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Healers and Health

If I tell you somebody will sing you, you'd laugh at me, yangka?

What's this blackfella talking about? No one can sing people!

In bringing the previous chapter to a close, I related the story of a man in his early forties who suffered a heart attack. Shortly afterwards, he was taken, with some urgency, by the Royal Flying Doctor Service (RFDS) to Derby Hospital. A week later he returned to the region and I asked him how he was feeling. He replied,

When I came back I found it hard to breathe. But yesterday the maparn took three dark red stones out of me [he points to his stomach] and now I feel much better. There is no pain now. They tell me I have to go back to Perth for a check-up. I am not going to have a heart operation, just a check-up.

In one short conversation this man summarised a number of competing interests in relation to his health. According to Western medical care he was seriously ill, but according to one of the local maparn (traditional doctors) he was recovering. Despite his own prognosis, a month later he was flown to Perth and underwent a heart operation. He died a few months later.

The Puntu of the Kutjungka region share a colonial and mission experience similar to that of many other Aboriginal people. They also share a similar range of biomedical health outcomes. These outcomes, and the broader discourses around Aboriginal health

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that encompass them, assume important meanings around the English word 'health'.¹ As suggested by the story just related, the Puntu of the Kutjungka region share understandings around 'health' that differ from those generally held by Western biomedical practitioners. Puntu attendance at community health clinics and their belief in particular health outcomes are seriously influenced by their own health beliefs, such as in the importance of maparn, the 'traditional doctor' or 'healer' (Peile 1997, p. 166).² As kanyirninpa is a deeply embedded value in desert life so also are concepts of what it means to be well, palya, and sick, nyurnu. To grow up in desert life is to grow up within a particular cultural context: being 'healthy' describes an embodied quality of living that includes the relationships a person shares with walytja (family), ngurra (land) and tjukurra (dreaming). To become a healthy adult male is to invite more than the expression of physical and bodily health.

In this chapter I will describe some of the main biomedical indicators of men's health in the region. Following that, I will give a description of maparn and their healing skills; how Puntu understand being well or healthy, palya, and how they understand being unwell or sick, nyurnu. This will, in turn, lead to a description of the health clinic and how the clinic engages the Puntu male body.

While there is a slowly growing body of knowledge about the current status of Aboriginal men's health, not much is known about the health of men in this particular region. Anthony Peile's work, *Body and Soul*, offers many valuable insights into Kukatja understandings around health, but little that specifically pertains to men (1997). Ernest Hunter's *Aboriginal Health and History* gathers valuable health data relevant to the Kimberley, particularly during those decades of great social change, the 1960s to 1980s, but the desert region merits only scant comment (Hunter 1993, p.187). In 1989 some of these desert men provided information for the Regional Report of Inquiry Into Underlying Issues in Western Australia (RCIADIC) (Dodson 1991, section 6:8). Within the past decade, and through some of the health data gathered by Mercy Community Health Service (MCHS), there is now some general mortality and morbidity data available for the region, encompassing the Halls Creek area.³

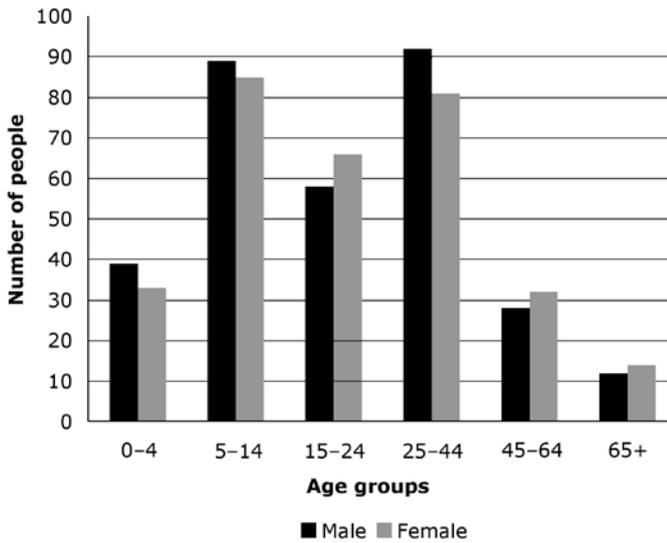
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In mid-2002 some of the men in the region underwent Well Men's Checks.⁴ Although limited in scope and representation, these checks confirmed the poor health of a number of men and indicated risks for further ill-health.⁵ A high percentage of the men smoked tobacco (83 per cent) and drank alcohol (79 per cent); a smaller number smoked marijuana (*Cannabis sativa*) (29 per cent) and sniffed petrol (14 per cent), and were found positive for Sexually Transmitted Infections (21 per cent).⁶ There was an almost equal group whose BMI (Body Mass Index) was underweight as opposed to overweight.⁷ Nearly half of the group measured more than 6.6 for BSL (Blood Sugar Levels).⁸

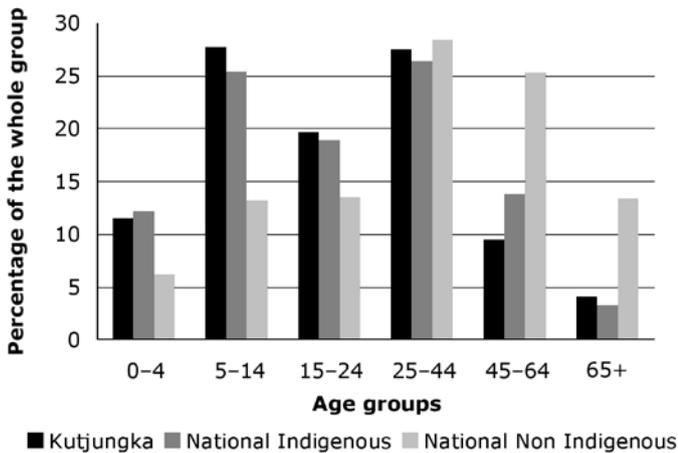
If we accept the 2006 Census as a reasonable but limited indicator of the region's population, 719 people were living in the Kutjungka region: 460 in Wirrimanu, 144 in Kururrungku and 115 in Malarn (ABS, 2006). Of this group — which included kartiyas who were mainly staff — it would seem that there were about 632 Puntu in these communities. Of these were 317 were male: Wirrimanu, 209; Kururrungku, 58; and Malarn, 50. Approximately two-thirds of the men of the region live at Wirrimanu.

There are a number of statistical phenomena within this region that can be found in other Aboriginal communities across Australia. For example, in the Kutjungka region those under 15 years of age comprise nearly 40 per cent of the total population, but those older than 45 years constitute only around 14 per cent. The number of older people declines quite rapidly after the age of 44 (see Graph 1). The very high number of young people can also be found in other Indigenous communities. For example, in Canada 21 per cent of the population are under 15 years of age but this increases to 37 per cent for Indians, 38 per cent for Metis and 43 per cent for Inuit (Morrison & Wilson 1986, p. 612). As revealed in the second graph, not only is there a greater proportion of younger Indigenous people than non-Indigenous in Australia, but there is also a far smaller proportion of older people to help 'grow them up' (see Graph 2).

Of those young Puntu in the Kutjungka region who had been born between August 1977 and August 1986, and hence were between 15–24 years at the time of the 2001 Census, at least ten



Graph 1. Distribution of male and female age groups in the Kutjungka region.



Graph 2. Comparison of Kutjungka region with Indigenous and non-Indigenous age groups within Australia.

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had already died by August 2001. Three have died since the 2001 Census, two aged 16 and one aged 17.

Within the decade 1992–2001, nearly 25 per cent of all male deaths in the region were motor vehicle related. Some resulted from rollovers, others resulted when the vehicle broke down and those who were injured could not receive medical help for some hours. Similarly, alcohol has also contributed to the deaths of many men in this region, and has been a significant factor in many motor vehicle related deaths. Hunter identified the period of major social change in the Kimberley as,

From the mid-1960s to the end of the 1970s. It was around the mid-point, in the early 1970s, that the restrictions on the sale of alcohol to Aborigines in the region were lifted. There was subsequently a sustained increase in the proportion of deaths from external causes — primarily accidents, motor vehicle accidents and interpersonal violence — consistent with the direct impact of alcohol on male behaviour. (Hunter 1993, p. 194)

This desert region has not been an exception. Some men have died as the result of an alcohol-induced illness, others as the result of alcohol-related violence; some have resulted from the desire to obtain alcohol at the Rabbit Flat roadhouse in the Northern Territory, 280 kilometres away from Wirrimanu.⁹ Two men, who attempted to drive to Rabbit Flat in the summer of 1992, disappeared and have never been found; the following year, two young boys also died when a vehicle returning from Rabbit Flat broke down.¹⁰ Three years later, another man died when his vehicle broke down between two communities. Within the past decade, more than half of all the deaths of young men under the age of 30, were influenced by alcohol. At least once a year, the region loses a young man through an accident or the result of violence; sometimes they are fathers with children. There are now a number of children and teenagers who have grown up without a father, some having been born after their father died.

The above statistics reveal a high-risk element involved in driving in remote areas, especially under the influence of, or motivation

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to obtain, alcohol. It also reveals the importance of mobility and alcohol for men, young men in particular. Roads are unsealed, vehicles are in constant need of repair and distances between the nearest communities vary from 50 to 120 kilometres.¹¹ Support services, such as emergency health care, are also seriously limited. There is evidence that in remote areas of this country young Aboriginal males (15–24 years) have a death rate twice that of Aboriginal youth in urban areas, with motor vehicle accidents being significant contributors to these death rates (Australian Institute of Health and Welfare 2000, p. 226).

In 2002 and 2003 there were the first cases of suicide in the region (and several attempted suicides), several charges of sexual assault (which resulted in imprisonment) and at least one incident of sexual abuse. These events all involved young men in the 15–24 year age group. While the incidence of suicide has, for more than a decade, occurred more dramatically in the West Kimberley, these three deaths of young men, two 16 years and one 17 years of age, suggest an emerging social and emotional health issue in this region (McCoy 2007b).

Puntu are aware that there are many sources and causes of physical pain and sickness, and that they have various means at their disposal to achieve personal healing and well-being. The following incident captures the complexity of sickness and healing possibilities that can interact in contemporary Puntu life:

It was a Saturday morning when news had gone around the community that an older woman was dying. People came and filled the house where she lay, unconscious in her bed. Some cried as they watched and waited. Attending her were maparn, local church leaders and nurses. Each provided moments of care and attention, attempting to save her from death. The nurses maintained a drip, the church leaders prayed and anointed her with oil and the maparn worked to remove the sickness from her body.¹² After a long period of time the old lady suddenly stirred and a little later sat up in bed. She seemed oblivious to the large and concerned gathering around her and shortly spoke and asked for something to eat. The change in her physical state was remarkable. Later, the nurses said that she had recovered

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from a diabetic coma but the church leaders and maparn also maintained that their interventions had made a significant difference to her recovery. Her family was happy and all those involved were pleased. She was alive and well, all due to the efforts of nurses, church leaders and maparn.¹³

There are three locations, or separate geographical spaces, where sickness and healing interact in the desert today. There is the clinic, often a small fibro-cement building, where a nurse, generally a female, is based. Her attention to sickness derives from a training in, and delivery of, a Western biomedical approach to illness and disease. There are local church leaders who provide, usually with prayer and holy oil, a Christian response to a person who is sick. They operate from the church or, if requested, visit those who are sick in the camp or in the clinic. There are also maparn in most of the communities. These are usually men, but can be women, who respond to people's sickness using a traditionalist model of diagnosis and healing. People usually seek their help in 'camp', where the maparn or the sick person live. Sometimes the maparn will visit the clinic, especially if a member of the family requests their presence. Today, most Puntu move quite deliberately in and out of these three geographical spaces. Sometimes, as in the story mentioned, all three groups will work closely together. As Janice Reid has summed up:

People are pragmatic in their search for a cure of an illness: they will utilise whatever resources are accessible to them. It is not necessarily the case, though, that changes in practice reflect changes in belief. In Aboriginal communities, a coherent body of medical thought shapes the interpretations of misfortune among young and old. (Reid 1982, p. 196)

While Puntu attend the local health clinic or seek Christian healing, they also say that they visit the maparn first, especially if the pain originates within the body and they consider that their sickness may be serious. They admit that women can be maparn as well as men. As some would comment, 'there were women, some maparn, a long time ago'. Men believe that most of these women are no longer alive and their gifts and skills were not handed on (Tonkinson 1982, p. 231). They also believe that children can have

maparn powers and cite the example of a young girl presently living in the one of the communities.

While both men and women have been maparn, such roles, as in other places, would appear historically to have belonged more to men (Elkin 1943, p. 123; Bell 1982, p. 220).¹⁴ This does not discount the particular ways in which men and women provide and sustain healing, but in fact suggests an ‘interdependence and complementarity’ of healing roles (Bell 1982, p. 220). This would seem to apply in this region. Women appear to resort more to the use of bush medicines and provide healing as a group, maintaining their health through ceremonial women’s business (Peile 1981, p. 29; 1997, p. 174). Tjarrtjarra describe these women and their healing powers (de Ishtar 2005, p. 3).

What has become clear is that maparn, especially men, continue to be active within this region and others (Cawte 1996; Ngankari 2001; Ngaanyatjarra et al. 2003). In 1960 Worms wrote, ‘today he is mostly replaced by the white Flying Doctor’ and in 1974 John Cawte noted, ‘the end is in sight...and their total eclipse may take no more than thirty years’ (Worms 1960; Cawte 1974, p. 27). Despite such observations, it is apparent that Puntu have maintained detailed, highly developed and intricate understandings of the causes of particular forms of illness and what can heal those illnesses. While these understandings are deeply embedded in strong cultural beliefs, this is not to say that they have not been influenced by contact with kartiyas and the provision of nurses and Western medical services (as also teachings and practices about Christianity) over more than fifty years. Puntu are conscious that they are living in a different world from their parents and grandparents. They are now exposed to relatively recent forms of sickness, and these have become important elements in their lives.

As a means of further understanding the work of maparn and the ways in which Puntu understand health and illness, I invited a number of maparn to paint something about their work. I suggested this for a number of reasons. Painting is now accepted as a medium of cultural expression within the region where paintings are done, not only for sale through Warlayirti Artists, the regional Art and

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Cultural Centre, but also for outdoor walls or floors of buildings, for church ceremonies, as banners and as gifts for kartiyas. I wondered whether paintings might provide not only a helpful way of understanding people's health beliefs, but also enable those beliefs to be re-visited and discussed at further times. I avoided suggesting what they might paint, but requested they paint something about maparn 'business'. Some took up the offer and others didn't. Some appeared more comfortable with this medium of expression than others; some painted privately, others painted with the assistance of their wives.

The paintings express the distinctive personality of each maparn. They also revealed a close connection between healing powers and ngurra (land), the human hand as an instrument of healing, and a strong conviction that their 'ownership' of healing gifts were given to them to be used 'for others'. In the first painting (*Maparn 1*) Fabian Polly Tjampitjin, a young man in his late twenties, recounted the time when summer floods prevented maparn from two of the desert communities travelling to another community to heal someone who was sick. Their presence had been requested, as there was no maparn available in that community. While his own activity demonstrated that young maparn are continuing this tradition, it also revealed that there are sometimes no available maparn in particular communities. Some have died and some have given up their practice. This young man received the gift of maparn from his father's brother and he felt that people appreciated his gifts. However, for some maparn the decision to relinquish their healing work can arise from the pressure and beliefs of particular Christian churches.

Despite the combined efforts of maparn, clinics and church healers, men readily admit that they are not as healthy as their fathers and grandfathers. While conscious of the health messages round the dangers of smoking, drinking, 'getting the shakes', consuming too much sugar, tea and flour they also admit, 'we just can't stop; we like it too much'. Change to diet and lifestyle has left them without regular exercise and with added health risks and new diseases. However, they continue to maintain very particular and cultural understandings of health and illness.



Maparn 1, Fabian Polly Tjampitjin

Not only is the term ‘health’ complex across cultures but it also suggests more than the absence of disease (Adelson 2000, p. 5). The most commonly used word that Puntu use today to describe ‘health’ is *palya*. *Palya* has been translated into English as, ‘1) good; correct; beautiful; 2) healthy’ (Valiquette 1993, p. 185). It covers a range of possible meanings, depending on the context.¹⁵

When someone returns after spending time in hospital someone might ask them, ‘*palyan?*’, ‘are you well?’, and they will often reply, ‘*yuwayi, palyarna*’, ‘yes, I am well’. The nurses or doctors may not consider the person to be ‘healthy’ — they may have an ongoing illness — but the person considers that they are *palya*. They are not currently experiencing pain, their body and inner spirit (*kurrun*) feel *palya* and they are home again with their family.¹⁶

‘I’m glad to see you, *palya*, I’m happy to see you,’ says one person to another they have not seen for a long time, ‘I’ve been worrying about you.’ Relatedness, especially with members of one’s *walytja*, is important for the experience of health. *Palya*, as one man described it, summarises the whole of a person’s life, the ‘inside, outside,

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everywhere'. He stressed the word 'whole'. Palya can describe one's experience of bodily well-being. It can also describe one's spiritual well-being (the location and status of one's kurrun) and one's social well-being (one's connectedness with walytja). When a father described his feeling for his son, when he stopped petrol sniffing and came home, he used the phrase 'tjurni palya'. Inside (his stomach or tjurni) he felt good and happy. While palya can be located in the physical body, it describes the person who is in relationship: with others, land, cosmic and spiritual forces.

When a man described a men's gathering that would talk about issues that were relevant to the men he said, 'We'll be happy; our health will be happy.' Men's social relatedness, as I explore in the following chapter, is an important element of men's health, as are rituals such as those involving sorry business. A young man described how he would go to a sorry meeting feeling sad but walk away feeling 'happy'. The public gathering and social activity healed his feelings of sadness.

What is also common in the use of the word 'palya' is the person's belief that a physical, spiritual and social harmony has been established. In some cases it is highly personal and individual, in other cases it emphasises the balance of social and cosmological forces (Wiminydji & Peile 1978).¹⁷ The person who returns from hospital, the young man who stops petrol sniffing, the men who gather together, and the ritual of a funeral can all be palya as they reveal the desire and effect of people to re-establish a balance and harmony between relationships. As Diane Bell described Kaitij women's understanding of health: 'health, happiness and harmony are intimately intertwined' (1982, p. 198).

Peile linked the word 'palya' with notions of the good and the beautiful and, quoting St Thomas Aquinas, suggested they described 'genuine aesthetic principles' (1997, p. 25).¹⁸ His argument was that health consisted of the body being 'cold and dry' with a person's kurrun (spirit) lying in the area of one's stomach. Health, he proposed, did not describe harmony or balance between people (1997, p. 130). Later in this chapter I discuss his notions of 'cold and dry'; I suggest that such descriptions do not preclude an emphasis

on the use of *palya* to describe health in terms of relationships. In fact, I suggest his use of ‘cold and dry’ can reinforce this argument.

Like Peile, I have not heard people describe a sunset as *palya* (1997, p. 25). However, one Puntu related to me the following story:

A car load of male Puntu was driving along a desert road and came across a group of *kartiyas*. This group had stopped their vehicle and were standing beside it, looking up at the sunset. Thinking that they were looking at some unusual heavenly phenomenon, the men asked them, ‘What are you looking at?’ ‘What a beautiful sunset,’ came the reply. The men got in their vehicle and kept going.

The men were amused and surprised that *kartiyas* would stop and admire something that, to them, was part of the regular experience of their desert life. It was not, as Peile has commented, that they were ‘reserved in commenting on the beauty of something Europeans would speak about as beautiful’, but there was no need for them to draw attention to something they considered normal. It is my understanding that the sunset would only have been singled out and described as *palya* if its relationship to Puntu had changed, causing it to be made better or improved. Peile described the Kukatja appreciation of the adolescent body as an example of *palya*. Perhaps, in this understanding, the adolescent body was *palya* because it was perceived to be in a process of development; it was in the process of becoming an adult body and, in this way, was both physically and socially beautiful. In my experience, the ‘beautiful and the good’ are not, for desert people, abstract concepts but linguistic metaphors used to describe the deeper harmony and interconnectedness that Puntu perceive exists in all desert life.

Palya suggests then an inclusive and relational understanding of health, a holistic notion that embraces not only the physical and the social, but also the spiritual and the cosmological. Maparn suggests the critical importance and inclusion of healers within that understanding.

Peile’s notion of ‘cold and dry’ offered several important descriptors of the Kukatja body and its experience of health. The Kukatja

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word 'yalta' has been translated into English as, '1) cold; 2) healthy; 3) better; well' (Valiquette 1993, p. 354). The word 'lalka' (also larlka), as, '1) dry; 2) healthy' (Valiquette 1993, p. 66). And while yalta and lalka are not commonly used today to describe manifestations of wellness or illness, there seems little evidence that using the terms 'cold' and 'dry' necessarily excludes social and relationship aspects of health. As others have shown, Peile has been sometimes contradictory in his use of 'cold' and 'dry' (McGregor 1999, p. 225).¹⁹ For example, when a child sniffs petrol their spirit becomes 'dry' and after drinking grog one feels 'cold' in the head (Peile 1997, p. 95). He has also described an experience of coldness that is associated with sorcery.²⁰ Neither of these examples would suggest an experience of health that might be considered palya.

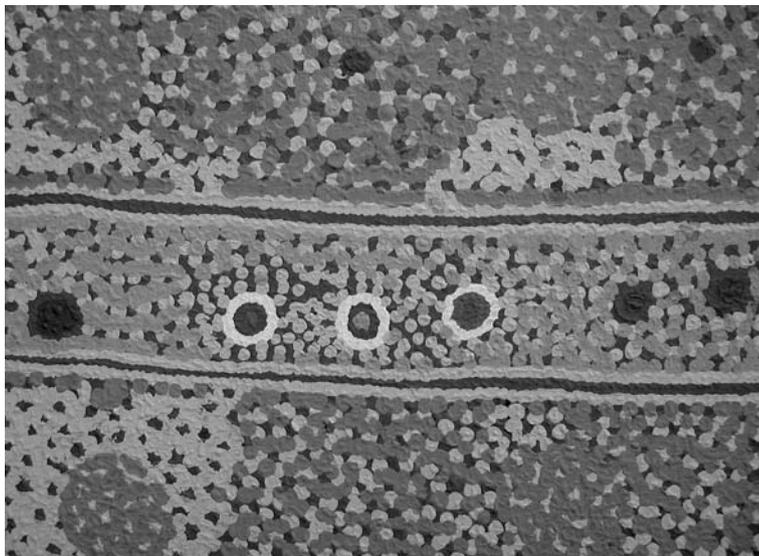
Learning to cope with the extremes of heat and cold, as also of wet and dry seasons, has revealed that many Indigenous peoples experience health by monitoring their own bodies within the demands and extremes of physical conditions. The Cree, for example, define health in terms of their ability to stave off the cold (Adelson 2000, p. 87).²¹ Hence, as Puntu say, if the body is exposed to excessive sun one can get sick; if one's body is too hot, one will move to shade, to avoid that heat. In a response to heat, the body seeks to be cool rather than cold. But if one's body is cold, one needs to find the warmth and experience of sweat to keep well, 'waru ngantjilpa palyarri', 'warming oneself at a fire will make one better'. It is my understanding that the desert physical body is ideally 'cool' rather than 'cold', as one of the signs of bodily health is the body's ability to be warm and to sweat. Hence, 'when they don't sweat... their body is out of, nganayi, control and when they sweat they know their body, ah it's sweating, I'm getting palya'. Peile also stated that the ability to sweat was a sign of health: 'I am strong [and healthy]. I go out in the sun with my bald head. Perspiration cools my bald head' (1997, p. 131). Hence, use of the words 'yalta' (cold) and 'lalka' (dry) to provide a detailed understanding of health can be problematic. However, they can provide valuable barometers and monitors of bodily health and sickness. They situate the physical body as preferably cool within an environment that is often hot,

and preferably warm within an environment that can be cold. While it would seem to be restrictive and unnecessary to limit notions of well-being, health or palya to these two concepts, they can be valuable descriptors that sensitively locate the physical body within a social and ecological world.

There are different words in Kukatja that are used to describe sickness or illness, such as the word nyurnu. This has been translated into English as, '1) sick; 2) slightly sick' (Valiquette 1993, p. 173). Surprisingly, Peile does not refer to this word in his work. When someone asks another, 'nyurnun?', 'are you sick?', they would be wondering if that person felt sick or pain inside. There are also other words such as 'marnmarlarrinparna', 'I am feeling pain'. Or they might use the word 'mimi', '1) sick; 2) incapacitated by illness; 3) having a wound' (Valiquette 1993, p. 94). While Peile suggests that mimi can describe a range of experiences and being 'sick', this word would seem, at least in more recent times, to refer to those particular and exterior sores associated with sickness. Hence a sexually transmitted infection (STI) is referred to as mimi.

Sometimes Puntu also use the word 'ngawu', meaning, '1) bad; evil; 2) not functioning normally on account of sickness' (Valiquette 1993, p. 145), suggesting one is getting sick in a more serious and possibly life-threatening way. This form of sickness is generally caused by the sorcery of another that can be difficult to diagnose. Not surprisingly, ngawu can express both the form of illness but also the emotion associated with illness. A father, worried about his son sniffing petrol, might describe his feeling as 'tjurni ngawu', 'he is deeply worried inside' (his stomach): Similarly, if a young person feels cut off from family or friends he might say he feels ngawu, and this can lead him to extreme behaviour such as petrol sniffing, stealing and alcohol. These different words for sickness indicate that the emotions associated with sickness, like those around palya, reflect an important social and relationship dimension of illness.

There are many ways in which people can get sick. Some refer to relatively simple causes such as getting sick from eating food that was too ripe. The sun can make people hot and sick. In the second maparn painting (*Maparn 2*), a person has come to Joey

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Maparn 2, Joey (Helicopter) Tjungurrayi

Tjungurrayi, also known as ‘Helicopter’, to be made well.²² The three white circles are people: the person who is sick, the maparn and the person who has been made well. They sit between two lines or rows of tali (sandhills, the red horizontal lines). The green circles are the different communities of the region, and the country is full of bush tucker (yellow).

‘Palyalarni,’ the sick person asks the maparn, ‘make me well’, and the maparn cleans the inside of the person’s body. In this case the person has a ‘runny tummy’ from eating too much bush food, such as kumpupatja or pura (bush tomato) or kantjilyi (bush raisins). The person has become well, palyarringu.

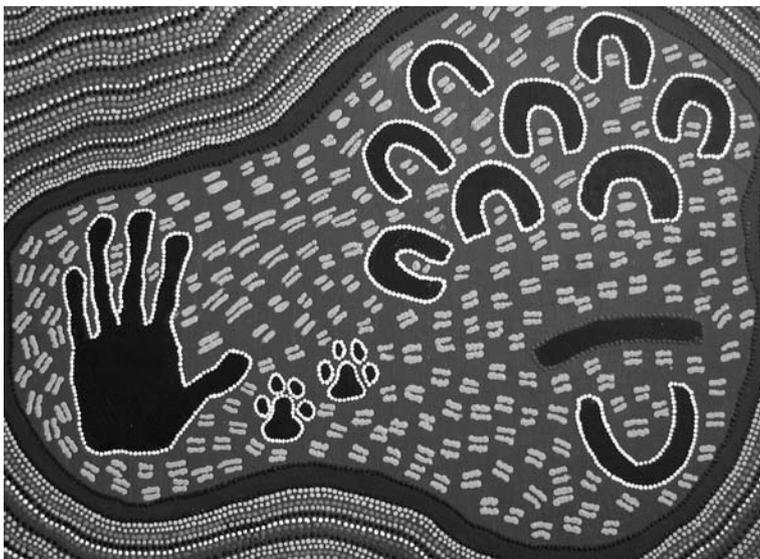
There are other forms of sickness. Headaches can come from ‘cracks’ in people’s heads. The wind can make people sick: ‘a stick can go through a person’s body and make a hole and as the wind goes through the person they feel hot’. A person can have ‘bad blood’. Their blood needs to be blocked from some internal bleeding. Or, it needs to be opened up from some blockage to the movement of blood. People can become sick from the actions of

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a murungkurr (tree spirit).²³ And wearing another person's clothes can make people sick (Peile 1997, p.134). This would seem to be an example of a more recent understanding of sickness which people have learned from contact with kartiyas.

A person can become sick if their spirit, their kurrun, shifts from its normal place. Instead of lying in the middle of the body, tjurni (the stomach), it could move elsewhere, such as to the back of the body or to the shoulder or feet. Or, if a person gets a fright, their kurrun could jump and then stay in the wrong place within the person's body. The maparn is able to put the kurrun back in its rightful place.

A further painting was done by a maparn in his forties, who grew up as a young man at new Balgo Mission and had then moved back to the Canning Stock Route with his family. He regularly returns to Wirrimanu. In this painting (*Maparn 3*) Flakie Stevens Tjampitjin has described a sick person, covered in murtu (red ochre) who has been brought by a family for him to cure. The people are surrounded by tali (sandhills) and also by many little maparn or healing powers.



Maparn 3, Flakie Stevens Tjampitjin

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His hand has touched the sick person and healed them. A kunyarr (dog) spirit accompanies him and helps him as he works.²⁴

The most serious and dangerous forms of sickness for Puntu are those caused by sorcery. For example, there are 'lids', foreign and invisible objects that can fly up and enter into the human body. The derivation of the term 'lid' is unclear.²⁵ Some men believe that 'lids' are like lead or copper wire; they exhibit similar material properties to nails, copper and iron. Others suggest a 'lid' is more like a fingernail (milpiny), shell or pearl shell. Still others describe their qualities as like bullets. Lids are invisible to the average person. Only maparn have the powers to see them. They can move through the air and cause serious illness.²⁶ They can especially be dangerous at Law time.

Lids are not the only form of sorcery. Some people are believed to have the power to put sickness in another, as also the power to remove that sickness. Despite contact with kartiyas, and more recent forms of diseases, such as cancer, if people hear that someone is sick their first thought will be that someone has made that person sick. That people have the power to make others sick, not only leads to mistrust of others, especially strangers, it also can make people very frightened.

Maparn, especially the older and more experienced, are often sought for their healing powers. The final maparn painting (*Maparn* 4) was done by an older man, Bill Doonday Tjampitjin, who travelled the Northern Territory and Kimberley as a young stockman. He is now a respected and experienced maparn who has been asked by Puntu from the region to go to regional and interstate hospitals and heal family members when they have been seriously ill.

In this painting he has described a particular country where men can go to receive special maparn powers. The artist detailed the story of a man who once went there to get maparn powers, so that evil spirits would no longer frighten him. Not only is there a strong connection between ngurra and maparn, but also between the fear that some sicknesses generate, and the need for strong and available maparn to alleviate those fears.



Maparn 4, Bill Doonday Tjampitjin

Most men, including maparn, say that ‘new’ diseases, including renal failure, diabetes, cancer or STIs, lie outside the powers of maparn. The difficulty Puntu have in dealing with these diseases is that they are perceived to be ‘new’. ‘The new diseases came out of nowhere,’ said one man. They do not arise from an understanding of sickness that has guided Puntu in the past. Regarding cancer one maparn said, ‘The maparn can feel them but will say, “You’ve got your own sickness, go and see a doctor.”’ Cancer does not belong to a memory of past illnesses but is associated with the colonial and mission experience. Recent changes to Puntu diet, lifestyle and health are also seen as interconnected. Kartiyas are therefore perceived not only as being instrumental in such changes, but also to have some power over these ‘new’ diseases. The rending of the Puntu social body, as described in the previous chapter, discloses an important link between the ongoing effects of colonisation, kartiya influence and power, and Puntu health. Disease, and the treatment of it, can be perceived to arise from the world that kartiyas control.

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The one who is sick with cancer cannot easily ask a maparn the question, as they may have in the past, 'what wrong did I do to receive this?' or 'why are others trying to hurt me?'

Hence, the boundary that separates the work of maparn from that of the clinic and its concerns is not clearly identifiable. While one maparn said that his work is 'stronger' than that of a doctor because 'he can fix someone right away', another said that his job was to fix the person who could then get pain relief from the clinic. In this latter sense, the clinic is perceived to provide medicines in similar ways to bush medicines, but it also can be perceived to replace other methods of healing. Whereas in the past, people might have been smoked for a 'runny tummy' they might now go to the clinic for medicine. This is not to discount the use of some bush medicines. People continue to use pilytji or murtu (red ochre) on a person's body when they are sick. This 'ancestral blood' can, among other strengths, protect a person from a 'lid' that can't smell a person who is covered in pilytji.

One young man in his mid twenties told how he used maparn and also attended the clinic. He did not express concern or anxiety about having two very different explanations, or methods of healing, for his sickness. He allowed both to offer their own forms of treatment: 'one in the morning and one in the afternoon, like taking tablets'. He would go in the morning to the maparn and then in the afternoon to the clinic. He believed that both helped his condition but, he then added, 'I believe more in maparn'.

The provision of a clinic-based health care in the region can be traced back to the early days of old Balgo. At that time the Government permitted missions,

the right of rural and pastoral pursuits on such reserves... provided the freedom of tribal life on outback reserves is not interfered with except in respect to medical considerations or other assistance as may be necessary in the preservation of tribal life. (Bray 1945, p. 13)

The Commissioner had noted that same year that leprosy 'was rising rapidly in [the] East Kimberley' (1945, p. 17) and the

missionaries were well aware of their failure to establish a medical clinic at Rockhole some years previously. The first nurse, as also the first kartiya woman at old Balgo, was Allie Evans who worked from 1951–55 (Nailon 2000, p. 198; Zucker 2005). The Sisters of St John of God arrived in 1956. The Western Australian Health Department took responsibility for the delivery of health services from 1975–88, providing nurses at Wirrimanu, supported by Royal Flying Doctor visits. In 1989 the Western Australian state government put the service of primary health care in the region to public tender, and it was finally given to the Institute of Sisters of Mercy Australia (ISMA). The provider of the service was then referred to as the Mercy Community Health Service (MCHS). In 1990 this new service began with four resident nurses based at Wirrimanu, and four part-time Aboriginal Health Workers. Initially the sisters — not all were Sisters of Mercy — were based at Wirrimanu. They made regular trips to the other communities until 1996, when nurses began to live permanently in Kururrungku and Malarn. In 1994, MCHS initiated the formation of a locally based Puntu health organisation that led in January 1995 to the incorporation of Palyalatju Maparnpa Aboriginal Corporation Health Committee (PMACHC). The phrase ‘Palyalatju Maparnpa’ may have been translated as ‘good health for all’, but, as Fatima Lulu, the first health worker at Malarn wrote: ‘The name we chose because it is important to us that the Aboriginal doctor is included by people first, after that then the Kartiya (western) doctor’ (1999, p. 1).

In each of the communities there is now a health clinic. They usually include an open meeting area where people gather and where the nurse or health worker provides initial attention. There is also another room where people can be seen more privately. In the smaller clinics the files, notices and fax machine are in the front, open area of the clinic. The Wirrimanu clinic is much larger than those in Malarn and Kururrungku, and has extra rooms where nurses and health workers can attend the more seriously sick. This clinic is the second health clinic built in Wirrimanu since people moved

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there in 1965. In August 2001 it was announced that approval for a new clinic had been given (Mirli Mirli 2001). It was opened on 5 June 2004.

There is evidence that the present clinic system has marginalised the health needs of men, particularly due to the nature of the clinic's personnel, priorities and its geographical space. Historically, kartiyya female nurses have staffed the clinic with the support of female health workers; there have been very few male nurses or health workers. As noted elsewhere, health clinics have become significant female domains where the majority of those who attend are mothers and grandmothers, often accompanied by babies and small children. Health concerns around infant sickness and mortality have clearly influenced this development. However, one consequence is that men's health has been compromised. In 1999 the MCHS concluded in its report, 'men's health issues are difficult to resource...due to the predominant female constitution of clinical workers in the health service' (O'Donnell 1999, p. 3).

The physical structure of a clinic can also create tensions across kinship and gender. Health clinics have been constructed with little sensitivity to Aboriginal values of space and kinship interactions (DodsonLane 2002, p. 15). Community clinics are generally small, enclosed buildings where patients and family are forced to sit close or facing one another. As the relationships that exist between men and women can extend from genial familiarity to strict respect (avoidance), men and women can equally experience discomfort and shame in these confined physical spaces. This can apply to men, especially when the person in charge is a woman and the majority of those attending are women.²⁷ 'What I mean,' said one man, 'like some men get shamed, see. They don't like going to sister.' Here, the 'shame' that is being described is more than embarrassment. The social and kinship dynamics that enable men and women to move and relate, within a wide range of personal interactions, are severely curtailed in the small physical space of a clinic. In 1999 a MCHS report noted, 'male attendance drops off sharply from age 10 upwards, throughout all male categories', and, 'adult males do not attend often, even when chronic disease has been diagnosed' (O'Donnell 1999, p. 3).

3. *Healers and Health*

As discovered elsewhere, there is an important link between the status of Aboriginal men's health and the presence of Puntu male health workers, male health practitioners and the provision of clinics that are more culturally appropriate for men (Wakerman 1999; Menon et al. 2001; DodsonLane 2002; Brown 2004). The MCHS health report of 1999 stated the problem succinctly: 'the men's health programme is difficult to resource in the region when there is no male on the health service staff' (Mercy Community Health Service 1998–9, p. 15; 1999, p. 19). Four years previously, they had noted the value and importance of having at least one male on staff, an importance confirmed by research in the Northern Territory (O'Donnell & Lock 1995, p. 13; Menon et al. 2001, p. 7). As one man said, referring to his postponement in seeking medical treatment, 'I kept it as a secret for a long time, you know... [because]...there was no Aboriginal orderly'.

However these factors, in themselves, do not fully explain why, 'male attendance drops off sharply from age 10 upwards, throughout all age categories', and how it is that 'adult males do not attend often, even when chronic disease has been diagnosed' (O'Donnell 1999, p. 3). In order to understand the 'healthy' or 'sick' Puntu male body, it is also important to understand important elements in the social and contemporary construction of this male gendered 'body'. It was only after I witnessed the frustration and embarrassment of men as they entered the clinic, especially at those times of the year when men's Law ceremonies were being performed, that I began to wonder about that relationship between the 'outer' male physical body and the 'inner' and personal self.

The Kukatja word 'yarnangu' has been translated into English as, '1) body; 2) somebody; anybody; group of people' (Valiquette 1993, p. 358). Yarnangu can refer to both a 'physical body' and also a 'person', similar to the Pintupi *yanangu* (Keeffe 1992, p. 32). The link between the physical and the social body is particularly well expressed in Kukatja where a boy, who is being initiated, can be referred to as *yarnangurriwa* (literally, 'body/person-becoming'); he is becoming both an adult male body and an adult male person. As with other Aboriginal languages, Kukatja reflects not only a close linguistic relationship between the words used for 'man'

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and ‘person’, but also the close relationship of those words with ceremonial initiation (Evans & Wilkins 2001, p. 495). Hence, ‘tjitjitjanu yarnangu punturringu’, ‘from being a child [his] body [person] became that of a man’. He was transformed, physically and socially, at initiation into becoming an adult male person.

The transformation of a boy into an adult person is accompanied by important cultural meanings that are intimately linked with his physical body (Willis 1997). His body, like the earth, sustains physical, social and religious meanings. These meanings are inscribed upon and within the physical body by the use of song, dance, ochre and painting as a man enters into the secret and sacred ceremonies associated with men’s Law. His body is not just a vehicle of entry into men’s ‘business’, a world that is carefully separated from that of women; his body becomes part of that secret and sacred men’s business that belongs to all of desert life and its cosmic ‘business’. Initiation transforms him, person and body, into an adult social body where new relationships are configured and developed.

When a wati (man) enters a health clinic he cannot separate his physical body from his relationship with the adult social body. His physical body, his membership of a male social body and his identity are intimately related, such that his ‘inner’ and the ‘outer’ bodies can be understood as ‘pleated’ together (Teather 1999, p. 9). His health, as Saltonstall describes the interplay between health, self, body and gender, ‘need[s] to take account of the body as personal and socially situated in the construction of self (and other selves)’ (Saltonstall 1993, p. 7). While his physical body is his vehicle of entry into the clinic’s social space, it is not the only part of him that claims respect and attention. Sometimes this space evokes a dissonant response to his sick or injured body.

Elizabeth Teather introduced the idea of the pleat in her exploration of the geographies of ‘life crises’ or ‘rites of passage’ (1999, p. 1). In *Embodied Geographies: spaces, bodies and rites of passage* — where researchers discussed very different geographies such as ‘schoolies week as a rite of passage’, ‘the transition into eldercare’ and ‘spaces and experiences of childbirth’ — Teather sought to challenge that body of knowledge that neatly separated the human body into an

‘inside’ and the ‘outside’. Her argument was more than a criticism of Cartesian dualism and the separation of mind and body. She sought new ways to describe the embodied self, the self and the body, the self and the world.

Teather turned to Elspeth Probyn, who had used Gilles Deleuze’s description of ‘the fold’ or ‘the pleat’, to explore ‘the doubledness of the body...constituted in the doubledness of body and self’ (Probyn 1991, p. 119). This process of ‘doubledness’ was subjectification, whereby the self was constructed within the world, and by the process of ‘folding’. The ‘outside’ became enfolded within the ‘inside’ and the ‘inside’ within the ‘outside’. Probyn approached the embodied self from a feminist perspective, wanting to include the body within a theoretical discourse, not simply as an objective entity separated from the self. She described Deleuze’s idea of the pleat:

this pleating (‘la pliure’) is thus the doubling up, the refolding, the bending-on-to-itself, of the line of the outside in order to constitute the inside/outside. While the outside and the inside are to an extent distinct, Deleuze’s metaphors can be used as ways of figuring the intricacy of the one stitched into the other. (1991, p. 120)

Deleuze identified four different foldings within the work of Michel Foucault. Folding can be understood through the folding of material bodies, the folding between forces (power), the folding of knowledge (truth) and the folding of the outside (becoming) (Deleuze 1995, p. 104).²⁸ In the desert, the process of becoming an adult male (‘yarnangurriwa’, literally ‘body-becoming’), suggests an embodied process where the adult male body ontologically changes in relation to social relationships and cosmic powers through an interaction with very specific social spaces. While acknowledging that all four foldings may apply to the desert adult male, here I wish to pay particular attention to the first folding, ‘the material part of ourselves which is to be surrounded and enfolded’ (Deleuze 1995, p. 104). This folding has been described as ‘the body’s material relationship with space: the ways in which bodies become embedded in the spaces around them and the ways in which spaces

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simultaneously become embedded in the body' (Malins et al. 2006, p. 511). It is within such a folding, or pleat, that the importance of an intertwining of the inner and outer desert male body can be better understood. At the time of male initiation, important meanings are enacted, inscribed and effected upon the male body. Simultaneously, these meanings fold back between the self and the desert social world. This is an example of what Deleuze described as, 'foldings that together make up an inside: they are not something other than the outside, but precisely the inside *of* the outside' (1995, p. 97).²⁹

The pleat as metaphor, but also as an epistemological and ontological concept, offers a helpful insight into this desert male body that is neither an exteriority, separated from the activity of one's inner kurrun or larger cosmic forces, nor an interiority, disconnected from social and relational meanings. Dichotomies that can be imposed upon this desert body — separating the physical from the spiritual, the body from the cosmic, the person from the social — deny important relational aspects for desert people that are dynamic and essential for living well and palya. The pleat offers a way of understanding this process of subjectification, where an adult male wati lives within a dynamic of interior and exterior worlds, and with social and cosmic meanings that are inextricably linked with one another. It helps explain some of the meanings that men bring and embody as they enter the health clinic.

Hence, as I have explored through this chapter, living healthy or palya becomes the embodiment of harmony that exists between physical, social and spiritual realities. It can be further suggested that in living well and palya there is a folding, a subtle pleating of the inner and the outer person, the physical with the social, the kurrun with the cosmic world. The metaphor and concept of the pleat remove artificial and fixed boundaries between the desert self and others, between inner and outer realities and meanings. However, while the intimacy between the 'outside and the inside' is what a male wati embodies, this can become quite problematic for him as he enters the health clinic.

A kartiya nurse would likely say that she would treat a male Puntu patient as she would a kartiya. She would likely treat all footballers

the same, for example. However this approach can marginalise, even trivialise, a Puntu and his health needs. The clinic will largely attempt to socialise him into its space using a biomedical approach to his human body. In this model his physical body can be treated separately from his kinship or social relationships. However, the male Puntu who presents himself in a clinic cannot separate his physical body from his adult and social identity. His gendered body expresses both his health and identity. Any man who has been through ceremonial Law will be very sensitive to the treatment he receives in a clinic, especially if the nurse is female. In some cases it will not affect his experience of treatment. However, if a nurse asks him personal questions in front of women, makes jokes about his health or body, shows little sensitivity about privacy, or loudly suggests he needs to be tested or treated for particular diseases, such as STIs, he may get very angry, shamed and upset.³⁰ At such times frustration is heard: ‘Oh heh’, asks one married man, ‘don’t we need a bloody thing, male nurse, eh?’ The issue for the man is not that he won’t be treated — although frustration can lead him to walk out of the clinic — but the cost and the risk of being treated. In the process of receiving treatment, other forms of care, important for his personal sense of well-being, can be ignored or trivialised. Not surprisingly, and to avoid these risks, men prefer to see male health workers, nurses or doctors. Young men, in particular, will seek the help of older men, as they learn to carefully negotiate their new adult status in a transformed physical and social body.

This is not to say that sensitivity or privacy is important only for men. Nor to say that women can’t offer clinic care to men. Sometimes, especially in relation to pain relief, the clinic will be the first port of call. As one man said, ‘Cold sick and headache they can go any sister’. A man might also negotiate his needs within the health clinic by asking another male to accompany him. He may do so for support and company, or he might be seeking assistance from the female health worker who has a more appropriate kinship relationship with his male companion. In these, and many other cases, treatment is achieved in an appropriate, nurturing and respectful way.

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There will be times, though, when a man will seek clinic care from another man. He might postpone attending the clinic until he can see a male nurse or doctor at another time: 'If a man is ever sick with an STD he doesn't go to the [female] nurse, he feels shame and he will keep that sickness.' He might even travel to the nearest town and visit its hospital: 'I would go to Halls Creek,' said one man, 'they've got Puntu there'.

The need for a more appropriate and gendered approach to Aboriginal men's health has been strongly recommended in men's health gatherings, research and health policy within the Kutjungka region, the Kimberley and elsewhere (Guyula 1998; Wakerman et al. 1999; Dodson Lane 2002; Lowe & Spry 2002; Wennitong 2002; Brown 2004; Working Party 2004). They have stressed that the health needs of men, their under-utilisation of clinic services and their experience of colonial history are all closely inter-connected.

Mark Wennitong, in *Indigenous Male Health*, has referred to the compromising of male role models due to fathers being either absent (in prison), or incapable (from alcohol). He has expressed concern for 'an increasing matriarchal family structure...that may have damaging consequences for the identity development of young Aboriginal boys' (Wennitong 2002, p. 39).³¹ Lowe and Spry, in *Living Male*, have commented that,

many adult Aboriginal and Torres Strait Islander males have also experienced separation from their communities and families in early life: because of sickness, imprisonment or removal under government policies. As well as the suffering from such separations, these experiences have interrupted and impaired their cultural processes of growing up as Indigenous males: resulting, for many, in uncertainty and lack of confidence in their cultural roles of parenting; as fathers, grandfathers and uncles. (2002, p. 30)

Other Aboriginal men have emphasised the importance of older men taking up their responsibilities including those towards younger men (Adams, cited in Lowe and Spry 2002, p. 12). These reports, and associated research, indicate the various ways in which the health of the Aboriginal male body has suffered, and how there

remain important historical, generational and gender issues to be addressed (Brown 2004; Working Party 2004).

Some health reports, however, demonstrate little understanding or appreciation of these gender issues in relation to health. For example, the 1999 Kimberley Regional Aboriginal Health Plan made no mention of the particular health needs of Aboriginal men or of women. The Plan noted that,

people in communities outside the larger towns usually have no choice of doctor, or even a choice of the gender of the doctor they see (or any choice in the gender of the remote area nurse or Aboriginal health worker who may be the only resident staff member). (Atkinson et al. 1999, p. 68)

It offered nothing about the health implications of that lack of choice on either gender. The National Indigenous Australians' Sexual Health Strategy (1996–97 to 1998–99) confirmed,

an urgent need for an increase in the number of Indigenous health workers, especially men given the under-representation of men, and because of the gender specific nature of men's and women's business. (ANCARD 1997, p. 92)

However, it did not explore the 'gender specific nature of men's and women's business' nor possible reasons for 'the under-representation of men'. This lack of attention to gender ignores the particular impact of history on Aboriginal women and men, and the specific ways in which male and female bodies have become wounded and sick.

My intention in this chapter has been to explore the cultural and gender factors that affect Puntu health. Being palya in desert society invites physical and social well-being as a person faces the presence of cosmic forces that can cause serious sickness, even death. Maparn provide an important healing service as they assist fellow Puntu to move from experiences of being nyurnu or ngawu to that of being palya. The health clinic, on the other hand, offers a very different geographical and healing space that has, over the years, developed into a particularly female domain. While the clinic offers tangible health benefits, it also presents particular obstacles to the adult male

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body (yarnangu) when social and ceremonial meanings have been inscribed upon and within it. In the following chapter I will look at the social construction of the Puntu male body in relation to the practice of kanyirninpa, where new holding relationships develop as boys become men. These relationships bear important consequences for male sociality, men's praxis and their health.