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‘They *Do* Think about Health’: Young Indigenous Women’s Ideas about Health and Their Interaction with the Health System

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Introduction

One day I was talking with a non-Indigenous service provider who asked me what my research was about. I told her I wanted to know how often young Indigenous women in Katherine thought about health and how they engaged with health and social services. Her response was that it would be 0 per cent because Indigenous people do not think about ‘health’ because health it is a Western concept. This service provider’s idea was in line with much of the literature, which states that there is no Aboriginal word for health (Atkinson 2002, 44; National Aboriginal Health Strategy Working Party 1989). However, to say that Indigenous young women in Katherine have no conception of the term health or ideas about health is to overlook the reality they live in. The young women in my research were living in a town where non-Indigenous people were in the majority; they attended school, engaged with Western media and used the Western health care system. As such, they cannot be regarded as isolated and independent from their surroundings (Merlan 1998). Moreover, the fact that there is

no word in Aboriginal languages that means health in the Western sense does not mean that people do not think about issues that are generally regarded as being in the domain of health and sickness.

Research on Aboriginal health often falls into one of two categories. Research from a biomedical perspective only looks at health from that perspective and is generally based on statistical indicators of mortality and morbidity, without acknowledging the existence of traditional beliefs. Conversely, much research on Aboriginal health beliefs focuses on traditional beliefs (Maher 1999), with anthropologists emphasising sorcery and traditional healing (see also Senior 2003). Both perspectives run the risk of overlooking the reality and complexity of people's views and behaviour. Indigenous health is an issue of concern for governments, service providers and researchers, which makes it imperative to consider whose perspectives are prioritised. Research findings need to reflect Indigenous people's own lived experiences.

The majority of anthropological research on Indigenous health has focused on the general population or on small children (see e.g. Carson et al. 2007; Reid 1983; Siggers and Gray 1991a). Research focused on Indigenous youth, on the other hand, is not always focused on health specifically (Burbank 1988; Eickelkamp 2011).¹ However, research with young people is important, as many health-compromising behaviours, as well as patterns of health service utilisation, are developed during adolescence (Vingilis, Wade and Seeley 2007). It is at this age that people become aware of their bodies and start making active decisions regarding their health (World Health Organization 2003, 7–9). If public health policies and the work of service providers are to contribute to improved health outcomes for Indigenous young women, it is necessary first to understand their views on health and what is important to them.

Many ethnographic studies on Indigenous health focus on remote locations rather than town contexts. Yet, young Indigenous women in towns are exposed to different influences on their health beliefs and behaviours than those in remote areas. Although there is increasing recognition that the living circumstances of Indigenous people in remote communities should be seen as intercultural (Burbank 2011), there is a stronger boundary between Aboriginal and non-Aboriginal contexts in remote communities

1 Exceptions include Chenhall and Senior (2009), and Senior et al. (2014), who looked at remote Indigenous youth mental health and sexual health.

than in towns. Whereas in the former, non-Indigenous people are always outsiders (i.e. never permanent), towns form home for both Indigenous and non-Indigenous people. In towns, Indigenous and non-Indigenous people mutually influence each other, and strict distinctions between Aboriginal and non-Aboriginal domains—between tradition and modernity—cannot be made (Merlan 1998, 4).² This is especially relevant when considering young people may have multicultural friendships and who attend school and activities such as sports together. Another difference related to location is that, although the populations of remote communities generally consist of people from various language groups, this variety is even more pronounced in towns.

In this chapter, I show the multitude of health beliefs held by Indigenous young women in Katherine. The chapter starts with a description of Katherine and the 12 main informants in this study. This includes an explanation of how their Indigenous identity can be understood, as well as a consideration of Katherine as an intercultural place. This is followed by a short overview of the methods used, then an exploration of definitions of health, including how services influence young women's views, as well as ideas around taking responsibility for health. Subsequently, I discuss the use of health services, focusing on the role of Aboriginal Community Controlled Health Organisations (ACCHOs). The final section before the discussion considers the changing role of bush medicine and traditional healing.

Indigenous Young Women in Katherine

This study was conducted in Katherine, a small town with a population of about 6,300 people in the Northern Territory, about 300 km south of Darwin on the Katherine River (Australian Bureau of Statistics 2018; Merlan 1998). Katherine has an elongated shape, with Northside and Southside situated along the river and Eastside a little further away along the Stuart Highway. Several Aboriginal communities surround Katherine, such as Kalano on the western side of the river, and Rockhole, which is located 15 km to the south-east. Katherine's climate is subtropical with a wet and a dry season and average daily temperatures from 25°C–35°C,

2 It is important to recognise, however, that the relationships are characterised by inequality, resulting in the experience of marginality by Aboriginal people (Merlan 1998, 2005).

although 40°C days are not uncommon. Due to the town's location at the intersection of two main highways, and the presence of several national parks and cultural centres and galleries, many tourists visit each year during the dry season. Katherine is also a hub for many agencies that service communities in a large surrounding area, as well as for Aboriginal people from communities who visit to see family and to access shops, bars and other facilities.

Around 25 per cent of the population of Katherine is Indigenous (Australian Bureau of Statistics 2018). The Jawoyn people are recognised as the Traditional Owners of an area that includes Nitmiluk National Park north of the town (Kearney 1988). Currently, there are competing and disputed native title claim applications for the town of Katherine. The other main language groups of the region are Wardaman and Dagoman, who are from areas south-west of Katherine, and Mayali from the north-east (Merlan 1998, 14, 23). People from many other language groups also live in Katherine.

Katherine has a public and a private high school. There are two boarding houses for students from towns and communities elsewhere in the Northern Territory. Wurli-Wurlinjang Health Service (hereafter Wurli) is the ACCHO servicing Katherine (Wurli n.d.). In addition, there are other health clinics, a hospital and many social services. The service provider population tends to be transient, with many young service providers coming from 'down south' to work in Katherine for a year or two.

This chapter primarily focuses on the views and experiences of 12 Indigenous young women, varying in age from 16 to 24 years. At the time of my research, four were still attending high school; five were employed, two of whom were enrolled in a Certificate III or Certificate IV course;³ one had a job lined up; and two were not working or enrolled in education, one of whom had a baby. Their living circumstances varied from living at a boarding house to living alone to living with a partner to living with family members. Four of the young women were born in Katherine, two had moved with their families from elsewhere in the Territory, two were boarding students from elsewhere in the Territory and two were from interstate. All had access to, and interest in, Western items and activities, such as mobile phones, music, television and sports (Burbank 2011,

3 These are vocational educational qualifications.

128–30; Chenhall and Senior 2009, 36–40). Most participants were religious and stated that they believed in God and Jesus, with the majority being Catholic.

As noted above, Katherine should be understood as an intercultural space. This understanding is linked with how culture is conceptualised. Hinkson (2010, 5) has noted that anthropologists working with Indigenous people in Australia generally understand culture in two different ways: classicism and interculturalism. The former focuses on classical anthropological topics such as kinship and cosmology, regards Indigenous culture as relatively independent and stresses cultural continuity over change. The latter focuses more on processes and change. Merlan (2005, 169–70) describes two ways in which the concept of intercultural can be understood. The first emphasises separateness, highlighting the differences between Indigenous and non-Indigenous people. Culture is then understood as 'high culture': an essentialised and past-based view that focuses on the concrete and visible aspects of a culture that is imagined as unchanging (Merlan 1998, 227–28). The second way shows how beliefs and practices are shaped in the interaction between Indigenous and non-Indigenous people, and considers culture as expressed in everyday sociality and experience. However, these understandings are not mutually exclusive. An intercultural analysis should draw on both approaches as outlined by Merlan (2005), showing how an understanding of culture interacts with people's lived experiences (Hinkson and Smith 2005).

Both approaches are relevant to my research in Katherine. The young women I interviewed in Katherine described culture as including language, art, respect, hunting and fishing, 'knowledge about my tribe', songlines, their Dreaming, the Law, kinship, bush medicine and traditional healing. Culture was talked about as something that could be 'lost' and as something that could be 'strong or weak'. This is similar to Merlan's (2005, 169–70) first sense of the term intercultural. At the same time, Indigenous young women's sense of identity, as well as their health beliefs, are a product of everyday interactions within a multicultural context.

Rather than following the three-pronged approach to Indigeneity outlined by the National Aboriginal Health Strategy Working Party (1989), in this study I use self-identification only.⁴ Some of the young women in this study were of mixed Aboriginal and European descent, but, for a variety of reasons, all but one always identified as Indigenous.⁵ With regard to Indigenous identity, the young women could broadly be divided into two groups. In the first group, Indigenous identity was unquestioned; they had mainly Indigenous ancestors and they grew up around their Aboriginal family; they had a skin name⁶ and had learned culture from their own language group. In the second group were young women for whom Indigenous identity was more ambivalent. These women had lost touch with their culture because their mothers or grandmothers were part of the Stolen Generations,⁷ or because they had not grown up around their Aboriginal family. They made explicit efforts to learn about Aboriginal culture, acquiring knowledge in a similar way as outsiders would.⁸ Some of them did not have a skin name. They felt that they needed to know about their culture to strengthen their Indigenous identity.

Methods

The findings in this chapter are based on one year of ethnographic fieldwork in Katherine.⁹ Prior to starting my research, I had already lived there for eight months, which enabled me to start building relationships

4 This allows a focus on the insider perspective of Indigeneity. Certain conjunctions of speech, comportment, phenotype and so on influence what some non-Indigenous locals perceive as typically Indigenous. Some of my informants would not be perceived as typically Indigenous, yet others would be, and, as such, they included a range of young women with regard to identity.

5 One young woman was, in her own words, 'a quarter Aboriginal', but she frequently identified as non-Indigenous. Indigeneity is only a small part of her biological heritage and, as she is fair skinned, people often assume that she is non-Indigenous. Her story provides an interesting case regarding identity and culture, as she grew up in a largely Aboriginal town and was mostly raised by several Aboriginal women who she calls her nannas. Compared to many of the other young women in this study, she is very familiar with traditional Aboriginal knowledge.

6 Skin names indicate the section or subsection that a person belongs to. Non-Indigenous people who spend time in communities are often given skin names as a way of managing and referring to them.

7 'Stolen Generations' refers to Indigenous children, often those of Western appearance, who were taken from their families to be adopted into non-Indigenous families or placed in orphanages.

8 For example, they did this on camps during which Indigenous youth go out bush for one or two weeks and learn about clan groups, weaving, bush tucker, traditional healing and other aspects of traditional culture.

9 This chapter is based on my PhD research. Ethical approval for this study was provided by the Human Research Ethics Committee of the Northern Territory Department of Health and Menzies School of Health Research (Reference Number 2013-2112).

and get to know the town. Although my focus was on Indigenous young women who were 16–24 years of age and service providers who worked with them, through my participation at various organisations and my daily life in town, many more people became involved.

During my time in Katherine, I volunteered with the YMCA at their Drop-in Night and Girls Program,¹⁰ and at the Good Beginnings' Supported Playgroups¹¹ in Katherine, Kalano and Rockhole. I had a casual job as a tutor at Callistemon, a boarding house for high school students, where I mainly worked with the senior girls. I also joined two service provider networks and participated in various events in and around town, such as NAIDOC¹² Week, Youth Week, a Stolen Generations Healing Camp¹³ and the Barunga Festival.¹⁴ For seven months, one of my housemates was an Aboriginal health practitioner and, over time, I had several housemates who worked for social services in town.

In addition to the informal and unstructured interviews that were a common occurrence during my fieldwork, I conducted semi-structured interviews using an interview guide with Indigenous young women and service providers (Bernard 2011, 158; Heath et al. 2009, 80–83). All semi-structured interviews were recorded and transcribed. Many of the young women I interviewed, if they did not know something, commented that they could ask someone else, such as their aunt or grandmother. I found myself repeatedly clarifying that I was interested in their *own* experiences and ideas. I explained that, rather than creating a pharmacopeia of bush medicine, for example, knowing that someone did not know much about something and the reasons for that lack of knowledge was the information I was after.

10 Drop-in Night was held every Friday from 7 pm to 10 pm. It was attended weekly by 100–400 children and young people. The Girls Program was held on Tuesday nights during school terms for girls aged 10–18.

11 The playgroups were aimed at parents with children from birth to five years old, providing an opportunity for children to play and develop school readiness. I attended each playgroup once a week.

12 NAIDOC stands for National Aborigines and Islanders Day Observance Committee.

13 This camp was organised by the Northern Territory Stolen Generations Aboriginal Corporation, a not-for-profit organisation that attends to the needs and concerns of members of the Stolen Generations and their families and communities, including family tracing and counselling (Northern Territory Stolen Generations Aboriginal Corporation 2019). The camp, which was targeted at women who are part of the Stolen Generations, was held one weekend at the rural campus of Charles Darwin University, Katherine.

14 This festival in the community of Barunga has been held yearly since 1985, featuring musical performances, sporting competitions and cultural performances and workshops.

During my research, I worked with two peer researchers, Tamara¹⁵ and Channy, who, when I first met them, were 16 and 20 years old, respectively. They were involved in different stages of the research.¹⁶ I also worked closely with Sonia, a traditional healer in her 50s. She ‘adopted’ me as her daughter and gave me the skin name Kotjan. Besides her role as mother, she also took on the role of mentor and teacher. She taught me about the kinship system and other facets of culture. She allowed me to help make bush medicine on several occasions and to watch her do traditional massages, both in the hospital and in other settings.

Defining Health

In literature exploring definitions of health, a distinction is generally made between the biomedical perspective, which focuses on health as the absence of disease, and a more holistic perspective, which is positively framed in terms of wellbeing in different domains, including socially (Johansson, Weinehall and Emmelin 2009). In 1948, the World Health Organization created the following holistic definition of health: ‘Health is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity’ (World Health Organization 1986). Many indigenous people in the world have built upon this definition of health. In public health documents, the most commonly used definition of health for Aboriginal people is:

Not just the physical well-being of the individual but the social, emotional, and cultural well-being of the whole community. This is a whole of life view and it also includes the cyclical concept of life-death-life. (National Aboriginal Health Strategy Working Party 1989, x)

15 All names used are pseudonyms.

16 We discussed my research proposal and interview guide to make sure that the questions were relevant and suitable for young people. I conducted multiple interviews so that we were able to explore important topics in-depth; during subsequent interviews, I often heard new information about topics we had discussed before. This was especially common when talking about sensitive or personal topics. Channy introduced me to other young women for interviews and we conducted these interviews together. Although I knew many young women before interviewing them, when I did not, the presence of Channy, who knew some of them well, helped to garner more in-depth information than I would have been able to get by myself. All interviews were conducted in English, with Channy sometimes clarifying my questions in terms that were more familiar to informants. Finally, I discussed my findings and my interpretations of the interviews with both peer researchers.

Constructed in 1989, this definition provides a justification for Aboriginal-specific health services and draws attention to the social and cultural factors relevant to Aboriginal people's health (Brady 1995). The working party that created it consisted of 10 government representatives and nine Aboriginal community representatives. Therefore, the definition may not reflect the variety of health beliefs of Indigenous groups and individuals across the country, and is likely to have more currency in the political realm than in most ordinary people's everyday lives (Boddington and Räsänen 2009; Brady 1995; Friderichs 2018). Currently, the definition is used in policy documents that address disease prevention and health care management. It is also taught in cross-cultural awareness programs to people who are going to work in Aboriginal health (Lea 2008, 99).

Rather than using terms and phrases such as 'holistic wellbeing' or 'not being sick', the young people I spoke to framed health in terms of behaviour. Health was generally described as healthy eating and keeping fit, and hygiene was sometimes also mentioned. There was a focus on physical health, although one of my interviewees, Kimberley, said: 'It's not just the body, it's the mind as well'. Some women added that being happy was important for being healthy. When asked if they felt healthy and why, most young people said they felt healthy, and their answers illustrated their views of health as a behaviour. For example, Tamara said: 'Yes. I eat salads and fruit every day'. This view of health as behaviour can also be seen in this excerpt:

MF: And do you feel healthy?

Bridget: Sometimes.

MF: Sometimes?

Bridget: Depends on what I have and stuff. After I do my—like I do sports and stuff or go for a run, I feel good. And eating good I feel good—if I've eaten something good—like healthy.

When talking about whether people felt healthy, physical health problems were rarely named. Bridget had a broken arm but she did not mention this when talking about feeling healthy. The young women often mentioned health issues at different times during the interview that they had not mentioned earlier, but these did not seem to affect their perception of their health.

The young women had learned about health from a variety of sources, including school, clinics, family members, their jobs¹⁷ and the internet. A significant way in which standard health messages of healthy eating and exercising were distributed in Katherine was through social services. Service providers said that they incorporated health in their work through providing healthy food, taking care of hygiene, encouraging active behaviour and doing activities that reinforced self-esteem, such as letting the girls who attended the YMCA Girls Program do modelling at the Women of the World Festival.¹⁸ My observations confirmed these statements; for example, at Good Beginnings, the children attending playgroups always had to wash their hands before having morning tea, and they were given sandwiches and fresh fruit to eat. The YMCA was another place where the standard health message was clearly present. One project of the Girls Program was organising a 'Rainbow Run'. Together with a local participant of the Indigenous Marathon Project, the girls started a walking/running group. They decided to organise a run and to open it up to the entire community.

In addition to exercise, health was emphasised in terms of food and further changes were made to ensure this: cordial was replaced by water, and the dessert, if there was any, was fresh fruit. The message about health was taken in by the girls who attended the program such as Ashley:

MF: So, what do you think of the YMCA?

Ashley: I think it's really good. It keeps kids busy ... They have good food, like healthy food and stuff, which is really good and gives the girls like an idea how, or what they can eat at home.

Despite providing narrow definitions of health as healthy eating and exercise, the young women I interviewed held much broader ideas about what constituted the domain of health, including ideas about spiritual sickness, mental wellbeing, medical care and biomedical diseases. One possible explanation for the narrow definitions of health they provided is that, particularly in the early stages of my research, they perceived me as

17 This includes the work of the peer researchers. On several occasions, they asked me questions about specific health issues, such as how you can tell when you have cancer, and what happens when you get an abortion.

18 The international Women of the World Festival has taken place at Katherine several times. It celebrates women and girls, and features a variety of speakers, exhibitions, performances and workshops.

a non-Indigenous service provider, knowledgeable about health, and the interview as a kind of exam. This is evident in the notes I made following a conversation I had with Felicity, a woman in her 30s:

Can you tell me what health means to you? What is health? Felicity seemed to find this a difficult question. Looked away and laughed a bit. I explained that there is no right or wrong answer, I just want to know what people think. She then said (still sounding a bit unsure): 'I guess it's healthy eating, getting a bit of exercise in'. And then 'that's what they say at the clinic anyway, you need to change your diet'. (Field notes, 29 May 2015)

Even if my informants knew that I was looking at health in a broader way, their answers remained the same. Several interviews started with a discussion of bush medicine, traditional healing, domestic violence, alcohol and drug use, being connected to country and other aspects that may be understood as part of health. However, when Channy or I asked the concrete question 'what is health?', the answers were always the same: 'eat healthy food, drink lots of water, run, do weights' (Aleisha). It was as if this question automatically brought out this response, no matter what other dimensions of health the young women identified when asked different questions. It made no difference whether it was Channy or me who asked the question.

Another explanation for why all the young women defined health in the same way was given by Tamara. When I asked her what she had learned about health at school, she replied, 'they pretty much tell me what I think', referring to our earlier discussions about health. She explained that others, if they were taking the same class, would provide the same answers. I explored with her the possibility of using a more encompassing term, which would make it clear during subsequent interviews that I was aiming to get broader definitions than those provided so far:

MF: Do you think it's right to say 'health' like most people would think, it's just that sort of Western idea?

Tamara: Yeah. They think going for a run and they'll think all that. The way I think.

Although Tamara agreed that health is much broader than this, she did not have any term that encompassed all that fits into this domain.

Health: An Individual Responsibility?

For a long time, health policies have been based on the idea that health is an individual responsibility (McCarthy 2006, 275). However, nowadays there is increasing recognition of the social determinants of health. Following a gradient, differences in socioeconomic status, education, employment, housing, social capital and other factors are understood to contribute to differences in health at the population level (Marmot 2011; Marmot and Wilkinson 2006).¹⁹ Although government policies such as Closing the Gap increasingly reflect this recognition (Department of Families Housing Community Services and Indigenous Affairs 2012, 69; 2013, 67), public health programs continue to emphasise behavioural change.²⁰ Underlying this is the assumption that people value their health, want to improve it and feel a sense of control over it. However, perceptions about the importance of health differ between health professionals and everyone else. Health researchers and public health professionals are focused on health by default; whereas, for lay people, health is just one of many aspects of their life (Bukman et al. 2014). People have differing health needs and experience numerous and different barriers to healthy behaviour. Similarly, feelings of control over health differ between groups of people.

Senior (2003, 229–31) found that many Aboriginal people in Ngukurr had a utilitarian or functional view of health: health was seen as a necessity that enabled people to perform everyday tasks, such as work. However, people in Ngukurr did not need jobs to have an income—there were few jobs available in the community and the majority of residents received social security payments. Therefore, there was a low need for health, as all they needed it for was to walk around the community to be social. In contrast, for most young women in Katherine, the value of health was more implicit. They said it was ‘important’ but did not elaborate or explain why, as seen in Katie’s roundabout explanation: ‘Cause it’s important ... It’s the way to go, keep your body healthy’. Only Robyn related the need to be healthy to her job.²¹ Although health was mostly considered to be important in itself, some

19 Social and structural factors that specifically influence the Indigenous population include the history of colonisation, dispossession, marginalisation, racism and ‘country’ (Burgess and Morrison 2007; Calma 2008; Carson et al. 2007; Nazroo and Williams 2006).

20 A critical discussion of Closing the Gap and how it relates to Indigenous identities can be found in Friderichs (2018).

21 Nevertheless, she did not talk about this when I asked her about the importance of health. It came up when talking about medications. She said that she did not like to take medications, but if she did not take them and got sick, then someone else who may have already worked that day might have to cover a shift for her.

of the young women talked about wanting to live longer. In relation to having a hospital in town, Katie said: 'it's good ... I don't wanna die. I'm still young'. Robyn said that living to an old age was important to her because she wanted to be around for her family. She never met her grandmother, who died at a young age, and the desire to meet her own grandchildren and great-grandchildren motivated her to stay healthy.

Most of the young women in this study, when asked about their expectations for future health, said that they expected their health to be good. They usually answered this question in terms of healthy behaviour. For example:

MF: Do you think you'll be healthy in the future?

Tamara: I try to keep fit. Keep training, playing sports, go to the gym.

In a sense, the way the young women defined health implied control over it. If health is defined as 'you stay fit, keep strong, eat healthy' (Tamara) or 'health is looking after your health' (Bridget), and a healthy person is defined as 'someone that looks after themselves' (Channy), this is something that people can (choose to) do. If health *is* behaviour, then it can be controlled. However, my informants also talked about the effect that this behaviour would have. Sometimes they did this in a general way and sometimes in terms of specific diseases. For instance, although diabetes and heart disease were common in Tamara's family history, she thought she would not get them 'if I don't eat much sugar'.

The extent to which people exhibit healthy behaviour depends on their assessment of the risk of ill health. On the one hand, it is generally thought that young people believe they are invincible, leading to risky behaviours and inactivity regarding their health (Wickman, Anderson and Greenberg 2008).²² On the other hand, fatalistic attitudes to health, such as those described by Senior (2003, 157–58, 175–76),²³ can also inhibit people from taking good care of their health, as they do not

22 However, there is some evidence that adolescents are concerned about their health, health risk factors and health-related needs (Ott et al. 2011; Waters, Stewart-Brown and Fitzpatrick 2003). Additionally, rates of smoking and risky drinking among young people have decreased, and the age of first drinking and smoking has increased (Australian Institute of Health and Welfare 2017, 11–12, 24), indicating a shift away from unhealthy behaviours.

23 Many people in Ngukurr had a fatalistic attitude to health because of lay epidemiologies and a sense of a lack of control over health.

expect their behaviour to make a difference. Neither appeared to be the case among the young women in Katherine. Discussions around their future health showed that they were aware of the high risk of contracting certain diseases because they were prevalent in their families. Although this made some young women unsure about their future health, they still believed that healthy behaviour would positively affect their health, and their attitudes appeared more realistic than fatalistic. In general, family histories of specific diseases made informants take more action regarding their health rather than becoming passive:

The fact that I have high cholesterol and I have such a big family history of poor health, I think that's what sort of motivated me a little bit more to keep my health a little more on the positive side because at the end of the day, everything that I do to my body is going to affect me in the future. It doesn't matter how small. Whatever I put into my body today is going to affect me in twenty years down the track. So it does worry me in the sense that I've already got everything against me. (Robyn, 20 years old)

The young women in this study showed a strong view of individual responsibility for health. Statements such as 'We can help, but in the end it's your body' from May, who worked as a service provider, and 'If you really wanted to get healthy, you'll do it' (Channy), show the view that the final responsibility lies with the individual person. This idea was not only applied to other people but also extended to themselves, as they all expressed the view that they should keep eating healthy foods and exercising for their future health. This emphasis on individual behaviour assumes that choices are made on an individualistic basis in a social vacuum, not recognising the structural impacts on people's behaviour (Cockerham 2005). Further questioning revealed that the young women's behaviour was influenced by their circumstances—for example, when their family or the boarding house determined what food was available to them. On a broader level, Robyn declared her disgust for fast food outlets, especially McDonalds, on several occasions. She asserted that the government needed to step in to make them less available and to have more fresh fruit and vegetables available in Katherine. Other young women agreed with this, but they struggled to come up with anything else that could change at the community level, reflecting the emphasis on individual behaviour.

Use of Health Care Services

An often used model for analysing health care systems, Kleinman's (1980) distinguishes between popular, professional and folk sectors. Each sector has its own aetiology, treatment methods and practitioners. In this model, health care providers and services are labelled as belonging to either the traditional/folk sector or the Western biomedical/professional sector. The underlying assumption is that what people perceive as the cause of their illness determines their choice of treatment, with the treatment residing in the same sector as the perceived cause of the illness. In line with this thinking, Aboriginal and biomedical health systems have been viewed as conflicting and mutually exclusive by both researchers and Aboriginal people (see Saethre 2007). However, research in remote communities has shown that the choice of health practitioner is often not based on the presumed diagnosis, but on other factors such as the practitioner's gender, whether the patient is familiar with the practitioner (i.e. has a connection), cost and convenience (McCoy 2008; Saethre 2007). This section discusses the health care-seeking behaviour of the Indigenous young women in Katherine who participated in this study, focusing on their use of Wurli, the ACCHO in Katherine.

All of the young women I interviewed had been to a doctor in the previous few months. The main reasons were for general and sexual health check-ups, cold and flu, and feeling sick in general. Other reasons included tonsillitis, pregnancy tests, boils, migraines, a check-up for a broken arm, runny ears, having collapsed and feeling very tired, and having a swollen leg and being unable to walk. Some young women elaborated that a check-up can include a diabetes check, and that check-ups are done 'to see if my heart and kidneys and all that are all right' (Channy).

The young women all attended Wurli. Although some had accessed other clinics in town (e.g. Kintore Clinic and Gorge Health), the majority went to Wurli when they needed to see a general practitioner. Most had been to the local hospital.²⁴ The hospital was accessed for more serious conditions, such as pneumonia, melioidosis²⁵ and broken bones, or on

²⁴ Indigenous people from remote communities are often reluctant to go to hospital due to loneliness, perceiving hospitals as places where people die, and also because of communication problems with medical staff (Brady 2003; Senior 2003, 127–28; Shahid, Finn and Thompson 2009). These factors did not play a significant role in Katherine (Friderichs 2018).

²⁵ Melioidosis is a bacterial disease transmitted through contact with soil that is widespread in tropical northern Australia.

weekends when Wurli was closed. Some informants had been to a dentist when younger, but they did not go anymore. Other health services were also used, including a chiropractor, physiotherapist, podiatrist, dietician and the Royal Darwin Hospital, but use of these services was rare.

Drawing a distinction between Aboriginal and Western health systems is useful when comparing traditional healers with Western doctors and clinics. However, ACCHOs do not neatly fit in this model. ACCHOs have been operating since the 1970s, providing health care to Indigenous people who may not access mainstream services due to factors such as cost and racism (Marles, Frame and Royce 2012). Their acceptance among Indigenous people varies. In several remote communities, the local clinic is perceived as an outside, non-Indigenous institution (Saethre 2007; Chenhall and Senior 2017). In Katherine, young women identified the care at Wurli as biomedical and, as such, not different from the care delivered at other clinics. The difference lay in the fact that Wurli was an Indigenous-specific service, providing a culturally safe environment. Although there are no clear-cut criteria for measuring the 'Indigenous friendliness' of services, such criteria can include having Indigenous staff, an Indigenous board of directors and CEO, and a reconciliation action plan; providing cultural awareness training to all staff; using culturally appropriate materials; the physical layout of the service; how many Indigenous people they serve; and being non-judgemental and community focused (Fredericks 2014; Whop et al. 2012; interviews conducted with service providers). Young women in Katherine mainly went to Wurli because they were 'used to going there'. Other reasons for preferring Wurli included having family that worked there, the fact that Wurli had Indigenous staff, the ample time taken to discuss health concerns, the lack of cost, the provision of transport, the ability to walk in without an appointment, short waiting times, and the presence of helpful and friendly staff.

Confidentiality is often mentioned as a barrier to accessing ACCHOs, especially for sensitive issues such as testing for sexually transmitted infections (STIs) and pregnancy. Aboriginal health practitioners are often known to patients as they may be community members and relatives (Hengel et al. 2015; James, Cameron and Usherwood 2009). This was clearly the case in Katherine, where many young women had relatives working at Wurli. Whereas I only heard of one instance of an actual breach in confidentiality, most of the young women worried about confidentiality when accessing Wurli. When asked why, they all replied in a similar way: 'because I know them, I know how they are, I know how

they talk'. Regardless of whether confidentiality was actually a problem at Wurli, the fact that young women perceived it as a risk when going there could influence their willingness to seek health care. Young people run significant risks in damaging their reputations among their peers if they find out they have an STI (Senior et al. 2014).

Worldwide, indigenous health services have been found to be the most suitable to address the barriers that indigenous people experience accessing primary health care (Davy et al. 2016). Nevertheless, criticism of ACCHOs on the grounds that they duplicate already existing medical services have been expressed (see Siggers and Gray 1991b, 405). Some of the young women in this study, as well as some older women of their mothers' and grandmothers' generations, did not go to Wurli when they needed health care, but they nonetheless thought it was good that the service was there. They felt that Wurli was good for 'Indigenous people', but did not consider that they needed this type of support themselves. They were positive about Wurli's practice of employing Aboriginal health practitioners who speak Kriol,²⁶ use of promotional material that is more visual and in simpler language than other clinics, and connections with communities. One woman, who was more comfortable using other health services, showed strong support for Wurli, not because of how it operated, but because of its symbolic role. She considered the existence of ACCHOs as a healing pathway and an acknowledgement of the history of Aboriginal people.

Despite valuing Wurli as an Indigenous-friendly service, there was a strong tendency among the young women in the study to feel that health and social services should be for everyone. This was supported by statements such as: 'I really don't like to see black and white separate. We're all humans. We should respect each other for what we really are' (Channy) and 'Wurli needs to be for more than just Indigenous people. It doesn't matter what race you are, your health is always still important' (Robyn). In addition, many Indigenous young women felt that having special services for them could create jealousy and racism from non-Indigenous people.

Some informants said that, for them, it did not matter whether they went to Wurli or a *munanga*²⁷ clinic, and that for mental health they would rather talk with an unknown, non-Indigenous person. However, these

26 Kriol is the creole language spoken by Indigenous people in the Top End of Australia.

27 *Munanga* is the regional word for non-Indigenous person.

statements were not supported by their actual behaviour, as they always went to Wurli. The culturally safe feeling they experienced at Wurli may have been implicit; they may not have realised or considered that other clinics might feel different. Familiarity with a service was an important consideration when accessing health care, and this would be lacking at other services. I also noticed that it often took the young women several conversations to open up to me, and that they only discussed their worries at places that felt supportive and safe, such as the church and the camps that some of them attended, and with friends and cousins. Notwithstanding the fact that many did not agree with Wurli excluding non-Indigenous people, having an Indigenous-friendly health service was crucial to many of them, even if they did not always realise or appreciate this.

Bush Medicine and Traditional Healing

One of the things that struck me during my research was that bush medicine and traditional healing were more common than I had expected. It was difficult to find out much about bush medicine and traditional healing before I started my fieldwork. Government reports about the health of Indigenous people in Katherine did not include any information about it (e.g. Li et al. 2011; Tay, Li and Guthridge 2013), and little research overall has been done on bush medicine and traditional healing in towns.²⁸ During my initial conversations in Katherine, no one talked about it. This type of healing was not part of the rhetoric around health. When I asked about it specifically, most people told me that it was rare in Katherine and emphasised that it was more common in remote communities (see Chapter 5) and in Central Australia, specifically noting that medical professionals in Alice Springs were more accepting of traditional healing. Some people expressed secrecy surrounding it: 'If it's going on, I don't hear of it, like. I know it could be hush-hush. It could be like a hush-hush thing'. The health organisation that serviced communities east of Katherine claimed on its website that 'incorporating traditional healing and the use of bush medicines' was one of their goals

28 One study that looked at the use of bush medicine and traditional healers in Katherine included only Indigenous people 40 years and older, thus excluding the views and experiences of young people. Although reported familiarity with, and occasional use of, bush medicines and traditional healers were 52 per cent and 35 per cent, respectively, only 4.9 per cent of participants had used bush medicines in the two weeks preceding the interview. In contrast, 82.2 per cent of people had used prescribed or over the counter medicines (Sevo 2003).

(Sunrise Health Service 2018), yet Wurli (n.d.), which claimed to be culturally appropriate, did not mention bush medicine or traditional healing on their website.

Later interviews and observations revealed that bush medicine and traditional healing were still being used in Katherine. Nevertheless, people's experiences with it varied. Although most young women claimed to have some familiarity with bush medicine, their knowledge about it was limited.²⁹ They could rarely tell me the name, look and use of certain plants. They gave descriptions such as 'there's this yellow flower. I can't remember the name' (Tamara) and 'use for bathing' (Julia), but rarely anything more concrete than that. Only a few of the young women had experience with traditional healing, and these experiences did not take place in Katherine.

There are two main ways in which Indigenous young women in Katherine learn about bush medicine and these mirror the ways of learning that Merlan (1998, 102) documented over two decades ago. The first was by 'observation, imitation, and internalisation of ways of doing things'. The second, which was more common among younger people in Merlan's (1998) research, treated Aboriginal culture in a more objectified, explicitly teachable, way. Reflections of these two ways of learning could still be seen and were mostly linked to how young women identified. Those for whom Indigenous identity was unquestioned learned about bush medicine from their family and elders as a part of everyday life. It was used for sickness; for example, Sarah told me her 'nanna' made her soak in a bath with *dumbuyumbu* (see Chapter 5) when she had chicken pox as a child. Learning occurred when family members took the young women out bush to collect bush medicine. Most informants who had learned about bush medicine in this way did not express any specific reasons for wanting to learn about it.

Those young women whose Indigenous identity was more ambiguous did not use bush medicine primarily for sickness and nor was it a part of their everyday life. They understood bush medicine as part of their culture and, therefore, as part of their identity as an Indigenous person. These young women expressed an explicit desire to learn about bush medicine

29 At least partly, this can be explained by the fact that acquiring this knowledge and the authority to speak about it comes with age (Dickson 2015, 37).

and other aspects of Aboriginal culture. In contrast to those for whom bush medicine was a part of daily life, they learned about it from various language groups, not family members.

One way in which the practise of bush medicine was becoming more formalised and less the domain of families was through the Banatjarl Strongbala Wumin Grup (hereafter Banatjarl), which was formed in 2003 (Jawoyn Association Aboriginal Corporation 2016). Banatjarl aims to save and bring back cultural knowledge, collaborate with other organisations in the Katherine region, and reduce violence and substance dependency among Aboriginal people. Several adult women mentioned Banatjarl as the place where they obtained bush medicine. This included women living in Katherine itself as well as in surrounding communities. These women referred to Banatjarl as soon as I brought up bush medicine and did not refer to any collection or preparation of bush medicine in the community itself. In addition to obtaining bush medicines through Banatjarl, some also stated that their children learned about bush medicine through this organisation. Besides providing bush medicine to people for whom acquiring it might otherwise be difficult, Banatjarl endeavoured to reintroduce and spread knowledge about bush medicine. They were teaching about bush medicine in primary and high schools and to medical students. They held bush medicine workshops at public events open to Indigenous and non-Indigenous people, such as the Women of the World Festival, a National Sorry Day event, NAIDOC week and the Barunga Festival, where they also sold containers with bush medicine. Bush medicine made during a private healing camp of Stolen Generations women was used specifically as a healing tool.

In all these instances, the plant that was used was *Marangmarang*. Dickson (2015, 284–85) and Senior (2003, 303) have described its traditional preparation at Ngukurr, which involves crushing and inhaling the leaves for colds, boiling the leaves and drinking the extract like a tea, or using it as a wash for colds, flu, sinus congestion, diarrhoea, sores and skin infections. Taking a distinctly modern approach, Banatjarl mixed *Marangmarang* ‘with some contemporary ingredients’. When I observed and assisted in making this bush medicine, it was made with olive oil and bees wax. The women from Banatjarl told me that they used to use emu or goanna oil, but they changed to using olive oil from the supermarket. They used a mortar and pestle, and modern equipment such as plastic containers, measuring cups, kitchen scales and a gas stove. This was the

only preparation of bush medicine I encountered during my fieldwork, although I have been told of other uses such as boiling the plant to make tea.

Some participants understood the Aboriginal and the biomedical health system to be mutually exclusive and subscribed to the idea that the cause of the illness determined the choice of treatment (Kleinman 1980, 90). For example, several young women said that, if women went to a men's dreaming site and got sick, they had to go to a traditional healer. During one interview, Channy and Brianna imagined what a Western doctor would say if someone came to them with an illness with a supernatural cause. In a tone suggestive of hearing an impossible idea, they said: 'Sorry? Sorry what's the trouble you wanna get help for?' This view was also conveyed the other way around: most of the young women I interviewed thought that, with a disease such as cancer or diabetes, people needed to visit a Western doctor, not a traditional healer. In fact, though the young women were not aware of this, Sonia had started using traditional medicine for what are regarded as biomedical diseases. This included giving a traditional massage to a stroke patient, and using bush medicine made from green ants, a lemongrass treatment, and massage on a cancer patient.

As mentioned above, numerous factors can influence the choice of practitioner (McCoy 2008; Saethre 2007). Location proved to be a major determinant in this study, with people saying that healing ceremonies happened out bush, whereas in town sick people went to Wurli or the hospital. Bush medicines are region specific, so, for the young women who came from other areas in Australia, the medicine that their language group used was not always available in Katherine. Having the time and knowledge to prepare medications is another inhibiting factor (Senior 2003); however, the provision of bush medicine in Katherine by Banatjarl partly solves this issue.

In terms of Kleinman's (1980) model, the Aboriginal health system cannot just be opposed to the biomedical model. It consists of two separate parts that need to be understood differently. Traditional healing can be seen as part of Kleinman's folk system: there are specialised healers with knowledge and skills that are not widely shared in the community. Bush medicine, on the other hand, is part of the popular sector: it comprises non-specialised knowledge of home remedies by lay people. In Katherine, a noticeable shift is occurring. In the past, knowledge about bush medicine was held by everyone; it was transmitted within the family and

its preparation and use occurred in the popular sector as self-treatment. However, at the time of my research, bush medicine was becoming more institutionalised and increasingly part of the folk sector through Banatjarl. Comprehensive knowledge about it was only held by some people, and it was being transferred in a professional manner, such as during workshops. This study's intercultural context, in which the expression of Indigenous identity and culture is salient, as well as non-Indigenous people's growing interest in traditional medicine, were factors affecting these changes.

Discussion

Contrary to the views of non-Indigenous health workers in Katherine who suggest that Aboriginal people do not think about health because health is a 'Western concept', this study clearly demonstrates that some Aboriginal girls and young women *do* think about health. Humans are adept at learning new things and new ideas. In an intercultural space (Merlan 2005) such as Katherine, learning across cultures is to be expected. Certainly, the young Aboriginal women I was privileged to spend time with have absorbed Western health messages regarding the benefits of eating healthy food and regular exercise.

The provision of information is an important first step in a public health effort to change individual behaviour, but other factors, both psychological and sociocultural, require attention. People have to want to change; they also have to believe that it is possible to change. The young people involved in this study valued their health and many expressed the desire for a long life. They had learnt that their behaviour affected their future wellbeing. However, additional factors must be identified before substantial changes in health behaviours can be achieved. These include factors that limit control over health behaviour arising from the intercultural environment.

Often, ethnographic studies of Indigenous health focus on remote Australia. Yet, many young Indigenous women live in towns where they are likely exposed to a more diverse array of social and cultural arrangements, many of which may influence their health beliefs and behaviour. There is increasing recognition that the circumstances of Indigenous people in remote communities can be understood as intercultural (e.g. Merlan 2005; Burbank 2011). However, there may be more defined cultural

boundaries between Aboriginal and non-Aboriginal people in remote communities; in remote communities, non-Indigenous people are almost always outsiders and are rarely permanent residents. Towns, in contrast, may be the lifelong homes of both Indigenous and non-Indigenous populations. Distinct groups of people, who may have different ways of making sense of the world, live in Katherine (Merlan 2005,169). Mutual influence is apparent and strict distinctions between Aboriginal and non-Aboriginal domains—between tradition and modernity—are often difficult to identify (Merlan 1998, 4). This observation is especially relevant for understanding young people who attend school, have multicultural friendships and engage in activities, such as sports, that are open to both Aboriginal and non-Aboriginal youth. Of course, cultures can and do change and there are always differences within cultures. There are also differences within individuals (Agar 1996) and an array of ideas about health can exist within one person.

The fact that the young women in this study defined health as eating good food and keeping fit does not mean they are completely Westernised. At the same time, their Indigenous identity should not be essentialised; being Indigenous does not mean that they will *only* use Indigenous-specific services or that they do not think about the concept of 'health'. Bush medicine and traditional healing can continue to be important for them (as a part of their identity if not as a health remedy) even if it is not important to their peers. Change is apparent everywhere; change is especially important to recognise in intercultural settings such as Katherine where the distribution of new beliefs and practices may be uneven. For example, the young Aboriginal women and girls I spoke to emphasised similarities with non-Indigenous people, but it is difficult to imagine older people doing this.³⁰ Thus, Indigenous young women's health beliefs and behaviour, as well as their sense of identity, should be seen as a product of everyday interactions within a dynamic and intercultural context.

30 For example, in Bourke (New South Wales), a town with a population composition similar to that of Katherine, people emphasised the perceived boundaries between the two groups rather than the overlap (Cowlshaw 2004, Ch. 5).

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