"It Is Hard to Be Sick Now": Diabetes and the Reconstruction of Indigenous Sociality

Françoise Dussart *University of Connecticut*

Abstract: Biomedical research on diabetes mellitus among Aboriginal Australians often presumes that misunderstanding and miscommunication undermine the treatment and diagnosis of chronic illness. But data collected in 2006 and 2007 challenge that presumption, suggesting that one community of Warlpiri people refashions biomedical notions of chronic and acute illness. Rather than misinterpreting etiologies and treatments of diabetes, the Warlpiri people tend to reinterpret them, making manifest in the medical universe the "indigenization of modernity" that Marshall Sahlins has observed in the domains of material and technological culture. The Warlpiri people respond to diabetes by balancing pressures and protocols of the medical clinic, the place where they live, and, at times, the charismatic Christian churches.

Keywords: diabetes, Aboriginal Australia, sociality, indigenized modernity

Résumé : Les études biomédicales sur le diabète mellitus chez les Aborigènes australiens présument souvent que cette maladie chronique est mal comprise et que le manque de communication rend son traitement incertain. Or, des données recueillies en 2006 et 2007 remettent en question cette présomption. Leur analyse suggère en effet que dans une communauté aborigène, les Warlpiri remodèlent les notions occidentales de la condition chronique et de la maladie aiguë. Au lieu de mal interpréter les étiologies et les traitements du diabète, les Warlpiri tendent plutôt à les réinterpréter, rendant ainsi manifeste dans l'univers médical « l'indigénisation de la modernité » que Marshall Sahlins a analysée dans les domaines de la culture matérielle et technologique d'autres peuples autochtones. Les Warlpiri affrontent leur diabète tout en essayant de trouver un équilibre entre les pressions et les protocoles de la clinique médicale, de l'endroit où ils résident, et parfois aussi des Églises chrétiennes charismatiques.

Mots-clés : diabète, Aborigènes australiens, socialité, l'indigénisation de la modernité

> The very ways societies change have their own authenticity, so that global modernity is often reproduced as local diversity. —Sahlins 1993:2

Introduction

According to the World Health Organization, diabetes mellitus kills more than 3.5 million people each year. Without concerted local and global effort, experts predict that the mortality rate for the disease will increase by more than 50% over the next decade (Diabetes Atlas 2007). The statistics among Fourth World Peoples—well documented in Sub-Saharan Africa, throughout the Americas and Asia (Ekoé et al. 2001; Joe and Young 1994; Mbanya and Mbanya 2003; McMurray and Smith 2001; Rock 2005)—are even more dire.[1] Indigenously populated regions of Australia have been particularly hard hit by the diabetes pandemic; Aboriginal residents of remote settlements are ten times more likely than the broader population to suffer Type 2 diabetes (Cass et al. 2005). In some Aboriginal communities, one in three adults is afflicted with the disease.

As a result of this dispiriting reality, a good deal of biomedical analysis has been focused on the affliction among indigenous populations. Typically, the work in question presumes that misunderstanding and miscommunication undermine treatment and diagnosis. But my analysis, based on data collected in 2006 and 2007 at a Central Desert Aboriginal settlement,[2] challenges certain aspects of that presumption. Field research suggests that many Aboriginal peoples, knowledgeable about the main etiological aspects of the disease, knowingly sidestep biomedical treatment protocols—strict weight management, the modification of dietary habit and exercise—and translate notions of chronic and acute illness to accommodate their own notions of neocolonial social identity. Indeed, rather than *mis*interpreting etiologies and treatments, Warlpiri people tend to *re*interpret the language surrounding diabetes, and in so doing make manifest, in the medical universe, the kind of "indigenization of modernity" that Marshall Sahlins has observed in the material and technological cultures of other Fourth World Peoples. Warlpiri people's response to diabetes displays a community not only capable, but compelled, to tailor medical protocols and discourse to indigenously constituted patterns of residential kinship and social connectedness, as well as distinctly Aboriginal notions of personal autonomy. By so doing, Warlpiri people reshape the local praxis of their sociality (Foucault 1973) in ways that undermine the universalizing discourses of national healthcare organizations, schools, correctional facilities, Christian churches and other "knowledge-making institutions."[3]

In a provocative essay titled "What Is Anthropological Enlightenment? Some Lessons of the Twentieth Century," Marshall Sahlins shows how indigenous peoples, threatened by the colonial pressures of assimilation, survive "by harnessing industrial technologies to Paleolithic purposes" (1999:vi). Far from being destroyed by the materiality of the market economy, these cultures under siege—in South Africa, in the Americas and Australia—repurpose Western commodities in ways that reify more conventional imperatives. This distinctive form of engagement with modernity (Sahlins 1999:xii) is not, however, limited to material culture. It can also be found in more abstract forms of intercultural exchange. For in much the way the Hawaiians and Kwakiutl for example refashion, say, European cloth to accentuate "differences of genealogy," the Warlpiri people rework, at often great emotional and physical costs, their relationship to chronic illness—a concept itself alien to Warlpiri culture—in ways that allow for the subtle negotiation of indigenous social identity in the face of "emergent modernities" (Etkin et al. 1990; Fee, 2006:2990-2992; Heil 2003; Paradies et al. 2007; Radhakrishnan 2002).

While some thoughtful researchers have noted, in general terms, the distinction between indigenous and biomedical perspectives on diabetes, even going so far as to acknowledge the potential benefits of treatment regimens that acknowledge both traditional and medicalized protocols, rarely do these investigators recognize that a fundamental dichotomy governing medical discourse—the distinction between acute and chronic illness—does not exist in conventional Warlpiri cultural repertoires. Warlpiri diabetes sufferers perceived diabetes as a "white person's disease" rendered all the more problematic because its Aboriginal victims eschew the lexicon conventionally applied to diagnosis and treatment. Nor is the complex social obligation generated by illness in Aboriginal settlements, a dynamic rooted in residential kinship patterns, comparable to Western paradigms. Absent the recognition, and close analysis, of such essential cross-cultural differences, strictly biomedical interventions among the indigenous are bound to be less than effective (Brady 1995; Ferreira and Lang 2006; Ferzacca 2000, 2001; Humphrey et al. 2001; Lea 2005; Rock 2005; to cite but a few). Following Margaret Lock's concern "with the relationship among politics, scientific knowledge production and its application, and the creation of so-called 'needs' among populations, together with the search for moral order and control in contemporary society" (1987:5), insightful works on deteriorating health and chronic illness amongst Aboriginal peoples in Australia have underlined the need to rethink collaboration amongst indigenous peoples, the state and its proxy, the medical establishment (see for example, Devitt and McMasters 1998; Heil 2003; Kunitz 2002; Sarthre 2004; Sutton 2001, 2009; Trudgen 2000). In discussing the impact of drastic cultural changes in a relatively short time on the lives of indigenous peoples, these works show how both ethnomedical and biomedical diagnoses and treatments are perceived, managed, reshaped locally and often enter in conflicts in neocolonial Australia. Everyday, Aboriginal peoples struggle to reconstruct their lives against the backdrop of governmental and medical discourses, which generally define their ways of life as "something the matter with them" (Sahlins 1999:xi). In short, I argue that understanding how Warlpiri diabetes sufferers cope with chronic illness and the various management modalities that the disease triggers (Young 1982), sheds light on how a sedentarized community inhabits a milieu of indigenized modernity. For Warlpiri diabetes sufferers and their kin, diabetes, sometimes called "the sugar-disease" or defined as "too much sugar in the blood," has plagued their lives since a couple of decades after they were forced to abandon their hunting and gathering lifestyle.[4] Very few interviewees evoked misconceived notions of genetics or environmental toxicity and even fewer attributed the causes of the disease to traditional forms of sorcery.[5] In fact, most people laughed when that possibility was raised. The reflection of this 41-year-old sufferer of diabetes is typical: "too much sugar in the blood and they [doctors] tell me that it runs in my family."[6] A middle-aged man who has lived with diabetes for 12 years exemplifies a lucid overview on the etiology of the illness:

> My diabetes did not come from sorcery attacks. Sorcerers did not give me diabetes, no one sang me [a sorcery practice] to give me diabetes. My kin or my enemies are not responsible for my diabetes. It came from white people's lifestyle. It came from the food we eat, maybe it is also in my family blood, the polluted air, the rubbish everywhere.

The etiology of diabetes is rarely discussed and most of the time relegated to an inevitable state of health. As one Warlpiri sufferer of diabetes explained: "Listen! This is the way we live—the way we are. We are not white."[7] By reducing the diagnostic to an inevitable biomedically-defined chronic illness, patients disable the sociopolitical resonance of a prescribed biomedical program of medication, diet, exercise and other lifestyle changes intended to stabilize their condition. They are not white, indeed. While others have highlighted similar findings, they generally attributed them to miscommunication between patients and medical staff and to a disregard for the contemporary health beliefs of their patients (see for example, Cass et al. 2005; Eades 1992; Guthridge 1998; Humphrey et al. 1998; Lowell et al. In press; Trudgen 2000). Miscommunications surely exist, but as Garro and Lang have argued in their work on Anishinaabeg and Dakota, most people are "well-informed about the standard medical explanations for their illness and the basic instructions for its treatment and they also continued to draw upon and to speculate about other kinds of knowledge regarding health and healing" (1994:321). With Garro and Lang, what I am interested in here is rather the agency of the sufferers of diabetes and how they draw upon different cultural repertoires and technologies to cope.

Malady and Modernity

The introduction—or rather, imposition—of Western culture, with its surfeit of supposed material "dividends" (cars, cheap clothing, fast food) has done little to improve the health of the area's earliest and once hearty inhabitants. The contrary is the case. The deteriorating physical and social plight of the indigenous population of the Central Australian Desert is well documented (Sutton 2009). In 1946, when Warlpiri peoples were forced to abandon their nomadic lifestyle to live on a government-run ration depot, their health declined dramatically. For decades, diseases that were otherwise eradicated in other parts of the population lingered on among the Aboriginal people residing in government-run settlements and missions.

The battalions of social welfare and medical experts dispatched to the Outback—often working at odds with one another—have done little to improve the quality of life among Australia's most marginalized citizens. Despite these sporadic and contradictory interventions, Warlpiri people, as most Aboriginal peoples and Torres Straight Islanders, have experienced an unprecedented surge in chronic illnesses—diabetes, cancer, end-stage renal failure and high blood pressure. And, of course, health is not the only thing that has suffered; their ritual life, also under assault, has been shaped by non-indigenous interventions. These two variables—health and ritual—are not unrelated. Indeed, traditional ritual life and kinship relations have always been a part of conventional "treatment" of illness. Yet with the introduction of fragmented governmental health policies and the erosion of indigenous protocols, Warlpiri people have been compelled to revise both their relationship to illness and to ritual life—to reconstruct their sociality in the face of ever-changing neocolonial pressures (Peterson and Sanders 1998).

It is in this context that I undertook two field trips—in 2006 and again in 2007—to conduct research in an Aboriginal settlement where government health investigators from the WYN, a health corporation tending to the medical needs of some 1,500 individuals residing in various remote indigenous communities outside Alice Springs, had documented an extremely high incidence of diabetes. In one survey, conducted in 2004, the health service diagnosed diabetes in 35% of the adult population, with 70% of those sufferers facing end-stage renal disease within the following five years (WYN 2005). Specifically, I conducted in-depth qualitative interviews with 84 diabetic patients (60 women and 24 men) between the ages of 16 and 81, as well as with 14 family members of diabetes sufferers.[8] These formal interviews were supplemented by residential observations; I lived with 12 sufferers of diabetes over a period of three months (Dussart in Schwarz and Dussart 2010).

Indigenous Sociality vs. Personal Autonomy

Prior to sedentarization (and in fact, until quite recently), the Warlpiri people were apt to trace physical or mental illness to one of two sources: sorcery by an enemy or the repercussions of some transgressive act. If the etiology of such illness appears distinctly non-Western in nature, so too was the nature of prognosis and treatment. Illnesses, always perceived as curable, necessitated complex social obligations of the healthy, a dynamic tethered to kinship.[9] Treatment focused on healing rituals and the use of local medicines. In essence, the notion of incurable chronic illness did not exist in the ways Warlpiri people recall their pre-colonial universe. When an illness with acute symptoms struck such as a severe flu, it was and still is always the *nyurnu* or "sick one" who would declare the malady. This is done by the display of atypical, even aberrant behaviour: wrapping oneself in blankets during extremely hot weather or sleeping in inappropriate public spaces such as the school during the middle of the day. These mise-en-scènes, in turn, trigger equally scripted responses from the kin relations of the sick one, who must evince concern and compassion in a highly regimented manner. To repeat: illness is always declared by the sick one, never by healthy kin. This is important to point out because the sick one's acknowledgement of illness carries with it a wide range of restrictions. Illness precludes participation in a vast range of consequential social activities—rituals, hunting and gathering expeditions and travelling to other places. These limitations are required to minimize the risk of further exposure to malevolent beings.

The task of monitoring the ill falls to residential kin. Failure to limit the activities of the unhealthy can precipitate charges of sorcery against the lax relative.[10] This monitoring dynamic, linking as it does the sick ones and kin, is emblematic of the broader "looking after" (*warrawarrakanyi* or *jinamardarni*) relationships that constitute the driving force behind all Warlpiri caring praxis.[11] But such connectedness cuts both ways; it dilutes an equally fundamental component of Warlpiri social identity: personal autonomy. And although all long-term illness places a strain on the fragile balance between the kin obligations ("looking after") that operate in the demand-sharing social economy and the autonomy of the individual, chronic "non-traditional" illnesses such as diabetes create a far greater disequilibrium both by their alien "chronic" nature and by adding a layer of non-indigenous medicalized protocols. Indeed, biomedical treatment of diabetes requires sustained clinical surveillance and self-discipline, all of which runs counter to the personal autonomy at the core of Warlpiri social identity. The result is a neo-colonial condition that undermines both personal autonomy and social connectedness, and adds unbearable "social suffering" to lifelong physical distress.[12]

Because diabetes treatment is often accompanied by pressure, from both extended kin and medical practitioners, to "stay in one place" (near a clinic), sufferers often keep the fact of their condition secret, revealing only to one or two family members the nature and scope of the illness. In fact, biomedically-defined chronically ill persons painfully resist stasis prescribed by both their relatives' traditional expressions of "looking after" as well as the biomedical institution. One cannot underestimate the negative impact of the immobility prescribed by local clinicians. The biomedical establishment systemically presses for those afflicted with diabetes to stay close to the clinic and limit travel. But this kind of restriction is anathema to contemporary Warlpiri people, erstwhile hunters and gathers whose identity is still very much rooted in nomadism. At a moment's notice, child or adult can decide to leave with often a bare minimum of necessities such as a blanket and some cash, or even nothing at all, to visit relatives, partake in distant rituals or sports events, go shopping in the distant town or accompany others for a long drive (see also Musharbash 2008).

They need to remain mobile. With increased access to motor vehicles, buses and taxis, healthy and sick Warlpiri individuals now travel frequently to maintain social relations with their kin often scattered over the Northern Territory, South Australia and Western Australia.[13] One diabetes sufferer, now deceased, noted:

> If you do not care for your mob [relatives], you are selfish, you are alone, you are nothing, you cannot ask for nothing. Nothing. You are rubbish. No one cares for you. You can't expect nothing, nothing. That is why we leave the settlement and follow our relatives. We may forget our tablets and then we cannot get them at another clinic for weeks. So we go without. If I feel too sick when I am away, I try to come back or go to another Aboriginal clinic. Then once I get them I feel a bit better [laughs].

The number of geographical loci where one "cares" or "looks after" one's relatives has exponentially increased in the last two decades, and so has the movement of inhabitants. Warlpiri people travel frequently and for long periods to various settlements and cities—a pattern of mobility that encumbers the treatment of chronic illness.

Chronicles of Chronic Illness (Birth of the Chronic)

Early on in my fieldwork, I interviewed an older woman suffering from diabetes who declared, "it is hard to be sick now." The woman in question had grown up before her people were settled, and enjoyed the healthful rhythms of traditional Warlpiri life—hunting and gathering. As a child she was nourished by the land. Now she was neglected by the government. Given her background, I took her seven-word statement to mean that it was difficult to stay healthy in the settlement and I attached to the comment my own indictment of a government that had corralled, marginalized and neglected her settlement for more than half a century. Inadequate education, food and healthcare facilities had taken their toll.

However, what I was hearing was not what she was saying. Two months after our first interview, during the evening hours of late summer, I asked her to elaborate on the seven words. It emerged that the difficulty she perceived focused specifically on the pressures that chronic illness generated in the negotiation of social obligations and the competing need for autonomy.[14] What she meant was this: reconciling the biomedical demands of chronic illness in a setting governed by dense sociality of a demand-sharing economy was "hard work."[15] In other words, it was not the illness per se that was "hard." The challenge emerged from the obligations associated with the pandemic chronic condition. Another diabetes sufferer echoed this despair, again only obliquely alluding to social pressure: "We have too many sick relatives today. Too many people are sick now, we have to stop thinking about it."

The social pressures that accompany pandemic chronic illness explain why the Warlpiri people so often assiduously downplay the incurable nature of diabetes. Few sufferers cast themselves in the role of the "sick one" because to do so risks untenable exclusion from ritual and social functions and impedes the ability to travel, activities that still constitute an elemental component of Warlpiri identity.

To avoid the label of "sick one," a sufferer of diabetes eschews the demonstrative protocols associated with traditional acute illnesses. He or she avoids public displays of physical or psychological pain, limits complaint and avoids arousing *luurrjirrimi* or pity. This is done to fence off pressures both from kin and the biomedical institutions charged with monitoring and mitigating disease.

The avoidance behaviour of the chronically ill inevitably leads to strained relationships with local medical staff.[16] Consider the observations of this 74-year-old woman, a long time sufferer of diabetes:

> We are never really healthy now you know, never healthy, no never healthy. We take pills we get a bit better, but we are still sick and we get sicker. When you're sick like me, you need to go on. If I go to the nurses, they tell me to stay put, to watch my diet, to not sit cross-legged, to do this, to do that. I told the doctor "give me more pills so I do not go on the machine" [dialysis machine], so I can go on [with my activities]. I cannot just be lying down on the ground here doing nothing [like a "sick one"]. I cannot just sit by myself. I have to go where my kin care for me and where I care for them. I do not want to be pitied. No, not pitied.

The middle-aged man quoted earlier reiterates this reticence in the face of chronic pain:

> I am always in pain somewhere in my body...I take my tablets so many tablets. If I go once without them for too long, the pains get worse. And that's that. I have to keep going...I cannot sit here and cry like a baby!

In short, diabetes sufferers regularly recoil when subjected to biomedical regimes of care because the protocols disrupt the delicate paradigm that balances kinship obligations and personal autonomy.

They respond to this imbalance by indigenizing certain aspects of the illness. Although diabetes sufferers readily acknowledge the etiology of diabetes, they regularly link the biomedically defined *symptoms* of the disease to traditional external origins such as sorcery. When pain is acknowledged, Warlpiri sufferers often invoke acts of sorcery that predate the biomedical diagnosis of diabetes they readily acknowledge. Other researchers have remarked on a dual assessment of the causes of chronic illness. For example, in their work on end-stage renal disease, Devitt and McMasters argue that end-stage renal patients "continued to find traditional Aboriginal causes of illness the most satisfying explanation for their disease" and at the same time, they also believed that their "illness was caused by 'bad food' or 'sugar'" (1998:86). Central Australian Aboriginal patients acknowledged in interviews conducted by Devitt and McMasters (1998) that lifestyle factors and sorcery caused their chronic illness.[17] In contrast, Warlpiri diabetes sufferers in 2006-7 did not provide a dual explanation for the causes of their chronic condition. Sufferers acknowledged diabetes as an incurable illness intrinsically linked to lifestyle changes brought by colonization and neocolonialism, but disconnected from sorcery practices. They generally interpreted diabetes-related symptoms—headaches, backaches, kidney aches, insomnia, infections—not as illnesses, but as embodied manifestations of sorcery acts predating their diagnosis.[18] In the face of the long-term transformative effects of two formidable old enemies—colonization and sorcery—diabetes sufferers are left with their daily struggles to control their ailments on their own terms in order to live what they deem to be a worthwhile Warlpiri life. They know that their diabetes will kill them and if not, sorcery will.

Consider this exchange I had with two women willing to discuss their diabetes:

> Woman A: It's in our family. Too much sweet food, too fatty. We used to be healthy when we lived in the bush [before sedentarization]. Now we are all sick. That's the white peoples' disease you know. That's the sugar disease. That's what it is.
> FD: What about sorcery?
> Woman B: [Laughing] No diabetes does not come because you have been sung [bewitched]!

However, the same two women, when discussing pains stemming from diabetes—cramps in their limbs and back, general fatigue, urinary problems, nausea—attributed their discomfort to acts of sorcery. The two women responded to my query about their pains that they were the result of a car accident caused by sorcery some 20 years earlier. One of the two noted:

> Someone had bewitched us. The driver was irresponsible, he did not listen, he went on the wrong road at a [ritual] time you should not go on that road. The car had a bad set of tires. Someone [with the help of a sorcerer] had switched [bewitched] the tires.

The other chimed in:

> I have had these pains [pointing to her lower back and legs] ever since, and now it is getting worse and worse. They [medical staff] could never fix me. The nangkayi [a local healer resident in another settlement] could not do anything either. That sorcery was really strong. Sometimes I cannot even walk in the morning and I get sharp pain in my legs and sometimes I do not feel my legs. That's an old pain. Since that accident I am in pain. Today, I'll stay put in the jilimi [single women's camp]. I cannot walk today.

So to repeat, while biomedical explanations of the causes of diabetes mellitus are acknowledged, the origin of *pain* caused by that disease is not.

The two women also evince how Warlpiri responses to chronic illness are influenced by social obligation. Woman A, whose kin obligations she could limit at the time the pain arose, retreated to the women's camp. She played cards and acknowledged her discomfort, supplementing prescribed pain-medicines with over-the-counter medication obtained from other women in the camp who were informed of her discomfort. Women B, on the other hand, was unable to take refuge in the women's camp because she had relatives visiting. To avoid being socially marginalized, Woman B muted her complaints. Although she took her prescription medication, she resisted all public expressions of her pain. Two days later, both announced that they felt "better" and resumed all their social activities.

Biomedical Technology and Sociality Reshaped

In principle, sufferers of diabetes who are under the care of local health workers have access to only the most global, efficient and modern technology—solid tablets of medicine taken orally. Patients receive a plastic pillbox each week containing a short supply of over-the-counter and prescription medicines. However, pharmacological protocols are difficult to reconcile with the rhythms of settlement life and so the Warlpiri often find themselves compelled to mitigate pain by relying on additional over-the-counter analgesics, and more specifically Panadol, the non-generic form of paracetamol sold in Australia.[19] These pills are taken, when available and affordable, to supplement or substitute for the medications provided by clinic workers.[20]

The local clinic, unequipped to respond to chronic illness, focuses nearly all its attention on acute care. Most sufferers of diabetes residing in remote Aboriginal communities do not have their medications adjusted for months or even years at a time, which often means that the efficacy of drug regimens inevitably declines over time.

As a result, patients have come to rely predominantly on pain medications to "control" their chronic illnesses as if they were acute conditions. Treatment is further undermined by inadequate clinic hours, a patchy centralized patient database, and Warlpiri patterns of mobility, all of which conspire to undermine efficacious treatment.

These impediments are captured in the observations of a 52-year-old diabetes sufferer:

> When I got diagnosed at first I was scared. The nurses are incompetent they never do anything when we tell them that we are going away. They never forward our medicines or give us enough. I go away sometimes for a long time to visit my granddaughters in X [a distant city]. I find ways to get my tablets. Sometimes, I feel weak, really weak, and then I know I need to take the pills...That is how Warlpiri people live...We cannot be selfish and stay here. White people are selfish; they go their own ways. They are alone I think. That's what I think...If I can, I take Panadol and then I feel better, but Panadol is not strong enough sometimes I need stronger medication, so I come back to the settlement or I go to the Aboriginal [emergency] clinic in town. Sometimes you need medications; sometimes you do not because you feel better. In fact I do not feel sick right now.

The suffering of a 25-year-old woman with diabetes[21] highlights both a clear understanding of the etiology of the disease and the pressures that arise from treatment:

> We Aboriginal people are not white, we have to go away and take care of our relatives...I go away with my relatives you know for important things such as funerals, or someone had an accident, or because we have not seen our daughter or grandson for a long time, or to visit a son or a grandson in jail. Many of us have diabetes, and so we take tablets, so many tablets, everyday...But I told the doctor to give me more tablets because I do not want to go on the "machine." Sometimes we have only sweet or fatty food to share with our kin. Sometimes we go away and it is difficult to get our medication in another clinic. If we lose them, we cannot get new ones...We have to wait [at the local clinic or hospital]. [We wait for] Nothing. The next day, we cannot go because we cannot get a lift to the clinic. So we get our tablets only when we come back to our home. I cannot just stay home...I have to decide for myself, I am boss for myself.

The differences that this young woman imagines between the life of a diabetic white woman—compliant, individualistic, selfish, and dominated—and her own, resonate well with governmental and medical discourses defining the reasons and treatment of her ill-health. But more specifically the testimonies of the two diabetes sufferers above underscore just how fraught treatment can be; the Warlpiri people must regularly negotiate competing medical and socio-political pressures, all the while attempting to ignore physical and psychological pain that might otherwise encumber the social system of extended kin relations. Most diabetes sufferers will abandon biomedical directives if they threaten essential kinship obligations and impinge on their personal autonomy.

Beyond Clinic and Kin: Charismatic Christian Currencies and Alternative Forms of Sociality

There is one more variable that enters into the discourse of the indigenous ill—a variable that takes "treatment" beyond clinic and kin. Some diabetes sufferers, when forced to navigate between medical and social protocols, opt to pursue a third path of "treatment": charismatic Christianity, a milieu which, as Peterson noted, presents "a moral and reflexive psychological space that is increasingly separated from the dense sociality of extended kin relations and abstracted from community" (2005:15). The Warlpiri people residing in the settlement where I conducted fieldwork pursue that third path to retool, adapt and re-align their social identity with the teachings of no fewer than four Christian denominations[22]: Baptist, Catholic, Pentecostal and Assemblies of God (AOG).

A majority of the settlement's residents belong to the Baptist Church, which has been a presence since 1948, two years after the government established the outpost. That said, church affiliation is extremely fluid, with allegiances shifting frequently among branches of the Protestant denominations and among various splinter groups that break off from them.[23] A significant proportion of young and middle-aged people belong to the local Pentecostal and AOG Churches.[24] Fewer than ten members of the settlement follow the tenets of the Roman Catholic Church.

While Baptist and Catholic denominations accommodate biomedical and indigenous responses to diabetes, the Pentecostal Church and the AOG campaign *against* them, even going so far as to dismiss the benefits of medicine and dietary vigilance.[25] Pentecostal and AOG church members also admonish new converts to abandon broad kin responsibilities and narrow the sphere of their social obligations to their spouse, children and other church members, and, of course, to God, since God alone provides the only means of reaching true personal salvation.

Fourteen persons afflicted with diabetes—one sixth of the sufferers I interviewed—noted that they had embraced Pentecostalism or the AOG soon after the onset of their diabetes. While half of that group abandoned charismatic teaching within a year, the other seven remained faithful. They did so, they explained, to disentangle themselves from a "rubbish way of life" plagued by demanding kin, alcohol, gambling and domestic violence. The "treatment" most common among the charismatic sufferers of diabetes was the sermon. Consider the imprecations of this 47-year-old Warlpiri male preacher with diabetes[26]:

> Only the Almighty saves, not pills. Stop drinking, clean the rubbish in your yard, dress with clean clothes, take showers, do not eat apples because they are the fruit of evil. Feed your children and send them to school, do not be afraid to abandon the rituals of the past. I know for myself that God is the only way. I know that God is your way.[27]

A 61-year-old woman with diabetes testified back[28]:

> I do not need medicine. I only need God. I am here. I am not sick. I never miss Church meetings. My husband missed so many Church meetings [at several different locations]. He did not listen. Now he is on the machine...I listened. I do not need pills.

Her testimony was immediately reaffirmed by another sufferer of diabetes, a middle-aged man:

> God told me to stop drinking, to stop looking on the ground for cigarette butts in the morning and to stop living in rubbish places, rubbish houses. He spoke to me and told me to love him, to love my family. I was sick. I was drinking. I was always away sleeping in rubbish places anywhere, in town, anywhere. I was saved by the love of God. Because God loves us we need to stop living in rubbish. Clean up your rubbish, clean up your yard. God is all we need.

AOG and Pentecostal sermons, testimonies and healing prayers regularly incorporate admonitions against alcohol, gambling and violence, and advocacy of personal and domestic hygiene. The efficacy of these imperatives cannot be entirely discounted. But, if abstinence from drinking alcohol may be beneficial, sufferers of diabetes continue to eat the same diabetic-unfriendly food available in their community. Pentecostal and AOG demands would appear to provide short-term psychological solace to persons afflicted with diabetes.[29] However, the concomitant impact of an inappropriate diet and a pharmacological prohibition offsets such benefits. Indeed, the health of converts deteriorates quite rapidly because they stop taking their medications, prompting more frequent visits to emergency facilities. The health of the Charismatic is further jeopardized by frequent and scattered Church meetings, some of which can require as much as 2,000 kilometres of travel, a burden that undermines both medical treatment and the social obligations of kinship. As a result of these and other pressures, many converts ping-pong between traditional Warlpiri and Charismatic Christian protocols. Such seesawing of social affiliation underscores the ever-present tensions among the ideals of a "modern indigenized Charismatic Christian person" emphasizing individuated agency, and those of a dense sociality and a lack of a private state in Warlpiri personhood.[30] In their pragmatism, sufferers of diabetes carry on by reshaping conventional, biomedical and Christian currencies.

Concluding Remarks

Fieldwork strongly suggests that while the Warlpiri people acknowledge the dangers of diabetes, they avoid much of the language, as well as the treatment protocols, advanced by bio-medicine. Instead, they deploy an indigenized response that eschews notions of the "chronic." This disavowal does not mean they remain "traditional" in their response. The sufferers of diabetes residing in a 21st-century Aboriginal settlement must negotiate modern medicine, traditional moral imperatives and the spiritual offerings of the Christian church, all the while preserving a deep-rooted sense of personal autonomy that constitutes one of the key components of Warlpiri identity. This is no easy task; survival hinges on the ability to balance the need for mobility—a prerequisite of social connectedness (whether through affiliation to kin or church)—and medical protocols that preclude constant travel. Always pragmatists, the Warlpiri people are compelled to respond to illness the way they must respond to all modern pressure—by retooling.

I do not mean to suggest that the Warlpiri response to diabetes is unique. Nor is it unconscious or thoughtless. The decisions made by the Warlpiri people regarding their choices of treatment—and they *are* decisions—parallel the perspectives of other groups. Consider, for example, the views of some morbidly overweight Americans cited in the work of Finkelstein and Zuckerman: "many individuals are making a *conscious* decision to engage in a lifestyle that is obesity promoting even if they believe that it will result in poorer health and reduced life expectancy" (2008:87). The diabetes sufferers I interviewed would appear to be taking advantage of what Marshall Sahlins called the "'conveniences' of modernity" (Sahlins 1999:411)—diabetes medications, automobiles, et cetera—to balance out personal autonomy and relatedness (Myers 1986). In short, they *indigenize* modernity, rather than simply succumbing to it.

As the interviews suggest, only by examining the extra-medical influences of social, personal and religious obligation can we hope to provide indigenous peoples with diabetes with efficacious treatment protocols. Only then can we reconcile the imperatives of individuals, kin, clinic and church. It is indeed hard to be sick.

Françoise Dussart, Department of Anthropology, U-2176, Beach Hall, University of Connecticut, Storrs, CT 06269-2176, USA. E-mail: francoise.dussart@uconn.edu.

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Notes

1 I am dealing here only with diabetes mellitus or Type 2, which mostly affects Aboriginal peoples in Australia.

2 I have purposely not given the name of the settlement, nor identified the individuals who shared their knowledge. There were numerous discussions at the settlement over whether or not the place and its people should remain unidentified at least for now. It was not possible to get a consensus in 2007. Since then, some interviewees have mentioned the fact that they want to revisit the anonymity issue in the hope that this research could impact health policies in the right direction.

3 I owe this term to Fred Myers.

4 Most Aboriginal peoples living in Central Australia were tested in earnest for diabetes only in the 1970s and 1980s. It is in fact difficult to have access to any reliable data on incidents of diabetes until the early 1990s.

5 The biomedical classification of diabetes has been and is still debated (see for example, Joe and Young, 1994; Paradies et al. 2005; Rock 2005).

6 I translated all quotes from Warlpiri into English. I have identified throughout the paper those which were in English.

7 Their desire to be differentiated from non-Aboriginal people and so, in other words, to have the right to live as Warlpiri, underscores a Warlpiri modern moral order.

8 During a return trip in 2009, all interviews were cross-checked with the interviewees.

9 For a more detailed account of that dynamic see Dussart 2000.

10 See also Heil (2003) for illuminating examples among rural New South Wales indigenous peoples.

11 For an early and particularly rigorous analysis of this dynamic, see Fred Myers' 1986 work on the Pintupi people, neighbours to the southwest of the Warlpiri, Coombs 1994 and Dussart 2000.

12 Rock similarly "expands conventional understandings of population health problems" by documenting the stress of indigenous diabetes sufferers residing in Canada (2003:131).

13 The kind of mobility contemporary Warlpiri people practice is a form of engagement with modernity (see also Hirsch 2001 on Papua New Guinea).

14 I owe this "lightbulb moment" to Professor Nurit Bird-David's manuscript titled "Feeding Nayaka Children and English Readers: A Bifocal Ethnography of Parental Feeding in 'The Giving Environment'" (2008).

15 See also Peterson 2005.

16 See also Coulehan et al. 2005; Devitt and McMasters 1998; Dussart in Schwarz and Dussart 2010; Kowal and Paradies 2005.

17 The connection between causes of chronic illnesses, lifestyle and sorcery practices is not similarly articulated throughout Aboriginal Australia. For example, Schwarz's work on the Yolngu people shows how sorcery is considered "the source of incapacitating illnesses" (In press).

18 It was only in trying to find out when the sorcery events had taken place that I was able to establish the fact that they generally predated the diagnoses of diabetes. Interviewees did not make the connection. Further research needs to be carried out to understand how causes and effects are articulated by contemporary chronically ill patients.

19 I want to stress here that the Warlpiri people, like most Fourth World peoples, have access to a Western healthcare system, while most other disenfranchised peoples do not.

20 The only over the counter analgesic available at the two local shops in 2006 and 2007 was the leading analgesic produced by GlaxoSmithKline, Panadol. Locally, Panadol is twice as expensive as in the supermarkets of the nearest town and often not available after hours. It is probably important to mention here that the leaflet inside a Panadol box warns patients that its use may increase risk of kidney disease, an illness most Warlpiri diabetics should fear. However, a recent study–though I was unable to find out whether or not it was funded by GlaxoSmithKline—surprisingly argued that over the counter analgesics such as Panadol may reduce glucose intolerance and body composition in mice fed a high fat diet (Kendig et al. 2008).

21 Her first sentence echoes the title and the topic of an insightful book by Claude Denis (1997) on similar issues: *We Are Not You: First Nations and Canadian Modernity.*

22 My analysis of Warlpiri engagement with Christianity has tremendously benefitted from reading the works of Schwarz (2006, In press) on contemporary forms of Yolngu Christianity.

23 There is no movement between Protestant and Catholic affiliations as far as I know.

24 The Pentecostal church is different from the other two churches of the Assemblies of God, which in turn have distinct names and leaders.

25 We may emphasize here that the ways biblical Christian perspectives on illness and health, by which both Pentecostal and AOG Churches abide, wed matters of Christian faith to the rewards of a "better" and "longer" life without developing a theology of illness such as diabetes, seem akin to biomedical admonitions anchored in a racialized weight-gene-centred paradigm.

26 As in other parts of Australia, Warlpiri preachers generally use English rather than Warlpiri.

27 Apples are the most commonly available fruit and also the cheapest.

28 She spoke Aboriginal English peppered with Warlpiri words.

29 It is unclear though whether the ways indigenous and Christian peoples cope with their pains are related to dietary habits and physical activities (see also Samuel-Hodge 2008).

30 I want to thank Peter Sutton for pointing this out to me in discussing an earlier draft.

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