors. Aspects of the local language and cultural acts such as *Marl*, *Yamurr*, and song and dance unite a person to these aspects of their life and are played out in everyday activities. Although the community is run by “whitefellas”, local people integrate aspects of non-Indigenous culture into their lives while still maintaining a strong Aboriginal culture in their daily thoughts and core cultural values. I found that this persists through the way relationships are maintained with human and non-human entities. The local Aboriginal culture has a strong influence on medical treatment and the way in which local people adapt, reject, hybridise, and resist it. The following chapter will provide a literary and theoretical framing on which I examine my data, including my experiences in the field.

⁹ “Whitefella” is the local term for a non-Indigenous person.

Chapter Two

Literature Review

Introduction

I have structured this discussion of the relevant literature on the focus of my research in order to demonstrate a critical understanding of how diabetes is situated in Western and Australian Aboriginal contexts. This chapter has contributed to an understanding of how biomedicine has been focussed more on the physical and individual body than psychological, environmental, and social influences (Foucault, 1963, p. ix). Culturally appropriate health care programs are yet to be successfully implemented to provide services to Aboriginal peoples, which are aimed to prevent misunderstandings and for Aboriginal peoples and non-Aboriginal health workers to close the ontological and epistemological gap by health workers gaining an Aboriginal cultural understanding of health (Cowlshaw, 2006, p. 431; Kristof, 2007, p. 443; Seathre, 2013, p. 5). From my Literature Review, I argue that, biomedicine undermines an Aboriginal person's spiritual capacity and is acted out through socially and culturally specific ways that reflect the wider social context. I illustrate that scholars argue that the treatment options offered will continue to be ineffective if Aboriginal peoples are expected to assimilate to Western culture and biomedical care (Cowlshaw, 2006, p. 434; Seathre, 2013, p. 99).

I will also discuss two areas of Aboriginal culture that are significant to Aboriginal social life (demand sharing and sorcery) and how they affect Australian Aboriginal health and specifically diabetes. Lastly, I will discuss the relevance of Tim Ingold's 'skilled practice' and Paul Stoller's exploration of the senses. Their contribution to my understanding of Aboriginal health and interpretation of the body came as a result of my increased understanding of Indigenous methodologies (which I will discuss in my Methodology chapter) and have added to my understanding of local Aboriginal culture and their interpretation of diabetes.

Biomedicine and Diabetes

Diabetes is an increasing health issue in Australia. To paraphrase The American Diabetes Association (2005), diabetes can be described as follows: diabetes is a chronic condition where levels of glucose (sugar) in the blood are too high. For our bodies to work properly, we need to convert glucose from food into energy. Blood glucose levels are usually regulated by the hormone insulin, which is made by the pancreas (a large gland found behind the stomach) (2005, p. S37). If the pancreas does not produce enough insulin or there is a problem with how the body's cells respond to the insulin, people will more than likely develop diabetes. So when people with diabetes eat glucose (found in a variety of foods ranging from breads, starchy vegetables, sweets and even dairy products) instead of being turned into energy, the glucose stays in the blood causing high blood glucose (2005, p. S39). Once the blood glucose is high, the most common symptoms for all types of diabetes are similar and include, excessive thirst, passing high volumes of urine (up to 30 litres a day), lethargy, slow-healing wounds, itching and skin infections particularly around the genitals, blurred vision, nausea and vomiting, weight loss, and mood swings.

Medical researchers, David Dunstan et al, explain that developing countries have the highest rate of diabetes in the world (2002, p. 829). In their study in seven rural Aboriginal communities across Australia, they found that the prevalence of type two diabetes was 7.4 per cent. Compared with developing countries, their research showed that Australian Aboriginal people have one of the highest rates of type 1 and type 2 diabetes¹⁰ in the world (2002, p. 828). Medical researchers, Mark Daniel and Kevin Rowley's research indicated that diabetes is over three times more likely to occur for Australian Aboriginal peoples than in the non-Indigenous Australian population (2002, p. 23). Further, they stated that before Aboriginal people incorporated a Western lifestyle, there was no evidence of diabetes in their population. Dunstan says that diabetes is reported in one in every sixteen Australian Aboriginal person in urban areas, and in rural areas, it is reported in one in every eleven (2002, p. 828). It is also the cause for one in every twelve Australian Aboriginal deaths.

¹⁰ In type 1 diabetes, the pancreas stops creating insulin. As a result, the body turns its own fat into a substitute. The burning of fat in the body generates dangerous chemicals in the body and can be life threatening. For people who are diagnosed with type 2 diabetes, the pancreas produces some insulin, but not enough for it to work effectively.

So why are Australian Aboriginal peoples more likely to develop diabetes than the non-Indigenous population? Medical practitioner Eberhard Ritz reports that diabetes is most commonly caused by obesity (1999, p. 795) and that obesity is 1.5 times more common among Indigenous peoples than among non-Indigenous people. Other reasons why a person may be diagnosed with diabetes is a lack of regular exercise, the consumption of too much fatty and sugary food, and poor living conditions (Dunstan, 2002, p. 833). Indigenous health researcher, Kate Senior, explains that information such as this is important for both communities and governments providing services, as they present relevant explanations for poor health. However, they do not provide a holistic understanding of the everyday lived experiences including personal and cultural health beliefs and behaviours (Senior, 2013, p. 156).

Biomedical care

Medical anthropologist, Jo Scheder, explains that there are similarities between groups of people who have a pattern of increased diabetes, and that diabetes is most likely to affect people migrating, or modernising, or socioeconomically disadvantaged (1988, p. 252). Often, she argues, what links these groups are “psychosocial variables” such as life events, family and environment, anxiety, depression and quality of life (1988, p. 253):

A population exposed to stressors that tax the physiological system may be at greater risk for stress-related disorders. Best described as a threshold effect, the physiological responses to psychological stress would push the individual who is at risk closer to a threshold for manifesting the disorder. Relative degrees of psychological stress and biological risk vary among individuals. Therefore, individual biopsychological responses to the environment are of interest, and part of the interest must focus on social conditions (1988, p. 254).

In comparison to Scheder's study on the similarities between groups of people with diabetes, medical anthropologist Michael Stoltzfus' study researched how individuals cope with being chronically ill while being treated within mainstream clinics (2013, p. 3). He tells us that medicine has developed so that some people with chronic illness can now live with their illness and that it has become an intrinsic element of the ill person's life (ibid). Stoltzfus argues that the biomedical approach to disease is to eradicate the illness from the person's body and considers a person to be healthy once the disease has left the body (ibid). Chronic illness, such as diabetes, however, is a permanent feature (or at least long-term) and those who are affected must learn to combine their illness within their "sense of personal, social, medical, and self-identity" (ibid). He says that the aim is not to cure the person, but rather to initiate a process for the ill person to learn to live with their illness through both biomedical and spiritual healing. This way of healing incorporates spiritual aspects, however, it remains focussed on the individual which is an inadequate method of healing in Yidiyi as health and healing is socially connected to living and non-living elements.

In Stoltzfus's view, people studying those living with chronic illnesses have contributed to a more holistic understanding of health within the biomedical framework (2013, p. 6). There is more focus on the spirituality of a person and how the individual connects themselves to their surrounding environment (ibid). Stoltzfus explains that the view of connecting the spiritual to the physical body is new. This is because, within Christianity, the spiritual person is categorised as separate from the physical. He explains that this is because the spirit is seen as sacred, interior and private (2013, p. 12). He argues that the categorisation of the spirit and body as two separate entities has restricted biomedical care, as it fails to concern itself with the whole person in "his or her spiritual or cultural understanding of healing and suffering" (2013, p. 13). Therefore, it is difficult for the chronically ill person to prepare themselves for the emotional, spiritual and social toll their disease may have if they seek it solely through biomedical care. Due to a lack of cultural awareness, most mainstream clinics in Australia focus predominantly on the body (Wendell, 2001, p. 27). Therefore, arguably, the majority of patients' experience of being chronically ill, is that while being treated through mainstream biomedical care they cannot

receive holistic care due to underfunding (Frank, 1991; Stoltzfus, 2013, p. 3; Wendell, 2001, p. 27).

Social theorist, Michel Foucault explains that biomedicine developed from understanding the body through objectifying it as opposed to treating it subjectively (1963, p. 27). One of the most well-known critiques of biomedical care is attributable to Foucault (1973) in *The Birth of the Clinic: An Archaeology of Medical Perception*. Foucault argued that biomedical care traditionally objectifies the patient because physicians originally classified disease, as they did the classification of plants, as part of natural creation (1973, p. 6). The similarity being that both were categorised. Illness in particular was disengaged with anything but the physical. As a result, the physician was interested in treating the illness rather than the whole person within their social environment (1973, p. 86). Through the objectified analysis of the body, the field of knowledge of the body developed and allowed for a hierarchical power relationship between the ill person and the doctor (1973, p. 98). The knowledge of the ill person, then, was made subordinate to that of the medical practitioner. The patient became vulnerable within the social structures and institutions in which they live. Foucault argues that the clinic is a form of governmentality connected to larger social and political structures, as it encourages the individual person to promote their personal physical health in order to function as a working person in society (1973, p. 103).

Thus far, the literature indicates that diabetes affects the Australian Aboriginal population as if they were in a developing country (Dunstan, 2002, pp. 828-829). From a biomedical perspective, the literature suggests that diabetes affects people who make unhealthy diet choices. A more complex understanding of the illness, however, implies that it is a stress-related disorder, most commonly found in lower socioeconomic groups. Largely, people living with chronic illness, such as diabetes, have contributed an awareness to a more holistic form of treatment within mainstream medical care. This is because chronic illness becomes part of a person's life and holistic treatment assists in how that person copes with their illness on a day-to-day basis.

Treating Australian Aboriginal peoples for diabetes within a biomedical care model

This short section indicates that while health care systems are government run, it is a challenge to integrate Aboriginal health beliefs into mainstream medical systems. As continually suggested by scholars, funding needs to be injected into community clinics to support community control and cultural programs that develop holistic medical care and establish and maintain positive relationships to be established and maintained between Aboriginal and non-Aboriginal people.

Those who advocate for holistic healthcare suggest that all people, regardless of ethnicity, should receive holistic care which is culturally relevant. For example, development researcher, Anne Lowell explains that as well as health care being culturally relevant it also needs to be provided with community control (1998, p. 11). Medical anthropologist Eric Seathre wrote that at the beginning of his fieldwork with the Warlpiri people in 1996, he witnessed the clinic's conversion from one that was a government institution to one that was community controlled (2013, p. 137). However, when he returned in 2009, it was reverted back to being predominantly run by the government. Warlpiri people stated that they had little or no control over the services that were offered and Aboriginal Health Workers generally chose to remain unemployed as they felt they were not valued in the workplace (ibid). Despite the eleven year difference between articles, both Lowell and Seathre explained that the attempts at community-run programs they researched fail to work as a result of a lack of funding and investing time in longer consultation and cultural training for non-Indigenous people (Lowell, 1998, p. 11; Seathre, 2013, p. 137).

Anthropologists argue that for health to improve in rural Aboriginal communities, funding needs to go towards cultural orientation programs for non-Indigenous people to become knowledgeable on *local* Aboriginal culture, to focus on building strong relationships between Aboriginal and non-Aboriginal people, and for the inclusion of culturally specific and clan-based health beliefs and practices into local medical centres (Lowell, 1998, p. 10; McMurray, 2005, p. 351; Selin, 2003, 181).

The importance of Indigenous knowledge

Aboriginal Indigenous researcher, Lester Rigney, recommends utilising “Indigenous philosophies, ideas and imagery” (1999, p. 9). Doing so, states Rigney, “makes intellectual space for Indigenous cultural knowledge and systems that were denied in the past” (Rigney, 1999, p. 9). For example, welcoming discussions on people’s Dreaming stories and being open to learning different social systems, while acknowledging them as integral, precious components of local people’s lives. Research done in this way respects Indigenous people and contributes to forming respectful relationships by acknowledging different ways of thinking and living, which in turn, may contribute to overcoming ill health.

An Aboriginal perspective of biomedical treatment

Similar to Scheder’s argument that diabetes is caused from psychosocial stress, Flick and Nelson explain that for Australian Aboriginal peoples, preventing and regulating diabetes is also part of dealing with the continual psychological effects of a colonising past and arguably the present (1994, p. 5). As discussed above, colonisation is still prominent in Australian society and can be found in government policy, processes and institutions.

In terms of every-day experience, Indigenous anthropologist, Gillian Cowlshaw found that the local people of Bourke in the Northern Territory interpreted their experiences as “white cultural hegemony” (2006, p. 434). One Aboriginal man told her, “They’re the one’s that’s got the problem, cause they’re trying to change us to fit into their society. Where this country belongs to us, they should be fitting in with us” (Cowlshaw, 2006, p. 434). Actions and reflections such as these expressed by Aboriginal peoples can be interpreted as “powerful expressions of Indigenous identity” (Seathre, 2013, p. 5). Seathre argues that they are acts of defiance and rejections of vulnerability within the mainstream structures Aboriginal peoples live in (ibid). The acts of resistance appear to be a matter of personal choice as they are often the minority of the marginalised group.

In their effort to understand diabetes and risk among Australian Aboriginal peoples living in Melbourne, medical anthropologists Samantha Thompson and Sandra Gifford found that people understood insulin dependant diabetes as a result of “living a life out of balance, a life of lost or severed connections with land and kin and a life with little control over past, present or future” (2000, p. 1457). Managing diabetes, as advised by the clinic, did not match the unpredictable reality of everyday life. This is because, health advice was to tend to a person’s individual health and was not conducive with the demand of attending to family (2000, p. 1465). Attending to health needs was not a person’s main priority. These findings showed that the person was connected within the social whole, particularly within the family unit. This was demonstrated in my research also.

The theme of family and relationships was key in Senior’s, work in understanding health beliefs and behaviour in an Aboriginal community in Arnhem Land. Senior found that the people who participated in her fieldwork understood health as “more akin to a good feeling of well-being and is influenced by relationships and family” (2013, p. 163). For example, one man she talked to said being sick was a burden on the whole family, not just the individual. He said, “If someone told me that my brother or sister had cancer then the whole family would be sick with worry” (Senior, 2013, p. 161). It was also a theme in the work of anthropologist Francois Dussart’s, who specialises in Aboriginal women’s studies. Dussart described her experience with the Warlpiri people, and said that being sick was a burden on the person because they were unable to fulfil their social obligations (2010, p. 80). When this occurs, she found that a person’s freedom is lessened because they have to ask people to care for them and in doing so removes them from social life as they can no longer give (ibid).

Dussart summarises the necessity to look after oneself through biomedical care to involve “clinical surveillance and self discipline” (2010, p. 80). To individually care for yourself in this way is contradictory to the social life of the Warlpiri people she worked with in Northern Territory. When Dussart asked a woman how regularly she took her medication for diabetes, she explained that at times she was socially obligated to visit family in a different town for lengthy periods and could not get treatment at another clinic and had to

wait till she returned home, but she said she “cannot just stay home...I have to decide for myself...I am boss for myself” (2010, p. 81). This means she can not make her social decisions based on her current health care programme. Through her experiences, Dussart explains that the result of biomedical care “is a neo-colonial condition that undermines personal autonomy and social connectedness” (2010, p. 80). An Australian Aboriginal person’s perception of their health is then renegotiated within Aboriginal social life and the past and current effects of colonialism.

Anthropologists living in Aboriginal communities or working with Aboriginal peoples in urban areas, indicate that they believe that biomedical care is problematic for only the Aboriginal population. As discussed above, there is a general concern that for healthcare to improve there is a need to holistically treat *all* people who are chronically ill rather than approaching health care with the perspective that the spirit and physical body is separate from one another (Frank, 1991, p. 18; Stoltzfus, 2013, p. 3; Wendell, 2001, p. 22). The biomedical model as a whole is, therefore, a broadly contested structure within medical anthropology.

It appears that there are two explanations as to why diabetes is higher within the Aboriginal population when compared to the non-Aboriginal population. Firstly, Aboriginal peoples have a higher rate of disease because of the ongoing psychosocial and emotional effects of colonialism within mainstream social and institutional structures. However, programs implemented in Aboriginal communities that attempt to decrease the rise in diabetes continue to be ineffective due to misunderstandings, a general lack of training in Aboriginal culture, and embedded dichotomies of what the healthy body looks like, which contribute to relationship breakdowns and ineffective health systems for Aboriginal peoples. It appears that the focus on the individual is so culturally ingrained in mainstream medical training that it is difficult to think beyond this concept. Through reading the literature, combined with my observations of living in Yidiyi, I knew that there were social aspects, such as demand sharing and sorcery, that were prevalent in the community. I therefore wanted to gain more of an understanding of these two areas from the literature and how they may contribute to Aboriginal perspectives of diabetes and wellbeing.

Demand sharing

Sharing of favours and material objects is a part of traditional Aboriginal culture. Academically, it is referred to as demand sharing. In explaining demand sharing, scholar of Australian Aboriginal societies, anthropologist Lester Hiatt, writes that in Aboriginal Australia

...the highest secular value is generosity. Readiness to share with others is the main measure of a man's goodness, and hospitality an essential source of his self-esteem...and is the outcome of a programme of moral education in which greed is condemned and magnanimity extolled (1982, pp. 14-15).

Renowned anthropologist, Marcel Mauss discussed social theory based on reciprocal exchange in his seminal text, *The Gift* (1954). Mauss illustrates how, in various hunter-gatherer societies there is a reliance on exchanging objects for the survival of the group and to build on social relationships and solidarity. Similarly, Ingold explains that in hunter-gatherer societies, the act of sharing is imperative for the “survival and reproduction of potential producers” to “ensure the perpetuation of society as a whole” (1980, p. 145). In his analysis of demand sharing, Aboriginal economic policy researcher, Jon Altman points out that it was not until 1993 when demand sharing was given “critical clarity” by central figure in the anthropology of Aboriginal Australia, Nicolas Peterson. Demand sharing was claimed to have been a continual social form of reciprocal sharing from the hunter-gatherer era. One of its important aspects was to always give to those in need (Peterson, 1993, p. 862). In the context of this analysis, I wanted to see how maintaining social relationships through demand sharing may have an effect on my participants’ diabetes.

In 2011, Altman discusses the current form of demand sharing in Australian Aboriginal culture as demanding items that can be lived without but are demanded for when “surpluses seem visible”, such as cigarettes, or food items which are demanded from kin, even if just after the person requesting has spent all of their own money on card games¹¹ (2011, pp.

¹¹ I often see groups of people (anywhere between 5-20) sitting outside of houses playing cards. On one occasion a work colleague of mine won \$5000.

188-193). However, it still serves the same purpose as it builds social relationships and confirms the solidarity of the group. Seathre observed how people avoid demand sharing. He found many people he spoke with chose to eat at the local fast food store even though they had diabetes and knew this type of food was bad for them, to decrease the risk of kin asking to share large grocery orders with them (Seathre, 2013, p. 50). This was because a person could leave the fast food store with enough food for one person and easily say they did not have money to buy for others. This demonstrates that, strategically avoiding demand sharing, means a person is not seen to be intentionally removing themselves from the social economy and therefore they can still be thought to be willing to fulfil their social obligations, if only they had the means.

Sorcery

Sorcery was also linked to social causes. The topic of sorcery arose in the literature as a contributing factor to Aboriginal ill health and diabetes in particular. Dussart's fieldwork with the Warlpiri people, found that recognition of the biomedical cause of diabetes was acknowledged as coming from "white people's lifestyle" or "too much sugar" (2010, p. 78) while the symptoms of diabetes were explained and experienced differently. When she asked a group of three Aboriginal women about their diabetes, for example, they explained that diabetes did not "come because of sorcery", although, the symptoms were attributed to acts of sorcery (2010, p. 81). Dussart interpreted this to be that the physical symptoms were not focussed on the individual body, rather, how a person complied to local cultural obligations and interactions with the spiritual world. For example, one woman said the pains in her back were from an act of sorcery when the driver in the car she was in went down a road in another clan's country that was prohibited due to a person passing away. Her pain has continued since (2010, p. 82).

Emotion

Illness among Aboriginal peoples is self-diagnosed through the assessment of personal feelings and reactions to medication (McDonald, 2006, p. 91; Seathre, 2013, p. 170; Senior, 2013, p. 171; Thompson & Gilford, 2000, p. 1472). Aboriginal anthropologist, Heather

McDonald explains that feelings are relational and depend on a person's engagement with the world through "sight, hearing, touch, smell, taste, feelings and dreams" (2006, p. 91). Senior had similar experiences and observed that the clinic was completely removed from the lived reality of community members and therefore, when people visited the clinic, biomedical explanations were not "culturally compelling or accurate" (2013, p. 171). Local explanations of health had a greater wholeness because they are entwined with cultural practices and define social relationships (Senior, 2013, p. 171). Self-diagnosis and treatment then was unique to the person within their social life and emotional self.

In researching aspects that I knew were part of community life, such as demand sharing and sorcery, it made me wonder about McDonald's argument that feelings are relational (2006, p. 91). I wanted to find out more about the anthropology of feelings, the senses and how these might illuminate Aboriginal perceptions of health and wellbeing in Yidiyi. According to Rosaldo, emotion is a cultural construct (1984, p. 140). She informs us that the anthropological study of emotion seeks to understand how the burdens of sociality contribute to the making of an individual (ibid). Emotions then, says Rosaldo, have a psychological connection to cultural life and society. The effects of the interpretations are always culturally informed in such a way "in which the actor finds that body, self and identity are immediately involved" (Rosaldo, 1984, p. 141). What and how then, do the emotions caused by, for example, demand sharing and sorcery, have an affect on the ways in which a person interprets their diabetes emotionally?

Humans and the environment

If feelings and emotions are a cultural construct and connected to the body and environment, I wanted to find out more about how I could go about engaging with my participants, since we are culturally different. According to Stoller, anthropology became more engaged with the senses after Bronislaw Malinowski's (1915-18) fieldwork with the Trobriand Islanders. He tells us that Malinowski focussed on writing ethnography with the intention of giving the reader a sense of his experience, placing emphasis on what he heard, smelt and touched (1989, p. 8). Although this was a positive move towards engaging with

the senses, Stoller argues that Malinowski's writing was still from a Western, rationalist, pragmatic position (ibid). Drawing on the phenomenological work of Maurice Merleau-Ponty, he argues that by thinking operationally we have lost "much of the substance of life-in-the-world by defining rather than experiencing" (1989, p. 92). Consequently, we have become further disengaged from our environment.

Stoller takes his readers on his anthropological journey into the realm of the senses, in *Sensuous Scholarship* (1997). He recommends that for anthropologists to truly immerse themselves in their fieldwork, they need to explore senses, such as taste, hearing, textures, and pain (1997, p. xiv). He is influenced by Richard Rorty's critique of Western philosophy, that we engage and communicate with the world and each other through rational and practical senses (1997, p. 3). Consequently, Stoller argues that Western philosophical knowledge has been mostly disembodied (ibid). During his fieldwork with the Songhay people, he found that a Songhay person's experience with the world was led by smell, taste and sound and are the main contributors to a "knowing of the world that is fundamentally embodied" (ibid). For example, Songhay sorcerers and griots learn about power and history by " 'eating' it - ingesting odors and tastes, savouring textures and sounds" (ibid). Stoller calls for a "sensuous scholarship" which would involve a more engaged, lived and embodied scholarship that would help us to better understand non-Western societies and "resensualise us" to become more interactive with our senses and environment (p. xviii). His analysis of the senses was particularly useful for me in understanding different treatment methods for diabetes.

I found Ingold's (2000) "dwelling perspective" practical in understanding the Aboriginal perspective of health. Particularly in terms of emotions, feelings and senses in relation to the different ways my participants treated their diabetes. His work complemented Stoller's in that he believes Western culture separates people from their environment. According to Ingold, this concept removes humans from nature making the relationship dichotomous. The cultural development categorised humans as having culture (2000, p. 148). His alternative is influenced by indigenous cosmologies and ontologies, where humans should be perceived as different organisms acting in ways that are biologically suited to their

environment. In this regard, humans do not exist as cultured beings, but as biological organisms. The social relationships that take place within the landscape are a result of different perceptions of the environment and different ways of working with the tools around them. For Ingold, the “dwelling perspective” involves acknowledging lives who have dwelt within the landscape before us, who have contributed to its formation, and have now left a part of themselves in the landscape that is dwelt in (2000, p. 189). In order to do this, Ingold asks us not to prioritise culture, as people primarily understand their world through their everyday interaction and involvement with the world. Although Ingold does not specifically discuss healing, this theoretic approach was particularly useful when comparing Western and Aboriginal perceptions of the body and methods of treatment. This is because the “dwelling perspective” exemplifies the interconnectedness of social structure, land, relationships, and healing.

Ingold asks us to acknowledge that people understand their world through their everyday interaction and involvement with the world (2000, p. 189). In other words, the very act of practice and interacting with our environment is dwelling. Through practical participation with those who dwell on the land, the anthropologist can seek to understand the land, the story, and human-environment relationships specific to place. For me, it was through living in this community, visiting locals country with them and listening to my participants’ stories that I gained an understanding of human-environment relationships through the topic of diabetes.

Ingold states that “skilled practice” is “a form of use, of tools and of the body” (2000, p. 343). It is not a property of the body but can be applied to an active and progressive system which the body is engaged in. Skill is, therefore, physical, mental and physiological and involves “the total field of relations constituted by the presence of the organism-person. Indissolubly body and mind, in a richly structured environment” (2000, p. 344). Ingold tells us that “skilled practice” is not applying machines to exterior objects or subjects to achieve an outcome. Rather, it needs to involve human qualities such as care, dexterity and judgement as each context that “skilled practice” is used in varies and is constantly shifting (2000, p. 345). In order to progress and learn, it is the activity of

engagement, of regular, controlled movement that generates the form, not the design that controls it (2000, p. 347). The “dwelling perspective” was useful for me to understand that a person’s wellbeing is connected to social and environmental relationships. His theory on “skilled practice” was practical to my research to, first, recognise how local people understand and treat their diabetes. I also used “skilled practice” as a tool to illustrate local understandings of Western medicine and treatment.

Ingold’s theory was also similar to Indigenous researcher, Norman Sheehan’s work, “the Indigenous knowledge approach” (2011, p. 68). In summary, Sheehan describes this as coming to understand the culture’s different layers and diverse ways of knowing in correlation with natural systems (2011, p. 68). I found this interesting as this perspective was also similar to Michael Jackson’s (1995) research with Aboriginal peoples. Sheehan says that, the approach acknowledges that natural systems play an integral role, in which humans are as “alive and active” the same way as all other components of the environment and that this is one way in which we are connected together (2011, p. 69). This view is also similar to ecologist, Fikret Berkes’ approach to sustainable ecology. Since the 1980s, Berkes’ term “traditional ecological knowledge” came into widespread use by Western ecological systems. Berkes claims that, ecological management has moved towards a broader holistic view, which “provides a vision of the earth as interconnected relationships” (1999, p. 4). This is a positive, yet “radical departure from the static, mechanical, disembodied view” of the world, which was formulated as the dominant Western worldview developed during the Age of Enlightenment (Berkes, 1999, p. 5). Sheehan argues, that because of the extreme diversity in cultural views associated with the relationships between man and nature, we (Western people) can never fully understand the implications of any action; thus, the Indigenous knowledge approach is about showing care and awareness of cultural difference in the way we “identify, explore, and assess meaning” (2011, p. 69).

Taking an Indigenous studies focus

I found that the literature was leading me towards either a medical anthropology or an Indigenous studies approach. I decided to focus on the latter although a lot of my thinking is based within the scope of medical anthropology. Medical anthropologist, Merrill Singer tells us that medical anthropology seeks to understand how global, historical, and political forces shape how an individual experiences and understands their health and illness (2011, p. 1). The processes, she states, “are all heavily influenced by social and cultural factors” (ibid). This thesis aims to answer these questions when seeking to understand diabetes in Yidiyi and has contributed to my thinking, particularly in terms of power structures and the cultural experience of illness. Although, after researching Indigenous methodologies (which I will discuss in depth in my methodology chapter), I decided to take the focus of Indigenous studies.

George Sefia Dei tells us that Indigenous studies is

the search for ‘epistemological equity’ through reclamation of identity, knowledge and politics of embodiment; and discusses how knowledge about our own existence, realities and identities can help produce a form of knowing legitimate in its own right and able to contest other ways of knowing (2008, p. 5).

Although a medical anthropological focus would have worked throughout this thesis, Indigenous studies (Aboriginal studies more specifically) helped me to center on the ways in which cultural differences contribute to an understanding of the tensions produced by the historical relationship between Indigenous Australians and non-Indigenous Australians. I have thus focused on researchers with an interest in Aboriginal epistemologies and ontologies and medical anthropology. A focus on Indigenous studies also ensured my participants were at the forefront of my research at all times.

Conclusion

This literature has been useful in the development of my understanding of diabetes from a biomedical and Australian Aboriginal cultural perspective. Biomedicine appears to be moving towards a more holistic approach in Western and Aboriginal healthcare contexts in that broader aspects of people's lives (social, economic, emotion and culture) than the physical body alone are being taken into consideration when treated for illness. However, in regards to Aboriginal communities, biomedical care seems to be stuck in terms of how to integrate it in a culturally appropriate way. Some anthropologists argue that assimilation attempts to integrate biomedical care into rural Aboriginal communities and is a contemporary form of colonisation. This accusation seems radical but appears consistent when analysing how non-Aboriginal mainstream social structures and ideals dilute Aboriginal people's identity. The literature points to a general understanding that the Aboriginal perception of health and wellbeing is emphasized in correlation with the Aboriginal person's capacity to function within their local social system. As all Aboriginal communities are different, my own research will not necessarily reflect similar ethnographic work in other Aboriginal communities. They are, however, useful sources of information, which have provided guidance in my own research.

The literature also showed that Aboriginal peoples are renegotiating the impact of colonialism. Characteristics specific to Aboriginal culture, such as demand sharing and sorcery, appear to be being reinvigorated to adapt to current, local, and social circumstances. This is why this research is needed in this community. It is a starting point to understanding health in this particular social context and is a way for local people to express their understanding of health and their illness within their cultural milieu.

Chapter Three

Methodology

Introduction

In the previous chapter I explored the notion that, since colonisation, Western science has been the predominant knowledge system which functions in all aspects of Western life; from politics to government policy, education through to medicine, and is therefore, inevitably circulated in social norms and thoughts. This has meant that Indigenous peoples have been colonised, and arguably still are, even through alienating and objectifying Western research methods (Tuhiwai-Smith, 1999, p. 45). Attempts to resolve Indigenous concerns have predominantly been analysed through a Western-centric lens and the outcome is often irrelevant to Aboriginal peoples. The results of programs that are designed for the benefit of Aboriginal peoples are inherently motivated to resolve and progress communities through “quick-fix” solutions and, therefore, frequently fail to focus on local processes and long-term community benefits (Anderson et al., 2012, p. 5; Jordan, 2005, p. 55; Rigney, 1999, p. 119). Aboriginal peoples may be left in disempowering positions to the point where, at times, regaining control is almost impossible through Western cultural paradigms. For non-Indigenous researchers, such as myself, I am aware that it is imperative that any research be done *with*, and not *on*, Aboriginal peoples and that research endeavors to understand the research question within Aboriginal culture, protocols and knowledge systems. It was my aim to follow culturally relevant processes. This chapter will discuss my thoughts and processes as I came to understand culturally appropriate research methods suited to Yidiyi. The methods I used are positioned within Indigenous methodologies and were the most culturally appropriate to Yidiyi. I also aimed to empower the community members involved in this research project through my research practices.

The methods I chose have been a considered process, academically and emotionally. The process began at the beginning of 2013: my Honours year. After living in Yidiyi for a few weeks and doing some background research on the area, I thought that doing a research

paper on women's use of kinship terms would be interesting. My supervisors informed me that conducting research with Indigenous peoples had to be well thought out, particularly the methods chosen to approach any research topic. I began by reading the Massey University Human Ethics Committee (MUHEC) code of ethical conduct; The Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS) (which is a similar document to the MUHEC guidelines but specifically designed for Aboriginal and Torres Strait Islander peoples), and researching into Indigenous methodologies. AIATSIS focusses on having knowledge of the culture the researcher is working with before research is carried out (emphasising aspects such as self-determination, Indigenous knowledge, appropriate consent, consultation and research outcomes that are locally beneficial, and the active engagement of community members). While I was reading, I approached three local women I had recently met and they were all happy to take part in the project. I had one more person to approach and I presumed research was underway. When I asked this person, her response made me realise that it was not the right time for me to initiate research. I approached her during work hours and explained my research topic to her. She looked at me as though I did not know what I was talking about and I felt as though she perceived my presence as an 'almost-stranger' and that it was rude to be asking her to take part in something without us knowing each other. This may have partly been a result of the language barrier, but I felt rude, imposing, disheartened, and confused. I discussed this with my supervisors and we decided to shift the focus of the research. I was relieved.

My 60 point Honours research paper was now split into two sections. The first section was a literature review on how I would approach research ethically in this community by comparing local protocols with current literature, in particular, Indigenous methodologies. Knowledge on Indigenous methodologies gave me a strong base to work from for this Masters research project and will be discussed in depth shortly. The second section was a life story of a Catholic nun, Sister Annie, who has lived here sporadically for thirty years. My aim was to find out how she has found her place in the world, and to analyse her connectedness with the community as a non-Indigenous person. The experiences she shared with me gave me some insight into the type of connections and relationships local people have with their land and each other.

During my Honours year, I gained the adequate research experience and cultural insight to conduct my Masters here. My research project prepared me to feel confident about researching ethically within an Aboriginal community. One of the reasons for that was that the year I spent here before I began my Masters gave locals time to feel comfortable around me, and also for me to feel comfortable in a new environment, so different to what I was used to. As a result, I feel that the relationships I have formed have not been forced for the purpose of research. Small formalities in the staffroom developed into longer chats about the day, to conversations about each other's families, to listening to Dreaming stories, locals experiences in their country or totemic land sites and visiting some people's country with them and their family. These experiences helped me to feel prepared to begin research with local participants. Below I will discuss the key methodological approach and methods I have adopted for this research.

Indigenous methodologies

The most significant point I have taken from Indigenous methodologies, is the need to be critically aware that Indigenous people's social structure and knowledge are not the same as Western models and that most research practices are derived "frameworks, processes and practices of colonial, Western worldviews and their inherent knowledge, methods, morals and beliefs" (Martin, 2001, p.2). Therefore, for research to mean anything for the Aboriginal people in Yidiyi, my research question needed to center on an Indigenous research agenda which situated Indigenous needs and goals at the forefront of research in the aim of decolonising research (Tuhiwai-Smith, 1999, p. 127). Decolonising research is about positioning Indigenous concerns and worldviews at the center of research in order to come to know and understand theory and research from Indigenous perspectives for Indigenous purposes (Chatterjee, 2001, p.1; Tuhiwai-Smith, 1999, pp. 39-40). Indigenous knowledge and theories challenge the hegemony and power structures inherent in Western theory production (Pillai, 1996, p. 218). Therefore, as a non-Indigenous researcher, I need to challenge the idea of hegemony. To do so involves

understanding colonial history, and ensuring that research has practical applications that empower and liberate the people through practical and ameliorative results, which, in contemporary Indigenous contexts means engaging in the decolonisation agenda (Ermine et al, 2004, p. 15).

In undertaking this responsibility, there were a number of considerations I needed to take in my methodological approach, in this community, as a non-Indigenous researcher, and they are as follows.

Neutralising power

Firstly, I am aware of my place in the community (as a tertiary educated, white, middle-class female), and of the possible uneven power relationships that my identity may create, regardless of colonialism. Colonialism is often celebrated as a pioneering movement and a relic of the past. As discussed in my literature review, for Indigenous peoples, the evolving future is still largely singular, particularly in terms of health (Minnich, 1990, p. 53). Western ways of knowing has subjugated Indigenous culture through layers of systems and power (Battiste & Henderson, 1998, p. 23; Reid & Robson, 2000, p. 5). Consequently, areas of power are not only structured into societies' systems, but in our everyday actions, interactions, and even thoughts. As a result, I could never eliminate issues of power in the broad societal sense. However, as I am aware there are uneven power relationships present, I aimed to work towards making these more balanced within my research. I established local members' "interests, knowledge and experiences" (Rigney, 1999, p. 119). To do this, the initial step I made to discuss issues of concern related to health in the community was with the local Indigenous leadership team at my workplace and also other community members. Initially, I assumed otitis media, a common ear infection, was going to be a topic people wanted to discuss. However, I found that through my conversations, diabetes was a more prominent health concern with the local community.

This shifted my research somewhat. However, I still had the same aim, which was to place participants' histories, thoughts, and beliefs at the center of my discussions. Continual and open communication, during interviews or day-to-day conversations, endeavoured to create what Indigenous researchers Norman Denzin and Yvonna Lincoln refer to as the "ethical space" (2000, p. 1048). They describe this space as a neutral zone that is extremely delicate but an opportune space for, "critical conversations about democracy, race, gender, class, nation, freedom, and community" (ibid). I wanted to find the physical space that provided the best "ethical space" where my participants felt the most comfortable. In Yidiyi, finding the physical space that was best suited as the "ethical space" has spacial limits as there are few neutral spaces for a number of reasons: there are no cafes, sitting on grass areas would mean a lack of privacy; as would visiting people's homes due to most houses being overcrowded. This left me with either the school, where I spoke with a number of people who worked there, or my home. However, I opted not to offer to interview people at home as often when you invite one person they bring at least four other people. No participant offered it as a suggestion. Considering the possibility of possible power imbalances frequently adds to ensuring trusting relationships between Indigenous and non-Indigenous people and is crucial in all ethnographic work (ibid). I did this through reflection in my personal journal (which I will discuss shortly) and conversations with my supervisors.

Local Aboriginal culture

In order for Indigenous methodologies to be effective, gaining an understanding of local Aboriginal culture in the early stages of research and learning through an ongoing process of interaction, conversations, and observations assisted in how I interacted with people respectfully. As well as this, they contributed to how I thought about diabetes during and after my conversations with people.

As I have discussed, part of my Honours year in 2013 was to become well-informed about local cultural protocols. Some of the actions I had to take included, not wearing anything above the knee or revealing too much of my upper body; avoiding long direct eye contact

with men as it insinuates interest; and understanding that you can not speak a person's name after they have passed away and when they have, avoiding the use of the word 'die' as it symbolises the end of someone's life journey (although, I have heard some locals use the word die, nonetheless, I avoided it myself). Practices such as these are physical actions that exemplify what is important within this social system and are symbols of respect that are expected to be followed. I also found that my own experiences talking with local people provided relevant approaches to working with Aboriginal peoples in this community. In 2013, Sister Annie taught me that silence during conversations while talking with someone is equally, if not more important, than talking. Time, the perception of it and the utilisation of it, is culturally diverse (Jance & Bulen, 2003, p. 41). Land, country and the personal relationship local people have with it is often personal, while also connecting families through bonds I have never experienced before (Jackson, 1995, p. 125). These cultural differences and recognition of these cultural differences are a few examples that have been helpful for me not only to approach research ethically, but to understand the culture, community dynamics, and to recognise and make sense of people's actions in their cultural context. I feel my understanding contributed to preventing misinterpretations of what I saw and experienced. This was crucial to my preparation for research here as it highlighted cultural sensitivity and helped me to ensure that ideas and methods were, as much as possible, shaped by my participants.

Narrative interviews

I wanted the interviews to take the same approach. To be led by my research participants. This is why I chose narrative interviews. Narrative interviews can be described as a form of interviewing where "participants engage in an evolving conversation; narrator and listener/questioner, collaboratively, to produce and make meaning of events and experiences that the narrator reports" (Reissman, 1990, p. 1195). As the conversation evolves, both the interviewer and respondent begin to make sense and meaning of what is being spoken. This process produces two-meaning-making participants and allows the researcher to gain more insight into the participants' experience (Gubrium & Holstein, 1998, p. 170). I felt this was the best method to employ as it meant any possible power

relationships between participants and myself were decreased as it positioned myself as learner and contributor. I found that narrative interviews were effective as on three occasions during interviews, two participants told me that they enjoyed their experience of talking with me and one said that the opportunity to talk with me was positive as it was an outlet for them to be able to express their concerns. Comments like those made me feel as though I was on the right track. Especially as, at times, the immense amount of literature about my role as researcher was quite daunting and I felt a huge responsibility to my participants to ensure the research was told from their perspective.

Narrative interviews are also culturally relevant. Indigenous knowledge-sharing, and meaning-making is inherently oral. It is experienced and acted ritually through forms such as dance, music, song, and rock and sand art (Morphy, 2008, p. 3). Oral traditions form the foundation of Aboriginal societies, connecting speaker and listener in communal experience and uniting past and present in memory (Hanson, 2009). Until recently, Western discourse has prioritised the written word as a preferred method of record keeping (Hanson, 2009). However, Aboriginal researcher, Maureen Simpkins praises the importance of utilising Aboriginal oral tradition as a decolonising approach and process (2009, p. 243). She describes Aboriginal storytelling as a learning experience for both the listener and speaker and a healing process for an Aboriginal person and/or community as it promotes traditional expressions and Indigenous knowledge (2009, p. 243). It made sense to me then, that my participants enjoyed telling me their stories and experiences with diabetes. I felt comfortable that, although I was not making a huge difference to people's lives and healing, I knew I was respecting their local healing methods through genuine interest and, therefore, not adding to the uneven power relations that has arisen from colonial research.

Although I wanted the participants to lead the conversation as much as possible, I was still inquiring about a research question and, hence, needed to ask probing questions. I prepared a set of possible questions that would allow me to understand the participants' illness in their cultural, social and historical context. I followed psychiatrist and medical anthropologist, Arthur Kleinman's set of questions designed for his patients with chronic

illness as a guide to shape my own, relevant to the topic of diabetes in this community.¹² Kleinman discovered that illness narratives needed to be contextualised and explains that each participant has an individual story and experience. Through the story, the patient “enmeshes the disease in a web of meanings that make sense only in the context of a particular life” (Kleinman, 1995, p. 14). Illness, states Kleinman, “acts like a sponge and soaks up personal and social significance from the world of the sick person” (1988, p. 32). By using narrative interviews to understand illness experience, the researcher is able to gain a sense of the participants’ way of knowing or world-making because the interview is led by the interviewed (Shimazono, 2002, p. 7).

I took heed of Kleinman’s discussion and as I have indicated, used a version of his guiding questions modified to be conducive with Yidiyi’s cultural setting and the particular characteristics of the interviewee (1980, p. 106). He advises the interviewer that interviewees may not feel entirely comfortable with the person asking the questions and may hesitate to discuss their beliefs (Kleinman, 1980, p.107). I found on a couple of occasions, my participants alluded to private personal experiences. At times, I felt as though they were open to talk about these but were waiting for a prompt from me. Sometimes, however, I felt it was better to say nothing and allow them to tell me if they felt comfortable to do so.

The questions I used were memorised before I spoke with participants and were also kept beside me. I occasionally looked at them to ensure I had covered them all. I spoke with all participants for approximately 1 hour each and was able to conduct follow-up interviews and have informal conversations with 5 of the 7 participants. Follow-up interviews were not tape recorded as they often only required a short answer and usually occurred at opportune moments. Before asking questions, I always told my participants that the discussion was for clarity in my thesis. I would always write down everything I could remember immediately after our conversation. However, this approach had limitations in that I could not reflect on our conversations, or interpret the conversations differently by

¹² After discussions with my supervisors and cultural advisor, I formed my own set of guiding questions that were locally, culturally relevant. They can be found in the Appendices (Appendix 1).

being a listener, the same way I did for the interviews because I could not listen to the recording.

Observations

As my research developed, I found that a lot of my observations contributed to my fieldwork and the ethnographic descriptions and analyses in this thesis. Living in this community for over two years has provided me with observational data. Professors in public health, Kathleen and Billie Dewalt tell us that "the goal for design of research using observation as a method is to develop a holistic understanding of the phenomena under study that is as objective and accurate as possible" (2002, p. 92). They suggest that observation be used as a way to increase the legitimacy of the study, as observations may help the researcher have a better understanding of the context and phenomenon under study (ibid). Moreover, my observations have contributed to a better understanding of what is happening in the culture and lend credence to my interpretations of the observations (Bernard, 1994, p. 93). They have also provided an intuitive understanding of what is going on in this community and allow me to speak with confidence about the meaning of data (Bernard, 1994, p.355). I am aware that observations are also limited in that I am not truly a part of local culture and observations are interpreted through a non-Indigenous lens. However, in my research, if I did not have my observations as data, I would not have been able to analyse from a holistic perspective within the scope of indigenous studies, as I was able to understand the culture more. After living here for a year, my observations and conversations also gave me some insight into who had diabetes while also feeling comfortable to talk with people in the community and work colleagues about it. I took the approach to talk with people about the topic of diabetes and my interest in it before I asked people to take part.

Recruiting participants

All participants consented to participate in my research. Not intentionally, they were either people I knew or through a mutual acquaintance. I approached close work

colleagues who I knew had diabetes through passing conversations. I told them about my research project and then asked them if they would like to take part by having a conversation with me about their diabetes for about an hour. I told them I did not want to pressure them and to feel free to talk about it with family first. Most people only took a few moments to say yes. Marie spoke with her husband first and Tjitjawu decided to speak with me once he knew I had spoken to other people with diabetes. I was hoping this approach would develop into a snowball effect (Bernard, 2006, p. 193), although, I found that people did not want to suggest other people who had diabetes in case they did not want to be approached. Initially I was hoping to have at least three more participants. However, I was content in knowing that my key participants trusted me which was important to me because of the historical distrust resulting from colonisation (Tuhiwai-Smith, 1999, p. 1). The following small excerpts contain a little background information on the key participants.

Key participants

Marie is 60 years old and has had diabetes for “a long time”. She has been employed in the community for most of her working career. Marie had an experience where her long term employment at the clinic was terminated abruptly. I found that the termination of her employment had a significant impact on her overall experience with Western health care. She told me that the reason why she wanted to talk with me was because she wanted “the truth to be told”.

Mary is 57 years old and has had diabetes for 10 or 15 years. She is not from Yidiyi but a small town approximately 200km away. She moved here after separating from her first husband as “he was no good” and is now married to a man from Yidiyi. She is the eldest of six children, all of whom are still living in her hometown. Although in another town, she still sees her siblings regularly. She is a good humoured woman, and known for her laughter.

Melissa is 47 years old. When she was younger, she moved to Adelaide and lived with nuns for a period. It was there that her English improved significantly, resulting in her later employment as a translator. She has never been married and has no children. She is an open and positive woman. Melissa has only recently found out that she has diabetes.

Mangul is 60 years old. She has had diabetes for about ten years. Three of her six siblings have passed away due to diabetes and rheumatic heart disease. They were all only about 20 when they died. She is from the same country as Tjitjawu. She has one son and five grandsons. I describe her as smart, strong minded, thoughtful, caring, and humorous.

Karbanni is a cheeky woman with great facial expressions. She is always laughing and we have great conversations together. She is 55 years old and has had diabetes for about five years. In 2013, she became severely ill and needed to take a month of sick leave as a result of her diabetes. Sadly, during this research project, Karbanni's husband passed away.

Pinpirrith is 60 years old and has had diabetes for about 13 years. Her English is very good and she is also fluent in the seven other dialects spoken in the community. Upon request, she also writes down songs for people in local bands who are not able to do so themselves. Pinpirrith was diagnosed with breast cancer five years ago, which also meant her work needed to be put on hold.

Tjitjawu (pronounced Chichawu) told me he was born in 1968. When I asked his age, he responded by saying he was 30, 40 or 50 (he is 47 if the year of birth is correct). He grew up in his mother's country and moved there when he was somewhere between 7 and 14 years of age. Although he did not have much schooling within the Western education system, he has a broad and deep knowledge of his land and culture. He is incredibly amusing and a joy to be around. He has had diabetes for "a while now".

Fieldnotes and journal

Throughout this research I kept a journal and wrote fieldnotes as a way to maintain and record my reflective process. Clifford Geertz tells us that as the anthropologist immerses themselves in daily community life and routines that meaning emerges through regular conversations and observations (1973, p. 18). As I lived, understood and reacted to experiences, they were documented in my fieldnotes and also used as a critical reflective process as meaning emerged and revealed itself (Emerson, 1995). Geertz describes this experience as documenting social discourse as it is encountered. The anthropologist is

inscribing social discourse; the anthropologist writes it down. In doing so he turns it from a passing event, which exists only in its moment of occurrence, into an account, which exists in its inscription and can be reconsulted (Geertz, 1973, p. 19).

My daily routines and encounters were written down frequently and reflected on in terms of what I was learning about the participants' daily lives.

My journal was also a personal record of my own cultural misunderstandings and assumptions. As a non-Indigenous researcher, anthropologist Robert Emerson who writes about the development of ethnographic research, suggests that fieldnotes should aim to preserve Indigenous meaning. To do so, preconceptions must be limited at all times and the researcher needs to become responsive to what others are concerned about, in their own terms (Emerson, 1995, p. 6). I particularly found Emerson's direction useful for Chapter Five. This chapter focusses on the differences between the literature and what locals told me about the importance and presence of Aboriginal healers, in particular. While the literature emphasizes the vitality of Aboriginal healers in Aboriginal communities, this study found no Aboriginal healers in Yidiyi and people in Yidiyi appeared unconcerned about this. Writing in my fieldnotes about the differences between the findings in the literature and those that emerged from fieldwork helped me to process my feelings of confusion. In doing so, I was also able to ensure that the research trajectory was by the participants and not the literature.

Ethical considerations

During my research, ethical considerations were reflected on regularly. Ethics are the values, principles, intentions, personal sense of responsibility, and self definition that guide behaviours, practices, and action towards others (Ermine et al, 2004, p. 15). Respect has been the most consistent way to guide a researcher towards appropriate ethical and cultural etiquette (MUHEC, 2013, p. 7). Tuhiwai-Smith explains that Indigenous ethical codes of conduct serve partly the same purpose as Indigenous protocols, which govern Indigenous relationships with each other and the environment (Tuhiwai-Smith, 1999, p. 121). Ethical considerations needed to be reflected on regularly in order to develop a more nuanced local cultural understanding. Being reflexive is a key research methodology (Dunbar, 2004, p. 18; Tomaselli, 2008, p. 348; Troyna, 1996, p. 6; Tuhiwai-Smith, 1999, p. 138). Tuhiwai-Smith states that “being critical about research approaches, relationships and the richness of data and analysis enables the researcher to maintain and advance stable relationships with families and communities” (1999, p. 138). What she means by this is that Indigenous research can be problematic as the researcher is often “trained” to follow research models that may not be best suited to the community’s cultural protocols. Being critical and questioning my actions on a day-to-day basis ensured that I was constantly asking myself questions about my behaviour, what material I was reading and researching, and whether I was interacting with people appropriately and respectfully and reflecting on my discipline.

A primary ethical consideration is that my research question was of benefit to the community. To ensure this, I gained written consent from a local land owner after a conversation about my research. As mentioned above, I met with the Indigenous leadership team at the beginning of the research process. The team is made up of employees at the local school and, to my knowledge, valued members of the community. All decisions made within the school need to be discussed with a group made up of the non-Indigenous heads of school and the Indigenous leadership team. It was important to me that I spoke with them about my thesis so I could obtain feedback and support. I also

went through a “meet and greet” process with my cultural advisor at the local store with other members of the community, to see how they felt about me asking members of the community about diabetes. Throughout the research process, I continued to discuss my thesis and reflect on my thoughts with participants, my cultural advisor and members of the community to ensure my project and interactions were continually beneficial to and for them.

It was recommended that I had a cultural advisor. I approached Eve. A local woman in her late twenties with very good English, who I was friendly with. She is very much involved with discussion regarding the development of the community and was more than happy to talk with me. Eve and I spent a lot of time together talking about various aspects of her life and the community. We discussed things such as, her family, how she enjoys living in the community, how things have shifted over the years and whether they were positive or negative changes, country, totems, and culture. She also transcribed part of my conversation with Marie who chose to speak in Yidiyindi. As well as forming a friendship, Eve contributed a great deal to my general understanding of community dynamics and culture. The time we spent together was of value for not only my thesis, but personally.

Through conversations and experiences, I found that gaining consent orally was more culturally appropriate than seeking written consent. Initially, I wanted to provide my participants with an option of either reading an information sheet and signing a consent form, or, by listening to me telling them about the research and giving consent orally. I went through the process of writing an information sheet and consent form and showed Eve. She said that most people did not have high literacy skills and would choose the oral option. She said that a few people read well but “talking would be better”. Following Eve’s advice, I provided the research information orally and then gained oral consent from each participant two times during interviews: once, before the interview and audio-recorder started, and then at the end of our conversation, so that I could have it on record. I kept all recorded interviews on my laptop which is password protected and on a USB stick, which I kept in a locked box in safekeeping in my home.

Participants were informed that they had the option to request interviews to be carried out in Yidiyindi if they wished. In this instance, I had planned that either Eve, or a person both the participant and myself trusted (and who was proficient in English) would be present during the interview to translate. It was important for me not to exclude anyone wanting to participate as it may be emotionally disempowering. As most structures within the community are not locally run, for example, the clinic and the local store. Being excluded from a community concern, as a result of not speaking English, would discriminate and further exclude the person as well as contribute to ongoing colonisation (Bishop, 1994, p. 177). Also, not including a person because they do not speak English would mean I would miss out on gaining some additional local knowledge. This person may also experience health differently because they are not proficient in English. They may either feel uncomfortable visiting the clinic and they may not be able to express their health concerns to the people at the clinic, or understand what medical practitioner's advice is.

Maintaining community and participants' confidentiality was also an ethical consideration. This was to secure the community's right to privacy and to prevent any possible negative repercussions this research may bring for both Indigenous and non-Indigenous participants (Mbilinyi, 1989, p. 238). To ensure this, I followed a number of steps. Firstly, I discussed with participants a possible name to use as a pseudonym for the community. No one seemed to mind what name I used, nor had one in mind. I therefore suggested the same pseudonym I used in 2013 for my Honours year, Yidiyi, which was chosen by Sister Annie (also a pseudonym). People were comfortable with this name. Late in the research, I also spoke to Sister Annie about appropriate pseudonyms for all local language terms used in this thesis: *Yidiyi*, *Yidiyindi*, *Yamurr*, *Marl*, *Rith*, and *mingki*. I gave participants the option of using a pseudonym of their choice which was applied in all journal writing and fieldnotes. I also told people before any recorded interviews were conducted that other members of the community may see them talking to me and, therefore, their complete anonymity could not be assured. All participants said that they did not mind if other people within the community knew what we were talking about. Also, five of the participants worked at the same place as I did, so most conversations looked as though we were having lunch together or were involved in a work related meeting.

Conclusion

This research project was based essentially on an Indigenous methodology approach to gain an understanding of diabetes at a local cultural level as a way to highlight the importance of Indigenous knowledge and to empower local community members. It was imperative to really grasp and understand the vital importance and responsibility I had to research appropriately before I began. By using Indigenous methodologies as my guiding methodological framework, I was encouraged to be critical of hegemonic power structures and knowledge throughout the research process. In doing so, I have recognised that there is a cultural divide between myself and my participants and that there was a need to create an ethical space where interactions could develop through respectful engagement. This occurred through dialogue, interactions, involvement and reflection. An Indigenous methodological approach allowed me to further my understanding of cultural systems in relation to natural systems and is therefore central to my analytical and writing approach for this thesis.

My engagement with ethical codes and protocols such as MUHEC, AIATSIS, and personal interactions taught me enough (although I am aware my current knowledge has only just grazed the surface of local Aboriginal culture) to feel comfortable to begin research ethically in Yidiyi. Living in the field, combined with an understanding of Indigenous methodologies, guided me, a non-Indigenous researcher, towards interpreting experiences and observations through a local cultural lens, which attempts to avoid misunderstandings and misinterpretations when understanding diabetes. Further, writing and talking about day-to-day interactions contributed to interpreting diabetes from a lived daily experience more thoroughly throughout the research process. I have understood the weighty responsibility I have as a non-Indigenous researcher and the ethic of care I have for the participants involved, and for the community. It was vital that I interacted with locals from the perspective that is directed from a local cultural understanding. As well as this, I acknowledged and was critical of hegemonic knowledge systems while being aware that my own knowledge is based in this system. It was therefore crucial and valuable that my methodological approach and methodologies navigated me through processes from a local

perspective as much as possible. I move now into the chapters that explore the data I collected by these means.

Chapter Four

Healing diabetes in Yidiyi

Introduction

In traditional Australian Aboriginal culture, health beliefs are based around maintaining a way of life that is consistent with cosmological and ontological worldview. Health is connected to the land, social structure and all living and non-living things. Colonialism, in the forms of governmentality, the influence to migrate and reside in one space, and an introduction to a new type of diet, has undoubtedly changed Aboriginal lifestyle and caused ill health. These three factors have changed and in some cases limited the way an Aboriginal person lives on a day-to-day basis. Diabetes, in particular, has been impacted by colonialism. Local people in Yidiyi attribute this change in lifestyle, (what they refer to as a “whitefella” way of life) as the cause of diabetes. Yet, despite the changes, including the implementation of mainstream Australian medical institutions in Indigenous communities, the local people I spoke with continue to practice their healing methods in tandem with the use of the clinic in some cases.

I have found through my conversations with participants that physical signs of illness is an indication that an Aboriginal lifestyle needs to be reconnected with; a style of living that is beneficial to rejuvenating the spirit and, in turn, the physical body. From conversations and observations, it has emerged that diabetes has been treated by a multitude of Indigenous and non-Indigenous healing methods in Yidiyi. These healing methods will be discussed in this chapter. First, I will provide a description of Aboriginal health beliefs and Aboriginal autonomy. As I will discuss, the ways my participants choose to treat their diabetes are related to the following: country, bush tucker, *rith*, elders, Christianity, and the clinic. In terms of healing diabetes, my participants told me that people not only treat their diabetes for physical symptoms but treatment includes improving their emotional, social, and community wellbeing, as well as their relationship with their country.

Aboriginal health beliefs

Aboriginal health beliefs and practices are interconnected with land and spirituality. To be healthy, is to follow Aboriginal law, which can be found in the Dreaming, locally known in Yidiyi as, *Marl*. All Dreaming stories, dance and song depict a person's growth from the land and locate a person cosmologically and ontologically (Williams et al, 2011, p. 6). The Dreaming prescribes socially-approved patterns of behaviour and avoidance of dangerous people, places and objects (Biernof, 1982, p. 143). Anthropologists such as Ingold, Jackson and Stoller (to name a few) write of the balance and harmony between the Indigenous person, nature and society (Ingold, 2000, p. 52; Jackson, 1995, p. 125; Stoller, 1989, p. 92). Imbalance in a person's life then, can upset the whole body. Maintaining health is about maintaining a balance between the physical, mental, spiritual and social system.

If a person becomes unwell, the traditionally-assumed causes of the illness include social and spiritual dysfunction. Maher tells us that today if a person is not engaging in Aboriginal law by interacting with their land, ancestors and social relationships, this may be the cause of illness or social disharmony (1999, p. 230). He states that, "health beliefs continue to play a role in providing meaning to events and thereby helping people to cope with serious illness and death" (1999, p. 229). He argues that this view emphasises the idea that individual wellbeing is always dependent upon a commitment to social obligations and responsibility to the land (1999, p. 230). In his research, he found that if a person is ill, for example, their focus on their social role may take preference over personal health because of the priority given to social relationships and the importance of their maintenance (ibid). Physical disruption in the body is but one symptom of being unwell. According to McDonald, health advice given by Aboriginal healers was traditionally based on how to live the right way, rather than physical symptoms and how to be healthy physically (2006, p. 88). Therefore, positive relationships between people and land are associated with the maintenance of good health. Failure to do so, results in ill health for the individual and community.

McDonald found that personal health assessments are based on feelings and feelings are connected to the body (2006, p. 90). Throughout the research process, her research made me think of Rosaldo's work which I discussed in my literature review. In particular, when Rosaldo tells us that emotions and the body are psychologically connected to cultural life and society (Rosaldo, 1984, p. 141). McDonald found that the Aboriginal peoples she worked with assessed ill-health through their senses, such as "sight, hearing, smell, touch, feelings and dreams" (2006, p. 90). Williams also found that senses are indicators that enable a person to judge what is happening inside the body and in the world around them (Williams et al, 2011, p. 6). Emotions, then, are culturally-informed and are relational. How they are experienced, expressed, perceived, and managed depends on what is considered culturally normative behavior by the surrounding society. This indicates that for this society (if not all), treatment of ill health requires holistic healing. Williams informs us that this involves emphasis on each of the elements: individuals, families, communities, as well as a person's relationship with the environment and nature is required but in connection to one another rather than atomised (Williams et al, 2011, p. 5).

Aboriginal autonomy

Specialising in Indigenous Anthropology, Robert Tonkinson, demonstrates that, for Australian Aboriginal communities, autonomy is predominantly understood as freedom from Aboriginal authoritarian structures, but not cultural identity and also involves the avoidance of demands of white Australian culture (Tonkinson, 2007, p. 42). However, Australian Aboriginal peoples' power is constrained through external forces, which, the majority cannot control. For example, government policies, such as the earlier referred to 'intervention' in 2007 (see p. 8). Despite government policy, power and control on a personal level is exercised through daily decision-making processes, my research showed that, how a person treats their diabetes is a response to a cultural interpretation of their emotional and relational connection to people and the environment and is, therefore, a personalised expression of their autonomy and collective indigeneity.

During fieldwork, I noticed that each of my participants treated their diabetes uniquely; it seemed there was no one specific way diabetes should be treated. I found that the difference in treatment methods mirrored Tonkinson's research on Aboriginal autonomy. For example, Tjitjawanu refused to take his medication daily as advised by the clinic. He felt that he only needed to take it when he was feeling the physical symptoms, such as dizziness. Although, sometimes he may just have a glass of water and rest. At other times he chose to seek medical attention from his children in the form of sweat (which I will discuss later). Karbanni on the other hand does take health advice from local authorities, such as elders. She said that she did not have to take their advice but she appreciated what they told her. Some members of her family chose not to take health advice from elders as she did. Alternatively, they either went to the clinic or decided to ignore their illness. Mangul and Mary decided to take their Western medication daily, as both felt it helped to reduce their physical symptoms and to continue with their daily routine. Moreton-Robinson argues that if an Aboriginal person takes on Western customs, they are not assimilating to Western cultural domains, rather, they are acquiring new knowledge in order to act and function in the context of their own culture and "within the dominant culture" (2000, p. 89). Hence, taking Western medication may not mean to acquiesce to Western culture but a desire to function within both Western and Aboriginal culture. I began to realise that the different forms of treatment a person took was intended to improve an area of their life which, in turn, would improve the physical and emotional symptoms diabetes caused.

Country

For an Australian Aboriginal person, a relationship with their totemic land, or "country" as it is referred to locally, is extremely important to a person's physical, emotional, spiritual and mental health (Fewquandie & Clarke, 1998, p. 2). With all the people I spoke with and continue to interact with on a daily basis, an affiliation with country is forged and sustained through the patrilineal line and connected through inherited totems and *Marl* stories specific to that country. Ethnographic fieldwork shows that an Indigenous person's relationship to their country is subjective rather than objective as they are emotionally and

physically connected to the landscape (Fewquandie & Clarke, 1998, p. 3; Keen, 2006, p. 521; McDonald, 2006, p. 90; Stanner, 1979, p. 230). Indigenous researchers, Deneita Fewquandie and Colleen Clarke, succinctly explain the connection saying:

When your ancestors have walked these places for millennia, they hold an energy of timelessness that invokes serenity and the feeling that one is not alone but in the presence of these ancestors who are able to communicate via the senses and convey the feelings and thoughts that are most conducive to healing. When we are able to sit on our land in contemplation and heal, feel or hear the spirits of our old people, then we have been to a place within ourselves of great depth and connectedness (1998, p. 3).

When I talked to Karbanni, she told me that her ancestors inhabit her country also. She associates the positive feelings of being in her country as emotional and physical forms of treating her diabetes. She told me that when she feels the symptoms of diabetes, she goes out country:

I talk to my people and swim there at the creek and make me feel good. I eat long bom¹³ for my diabetes to go down.

Which way of healing is better for you? Clinic or going out country¹⁴.

Going out country. That way is good for us, Aboriginal people.

Why is that?

Don't eat anything with diabetes [that is, with sugar in it].

When in her country, Karbanni eats food that reconnects her with her country but also helps to maintain a healthy body. Her description of conversing with her ancestors are similar to Clarke and Fewquandie's (1998) findings: Time spent in her country appears to be moments where she "communicates with her spirits via the senses" (p. 3). I see this in the way she physically embodies the environment around her, she swims in the water, eats the food it provides, and communicates with her ancestors through embodied dialogue: all

¹³ A small cylindrical shellfish.

¹⁴ Here, and in all interview excerpts I use, italics will be applied for all words spoken by me.

of which appear to be a rejuvenating experience. She never said specifically that it was a calming experience, although I asked her how she would compare her time out country with her time in Yidiyi and not having immediate access to her ancestors, food, and land. She said that diabetes made her feel “angry and you know...tight. Angry in your body”. While being out country made her “feel good”. I found this to be similar to McDonald’s work in Western Australia. When researching local people’s understanding of their health and illness, McDonald found that “Aboriginal understandings of the body and health derive from the experienced body: the living, breathing, pulsating body” (2006, p. 90). During our conversation, I felt that the time Karbanni spends in her country enables her to embody her spiritual connection to her land. Her overall experience in her country made her feel physically, emotionally and spiritually well, showing a strong and necessary connection between herself and her country. Bush tucker metonymically exemplifies the inseparability of body and country.

Bush tucker

Many local people are informed by the local clinic and advertisements on the local Indigenous television channel that eating sugar is a bad lifestyle choice yet they continue to do so. The majority of people I spoke with associated going out to country as a way to eat food that is healthy for them and specifically, to eat food that will make the physical symptoms of their diabetes go away. For example, Karbanni eats long bom when in her country. Tjitjawu similarly told me that he only eats meat and rice or damper¹⁵ when he is at home and that he prefers his meals when he is on his land. Mary too goes to the bush to seek healing food:

Whenever I start to feel a bit sick or the clinic tells me my blood sugar is too high, I go out bush and eat cat fish. Catfish is my totem, and kangaroo. It makes me feel better.

¹⁵ A wheat flour-based bread, which does not require yeast. Usually cooked on the coals of a campfire.

I found the fact that Mary eats her totem interesting as most people do not because it is more often felt that the avoidance of totem consumption shows loyalty to, and connections with the past and ancestors (Kaberry, 2005, p. 123). When I asked her about whether she was allowed to eat her totem she simply answered, “Yes”. Known for her work in feminist anthropology, Phyllis Kaberry tells us that in some areas of Australia eating a totem is not taboo if it is “found” dead (2005, p. 127). However, Mary is comfortable with hunting for it. In support of eating it, one local person told me that they used to eat their totem, the kangaroo, as it was a vital food source and without it they would not have survived.

It seemed to me that although the local store provides healthy food, the food that is ordered there does not seem consistent with a pre-colonial Aboriginal diet. For example, I have had a number of conversations with various local work colleagues while in the store’s vegetable section. People would ask me if I liked the vegetables I had in my basket, such as capsicum, avocado, or bean sprouts. They would tell me that they did not want to eat them as they made them sick. I have also noticed that local friends or students at school are hesitant to try a piece of asparagus or beetroot from a salad I am eating for lunch. They say it is because they are concerned that it will make them vomit. Nutritionist, Harriet Kuhnlein, found that if foods people can associate with are introduced into local stores, not only may a positive diet be reinvigorated, but also a cultural revival (1996, p. 435). Stocking “bush tucker” in the store such as kangaroo, yams, green plums and barramundi, may encourage more people to purchase healthier options at the store while also promoting cultural renewal. Introducing locally culturally appropriate food into Yidiyi stores is challenging to obtain as it can not be sourced from supermarket suppliers (although, I found the prospect of stocking the store with food people could culturally associate with to be a logical way to encourage healthy eating). As I was becoming more aware of local remedies, one that took my surprise was body sweat.

Body sweat

Body sweat is a material substance that has come up in conversations and observations in a variety of ways many times during my time in Yidiyi. Body sweat has local

significance, in that it has individual and family characteristics and/or healing qualities. Firstly, body odour can be individually identified, as I observed on one occasion when five young boys were playing during recess at the local school. They had taken their shirts off to play. When the bell rang, one boy proceeded to pick up one school shirt at a time (all of which were the same size and colour) and smelt them. After smelling a shirt, he threw it to the, presumed shirt's owner, until he found his own and left the remaining two on the ground for the other two boys to identify.

Secondly, body odour also connects a person with ancestors as we found when my partner and I travelled with a local friend, Barry, and his family out to his country. Once we began to cross the boundary into Barry's land, he did a number of things to announce our arrival. During the drive, he called out to his grandfather in Yidiyindi, telling him we were coming and not to worry. Later he asked us to pull over so he could wrap his singlet around the bumper of the four-wheel drive so that his ancestors could smell his distinctive body odour. Also, so his ancestors knew we were friendly guests and accompanying him, he wiped his armpit sweat on our hands. I felt that this procedure preserved feelings of belonging, connection, and ownership for Barry. For me, it created a sense of surreal presence and energy. Intentionally, he established an environment that encouraged me to feel that his ancestors inhabited the place.

Thirdly, body sweat has healing qualities that give people power. Tjitjawu told me that sometimes when he is feeling the symptoms of his diabetes, he asks his children to wipe their sweat on his body. In doing so, his body is rejuvenated. Also, my partner Matt has told me of numerous occasions where some of his students wipe the sweat off his face and rub it on their bodies to obtain his power. To further support this point, some people's inherited clan totems are either vomit, abscess, or headache. If a person develops one of these, they can visit the person who has this totem for healing. The process of removal involves the person with the totem wiping their body sweat on the ill person. Having any one of these totems gives them the power to remove a malevolent spirit in the form of, for example, headache, that has entered a person's body and return it to their country where, for example, the headache Dreaming site can be found. I could not find any literature on

the general use of body sweat or odour. The closest association I could find was from McDonald's description of an Aboriginal healer who has healing powers in their body sweat and may use it for healing purposes (2006, p. 280). *Rith* (pronounced rit with a rolled r), on the other hand, was common in the literature but not as a form of healing.

Rith

Rith, known in the English language as small people or little people, are recognised in all regions of Aboriginal Australia (Allen, 1992, p. 389; Merlan, 1986, p. 481; Seathre, 2013, p. 62; Tonkinson, 1978). Descriptions and Aboriginal names can vary but all small people are thought to inhabit the countryside. Eve told me that they are rarely seen but are reported to look like an Aboriginal person and are not small at all. She told me that the people might be small in other places but nowhere that she had knowledge of.

Anthropologist, William Stanner, explained that little people do not inhabit Dreaming sites (1936, p. 193). They have their own spirit center in one area of land in a region, which I later found out is on Pinpirrith's country. In this place, there are stones in the shape of a child, forging rocks as *rith's* mythological spirit center. *Rith* are not limited to this space and are able to roam the region in varying places, such as water, trees, logs, wind, and leaves (Stanner, 1936, p. 194). They are considered to be active agents of conception and said to return with men from a hunting trip usually in the form of a fish and enter a female under her toenail. There is no separation between spirit children and embodied children: they are on the same "continuum and is what ties the supernatural and natural world together" (ibid). A child is thought to be a spirit child until they take on human qualities such as smiling and talking (ibid).

A child can be a *rith* either of someone living or dead. They are recognised as a spirit child if a birth mark is shared with a person from another clan or family. The recognition of a person as a spirit child establishes special relationships between him/her and the family of the deceased or living person (Ward, 1983, p. 42). This connection identifies the *rith* as the person's non-biological son or daughter. If the connected person is still alive, the living person can not touch or have any direct contact with the child until an exchange ceremony

occurs between the two families (ibid). *Rith* are still part of Aboriginal life in Yidiyi. A past co-worker of mine told me that her mother was a *rith* as she shared a birth mark with an older man from a different clan in the community. She told me that the two families have strong ties with each other as a result. Karbanni spoke to me about visiting the *rith* on her country whenever she went there and that the small people had healing qualities:

Yeah, small people. That's two man from my country. [I] went there and make me feel good.

When was that? Last year when you were really unwell?

Yeah, I went to the hospital and then me and my husband went out country.

Who were the small people. Do you know who they were?

My people.

Can you talk to me about what happened?

Private.

I was anticipating hearing about Karbanni's relationship and experience with *rith* but respected that I was not of the correct culture or that she trusted me enough to be informed. I found it interesting that she referred to the *rith* as healers in her country. It differed from Stanner's fieldwork where *rith* were never described as people who had relationships with other people before they entered a human. It made me wonder if her experience with them helped her to reconnect spiritually. I was curious about her experience, as prior to this conversation, Karbanni told me that there was no local healer for her to visit for her diabetes, and that she could only seek advice from elders, which I will discuss shortly. As mentioned, I knew from conversations with other people in the community that today *rith* still creates relationships between people and families. I also knew that although diabetes was caused from living a "whitefella" lifestyle, the locals were using their own healing methods as forms of treatment. I found Karbanni's narrative particularly interesting as she sought healing from *rith* which did not appear in the literature as an Aboriginal healing method for illness. In fact, in the literature, I found nothing discussing a person having personal relationships with small people.

At one stage during my fieldwork period, Karbanni had just been in Darwin hospital for a number of weeks for treatment for her diabetes. Although her health improved, she credited her health rejuvenation to the Aboriginal forms of healing she sought after her visit to the clinic. For Aboriginal peoples, this is not uncommon (Seathre, 2013, p. 96). In the excerpt above, it is her visit to country that Karbanni attributes to making her well again. This was similar to Seathre's fieldwork with the Warlpiri people, as they gave credit to local healing methods for being more effective than clinical treatment in their improved health, when both systems of healing had been used (ibid). He argues that this should not be "dismissed as simply the result of biomedical ignorance, but rather understood as a meaningful tool through which the value of Aboriginality is articulated" (ibid). Karbanni's experience reflects this statement. She is happy to accept Western treatment, however, in this instance I presume that she sought biomedical attention and also Aboriginal healing methods in order to gain a holistic sense of overall wellbeing. She attributed her experience at the hospital to treating her physical symptoms which diabetes caused, while the time in her country attended to her physical, spiritual, and emotional needs. Karbanni received her health advice from elders. Elders are considered a reliable source of suitable local treatments.

Elders

In traditional Australian Aboriginal culture, elders play an influential role as to what form of healing or area of their life needs attention in order for their health to improve. Jacob explains that most commonly, Australian Aboriginal elders are senior male members belonging to a common language group (1991, p. 58). Conventionally, Aboriginal male elders are selected based on their personal qualities, such as bravery, hunting skills, and/or compassion, as well as their knowledge of traditional law (ibid). They provide leadership on matters concerning disputes, education, and marriage partners. In traditional Aboriginal society, advice from elders is usually followed and not questioned. They do not instruct people on how to be healthy, but on how to live the right way: the ancestral way (McDonald 2006, p. 88).

As mentioned above, Karbanni sought advice from elders in her family about which form of treatment to follow for her diabetes in order to improve her lifestyle. In the following segment of our conversation, we were talking about the various forms of healing she uses as advised by her elders: the clinic, country (which includes the natural surroundings and food supply), and *rith*:

So for you, when you can feel your diabetes is bad, you take a mixture of pills and local Aboriginal stuff. So do you have to do both at the same time? Or can you do one or the other?

You can only do one at a time.

What makes you decide which one you will use?

From old man, old people.

For you, which one is the better one?

Aboriginal.

In the above excerpt, Karbanni is advised by elders that the clinic's guidance to take pills for her diabetes is useful but can not be used in tandem with Aboriginal methods. Most of the people I spoke with had no problems with taking advice or prescribed medication from the clinic. However, the majority of the time, their preferred method of healing was "Aboriginal" because these treatment options gave them an overall sense of wellbeing rather than only addressing physical dysfunction/symptoms. Personal decisions to use local healing methods may be representative of a division between ethnic groups. For example, Karbanni sought advice from elders because she respects them and their judgement on how to regain her spiritual and physical wellbeing (McDonald, 2008, p. 88). Therefore, to me, the advice she received seems to be the most culturally relevant. While the clinic provides healing in terms of physical ailments, Aboriginal healing methods also attend to her spiritual and emotional health. Although not traditionally an Aboriginal healing method, Christianity could also be used for diabetes as it too treats spirituality and emotional wellbeing as well as being a means for social connection. It is similar to Aboriginal healing methods, such as *rith* and at times body sweat, as it connects the natural and supernatural world.

Christianity

Most Indigenous communities have an explanation of how Christianity was integrated into their culture (Dussart, 2010, p. 80; Furland, 2005, p. 5; Jolly, 1989, p. 3). Christianity has become part of everyday lifestyle for many Aboriginal people in Yidiyi. It is utilised as a holistic way of healing diabetes, while also contributing to the general emotional wellbeing of some of the people I spoke with. As I discussed in my background section, the Virgin Mary was seen in a dream of one man, Minji, who was cast out of his clan for murder (see p. 6). I have been to the place where Minji had his dream. I went with a work colleague who was related to him. He wanted to visit the site to revitalise himself spiritually after an increased amount of fighting in the community. In this place, a statue of the Virgin Mary can be found. I have been told that this place holds healing power as does the sand around the statue. For example, a friend of mine told me that she was at the hospital with her son, a baby at the time, who was not well. She did not tell me specifically what was wrong but she said that there was another child with the same illness. She brought some sand in to the hospital to rub on her child to complement their hospital treatment. Her son survived while the other baby did not. It was the sand, she said, that kept him alive. During interviews, I found that the topic of religion, prayer and God emerged on a number of occasions in connection with wellbeing and also as a form of treatment for diabetes. When talking to Melissa, a practicing Christian, it was clear that she was of the opinion that her trust and faith in God alone, would make her better:

Just my God and trusting myself. The only person I trust is God. I only putting him in front of me, so, he's the only one. He created me and he owe my life. That's the only person I trust.

In terms of your health, or everything in your life? You don't trust family?

Yeah, family. But in my personal health like [diabetes] I only trust God. So I can just get around the community thinking about this way, that way, thinking of a better way for us. Not thinking about my own sickness.

Melissa's comments were contrary to Dussart's (2010) fieldwork with the Yolngu people in Arnhem Land. Within the Yolngu social context, Dussart argued that Christianity is a variable that enters into the discourse of the Indigenous ill, which takes treatment beyond the clinic and kin. Pure faith in God, as a form of treatment for Aboriginal peoples is, he

argued, “a moral and reflexive psychological space that is increasingly separated from the dense sociality of extended kin relations and abstracted from community” (2010, p. 83). Melissa’s account seems to contrast with this view, however. She alluded to ignoring her personal ill health in order to focus on her personal actions that will benefit the community’s wellbeing. I believe, that by appointing the responsibility of her health into Gods’ hands, she is able to think about her general contribution to the community and what is making the community ill as a whole as opposed to focussing her energy on her individual self. In other words, she has blended her Aboriginal values and beliefs with Christianity for the benefit of community and self.

The clinic

Along with all other methods of healing discussed in this chapter, the clinic is used as one more form of treatment for diabetes. However, healing advice from the clinic was to take diabetes tablets daily, for five of my participants this counteracted other healing methods. My participants offered a broad range of opinions and experiences of the clinic.

Melissa, for example, does not mind going to the clinic. However, she does not take her medication either:

I don’t mind going to the clinic. But in my personal life, I’m just kind of putting everything behind my back and to focus on my own life and not to focus on the sicknesses. Just focus on that one person to trust [God]. My mind is telling me, don’t trust anything.

So when you say don’t trust anything. What do you mean?

Like not to take pills that much. Pills is no good. The air is medication. The fresh air, water. When I’m not taking tablet, I don’t feel any pain in me.

Marie told me that the clinic knew she did not take her tablets when they measured her blood sugar but she would tell them she did anyway. This suggests that the communication levels between her and the medical practitioners is not one of mutual respect or trust. If it was, Melissa and Marie may be more inclined to take their diabetes tablet daily, which may improve their health and the clinic may develop a better understanding of Aboriginal

healing methods. This information may contribute to improvements in the way the clinic approaches the health needs of their patients.

Most people I spoke with said they had no problem visiting the clinic. Pinpirrith was such a participant:

It's alright for me. Talk to the nurses, the diabetes nurse. Talk to all the specialists when they come in from town.

And that's good?

Yeah. That's when I go to the clinic and see all the specialists and do fingerpricks and blood sugar.

She spoke in a positive way about the clinic and mentioned names of the nurses who worked there, almost as though it was a social occasion. Marie, on the other hand, was very passionate about talking about her negative experiences there and alludes to unfavorable feelings towards non-Indigenous peoples.

Well I can only say for myself, I don't like going there, for myself. You know, I don't like asking the nurses to do that to me because, they already making us sick, the sugar, from white people. But, like in our culture, our brothers are listening [to] what the nurses are calling out for [in the reception area or from the car]. The brother, they don't want to listen. You know, I have a brother and he sits next to me. And [the health workers] say, we're going to take you to the clinic and that's a shame job. And my brother he might think, bah, my sister is a very sick person and need medication.

Why is it shame being sick?

The brother, he don't want to know the [female] body of us. If the nurses want to come they need to go and sit with the person they want to see and have a talk and the person can say "I can come", but [they should] not yell from the car, that's a bit rude.

As Marie lives about ten kilometres away from the clinic, the clinic offers transportation to pick people up for their appointments. She felt that when the non-Indigenous clinic workers came to collect people for their appointments that the nurses yelling from the car was impolite as it was an obvious way of telling everyone around that she is sick while also

thinking that it was a generally impolite way to pick someone up. (In my experience, when I see nurses doing home visits they are always out of the car talking with people). As well as this, it is inappropriate for a brother to know the details of the health of his sister (Kendell & Barnett, 2014, p. 4). As our conversation continued, Marie began talking about the mechanistic process she experienced inside the clinic.

Yo, it's not their brain working for them, it's the machine. It's not looking at what's wrong with the person. Getting machine, taking the number, writing it down and doing it for them, put it in the folder. And they telling us, yo, your blood bit high, your sugar too high, like that. But we still taking our same medicine all the time. But really, I don't take any medication.

Marie insinuates that when she visits the clinic she feels as though she is not receiving holistic care. Her comments drew me to Ingold's theory of "skilled practice" as she feels as though it is essentially a mechanic impersonal process which is not learning through interaction with the tool by either herself or the practitioner (2000, p. 344). Ingold's suggestion that the environmental context in which the tool, or in this case the machine, is being used should not always be based on the original pre-existing formula (2000, p. 345). For example, currently, the practitioner is trained to use the machine in a particular way. However, this type of interaction is not conducive to Marie's cultural beliefs or the way she wants to receive healthcare, in that the patient should be treated holistically rather than only for their physical symptoms. Ingold argues that the transmission of skills should not depend on formulas and rules and should depend on "sensuous engagement" (2000, p. 346). If the machine involved interaction by both people and was complemented by discussion, this would integrate care, judgement and technology to the consultation process and would combine both cultural worldviews. Ultimately, this would develop a relationship-focussed process while working towards mutual cultural understanding.

Despite Marie's negative experiences at the clinic, a non-Indigenous nurse, who has lived in Yidiyi for over four years, reported holistic and culturally-relevant improvements at the clinic. During my conversation with her, she did not mention how compliant or non-

compliant her patients were at taking their Western medication for their diabetes. Rather, she spoke about ways in which the clinic was aiming to improve their relationships with local people. She and I spoke about the different clan dynamics in the community and how her knowledge of different families helped her to have meaningful conversations with her patients. Also, despite the extra time it took, she and her staff had begun doing more home visits so that they could not only talk to the individual about their health but talk to the whole family. In one of my conversations with Karbanni, she said that she enjoyed the home visits as she did not have to travel to the clinic and her family was around her.

The clinic had also hired new staff from various clans in the community for reception positions so that people needing to visit the clinic had the choice to talk to a person whom they could associate with, in order to encourage people to feel comfortable enough to visit. To further strengthen local engagement with the clinic, local people were enrolled in health courses so that they could assist the nurses during consultations. My conversation with the non-Indigenous nurse suggested that the clinic is developing its treatment of patients. Patients are being treated as social persons, which Indigenous anthropologist, Daniela Heil argues is imperative for Western health care institutions to adapt to in rural Aboriginal community settings (2009, p. 98). Moreover, the information she told me indicated that she and other clinic staff were working towards practical methods that respond to the local community dynamics so that health care and treatment is reflective of local cultural complexities inherent in the community as opposed to culturally inappropriate methods.

From my conversations it was clear that for meaningful health care at the clinic to continue to develop, establishing relationships with local community members was essential. This point is accentuated by Lowell, as a key initiator of effective rural Aboriginal community health (1998, p. 35). Although this article was written 15 years ago, Seathre tells us that Lowell's argument remains fundamental in improving health care (Seathre, 2013, p. 5). One of the key changes mentioned by the health nurse I spoke to was the amount of time she had spent in the community. Living here for over four years has enabled her to establish relationships to gain some understandings of local community dynamics. As King does, I see the length of time non-Indigenous people spend in an Aboriginal

community as correlating to the creation, strengthening and maintaining of relationships (2013, p. 311). From personal experience, after living here for nearly two years, I feel as though my relationships with local people are only just beginning. Some of the local people only began talking to me after I had been living here for one year. In order for the health of Aboriginal peoples to improve, I also feel that Indigenous and non-Indigenous relationships require commitment and patience. As a person living in this community, I know that investing time and energy in forging relationships adds to the overall health and wellbeing of the community.

Moreover, for health care initiatives to be successful, Aboriginal peoples must be able to relate to them. According to Williams, a number of steps must be taken to improve how Aboriginal peoples relate to Western health care models. First, the cause of “community dysfunction” must be discussed in open forums in terms of general community concerns. This is because Aboriginal wellbeing and healing is related to social wellbeing. To do this, “ownership, definition, design and evaluation of healing initiatives” need to be led by local people (Williams et al, 2011, p. 5). Second, and by extension of the previous point, health initiatives, not only Western health care models, need to be based on Aboriginal worldviews, for example, for diabetes in Yidiyi. Third, this would require that Indigenous and non-Indigenous health care workers collaborate to define the preventative care needed and the cause of diabetes. This would strengthen relationships, cultural understanding and integrate local people and their cosmologies into the functioning of the clinic. This would also contribute to a more holistic health care model that is responsive to local Aboriginal worldviews and needs.

Conclusion

Local Yidiyi and biomedical treatments have dissimilar histories, philosophies, aetiologies and treatments, yet the people I spoke with are able to concurrently utilise and identify causes, treatments and technologies from both. However, during my conversations and observations, I found that local remedies for diabetes are generally considered to be better because they are thought to be more effective. Diabetes is understood to be caused by a

change in lifestyle, from a traditional to a “whitefella” lifestyle, showing that local people recognise the negative effects that colonialism has had on their health. Not all of the local Aboriginal healing methods I discussed were present in the literature, such as body sweat and *rith*. They were, however, all similar in that Aboriginal healing methods connect a person to an overall sense of wellbeing related to the natural and supernatural environment. This is one of the reasons why Christianity is considered to be a useful form of healing for diabetes. Specifically, Christianity was substantiated in Yidiyi through a dream of a local man. The place where the man is said to have had the dream has healing qualities in the sand. The sand is the physical connection which links the natural and the supernatural together. This is similar to other local healing methods, for example, body sweat, bush tucker and country. This is perhaps one of the reasons why the clinic may not be as effective as it could be as it does not have a connection that links the clinic to supernatural or environmental elements.

One of the key points raised in this chapter is Marie’s comment about how she wants to be more physically engaged with the tools used at the clinic. The argument that local Aboriginal peoples need to engage with the physical environment in order for it to have meaning is discussed in depth in the following chapter. Moreover, taking the recommendations to endorse local healing methods, in the next chapter I will also discuss two areas of Aboriginal healing, Aboriginal healers and bush medicine, that was not spoken about by local people the way it has been in other rural Aboriginal communities. My analysis highlighted some of the contradictions I encountered during research, which will be discussed in the following chapter.

Chapter Five

Exploring contradictions

Introduction

In Chapter Four, I established that a number of my participants have integrated Western healing methods with local cultural healing methods as a way to benefit from both cultural systems. As I have argued, Aboriginal health requires “living the right way”. Aboriginal ill health, argues McDonald, is induced by three main causes: natural, human and supernatural (ibid). Maher’s research (1999) illustrates that for Aboriginal peoples to maintain good health, they must adhere to locally-approved Aboriginal law, including avoiding certain dangerous people, places and objects (p. 232). He further says that knowledge about behaving appropriately is learned through engaging with dance, song, stories and painting (ibid). Moreover, most illnesses resulting from natural causes may be treated by remedies from the earth. Similarly, Ingold tells us that Aboriginal peoples cosmologies and ontologies are constructed by their environment and, therefore, are inseparable from it (2000, p. 154). Therefore, Aboriginal healing requires a person to reflect on the way they are living and may require more or less engagement with certain aspects of life.

Two of the central ways to heal that arose in the literature were Aboriginal healers and bush medicine. From reflecting on my experiences that have contributed to these chapters, I realise that the people I spoke with had different views and knowledge about these two topics. During my fieldwork, I had expected to hear about both but had not (at least not in the way I had anticipated). I found this very interesting, especially because they were two areas that often came up in the literature, particularly their promotion as ways to reverse the increase in Aboriginal ill health. As I will discuss, the literature around bush medicine and Aboriginal healers focussed on pre-colonial diet recommendations. As diet is an integral component in the treatment of diabetes, I became interested in thinking about how diet had changed and whether the meaning of food had too. I was then drawn to the local idea encapsulated by the word *Yamurr* (the name for the region, also meaning, coming together

as one people as well as the local form of governmentality I discussed in the background section. See p. 11) as a possible locally relevant approach where local people could inform each other and learn together about the health risks of diabetes. However, I became confused by the different local interpretations of this word too. Asking questions about *yamurr* made me feel both comfortable, that the word was still being utilised for local concerns, yet uneasy by the mixed interpretations expressed to me by locals. I found *yamurr* to be another topic of cultural significance (similar to bush medicine), that due to the lack of practice, cultural knowledge was being lost and, thus, contributed to the rise in diabetes in Yidiyi.

This chapter is organised into three sections: Aboriginal healers, bush medicine and the meaning of food. Each of the sections will first discuss what the literature says about these topics, then present my research data and compare and contrast it to the literature. Following this, I will discuss how both the literature and my participants led to my conclusions in terms of how to improve health, and specifically diabetes, in Yidiyi. Throughout this chapter, my data lead me to continue to argue for the relevance of a physically and environmentally engaged approach. This would aim for a sense of reflective localised “skilled practice” that local people could engage with in a culturally appropriate way.

Bush medicine

The literature illustrates that bush medicine is not only a way to heal but is a traditional way to connect Aboriginal peoples to their spirituality and environment. In Yidiyi, the difficulty of accessing plants in contrast to the convenience of the clinic prevents their regular use. My research indicated that Aboriginal peoples in Yidiyi benefit most from bush medicine when it is transmitted through “skilled practice” and that the act of learning about bush medicine may improve, maintain and strengthen relationships between local people and their environment.

Bush medicine in an Australian Aboriginal context

According to Clarke, “symbolically, plants feature heavily in Aboriginal myths and religious beliefs” (2008, p. 2). Moreover, Maher tells us that bush medicine is inclusive of all things provided by the earth, such as plants and animals (1999, p. 232). Particular foods are recommended and/or specific plants are prepared in order to heal particular ailments. McDonald’s (2006) research with Aboriginal peoples in the Kimberleys concluded that eating meat, (particularly warm kangaroo blood) found in the bush was the best medicine as it replenished the human blood, “strengthens the body, revives the spirit and enlivens the senses” (p. 5). Bush medicine is one aspect of Aboriginal life which integrates an Aboriginal person into their environment and contributes to Dreaming, cosmologies and the body. Consuming bush medicine adds to the wellbeing of the physical and spiritual self as it physically connects the body to Aboriginal cosmologies.

Maher argues that most Aboriginal people who live rurally know the healing properties and information needed to prepare and use bush medicine (1999, p. 233). Ways to use it, he says, include “herbal preparations, diet, rest, massage, and external remedies such as ochre, smoke, steam and heat” (ibid). This knowledge, says Williams, is classified as Indigenous knowledge and should be taught to Aboriginal peoples by Aboriginal peoples in order for it to embody the traditional lifestyle of a community or people (2011, p. 2). However, ethnobiologists, Shaouli Shahid and Ryan Blear’s (2010) research, showed that most Aboriginal peoples had difficulty accessing plants (p. 6). Moreover, Seathre’s participants found that going to the clinic was a much more convenient option (2013, p. 18). Yidiyi culture is taught at the school by local people one afternoon a week. During this time, bush medicine is not addressed. This made me inquisitive about how bush medicine was taught in Yidiyi and what it meant to local people and how accessible it was anyway, even if it was taught.

Bush medicine in Yidiyi

My fieldwork similarly reflected the literature in that bush medicine was difficult to access and the clinic was a more convenient option. That is not to say that there was not knowledge of bush medicine. For example, I always asked people about bush medicine and if they used it. People often told me about a tree near the high school that could be used for treating colds if chewed or drunk as tea. However, most people said that even when they did have a cold they would not use the plant as the taste was not appealing and the clinic was more convenient. Another common remedy was a plant with a purple flower that could be used to relieve the sting of a catfish if applied when scorching hot. Another was a small yellow fruit with the inside like a passionfruit which could heal eczema if rubbed on the affected skin before it was ripe. During my fieldwork, I found that when asking my participants and other local people about whether they used bush medicine, one of the above examples was a common response as their answer. I questioned my approach at times, however, because if someone told me that they did not know of any remedies I would suggest the above examples and sometimes they would have knowledge of it. Demonstrating that perhaps the language barrier prevented answers or I was not asking the right questions. When I asked people during my interviews if there was a specific plant remedy for diabetes, the answer was always “No”, as diabetes was a relatively new health problem. The only local remedy I was told of locally that could be consumed to mitigate the physical symptoms of diabetes, was bush tucker. I found that knowledge about bush medicine varied between individuals but all people were happy to use the clinic due to its ease and convenience. The people who seemed to have extensive knowledge on bush medicine did not use it regularly as it took a long time to prepare and access was limited if they did not have a vehicle to learn or teach on their country.

Although, one local woman I spoke with who owns a vehicle and visits country regularly with family exemplified the importance of “skilled practice”. She told me about the enjoyment of taking her grandchildren to country whenever possible to *show* them, while teaching them about the landscape, how to collect and prepare bush food, and to give them information on various plants and their healing properties. Through my observations,

while one person in a household may own a vehicle, it is not uncommon for the vehicle to be written-off within months, sometimes weeks. Cars upside down and rusted on the side of the road is a regular sighting. On one visit to Tjitjawu's country with his children, he told me he had not been there for about thirty years because of a lack of transport and that his children, the eldest being 17, had never been there at all. Therefore, overall, it seemed to me that plants had not been systematically or consciously integrated into healing diabetes as a form of local treatment because diabetes was too new and locals did not have the opportunities to utilise 'skilled practice': to know through doing (Ingold, 2000, p. 344) and apply their knowledge of healing plants and other healing practices.

The future of bush medicine in Yidiyi and "skilled practice"

My field work left me with the conclusion that limited access to country may have an affect on an engaged educational approach to bush medicine within this Aboriginal context. I was, in the end, concerned about the lack of regularity of the transference of knowledge, particularly on plants and bush tucker, as cultural connection with them seemed limited.

Very late in my fieldwork, I found a book in the local school library¹⁶ published in 2009 with written contributions from over 40 local elders in Yidiyi, from two of the seven language groups at the local school library. The book consists of the names and uses of over 415 local plants and animals. According to the introduction, their motivation to write the book was to document their knowledge about their traditional language names, cooking methods, and medicinal healing qualities. A vast amount of knowledge related to the ceremonial uses of culturally-sensitive information and other non-public information was not disclosed as it was private for men's or women's business only. Conversely, extensive medicinal information about the plants and animals was discussed in the book. There is not much fauna in the book that is said to have healing qualities, however, long boms and mangrove worms have been the topic of many of my discussions with local people in terms of the enjoyment of eating them. Interestingly, mangrove worms are considered to be a

¹⁶ To protect the identity of the community and my participants, this book will not be named and will not be listed in the references.

health-promoting food, useful for boosting milk production for nursing mothers and good for anyone who is feeling unwell. Long boms are said to be good for stomach pains and, more recently, they have been found good for curing hangovers. Karbanni and Mary told me they eat long boms when they are feeling unwell with their diabetes. Long boms are simple to collect and can be found in most people's country when it is situated by the sea.

This made me wonder if it may be possible for local Aboriginal health workers to take groups of people to seaside areas to collect long boms. This would provide a good food source and give people an opportunity to visit country outside of the Yidiyi township, with the potential effect of revitalising the spirit for those whose country is visited, and also to promote social and physical activity. I see the book as a fundamental source for the community and the future of bush medicine which, in my opinion, should be integrated into the local clinical environment. Local people I work with who saw the book on my desk would sometimes start a conversation with me about it by flicking through it and telling me about a connection they had/have with one of the contributors. After my experience working in the department of adult education, I presumed earlier that locals would have little interest in the content because most local people I work with are disinterested in reading a lot of words or have low literacy skills. This also emphasizes the point of teaching people about bush medicine through "skilled practice" where the body actively engages with the environment as opposed to reading (2000, p. 344). Doing so could enliven a person's relationship with their country spiritually while promoting healthy eating.

Aboriginal healers

I found the topic of Aboriginal healers to be even more vexing. The literature I read had clear information about Aboriginal healers and their importance in maintaining Aboriginal beliefs and wellbeing. When discussing Aboriginal healers with my participants and local and non-local people, however, I received a variety of different answers. These contradictory responses made me unsure about whether people were giving me inaccurate information. Ultimately, despite the different stories I heard, my research showed that

local people seemed comfortable with the clinic as their main source of healing. In comparison to the literature, which assumed that local Aboriginal healers should be re/integrated into the Western clinical environment, I was left feeling unsure about the benefit of Aboriginal healers in this community with more questions than answers about diabetes and the future of health in Yidiyi.

Aboriginal healers in the literature

Most sources I read on traditional Aboriginal healers were similar in their description of the role. Clarke's fieldwork experience illustrated that a healer is most often an elderly man (2008, p. 9). Before colonisation, all adults in a community would have basic knowledge of bush medicines, with the healer having special access to spiritual power and knowledge (Clarke, 2008, p. 9; Maher, 1999, p. 233; McDonald, 2006, p. 90; Seathre, 2013, p. 65). According to Clarke, traditional healers obtain their power from dreams or by being given "magical charms" from other living healers (2008, p. 9). Clarke's research showed that very rarely power is handed down from father to son. More commonly, future healers are chosen for their "developing social skills and aptitude for learning" (2008, p. 10). Berndt and Berndt write that healers need to undergo particular initiation rites before they gain the necessary qualities, and once obtained they sometimes also have the power of a sorcerer (1988, p. 331). They receive formal training from other healers, explains Maher, giving them the ability to remove the effects of sorcery on a person by gaining the ability to enter an ill person's body and to restore the overall wellbeing of the soul or spirit (1999, p. 233).

In the 1950s, McDonald states that, Aboriginal healers "were relegated from being central to peripheral actors in their own communities...and hovered on the fringes of hospitals" (2007, p. 282). In Williams view, the colonial suppression of Aboriginal culture has disrupted the transmission of cultural knowledge (2011, p. 9). Furthermore, that more cultural knowledge and the use of traditional healing practices is retained more than may be obvious to an outsider (ibid).

Local Aboriginal healers in Yidiyi

After reading the literature, I knew that a healer's role differed depending on the group concerned in Australia. Nonetheless, I presumed that finding one would be quite straightforward. I was wrong. During my interviews, I asked my participants if they could see anyone local for their diabetes. The answer was always "No". I presumed that this was because diabetes was a new illness in the community and a local healer could not recommend a remedy based on plants as a form of treatment, unlike country or body sweat, which had been utilised. When I asked them if they saw anyone local for general illnesses, the answer was also "No", or, "Other people might" (inferring that they did not). A common question I also asked locals was: who did they see before whitefellas came? They did not know. One woman told me that in the past they all knew bush medicine so they did not need a local healer. When I asked if they would want to see a local healer, the reply was, "No", the clinic was sufficient. I asked Karbanni if the elders that she sought health advice from had the ability to heal like a doctor, and she said "No". On the other hand, Tjitjawu told me that he could visit family in another region of the Northern Territory:

Yeah I go to my family, far away. Like I see them and they try to check my body.

How do they do it? I'm interested. How often do you need to go?

They just check your body, everything that you've got on your body. They touch that thing and give it back to the same bloke who give you that thing. I only go when when I'm crook. But I'm not crook. If I wanna see someone I just go to the hospital mob¹⁷ or family.

In this part of our conversation Tjitjawu had told me that illness is caused by the sorcery of one person and that his family connections in other regions are able to remove the sorcery and return it to the person who inflicted it upon him. Although, even though this was an option, he later said that he had never needed to go. Reflecting on all of the responses I got when asking about local healers, I was therefore, under the impression that there had never been Aboriginal healers in this area. Also, that all people had knowledge on the healing

¹⁷ Local people refer to groups of people or things as mobs.

qualities of plants and could use their body sweat to heal but mostly chose to use the clinic out of convenience. Further, that perhaps in the past, if someone was extremely ill they visited other clans in surrounding regions, which would have also maintained social connections. On one occasion, I attended a “whitefella”¹⁸ party and became involved in a conversation with an older man who had lived here for several years. I told him about my research and in response he said that in recent years he had been told some “very weird stories about sorcery and healing” but was sworn to secrecy and, hence, prohibited to talk to me about them.

Late in my fieldwork I met a man, I will call ‘Mark’, who claimed to be an Aboriginal healer. He was at the school to participate in teaching children about their culture for the day. He walked past my office and saw the local book on bush medicine on my desk. He struck up a conversation with me on the topic and soon told me about his role as a traditional healer. He told me that his father was a healer and that he would train his son in the craft as well, which contrasted with what Clarke had said: that a healer was usually chosen and that the role was not passed down generationally (2008, p. 10). It surprised me when he told me people visited him most nights for healing, as local people told me they did not visit a healer when they were unwell. I asked him whether anyone came to see him if they were unwell with diabetes. He said “Yes” and added that he would suggest they eat bush tucker, specifically, seawater turtle, red kangaroo and long boms. He told me that in addition to bush remedies he would often use his sweat to assist in healing people who were ill. During our conversation, he said that he just recently finished working at the clinic as an Aboriginal health worker. He said that any local person, regardless of whether they were in a different clan group, could come into the clinic and ask to see him specifically. I found this interesting as, despite feuding between families, he was more than willing to help any person. After hearing about their illness, he would suggest a particular bush tucker to eat or drive the person to where his recommended healing method was located and treat them either with a plant or the healing qualities of a particular landmark. When I asked him why he stopped working at the clinic, he said he “Just needed

¹⁸ Social events are often segregated as local people are prohibited to drink alcohol. Non-Indigenous people are allowed to drink alcohol, provided they have a permit signed by a local elder and police officer.

a change”. When asked if he was treated well at the clinic by non-Indigenous people, he said, with certainty, “Yes”.

I was excited by our meeting and began asking local people about his role. I presumed that perhaps I had just been asking the wrong questions or had been phrasing them the wrong way. “Oh yeah,” two men said to me with a tone of realisation when I asked them why they had not told me about Mark and his role as an Aboriginal healer. However, other people I mentioned this to would look at me with confusion and say they did not know that he was. On one occasion, I was sitting with a group of five women and I asked them about Mark’s position. After I had relayed what he told me about his employment at the clinic they all started laughing at me in hysterics. “He’s a man doctor!” they said. All of a sudden they lowered their voices and said “Men’s ceremony only”. They proceeded to tell me he did not heal at all, that he would only perform “men’s business” during ceremony time and that was it. They all, even the woman who lived across the road from him, said they did not know of any men or women visiting him at home or at the clinic. They also told me that they never see anyone local for illness and were more than happy to go to the clinic. I was even more perplexed. I rang the clinic and asked the Aboriginal receptionist what Mark’s role was. She transferred me to a non-Indigenous staff member. When I said to her that Mark had told me he was a healer, she responded with an immediate “No, he was just a driver. That’s it”. It was possible that he functioned as a man doctor under the radar of non-Indigenous staff members.

When comparing my experience with the literature, I found it difficult to accept that there had never been a local healer before the missionaries’ arrival. Perhaps there were local healers before the migration into Yidiyi but Seathre’s experience of the convenience of the clinic and William’s suggestion of the suppression of traditional healers may have encouraged their decline. It made me consider what Mark and other community members had told me about his role as a traditional healer and to consider that perhaps, regardless of what he or others told me, what he has experienced as his role, was what he wanted for the community and the clinic. Nonetheless, after the non-Indigenous man at the social

gathering told me that he was trusted to keep information a secret, I was lead to think that people were withholding information from me as it was none of my business.

Where does this leave me?

Shahid and Bleam (2010) conducted a study on the meaning and use of bush medicine and traditional healers for Aboriginal peoples in urban and rural areas of Western Australia. Their findings showed that clinics are representative of the dominant society and result in a loss of cultural knowledge for Aboriginal peoples (2010, p. 7). They argue that making traditional healing systems accessible to Aboriginal peoples contribute to repairing some of the damage made by colonisation by giving comfort and peace to the person while also empowering them (2010, p. 8). From this research, the point I want to emphasize, is that perhaps there was no local healer and everyone had the ability to heal. If so, I felt incredibly uneasy and sad about the fact that most people could not tell me about bush healing remedies and that perhaps local cultural knowledge was being lost. For example, the outcome of migration into Yidiyi in 1935 meant that local people now have limited contact with their country and, therefore, limited opportunity to learn bush medicine. Also, while I felt positive about the local integration of accepting the clinic as a form of healing alongside my participants' Aboriginal healing methods, Shahid and Bleam's research concerned me about a number of things. First, the convenience of the clinic meant that people did not need to prepare the plants anymore and could simply go to the clinic instead. Secondly, not learning or practicing bush medicine meant that "skilled practice" was not in use and, subsequently, engaging with the land through this skill was minimal. This ultimately means, the *acts* of connecting a person with the land was not utilised.

What I knew for sure was that although I had received mixed information about how prevalent bush medicine and Aboriginal healers were, Chapter Four discussed the way that the clinic is beginning to change to be more holistic in its treatment methods by improving relationships between staff and local people (see p. 67). Although visits to the clinic seemed to be mainly to relieve physical ailments, particularly concerning diabetes, the clinic is an important (and more than just accepted) part of treating ill health in Yidiyi. While there was knowledge and some use of bush medicine, it did not appear to be used

frequently and the clinic was the preferred option due to convenience. I found that the local healing methods used to treat diabetes, on the other hand, were used to live the “right way”, revive the spirit, and to maintain relationships with country and family. All of these treatments encouraged me to think about how healing methods had changed over time. This then lead me to think about how, although people knew bush tucker was the best form of diet to live the “right way”, peoples diet has developed to consume an enormous amount of sugary and fatty foods (as I observed from what people buy at the local store). What did Western food mean to people? Was there a correlation between the meaning of pre-colonial foods and foods you could buy at the shop?

Diabetes and the cultural meaning of food

My research indicated that local people in Yidiyi have associated some of the cultural meaning attributed to pre-colonial diet, to sugary and fatty food. (In particular, demand sharing). I also found that while demand sharing contributed to the social connectedness of people, it may also prevent people from being able to consistently eat and prepare healthy store-bought food. “Skilled practice”, is once again a relevant suggestion in that cooking classes would improve diabetes rates in Yidiyi: The act of learning to cook with others is a social action which physically engages the person with learning to cook healthy food.

Diabetes, food and Aboriginal peoples

In an attempt to make sense of observing the consumption of large amounts of sugary and fatty food, I refer to an article about an urban Aboriginal community in Melbourne, where Thompson and Gifford (2000) conducted research into why people with diabetes continue to eat sugary and fatty foods, even with knowledge of its health risks. They conducted an ethnographic study focussed on how food is symbolic for people with diabetes. Their findings showed that the act of collecting, preparing and sharing food is symbolic of connectedness to a place, past, family, and identity (2000, p. 738). Moreover, although foods have shifted from a pre-colonial diet, the social connectedness that food provides to people continues within their current family and social networks. This is one reason they continue to eat sugary and fatty food. To intervene and change a person’s diet would

disconnect them from these ties (2000, p. 739). Therefore, meaningful intervention would need to involve a change in diet for the whole family and a mindfulness of food as connections to past, family, and land.

Food in Yidiyi

I find Thompson and Gifford's findings around the symbolic relationships to food similar to my fieldwork findings. Firstly, my conversations showed that food from country connected a person to pre-colonial traditional values. Mark told me that when people come to see him about their diabetes, he recommends they go to their land and eat bush tucker such as kangaroo and long neck turtle. Also, as I said in Chapter Four, Karbanni and Mary eat the food their country provides, such as long boms and catfish. These examples indicate that one of the local ways to heal diabetes is through eating foods which reconnect a person with land, ancestors, and past.

However, local people in Yidiyi continue to eat a lot of fatty and sugary foods. While food found in country connects a person to the values of their traditional past; sugary and fatty foods are also vehicles for some of those values, such as demand sharing and family, and connection to the past pre-migration and after the missionaries' arrival as they have become apart of everyday diet and routine. Marie told me that, despite her mother passing away due to diabetes, community members have now incorporated sugary and fatty foods as a part of their everyday diet:

Now, it's new generation and we buy like, sugar from the shop. And you know those drinks, like Coke. Soft drinks yo. Cake.

As well as the above interview example, I remember many of my experiences and observations around the sharing of sugary food during my time here. For instance, I often see families sitting outside the store after doing their shopping and sharing large bottles of soft drink, ice-blocks and chips. Another example was when a local friend of mine came to visit me and had brought a large bottle of soft drink. A man yelled out to her from a distance and we had to wait at the gate so that he could have a tiny sip of her drink. They did not have any conversation, and after, he turned around and walked away. Another

recollection was of seeing different locals at the store regularly standing outside the shop and asking passersby to buy them a soft drink. Sugary and fatty food seem to be the most readily available foods to consume immediately and to share the most easily. The previous examples also demonstrate that the way food can be interpreted in Yidiyi is extremely complex. Fast food is connecting people to the contemporary landscape and inhabitants of Yidiyi. It was possible that the introduction of sugary and fatty foods had now become symbolic of emotions attached to pre-colonial times (Rosaldo, 1984, p. 140).

Knowledge of how to cook healthy meals also seemed limited. I would often see posters in the local store that promoted healthy eating. On one occasion, Eve and I made a frittata together. She was very interested in how to make it. She said she and her family did not cook many meals at home due to their limited cooking utensils, knowledge on how to cook, and many people do not own fridges or freezers. Tjitjawu told me that, when he could, he ate meat for dinner, occasionally accompanying it with damper. My conversations and observations suggested that damper was often a dinner time meal which was accompanied with tea. I was also told by numerous people that buying groceries for a week at a time from the local store was difficult as wider family could help themselves to the food in the house and there would soon be none left and no money to buy more. Although, on the other hand, Pinpirrith told me that she cooked regularly at home for her family.

My other son, you saw him, he's my carer. He helps me to cook... I get fruit or veges, or chicken. Just get all the skin off. Cut them up and [cook] all the meat with veges... Yeah I got it all there. For the kids.

Health and an emphasis on “skilled practice”

It seemed to me that public health messages to eat healthy food may not be working as they did not involve a “skilled practice”. That is, they were not accompanied by cooking classes. It seemed to me that the act of learning and cooking as a family was necessary. This could be done by initiating cooking programs in the school's kitchen. However, this did not solve the issue of being able to afford to buy cooking utensils or predict when outside family members would demand food. Buying food at the beginning of the week could leave a family with no food for most of the week. I was unsure of how eating

healthily could become everyday practice for most people. However, I feel that if “skilled practice” is utilised in areas, such as learning bush medicine and cooking, people in Yidiyi could potentially make dietary lifestyle changes (or at least they would have acquired some new knowledge or skills).

***Yamurr*, the future of decisions and diabetes**

I began thinking that the promotion of learning bush medicine and healthy eating could be a topic of discussion with local clan leaders at the *Yamurr* council. After asking questions about the meaning of the word early on in my research, I knew that *yamurr* was the name of the region and coming together as one people. Near the end of my research I began asking more questions. This time, I found that *yamurr* was a confusing topic. There was a difference in the amount of knowledge known about the meaning of *yamurr* between older and younger people: older people could tell me that it was the act of coming together. At the same time, people 30 years or younger, could not express what *yamurr* was. Rather, they told me that it was only the name of the region. This may have been due to either the language barrier or perhaps I was not asking the right people. I was not sure. Similar to the decrease in knowledge transference of bush medicine, I became concerned that general cultural knowledge was not being transferred to younger people. For example, older people could generally answer my culturally related questions while younger people could not. Responses to my questions were often recommendations to ask an elder.

In general, I was trying to make sense of all the different things I was being told and not told and what this meant for the future healing of diabetes in Yidiyi. I felt that while there was a strong presence of indigeneity in Yidiyi, there also seemed to be a lot of knowledge that was not being passed down to the younger generations. This may have been due to, as Ivory suggested, younger people’s resistance to some of their cultural heritage (2013, p. 4). Another reason could be that elders did not feel that younger people were of age, or worthy, to become informed about cultural knowledge. Although I talked to younger people in casual conversations, I was also aware that all of my participants were over the age of 45, which meant that I was limited in my interview data in finding out whether

younger people used pre-colonial methods of healing for their diabetes. Ultimately, I am concerned about health and wellbeing in Yidiyi and the continual rise in diabetes. I feel that the presence of the *Yamurr* council is reassuring: there is a core local decision-making system in place. However, I am also of the opinion that the future effectiveness of the *Yamurr* council, particularly in terms of community ownership, is dependent on government policies that impinge on the successfulness and ability of local people to make community owned decisions for the benefit of Yidiyi.

Conclusion

Throughout this chapter I have written from the perspective of a combination of the literature, my interviews, conversations, and observations while living within the community. In doing so, I feel that I leave this chapter with more questions than answers. In terms of diabetes, this chapter shows how complex it can be to incorporate bicultural medical systems when seeking to lower diabetes health statistics. The factors that need to be taken into consideration are diverse and unique to this community and the individuals who live here. While literature can be a guiding factor, finding a solution requires much more research in this community involving all clans and a variety of ages.

I think that what this research has taught me, particularly when comparing it to the literature and in combination with my experiences, is that local cultural medical practice is changing in a way that is unique to Yidiyi. Although the topic of a local healer is unclear from my perspective, through my conversations and observations, active education while *on* the land on the uses of plants and fauna would contribute significantly towards the physical and emotional wellbeing of the community and the future healing practices for diabetes. As I stated, learning for local people in this community appears to involve skilled practice. This mode of knowledge transfer, combined with my understanding that local people would like to visit their country more regularly, indicates that acquiring knowledge of the plants and fauna *of* and *on* a person's land would be a skilled practice that would contribute significantly to a person's social, emotional and spiritual wellbeing. In the following chapter, I further explore local complexities that are specific to Yidiyi. In

particular, the uniqueness of local social relationships and how these relationships are interpreted within the local clinical environment and what this may mean for the future healing and wellbeing of local people in Yidiyi.

Chapter Six

Local social structure, relationships and the clinic

Introduction

In the previous chapter I was left feeling confused about what my participants felt is the best way forward for healing diabetes. However, I did know for certain that, as Chapter Four established, the relationships with human and non-human entities for the local people of Yidiyi affects the health of an individual and that Aboriginal health is grounded in cultural, social and emotional wellbeing. This chapter is an extension of that argument in terms of the context of social structure and relationships. I compare social structure and relationships with how they are interpreted within the local clinical environment between Aboriginal and non-Aboriginal people in the community. I have found that there are social relationships of several kinds. Firstly, I will discuss the social relationship an individual has with their land within an Australian Aboriginal context. Continuing from my discussion of local social structure I outlined in the background chapter, I will discuss my conversations and observations in terms of how conflicts between clans affects health for the individual and for the community. As well as this, cultural social obligations such as gender rules and demand sharing also affect the health of an individual and group. I also look at how local social problems are dealt with, or not dealt with, at the clinic.

Sensing the land as social

In, *At Home in the World* (1995), Jackson's research with the Warlpiri people taught him to experience the land and acknowledge a sense of place and home, that was unconventional in terms of his own relationship and perception of home. For example, after spending a night camping on the desert landscape, Jackson narrates his interpretation of how the Warlpiri people experience land as home:

It isn't just the tricks of changing light that animate the rocks and suggest the forms of living things. It is the way you come to learn, living with

Aboriginal people, that the landscape is never devoid of meaning, even when it is deserted. The landscape is a social map, whose legend you must learn. The human body and the body of the land share a common language. Person and place coalesce. Whatever happens to one, happens to the other (1995, p. 125).

In terms of my own fieldwork experience, Jackson's ethnography confirmed that the landscape is connected to the social. My research showed that people have personal relationships with the land, they share a relationship with the land with other members of their clan and ceremonial group, and they are able to continue to have relationships with their ancestors through the land and their totems who inhabit the land. If land is connected to the social, then what in particular is happening to the landscape that may be having an effect on local people's health? As discussed in Chapter Four and through personal experiences, I became aware that for local people, the landscape was bursting with meaning, and this meaning could be found in *Marl* stories. I had also established that for the majority of people in Yidiyi, in order to be on one's own land, they must sometimes travel for hours. Therefore, the spiritual relationship the individual or group has with the land is not experienced regularly since the migration into Yidiyi in 1935. In addition, I knew that the migration had brought clans closer together and was still affecting the social structure. I was interested to see if the change in social dynamics had any ramifications in terms of diabetes and health.

Local social disharmony, sorcery, ill health and death

Now that clans live in a close proximity to one another there has, according to locals I spoke to, been an increase in fighting. Regular fighting now appears to be the norm. From my conversations within the local community, it seems that it is difficult for young local people, particularly men, not to become involved in the arguments and fighting that occurs between clans. Like many middle-aged men in the community, Tjitjawu was involved in feuds when he was younger but is not associated with it today. Today, the fighting mostly consists of two groups of people yelling from a distance throwing rocks and metal poles at

one another. However, I rarely hear of anyone being physically hurt by the objects. From my two years in the community, I know that the feuding can last anywhere between one night or every night for up to a month. The fighting is usually late at night and can continue until sunrise, involving mostly men. As non-locals, we are advised to keep out of local politics.

During numerous conversations with Tjitjawu, he made comments about how the fighting affects his and the communities health and wellbeing. One of the reasons he gave me was because some local people used their totems in the wrong way. He told me:

We can't touch all them totems. I can't do that. Some people do that. They taking all them totems for their mob and using them here. That no good. Hurting them, killing them. Some people who like the argument. See, they never used to do that back in the days. But I don't do that to people. I don't touch my totem. There's no rule for totem no more.

Here, Tjitjawu says that some people had been rubbing their totems on their bodies which consequently harmed people in the wider community. I was not sure about how this process worked and I tried to ask him more about it but he could not tell me the details or tell me who was doing it. He said it was “Bad people, black magic” and to “Stay away”. As many scholars have noted, attributing social disharmony to sorcery is common and is traditionally understood to be the cause of ill health and unexpected death (Dussart, 2010, p. 78; Maher, 1999, p. 231; McDonald, 2006, 91). For Tjitjawu, explaining things in terms of sorcery is a culturally relevant way of explaining larger community problems. To me, the way Tjitjawu talks about his concerns in a culturally-relevant way, through sorcery, is an expression of indigeneity and agency over community matters. In other words, the increase in ill health and also in gang rivalry are out of Tjitjawu's control. Asserting cultural meaning shows Tjitjawu's agency as it is a culturally-relevant way of explaining and understanding local social concerns.

It was not only Tjitjawu who attributed sorcery to ill health. Mark, the Aboriginal healer, connected death in the community to sorcerers, known locally as “kidney fat men”, when regular fighting occurred. From Deborah Rose, environmental philosopher, and my

conversations with locals, I understand that a kidney fat man can be described as a living man who is a sorcerer (2000, p. 160). Melissa told me that if your hair or clothes are left lying around, as opposed to being burnt, the kidney fat man has the power to cast sorcery on the person if he finds the items. One work colleague told me that her grandfather was a kidney fat man and was renowned for murder. Today, I found that no one knows who the kidney fat men are. For example, late in my fieldwork, Mark told me that he saw “three kidney fat men” during a night of frequent fighting in the community between gangs. He was clearly shocked and upset about this sighting, which led me to ask him if it was unusual to see so many. He said it was “very strange”. I then asked him if he could identify the men. “No”, he told me. It had been too dark and they had his back to him. When I asked him why he had seen so many, his response was that there was too much fighting and that too many of the elders were teaching more than one person their “bad tricks”. He said to me, “People are dying, people are dying”. He was not referring to anyone of a particular clan group; he meant people in general. Similarly, Rose’s research showed that kidney fat men are blamed for social disharmony between people and can be held responsible for death (2000, p. 163). All three examples explain sorcery as the cause of death. For Mark and Tjitjawu in particular, the increase in sorcery is seen as the cause of the increase in the social disharmony between local people, while also giving a reason for ill health and death. However, I had not heard that sorcery could cause diabetes. After hearing their stories, I was not satisfied with connecting ill health and death solely to local social disharmony.

Social obligations

As well as local social issues, Western cultural values impact on the social structure and sense of wellbeing of the community. Similar to the local treatment of diabetes, there appears to be a strong ongoing negotiation to how aspects of Western cultural values that essentially underpin all of the government run organisations in the community are accepted within pre-colonial Aboriginal values. I found that, specifically, the Western perception of Aboriginal social obligations, for example, gender and demand sharing, had an effect on

the outcome of social relationships within the clinic between Aboriginal and non-Aboriginal people, as I discuss next.

Applied medical anthropologist, Sri Sreenivasulu explains social obligation broadly as

...an ethical theory that an entity, be it an organisation or individual, has an obligation to act to benefit society at large. Social responsibility is a duty every individual has to perform so as to maintain a balance between the economy and the ecosystems...This responsibility can be passive, by avoiding engaging in socially harmful acts, or active, by performing activities that directly advance social goals (2013, p. 31).

This definition of social responsibility applies to Australian Aboriginal peoples but should be explored further to include specific cultural values. A practical resource, *Working with Aboriginal and Torres Strait Islanders and their Communities* (2014), produced by the Aboriginal Services, illustrate that Aboriginal kinship and family structures bind Aboriginal people together in all parts of Australia, both psychologically and emotionally (p. 14). They further say that Aboriginal people have family and kinship responsibilities that are not typical of non-Aboriginal families. This is inclusive of culturally specific responsibilities, such as gender roles, demand sharing and kinship obligations. Their purpose involves actions that work to connect and reproduce emotional links for the benefit of the health and wellbeing of all people (ibid). I will now discuss two locally relevant topics: demand sharing (which was introduced in the literature review on p. 24) and the influence gender rules have on social responsibility, which were examples that have come up frequently during my time in Yidiyi.

Demand sharing

Mangul often talks to me about the demands of her family. As an employed person, Mangul has a regular flow of income. As we talked, she told me how she always gives her

family members money when requested, although she found it frustrating at times. When I asked her if she could ever say no, she said

How could you say 'no' to family? If you say no, it hurts in here (puts fist to heart). It's really *hard*.

What about food at night? Can other people come round?

Yeah, they always do, my family.

What if you don't have enough?

You still share it. Cause maybe one day you'll need something.

If Mangul was to decline, she runs the risk of shaming the person asking and herself, especially if they knew she was able to provide. Linguist, Andrew Butcher claims that the word "shame" for Australian Aboriginal peoples encompasses

not only a feeling of guilt when one has done something wrong, but also a wider feeling of shyness, fear, or embarrassment at standing out from the crowd - even in a positive way, such as when receiving praise (2008, p. 638).

Mangul is socially obliged to give to her family to prevent shame. If she did say "no", she would alienate the person requesting and damage their relationship. I also experienced this as one time I was asked for money by a close work colleague and declined him. The person asking avoided me for a week. The experience made me feel guilty, upset, confused and rejected. Therefore, as a non-Indigenous person and taking into account that my relationships with local people are not bonded as kin, I imagine being treated in this way would be extremely hurtful and should be avoided whenever possible. If I do not know the person well, as suggested by Peter and Taylor (2006), I simply apologise and give a simple explanation as to why I do not have any money (p. 109). For example, not having any cash on me at the time. This is acceptable as it is not an abrupt "no" and is not a response that causes shame.

Although Mangul sometimes feels frustrated by the obligation to give money and share food, even when she does not have much, she also asks for and receives help, from her nieces in particular:

Sometimes, when I've got diabetes, I find it really hard to clean up at home. I tried to clean up the other day and I couldn't continue because I was sweaty, shaky.... Then I got my niece who lives next door. "Belinda", I said, "Come over here". She took the mob off me and then that's it, she did the cleaning up for me. I've got a couple of nieces from my brothers but the main ones are Lucia's kids (one of her sister in law's children). They help me a lot. They always come round to my place. So I'm lucky that I've got family.

In this regard, Mangul consistently giving material items, such as money and food to family, secures her social position and allows her to "demand" assistance and receive it when needed. This is similar to Mauss's book *The Gift* (1954) which I referred to in my literature review (see p. 25). More recently, Mangul's comments are also comparable in Seathre's fieldwork where he saw food as a commodity and a symbol (Seathre, 2013, p. 34). In Mangul's case, food and money are articles of trade. Due to her occupation and tertiary education, Mangul's wage is likely to be much higher than those family members around her who receive Centrelink payments as their main source of income. Hence, symbolically, she utilises her income to reproduce and/or maintain her social relationships and trades it for labour when she is incapable, as a result of her diabetes. Demand sharing gives Mangul the assurance that she will be looked after when ill. Therefore, demand sharing does not encourage individuation or the values and interests of a single person. Rather, it affirms a communal social network and is inclusive of the social, emotional and cultural wellbeing of the whole community. It secures or creates bonds between individuals, within families, and clans.

Gender

As mentioned in the background section, since the missionaries' arrival, gender roles have changed, particularly since migrating from their own land to the town centre, the introduction of easily accessible food, and the addition of Centrelink payments as it

reduced the need for men's main role as hunter and women's as gatherer. In terms of health, this has had an effect on restricting a person's engagement with and knowledge of the land. As I have continually argued, an Aboriginal person has an emotional attachment to the land and disengagement with land causes spiritual loss and potentially ill health (Flick and Nelson, 1994, p. 5). This loss and disengagement can also result in feelings of anxiety and depression (Scheder, 1988, p. 254). Therefore, the loss of responsibility and the transition in gender roles has added to the overall change in day-to-day diet as well as causing emotional stress and ill health, such as diabetes.

Local gender protocols and the clinic

Although there has been a general shift in the roles of gender in the community, traditional gender protocols are still followed. For example, brothers and sisters only talk to each other when it is unavoidable. It is also uncommon for males and females to be friends. I was told frequently that the clinic accommodated for local gender protocols by having separate men's and women's consultation areas, as well as the option to see a male or female staff member. However, according to one local woman I spoke with, Marie, some culturally specific gender etiquette is not followed by clinic staff. For example, as I discussed earlier in Chapter Four (see p. 64), Marie told me that occasionally when the nurses pick someone up from their home they yell from the car to call for them and this is regarded as 'rude' or disrespectful behaviour, especially if it is in front of their brother. This leaves open the possibility that they do not know or do not bother.

Marie makes the point that due to traditional Aboriginal kinship law, it is inappropriate for Marie and her brother to have any kind of personal relationship. For most Australian Aboriginal peoples, it is not permitted for males and females to say each others' name, talk to, or sit near one another. I have noticed that each family follows these rules as strictly as they see fit. For Marie, for example, it is improper for her brother to know her "women's business". Lowell argues that non-Indigenous clinical staff are often under-trained in cultural awareness (1998, p. 34). I think this is an example where, at times, kinship relationships have not been thoroughly taken into consideration for training purposes. If

the clinic staff do not fully understand that following gender protocols is a social obligation, then the clinic could be experienced by local people as a disruption or an area that does not contribute to maintaining social relations. On the other hand, most locals I spoke to feel that the clinic addresses local gender protocols appropriately.

Relationships

Demand sharing and gender protocols demonstrate that preserving relationships is deeply connected to the health of an individual and the community in Yidiyi. Within a family unit, each member has an obligation to be mutually supportive (King, 2009, p. 82). Failure to meet these obligations means wider family members are permitted to intervene in a relationship if, for example, a husband or wife were to act neglectfully towards one another or their children (Broome, 1994, p. 16). According to King, at a personal level, social obligations to immediate and extended family members contribute to the overall wellbeing of the Aboriginal person (2009, p. 82). I found this to be consistent when talking to Mary. She describes her body as “strong and healthy”, despite having diabetes. She identified herself as being “sick” as the result of an unbalanced relationship in her life. Mary felt that she commits to her social responsibilities in the home, to her partner and family. She was upset when she discussed her partner’s lack of obligation to maintain his responsibilities to her. By not fulfilling his obligations to Mary, her partner is disconnecting himself from the family unit. In her opinion, his lack of care to maintaining his social obligations to her is what makes her “sick”. Mary’s perception of health is associated with both her physical and emotional wellbeing. Her diabetes is under control and is, therefore, not making her ill. It is her emotional wellbeing that she is concerned about, and the emotional stress at home is making her unwell. This example demonstrates that a person’s ill health or wellbeing is not focussed solely on the body but rather is in response to the willingness to act as a contributing member to one’s family and community.

Relationships with the clinic

The cultural importance of maintaining healthy relationships to ensure good health also resonates within the clinic. Relationships shaped Marie’s experience with her diabetes.

She used to work at the clinic and felt very strongly about certain aspects of it. She began our conversation by telling me about a non-Aboriginal person who worked at the clinic during her employment there. The person, she said, was unfair to the local people. “They changed all the rules”, she told me, so that people would get picked up from their homes to ensure a consultation. However, they would have to wait hours to get a ride home, if they got one at all.

The way a previous person who worked at the clinic has helped to shape Marie’s feelings towards the clinic even though it is under new management. Marie told me that this is one of the reasons she does not want to recommend young people to go to the clinic. In summary, Marie feels as though the introduction of food brought by “whitefellas” is the cause of diabetes in the community and is confused and angry that they are also supposedly offering the cure.

In Marie’s case, relationships play a key role in shaping an individual's response to personal health treatment. An example of how important it is to ensure positive relationships between Aboriginal and non-Aboriginal people can be seen in the fieldwork of linguistic anthropologist Kate Anderson and Jeannie Devitt (2008). They interviewed 241 participants about their life experiences with diabetes (p. 500). They found, particularly for those who have English as a second language, that one bad experience at the clinic, of varying degrees, can deter a person from ever returning to the clinic (p. 501). For example, if they do not understand biomedical terms, they might be unintentionally made to feel stupid. As a result, they may not return (ibid). They argue that, one way for Australian Aboriginal peoples to feel comfortable visiting the clinic is to provide longer consultations. More time would allow for a comprehensive biomedical understanding and for the opportunity to exchange life stories and experiences between patient and practitioner. Their research demonstrated that relationships between Aboriginal and non-Aboriginal peoples are fragile. Moreover, that all interactions, as a non-Aboriginal person, need to be monitored, through reflection in the use of thoughtful, contemplative conversational dialogue, in order for their behavior to be culturally appropriate.

In contrast to Marie, Pinpirrith enjoys visiting the clinic. I ask her if she visited a diabetes nurse who lived here when she was in town. She replied,

Yeah. That's when I go to the clinic and see all the specialists and do fingerprints and blood sugar. They ask me, "You doing it all the time or once a day?" But I do it in the mornings, the insulin.

Pinpirrith, it appears, does not mind going to the clinic. In fact, her upbeat tone of voice also told me that she enjoyed her visits, which was a distinct contrast to Marie's responses and to much of the literature about such attitudes to clinics. There is little literature presenting Aboriginal peoples positive interactions with clinics. Therefore, I can only presume that in comparison to Dussart (2009) and Christie and Veran's (2014) findings, Pinpirrith's experiences are because her contact with the clinic is the opposite to what shapes many people's resistance to it: she has a biomedical understanding of diabetes¹⁹ (Dussart, 2009, p. 207); she has not told me about any instance of negative communication with medical practitioners; and she is well spoken in English, which may give her a deeper understanding of Western culture (Christie & Verran, 2014, p. 502). As well as this, Pinpirrith's aunty was married to a non-Indigenous person. Pinpirrith has a close relationship with him and refers to him as "uncle". All of these factors may contribute to her positive response to Western medical treatment of her diabetes and her interactions with the clinic.

For an Aboriginal person, Pinpirrith's feelings may be in the minority. A local nurse, Jenny, told me that she observed a miscommunication in health advice between a non-Indigenous practitioner and a local person with diabetes:

Maybe they understand a little bit at the time but I still don't think they understand to be honest. I know one of the nurses, she sat here for an hour with two women and they were going through [an information booklet on diabetes] slowly, and they were both nodding, yes, yes. But I still don't think they understood. They may have got little bits.

¹⁹ To support this view, Pinpirrith appropriately used words such as: "dialysis", "kidney", and "renal failure".

Local people saying “yes” may be because they are more culturally inclined to do so even though they may not understand. Jenny remembers a conversation she had with a local person who suggested a more hands-on approach would better explain the health risks of diabetes to Aboriginal locals:

I know one day here, John was saying, “We’re hands on people, you know, you can’t get us to read this and this, we’re hands-on people. If you mob, want to get something put through to us, you get us all down at the old church and put it on a table so we can touch and feel and look and learn. We get all these scabies and we can read and read and read but one day all those nurses took all those microscopes and we could see, we looked under the thing, we saw what they can do and we all understood.

These comments resonate with Ingold’s “skilled practice”. In the above statement, John makes reference to the importance of using the microscope so that he and others could gain an insight into what scabies are. I also think “skilled practice” decreases the power relationship between the patient and practitioner (2000, p. 189). This is because the patient is situated as a hands-on learner and is no longer an “object of knowledge” (Foucault, 1973, p. 66). This more hands-on approach reiterates my discussion made earlier, when Marie critiques the use of the blood testing meter (see p. 63). I suggested that both the patient and practitioner use the machine. This may help community members to understand a range of illnesses through active learning rather than purely through explanation.

As well as the local who suggested the “hands-on approach” to Jenny, Marie helped me to understand the benefits of a more interactive and dialogue-focussed consultations, as opposed to the principle use of the machine for diagnosing and healing patients:

It’s not you doing the thing it’s the machine [the blood testing meter] doing for you. And you just get the number and you write it down and putting in folder. The folder just stays there and the same number go there [every time I visit]. It’s not looking at what’s wrong with the person.

In Marie's opinion, consultations at the clinic are lacking in their patient-practitioner interactions. Marie feels that when she visits the clinic, the person seeing her does not see her as a whole person, nor are they attentive to her broader lifestyle and culture. In her view, they should be talking with her about what may be going on in her life that may be making her ill. Instead, her consultations consist of a mechanistic interaction, focussing on the biophysical causes and symptoms of a singular illness (diabetes), which is the same every time she goes.

For Western medical treatment to improve for Aboriginal peoples, the concept of a more holistic interaction between patient and practitioner need not only be applied to Aboriginal peoples. As mentioned in my literature review, Foucault claimed that the development of medicine in Western culture contributed to an unbalanced power relationship between patient and practitioner (1973, p. 86). As a result, the patient was not in a position to "teach" their practitioner about their personal experiences. Through my conversations with local nurses and through the literature, it seems that there is insufficient government-funding to employ adequate staff for longer consultation periods, nor are there orientation courses that medical staff must complete successfully before entering an Aboriginal community (Lowell, 1998, p. 25; McMurray, 2005, p. 351; Ring and Firman, 1998, p. 528; Seathre, 2013, p. 99).

Conclusion

This chapter has focussed on local social concerns that contribute to the increase in diabetes. The regular fighting, as well as the physiological effects that spiritual disconnection to a person's country has on emotional and, in turn, physical wellbeing, contribute to an already socioeconomically disadvantaged group. My fieldwork experiences exemplifies, however, that there is a strong persistence of traditional cultural values such as, gender relationships, and demand sharing in Yidiyi. Most importantly, gender relationships and demand sharing are founded on shaping and maintaining relationships with Aboriginal peoples and, as others have noted, non-Aboriginal people too. In the literature review chapter, I also pointed out that non-Indigenous patients are

expressing their need for a more holistic way of healing that does not focus solely on the body (Frank, 1991, p. 18; Stoltzfus, 2013, p. 6; Wendell, 2001, p. 18). This research illustrates that these relationships are crucial to the health of the individual and broader community.

The data illustrates that the way to improve these relationships is through a number of locally-suggested avenues. Firstly, local cultural engagement with country is imperative to reinvigorate culture and to provide a positive way for locals, including gang members, to interact and acquire knowledge. What I found to be somewhat perplexing is that, although local people have suggested to non-Aboriginal health practitioners that the best way for them to learn is through a “hands-on” approach, health education remains almost entirely text-based. Through my research, it is clear that for locals, at least, ultimately, health is holistic. Therefore, to develop the wellbeing of locals, relationships between Aboriginal and non-Aboriginal people must be improved. Within the community and specifically in the clinical environment, this requires a sharing of knowledge and a holistic understanding of people’s lives in order to find ways to develop the communal and in turn, individual health. As a way to improve Aboriginal health, to decrease the number of Aboriginal peoples with diabetes and to positively develop the Western health system in general, local and bicultural interactions need to involve physical engagement with the environment and technology, as well as time and effort to understand the whole person within their cultural milieu, to develop mutual perceptive understandings. This way, both patient and practitioner will be able to engage with each other to achieve mutual cultural understandings, essentially by improving relationships. Furthermore, if *all* non-Indigenous clinic staff are extensively trained on local gender practices by a local person it would not only provide local employment opportunities but would help with monitoring correct protocols, plus it would help shift power relationships by positioning the Aboriginal person as teacher and non-Indigenous person as learner. These suggestions, I argue, will ultimately create positive social bonds and decrease the rates of diabetes for Aboriginal peoples in Yidiyi.

Chapter Seven

Conclusion

This thesis has centered on how the seven key participants I worked with understand their diabetes. I began my project with the intention of carrying out research to understand diabetes and health and wellbeing, with my participants at the forefront. One of my main aims was to reflect as much as I could on my participants' perspectives on health and on how my participants work to achieve a healthy body and lifestyle, while living with diabetes. Through looking at diabetes, I have come to a greater understanding of Aboriginal views on health, wellness and what is important to the lives of Aboriginal peoples in Yidiyi. I have learnt that culture, environment, emotion, historical events and society all have an effect on the body and the general wellbeing of an Aboriginal individual living in Yidiyi.

For me, one of the most significant points I have taken away from this research is that nearly all the local people I spoke with integrate Western models of health treatment into the treatment of their diabetes (despite their sense of it being caused by whitefellas). I found that my participants' view of health is embedded within local Aboriginal cosmologies and it is, thus, interconnected with the social and physical landscape. My data showed that the negotiation between local and Western healing methods to treat diabetes reflects a mode of health care which is being created and recreated. I have learnt that Aboriginal health and wellbeing is much more complex than simply an aim to heal the physical symptoms of illness. This is because all the local Aboriginal healing methods for diabetes work to connect an individual to other human and non-human entities.

The connection of health, the body, and emotions has been one of the most fascinating areas of this research for me. When I think about it now, it seems logical that they are linked. From the literature, my two years of living in Yidiyi, and the responses I have had from my conversations with local people and participants, I am aware of the impact Western culture has had on local people's lifestyle and, in turn, their health. For example, migration has had an emotional strain on people as they are now living within the close

vicinity of clans that historically they never had done before. As a result of migration, engagement with country and ancestors is, for many, minimal. There has also been an extreme change in diet since colonisation. These points have physically and, in turn, emotionally separated local Aboriginal peoples from engaging with their land, thus causing emotional and physiological dysfunctions in the body, leading to ill health outcomes, such as diabetes.

As my participants mostly also used Western methods to treat their diabetes, my learning how Western treatment has developed, enabled me to critically reflect on what my participants told me. Generally, Western health care does not focus on improving relationships in order to maintain a healthy body. From this research, I have learnt that it should. In Yidiyi, some non-Indigenous nurses are taking steps towards what the literature suggests needs to occur, which is developing a more relationship-focussed approach in their health care for local people. Despite this, I was slightly perplexed that while non-local people were being told directly or indirectly that they wanted a ‘hands-on approach’ to health care, it had not been established. There is also a need to focus on establishing strong relationships between local Aboriginal and non-Indigenous people. Failing to do so is resulting in cultural misunderstandings and inadequate education of local culture for non-Indigenous people.

Integrating a “skilled practice” would greatly contribute to decreasing the number of people diagnosed with diabetes in Yidiyi. For example, learning healthy eating and cooking from cooking classes. Taking a relationship-focussed approach by continuing consultation visits in the home while family members are present would be beneficial. Marie’s suggestion of a ‘hands-on approach’ in the use of machines during consultations in the clinic so that both practitioner and patient share the use of the tool would also be an improvement. Another development would be to integrate trips to country as a complementary treatment to seeing a doctor. These trips could include the collection of bush tucker and learning of bush medicine from elders. Education on country could also be implemented as a pathway for older local gang members as a way to interact with the younger generation. Integrating appropriate food that people could culturally associate to in the local store may encourage a

healthier diet. However, these suggestions would require conversations through the *Yamurr* council to ensure they were initiated by community members for community and would be applied in a culturally appropriate way. As discussed in Chapter Six, this would depend on how government policies, such as the intervention, has an effect on the working validity of the *Yamurr* council at the time.

I feel that my exploration in understanding diabetes in this community became a journey of understanding some of the complexities that contribute to an individual's and group's experience with their illness. These complexities included government policy, neo-colonialism, cultural social obligations, the combination of bicultural understanding of illness, migration and relationships. I have found it challenging at times, particularly in the realisation that research is not straightforward and answers reflect individual interpretations of lives and illness. My research experience has made me appreciate individual life experiences and encouraged me to reflect on how I form and maintain relationships, particularly with the local people in Yidiyi.

Although all Aboriginal communities are different, what I was most surprised about during the research period was the contrast in the literature and my fieldwork in terms of integrating an employed local healer at the clinic for the benefit of the community. To explain, as I discussed in Chapter Five, I could not make an argument that Yidiyi would benefit culturally if they (re)integrated a local Aboriginal healer as local people did not suggest it, nor did they want it when I asked them. Local people are currently in the process of negotiating with Western health care and culture so that they can incorporate it into their own. The power of body sweat and the ability of an individual to be able to heal one another as a group and across clan groups, showed me a unique way to heal and the unified connection family had to one another and an indication of a pathway to inter-clan relationships. This demonstrates a strong resilience against full assimilation into Western socio-cultural norms and a signal that health care has the opportunity to improve for Aboriginal peoples, provided that bicultural relationships improve and government policy does not suppress Aboriginal cultural values.

This thesis is a contribution to the literature in Indigenous studies. It demonstrates my anthropological journey of discovery into a culture that implies resilience against assimilation and to living entirely within a Western medical framework. My participants' personal methods of healing diabetes is a reflection of strong cultural connections to land and other human and non-human entities. The local people I spoke with and my participants' capability to negotiate between two healthcare systems, that are essentially so distinct, shows that Australian Aboriginal culture is active and durable.

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Appendices

Appendix 1: Key questions for people with diabetes

1. What is the Yidiyindi word for diabetes?
2. What is diabetes? What happens inside of your body?
3. Do you know how you got it? What was it like, do you mind sharing it with me?
4. What was it like when the people at the clinic told you you had diabetes?
5. Does it ever stop you from doing things with family or going to work?
6. Do you know how long you will have it for?
7. Can you see anyone local for it?
8. What's it like going to the clinic, what are your experiences like there?
9. What do you think of the advice you get from there?
10. How do you eat food at night with your family?