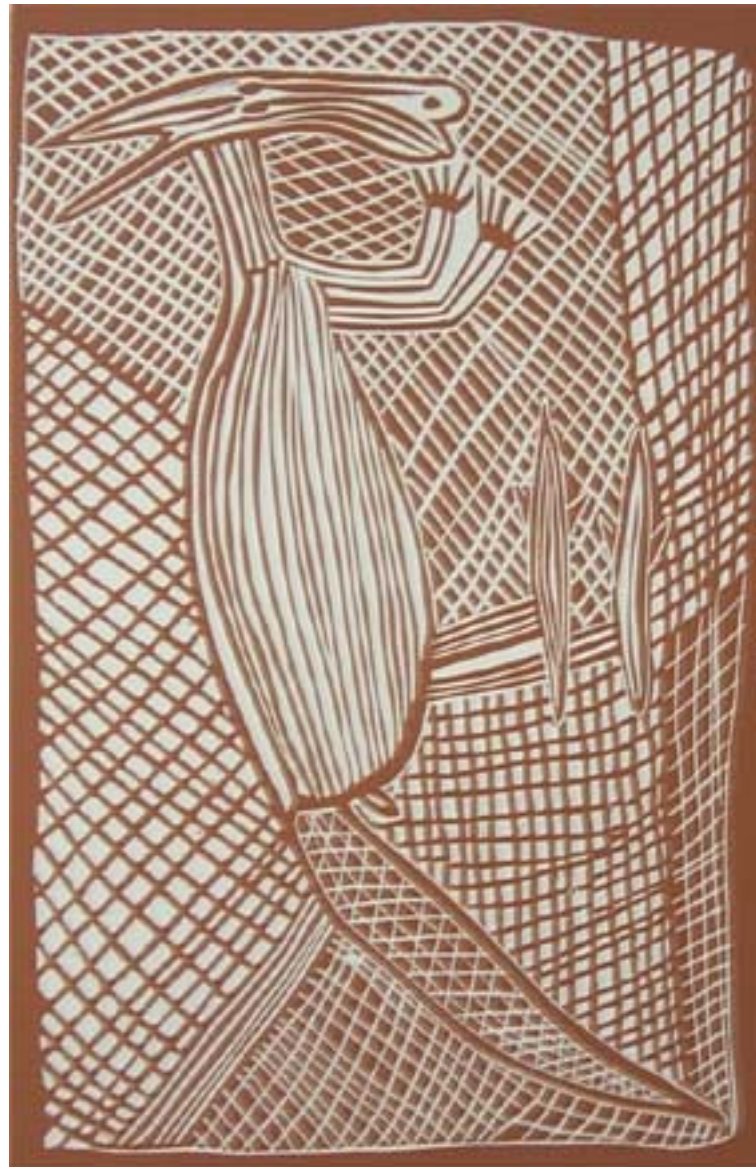


South East Arnhem Land Collaborative Research Project



University of Wollongong



Working Paper Series

Health beliefs and behaviour: the opportunities and practicalities of “looking after yourself” in Ngukurr

Kate Senior

Working Paper Series No. 5

The SEALCP Working Papers

The University of Wollongong and Rio Tinto Ltd. established the South East Arnhem Land Collaborative Research Project (SEALCP) in March 1999. The project is associated with the University's Institute of Social Change and Critical Inquiry.

The South East Arnhem Land Collaborative Research Project is an ethnographically focused research project investigating the cultural, social, political and economic circumstances and potential changes in communities of the South East Arnhem Land region of the Northern Territory. The project clients are the Ngukurr community and Rio Tinto Ltd. The clients, together with representatives from the Northern Territory Government and the Northern Land Council constitute the Advisory Committee to the project.

The central concerns of the project are to produce comprehensive historical and contemporary social, cultural, political and economic profiles of the communities, develop an understanding and appreciation of people's attitudes and aspirations, including their reception of mining exploration, address the issues of the development of mining and the potential impacts of these developments and how they may be managed by and with the communities effected.

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December 2000

The views expressed in this working paper are those of the author and do not necessarily reflect an official SEALCP position

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Preface

This report is based on research carried out in the Ngukurr community from September 1999 to October 2001. The most concerted period of field work was carried out in late 1999 to early 2000, but I have continued to remain in contact with Ngukurr residents and have made several short term visits since that period. Many people in the community generously gave their time to talk about health issues. Particular thanks are due to the Ngukurr health workers, Alexander Thompson, Frida Roberts and Ruth Joshua who were my first informants about health in Ngukurr and continued to be the source of invaluable information. Cherry Daniels, Betty Roberts, Hazel Farrell, Kevin Rogers, Norma Joshua and Anita Thompson discussed traditional health beliefs and bush medicines at length with me.

Janet Fletcher, the Ngukurr RN, generously provided me with the clinic returns data for 2000.

This research would not have been possible without the assistance provided by Miranda Rogers, Keith Rogers and Daphne Daniels.

Outside of Ngukurr, Territory Health Services provided SEALCP with the relevant hospital separations data. Andrew Bell and Kirk Whelan from the Katherine West Area Health Board provided important insights into the regionalization of health services and the benefits this initiative may provide.

John Bern provided detailed editorial scrutiny and Kim Oborn prepared the document for publication.

Finally, thanks are due to David Perkins from the Centre for Health Service Development who read drafts of the report and provided detailed and constructive criticism, which greatly enhanced the final product.

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Introduction

In the past we never used to get proper good treatment. Now there is modern plumbing and modern food and more sickness. Why does this happen? (Senior Aboriginal Health Worker, November 1999).

This paper aims to explore the extent to which people in Ngukurr are prepared to and are able to take responsibility for their own health and the extent to which people feel able to prevent illness. It also explores how people perceive their responsibility in relation to their health and is an examination of differences in agency and responsibility. I examine the barriers that exist to individual agency in health, which stem from different understandings of the patterns and causation of disease, and poor level of effective communication with the health care services that are available to the community.

Health services available to the Ngukurr population

Sen (1999: 15) describes access to health care as being a fundamental human freedom, which allows people the opportunity to live long and healthy lives. This, he argues is a key component of a good quality of life. The cost of accessing services and purchasing medication is an important barrier to health care in many societies (Maclean, 2001: 20), but Ngukurr, in common with other remote communities in the Northern Territory, has a health clinic that provides a free service and all medications are provided free of charge.

In addition to free health care, a number of additional health enhancing services are provided to Ngukurr residents. These include the provision of a standard form of housing, the provision of safe drinking water and sanitation to households, the routine spraying of houses to control insect pests and the periodic dosing of dogs for parasites. These services occur with little involvement or agency of the individuals and are what Cohen (1986:18) described as “goods (that) cause further desirable states directly without any exercise of capability on the part of their beneficiaries”. In terms of the basic necessities of health, there is in Ngukurr, an imposed equality and Ngukurr’s living conditions have recently been described as being some of the best for Aboriginal communities in the Northern Territory (Runcie & Bailie 2000). These alone however, are not enough to free Ngukurr from the continuing burdens of premature death and morbidity.

The Ngukurr population are disadvantaged in terms of the level of health services provided to them. This disadvantage is most acutely felt in the number of health professionals in the community. Currently two nurses (one permanent and one casual) and eight health workers staff the clinic. There is no resident general practitioner. A review of health services carried out by Bartlett and Duncan (2000) indicated that on the basis of its population, Ngukurr was entitled to five nurses and two resident GPs, as well as the health workers. Lack of staff influences the range of services that the clinic is able to provide. For example, there is no active health promotion being carried out by clinic staff in the community.

Commonwealth Government recognition that remote communities, with relatively small populations, have difficulty in generating sufficient resources to purchase the level of services that they need has led to initiatives to provide health care on a regional basis (Bartlett & Duncan, 2000:13). In this way a group of related communities can work together to purchase the services that they need. The Commonwealth initiated Coordinated Care Trials were implemented to test the delivery of health services in this way in the Northern Territory¹. Trials were carried out in the Tiwi Islands and communities in the Katherine West region between 1998-2000 (Menzies School of Health Research, 2000). A key feature of this type of health service delivery is community involvement in determining what services are necessary. This is achieved through the development of Health Boards with majority community representation (Bartlett & Duncan, 2000: 114).

Freedom and responsibility for health

Sen argues that it is the individual's responsibility to decide what use they make of any particular opportunities (1999: 288). He stresses that:

The denial of opportunities of basic education to a child or of essential health care to the ill, is a failure of social responsibility, but the exact utilisation of the educational attainments or of health achievements cannot be but a matter for the person herself to determine (Sen, 1999: 288)

This however, is problematic as it lacks a consideration of social context and appears to imply that the only choice an individual has to make is how to make best use of the health (or other) advantages they obtain from a particular service. There is however an intermediate problem, which is how and if people choose to utilise the services available to them. In a society that provides ready access to health care, the choice of not using that service, or not responding to the messages of health promotion campaigns is a freedom which people have. Many people in non-Aboriginal societies strongly resist what they see as any coercion to be healthy or to change lifestyle patterns. Furthermore, people may also differ in the value they ascribe to health and the individual efforts they are prepared to take to achieve health.

The question in Ngukurr is whether people are making knowledgeable free choices about their health care, or whether they face barriers, either internally or externally imposed, which prevent them from taking responsibility and developing an active relationship with their health services.

Although access to health care is a prerequisite for good health, it does not ensure it. Health is influenced by people's relationship with their health care services, their

¹ The Coordinated Care Trials were a national initiative involving both Indigenous and non-Indigenous people. The non-Indigenous trials focussed on providing more effective care coordination for people with chronic disease and disabilities. In addition to these aims the Indigenous trials also tested a new funding arrangement which involved the pooling of Territory Health funding and the cashing out of Medicare and Pharmaceutical benefits (Bartlett & Duncan, 2000: 114)

recognition and understanding and methods of treating illness, and their understanding of the norms for a healthy body as well as their material, social and physical surroundings. But perhaps most important, it is how a person translates their knowledge into care of themselves and their family.

The factors that exist in the Ngukurr community, which influence people's attitude and belief in the efficacy of health care are:

1. The communities past experience of ill health and people's capacity to manage these conditions compared with the perceived efficacy of these methods within the current context;
2. The meaning of health and the perception that good health is a state worth achieving;
3. The way people interpret patterns of sickness and death in their communities and how these influence their feelings of risk and vulnerability; and
4. The confidence that people have in their health services and the costs of these services compared with the perceived benefits that they provide.

1 *An overview of health in Ngukurr*

Ngukurr has a health profile, which is typical of many remote Aboriginal communities². Ngukurr retains low life expectancies, especially for men and high levels of avoidable morbidity. Infant malnutrition remains at a rate, which is higher than for other Aboriginal communities in the region (Taylor, Bern & Senior, 2000: 89). Health promotion activities in the community were minimal during the study period (1999-2001) with the clinic stretched to capacity providing acute care and monitoring already existing health problems, such as diabetes.

Mortality

Ngukurr has a death rate that is 4.5 times higher than that of the general Australian population (Taylor, Bern & Senior, 2000: 80). People's awareness of death as a frequent event is heightened by the fact that a death in the community involves everyone. Death interrupts the life of all residents in the community. Upon notification that someone has died a sorry day is declared, work ceases, school children are sent home and the shop is shut. Later when the body is returned to the community family members are required to hide indoors. Finally the entire community stops work and schooling to attend the funeral. Lost days due to deaths and funerals impact most adversely on the education of

² Taylor (cited in Sutton, 2001) comments that there are few indicators of health that have shown improvement in remote Aboriginal communities in the last thirty years. Those that have shown improvements such as infant mortality rates are due to the very low base for comparison.

children, whose outcomes are already affected by irregular attendance. At the end of term in October 2001 only one week out of ten that had not been affected by such an event.

Morbidity

Infectious and parasitic diseases and respiratory problems dominate the morbidity of infants and children in Ngukurr. These sorts of illnesses are influenced by such factors as lack of hygiene and rapid rates of transmission in overcrowded houses. By early middle age morbidity is dominated by chronic diseases such as circulatory disease, respiratory disease and diseases of the digestive system. These diseases are often described as being “lifestyle diseases” as they are influenced by the choices an individual makes regarding such things as diet, exercise and cigarette smoking. Health promotion, which attempts to raise awareness of risk factors and provides education on possible modification to behaviour to improve health is an important tool to prevent these diseases, but is something which is under-utilised in Ngukurr.

Minor morbidity

As well as those illnesses that are serious enough to warrant evacuation to hospital, Ngukurr residents suffer from high (but difficult to accurately enumerate) levels of more minor morbidity. Some indication of the levels of minor illnesses can be gained from the number of presentations at the clinic³. The Ngukurr population makes frequent use of the clinic. The figures for March 2000 show that there were 675 presentations at the clinic representing 638 individuals (out of a total population of about 1000 people). Of the presentations 352 were children and 323 were adults. Anecdotal information from the staff and personal observation suggests that these presentations are dominated by skin infections, colds and flu, and diarrhoea and vomiting in young children.

These “everyday” infections can have profound effects on people’s quality of life, both at the time and well into their futures. Skin diseases such as scabies are common and recurrent in Ngukurr. Such diseases may have profound effects, particularly on the quality of life of children in the community as they have the potential to effect educational outcomes. Children may be distracted from their work by the irritation of such conditions, or be kept away from school entirely due to the reaction of the majority non-local staff to these conditions.

Persistent ear infections lead to intermittent deafness among children in the community. Although the school screening program (carried out annually by Territory Health Services) does test hearing and treat children who are identified as being deaf, the problem is a recurrent one, with children continually being re-infected. Transmission of pathogens that cause the ear infections is facilitated by overcrowded living conditions and poor nutritional status (Couzos & Murray, 1999: 252-253). Hearing loss in infancy can affect language development and hearing loss in school age children can compound the

³ Although as this paper will explore, people express many reasons why they may wish to avoid the clinic and treat illnesses at home or with bush medicines.

difficulties of a child who is already struggling to understand concepts that are explained in an unfamiliar language (NTDE, 1999).

As well as having an indirect effect on people's future through limiting education the diseases of childhood may also directly contribute to the infections experienced by adults. Mathews (1997:288) has shown that Group A Streptococcal infections, which are common in childhood and are often the results of a secondary infection to scabies may predispose people to suffer from rheumatic fever. Recurrent attacks of rheumatic fever may lead to rheumatic heart disease, which is often the cause of heart attacks in adults. The mean age of Aboriginal people dying from such heart attacks in the Northern Territory is 36 years (Carapetis & Currie, 1999: 162).

Self assessed health

Authors such as Anderson (1996) and Folds (2000) argue that the type of indicators listed above do not measure the things that Aboriginal people consider are essential for good health. They consider that an Aboriginal understanding of health is more akin to a feeling of well being and is influenced by such things as relationships with family. Their arguments gain strength from the fact that Aboriginal people when asked to evaluate their own health have consistently rated their health as good or excellent, despite scientific data that would indicate otherwise⁴. As part of the household survey in Ngukurr which was conducted in 1999 (Taylor, Bern & Senior 2000: 91), questions were asked about how people rated their health and their satisfaction with health. In keeping with previous trends, people in Ngukurr tended to rate both their personal health and their satisfaction with health as high. However discussion of these results indicated that although different understandings and values of health contributed to people's assessment, other factors such as level of education and feelings of personal control over life and health were also important issues. Although people indicated that they did not have high levels of individual concern for their health, they did express repeated concern about the health of the community, which was linked to dissatisfaction with environmental conditions and health services (Taylor, Bern & Senior, 2000: 95).

2 Past experience of health and illness

An important aspect of how people view their ability to deal with disease stems from their familiarity with these conditions and the body of knowledge and resources they can access to deal with them.

The first Europeans who visited Arnhem Land commented enthusiastically about the health of the people they found there. People were described as being lean and active and having few obvious diseases and a plentiful food supply. Thompson said of the people he encountered at Bennet Bay on the East Arnhem Land coast:

⁴ For example the National Aboriginal and Torres Strait Islander survey (1994) found that 40% of males and 54% of females with a heart problem considered themselves to be in good, very good or excellent health (Cunningham, Sibthorpe & Anderson 1994: 24).

‘Besides dugong and turtle, fish and game were plentiful and the natives were in splendid condition, well fed and happy’ (Thompson, 1948: 164).

Certainly this impression is supported by the pathology of skeletal remains from the area. Webb (1996) found that there was little evidence for sustained malnutrition, or even seasonal shortages of food in the area. The possible health problems were few, but included the results of injuries, arthritis and wear and tear on the body (particularly teeth). Nomadic people moved away from camps before they could become too polluted with refuse and excrement and so avoided parasitic diseases. Infectious diseases are also rare in small, highly mobile groups, although people may have suffered from Yaws, which is an endemic form of Syphilis. People would also have suffered from the everyday effects of the heat, dust and insects, particularly mosquitoes (Thompson, 1948).

People who have little experience of illness may not need to develop complex ways of treating them or extensive pharmacopoeias of herbal remedies. Voeks and Sercombe (2000: 687) suggest that the low levels of illness associated with this type of lifestyle account for the differences in repertoire of healing knowledge and techniques that they observed between a hunter gatherer and an agricultural population they observed in Borneo. A limited previous knowledge of disease and associated methods of healing could have serious consequences as a population becomes sedentary and new diseases arise that their conservative medical model has no ability to cope with. There is also a danger that the failure of such a model to deal with new diseases may lead to its abandonment (Voeks & Sercombe, 2000: 688). Detailed pharmacopoeias have been described for Aboriginal groups, such as Webb’s (1969) classification of medicinal plants used by the Yolngu of Arnhem Land. However, it is clear that this wide range of medicines was used to treat only a limited range of conditions (described in Scarlett, White & Reid, 1982: 185-187).

Responsibility for health in the context changing diseases

People may have been healthier under the protection of the mission, or at least during the later years of the mission than they are now, but this was achieved at the cost of the mission assuming responsibility for people’s bodies. This created a dependency that continues to effect health behaviour today, as one woman pointed out:

When the missionaries left everything changed, but the missionaries told us what to do, but didn’t explain anything. That has a big effect on people now.

In contrast to the knowledge and responsibility that people were able to take over their bodies when there was a limited and known array of diseases and corresponding cures, was the situation after contact with Europeans and during the Mission administration of the community. Contact with Europeans resulted in the destruction of independent Aboriginal society in that area. Competition for land began after the first cattle were introduced in 1872. Until 1903, there were sporadic Aboriginal attacks on cattle and

Europeans and equally sporadic and ad hoc retaliation (Bern, 1974: 78). After the Eastern and African Cold Storage Company moved into the area in 1903, the killing of Aboriginal people became more systematic. By 1905, the company had failed and the most of the Europeans had left the area leaving behind an Aboriginal population who were ‘uprooted, harassed and decimated’ (Bern, 1974: 79).

Those who remained were also victims of new diseases. In contrast to the ‘splendid condition’ of the Aboriginal people of the north east Arnhem land coast described by Thompson is the following description of the health profile of the people living in the area which was to become the Roper River Mission:

No detailed research is required to realise the ghastly state of Aboriginal health in those early years. The widespread infestation of large Aboriginal populations, and the debilitating and devastating results of exotic diseases such as leprosy, venereal disease, tuberculosis and hookworm were most evident in the frontier missions of Roper and Oenpelli (Cole, 1985: 176).

The level of ill health that the first missionaries observed provided further justification for developing missions, as they considered that without assistance the people in the region would not survive (Cole, 1985: 58).

Older people in Ngukurr speak with nostalgia about the Mission and about how healthy people were then compared with the current situation. But the mission achieved health through regulation of people’s lives (Bern, 1974: 86). Children were reared apart from their parents in dormitories, whereby the ethic of hard work, industry, cleanliness and Godliness could be enforced. Children were washed before attending school and an adequate nutrition was ensured by the provision of regular meals in the refectory. Although this picture was one that the mission saw as being ideal, it was not always possible to achieve, especially in the early years of the mission. Their influence over the adult population was variable as people moved in and out of the area (Bern 1974: 83). The mission’s ability to provide nutrition was often restricted by the destruction of their vegetable gardens by floods or through lack of staff to tend the gardens. In 1933, the Government subsidies for the Mission were withdrawn, (Cole, 1985: 74) with one of the contributing factors being an adverse report on the health conditions (Bern, 1974: 84).

At the same time as an emphasis on hygiene and healthy living, the missionaries brought with them different understandings of disease. They feared diseases such as leprosy and tuberculosis due to beliefs about the high possibility of transmission to both the community members and the mission staff. There was a new vigilance in the identification of disease in the community and surrounding area, facilitated by diagnostic tests, which could identify the diseases even in their early stages.

Lewis, writing of the Gnau people in Western Sepik, illustrates the discrepancy between the local understanding and experience of disease and that of the European authorities. The triviality of the complaint (in its early stages) did not appear to justify the attention of the health education patrols or the policy of segregation:

Leprosy did not look serious to the Gnau. People did not die from it. The signs were just marks on the skin (most cases among them were of tuberculoid leprosy), it was a mild (*wuyinda*) skin condition; it did not hurt or incapacitate. (Lewis, 1993: 113).

To be identified as having leprosy, precipitated a process of segregation and removal from the community, often for extended periods. Phillip Roberts, a Ngukurr man, in *I the Aboriginal* described how his mother died in a Darwin leprosarium and his brother was institutionalised for twelve years before he was cured (Lockwood, 1962: 163). He also described Aboriginal people living in fear of being identified as having leprosy as although the disease itself might have been poorly understood, the consequences of having it were not:

It is not so long ago that leprosy patients fled into the bush and stayed there when the medical plane visited the Roper. They knew from experience that most of the people who went to Channel Island were never seen again (Lockwood, 1962: 163).

Lay treatment of illness

Unlike serious illnesses, which require specialist medical attention, non-urgent minor illnesses present individuals with some latitude for decision making regarding possible treatments for themselves or their families. They may of course decide to do nothing, or they may decide to seek medication to relieve the symptoms. Ngukurr residents have several options available to them. They can purchase from a limited range of over-the-counter medications from the local store, they can collect and prepare bush medicines or they can visit the clinic and obtain treatment. In the rhetoric of the community a clear preference was stated for the use of bush medicines, and it was frequently indicated that recourse to these would form the usual first course of action. Ngukurr people were familiar with a variety of bush medicines (Appendix 1) which were predominately used to treat the symptoms of colds, sores and headaches. These were understood as being superior to clinic medications as people said that they understood these medications and knew how they worked. There also seemed to be a strong moral imperative to use bush medicines as these represented the “good” old ways, in the same way as bush foods were considered to be better than modern shop bought alternatives.

Use bush medicine first, we generally don't keep any medicine, maybe only for the grandchildren. If we get sick, try to get bush medicine, maintain old ways as they are good for you. I don't go to the hospital (the clinic), I reckon that my body can build up defence with assistance from bush medicine.

Bush medicines were not only described as a resource to be utilised to relieve the immediate symptoms of an illness. They were also described in terms of their importance in maintaining health. Some were considered to act as a ‘tonic’ if used on a regular basis,

while others were described as being useful to prevent illness, such as the regular addition of Ti-Tree to babies' baths to prevent skin infections. But discussion about these preventative practises was not centred around what people did do, but what people should do. There was comment that people were healthier in the past because of these practises and that the clinic and Women's Centre should be involved in teaching people how to use bush medicines to maintain the health of themselves and their families. There was little evidence, however, that people were currently using bush medicines on a regular basis.

The use of bush medicines was an area in which there was a clear difference between what people considered was the most appropriate behaviour and what they actually did. This lack of agreement was also noticed by Scarlett, White and Reid in their description of the bush medicines used by the Yolngu (1982: 169). They commented that despite the decline in use and apparent preference for clinic medications that:

No-one consulted expressed doubts about their effectiveness, They are still well known and enthusiastically listed by many adults as a unique asset of their own society.

The level of use of bush medicine was difficult to enumerate, but the use of the clinic for everyday illnesses was high. Some indication of the amount that bush medicines were used was obtained by asking people who complained of illness what actions they were going to take. People often conceded that they had used the clinic, but that they would have used bush medicines had they been in a position to obtain them. Often people talked about their symptoms and described the bush medicine they would have collected:

When I get sick I get bush medicine first. Last night I didn't go out for bush medicine. White gum, you can boil it and inhale it and also bush tea, which is good for colds. But last night I had to go and get some Amoxylin from the clinic.

Bush medicines were difficult to obtain as, with the exception of bush tobacco, they usually grew outside of the community and necessitated the use of a vehicle to collect them. When transport out of the community was available, people's priorities were usually to go fishing in preference to looking for bush medicine. Again people often mentioned that they could collect a particular medicine for someone in the community, who was suffering from an illness, but usually they did not actually do so.

In contrast to the other medicine choices, bush medicines had to be prepared before use, which usually required them to be pounded and boiled into a tea. A trip to the clinic provided medications that were considered to be inferior, but more convenient, given the pragmatics of achieving relief from discomfort as soon as possible.

A seemingly acceptable compromise in terms of self-treatment was to use an over-the-counter medication purchased from the local shop. The range of these available was very limited and included Panadol, Vicks and balms for muscle aches. Panadol was rarely bought, as it was a medicine that was regularly dispensed by the clinic free of charge, and

was considered by many to be either ineffective, or dangerous (people commented that Panadol made them dizzy). Vicks however, was favoured. It had several qualities that appeared to make it attractive. It was not associated with the clinic and it was not in tablet form. Furthermore it is pungently aromatic like many of the bush medicines and like them was considered to have numerous applications. People extended the uses of Vicks past the recommended applications. I observed Vicks being taken internally to treat colds, sore throats, upset stomachs and “nerves” and being applied to the forehead and neck to treat headaches. As one older woman, who suffered from several potentially life threatening chronic diseases, said:

It's my favourite medicine, I can use it to treat everything.

3 *The meaning and value of health*

The value of health

As long as you can do what you want to do, then you don't worry about health.

The Household Survey in Ngukurr (Taylor, Bern & Senior, 2000) asked people to evaluate their own health status. Although some people considered that there were health problems in the community, many stated that they were not individually concerned about health worries. Most people considered their health to be very good to excellent.

The emphasis that people gave was on health as a state that allowed them to carry out the things they desired to do in their everyday life. As long as a person's health condition did not start to interfere with these things, then it was not a major cause of concern. For example, people in the survey would explain that they had diabetes or other chronic conditions but still say that they were perfectly happy with their health. This response has been encountered in other surveys. Blaxter (1997) consider it evidence of people's adaptability, and the importance they ascribe to given to getting on with life and not giving in to illness. In Ngukurr, this attitude towards health is evident in the definitions for the Kriol term 'Gudbala Laif' which was used to describe health, which included such things as 'having a happy life; doing things that you want to do and having the family around you'.

Non-Aboriginal residents of Ngukurr were shocked by this apparent lack of interest in health and interpreted it in terms of idleness and apathy. Health would improve, if people in the community were motivated enough to make the necessary changes to their lives.

My greatest concern, considering that plenty of money goes into health is the inability of people to take responsibility for their own lives. They have filthy houses and dogs, they know this isn't right but they won't act on it. The key of motivation is missing their world view is "if I die, I die".

My first Ngukurr informants on health and illness were the health workers at the clinic. I found one of the senior health workers sitting on the floor of the examination room sorting through files. The health worker seemed quite surprised that anyone would need to ask about health beliefs, as it was all quite simple. If people were sick then they should go to the clinic. “Good health is easy,” the health worker said, pointing to the various educational posters on the wall.

You eat the right things and look after yourself, clinic medicine is best, Some old ladies might use bush medicine, but I wouldn't use it myself.

Another senior health worker considered that Aboriginal health had deteriorated due to the adoption of non-Aboriginal ways:

Before people didn't have kidney problems, high blood pressure, diabetes or heart problems, the changes are not coming from Aboriginal but from white society.

This health worker also considered that changes in people's health would only come when people started to take responsibility for their own health, both in terms of prevention of disease and quick recognition and treatment of problems when they arose.

At the same time as individuals were stating that they were healthy, many people raised concerns about the health of the other people in the community. Health of the community as a whole was seen to be deteriorating, caused by a reliance on Western (and particularly take-away food), lack of exercise, and too much smoking. Social disharmony was also discussed as a cause of poor health; particularly fighting and swearing.

Certainly many people thought that health in the community was worse than it was in the past. One older woman who had grown up during the Mission commented:

We were healthy in the past, people were happy healthy and strong. Big muscly men and women. Men and women today are nothing. All worn out from too much grog and rubbish food, they don't look after themselves.

Causes of illness

Local understandings of disease divide conditions into those which have a natural cause (including diseases introduced by Europeans) and those which are caused by supernatural agents. The majority of diseases in Ngukurr are considered to fit into the first category and can be treated with home remedies, bush medicines or consulting the clinic. Sorcery's direct effect on health is thought to be more limited. It is cited as the cause of sudden or unexpected deaths and for pains that persist after clinic treatment. Its limited contribution is not reflected in the importance ascribed to it in the community and the emphasis people made about protecting themselves against it. Table 2 outlines the classification of illnesses in Ngukurr. These are broad categories and actual interpretation of causality may vary from person to person.

Table 1: Classification of the causation of illnesses in Ngukurr

TYPE OF SICKNESS	EXAMPLE
<p>Natural</p> <p>Supernatural</p>	<ul style="list-style-type: none"> • Illness caused by the weather, dust etc • Introduced “white fellow” diseases • Hereditary conditions • Some accidents • Mental health problems caused by drinking or substance abuse • Deaths of very old people, or people with a known health condition • Sudden or unexpected death • Acute or abdominal pain that cannot be explained by the clinic • Mental health problems that cannot be explained • Congenital deformities in children that cannot be explained by heredity factors • Some accidents

Division of illness into these broad categories is, however, an over-simplification, as there are some illnesses that do not fit easily into a single category. This haziness influences people’s actions regarding these illnesses, including their perceived ability to affect a cure or treat the symptoms. The following is an example of an illness that did not fit easily into either the supernatural or natural category.

Towards the end of the dry season, young children became covered in small boils. These were considered to be a punishment for a person calling the name of their poison cousin. But because children were “silly” and did not understand the restrictions such boils were thought to be natural and inevitable. Eventually as the children become knowledgeable about their place within the kinship system and the restrictions on calling certain people’s names they would cease to be troubled by boils. Because of this, these boils were not something that worried parents, they were merely considered to be a stage in their child’s life, which they would grow out of. Although they were an illness that was considered to be supernatural in cause they were treated like an everyday, mundane problem.

Everyday illnesses

There are several everyday causes of illness, which although a cause of discomfort for the individual concerned, do not cause much anxiety. These diseases have been around before contact with Europeans and are considered to be a natural and inevitable part of life. They usually have humeral or environmental causes. These types of illness beliefs,

such as the belief that getting cold will cause a cold, appear to be universally held (Craig, 2000: 707).

Wind, rain and dust are cited as the main disease causing agents in Ngukurr in the past, which resulted in coughs and colds, sore eyes, bone aches, sores, fever and toothache. Although it must be noted that there is a site known as a “bad cold dreaming” within the Ngukurr community. Disturbance of this site is considered to result in bad colds for everybody and “even the dogs would get sick”.

White fella sicknesses

White fella sicknesses are recognised as being caused by the introduction of new foods, practises such as smoking and drinking as well as introduced viruses. Changed living practises, such as the change from nomadic to sedentary living are also recognised as the cause of new diseases. For example respondents point out how fit and healthy people were when they had to walk long distances to obtain food. People also commented that ill health is caused by taking too many tablets and drinking the highly chlorinated water in the community.

Some of the diseases that people suggest as fitting in this category are diabetes, heart problems, alcoholism, “smoking sickness” (respiratory problems), drug abuse, petrol sniffing, flu, whooping cough and AIDS. People are not sure whether leprosy was around before European contact.

Despite the prevalence of some conditions in Ngukurr people often had limited knowledge about causation or the effects of the disease. This is evident in the following remark, which had been preceded by a discussion of good diet and its importance for health.

I often wonder why you get diabetes. We had check ups last year for diabetes. Alex (the senior health worker) was up at the shop doing the test, you take a little bit of blood, he was testing everyone's blood. Everyone wanted to come and have their blood tested, it was kind of exciting, we all wanted to know if we were sick and everyone started lining up.

When people talk about these types of illnesses, most suggest that people can improve their situation by changing their diets, including more bush foods in their diets, and having more exercise. Bush medicines could be used to treat some of the symptoms, but these were generally illnesses that fell into the domain of the clinic. People were very familiar with the standard public health messages (relating to diet, exercise, smoking and drinking). But knowledge does not necessary translate into altered behaviour (Davison et. al., 1992: 963).

In some cases knowledge has to be matched by availability of resources necessary to make the change. A good example of this was in the area of diet. Obtaining a balanced diet is often difficult due to problems with the availability of food in the shop (especially

during the wet season) and the price of these foods as compared with the alternatives available from the shops selling take-away foods. The limited availability and high cost of foods is coupled with poor cooking facilities and limited education and experience in preparing a meal combined from the various ingredients purchased at the shop. During the Mission period, the preparation of meals was not the responsibility of the individual. Then Ngukurr residents were provided with three meals a day at the Mission refectory. Although this does not apply to the majority of adults today, the legacy of this dependency is that people do not have a level of knowledge or familiarity about how to combine various shop bought foods into a meal:

If people cook and eat the right sorts of food at home we will all have a healthy life, I would like to learn about cooking proper meals for myself and my family. I would also like to learn about how to budget money, we get a lot of money, but it all goes. We buy expensive food and don't prepare the right sort of meals.

The Women's Centre is well placed to provide education about the preparation of meals, and is well equipped with industrial style stoves and cooking equipment which in theory are available for all the women in the community to use. Some women attend cooking classes and utilise the equipment to prepare food for their families. However, the Women's Centre is only utilised by a very limited number of women, and is rarely used by younger women. Furthermore, the activities of the Women's Centre do not appear to extend beyond this limited sphere. There is, for example, no discernible difference between the domestic situations of the women who attended the Women's Centre and those who did not.

Good health as an ideal to aspire to

The relationship of education, particularly the education of women to increased survival and health of children has been demonstrated in many contexts (Caldwell et al 1990). Educated women are more likely to recognise symptoms at an early stage and to take appropriate action or to interact with representatives of the health service more effectively. Lindenbaum's analysis of education and changing health behaviour in Bangladesh offers another (complimentary) perspective. She argues that the practice of health promoting behaviour such as personal hygiene, clean houses, clean children etc. are also linked to people's perception of such states as being desirable. The adoption of healthy behaviours is linked to the message that such practices provide to onlookers about the individuals changed social status, and can be achieved in the absence of knowledge about such things as germ theory:

The experience of education, wearing unsoiled clothes, passing the daily inspection for scabies or other skin disorders, imitating the behaviour of the wealthier middle classes, learning about sanitary habits, as well as experiencing a public time-ordered existence leads to the creation of the 'educated person' whose manners psyche and relationships with others are transformed (Lindenbaum, 1990: 435).

Lindenbaum argues that changes in behaviour that results in better health are often motivated by more 'trivial' concerns such as aspirations to appear as a member of a higher social class. An example she provides is the fact that altered patterns of hygiene in France in the Nineteenth Century were guided more by etiquette books as norms of polite behaviour rather than by any motivation to avoid disease (Lindenbaum, 1990: 434). Health, and the dedication to achieving health become a defining characteristic of a particular social group (Crawford, 1980). Under this model, changes in health behaviour require that there is a social hierarchy and that people have a desire to emulate those people who they perceive to be above them.

In Ngukurr, people mention the importance of such things as part of a general rhetoric of good health for the community, but such things as a clean house are never mentioned, as contributing to an individual's self image or the image they wish to project to others about themselves.

The difficulties of achieving some of these changes in overcrowded houses where individuals may lack domestic control are manifest. However, even if possible to achieve change under these circumstances, there remains a question of whether people would wish to associate themselves with these particular sets of values.

Those people in the community who espouse middle class values of health and hygiene are the non-Aboriginal residents, from whom Ngukurr residents experience a marked social difference. Social intercourse with non-Aboriginal people outside work hours and casual visiting is infrequent. The Aboriginal population in Ngukurr frequently points out the differences in living standards between themselves and the non-Aboriginal population. Although the structure of the housing for the non-Aboriginal population is essentially the same as that for the Aboriginal population, there are noticeable differences in the level of upkeep of the houses. Non-Aboriginal houses are not subject to the same pressures due to overcrowding as Aboriginal houses and are therefore in a considerably better state of repair and many staff members move into furnished houses. Aboriginal houses are not furnished in the same way. The quality of life of the non-Aboriginal population seems very difficult to aspire to from the general community perspective.

The Aboriginal population regard some of the 'healthy' behaviours of the non-Aboriginal population with some amusement, such as the habit of going for evening walks along the road to the airport. Walking for pleasure is considered to be a particularly Munanga (European) activity by people who walk often, but reluctantly, when no vehicle is available.

4 *Lay epidemiologies and external threats to health*

Health behaviour is influenced by people's observation of the patterning of illness and death in their own environments, a process described by Davison et. al., (1992) as a 'lay epidemiology'. From these patterns individuals construct an assessment of their own vulnerability and risk and the likelihood of any beneficial impact of moderating their

health beliefs. People monitor patterns of disease that appear to run in the family and assess their own risk on the basis of this. Diabetes and kidney disease are considered to run in families in Ngukurr:

Blackbella way causes sickness if you get sick for nothing. But if your mummy and daddy's like that then it might be family. My daughter got her kidney problem when she was six. It's in her dad's family and in my family, both families have kidney problems.

Further complexity to the lay epidemiology is added by observation of cases that do not fit the 'rules' about the association between risk factors and disease. These anomalies confuse people's understanding of patterns of disease and their own risk as Davison et. al., explain:

The fact remains, however, that within the general statistical tendencies that are observed within populations there lies a more chaotic distribution of illness and death. Some fat smokers really do live till advanced old age and some svelte joggers really do 'fall down dead' (Davison, et. al., 1992: 683).

As in any society (but perhaps particularly obvious in a community where all members are well known to each other) people in Ngukurr observe cases where individuals do not appear to practise any of the behaviours, identified as being high risk, but still succumb to premature mortality:

'I knew people who died in the past, they hadn't been smoking or drinking or eating too many greasy things, but some still die at a really young age'.

Montgomery (2000) in his analysis of the factors affecting perceived mortality decline argues the patterns that individuals observe and those seen by the epidemiologist and statistician are difficult to reconcile. This is because people construct their ideas on the basis of limited frame of reference and because death is a more significant event than its counterpart, survival. In a community, which has high levels of premature adult mortality such as Ngukurr, people's perceptions that they will also succumb to the same patterns of mortality are high and perceptions that they are in a position to alter this pattern are low.

This is clearly seen in attitudes surrounding smoking. Diseases linked to smoking such as heart and respiratory diseases are major causes of death in Ngukurr. People are aware of the dangers of smoking, but often expressed the belief that once a person starts smoking that "smoking sickness" was inevitable, therefore there is very little incentive to give up. As one young woman said "I know I'll die of that smoking sickness". This is in contrast to the messages provided in the anti-smoking material promoted by Territory Health Services, which emphasise the short and long term improvements in health that a person can expect as a result of giving up (THS, 1999).

Fatalistic views about smoking have been observed in other surveys. Chamberlain and O'Neil (1998) who examined the effect of socio-economic class on smoking behaviour found that smokers from low socio economic groups tended to be more fatalistic regarding their health in general and their ability to give up smoking. They considered other external threats to their health such as working in dangerous environments, pollution, poverty, stress etc, coupled with their observations of patterns of mortality among their peers and were not assured that giving up smoking would improve their chances of health or longevity. In comparison, smokers from high socio-economic groups tended to emphasise that they were in control of their smoking, that it was a habit which they currently enjoyed, but which they could give up in the future (Chamberlain & O'Neil, 1998).

5 Sorcery as external threat to health

Further contributing factors to people's perception of their ability to avoid disease are beliefs that some sicknesses and many deaths are attributable to sorcery. Beliefs about sorcery in Ngukurr are complex, but a key factor influencing people's belief in the efficacy of personal efforts to improve health is the belief that sorcery is unpredictable and often accidental.

At the same time as the health workers were explaining a biomedical view of health, which emphasises the importance of good diet, and regular clinic visits, I was given another view of the way that health was considered by the sudden death of a middle aged man in the community. His death was unexpected, he was seen to be well one minute and dead the next. The community and particularly his widow received the diagnosis of a heart attack with some scepticism. The search for the cause of his death and the attribution of sorcery dominated discussions in the community. There were meetings to determine the killer and fights and stone throwing between community members. By the end of the year, the man's widow was still talking of bringing in a special clever person from a desert community who could work out who was responsible.

Sorcery may be considered to be the cause of any sudden or unexpected illness that cannot be adequately diagnosed by the mainstream medical service, or is used as a diagnosis of the cause of sudden death in a person who was otherwise considered to be healthy. The perception that people die suddenly and often very young in Ngukurr is a valid one. The hospital separations data for the community reveals that people (particularly men) start experiencing cardiac arrests in their early thirties. It is important to note that not all deaths are attributed to sorcery. Deaths of very old people or those known to have a serious illness are considered to be natural as opposed to supernatural in causation. The death of a senior man, known to be very ill as a result of a long-term respiratory disease, did not result in any searches for the cause, despite his status.

Symptoms that people recognise as being caused by sorcery include sudden pains in the chest and mental health problems. Sorcery may also be used to cause accidents; for example a car may be made to crash. People can be the agents of sorcery, but so can malevolent non-humans such as *Debil Debils*.

In the pilot of the household survey the number of people who spontaneously mentioned fear of sorcery or “Black fellow business” as making them feel unsafe surprised us. We surmised that it was something that may have been topical at the time, as there had been two deaths in the community while the survey had been administered. These results were however replicated in the main survey, which was carried out three months later. I found that discussions about health and sickness inevitably led to discussions about sorcery, indeed people were often happier to discuss sorcery in detail rather than other causes of illness. This may have been because of their interest and confidence in this particular model of causation. The detail and intensity of some of the replies convinced us that fears about sorcery were abiding ones in Ngukurr.

Sorcery beliefs in Ngukurr

Ngukurr residents know of several types of sorcery. These can be divided into sorcery, which is legitimate in the sense that it is a sanctioned form of punishment through ceremony and law, and malicious sorcery practised out of hatred greed or spite. Legitimate sorcery, is that which is performed on an individual as punishment for ritual and social misdemeanours. Performance of the ritual cults (*Gunabibi* and *Yabudurruwa*) was formerly considered to be the time when offences were noted and action taken to punish the offender. But Ngukurr people emphasise that these ceremonies had become ‘soft’ and that offences were paid for in cash and not people’s lives. However, initiates in a third (and lesser known) ceremony, the *Balgyin* were considered by some people to carry on this role, as described by Bern (1974: 281):

The Ngukurr people identified the *Balgyin* cult and its leaders as the main source for executing punishment of ritual offences throughout the region. People not initiated into the *Balgyin* ceremony stated that the ceremony was hard or a killer. By this they meant that the *Balgyin* law was strict in relation to that of other cults and particularly that offences against it led to the death of the offender or his kin or both. *Balgyin* men allegedly extended the punitive jurisdiction to cover alleged offences committed in the contexts of other major cults as well.

These beliefs contribute to the way Ngukurr residents perceive their risk of death and disease and the relationship between behaviour and vulnerability. The link between wrongdoing and punishment is not clearly defined. Punishment may not be immediate and it may be directed against a person’s kin rather than themselves. Correct behaviour, therefore provides no guarantee of immunity. The situation is made more complex by people’s perception that those involved may overstep their jurisdiction due to what was described as an ‘addiction’ to killing.

Despite extensive lists of possible wrong doings that may result in illness, none of the individuals in Ngukurr who had described themselves as victims of sorcery offered a reason why they had been particularly singled out (again making the link between behaviour and effect difficult to establish). This echoes Reid’s findings in Yirrkala:

Ideally sorcery is only perpetrated on someone who deserves the punishment. In fact many of those who believe they have been victims of sorcery disavow any personal responsibility for the attack. They attribute it to the malice of the sorcerer, say it was a case of mistaken identity, or believe they were attacked by a relative's wrong doing (Reid, 1983: 48).

As well as those people sanctioned by ceremony, individuals are also considered to be able to practise sorcery and can be motivated by more trivial concerns such as jealousy and dislike. *Wirlgin* is the name given to this form of sorcery. It is often associated with women and involves obtaining something belonging to the intended victim, usually part of an article of clothing:

You get someone else's belonging and cut it up with a knife or break it into strips and put it away in a tin. It must be a strong tin with a lid. You go to the red-hot charcoal in the fire and put the charcoal in the tin and close it really tight and then put it where no one will see it, it must be top secret.

Death from this sort of sorcery is slow and lingering, and usually involves the person wasting. Death can be prevented if the tin is found (the victim or their family may dream of its location) and the piece of clothing is thrown into water. Other practices involve the use of a person's hair, fingernails, or other detritus intimately associated with them. A person's footprints may be speared to cause them pain while walking or their spit can be put into an ants nest to cause a sore throat.

Sorcery can be accidental in that it can be misdirected and miss its mark, or in the sense that it can also be inflicted by malevolent non-human agents, such as *Debil Debils*. There are stories in the community about sorcery attacking the wrong person because they had a similar name as the intended victim. Most people stress the importance of not sitting outside at night under a bright light just in case this captures the attention of any curses that are thought to float around the community.

The following is an account of one man's encounter with a *Debil Debil* and the illness inflicted upon him by this chance encounter:

*I was walking out and my white clothes stood out. I was near the old airstrip. I saw a light flashing in the distance, a bright light flashing. I slipped, I felt a sharp pain, it pierced me inside. Thought it was nothing so I went home, but it started getting worse. I took Panadols and I went to see the nurse on duty, more Panadols, but the pain got worse. I started looking for the old man (my uncle), went looking around but he was out. I wrapped myself in a blanket and the pain was hanging on like appendix. It happened over my appendix and after that I got appendicitis. I wanted to sleep, but couldn't, the pain kept me awake all night. In the morning the old fellow came, he told me *Debil Debil*, watch out, bad one. Uncle got a cup and soaked his hands, showed everyone, everyone was a witness that there was nothing in his hands. He pressed the area with his hands and*

felt the area all round. Things came out, 30cm long and thick. A kangaroo bone came out, a Debil Debil bone. He smashed the bone up so it couldn't go back to the Debil Debil, this gets rid of the power of the Debil Debil. I got better, no scar, you can't find any scar.

Who is responsible for sorcery?

Many authors examining sorcery beliefs in Aboriginal Australia describe it as being perpetrated by people from outside the community, by strangers (Meggitt, 1962: 36) Marwick, 1964: 280). This is in contrast to African beliefs where anyone is thought to be capable of sorcery and practises (often involuntarily) within their own community (Evans Pritchard 1937). Reid notes, however that with the development of large communities, the typical social structure has become so radically altered that sorcery accusations are possible from within the community:

Relations in the community have intensified since settlement and social boundaries have become changeable and ill-defined. Men and women whose families and clans are only distantly related are marrying. 'Stranger Yolngu' are coming to stay at Yirrkala and drink at the hotel. People of clans which own widely separated territories now live round the corner from each other. Young people are now defying their elders. Men get drunk and say things that enrage others. They beat their wives. Some, it is said, are obtaining objects of sorcery from other places to use at Yirrkala. The enemy, in various guises is now within. (Reid, 1983: 153-154).

Other accounts of Aboriginal sorcery beliefs and accusations indicate a general fear of strangers, but a realisation that people with the motives to commit sorcery may well be from within the group. Sansom (1980: 62), in his description of Darwin fringe dwellers, found that the people who could be expected to develop a grudge large enough to perform sorcery were people from within the group. It was for this reason that people exerted so much caution when drinking together in order to prevent someone slipping poison into a drink. Methods employed to reveal the sorcerer rely on the fact that that person will display a series of recognised symptoms, which will be observed by the community, as in the following example described by Turner (1974: 107):

Without his shadow, he starts to get hot and sick and has to go down to the river and wash all the time-every fifteen minutes-to wash and cool himself. If he is working and he hits himself or scratches himself, his arm or leg or part of his body will become sore and stiff. Then he begins to go mad. People watch for anyone who acts like this. When someone does they accuse him.

Sansom (1980: 62) argues that sorcery by outsiders is feared because it is more difficult to determine the perpetrator if they are not from the immediate community. This is in contrast to the procedures that exist within the community (such as vigilance to identify anyone behaving in an unusual manner) to expose the sorcerer. People in Ngukurr are

suspicious of strangers and people from other nearby communities. For example sorcery is considered to be much worse in Numbulwar, and people said that this is a contributing factor to their decision to remain in Ngukurr. Ngukurr residents are however, emphatic that people practising sorcery lived within the town.

Informants state that they know who these people were, but they rarely indicated an individual of whom they are suspicious. In all the cases of sudden death and illness due to suspected sorcery that I experienced in Ngukurr, the suspected perpetrator was never publicly identified, although people formed their own private opinions as to who was responsible.

Prevention of sorcery

Protection of oneself and ones family against sorcery is one area where people can provide a great deal of information about self-care:

It's the main thing in Aboriginal people's life, you have to teach kids how to stay out of trouble. Every bed time you remind kids not to leave their things lying around and when they have a haircut to bring it back, put it in a plastic bag and lock it away.

Care needs to be taken not to leave clothes out on the line after dark, not to leave thongs or shoes where people can take them, not to leave the cup you are drinking from where someone could slip poison in to it, not asking strangers for cigarettes. It is also important not to sit in the bright light outside at night (people used to ask me to turn off my outside lights when they visited) and not cook meat outside in the dark as this sort of conspicuous behaviour may attract a curse or the attention of a *Debil Debil*.

In practise, however this could be seen as ideal behaviour. Bowden who examined sorcery in a Western Sepik community, commented that the belief that personal 'leavings' (from clothes, to fingernails, excreta and left over food) could be used to ensorcell someone meant that the village was always spotlessly clean (1987:188). In Ngukurr washing is left out on lines or draped on fences at night. People do leave shoes lying around and quite frequently complained that someone had stolen their thongs and dogs raided rubbish bins and spread left over food around the community. Precautions did however become more marked during times of stress in the community, especially surrounding a death.

Extensive lists were also provided to me of the prohibitions concerning certain foods that a pregnant woman should avoid in order to avoid having deformed children, or children who fail to thrive. When a child is born with these problems, then the mother reviews her past life to see what she has done wrong. But there are other reasons why a child may be born with deformities:

My son and daughter are very close, there is something wrong with their feet, nothing to do with eating your dreaming or eating other things, but

our ancestors had the same thing. It happens in white society too. When I saw that I was very frightened, thinking “what did I do wrong?” “No, don’t worry my family said, they inherited this, It’s not your fault”.

People describe detailed preventative knowledge to avoid being the victim of sorcery, however they do not practice it with the type of diligence describe above for the Sepik Villagers (described above). This appears to relate to the realisation that control over this aspect of their lives is limited. Links between succumbing to an illness and behaviour are often difficult to establish, and are exacerbated by the fact that sorcery is considered to be arbitrary and unpredictable. Curses are not only believed to be the direct result of a person’s inappropriate behaviour, they can also be misdirected or accidental. Retaliation for a past wrong-doing may not directly affect the individual responsible, but may be directed against their children or relatives many years after the event. A curse shot into the community may fail to reach the right person because of confusion over similar sounding names or it may hit a person who brings attention to themselves by sitting in the light at night. Unwelcome attention from a *Debil Debil* may only be due to sitting in the bright light or wearing brightly coloured clothes, or walking out alone.

Sorcery and the Western Health system

Sorcery beliefs create potential for miscommunication between the community and the western health system. The threat of sorcery as a disincentive to personal behavioural modification has been discussed above. It is also important however, that medical practitioners’ attitudes to sorcery beliefs also have the potential to limit the communication between patient and staff. (Sutton, 2001: 140-141) outlines this tension in the following way:

So how do members of a community in which youth suicides are believed to be caused by sorcery react to the perceived double message that they are now getting from governments and para-governmental agencies, which goes something like this:

1. That people will be assisted to make every effort to combat the social, emotional and chemical triggers for suicide;
2. That the state no longer wants people to change their culture?

The conviction that most deaths are caused by sorcery leads to problems interpreting the information supplied by the coroner and the clinic as to the cause of death. A recurring theme throughout my interviews and discussion about ill health and deaths is people’s concern that they did not receive what they regarded as detailed or accurate information about the cause of death. The staff at the clinic however say, that a letter is always sent to the family explaining the cause of death. It is the content of the letter, which caused the confusion. As Reid and Mununggurr explain (1977: 5) the coroners’ statements do not provide a cause of death that is understandable in the context of beliefs about the causation of death or satisfying in that it answered why a particular individual was

stricken at a particular time. Weeramanthri found in his interviews with health professionals, that their beliefs about Aboriginal sensitivities surrounding death and the potential that death had for generating accusations of blame lead them to withhold the information that people considered to be most important:

The possible emergence of blame on one of its guises was seen by medical practitioners as a reason for them not to give the “full story” to families after death, not to ask for a post mortem, not to enter alcohol abuse on a death certificate, not to have a post death conference and not to participate in a process of mortality review (Weeramanthri, 1997: 1013).

In the light of these comments, the proposal put by Ngukurr residents that the withholding of information on the death certificate is motivated by fear of causing fighting and unrest in the community seems to be very close to the truth.

6 Confidence in health services

For the modern health care system to take a more prominent place in decision making it must first display its superior effectiveness in regard to either prevention of illness or cure, and the system must be organised to permit access to care of adequate quality (Montgomery, 2000: 806).

Choice between Western and traditional medicine

Despite the high levels of clinic usage there is, throughout the material I collected evidence of a distrust or ambivalence towards of the clinic and Western medicine. With one exception, the health workers at the clinic all considered that bush medicine was preferable to the medications provided by the clinic. The same group of people considered that sorcery is the cause of some illnesses and that such illnesses require different treatment than the clinic provides. The health workers suggest that a sensible strategy would be to first try clinic medicine, but if that did not produce a cure to suspect sorcery and seek a traditional healer:

If you have a pain somewhere in your head and body and you go down to the clinic and still the pain doesn't go away. Then you should check them with the witch doctor, and then you might get better. But you don't know what really fixed him, whether it was Munanga medicine or Black fellow medicine.

The belief in traditional healers is also marked by a degree of ambivalence. There is considerable variation in the level of confidence that Ngukurr people expressed in such practices. Some people said that all the healers in Ngukurr were “rubbish” and that they would have to find a healer from outside the communities. Others commented that drinking too much had weakened the skills of local healers. Finally people expressed a level of distrust in healers, stating that their position was ambiguous:

Witch doctors can be good or bad, they can also take people's lives away too. That still happens here.

Ngukurr people acknowledge that choice among the different forms of medical practises available depends on the type of illness but the course of action is not clearly defined and is usually determined through a process of elimination. When Western medicine cannot provide a diagnosis or western medicines fail to produce an improvement, then people may turn to traditional healers. Few people expressed complete confidence in healers, rather a series of reservations were expressed ranging from lack of confidence in their skills to fears due to the moral ambiguity of the individual.

Use of the clinic

The health clinic in Ngukurr is heavily used. People however express reservations about attending the clinic and doubted the ability of the clinic to deal with health problems. People's relationship with the clinic is marked by passivity, rather than using it as a resource to aid the active management of individual health care. This passivity however, is also a result of the way in which the clinic operates. The clinic is not actively engaged in health promotion or providing education about health and so is unable to support or encourage steps towards individual responsibility.

There is an argument that this sort of relationship with health services is what people desire. Folds (2001) in his analysis of the Pintupi and their health services argues that "Band Aid Clinics" who "endlessly treat but never cure" meet the requirements of the Pintupi who extract what they need from a Western health system without compromising their cultural integrity.

Folds argues that the health promotion approach of asking people to change their behaviour to achieve health is insulting to the Pintupi who consider themselves to be healthy, by their definition of what health entails (Folds, 2001: 104). Folds, however also reveals figures about the evacuation of children to hospital, often for extended periods:

According to the Pintupi homelands Health Service (PHHS), from 1993 to 1994 a third of the 60 children under five years old resident at Walungurru were evacuated by air for serious illness, staying an average of nineteen days, but some for three months or more, in Alice Springs Hospital . . . only a very small percentage of Pintupi Children get through the first few years without needing hospitalisation, much of it involving lengthy stays (Folds, 2001:102).

For a community who valued family and children as an essential part of health, such separations, which are a product of a 'Band Aid' approach must be detrimental to people's sense of wellbeing.

The type of interaction with the clinic that Fold describes for the Pintupi and which is evident in Ngukurr has been described in other cultural settings (for example Eade's

(1997) description of health behaviour among Bangladeshi residents in Britain). However, Eade observations that the boundaries of each medical practise and people's beliefs are neither static nor uncontested, are pertinent here (Eade 1997: 250). It does not follow that people would be unwilling to alter their practises if they see advantages (especially in terms of quality of life) in doing so.

Despite people's stated avoidance of the clinic, the figures show that the majority of the Ngukurr population visited the clinic at some time during March and the figures are similarly high for other months. On the basis of my observation and discussions, people's attitudes in regard to the clinic's role in their health fall into four categories:

1. People who are active in pursuing health care and have developed a strong relationship with the clinic;
2. People who use the clinic, but who are passive recipients of a service;
3. People who avoid the clinic even when unwell; and
4. Well people who do not use the clinic due to lack of need.

Two women I talked to emphasise the need to develop a relationship with the clinic and its staff. These women are alike in the fact that they had high levels of education (both had previously been teachers at the school).

These women determine the terms of this relationship and visit the clinic according to their needs. The services the clinic could provide both in terms of immediate health care and preventative health care are incorporated into their everyday life. They ask questions, they prided themselves on their self-care and they also suggested that the health workers are there to offer advice on how to have a healthy life. Going to the clinic and taking care of yourself is not only essential for the individual but also for the health and well-being of their family:

People should make regular trips to the clinic, not only for them, but also for their families. You don't want them to turn around and say that people passed away for no reason, this makes people really worried. The families start fighting with each other for no reason.

This view, which stresses the use the individual could make of the clinic to improve their own health is a minority one. The majority of people exhibit a passive relationship to the clinic and their health. Although they are often concerned enough to visit the clinic, they handed over the responsibility of their condition to the staff. People complain that they are not given enough information about their medications or the results of tests, but they are waiting for this information to be provided, rather than actively asking questions.

Many people talk about responsibility of the clinic to monitor their bodies and check for diseases. They consider that this would be possible through the use of x-ray machines with which the doctor could make the body transparent and see diseases before they took

hold. This is because the early symptoms of disease were not discernible to the individual until it was too late. The doctor's exclusive and privileged view of the body, which ignores the individual's own understanding of their body and their symptoms is something which was repeatedly requested in Ngukurr. There appears to be the understanding that this sort of intervention is the sort of thing that was available to non-Aboriginal people and was hence the reason for differing levels of ill health. The importance of seeing inside the body, in order to make an accurate diagnosis is stressed in many different contexts, for example the eyes of a clever person are considered to be able to see right through someone in order to discover any foreign objects. God is also described as having similar powers by some of the Christians in the community:

We know who our doctor is, God is our doctor, he can see through our bodies, he created us all.

Health workers at the clinic reinforced the idea that looking and feeling healthy was no certainty of being disease free:

People don't know what they have inside them, maybe TB, maybe cancer.

The clinic is held responsible for remembering when patients were due for check-ups and when they need replacement medication. People remark that it would be better if all medications are stored by the clinic, and that people went there to take them. This is because clinic medications are considered to be potentially dangerous and people did not want to take the responsibility for storing them in their own houses.

It's dangerous for kids to take tablets, there are not enough shelves in the houses to put them high away from the kids. All medicine should be given in the clinic, they have to get people in everyday, they have a car. There are too many problems with having medications at home, little kids may think that they are good to eat'.

The third group of people vocal in their distrust of the clinic and even active in their avoidance of it. These people usually state that the clinic does not provide a good enough service, that if they went they would have to wait for hours and that the clinic provided preferential treatment for some sectors of the population. These perceptions appear to be influenced by hostilities people had for certain families and the non-Aboriginal population:

At the clinic people pretend that they are busy. If a latecomer comes in and is related to the health workers they are seen straight away. It is not fair. White people are treated straight away, I feel terrible about this.

People also express fears about what would happen to them at the clinic. Some women comment that going to the clinic is feared because of the embarrassment and shame caused by physical examinations. Some women in the community control their fertility with three monthly injections. Prior to the administration of these injections it is

necessary to do a pregnancy test. The clinic's failure to ensure some privacy for these women who were required to carry a urine sample through a public hallway, is a frequently raised point of concern, as voiced by a young mother:

People are ashamed of getting check ups. Pregnant women are asked for urine samples and they don't like that. They will stay at home and won't go for check-ups.

In the case of illness, both women and men express concerns that the clinic is the first step to being diagnosed with a serious condition that would necessitate the removal of the individual to Katherine or Darwin to hospital. This concern had three components; the worry that this sort of information would cause relatives; the potential of having to leave the community, and the prospect of an operation.

The third group's fear of the clinic meant that they only attend when they have serious health problems. In these cases their suspicion that going to the clinic results in operations or death is often confirmed. This distrust, and fear of the ramifications of clinic attendance on the life of the entire family was voiced by a young man, who commented:

People don't want to know about sickness inside, if they find problems they'll go and chop you up and then you'll have sickness. As soon as you touch hospital you get sickness. Medicine that they give us, it kills us that's why we stay away from the clinic. If someone told me that my brother or sister has cancer then the whole family would be sick with worry.

People, who do attend the clinic and take Western medication, do so with a number of conflicting beliefs in their minds. The clinic and its medicine are potentially dangerous, Western medicines are inferior, and as a matter of pride a person should try to stay away from the clinic and deal with health problems in a traditional manner. On the other hand there are people in the community (particularly the older women) who say that as a matter of personal responsibility you should go to the clinic when you are sick, as sickness brings anxiety to families and should be dealt with as soon as possible.

These conflicting ideas may be the cause of the failure of people to meaningfully interact with the clinic or to gain benefit from the effort made to attend despite the long waiting times and the potential for embarrassment during examinations. There is evidence of a lack of trust in the treatments that the clinic provides, especially those which have to be taken over a particular period of time before an improvement is apparent. Typically people fail to comply with medications such as courses of antibiotics⁵. People comment

⁵ Non compliance with oral medications is not a problem confined to Aboriginal people. For example a recent (non-Indigenous) study in Australia of compliance following hospitalisation of chronically ill patients found that half the sample used their medications incorrectly (Stewart & Pearson, 1999). A study of adherence to prescription medication among medical professionals (who could be expected to represent a group among whom adherence would be highest) found that 80% adherence to a prescription regime was the best outcome that could be expected (Corda, Burke & Horowitz, 2000).

that such medications make them feel “sick” or “dizzy”. I also observed medications for scabies being discarded because they were considered to be “too dangerous” to have around, or that the requirement to treat the whole family and wash all bedding was considered to be too difficult.

The extensive research that has been conducted on patient compliance has revealed several factors that related to failure to adhere to medical instructions. A major barrier is cost, which is not an issue to Ngukurr residents. Other factors that are more relevant to the Ngukurr setting are patient’s lack of knowledge about the medication and how it works (Barat et. al., 2001), limited communication between medical staff and patients (Apter et. al., 1998), and lack of confidence in medical services (Raiz et. al., 1999).

The following responses, which were provided by a cross section of Ngukurr residents indicate that the factors above may have a significant influence on their adherence to medications.

I am a diabetic, but I don’t take medicine any more. Medicine makes me more sick. (Female 50’s)

The hospital drugs make us sick. They give us really high doses and sometimes our body can’t cope with this. Probably medicine turns the other way. Maybe we are allergic to medicine. (Male 30’s)

People are scared of the clinic. They think that is person working in the clinic might poison me or open people up like sorcerers do. (Female 30’s)

They don’t explain what they do at the clinic. Like checking weight, they don’t explain what is good and what is bad. They don’t explain what your blood pressure means. You don’t know what they are giving you, they don’t explain what is in medicine. You don’t know if you are on a high or low does and people may end up taking too much. Like Amoxicillin, only a scientist could tell you what is in it. (Female 20’s)

The community’s expectations of the clinic

The community expects the clinic to practise a surveillance role that it cannot possibly provide. This is an example of one of the many differences in expectations of the role of health care and those people employed to provide it that exist in the community.

The clinic is frequently utilised by the community, but with the exception of the health workers, community members have very little involvement in the activities or decision making of the clinic. Their role is limited to a passive one as patients. The clinic is not considered to be part of the community’s responsibility. It is thought to be a non-Aboriginal institution and as such, people expect it to provide what they think is normal for a mainstream medical service. This is in contrast to the views of the non-local clinic staff and the aims of Territory Health Services as the following examples illustrate.

Position and expectations of Aboriginal Health Workers

One of the strengths of the Ngukurr Clinic is that it has a significant group of local health workers. But the role of the health workers and the expectations of the community regarding them, is one of the main tensions. There is a difference in the role of the health workers as perceived by the community and as they are perceived by the health system. The emphasis placed on their role by Territory Health Services is that of cultural brokers who 'ensure the acceptability of the service to Indigenous Australians' (House of Representatives Standing Committee on Family and Community Affairs, 2000: 97). This fact is emphasised in the following submission to the Senate Standing Committees on Family and Community Affairs by the Menzies School of Health Research. They commented that health workers are:

Currently trained to act as cultural brokers, to provide first aid and early management of common conditions and to recognise many health problems that are immediately life threatening. AHW do not have the skills of more highly trained professionals; generally they are not trained to deal with chronic conditions that have serious long-term implications for health, nor to implement preventative programs (SCFCA, 2000: 98).

Health workers in the eyes of the community, however, are health professionals who are expected to operate in the same way as the other (non-local) people employed at the clinic. People express frustration when health workers are not able to answer their questions or when they have to refer to the non-local staff for advice. There are expectations of professionalism and dedication to the job, which appeared to be far greater than those of any other Aboriginal people working in the community:

When people wake the health workers up at night they grumble. I wanted to write a letter to the Health Department to complain. They ask you to come earlier, but you can't expect people to get sick on time, that's their job.

I'd like people working at the clinic to be real reliable, not grumpy. They are getting paid to work there and should set a good example. They should show that they care and worry about people when they are sick.

The clinic's role in supporting healthy policies

Health centres in Aboriginal communities are expected by Territory Health Services to promote and model healthy living practices (THS 1999: 5-4). A key healthy living practice is encouraging people to give up smoking. Territory Health Policy states that all THS facilities and vehicles must be smoke free (THS 1999). Furthermore, they encourage the creation of smoke-free policies within communities in buildings such as the Women's Centre, Council Offices Schools and other public buildings with the aim of setting a good example, and minimising the risk of passive smoking for people within these environments.

Although the inside of the clinic is smoke free, this regulation does not extend to the outside waiting area, at the main entrance to the clinic. Among other people smoking outside are the health workers, an observation that is frequently made by community members, who express the view that health workers are not setting a good example. In a recent report examining issues and responses to Indigenous smoking for the Australian Medical Association and the Australian Pharmaceutical Manufacturers Association (Market Equity 2000: 58), the authors describe the “huge credibility gap” of health professionals who continue to smoke but encourage others to give up the practice. High rates of smoking by Indigenous Health Workers were considered to be the most important barrier to addressing the problem of smoking in communities.

By condoning the practice of smoking at the same times as expounding the dangers of smoking (the inside waiting room has posters about the health risks and visiting doctors repeatedly advise people to give up) a confused public health message is given to the community.

The values of the clinic

The premise on which modern day health services are based, is that people will take some responsibility for their own health (even if this means recognising that one is sick and seeking medical care). But some people are better equipped than others to develop such a relationship. People in higher socio-economic groups tend to take a more active role in their health care than people in lower socio-economic groups. It is no surprise then, that improved education is associated with improved health as Caldwell and Caldwell’s research has repeatedly demonstrated (1990, 1995,). Educated parents, and particularly mothers, have healthier children as they are better equipped to recognise health problems early and also to develop a positive relationship with health services (Caldwell & Caldwell 1990). Others investigating the link between education and health (Lindenbaum 1990) comment that people tend to have better hygiene, which is only partly attributed to a heightened awareness of germ theory. Educated people practise good hygiene because they recognise this as appropriate behaviour for people with an education.

The clinic staff and health services may be expecting skills (born out of education) which many people in the community do not have. Improving education is an obvious solution to improving health, but schooling in Ngukurr is beset with the same sets of conflicting expectations as the clinic (see Senior 2000). The school curriculum is based on an expectation of parental help and involvement, but many members of the Ngukurr community regard education of their children as the responsibility of the school and not the parents.

7 *Barriers to health improvement in Ngukurr*

Ngukurr residents know that health is a problem in the community. It would be difficult not to notice the regular evacuation of seriously ill people to hospital or the regular procession of funerals. People comment that there are too many deaths, too many sick skinny kids and that premature death is taking away all the ceremony men. Sickness and

death are not regarded with equanimity, rather they engender widespread anxiety and grief. There is, however, little contiguity between the realisation of ill health and the distress it brings and individual motivation to improve health or avoid illness.

An important motivation to changing behaviour regarding health are people's aspirations to be seen as being healthy, perhaps not because of the direct benefits, but because it differentiates and raises them above their peers. People in Ngukurr are confronted by the fact that the people who represent these health ideals are the non-Aboriginal community. Adopting the healthy behaviours of these people is often seen as impossible (due to the perception that the non-Aboriginal residents have unfair advantages such as their housing and possessions).

Ngukurr residents have a set of beliefs about the current causes of ill health in the community, which influence their motivation and perceived capability to improve their own health. The first is that the ill health that many people now experience did not happen in the past. Europeans have imposed new diseases and the adoption of new behaviours (such as smoking drinking and eating unhealthy food) upon Ngukurr residents. It is therefore the responsibility of outsiders to remedy the situation.

A belief in the inevitability of ill health also creates a barrier to responsibility. These beliefs arise from the frequency that disease is observed to occur in the community. High levels of morbidity and premature mortality are common in the community. These patterns of illness are therefore what people expect as part of their normal life course. In this sort of environment there is little incentive to modify behaviour as there is little evidence that this effort will be effective.

A further external threat to health and disincentive to adoption of healthy behaviours is the belief in sorcery. Sorcery can be both arbitrary and accidental and so while there is detailed knowledge about prevention, people's experience has shown that such strategies have limited effect.

Individual motivation to self-care is also affected by their relationship and understanding of the health services available to them. In Ngukurr the clinic is the focus for health-care as health promotion activities outside of this building do not exist. People's relationship with the clinic is marked by communication difficulties. People and staff often have different understandings of what health services should provide (based on what they have interpreted as being normal practise for mainstream services). The clinic operates on the premise that people will take some responsibility for their health and that they will discuss their needs and questions with the staff. Patients however are more inclined to pass the responsibility for managing illness to the clinic. The expectation that the clinic is the body responsible for an individual taking their medication at the right intervals (preferably by delivering it to their homes) is an example of this. At the same time lack of communication (caused by patients not asking questions and health workers not providing information) adds to people's lack of understanding and distrust of treatment regimes.

The clinic, as an institution of the western health care system provides contradictory messages about its role. It is considered, by the community to be a non-Aboriginal institution, and yet the community observe and comment on practices that they considered unacceptable for this sort of service (i.e. they wouldn't happen in a mainstream hospital or health service). The clinic staff expect people to be involved in their own health care and yet create dependency by routinely collecting people who they consider should be attending. Finally ideas about what mainstream health care entails also creates a tension, particularly the idea that the clinic should be able to screen and detect disease in all people in the community.

Health beliefs in Ngukurr are well summarised by the following song written by Keith Rogers for the Ngukurr band Broken English.

From Distant Shores (Rogers 1989)

*You look to the east as the sun sinks to the west
Black clouds gathering in some distant shores
Then you feel the coming of the rain, so I can feel the pain*

*Where the south wind blows nobody knows where it goes
You look to the east and the sun sinks in the west*

*Where are all the people of this world, where are we going?
Killing one another, destruction, pollution-the world has its ways
Even though we tried our very best we must put it to an end*

*Where the south wind blows nobody knows where it goes
You look to the east and the sun sinks to the west.*

The author of the song described it as an AIDS song. He said “I knew that disease was coming and I wanted to warn my people”. The song describes a foreign disease gathering its strength on a distant shore, preparatory to travelling towards the community where the author lives. As with all other “new” diseases it is perceived of as being thrown at the community from the outside. The song is based around the yearly and daily cycles of life. At the beginning the sun is setting, but at the same time as the day is drawing to a close another cycle is beginning as black clouds herald the beginning of the wet season. Although it is almost a certainty that it will rain during the wet season, the place where the rain will hit is unpredictable, especially at the beginning of the season. This encapsulates two essential health beliefs in Ngukurr; the first that illness is arbitrary (like sorcery it can strike an individual by accident) and the second is that illness is seen as something which individuals have little or no power to control. As Keith explained:

*There is a worry that you can't do much about this. It's like you can try
and send the rain away, and there are some old people who can do this,*

but after a while they get tired and they can't do it any more and the rain comes anyway.

This song does not fulfil the requirements of a successful public health message. Rather than encouraging individual control over health it emphasises powerlessness in the face of external and unpredictable threats of disease.

Conclusion: the possibility for a different relationship with health services?

The provision of health services to a community is not sufficient to improve the health of the residents. Health improvement occurs when people are motivated to change their own behaviours (including the way they interact with the clinic) to achieve a goal of good health. Under current conditions, however there are few stimuli for Ngukurr residents to take this path. In their experience death and illness are not things over which an individual has control. Health promotion has been successful with those people who treat good health as a goal and regard it as an indication of their status. In Ngukurr this transformation is either considered to be impossible, or possibly undesirable. Finally, for any efforts in health promotion to be successful, Ngukurr community members need evidence of improvement to encourage them that their efforts are worthwhile (Montgomery, 2000). Changes may not be apparent to the individual, it is therefore important that information about health status is collected at baseline and regularly communicated to the community.

The Coordinated Care Trials have initiated community Health Boards to encourage people to take a more active role in determining what they want from their health services, motivated by a rhetoric of public health which emphasises the importance of individuals taking control of their own health.

Some people in the community are aware of the Coordinated Care Trials that are operating in the Katherine West region and on the Tiwi Islands. People were particularly interested in the establishment of health boards composed of community representatives. The establishment of health boards was a key outcome of the Coordinated Care Trials. In Katherine West and Tiwi Islands the Health Board becomes responsible for the pooled funding of the trials and the allocation of resources for identified health needs (in terms of infrastructure, staff and education). Such participation was considered by the Trials' sponsors to be essential to empower communities to be more active and responsible in their own health care (Commonwealth Dept Health and Aged Care, 2001).

It appears however, that some community members have interpreted Health Boards as being a team of health workers who would be more compliant to community wishes and demands. The role of the Health Board would be to provide more intensive intervention and monitoring of individuals, preferably in their own homes to reduce the need to go to the clinic:

Need to look after people with sugar problem, blood problem and attend to them every day and see that they are having their medication on time.

People don't like leaving their homes, the health board could provide mobile health care.

This interpretation, which is generated by partial information and continuing ignorance about the individuals' role in maintaining their own health is at odds with the aims of the Coordinated Care Trials of empowering individuals and communities to take more control of their own health.

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Appendix 1: Bush medicines used in Ngukurr

	<p style="text-align: center;">Guyiya <i>Grewia retusifolia</i></p> <p>Description: Small scrub with white flowers from November to February.</p> <p>Treatment for: Internally for diarrhoea, or externally for treating sores and boils.</p> <p>Preparation: Wash the roots, scrape off the skins and pound it up until it turns into a starchy paste. Apply to sores or swallow.</p>
	<p style="text-align: center;">Dumbuyumba <i>Santalum album</i> (Sandalwood)</p> <p>Description: Shrub or small tree to 3 metres, small red flowers and black fruit.</p> <p>Treatment for: Sore throats, colds, flu</p> <p>Preparation: Boil up the leaves, strain and decant liquid into a bottle. Drink as required.</p>
	<p style="text-align: center;">Gulban <i>Melaluca stenostachya</i> Small leaved Ti-Tree</p> <p>Description small tree with small aromatic leaves.</p> <p>Treatment for: Colds, flu, sores, skin infections, Kidney problems.</p> <p>Preparation: Boil up leaves and drink liquid or apply externally to sores. Liquid can be put into babies baths to prevent them getting skin infections.</p>

	<p style="text-align: center;">Bannarr Tree <i>Owenia vernicosa</i> Marble Tree</p> <p>Description: Tree 4-12 metres high</p> <p>Treatment for: Sore eyes, boils and sores (also is a fish poison)</p> <p>Preparation: Scrape the bark and the stem, and pound then boil. The liquid should turn red. Strain it to get the bark out. Use the liquid as an eye- wash or externally to treat boils and sores. This is poisonous, and should only be applied externally.</p>
	<p style="text-align: center;">Bush Onion <i>Crinum angustifolium</i></p> <p>Description: Lily with white scented flowers from October-February.</p> <p>Treatment for: sores and snake bites</p> <p>Preparation: Chop up the bulbous root of the plant and boil it. Apply liquid to sores or snakebites. This is a poisonous plant, do not swallow any part of it.</p>
	<p style="text-align: center;">Buduga <i>Clerodendrum floribundum</i></p> <p>Description small straggly tree 4-10 metres.</p> <p>Treatment for: ear infections, sores and flu</p> <p>Preparation: Boil up leaves and stem, strain liquid and store in a bottle. Wash with it to treat sores and ear infections and drink for colds and 'flu.</p>

	<p style="text-align: center;">Paperbark <i>Melaleuca leucadendra</i></p> <p>Treatment for cough colds headache or general illness.</p> <p>Preparation: Boil leaves and use as an external wash or as an inhalant or drink for coughs, colds and headache.</p>
	<p style="text-align: center;">Smelly leaf plant <i>Pterocavlon serrulrtum var. velutinum</i> Bush Tobacco</p> <p>Description: Low shrub with hairy leaves carrying an aromatic smell when crushed.</p> <p>Treatment for: Scabies, diarrhoea, colds</p> <p>Preparation: For colds simply crush the leaves and inhale. For Diarrhoea and scabies, boil the leaves until the water turns green and then drink or use to wash with.</p>

Garndalpurru – Sambo Burra Burra (2000)
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