

Why Visual Ethnography Should Be Used to Incorporate Traditional Knowledge Into Health Promotion in Remote Aboriginal Communities

SAGE Open
April-June 2019: 1–7
© The Author(s) 2019
DOI: 10.1177/2158244019856950
journals.sagepub.com/home/sgo


Adam Thompson¹ 

Abstract

Health promotion within Aboriginal communities has typically come from a top-down approach with government-funded health research directing the nature in which health information is disseminated. Previous literature has argued for two-way interaction that requires an equivalent bottom-up approach to integrate community beliefs and perceptions. Good hygiene has been the focus of many health promotion campaigns to reduce the presence of a wide variety of pathogens, but to date, there have been few attempts to incorporate traditional knowledge into such campaigns. This article proposes that visual ethnography, specifically community video, provides a good method for understanding community beliefs while simultaneously creating health promotion materials within the local culture.

Keywords

cultural anthropology, anthropology, social sciences, social anthropology, health communication, human communication, communication studies, communication, science communication, cultural communication, media & society, mass communication, intercultural communication, research methodology and design, research methods

Health care and health education seemed essential, but they could be interpreted as assimilationist: for example, teaching Aboriginal people how to think about food and hygiene in a Balanda way, instead of an Aboriginal way. It seemed to me that the immediate necessity of health care was more important than philosophical questions about the imposition of one culture onto another. We had to accept that in some cases, imposing our culture would benefit Aboriginal people. But I had learnt that Balandas would never ever articulate it in those terms. There was a strong taboo in the White community against being an assimilationist. The whole community was founded on the post-Whitlam ideals of land rights and self-determination. In practice, this meant that covert, unintentional assimilation—such as health care—went unspoken.

—Mary Ellen Jordan (2005)

Background

Kearns et al. (2013) reviewed clinical presentations during the first year of life for 320 children living in five remote communities in the Northern Territory, Australia. The median number of presentations was 21 with 14 of these being for infectious diseases including upper respiratory tract infections, ear disease, skin disorders, and diarrhea. These diseases are so common that they have become normalized and

are now perceived within communities as common stages of child development (Kruske, Belton, Wardaguga, & Narjic, 2012). The major contributing factors to this high disease burden are poor hygiene and limited housing, which leads to too many people living within a house not built for large extended families (McDonald, Bailie, Brewster, & Morris, 2008). Luby et al. (2010) has shown that hygiene education, hand washing with soap, and encouraging frequent bathing may result in significantly lower rates of impetigo and pneumonia. Stubbs, Hare, Wilson, Morris, and Leach (2005) showed that Aboriginal children living in remote communities are 23 times more likely to have hand contamination with both *S. pneumonia* and *H. influenza* than children attending urban child-care centers.

Persistent middle ear infection, or chronic suppurative otitis media, is one of the infections for which particular attention has been given, as it can lead to significant hearing

¹Menzies School of Health Research, Casuarina, Northern Territory, Australia

Corresponding Author:

Adam Thompson, Menzies School of Health Research, PO Box 41096, Casuarina, Northern Territory 0811, Australia.
Email: adam.thompson@menzies.edu.au



loss and a diminished quality of life. To date only one study has performed qualitative research methods on Aboriginal perceptions and knowledge about this disease (Jeffries-Stokes et al., 2004). One of the many recommendations of this study was “To reduce the high transmission rates within communities, the importance of washing, in particular hand washing, should be emphasized given the reported very high carriage rate of respiratory pathogens on hands of Aboriginal children and carers” (Jeffries-Stokes et al., 2004, p. 263). The connection between ear infections and hand washing is poorly understood among many people living in remote communities where the contagiousness of nose and ear discharge is under-appreciated (McDonald & Bailie, 2010).

There are other barriers that have been identified preventing hand washing from becoming a regular activity and preventing the spread of disease. Despite the success of “No Germs on Me” media campaigns to communicate the importance of hand washing, soap is still seen as a luxury item of lesser importance to purchasing food and other desirable goods such as cigarettes (McDonald, Cunningham, & Slavin, 2015). Furthermore, very young children are given the freedom to reject hygiene training and responsibility for such needs is often placed on young girls who have not yet developed good hygiene practices themselves (McDonald et al., 2008). These factors are perhaps aggravated by perceptions of cultural denigration and colonialism by Aboriginal people who see hygiene interventions as a continuation of derogatory practices of the past (McDonald et al., 2008). As a result, hand washing initiatives are not meeting their goals.

Health Promotion Programs in Remote Aboriginal Communities

Health promotion programs for the management of chronic disease are recognized as potentially being one of the most cost effective methods for the promotion of good health. However, the success of health promotion programs depends on the active participation of communities. Barnett and Kendall (2011) performed qualitative research across three Queensland Aboriginal (Murri) communities within rural, regional, and urban environments on the success/failure of the Stanford Disease Self-Management Program (CDSM). They found that the success of the program depended on its ability to incorporate local cultural traditions and knowledge bases, specifically in four key areas.

1. Programs should respect the local gender and elder structure. Indigenous health issues are often divided between men’s and women’s business, and cultural protocols govern communication between genders on certain issues.
2. Greater enthusiasm is often held for the use of traditional bush medicine in preference to introduced Western medicines.

3. The most successful method of communicating health information is through peer-to-peer information sharing through family connections.
4. The involvement of community members in the planning, organization, delivery, and follow-up was necessary and allowed programs to be adapted to and owned by the community

The second recommendation is particularly applicable to our project. Barnett and Kendall (2011) write,

Some participants opted for traditional or natural medicine due to their lack of trust in Western medicine. Acquiring and consuming bush medicine was an attempt to restore and protect their culture, but also to gain a sense of control over their health. (p. 30)

A distrust of Western medicine may result in some communities due to medical research on Aboriginal Australians throughout the first half of the 20th century that focused on blood group testing that was meant to prove racial inferiority (Thomas, 2001). In contrast, the use of traditional bush medicine relies on the spiritual connections to Land developed throughout the community’s long history.

Barnett and Kendall (2011) found that each of the three communities was unique requiring health promotion programs to be developed independently. Oliver (2013) performed a literature review on the use of bush medicine within primary health care in Aboriginal Australian communities. Her results support those of Barnett and Kendall in that each community was unique in how it incorporated bush medicine into its modern health care. This approach contrasts with the culture of Western medicine which attempts to generalize programs to effect the largest population. A research approach that incorporates the history and context of the community including its Indigenous knowledge will have a much greater effect.

Kendall and Barnett (2014) further emphasize the importance of looking at collective action and emphasize the holistic nature of health. These were found to be common themes across Indigenous communities in the Pacific region, United States, and Canada (Hurst & Nader, 2006) along with a focus on the burdens placed on young Indigenous people living in both the global and Indigenous cultures. Rigney (2001) describes the struggles of Indigenous knowledge to be recognized within Western science. Kendall, Sunderland, Barnett, Nalder, and Matthews (2011) propose that, “Indigenous knowledge could exist independently of Western scientific knowledge and might provide viable solutions that do not require scientific verification” (p. 1722).

In summary, health promotion programs will have the greatest effect if they incorporate active community participation, traditional bush medicine, with a particular focus on young people. Accordingly, our program chose to focus on promoting health by teaching bush medicine within schools through the active participation of community elders.

Cultural Difference As It Relates to Hygiene

“Often we believe that we need to change cultural habits in order to improve health. We need to realize that we are dealing with structures that are themselves important for sustaining health, and always act knowledgeably and with caution.” (Kiefer, 2006, p. 6)

Good hygiene, the removal of pathogens that may otherwise cause disease, is a universal practice among all cultures. The method and practices used within a specific culture, however, will be specific to the environment in which that culture has developed. This is true of medicine as well. In Western cultures, hygiene revolves around the commercial production of soaps from a source of oils and lye and bathrooms that are in most cases dependent on access to plumbing. This practice developed within complex civilizations with well-developed trade networks and a large supply of oil such as olive oil (V. Smith, 2007). Today, this culture works well where plumbing has developed and where soap may be easily purchased in a store.

Indigenous Australian cultures developed in a different environment, the Australian bush. Small, semi-nomadic groups developed complex kinship systems by which to share and conserve their environment (Gammage, 2011) and mass harvesting of natural foods provided for ceremonial gatherings (Pascoe, 2014). By living, for at least half of the year, in small groups, Indigenous Australians would avoid the accumulation of pathogens, a practice in itself that can be characterized as good hygiene. Indigenous Australians also developed a keen knowledge of their environment, its plants and animals, which was passed down through generations. Today, this still constitutes a well-developed knowledge of plants and their uses, including the use of plants as soap. The leaves and fruits of certain trees containing abundant amounts of saponin could be easily accessed from the natural environment where they grow. Traditional settlement patterns were focused around natural water sources that provided for bathing. These waterholes often took on spiritual qualities for the life-giving properties including hygiene.

Today, living within the Australian bush in a small settlement commonly referred to as an outstation, Indigenous Australians depend on their traditional knowledge. This environment and settlement pattern more closely resembles precontact settlements, in which traditional cultures developed practices of good hygiene. The culture fits those living in outstations in the bush where there is limited access to stores. One must get what they need from the plants and the environment, including soap. In a modern city, the environment can be quite different. To get soap and other goods, one is less likely to find them growing wild in a large-enough supply to provide for all. One must purchase things from a store. Remote Aboriginal community centers lie between these two environments. These community centers have a

much shorter history. Their cultures are still developing and have gone through many stages. Many first developed with the arrival of stockmen and buffalo hunters who provided employment in occupations the people were adept at while allowing traditional cultures to continue in an attitude of protectionism (1890-1925). These were followed by assimilationist practices of missionaries and early government interventions (1925-1970). Later, and up to present, self-determination has characterized these community centers (1970-2017). Those living in such communities are likely to be understandably confused as to the direction they should take. True self-determination requires that people within remote community centers have access to both sets of knowledge and the opportunity to choose for themselves.

Soap Trees in Remote Aboriginal Communities

Almost 30 years ago, Etkin (1988) recommended that “a proper study of ethno-pharmacology should embrace a broad ecological perspective that is both bio-behavioral and multidisciplinary.” Yet recent reports (Albuquerque et al., 2014; Reyes-Garcia, 2010) have found that ethno-pharmacological studies have continued to focus on analyzing lists of medicinal plants for their basic pharmacological constituents without acknowledging the plants role in the medicinal practices within the Indigenous culture.

Indigenous cultures around the world maintain a complex knowledge of the environment in which they live, known within social scientific literature as traditional ecological knowledge. Traditional ecological knowledge is the result of a continued subsistence economy whereby people forage and/or cultivate food and medicine from the land. In the modern globalized culture to satisfy one’s basic needs, one goes to the store to obtain items disconnected from their origin. One does not see the slaughter of animals, the harvest of plants, and the concoction of medicines. Within a foraging economy, one obtains these things from the Land. The process of feeding oneself is engrained with the traditional ecological knowledge passed down through the family of natural seasons and traditional foraging practices. To disconnect the food from the cultural methods by which it is obtained and subsequently shared is to ignore the significant culture knowledge that makes life for such cultures possible. The same is true of its medicine.

To successfully address these issues, it is worth investigating notions of hygiene in the traditional culture. Research has documented the use of traditional medicinal plants for hygiene, such as a type of soap, by many different Aboriginal Australians, including the Yaegl of New South Wales (Brouwer, 2006; Packer et al., 2012), Tiwi Islanders (Puruntatameri, 2001), as well as the Northern Territory communities of Maningrida and Minjilang (Aboriginal Communities of the Northern Territory, 1993), Milingimbi

(Wightman, 1989) and Belyeun (M. Smith & Wightman, 1990). As Webb (1969) points out, “The convergence of use of the same species in different localities, and the survival of the reputation of alleged remedies, provide some circumstantial evidence in favour of the efficacy of such species.”

Within remote Aboriginal communities, these “soap trees” could potentially be incorporated into a program for washing the hands and body. Within Indigenous Australian cultures, the use of these plants and other bush medicines was traditionally known by all adults and children, with the woman in the household being the key disseminator of such knowledge (Reid, 1982). The incorporation of such knowledge into hygiene education would create a pluralistic system in which Western-based soap and traditional medicinal plants can be used interchangeably to improve health. The use of these traditional plants could address those issues preventing hand washing. It could be harvested from the bush instead of being purchased. As traditional knowledge, it can be embraced by the whole community.

Furthermore, going out bush to retrieve medicinal plants is widely acknowledged by Indigenous Australians as a healthy practice improving body, mind, and spirit (Burgess, Bailie, & Mileran, 2008). A recent study (Lowell, Kildea, Liddle, Cox, & Paterson, 2015) described the role of senior women in traditional health care practices in the Northern Territory who encourage pregnant women to “go out” to the bush, as it is in this domain that women are empowered within their traditional roles. This situation is seen in other Indigenous Amazonian communities as well where women play a role as managers of household health including the collection of medicinal plants (Wayland, 2001). Saponin-producing plants are used around the world as soap: *Saponaria officinalis* (soapwort) is used throughout Eurasia, *Sapindus mukorossi* (soapnut) is used in Nepal and India, *Quillaja saponaria* (soapbark) is used in Chile, *Chlorogalum pomeridianum* and *C. angustifolium* (soaproot) was used by Native Americans, *Phytolacca dodecandra* (soap berry) is used in Ethiopia, and *Colubrina asiatica* (lather leaf) was used in China Samoa, Fiji, and Hawaii. Thus, the potential exists for incorporating soap plants into health promotion around the world.

Theory of Health Promotion

Historically, health promotion has typically focused on individual behavior following a behavior change model whereby healthy behaviors, such as exercise, eating a nutritious diet, and getting plenty of rest, are promoted while unhealthy behaviors such as smoking and excessive consumption of alcohol or bad foods are discouraged, though, increasing attention is now being given to the influence of one’s socio-cultural environment in influencing health promotion (Bandura, 1998; Stokols, 1996). The biomedical field often conceptualizes problems in terms of laboratory conditions in which external factors are controlled to understand

the influence of specific variables. Accordingly, laboratory studies have been able to accurately determine that specific bacteria (*H. influenza*, etc) contaminate hands, colonize nasal passages, and then migrate to ears to cause otitis media. Therefore, the decontamination of hands through hand washing will reduce occurrences of otitis media. However, behavior is far more complex. In her book *Doing Health Anthropology: Research Methods for Community Assessment and Change* (2006, p. 43), Christies Keifer states:

[Because of the close interdependence of various parts of local culture] it is nearly impossible to target a small area of behavior – such as health practices, for example – and predict how that part will change under specified conditions, such as the introduction of new knowledge or technology. Rather, what is needed to solve human problems is a very wide knowledge of the entire system of belief, activity, and environment of which the targeted behavior is an integral part.

The present research on soap trees, therefore, hopes to do more than simply describe an alternative technology for hygiene, albeit one that is rooted in traditional culture. The present research must address the beliefs that surround the soap tree as they relate to hygiene, to understand beliefs on hygiene. How do these plants improve health? When and where will they be used? How do such beliefs and actions fit into the personal history of people’s social experiences?

Visual Ethnography

Our study aims to assist local people within Aboriginal Australian communities to create their own documentaries about soap trees. In this way, they will perform their own self-reflective visual ethnography.

Decolonizing theory aims to transform the relationship between researcher and participants. In the past, this relationship has maintained the same power dynamic of colonization with the power remaining with the researcher. Understandably, Indigenous people around the world have grown uncomfortable with this relationship and rejected anthropological research. Decolonizing theory instead aims to give power to Indigenous people to define themselves and share their culture with others in the manner they see fit (L. Smith, 1999). The challenge for the modern ethnographer is to be able to provide that opportunity.

Video has been proposed as a decolonizing strategy for intercultural communication based on its ability to focus beyond the subject and take a holistic perspective. In viewing video as a third party the subject is then able to engage in critical analysis alongside the researcher. In one example, migrant patients were able to talk more openly about their interactions with child and family health professionals while viewing video of those interactions alongside a researcher (Grant & Luxford, 2009).

Participatory video, or community video, offers a unique opportunity for the research participants to share control of

the production process with the researcher (Garrett, 2011). While ethnographic research as an academic pursuit has traditionally been bound by a language and theoretical background that alienates the participant, video is a democratic pursuit in which almost anything can be done. The role of the ethnographer then is to allow the participants to express their beliefs and perceptions in the fullest manner. To converse with people for who English is a second, third, or fourth language and who practice an oral culture that gives little credibility to the written word, it makes sense to focus on oral narratives and visual images. Creating lengthy articles and dissertations in English excludes many participants from the products of the research of which they are a part. A video documentary, however, is more publicly accessible.

Ethnographic knowledge is therefore a collaborative process in which the researcher is engaged in constructing a story alongside the participants. This requires both researcher and participants to think critically about what they wish to represent and is a valuable technique to foster introspection and critical consciousness (Bell, 2016). This critical consciousness is necessary for behavioral change to take place according to the trans-theoretical model which acknowledges that contemplation and preparation must first occur to motivate behavioral change.

Video has been described as an empowering visual medium. It offers marginalized groups an opportunity to reproduce and understand their world as opposed to the dominant representation depicted in mass media (Barnes, Taylor-Brown, & Wiener, 1997; Pink, 2001). Its potential to give voice to underrepresented groups such as children and youth has also been acknowledged (Canosa, Wilson, & Graham, 2017). For decades now, people in Aboriginal Australian communities have had Western concepts of hygiene and handwashing described to them by the dominant culture, first by missionaries and more recently by health promotion campaigns. But, as yet, they have had little opportunity to define traditional hygiene practices. In effect, this has continued to force upon them the colonized view of cleanliness. If given the opportunity to create a documentary of traditional hygiene practices, communities can then create their own health promotion videos that redefine their cultures as traditionally being clean and healthy (which historic records support). The key to good health for many Indigenous people is the restoration of traditional culture and values that once made them strong and healthy.

It is only recently that digital video has become accessible to all. Ten years ago, the creation of a documentary would require an expensive camera and video-editing machine that was only accessible to a passionate filmmaker willing to spend the money. Today, smartphones can capture high-definition video and every computer is capable of running basic video-editing software. Ethnographer's experience with video in the past often grappled with the boundary between filmmaker and participant because video making capabilities

were few (Pink, 2001). Today that boundary is almost non-existent. With modern technology, just about everyone has created a video at some point and experienced seeing themselves in video. It is this recent technological change that provides the common audio-visual language for the researcher and participant to communicate together and allows them, in effect, to become co-researchers in the same project. Working together, the researcher is also able to reflect on his or her own preconceptions.

While the creation of a documentary allows for a visual ethnography as described above, it also provides an opportunity for oral narratives to be recorded. Incorporating a local co-researcher as the filmmaker, allows them to also be the interviewer changing the power relationship that existed before. In this way, the informant being interviewed becomes a collaborator in the creation of a narrative about themselves and their culture rather than being interrogated. It is this flexibility that allows for video to be a collaborative project that can involve an entire community and give the opportunity for people to provide their own voice where ever they feel comfortable (Mitchell & Lange, 2011).

Summary

Aboriginal Australians suffer a higher disease burden than most Australian citizens. The modern Aboriginal community is a product of the past 100 years of two cultures converging that has created a unique social environment. Traditional and Western cultural knowledge is still in the process of adapting to these communities. It is widely recognized that improvements in access to hygiene infrastructure could reduce the disease burden. However, as yet, few attempts have been made to incorporate traditional knowledge into health promotion campaigns that could better meet the demands of these communities. Using community-driven video ethnography, one can document traditional hygiene practices, including the use of soap trees, to create health promotion materials that are based in the local culture.

Visual ethnography is an appropriate means to incorporate Indigenous viewpoints due to its ability to empower community participants to direct research as co-researchers. This method is equally applicable to Indigenous people around the world toward creating new practices for intercultural health. Medicinal plants have been used by many different cultures for hygiene. Exploring this topic provides the opportunity for deeper discussions on hygiene and health in a respectful two-way conversation. This article is written in the hope that others may be inspired to develop similar projects in the future.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: Funding has been provided by the Centre of Research Excellence in Ear and Hearing Health of Aboriginal and Torres Strait Islander Children and the National Health & Medical Research Council.

ORCID iD

Adam Thompson  <https://orcid.org/0000-0002-0580-7482>

References

- Aboriginal Communities of the Northern Territory. (1993). *Traditional Aboriginal medicines in the northern territory of Australia*. Darwin, Australia: Conservation Commission of the Northern Territory of Australia.
- Albuquerque, U., Medeiros, P., Ramos, M., Júnior, W., Nascimento, A., Avilez, W., & Melo, J. (2014). Are ethnopharmacological surveys useful for the discovery and development of drugs from medicinal plants? *Revista Brasileira de Farmacognosia*, *24*, 110-115.
- Bandura, A. (1998). Health promotion from the perspective of social cognitive theory. *Psychology & Health*, *13*, 623-649.
- Barnes, D., Taylor-Brown, S., & Wiener, L. (1997). "I Didn't leave Y'all on purpose": HIV-Infected Mothers'; Videotaped legacies for their children. *Qualitative Sociology*, *20*, 7-32.
- Barnett, L., & Kendall, E. (2011). Culturally appropriate methods for enhancing the participation of Aboriginal Australians in health-promoting programs. *Health Promotion Journal of Australia*, *22*, 27-32.
- Bell, T. (2016). Visually engaged ethnography: Constructing knowledge and critical consciousness. *Journal of Media Practice*, *17*, 126-137.
- Brouwer, N. (2006). *Traditional medicinal knowledge of the Yaegl Aboriginal community of New South Wales: An ethnobotanical, biological and chemical study*. Sydney, New South Wales, Australia: Division of Environmental & Life Sciences, Department of Chemistry & Biomolecular Sciences, Macquarie University.
- Burgess, P., Bailie, R., & Mileran, A. (2008). Beyond the mainstream: Health gains in remote Aboriginal communities. *Australian Family Physician*, *37*, 986-988.
- Canosa, A., Wilson, E., & Graham, A. (2017). Empowering young people through participatory film: A postmethodological approach. *Current Issues in Tourism*, *20*, 894-907.
- Etkin, N. L. (1988). Ethnopharmacology: Biobehavioral approaches in the anthropological study of indigenous medicines. *Annual Review of Anthropology*, *17*, 23-42.
- Gammage, W. (2011). *The biggest estate on earth: How Aborigines made Australia*. Crows Nest, New South Wales, Australia: Allen & Unwin.
- Garrett, B. (2011). Videographic geographies: Using digital video for geographic research. *Progress in Human Geography*, *35*, 521-541.
- Grant, J., & Luxford, Y. (2009). Video: A decolonising strategy for intercultural communication in child and family health within ethnographic research. *International Journal of Multiple Research Approaches*, *3*, 218-232.
- Hurst, S., & Nader, P. (2006). Building community involvement in cross-cultural Indigenous health programs. *International Journal for Quality in Health Care*, *18*, 294-298.
- Jeffries-Stokes, C., Lehmann, D., Johnston, J., Mason, A., Evans, J., Elsbury, D., . . . Lehmann, K. (2004). Aboriginal perspective on middle ear disease in the arid zone of Western Australia. *Journal of Paediatrics and Child Health*, *40*, 258-264.
- Jordan, M. E. (2005). *Balanda: My year in Arnhem land*. Crows Nest, New South Wales, Australia: Allen & Unwin.
- Kearns, T., Clucas, D., Connors, C., Currie, B., Carapetis, J., & Andrews, R. (2013). Clinic attendances during the first 12 months of life for Aboriginal children in five remote communities of northern Australia. *PLoS ONE*, *8*(3), e58231.
- Kendall, E., & Barnett, L. (2014). Principles for the development of Aboriginal health interventions: Culturally appropriate methods through systemic empathy. *Ethnicity & Health*, *20*, 437-452.
- Kendall, E., Sunderland, N., Barnett, L., Nalder, G., & Matthews, C. (2011). Beyond the rhetoric of participatory research in indigenous communities. *Qualitative Health Research*, *21*, 1719-1728.
- Kiefer, C. (2006). *Doing health anthropology research methods for community assessment and change*. New York, NY: Springer.
- Kruske, S., Belton, S., Wardaguga, M., & Narjic, C. (2012). Growing up our way: The first year of life in remote Aboriginal Australia. *Qualitative Health Research*, *22*, 777-787.
- Lowell, A., Kildea, S., Liddle, M., Cox, B., & Paterson, B. (2015). Supporting Aboriginal knowledge and practice in health care: Lessons from a qualitative evaluation of the strong women, strong babies, strong culture program. *BMC Pregnancy and Childbirth*, *15*, 19.
- Luby, S., Kadir, M., Yushuf Sharker, M., Yeasmin, F., Unicomb, L., & Sirajul Islam, M. (2010). A community-randomised controlled trial promoting waterless hand sanitizer and hand-washing with soap, Dhaka, Bangladesh. *Tropical Medicine & International Health*, *15*, 1508-1516.
- McDonald, E., & Bailie, R. (2010). Hygiene improvement: Essential to improving child health in remote Aboriginal communities. *Journal of Paediatrics and Child Health*, *46*, 491-496.
- McDonald, E., Bailie, R., Brewster, D., & Morris, P. (2008). Are hygiene and public health interventions likely to improve outcomes for Australian Aboriginal children living in remote communities? A systematic review of the literature. *BMC Public Health*, *8*, 153.
- McDonald, E., Cunningham, T., & Slavin, N. (2015). Evaluating a handwashing with soap program in Australian remote Aboriginal communities: A pre and post intervention study design. *BMC Public Health*, *15*, 1188.
- Mitchell, C., & Lange, N. (2011). Community-based participatory video and social action in rural South Africa. In *The SAGE handbook of visual research methods*. London, England: Sage. Retrieved from <http://methods.sagepub.com/book/sage-hdbk-visual-research-methods>
- Oliver, S. (2013). The role of traditional medicine practice in primary health care within Aboriginal Australia: A review of the literature. *Journal of Ethnobiology and Ethnomedicine*, *9*, 46.

- Packer, J., Brouwer, N., Harrington, D., Gaikwad, J., Heron, R., & Yaegl Community Elders., . . . Jamie, J. (2012). An ethnobotanical study of medicinal plants used by the Yaegl Aboriginal community in northern New South Wales, Australia. *Journal of Ethnopharmacology*, 139, 244-255.
- Pascoe, B. (2014). *Dark Emu*. Broome, Western Australia, Australia: Magabala Books.
- Pink, S. (2001). *Doing visual ethnography: Images, media, and representation in research*. London, England: Sage.
- Puruntatameri, J. (2001). *Tiwi plants and animals: Aboriginal flora and fauna knowledge from Bathurst and Melville Islands, northern Australia*. Darwin, Australia: Parks and Wildlife Commission of the Northern Territory.
- Reid, J. (1982). *Body, land, and spirit: Health and healing in Aboriginal society*. St Lucia, Australia: University of Queensland Press.
- Reyes-Garcia, V. (2010). The relevance of traditional knowledge systems for ethnopharmacological research: Theoretical and methodological contributions. *Journal of Ethnobiology and Ethnomedicine*, 6, 32.
- Rigney, L. (2001). *A first perspective of Indigenous Australian participation in science: Framing Indigenous research towards Indigenous Australian intellectual sovereignty*. Adelaide, Australia: Aboriginal Research Institute, University of South Australia.
- Smith, L. (1999). *Decolonizing methodologies: Research and indigenous peoples*. Dunedin, New Zealand: University of Otago Press.
- Smith, V. (2007). *Clean a history of personal hygiene and purity*. Oxford: Oxford University Press, UK.
- Smith, M., & Wightman, G. (1990). *Ethnobotanical notes from Belyuen, Northern Territory, Australia*. Darwin, Australia: Conservation Commission of the Northern Territory.
- Stokols, D. (1996). Translating social ecological theory into guidelines for community health promotion. *American Journal of Health Promotion*, 10, 282-298.
- Stubbs, E., Hare, K., Wilson, C., Morris, P., & Leach, A. J. (2005). Streptococcus pneumoniae and noncapsular Haemophilus influenzae nasal carriage and hand contamination in children. *The Pediatric Infectious Disease Journal*, 24, 423-428.
- Thomas, D. (2001). *Reading doctor's writing: Race, politics and power in indigenous health research, 1870-1970* (Doctoral thesis). Northern Territory University, Darwin, Australia.
- Wayland, C. (2001). Gendering local knowledge: Medicinal plant use and primary health care in the Amazon. *Medical Anthropology Quarterly*, 15, 171-188.
- Webb, L. (1969). The use of plant medicines and poisons by Australian aborigines. *The Australian Journal of Anthropology*, 7, 137-146.
- Wightman, G. (1989). *Ethnobotany, vegetation and floristics of Milingimbi, Northern Australia*. Palmerston, Australia: Conservation Commission of the Northern Territory.

Author Biography

Adam Thompson is a PhD student at Menzies School of Health at Charles Darwin University. His background is in anthropology and documentary filmmaking. He specializes in working with indigenous people to create their own documentary films presenting their knowledge and culture as a record for younger generations.