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– ARTICLE –

‘WE’RE HANDS-ON PEOPLE’: DECOLONISING DIABETES TREATMENT IN AN ABORIGINAL COMMUNITY IN NORTHERN TERRITORY, AUSTRALIA

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ABSTRACT

This study which was conducted in a remote Aboriginal community in Australia’s Northern Territory in 2014, sought to understand diabetes from a local Aboriginal perspective. Participants drew on a variety of holistic healing methods for their diabetes in the absence of recognised community healers. The study found that the seven adult Aboriginal diabetes patients in this longitudinal ethnographic study chose to employ self-healing strategies that variously reflected local Aboriginal cultural values and practices. The study proposes the development of McKivett, Paul and Hudson’s (2018) framework for use in diabetes clinics in Aboriginal communities. Such a framework would offer a combination of local and biomedical treatment options that would best support Aboriginal diabetes sufferers within the clinical setting, as well as actively supporting the patient in their own treatment. The authors suggest that the implementation of such a framework may contribute to the decolonisation of diabetes clinical settings and practice in Aboriginal communities and, ultimately, reduce the symptoms and prevalence of diabetes in Aboriginal populations.

Keywords: diabetes; Aboriginal peoples; decolonisation; biomedicine; indigenous healing.

INTRODUCTION

Australia’s Indigenous peoples have the highest rates of Type 2 diabetes and its complications nationally and globally (Australian Department of Health 2015, 16). Australian Aboriginals and Torres Strait Islanders have a much lower life expectancy than non-Aboriginal Australians. For Aboriginal and Torres Strait Islanders born between 2015 to 2017, life expectancy was estimated to be 8.6 years lower than the non-Indigenous population for males (71.6 years compared with 80.2) and 7.8 years for females (75.6 compared with 83.4) (Australian Institute of Health and Welfare 2019). Diabetes is one leading cause, contributing to one in every twelve Australian Indigenous deaths (ibid, 2019).

There are three main types of diabetes: Types 1 and 2 (which are classified as chronic diseases) and gestational diabetes mellitus (GDM). GDM is a temporary condition that usually disappears after pregnancy but for some women the condition becomes chronic (Healthline 2020; Health Navigator 2020). Diabetes is caused by the presence of high levels of blood glucose (blood sugar) within the patient's internal biochemistry. These high sugar levels are caused by problems with the body's supply of Insulin which facilitates the transformation of blood sugar (glucose) into energy (Health Navigator 2020). In Type 1 diabetes people do not produce insulin because the cells in the body that create it have been attacked by the person's own immune system. In the more common, Type 2 diabetes, problems arise because people do not respond well to insulin and as the disease progresses, the body fails to make enough of it.

Type 1 diabetes is lower amongst Aboriginal and Torres Strait Islander peoples than non-Indigenous Australians, at nine and eleven cases per 100,000 respectively (Australian Institute of Health and Welfare 2019). However, Type 2 diabetes is an underlying or associated cause of over half of all diabetes deaths (ibid). Aboriginal and Torres Strait Islander adults are almost four times as likely to die from Type 1 diabetes as their non-Indigenous counterparts (ibid). This may be because Aboriginal Australians and Torres Strait Islanders are less likely to report or seek clinical treatment for their diabetes. The number of cases in which Type 2 diabetes was found in Aboriginal peoples is increasing as are cases of GDM, adolescent and childhood diabetes (Australian Department of Health 2015, 16).

Other than diet choices and socioeconomic status, government websites such as The Australian Institute of Health and Welfare provide scant epidemiological data to explain the high prevalence of diabetes in Aboriginal and Torres Strait Islander populations. This lacuna is reflected in clinical practice in which the treatment of Aboriginal peoples' diabetes in Australia remains dominated by biomedical approaches and lacks a range of culturally recognised interventions (Cass *et al.* 2002; Lowell *et al.* 2012; McKivett, Paul, and Hudson 2018; Seathre 2013).

Should Australian Aboriginal peoples choose to understand diabetes from a biomedical perspective, language and cultural differences restrict accurate translations (Lowell *et al.* 2012; McKivett, Paul, and Hudson 2018; Thompson and Gifford 2000). This is because the basic premise of biomedicine sits at odds with much of rural Aboriginal people's understandings of embodied health. Traditionally, the scope and scale of biomedicine is set by the limits of the individual physical body, therefore it is currently ill-equipped to treat the person (including their body) in a relational sense. That is, traditional biomedicine does not incorporate the social, material, natural, and spiritual relationships that contribute to personhood and contribute to the person's overall wellbeing. (Foucault 1973; Lock and Nguyen 2018; McKivett, Paul, and Hudson 2018). In Australia, neocolonialism persists within medical institutions (as evidenced in the previously cited inequitable health statistics) via the durability of the biomedical framework and the inadequate incorporation of Aboriginal people's relationships (for example, with their land and ancestors) in healing practices. The authors posit that this is likely to contribute to the increasing cases of diabetes in Aboriginal communities and thus signal a need for local Aboriginal involvement in the review and redesign of clinical consultations and clinical environments. Our research findings suggest that the biomedicine offered in diabetes clinics should be offered as supplementary to, or extensions of, pre-existing healing practices carried out in Aboriginal communities and on totemic lands for Aboriginal peoples who prefer Aboriginal healing methods to biomedicine.

Medical anthropologists agree that social relations are key contributors to individual health and illness. Rather than treating the body as a discrete biological unit, medical anthropologists comprehend the human body as a material manifestation of self and social relations (Dreger, Mackenzie, and McLeod 2015; Kleinman 1980; Foucault 1973; Lock and Nguyen 2018; Scheper-Hughes and Lock 1987). Relatedly, psychological research reveals that stress contributes significantly to the development and maintenance of diabetes, particularly for Indigenous peoples (Dreger, Mackenzie, and McLeod 2015). However, despite a growing body of research that seeks to inform culturally appropriate health care programs in Aboriginal communities, there is an absence of successful implementation which would significantly close the ontological and epistemological gaps between Indigenous and biomedical healthcare (Cowlishaw 2006; Seathre 2013; Sherwood and Edwards 2006). In addition, despite recognition by health professionals of the legitimacy and efficacy of Aboriginal treatment practices and patient involvement, relationship breakdowns between Aboriginal and non-Aboriginal people continue (Laplante 2015; Lowell *et al.* 2012).

The decolonising approaches presented in this study are useful therefore as they may serve as a guide for other clinical contexts. Research undertaken by Aboriginal health nurses also recognises the ongoing health issues and relationship breakdowns between practitioner and patient (Edwards and Taylor 2008; Rix, Barclay, and Wilson 2014; Sherwood and Edwards 2006). Cultural awareness is a starting point in acknowledging the affects colonial history has had on Australian Aboriginal people's health both locally and nationally (Edwards and Taylor 2008). However, the need to have an ongoing critical awareness of colonialism and how it has been integrated into health systems and the way practitioners deliver health care through subconscious judgements is crucial (Edwards and Taylor 2008; Rix, Barclay and Wilson 2014; Sherwood and Edwards 2006). Edwards and Taylor (2008) recommend genuine reflection as a way for practitioners to decolonise within themselves and to change the way they respond to their patients. By doing so they suggest that practitioners will become more respectful of the voices and opinions that come from Australian Aboriginal peoples (Edwards and Taylor 2008). Rix, Barclay, and Wilson (2014) explain that self-reflection can unpack white privilege. To deconstruct the Western clinical focus, however, requires boldness of action to change practitioner pedagogy and ensuring self-reflection is consistently implemented through regular training (Edwards and Taylor 2008; Sherwood and Edwards 2006).

The processes suggested in McKivett, Paul, and Hudson's (2018) framework suggests a deconstruction of the Western clinical focus. It is a decolonising process as it places Indigenous knowledge and theory in the clinical environment through a reflexive process, particularly for its non-Indigenous participants. The framework's structure directs participants to continually practice processes whereby 'Indigenous knowledge and theories challenge the hegemony and power structures inherent in Western theory production' (Pillai 1996, 218). McKivett, Paul, and Hudson (2018), from the Adelaide School of Medicine, explored the role and impact of the predominantly biomedical clinical communication process on Aboriginal healthcare provision. They identified the need for non-Aboriginal healthcare consultants to more meaningfully communicate with their Aboriginal patients. The research team explored new ways to do so by drawing on the successful Calgary-Cambridge communication approach which had been adapted in the New Zealand health system resulting in a community assessment framework called the Meihana model (ibid, 598). The Meihana model (Pitima *et al.* 2007) aims to assist health practitioners in their clinical interactions with Māori patients. The Calgary-Cambridge communication approach 'outlines five key steps for practitioners to undertake that integrates both process and content domains. The five steps include initiating the session, gathering information, providing structure, building the relationship and explanation and planning' (ibid, 599). The framework developed by McKivett, Paul, and Hudson (2018) focusses on four domains: content (understanding Aboriginal worldviews); process (acquisition and delivery of content toward shared understandings); relationships (culturally appropriate relationship building skills) and environment (a welcoming environment). All domains of the framework are to be developed with an overarching appreciation of the historical context of Australian Aboriginal people (*ibid* 2018, 601–602).

The fundamental aspect of this model is that the medical practitioner plays a crucial role in terms of acknowledging personal biases and the role of ethnocentrism in their interactions with others. McKivett, Paul, and Hudson (2018) explain that practitioners learn to understand themselves and how their cultural identities influence each domain. The key findings presented in this paper, could valuably contribute to the development of McKivett, Paul, and Hudson's (2018) framework to decolonise diabetes clinics in Aboriginal communities. However, before implementation of this framework (or any framework) in this community, further consultations and focus groups with the various communities would need to transpire to ensure community involvement from the outset, local decision making, local leadership and the opportunity to adapt the/a framework to be locally culturally relevant.

METHODS

The study was conducted in a remote Aboriginal community (population: 3,000) approximately 500km south of Darwin. The name of the community will not be revealed in any research outputs to protect the identity of the research participants. The first author had resided in the community for a year before research began. The two years in the field yielded extensive field notes from observations and interviews. The research was ethnographic and based on interviews with seven participants. The interviews were structured to resemble culturally familiar 'yarns', as discussed later. Participants discussed their own unique treatment methods for their diabetes and as a necessary clarification for the scope of this paper, two of the participants stated they had Type 1 diabetes, three said they had Type 2 diabetes, while the remaining two participants said they were unsure what type they had, but that they knew they had diabetes[4]. In addition, when the participants make reference to Aboriginal 'healing' in this paper they are referring to the Indigenous participants' methods of controlling their diabetes. This involved healing the individual within their broader socio-ecological live and these self-healing methods and choices were motivated by the desire to choose to live their lives the way they wanted to.

A decolonising approach

For non-Indigenous researchers, Linda Tuhiwai-Smith argues, it is imperative to position Indigenous concerns and worldviews at the centre of research in order to come to know and understand theory and research from Indigenous perspectives for Indigenous purposes (Tuhiwai-Smith 1999, 39–40). For non-Indigenous researchers this means that critically reflecting on their own Western backgrounds and history and acknowledging cultural differences respectfully is vital (Edwards and Taylor 2008; Martin 2001; McKivett, Paul and Hudson 2018; Rix, Barclay, and Wilson 2014; Sherwood and Edwards 2006).

For this study to have any cultural significance for the Aboriginal people in the study site community, the research needed to centre on an Indigenous research agenda which situated local needs and goals at the forefront of research (Tuhiwai-Smith, 1999, 127). To this end, a respected Aboriginal member of the community and work colleague who was a member on several community-based boards agreed to fulfil the role of cultural advisor for the study. Consultations, recruitment, and the treatment of Indigenous knowledge was led from the advice and perspectives of local people throughout the research process. The research design, including the topic of research, recruitment of participants and interview approaches, was discussed with the cultural advisor and with local work colleagues and friends to ensure methods and interpretations were culturally appropriate. Two of the lead author's colleagues and respected members of the community who suggested diabetes as the research topic had diabetes themselves and wanted to know more about it but did not wish to discuss their own health as they felt this was private. Therefore, trust, personal privacy and individual perspectives on personal health may have influenced the number of people wishing to discuss their diabetes.

Critical awareness of similar conventional studies based on 'frameworks, processes and practices of colonial, Western worldviews and their inherent knowledge, methods, morals and beliefs' is important when undertaking decolonising research (Martin 2001, 2). However, as the lead author was not a local Aboriginal person, analysing the role of herself and those working with Aboriginal people in a clinical environment was central to the research agenda. As discussed, undertaking decolonising research involves understanding local cultural history within the cultural context as well as within Australian policy and Western institutional influences (Edwards and Taylor 2008; McKivett, Paul, and Hudson 2018; Pillai 1996; Sherwood and Edwards 2006; Rix, Barclay, and Wilson 2014; Tuhiwai-Smith 1999). This study utilised Tuhiwai-Smith's recommendation of focussing more on the process of working with Aboriginal peoples, than on the outcome (Tuhiwai-Smith 1999). Reflexive practice (Rix, Barclay, and Wilson 2014) throughout the research was achieved by discussing experiences and perceptions with local community members, the co-authors, work colleagues and close friends. The lead author also kept a journal where she wrote down thoughts and observations of her own Western worldviews and how they influenced the research process within the community. The co-authorial team carried this into the analysis and writing phase to critically reflect on how this might influence the research product and how the research outputs might impact the participants and the community.

Participants

Six of the participants were female, one was male, and all were forty-seven to sixty years of age. The pseudonyms chosen by the seven participants are: Melissa, Lucy, Teresa, Majella, Mary, Marie and the male participant David. Other central informants included two non-Aboriginal nurses who lived and worked in the community. Participants were invited to participate if they identified as Aboriginal, were from the study community, were over the age of sixteen, and diagnosed with Type 1 or Type 2 diabetes. Following advice from the local cultural advisor, invitations to participate were extended to eligible community members through conversations at the local store: a site of social gathering inclusive of local people from all clan groups. The cultural advisor, Rose (a pseudonym) accompanied the lead author to the local store to introduce the researcher, to explain the research project, and to invite participation, all in the local language. However, most participants were recruited through 'snowballing' via word of mouth (Lewis-Beck, Bryman, and Liao, 2004).

Two work colleagues, who themselves had diabetes, did not want to take part in the study as they were anxious that other community members may find out that they were ill, and would be perceived by others as irresponsible in terms of their lack of self-care or weak character. The reason for the two colleagues' reluctance may have been more widely shared across the community and was likely to have affected the size of the voluntary participant cohort. However, those who did volunteer to participate in the study were open and unashamed about discussing their diabetes before interviews began. This offered early data on diverse perceptions of diabetes and identity in the community. It also shows that those who volunteered to participate may not represent the whole community.

Consent to participate in the study was gained orally and sound recorded before interviews began as the cultural adviser, Rose, suggested it was the best way forward as a lot of local community members were not literate. Two one-hour interviews with two non-Aboriginal diabetes clinicians provided additional contextual narratives of their experiences nursing diabetic patients in the community. Informal conversations with other local Aboriginal peoples (typically with work colleagues and their family members) during the research period provided broader context and opportunities for triangulating contributions from key participants.

Yarning as a decolonising research method

'Yarning' was applied in this study as a decolonising research method. Yarning is mode of sharing information that contributes to strengthening relationships and a sense of belonging (Bessarab and Ng'andu 2010; Towney 2005; Walker *et al.* 2014). Although, the term 'yarning' was seldom used in the study site, its practice was nevertheless implicit and ubiquitous. When yarning, questions are seldom answered directly; rather, they are presented as a story which may reflect the person's feelings about the question (Bessarab and Ng'andu 2010, 38). For example, when Marie was asked if she felt comfortable going to the clinic to treat her diabetes, she responded by telling a story about having previously worked at the clinic, and then leaving after a conflict with the manager. When Mary was asked how she felt about having diabetes, she said she did not mind. She then went on to tell a story about the way her husband treated her and how she was concerned about this. There were many instances where the researcher sought clarification either during the yarn or following the yarn to ensure there was no misinterpretation.

Yarning 'prioritise[s] Indigenous ways of communicating, in that it is culturally prescribed, cooperative, and respectful' (Walker *et al.* 2014, 1216) and thus appropriate to a suite of decolonising research approaches. Yarning can contribute to decolonising research because it requires the researcher to be accountable to their participants. The researcher must prioritise the participants' mode of engagement over their own. This may involve slowing down, respecting silences, and allowing the stories to unfold (Bessarab and Ng'andu 2010, Farrelly 2014).

Yarning was central to relationship-building: not only between the lead author and her participants, but also with the wider Aboriginal community. 'Indigenous identity is defined by relationships' (Towney, 2005, 40) and 'yarning' is a unique part of Australian Aboriginal culture and a tool to connect Aboriginal people to each other through cultural protocol and relationships. Talking about what people value and what is important to them creates a platform that brings people together to further discuss these things (Towney 2005).

All participants chose to speak mostly in English but at times spoke in their first language when they could not articulate what they wanted to say or felt more comfortable. Ensuring participants were in a place where they felt the most comfortable during yarns was important. Rose reassured the participants that yarns could be conducted in quiet, private places where the participants felt comfortable to openly share their stories if they so choose. All yarns with participants were voice-recorded and transcribed within twenty-four hours. They lasted approximately fifty minutes each. Notes were written immediately after and transcriptions were checked for accuracy. Rose translated all parts of the first language sections of the yarns. As the research evolved transcriptions were coded according to themes participants signalled as most significant. The main themes that the participants spoke about were highlighted and compared with the other participant interviews, key themes derived from the field, from notes, and the literature review. Additional conversations with Aboriginal locals throughout the research period added further context to the research.

This study was approved by the Massey University Human Ethics Committee. Permission to research was sought from the traditional owner of the land and a local leadership team. The Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS) guidelines for ethical research in Australian Indigenous research provided a guide to working with Australian Aboriginal peoples. Oral and sound recorded consent was sought from key participants. As stated above (AIATSIS 2019, 10), oral and written consent was sought from the traditional owner of the land in which the community reside, five elders (suggested as people to approach by the traditional owner), and the eldest traditional owners of the vomit and abscess Dreaming stories presented here.

RESULTS

Co-designed healing practices

A key finding was that, in contrast to much anthropological research (Clarke 2008; Maher 1999; McDonald 2006; Seathre 2013; Williams, Guenther, and Arnott 2011), no one individual in the community was recognised as holding expert health-related knowledge to be distributed across the community and intergenerationally transmitted. Indeed, nobody in the study community recognised anyone holding this role. Rather, a range of individuals and groups of varying ages administered a variety of Aboriginal remedies for diabetes, ailments and emotional advice. There were some people who knew traditional remedies better than others. For example, they knew which plants to use on skin problems (such as stings from a catfish), specific places to visit for healing or the use of body sweat for physical and emotional healing (which will be discussed later). However, no one self-identified nor was identified as a healer of all things. The remedies used by locals attended to the health of the whole person: their physiological, psychological, and social needs. These local healing approaches were generally (but not always) considered superior to Western biomedicine in their efficacy. Moreover, participants revealed that the treatment received from the clinic would be more effective if combined with Aboriginal treatments and stressed that these should be administered via a hands-on and dialogic approach. These approaches will be detailed in this article.

The participants' perceptions of health and wellbeing, and the associated treatment of their diabetes and other ailments, was consistent with medical anthropological literature that suggests that good health incorporated more than just the physical state of the person. For example, multiple research findings recognise that meaningful and sustained health also depends on the person's capacity to function within complex and relational socio-ecological systems (Dussart 2010; McDonald 2006; McKivett, Paul, and Hudson 2018; Seathre 2013; Senior and Chenhall 2013; Thompson and Gifford 2000).

Participants' treatment methods attended to a variety of health conditions, treating not only physical symptoms of illness but also emotional, social, and community wellbeing symptoms. Participants' methods also often involved strengthening their connections with their totemic land (locally referred to as a person's 'country') and by extension, their relationships with their ancestors. Some participants shared the same or similar treatment methods, but overall, participants treated their diabetes differently. The table below presents the methods participants used to treat their diabetes. Even though different participants may use some of the same treatment methods, they are used in various combinations with other methods. The methods used to treat diabetes are organised in themes rather than presenting these as individual narratives. With further development, these themes may be usefully applied in cross- and intra-cultural comparative analysis in Aboriginal Australian communities.

Elders as sources of healing knowledge

As seen in Table 1, Lucy was the only participant to seek diabetes treatment advice from her elders. She felt that efficacy was best achieved if only one healing approach was administered at any one time. For example, she said that she would either take the tablets provided by the clinic *or* use Aboriginal healing methods. She sought advice from elders in her extended family to determine which healing she should receive (Aboriginal or non-Aboriginal). Her preference was for Aboriginal healing approaches because they were 'my way, my culture'.

Table 1. *Participants' Totems and Individual Healing and Treatment Methods used for their Diabetes*

	Participants' totems and treatment / healing methods used for their diabetes							
Name & type of diabetes	Elders	Ancestors/ little people	Country	Bush food	Sweat	Clinic	Christianity	Central totems participants identified with
Participants with type 1 diabetes								
Lucy	Yes	Yes	Yes	Yes		Yes		Black cockatoo, Porcupine
Teresa			Yes	Yes		Yes		Lightning, black snake
Participants with type 2 diabetes								
Melissa	Yes		Yes			Yes	Yes	Vomit, wild dingo
Majella			Yes	Yes		Yes	Yes	Lightning, black snake
Marie			Yes			Yes	Yes	White cockatoo, white yam
Participants who are unsure what diabetes they have								
Dave					Yes	Yes		Owl, goanna
Mary			Yes			Yes	Yes	Kangaroo, moon

In this community, a person is considered to be an elder if they are around sixty years of age and over. However, a person can be considered a respected member of the community when as young as thirty-five years of age. Younger community members can have higher status than an elder if they hold an active leadership role within the community. To be a traditional owner (leader of a clan group or land) or to be of very high status in the community you need to have a combination of age and respect. Such people are also referred to as elders or traditional owners. The level of respect they receive is widely accepted by all community members. Some elders in the community said that they felt disrespected, particularly by younger local Aboriginal men who, against elders' directives continued to fight with other clans. There was also a growing disregard for traditional knowledge and ritual, which discouraged intergenerational transmission of traditional knowledge. This may adversely affect the future use of Aboriginal healing methods in the community.

Using country bush tucker and ancestors to treat diabetes

Except for David, all participants explained that being on their country with ancestors and eating food on their country was the most effective healing method for diabetes. The two aspects of healing are interlinked because a person needs to be on their country to interact with their ancestors and collect bush tucker.

> I went to the hospital and then me and my husband went out country. I talk to my [ancestors] and swim there at the creek and make me feel good. I eat *long bom*[5] for my diabetes to go down (Lucy).

Lucy emphasised the importance of eating foods while on her country when she feels unwell while Marie refers to *avoiding* certain foods. 'Bad food' was consistently associated with the local store or takeaways and 'white people's food'. Conversely, all food gathered or hunted from a person's country was considered nutritious (for example: seafood, kangaroo, pandanus seeds, bush potato, and bush plums).

The role of totems and the healing power of sweat

Aboriginals resident in the study community usually referred to one or more totems inherited by their father which simultaneously connected them to their 'Dreamtime' stories, land and people. Dreamtime refers to a period of creation made by pre-existing ancestral spirits (Dean, 1996, 3). During this process, Aboriginal people's ancestors established a set of irreversible structures that were set to be followed eternally, such as life, law and moral codes (ibid). The ancestral spirits transformed into different elements of the environment, such as plants, animals and land. This period gave meaning to everything. In other words, the land itself was a sacred place. Each person had one or more totems where a Dreaming site occupied their land (the place where the human evolved into an animal) and then had an additional two to five totems made up of being either: fauna, flora, solar system, or illness totem (such as vomit or abscess). A person with, for example, abscess or vomit as their totem has the ability to communicate with ancestors and ask them to remove the vomit or abscess (manifestations of a negative spirit) from the ailing person by talking to their ancestors and wiping their body sweat on the person. The participants were asked if there was anyone local, they could see for their diabetes. Marie responded by saying 'no, there's no totem for that'. Marie acknowledged that that this was because there is no person with diabetes as their totem and therefore, they cannot use their sweat or talk with ancestors to remove it from another person. However, David, on the other hand got his family members to wipe their body sweat on him when he was feeling 'weak' from the diabetes. As totems are an integral part of life they are recorded in the table, however, no participant said that they healed diabetes and they are therefore not discussed in depth. The healing power of sweat and its relationship with totems, country, and people does assist in healing diabetes and is, therefore, discussed further.

The only male participant in this study, David, seldom had the opportunity to visit his country. However, as a healing alternative, and like the healing totems of abscess or vomit, he would ask his children to wipe their body sweat on him when he was feeling the symptoms of his diabetes. He said that this was a way to rejuvenate his body 'to make me feel good again'. He referred to this as enacting an autonomous healing method, describing it as 'my way.' This may indicate that where no other alternative was available, as Aboriginal community members may make use of fragments of familiar efficacious traditional healing practices when specific traditional remedies are not available.

Throughout this study, sweat was the topic of numerous conversations. People who had abscess or vomit as their totem could wipe their sweat on the affected person as medication and, if left unwashed for twenty-four hours, the abscess or vomiting, caused by a negative spirit, would begin to clear. During visits to a person's country, body sweat was also wiped on the outsider (including the primary researcher) as a way to communicate with ancestors on the land that the person entering meant no harm. Another use was to wipe it on toddlers (including the primary researcher's child) to support them to walk. Waegemakers Schiff and Pelech (2007) recognised the use of sweat in ritual or ceremonial acts in other cultures including some Native Americans, Finnish, Japanese, and the Mayan and Aztec people of Mexico. For these cultures, the individuals own sweat is known to indicate measurable changes in spirituality. However, there is no literature on the use of other people's body sweat as a healing agent. This may be unique to this community and could be incorporated as a healing method at the local clinic.

Negative and positive experiences at the clinic

Clinic experiences varied between participants. In contrast to the six other participants, Teresa only treated her diabetes with what was provided by the clinic. There was a social reason for this as she said she enjoyed conversing with the nurses there. This was facilitated by her high level of English proficiency relative to the other participants. Consequently, Teresa's interview was frequently marked with biomedical terms related to her diabetes:

> It's alright for me. Talk to the nurses, the diabetes nurse. Talk to all the specialists when they come in from town…That's when I go to the clinic and see all the specialists and I do finger pricks and blood sugar.

Conversely, Marie passionately expressed her negative experiences at the clinic and alluded to unfavourable feelings towards non-Aboriginal people:

> Well, I can only say for myself, I don't like going there, for myself. You know, I don't like asking the nurses to do that to me because, they already making us sick, the sugar, from white people.

During her interview Marie often spoke negatively about the non-Aboriginal people she had worked with. She felt they treated her unfairly and she also resented non-Aboriginal missionaries for replacing the traditional community diet with more convenient yet unhealthy options such as sugar and flour. The irony of receiving diabetes treatment from white diabetes clinicians has not escaped her: she was thus not about to accept help from the same group of people who had introduced diabetes to her community.

Healing through Christianity

While Marie felt resentful towards non-Aboriginal people, she embraced Christianity. Christianity has become part of an everyday lifestyle for many local Aboriginal people. Like other Aboriginal communities, Christianity has been combined with Indigenous beliefs to form an Indigenised or syncretic belief system (Dussart 2010; Hinkson and Beckett 2008). All participants had a strong faith in God, although David said he doesn't pray regularly: 'Oh yeah I do [believe in God], but I don't really get into that stuff' (David). Most of the community incorporated Christianity as a holistic approach to healing diabetes and other illnesses. Like Marie, Mary also uses prayer for the pain her diabetes was causing her, saying that she would 'just say a little prayer' to make herself feel better and Melissa, too, spoke a lot about her faith in God, particularly with reference to controlling her diabetes:

> I don't think about my illness and what is going on inside of me… The only person I trust is God… He is the only one that can heal my diabetes.

The need for a decolonised diabetes clinic

All participants except for Marie were content to continue to use the clinic as a source of healing in combination with their chosen local healing methods. However, while the research participants syncretised their belief systems and their healing systems outside the clinic environment, clinical consultations have not accommodated Aboriginal healing practices and associated cultural knowledge, skills, natural resources, values, and beliefs into their own service provision. Marie gave her account of the mechanistic processes she associated with the clinic:

> Yu, it's not their brain working for them, it's the machine. It's not looking at what's wrong with the person. Getting machine, taking the number, writing it down and doing it for them, put it in the folder. And they telling us, yu, your blood bit high, your sugar too high, like that.

In her opinion, consultations at the clinic lacked patient-practitioner interactions. She said that she would benefit from more interactive and dialogue-focussed consultations, as opposed to the principle use of the machine for diagnosing and healing patients. Marie doesn't think that the diabetes clinician sees her as a 'whole person', nor are they attentive to her socio-ecological context. In her view, they should be talking with her about what was going on in her life that might be making her ill. Instead, her consultations consist of a mechanistic interaction, focussing on the biophysical causes and symptoms of an illness treated as isolated from its complex social, cosmological, physical, and emotional causes and effects.

A similar view was revealed in an interview with a non-Aboriginal nurse working in the local community who recounted a conversation she had with a local elder who requested a biomedical consultation involving a hands-on approach:

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

The nurse had lived and worked in the community for two years. Some clinic staff have the same, and occasionally more, longevity in the community but most clinic staff were 'fly-in, fly-out', staying only a few months or weeks. Like other organisations within the community and like other remote Aboriginal communities, high staff turn-over of non-Aboriginal residents is frequent, preventing consistent, meaningful relationship development, a non-Aboriginal understanding of local community life, and a reciprocal cultural understanding between non-indigenous and local Aboriginal peoples.

DISCUSSION

Individualised culturally meaningful healthcare

This study shows that Aboriginal peoples seek optimal health through a holistic and integrated approach to wellbeing. Sustained and positive relationships with community members, ancestors, and 'country' are key to good health. Participants reported that health care that primarily focussed on the body is not effective for diabetes patients in this community. There is a need to include local culturally meaningful health care based on mutually constituted knowledge, experiences and values. To implement this effectively this study suggests that local diabetes treatment should involve a practical, hands-on approach reflective of local knowledge transmission strategies.

Ingold (2000, 343) demands an ecological approach to learning and defines skill as the sum of the physical, mental and physiological: 'the total field of relations constituted by the presence of the organism-person, indissolubly body and mind, in a richly structured environment'. The 'skilled practice' used by the participants to heal their diabetes drew on the physical, social, and spiritual realms. Their chosen healing methods were those that fit best within their own web of relations, experiences, and beliefs. The incorporation of a person's chosen Aboriginal healing methods into the clinic can be understood as an extension of these pre-existing relations. This is very much at odds with the practice of the clinic which treats self-care as 'a property of the individual human body as a physical entity, a thing-in-itself' (Ingold 2000, 343).

Holistic change within the clinic

While one of the participants was satisfied solely with the care she received at the clinic, all Aboriginal participants' stories illustrated that the clinic was viewed as a place that did not provide an integrated and holistic approach to treating diabetes. The explanations offered by participants for why they did not take the diabetes medication prescribed by the clinic varied. Negative experiences at the clinic involved the way they were treated by staff, their disapproval of the way their consultations were focussed only on their physical bodies, and how their bodies would negatively respond to prescribed medication.

Uneven power relationships often found within medical institutions is a primary barrier between patient and practitioner and is referred to by Foucault as the medical gaze (1973, 109). The medical gaze, or the practitioner's system of orientation, disregards Aboriginal non-biomedical healing by selecting only the relevant elements of the total data stream available to our senses (Foucault 1973, 69) and ruling out the rest. Related to the medical gaze is Foucault's 'biopower' which refers to the 'numerous and diverse techniques for achieving the subjugation of bodies and the control of populations' (Foucault 1976, 140). An acknowledgement of biopower is needed by non-indigenous practitioners or community development officers working with Aboriginal peoples. Only then can culturally relevant health care programs be developed and sustained. These are communities that have been subjugated and controlled for decades through colonisation. An awareness and acknowledgment of biopower, and its damage, is urgently needed given Australia's Indigenous people's health statistics.

Addressing biopower by decolonising Aboriginal people's bodies requires the inclusion of Aboriginal healing methods in the clinical space and practice. The research participants felt that if they were treated as active agents in their own treatment; if practitioners explained what they were doing and what was expected of them through hands-on interaction with the medical equipment coupled with clear explanations; if clinic appointments involved conversations about their day-to-day life, and if they were supported in their own traditional self-healing practices, then their health would significantly improve. Patient and practitioner could share roles as both teachers and learners. Changing clinic consultations to enable local people to relate to practitioners would be one way to improve social relations between Aboriginal and non-Aboriginal people, as well as contributing to improving the health of the patient, and by extension, their social wellbeing.

Participants' stories about their visits to country also emphasised the importance of a hands-on approach to clinical consultations. Many locals learn to hunt and gather as well as listen to stories about their cosmologies and ontologies while on their land. This kind of knowledge transference is applicable to the clinic. In the clinic, the medical practitioner is trained to use a machine in a particular way–focussing primarily on the physical rather than the social body. However, this approach is not conducive to local epistemologies and ontologies. Ingold's (2000) argument that the transmission of skills does not depend on formulas and rules and instead relies on 'sensuous engagement' through a hands-on application, applies in this context. The research suggests that diabetes consultations would be improved if it involved explanations of the value and application of medical equipment and medication in terms that were accessible to the patient. This would flatten power relationships between patient and practitioner to prioritise a process of co-creation of healing knowledge and skills that can only be achieved with time and the attention to relationship-building. In 1998, Lowell reported that longer consultation periods were yet to be actualised due to insufficient government-funding to employ more staff. More recently, Wakerman *et al.* (2017) describes the same enduring factors saying that poor health in rural communities is characterised by an inequity of Public Health Care funding.

Despite some of their misgivings about biomedicine, most participants in this project wanted to use the clinic as a site of healing for their diabetes and other physical ailments. They offered suggestions to improve consultation operations, showing a desire to enhance or reconcile relationships between Aboriginal and non-Aboriginal people in the clinic or community as a whole. One reason for a desire to improve clinics is because clinics are more accessible and proximate, relative to country, as a site of healing. McKivett, Paul, and Hudson (2018) provide a useful framework that clinicians may refer to if they wish to deconstruct the political power applied by biomedical institutions to Indigenous patients. In order to balance uneven power relationships, Indigenous people's interests, knowledge and experiences (Rigney 1999) will need to be meaningfully incorporated at all levels of clinical design including planning, management, implementation, monitoring, and evaluation. The effectiveness of the framework will rely on the extent to which the framework acknowledges the strategies of authority over knowledge, power, and the processes of subjectivation (Foucault 1976, 245) in specific clinical settings. The results of this study could be expanded and deepened and incorporated into McKivett, Paul, and Hudson's (2018) framework to decolonise clinical practice in this community.

Practical frameworks such as this could be used in this clinical environment as a guide for adaptation by non-local practitioners and community members to meet community needs. The framework could guide the production of a community-made induction video for new clinic staff and it could be applied on a day-to-day basis during consultations. McKivett, Paul, and Hudson (2018) provide a model whereby local culture sits at the heart of clinical practice.

CONCLUDING THOUGHTS

If Australian clinics do not take action to heal local Aboriginal peoples in more local culturally appropriate ways, diabetes, as well as other health issues, may continue to increase disproportionately to those of non-Aboriginal people in

Australia. Contrary to the assumptions made in the Indigenous health literature, the research found that individuals in the study community did not seek relief from the symptoms of their diabetes from a singular traditional community healer. Rather, participants drew on other sources such as totemic land and its natural resources, ancestors, Christianity, and totemic substances such as sweat. Healing from these sources is hands-on, and healing knowledge was similarly transferred inter-generationally through ritual and informally through story telling and/or while on country.

This research is also valuable to the field of Indigenous studies, medical anthropology and nursing studies health policy as it illustrates Aboriginal perceptions of the way biomedicine is currently applied to treat people with diabetes. The research finds that members of this community are resistant to complying with a solely biomedical framework. Rather, in this community, syncretisation of medical systems demonstrates the potential for a new, culturally meaningful and sustainable, set of diabetes healing policies and practices. Participants' personal methods of healing diabetes reflect strong cultural connections to land, ancestors, and people. The research participants have suggested that the current clinical consultations are not culturally compatible as they focus solely on the physical aspects of the person to the exclusion of, and disconnection from, other core cultural aspects of their lives. Additionally, consultations do not allow time for patients and practitioners to engage in conversations that adequately capture the whole person in place, nor enough time to apply hands-on learning. Recommendations to improve diabetes consultations were provided by participants. The authors recommend that the finding of this study be broadened and deepened to develop McKivett, Paul, and Hudson's framework (2018) so that it may be meaningfully applied in the participants' clinical context. Participants' contributions reinforce the call for local cultural involvement, power sharing, and relevance in the delivery of decolonising biomedical system that offers effective, inclusive, and culturally syncretised health care.

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NOTES

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4 It was not possible to determine what specific Type of diabetes the participants had based on the treatment prescribed for them by the diabetes clinic as both Type 1 and Type 2 can be treated with insulin.

5 A small cylindrical shellfish.

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