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The Circulation of Blood and Care: Value and Kidney Disease Amongst Yolŋu in Northern Australia

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ABSTRACT

In health care and care scholarship, care is often cast as a gift that exploits caregivers, or generates social debts and inequalities among people who require it. I broaden understandings of how care acquires and distributes value through ethnographic engagement with Yolŋu (an Australian First Nations people) with lived experience of kidney disease. I expand Baldassar and Merla's concept of the circulation of care to argue that value, like blood, circulates through caregiving practices of generalized reciprocity without transferring worth between caregivers and receivers. Here, the gift of care is neither agonistic or purely altruistic, entangling individual and collective value.

KEYWORDS

Caregiving; kidney disease; kinship; reciprocity; value; Yolŋu

At a suburban renal unit, patients sit in vinyl armchairs while their blood circulates between their arms and the dialysis machines beside them via transparent tubes. The unit, in Darwin, the capital of Australia's Northern Territory, is populated densely by patients, health professionals, and an array of medical equipment, sharps disposal bins, and trolleys. The footsteps of renal nurses on linoleum floors intermingle with the televisions installed in front of each chair and the quiet humming of patients' blood filtering through the machines. Despite the bright lights and white noise, most patients pass their four to five-hour treatment sessions by catching up on sleep.

Kidney disease disproportionately impacts Indigenous people in Australia and internationally (Cass et al. 2004). In the Northern Territory, approximately 85% of the renal patients are First Nations people displaced from their communities to the urban centers of Darwin and Alice Springs to access dialysis treatment (Gorham et al. 2019). Against the specter of displaced patients hooked up to machines essential to sustain their life, health professionals tasked with caring for them who I interviewed frequently articulated desires to “empower” patients; and their empowerment narratives were paralleled in policy documents that envisioned greater patient involvement in treatment regimens and health services governance (Northern Territory Government 2017). While health professionals described a range of ideas for achieving patient empowerment, their visions centered on projects to reduce patient dependency on health care systems. Dylan for instance, articulated an empowerment proposal in which some patients would be given roles as advocates and would assist new patients to adjust to life in Darwin. He explained to me:

We can actually empower them and make them feel a part of something rather than this burden in life which people feel when they're dislocated from their families and communities. If they can give back, everybody knows if you can give back that feels better than receiving.

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Media teaser: How can we understand the value of care beyond the exploitation or devaluation of caregivers, or by construing people who require care as burdensome?

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In policy documents and in the narratives of health professionals, such as Dylan a conceptualization of care as a gift that invests moral value in providing care to others (and perhaps oneself) emerges, which casts people who receive care as burdened with social debts. Health professionals such as Dylan saw themselves as providing opportunities for patients to assuage the social debts that patients were seen to have acquired to health systems. They did not appear to contemplate other regimes of value that the giving and receiving of care may invoke.

Care has often been conceptualized as a gift that alters the moral status of both caregivers and those in their care. Implicated in the making and sustaining of relational modes of personhood and kinship ties, the giving or receiving of care can be understood as part of whom one is in relation to significant others; an aspect of social roles, obligations and entitlements; and an expression of moral commitments and affective sentiments (Buch 2015; Mol 2008; Thelen 2015). Concurrently, care is often approached as essential but burdensome labor that creates or sustains inequality, as, a gift that produces social debts and dependencies (Heinemann 2015; Seo 2016; Thelen).

Feminist theorists have often argued that societies accrue social debts to caregivers (Fineman 2004; Klein 2021; McCluskey 2002). Many have engaged in normative projects to reclaim the value of care and the productive value of caregivers. Gilligan (1982) contrasted feminine ethics of care, premised on compassion, negotiation, and responsibility with masculine ethics of justice, characterized by rights, rules, and fairness, arguing for the legitimacy of women's morality. Some feminist theorists have sought to recast care as "work," situating care within the realms of production and the formal economy (McDowell et al. 2005); and within the domains of politics and citizenship (Sevenhuijsen 1998; Thelen 2015; Tronto 1993).

This body of work has, however, been challenged in critical disability studies and social gerontology. Scholarship within these fields illustrates that casting people who receive care as accruing social debts to caregivers objectifies them as passive and burdensome and fails to attend to nuances in the reciprocities of care (Fine and Glendinning 2005; Weicht 2011). Along with some other feminist theorists, scholars within these fields have contested the problematization of physical, social, and economic dependency, arguing that liberal ideals of autonomy and self-sufficiency are modeled on the lives of white, middle class, middle aged, able-bodied men (Barnes et al. 2015; Feder Kittay and Feder 2002; Weicht 2011). Some suggest that analytical attention should be brought to bear on autonomy, agency, and interdependency within relations of care; and that care should be repositioned as a societal responsibility, in ways that do not alter the status of people who are cared for (Fine and Glendinning 2005; Rummery and Fine 2012; Weicht 2011).

In this article, I aim to move beyond binary conceptualizations of care as either exploiting or devaluing caregivers, or generating social debts and inequalities among people who require it, by broadening understandings of the ways in which care may acquire and distribute value. Bringing together the scholarship of care and economic anthropology, I approach care as a relation that is both social and economic, invoking both moral commitments and sentiments; and understandings of the entitlements and obligations associated with the basic needs of life. I describe an ethics of care as practiced by Yolŋu, an Australian First Nations people whose country is located in north-east Arnhem Land (Figure 1). Through ethnographic engagement with Yolŋu with end-stage kidney disease and their caregivers and other family members, I illustrate how Yolŋu invest value in both the giving and receiving of care. The anthropology of care illustrates that family care is often intimately entangled with health care; and that distinctions often made between formal and informal care invoking binaries of expert and embodied knowledge, science and affective sentiment, treatment, and care cannot be sustained (Mol 2008; Thelen 2015). While the article presents an ethnography of Yolŋu patients' family care, drawing on this scholarship, I also consider the implications of the arguments advanced for health care practice.

I expand Baldassar and Merla's (2014) concept of the circulation of care, developed to describe the asymmetric reciprocities of care that sustain transnational families across national borders. Baldassar and Merla illustrated how care in their interlocutors' families took the form of generalized reciprocity, a weak mode of reciprocity developed by Sahlins (1974:193–4) in

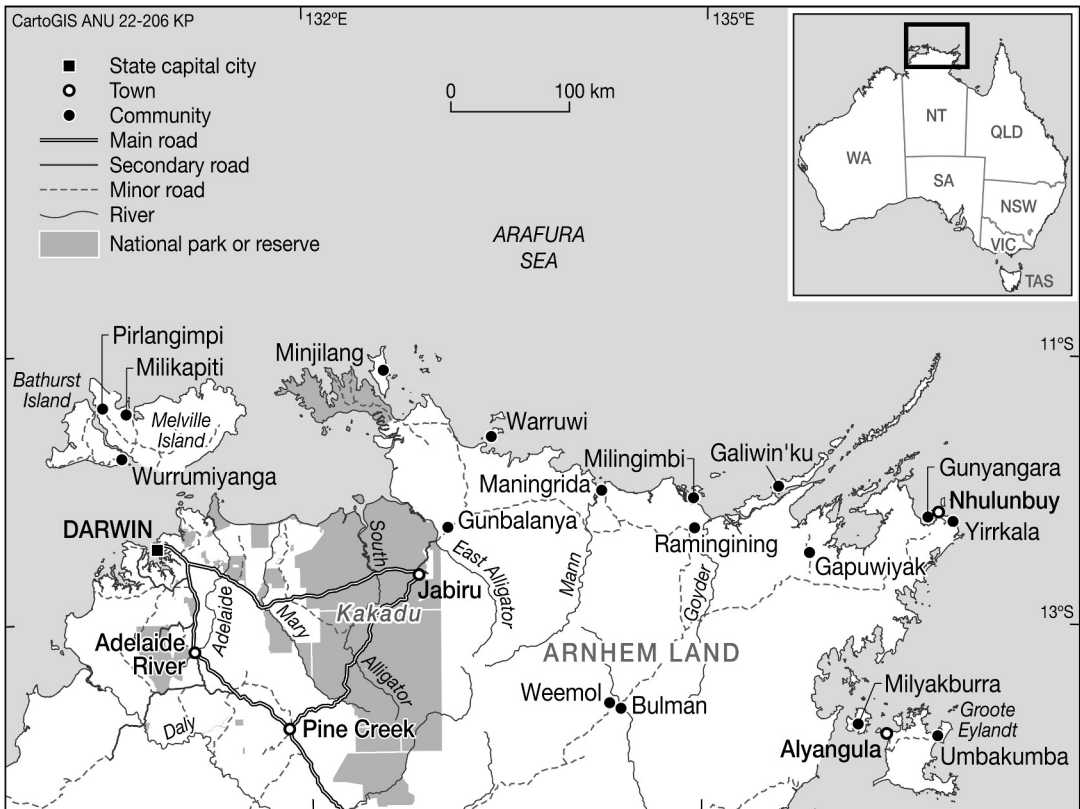


Figure 1. Study region in the Top End region of the Northern Territory of Australia.

which obligations and entitlements may exist only in potentiality, recompense may be indirect or delayed, and in which there is no accounting of social debts in terms of number or magnitude. I augment understandings of the obligations and entitlements of care constituted through generalized reciprocity, which foreground the complex circulation of labor, affective sentiment, and material resources rather than direct exchanges. I consider how value is put in motion in circuits of care, drawing on Graeber's (2001) work on value. According to Graeber (2001:3–4), quoting Kluckhohn (Kluckhohn 1949:358–9), value orientations are “assumptions about the ends and purposes of human existence, the nature of knowledge, what human beings have a right to expect from each other and the gods, about what constitutes fulfillment and frustration.” Graeber conceptualized value production as a dynamic process of action and recognition.

I show that value, like blood, can flow through circuits of care in ways that do not transfer worth between caregivers and receivers. Yolŋu patients' blood and its circulation through bodies and dialysis machines serve as an analogy for the circuits of care in patients' homes that flow through practices of generalized reciprocity. Yolŋu conceptualize blood as a representation of kinship, and patrilineal clans are understood to constitute “one blood” (Reid 1983). As one interlocutor commented, “Dad is my blood, Mum is my heart.” Nevertheless, kinship is not necessarily a stable category, and can be made and performed, as I will illustrate. Circuits of care in Yolŋu families are animated by the physical labor of caregivers, the welfare resources, such as social housing and social security that patients accrue and share, the past nurturance of younger caregivers by patients and the collective value invested in Elders' knowledge and power. I illustrate how value is put in motion in circuits of care through processes of action and recognition, in ways that foreground interdependencies within relations of care. I argue

that the gift of care that circulates through practices of generalized reciprocity is neither an agonistic or purely altruistic gift, but a gift that entangles individual and collective value.

Methods

Many dimensions of care escape the verbal, and understanding values and practices of care requires a particular intimacy and immersion. I adopted an epistemological stance in which at least some meanings and values of care may be grasped through participatory observation of care practices ethnographically and by listening to interlocutors' care narratives. This stance to some extent overlaps with Yolŋu ontologies in which knowledge emerges from everyday interactions, is active, contingent, collaboratively constructed, and constantly renewed; and is "done" rather than "discovered" (Christie 2006; Marika-Mununggiritj 1991). However, the everyday and intimate nature of family care also necessitated safeguards to ensure that interlocutors did not feel that I was overly-intruding on family life.

These imperatives, and my positionality as a non-Indigenous person socialized into a Western lifeworld, necessitated developing close relationships with Yolŋu collaborators who were involved in the research process. The project was conducted in collaboration with two Yolŋu co-researchers, the late Mr Muŋuŋpurr, himself a renal patient, and another co-researcher who was caring for a family member undertaking dialysis and who cannot be named due to her recent passing. Co-researchers advised on the conduct of fieldwork according to Yolŋu protocols of interpersonal relations. They brokered introductions to Yolŋu renal patients within their personal networks, assisted me to explain our research, helped obtain informed consent from interlocutors and at times acted as intermediaries between interlocutors and me, ensuring that fieldwork activities were respectful. They facilitated some interviews and advised on the interpretation of data. They also shared their own narratives of kidney disease and care. Although the co-researcher roles were paid positions, and formally I related to co-researchers as their work supervisor, in a Yolŋu lifeworld the co-researchers were my seniors and were both respected members of their communities; and I predominantly related to them as adopted kin. Early in our fieldwork Mr Muŋuŋpurr adopted me as his *gäthu* (daughter), and this placed me in a *dhuway* (cousin or sister-in-law) relationship with the other co-researcher and more broadly in a network of kin relations with all of my Yolŋu interlocutors.

In collaboration with Yolŋu co-researchers, I undertook 16 months of ethnographic fieldwork from November 2017 to February 2019 in Darwin, where most Yolŋu receive treatment, and north east Arnhem Land, on Yolŋu country (Figure 1). We were closely engaged with 15 patients and their families. Patients represented a mix of clan and family groups and gender identities, and their ages ranged from late 30s to late 60s, although most were in their 50s and 60s. We conducted participatory observational research and 57 individual and group interviews with patients and their caregivers, in Australian English, Aboriginal English, and Yolŋu Matha, at their places of residence and in public places, such as parks and reserves. As caregivers were often much younger than the patients they were caring for, and this could imply social inequalities, particularly where patients were Elders, where possible, we interviewed caregivers separately to patients. More broadly, I became embroiled in interlocutors' life projects and attempts to access support services when interlocutors invited me to accompany them on hunting trips, to public events, and to appointments at medical and social services. I also completed qualitative interviews with 35 health professionals, health policymakers, and housing department officials in Darwin and north-east Arnhem Land.

I adopted processes for recognizing interlocutors' data sovereignty that aimed to reflect both Yolŋu ontologies and national research guidelines (National Health and Medical Research Council 2018). All interlocutors signed consent forms translated into Yolŋu Matha. Throughout fieldwork and at its conclusion, with co-researchers I also revisited specific statements and observations with interlocutors to check my interpretation and confirm ongoing consent for recording and publishing this material. Interlocutors have chosen the ways in which they have been identified in this article, with the exception of those who passed away or left Darwin and became uncontactable prior to discussions

about the use of their names. These interlocutors have been de-identified. As required by ethics committees granting approval for this project, during the informed consent process I asked interlocutors about how their data should be handled should they pass away. Interlocutors generally asked that their families make decisions about their data on their behalf. Following the deaths of several interlocutors, I therefore consulted with their families to determine whether interlocutors' data should be destroyed or maintained, and if the latter, whether it could be published immediately or following a period of grieving. In all cases, I respected the wishes of interlocutors' families and also offered to provide families copies of notes, recordings, and photographs, which were in some cases taken up. Health professionals quoted in this article, who were involved on the basis of their professional roles, have been allocated pseudonyms.

In this article, I primarily present the narratives of two interlocutors, N̄arritj and Bułanydjan. N̄arritj was a caregiver to Bułanydjan, his mother's mother, who was undertaking dialysis in Darwin. Renal patients may require care for an array of symptoms, complications, and dialysis side-effects, such as compromised immunity and frequent bouts of respiratory illness, bone disease and frailty, nausea and vomiting; and in order to make substantial dietary changes (Puszka 2019). Moreover, the social distress produced by end-stage kidney disease and displacement could necessitate Yolŋu practices of keeping company in sickness and health, as described by Coulehan (1995), and could entail caregivers and in some cases whole family groups relocating to Darwin, temporarily or permanently, in addition to patients themselves. Bułanydjan required a wheelchair due to her frailty and was reliant on N̄arritj's assistance to undertake many basic physical functions, such as bathing, dressing, and eating. N̄arritj was in his late 20s and openly identified as a *sistergirl* (a transgender First Nations woman). As he adopted different gender identities in different contexts and identified as male in conversations with me, referring to himself as "Bułanydjan's grandson," I refer to N̄arritj using male pronouns here. N̄arritj and Bułanydjan's relationship and experiences may not necessarily be representative of the care of other Yolŋu patients. Not all patients required the same level of care as Bułanydjan and some were considerably younger than her, while N̄arritj's gender identity was considered by Yolŋu to be non-normative. However, these attributes also led them to reflect on and discuss normative expectations and practices of caregiving in Yolŋu families, and their narratives therefore provide an informative contrast. I have drawn on N̄arritj and Bułanydjan's narratives, supplemented by the narratives of other interlocutors, to draw out similarities and contrasts, to first describe: the social organization of care in Yolŋu patients' families; the social value of care conferred on patients and caregivers; the ways in which families constituted the reciprocities of renal patients' care; and to then discuss the circulation of value and care. While there is no scope within the article to fully consider how value is produced and distributed as patients' care flows through other regimes of value beyond Yolŋu domestic moral economies, I begin to contemplate the entanglement of divergent regimes of value in the conclusion.

The social organization of care for Yolŋu renal patients

N̄arritj explained the division of caregiving labor in Bułanydjan's household between himself and three of his younger aunts, describing his allocation of physical tasks:

Like Jasmine is a carer, I'm Bułanydjan's grandson, Bethany is her niece, Karina is her niece. We all do parts of looking after her, sharing. My main job is to shower her, take her to the toilet, take her for walks. Jasmine is her carer, her job is to pay the power bills and the rent. Jasmine and Karina keep the house clean inside and out.

N̄arritj appeared to refer to only Jasmine as a "carer" because she was the only caregiver receiving the Carer Payment, a social security benefit paid to people performing particular types and quantities of care (Puszka 2019). In particular, both N̄arritj and his grandmother foregrounded N̄arritj's role in assisting Bułanydjan to transfer in and out of her wheelchair, describing both his physical strength and attentiveness to Bułanydjan's bodily sensations. Bułanydjan noted that N̄arritj was the only caregiver able to lift her without causing her pain, telling me repeatedly, "my body it only knows N̄arritj."

Narritj and Bułanydjan's comments locate Narritj's care within social roles of young Yolŋu associated with the performance of physical labor. While physical tasks were not the sole preserve of young people, youth were often expected to undertake domestic labor such as cleaning, caring for families' children, collecting firewood, and odd jobs, such as fixing broken vehicles; and were allocated physical tasks associated with ceremonies such constructing shelters to house guests, hosing down ceremonial grounds, preparing food and contributing to ceremonial performances through dancing. One interlocutor, Annie, explained, "you labor for your *n̄āṇḍi* (mother and her people)." However, many youth were unable to enact social expectations of their labor through employment within the formal economy. The capacity of Yolŋu to hunt and gather in customary economies is also encumbered in similar ways to that of their neighbors, the Kuninjku, as described by Altman (2018). For Yolŋu as for Kuninjku, work readiness programs mandated by social security mutual obligation requirements and a lack of access to contemporary means of hunting and gathering, particularly vehicles, could complicate their capacity to hunt and gather. The displacement of many families to Darwin for medical treatment further limited access to hunted and gathered food. Diminishing opportunities for youth to perform social roles could thus work to reinforce families' expectations of them as caregivers.

Narritj explained that the propriety of his intimate care for Bułanydjan was sanctioned through kinship, due to their *māri* – *gutharra* relation (between a mother's mother or mother's mother's brother; and daughter's child or sister's daughter's child). He explained,

I'm mainly there for Bułanydjan because in the Yolŋu way only grandsons and granddaughters, *gutharra* can give a shower. When *gutharra* does that, I'm allowed to touch her private parts. That's my job. She won't feel uncomfortable, awkward. All my brothers and all my sisters (in a *Balanda* (Western) way you might say cousins) can help with the shower, but her favourite is Narritj.

Bułanydjan elaborated that it was appropriate for Narritj to care for her due to both their age difference and kinship relation. Various interlocutors described *māri* – *gutharra* relationships as permitting informality and intimacy, and as relationships in which joking and playfulness were expected within age-based hierarchies.

Māri – *gutharra* relations exist in Yolŋu society as kin relations, but also as a relation between clans. While clan membership is patrilineal in Yolŋu society, clans themselves relate to one another through matrilineal relations, as child and mother, grandchild and maternal grandmother, and sister clans. Relations between clans are constituted through interlocking rights and responsibilities in relation to tracts of country and its resources, and Yolŋu have particular responsibilities to care for the clans and estates of their *n̄āṇḍi* (mother) and *māri* (mother's mother) (Williams 1986). In the recent past, *māri* – *gutharra* relations between clans were also enacted through a system of marriage bestowal, in which men typically received wives from their *māri* clan (Keen 2004).

The gendering of care in patients' households was more ambiguous than the ways in which caregiving obligations were understood through the categories of generation, kinship, and clan membership. Amongst my interlocutors, there was a lack of consensus over whether relations of care should comprise caregivers and patients of differing gender identities. Several expressed similar sentiments to Bułanydjan, who sidestepped Narritj's ambiguous gender identity, arguing that caregivers of another gender who were in an appropriate kinship relation were acceptable if there was a large age difference with patients. Others disagreed, and expressed similar perspectives to Waymamba, who thought that patients were (and should be) cared for by caregivers of the same gender identity as patients. She explained, "everybody's involved also, whether you're male or female, look after old man and woman." However, I encountered three young cis-gender men who were caring for elderly female renal patients. A further elderly female renal patient expressed a desire for a male *gutharra* to care for her. A lack of consensus over the gendering of care could potentially indicate changing expectations of care. The increasing participation of young men in caregiving roles is also understandable through the availability of few alternative means of performing social roles associated with physical labor, and perhaps for some also the availability of the Carer Payment.

Expectations of renal patients' care emerge through my interlocutors' narratives as structured by the intersecting rights and responsibilities associated with generation, kinship, clan membership, and, more complexly, gender. As the following sections will illustrate, these social roles and structures, like blood vessels, informed how the reciprocities of care were constituted and how value circulated in relations of care in Yolŋu social bodies. However, when negotiating how renal patients would be cared for, families were also likely to take into account pragmatic considerations, such as young people's responsibilities of care to their own young children, when present. Furthermore, as the following sections will illustrate, relations of care, such as that between N̄arritj and Buḷanydjan are not naturalized and may be made, maintained, fractured, or renewed through social action and in specific circumstances.

"Respect:" The social value of care conferred on Yolŋu with kidney disease

Both Buḷanydjan and N̄arritj volunteered candid details of the intimate form of labor that Buḷanydjan's care entailed on several occasions to me, without any prompting on my behalf, speaking of toilet doors left open and the washing of intimate parts of Buḷanydjan's body. Buḷanydjan did not appear to feel embarrassed or depersonalized by being assisted to carry out such tasks. For example, she explained to me what getting changed in a wheelchair involves in considerable detail, suggesting N̄arritj's care elicited her pride in being cared for. N̄arritj himself described assisting Buḷanydjan to shower as showing his "respect" for her, and explained that "when I first met (came to care for) her she didn't really feel confident with me, understand me," but after he first assisted his grandmother to shower, "she could see I was there for her, I respected her. Then she was very confident."

Concepts of "respect" and "shame" are fundamental to the Yolŋu vernacular of care. Providing care was often described as expressing one's "respect," particularly for Elders. "respect," in some circumstances, could refer to appropriate conduct in relation to or in the presence of anyone older than oneself. For example, an elderly man reprimanded a child, who I related to as an adopted *yapa* (sister), for her misbehavior directed toward pets and other children. The older man admonished the young girl to "stop disrespecting your sister," referring to me. While "respect" could be enacted in care given to anyone considered to be one's senior, respect for Elders took on a particular meaning as a relation of deference. Dianne, another patient, castigated younger Yolŋu who failed to perform social roles associated with providing care to patients from an older generation, explaining that, "not respecting rom (laws, rules or norms in this case, associated with care) devalues our culture. Old people lose value, *m̄arr* (their power, derived through strength of relationships)."

While care within families expressed respect and social value, interlocutors, including patients of various ages, described being without care as a source of "shame." The concept of "shame" in Aboriginal English is typically described in the ethnographic literature as expressing embarrassment, anxiety or unease that results from transgressions of social norms or social isolation (Kwok 2012). Shame therefore may not necessarily result from personal wrongdoing, and may not simply reflect shyness. While a lack of care for renal patients could incapacitate them in bodily and social ways, the "shame" of being without care referred to an absence of respect. Annie described a lack of care from relatives that required her to attend her treatment alone as making her feel "shame."

Yolŋu representations of care as expressing respect meant that renal patients' loss of personal capacity was not necessarily a source of embarrassment. Like N̄arritj and Buḷanydjan, other interlocutors also provided accounts of care with some pride. The first time I met one elderly renal patient, along with his daughter's daughter, the young woman volunteered a description of her domestic labor, describing assisting her grandfather to shower, in his presence, and without evidently invoking his embarrassment. The social meanings Yolŋu attribute to care shaped a patient subjectivity in which bodily dependency was not redolent with stigma, and in which patients' care conferred value on them, diverging sharply from a logic of care advanced by Dylan as entailing devaluation through social indebtedness. Like dialysis treatment, in which patients' blood circulates through machines that remove waste and toxins before restoring it to their bodies, families' care recirculated patients' social standing.

Status: The social value of care conferred on caregivers

Narritj described his care for Buḷanydjan as productive of her acceptance of his gender identity. While Buḷanydjan did not at first “understand” him or “feel confident” with his assistance, according to Narritj, the bodily communication invoked in performing physical labor, such as helping Buḷanydjan to shower, which required Narritj to come to “know her body just as well as she does,” cultivated intersubjective feeling. Narritj related,

In Yolḷu society the rest of my kind are not accepted, sistergirls. But with Buḷanydjan she jokes, refers to female parts, makes me feel happy, accepted . . . she says I’m a woman trapped in a man’s body . . . It was a big change for her too, to be seen by people like me before we had that relationship, but she is beautiful to me, now she fully understands my lifestyle.

By providing care, Narritj earned social approval beyond his family. Other interlocutors also noted that “only Narritj” appeared to be capable of fulfilling many of Buḷanydjan’s needs and that he was performing an “important role.”

Narritj attempted to recreate sensory worlds by cooking for Buḷanydjan, and in doing so, gained privileged access to her memories and knowledge. He told me,

Like some food critics say, a taste of the best food brings memories. . . when I cook her rice she has a different flavour to rice. Yolḷu have songlines about rice. People cook it in a different way, you’ll see it at Galiwin’ku, soft and chunky, mixed with tinned beef and spaghetti. She said take me back to Elcho (Galiwin’ku). So I cooked that and made hot black tea, she tasted it and straight away she was sharing stories from Galiwin’ku and what she used to do, confidential stories. She tells me stories, secret stories she doesn’t tell anyone else, that means I’ve earned her trust as one of her carers.

Notably, Eldership in Yolḷu society is not only a status of age but also a status associated with knowledge and authority, applying to older Yolḷu who have acquired particular knowledge over their lifecourses and whose parents are no longer alive. One Yolḷu woman in her late 40s could acquire the status of an Elder through her knowledge and ability to exercise authority, where another in her early 40s who was thought by others to lack responsibility could be described as a “young person.” Providing care, as an enactment of social responsibility associated with age, thus has the potential to shape the lifecourses of caregivers in Yolḷu society.

The desirability of care work among some younger Yolḷu can be further apprehended through the investment of caregiving in collective forms of social value within Yolḷu families. As discussed above, Dianne described care for Elders as nourishing their *märr* and safeguarding the inheritance of knowledge that was invested in Elders but belonged to whole families or clans. Evoking Yolḷu representations of blood as a sacred substance of kin relationality, Dianne further explained, “if I’m sick, there’s people looking after my blood and the body containing it.” A *djunḡaya* (often translated as “caretaker” or “manager”) is a man or woman with certain responsibilities toward their mother’s clan and its country and ceremonies, who manages affairs and brings people together to make decisions, including during end-of-life proceedings. Of the blood of each clan, and the bodies that hold it, Dianne explained, “*djunḡaya* manages it, *gutharra* cares for it.” In Dianne’s account, caregiving for older or unwell kin represents an act of caring for a social body and the substances that bind it and make it well.

Caregivers’ labor, as a contribution to the collective value invested in relationality, Elders’ knowledge and potency, and ultimately, the survival of a Yolḷu way of life, confers moral value and social status on caregivers. Paradoxically, Narritj’s sistergirl identity embodies what Meiu (2015) describes as a “queer moment,” or a subversive means of achieving otherwise normative forms of value, generated here by caring for the collective blood of a social body. The production of individual and collective value can thus be understood as intertwined in the performance of care in Yolḷu patients’ families.

Care enacted through relations of reciprocity

Buḷanydjan had many needs and made many requests of all of her caregivers, often directing their labor in particular ways. N̄arritj noted the particularity and intensity of Buḷanydjan's requests, describing her as "an old-fashioned diva." Nevertheless, N̄arritj was committed to caring for Buḷanydjan despite the lack of remuneration for his labor. Unlike his aunt Jasmine, N̄arritj was not receiving the Carer Payment, and he also contributed to household rent, bills and groceries with income he earned from a part-time job at a local supermarket. However, I was not left with a sense from Buḷanydjan or N̄arritj that either of them considered their relationship to be one of unidirectional dependency. He agreed that Buḷanydjan was also looking after him materially and through consideration of his needs, telling me, "She is providing a roof over my head. She's always looking out for me, tells me, grab some clean sheets. She looks after me very well." N̄arritj, meanwhile, had a male māri who was also a renal patient living in Darwin. The man, who was one of Buḷanydjan's brothers, was sleeping rough, with no means of accommodating caregivers and other relatives. N̄arritj visited his grandfather at the hospital from time to time but was not caring for him in the same intimate way in which he was caring for Buḷanydjan.

The material needs of renal patients had acquired much greater legibility in Australian social policy than those of many of their caregivers and other kin. As N̄arritj illustrates, not all caregivers were eligible for the Carer Payment; and while other caregivers could often access unemployment benefits or, for those aged under 25, the Youth Allowance, these benefits were paid at levels that fall well below the poverty line, and at much lower rates than the Carer Payment (Puszkas 2019). In contrast, renal patients tended to qualify for the Disability Support Pension, which was paid at much higher rates (Puszkas 2019). Furthermore, renal patients met vulnerability-based eligibility criteria for the priority public housing wait list, where others, including many of their kin, were subjected to long wait times that reached six to 8 years on average during my fieldwork (Puszkas 2020). Although welfare resources were provided to patients to support their own basic needs, on the basis of their limited ability to undertake work in the formal economy, patients often provided material support to their caregivers and wider families by sharing their Disability Support Pensions and social housing abodes with kin.

The reciprocities of care in the families of renal patients encompass material as well as other forms of care. However, as N̄arritj illustrates, caregivers' contributions of labor cannot be interpreted as a direct exchange for housing, income, and food, or as purely mercenary. The anthropology of Australian First Nations societies has often characterized the nurturance of children and youth by older generations as providing the basis for children's subsequent obligations over their lifecourses to their caregivers; while children's nurturance is also described as providing the basis upon which an older generation accepts ongoing responsibility to provide them with food, shelter, protection, and knowledge throughout life (Finlayson 1989; Myers 1986; von Sturmer 1980). Furthermore, as Blakeman (2015) has argued of Yolḷu practices of exchange of material objects, value is invested not in objects themselves but in acts of reciprocity that reproduce interdependent relations and intersubjective feeling. Remuneration for caregiving, through the Carer Payment and the material reliance of young Yolḷu on older generations, thus incorporates care for renal patients into Yolḷu moral and emotional economies, and social expectations of age.

Care for Yolḷu with kidney disease can be understood as taking the form of generalized reciprocity (Sahlins 1974:193–194). Younger Yolḷu care for older generations as an open-ended form of contribution that encompasses both abiding and immediate obligations and entitlements. Among interlocutors, rumors frequently circulated that certain kin were "not properly looking after" relatives undertaking dialysis, although these kin still generally received material support from their families. However, there were limits to the tolerance of both caregivers and patients who did not receive what they understood themselves to be owed. Yolḷu domestic moral economies of care foreground the circular flows of care and value that sustain physical and social bodies, and not transfers or exchanges requiring direct reciprocation of labor and resources.

The circulation of care and value

To some extent, a Yolŋu ethics of care, when fully realized, may actualize the visions of both feminist and disability movements, despite emerging from different ontologies, by both recognizing and valuing the contributions of caregivers and achieving the social inclusion of people who require care. Caregiving, understood as nurturing the lifeblood and collective inheritance of families and clans, imbues caregivers' labor with the worth of essential and meaningful work. Yolŋu moral values of care also precipitate Yolŋu understandings of the bodily dependency of patients on their caregivers, in ways that are not constitutive of social inequalities. Yolŋu practices of care can thus be understood as not only implicated in the making and sustaining of a relational mode of personhood, as the anthropology of care has often illustrated (Buch 2015), but as also augmenting the social status of both caregivers and renal patients cared for. This of course does not mean that caregiving might not conflict with other values and activities. Nevertheless, the particular circumstances of renal patients' conditions may work to fortify Yolŋu values and practices of care: of chronic disease epidemics, few nursing homes and other support services in remote areas, social security incomes for (some) caregivers and limited other means for young people to perform social roles in both formal and customary economies.

A Yolŋu ethics of care might be considered an instance of "radical care" (Hobart and Kneese 2020), running counter to prevailing Western societal values that foreground individual achievement, particularly in formal economies, and accompanying neoliberal social policy agendas that poorly remunerate care. However, ethnographic examples abound of care imbued with a high degree of worth in connection with its moral value. Aulino (2016) describes how caregiving in northern Thailand is understood as producing Buddhist merit and good karma. Warren and Sakellariou (2020) discuss how people with neurodegenerative conditions and their caregivers in Australia and the UK cast caregiving as an extension of social roles, in ways that avoid constructing care and the people who require it as burdensome. Jolliffe and Worland (2018) illustrate how Karen associate care for Elders with the intergenerational transfer of Elders' knowledge, and with the Karen notion of honor. As with these accounts, Yolŋu understandings and practices of care may be to some extent culturally and contextually specific, while similarly investing value in both caregivers and those who require care.

Drawing on Graeber (2001:1–2), care can be understood as carrying value in at least two separate but interconnected registers. It can express a set of moral commitments informed by cultural schemas associated with the important things in life, meaningful action, our expectations of others and ourselves (Dawson and Goodwin-Hawkins 2018; Stevenson 2014). At the same time, care can be conceived of as imbued with a particular worth, which may or may not be measurable, exchangeable, or compensatable in monetary terms; something, which might in some instances be treasured, while in others devalued or exploited to create surplus value (Baldock 1997; Hochschild 2000). In the first sense, a Yolŋu ethics of care as practiced by renal patients and their caregivers expresses value in people, kinship, *märr*, Elders' knowledge and moral authority, and clan alliances. In the second, through this set of value orientations, Yolŋu practices of care confer value on both caregivers and people cared for. I suggest that the ethnographic account presented here of a Yolŋu ethics of care can not only broaden our understanding of the range of moral values and practices of care, but also of the ways in which care may carry and confer worth. In the following, I attend to the dynamic interplay between these registers of the value(s) of care.

A Yolŋu ethics of care illustrates how care can sustain particular kinds of life and confer worth in analogous ways to blood, through its circulation. As Baldassar and Merla (2014) argue, care, when it takes the form of generalized reciprocity, can be understood to circulate as it is embedded within family members' enduring, open-ended commitments to one another that are never canceled out through reciprocation. Care in Yolŋu families flows in multiple directions, and can be further apprehended as leaving traces of value in the bodies of patients cared for and in the respect attributed to them, as well as in the social esteem and material well-being of caregivers. Circuits of care propagate rather than redistribute or transfer value among caregivers and receivers. Gifts of care, while at times

taxing of caregivers, do not produce social debts among kin as care is encompassed within broader material and non-material co-contributions in both an immediate temporality and over lifecourses. In other words, families do not cast patients' care as burdensome as it is understood as an element of the give-and-take of life. As Graeber (2001) argued in relation to generalized forms of reciprocity more broadly, value is not transferred from patients to caregivers because the gift of care is never entirely alienated from the giver, whose contribution of labor is recognized. Due to the association of care with givers, caregiving does not bring care into commensuration with other forms of contribution, but rather, keeps care and value in motion.

Value does not flow in circuits of care in ways that alter social hierarchies, as in agonistic forms of gifting. As Graeber (2001) noted, gifts that are not commensurable with other contributions do not create equality between contributors. Yet, neither is care seen by Yolŋu as appropriating value from caregivers to care receivers. Some feminist critiques hold the gendering of care and the non-remuneration of women's household labor to be the universal source of women's oppression (see for example Beneria 1979; Jackson and Jones 1998). Gendered and particularly generational divisions of caregiving labor in Yolŋu families, however, are subject to different forms of value and exchange than those presupposed in such analyses. Notably, First Nations feminists have often articulated pronatalist aspirations, which celebrate the social roles of First Nations women as caregivers and which seek to change the position of First Nations women in broader society but not necessarily in First Nations societies (Moreton-Robinson 2000). Care is inalienable from its givers because it contributes to collective forms of value in which all partake. Strathern (1988) illustrated how in Hagen, Papua New Guinea, women's household labor is invested in the rearing of pigs that subsequently produce social value in ceremonial gift exchange undertaken by their husbands in a public domain. Although status hierarchies of gender exist, women are not alienated from the products of their labor as they partake in the social status acquired by their husbands through the gifting of the pigs. Somewhat similarly in Yolŋu families, flows of care do not ultimately alter the relative status of caregivers and those in their care.

However, value does flow in circuits of care in ways that have the potential to shape the social status of caregivers in other ways. Circuits of care may invoke intersubjective feeling and obligations to others, but not necessarily pure altruism. Caregiving in Yolŋu families can be understood as conferring social value on caregivers in comparison to their peers. The desirability of care work among some younger Yolŋu caregivers can be apprehended, at least in part, through the capacity for caregivers to gain recognition as people who respond to others' needs, within generational hierarchies. As in Graeber's conceptualization of value (Graeber 2001:45–47), social worth can only truly be realized through others' eyes. While N̄arritj's sistergirl identity marked his relationship with Buḷanydjan as an interdependent relation of mutual recognition in particular ways, I argue that interdependent relations of mutual recognition are intrinsic to circuits of care animated by generalized reciprocity.

Conclusions

As my Yolŋu interlocutors demonstrate, the circulation of patients' blood through their bodies, and its capacity to continue flowing through dialysis machines, depends on the circulation of care in their families. At this juncture, it is worth considering the epistemic violence inflicted by assumptions about the gift of (health) care and the way it distributes value illustrated in the opening vignette. Renal service policy documents and health professionals articulate particular notions of patient empowerment. These were enacted by some health professionals in ways that cast renal patients' health care as commensurable and exchangeable with other forms of care, as attracting social debts to patients' families and health care systems, and as repayable through patients' contributions to renal services, in ways that might invoke the "disrespect" of Yolŋu patients. Conceptualizations of care as a burden that transfers value from patients to health professionals and health systems animate "self-management of care" discourses in biomedicine that hold caring for oneself to be empowering, and receiving care from others to be

inherently devaluing. Self-management discourses that invest value in patient independence and the recalibration of relative value through patients' immediate reciprocation, are enacted by health care systems in ways that increasingly shift health care into patients' homes (Danholt and Langstrup 2012). Self-management programs often attempt to remodel patient conduct and subjectivity according to neoliberal ideals of individualistic, self-sufficient personhood (Borovoy and Zhang 2017; Lupton 2013), in ways that have the potential compromise the sets of relations and reciprocities through which care and value circulate in Yolŋu families, and which sustain patients and their treatment.

As the anthropology of care has comprehensively shown, and as such points of contention further illustrate, care is a morally ambiguous practice that may contain possibilities of enacting moral commitments and exploitation, responsibility and paternalism, personhood and dehumanization, love and violence (Heinemann 2015; Stevenson 2014). Nuanced conceptualizations of the ways in which value is produced and distributed through care are therefore needed, beyond polarized approaches that assume the exploitation and devaluation of caregivers or the generation of social debts and inequalities among people who are cared for. In this article, I have argued that when care takes the form of generalized reciprocity, value may circulate through care in ways that do not necessarily transfer worth between caregivers and receivers or transform their relative social standing. The value of care in this instance can be understood as emerging through dynamic processes of action and recognition. In the circuits of care I have described, we need not necessarily assume that either bodily or economic dependencies entail stigmatized forms of social dependency. Rather, the circulation of value through care calls on us to attend to how interdependencies are constituted and legitimated and how altruism and self-interest are entangled in the production of individual and collective value. Care in this instance is perhaps more akin to an investment than a gift, which over a range of temporalities can nurture value, particular forms of life, and life itself.

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