

Medical pluralism and kincentric care in Indigenous Australia: Yanyuwa experiences of illness and the importance of keeping company

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Abstract

For over four decades we have collaborated as a team of anthropologists and Indigenous Elders of the Yanyuwa language group. The Yanyuwa are the Indigenous owners of lands and waters in Australia's Gulf of Carpentaria. While medicalized healthcare has not been our specific research focus, wellness and ill health have been recurring themes. Death has been tragically prevalent. So too has been a sense of liveliness among households in the remote township of Borroloola. This paper explores ethnographic moments that speak to how Yanyuwa experience illness, as a bodily, relational, and communal possibility. Building out from these, we reflect on how people in this community seek to survive, in part, through kincentric relationality: the art of *keeping company*. Reflecting on culturally nuanced responses to illness supports anthropological engagements with connections that heal and those that pose a threat, offering some insights to progress efforts in medical pluralism and kincentric care.

KEYWORDS

keeping company, kincentric care, medical pluralism, Indigenous Australia, Yanyuwa

INTRODUCTION

In 2006, during a period of fieldwork, the authors of this paper were part of a conversation that took place in the remote community of Borroloola, Northern Territory, Australia. Author, Amanda Kearney has collaborated with Yanyuwa since 1999, having been introduced to the community by co-author John

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Bradley, who himself has collaborated with Yanyuwa since 1980. The group of Yanyuwa women who led this conversation ranged in age from their mid-30s to early 80s and included authors Dinah Norman a-Marrngawi, Mavis Timothy a-Muluwamara, and their close kinswoman Annie a-Karrakayny. What is remembered from this discussion is a question asked by Elder Annie a-Karrakayny: “Why do our people die?”

Annie posed the questions in a rhetorical spirit, as a search for meaning. It sat amid a broader conversation that included time spent discussing the sudden death of Annie’s son. Her son had left the township urgently via medical evacuation to the region’s major city of Darwin and did not return alive. His mother was not informed of the evacuation, nor was any of his kin, leaving the family unaware until the terrible news of his death arrived. The event emphasized a breakdown of trust between health care providers in this remote Aboriginal community and its Indigenous residents; it also signaled the dangers of disconnection and taking Yanyuwa far away from their trusted kin who can care for them during times of illness. Families feel dismissed when they are not informed of medevacs involving their kin, and this leads to a growing sense of mistrust in Western health care services. Experiences such as Annie’s are not isolated and are known to induce a sense of uncertainty for families and fear of what will happen to their kin when they are taken away from their home and township in this part of remote northern Australia.

During this same conversation we discussed the remote township’s health clinic, problematic nurses, and the recent diagnosis of a young Yanyuwa woman with ovarian cancer. Her diagnosis had come too late and, according to the women, after a great many months in which the local remote area health clinic had repeatedly prescribed her Panadol, paracetamol—a non-opioid analgesic and antipyretic agent used to treat fever and mild to moderate pain. Sometime later this young woman was moved from her home to the local aged care facility, where she received care, and later to the hospital in Darwin. She died there, in the company of Mavis a-Muluwamara, her *likili-nganji* (most necessary companion/family), who had travelled with her and stayed by her bedside until the end.

Stories such as these foreground the central concern of this article: that illness and death in Borrooloola must be understood on more than biomedical terms and should also be read through the lived realities of kinship, Country, and Indigenous Law. The practice of capitalizing the terms Law and Country in this paper reflects a preferred Indigenous Australian convention. Capitalizing these terms shows respect and highlights the importance of Law and Country for Indigenous people. It also signals that these are official designations and denote the ancestral lands, waters, culture, and origins of specific Indigenous language groups. For Yanyuwa, Law is a nuanced schema for human existence that goes beyond a system of justice or governance to shape and give meaning to all aspects of life. Yanyuwa conceptions of self, land, and sea emanate from their Law, and Law exists as a lattice of conceptual interconnectivity binding families to one another, to the broader natural environment, and to place and ancestors. Illness and care can also be understood in relation to Law, for they are deeply shaped by relations of trust and mistrust—care as trusted between kin, and Country, and mistrust in the separation of Yanyuwa from kin and Country. By recounting a series of grounded experiences, we advance medical anthropology by theorizing kincentric care as a health paradigm in which wellness is produced through trusted relations among people, kin, Country, and nonhuman kin, rather than located solely in individual bodies that move through Western medical systems.

By extension we frame illness and care through a lens of medical pluralism, which refers to the co-existence, interaction, and negotiation of multiple explanatory models and care practices, including biomedical, kincentric/relational, and ancestral within the everyday management of illness, care, and dying in Borrooloola. Drawing on four-plus decades of collaborative ethnography, we document plural etiologies and show how living Indigenous Law shapes care, decision-making, and survival. Ethnographic cases organized around accounts of dialysis displacement, medevac experiences, delayed diagnosis, and keeping company (*likili-nganji*, *yumarra*) reveal accompaniment with kin and Country as an essential clinical infrastructure. We argue that disconnection from kin and Country is pathogenic,



FIGURE 1 Yanyuwa Country, Northern Australia (Source: Author).

with direct implications for ongoing health care provision and service design in remote community settings like Borroloolo. In Borroloolo, health outcomes are inseparable from questions of trust: in kin, in Country, and in the institutions that claim to care for Indigenous lives.

PANADOL FOR EVERYTHING: WESTERN MEDICINE IN A REMOTE ABORIGINAL COMMUNITY

Borroloolo is located 1100 km from Darwin, in Northern Australia (Figure 1). The population is around 755 people, with the majority being Indigenous people of the Yanyuwa, Marra, and Garrwa language groups (Yanyuwa et al., 2003). Founded in 1901, Borroloolo township has all the hallmarks of a colonial outpost into which Indigenous people were relocated and moved gradually from around the 1950s. Located within the township is a health clinic, established around 1967, which over the years has moved from small to medium-sized facilities, contracting and expanding in capacity with a part-time and other times permanent doctor, remote area nursing staff, a visiting dentist, and more recently some mental health services (Figures 2 and 3). In 2006, around the time of the above-mentioned conversation, the clinic did not have a full-time doctor, and we had witnessed several verbal altercations between nursing staff and locals within the clinic. At present the clinic does not have a full-time doctor. In addition, there are currently no Aboriginal nursing staff working at the clinic, with the only local Yanyuwa person employed by the clinic being the “driver” who picks up patients and returns them home.

In 1981, when John Bradley, was living in Borroloolo, and working as a teacher at the local school, he himself nearly died of a burst appendix. When seeking urgent medical assistance at the local health clinic, nursing staff had dismissed his concerns, telling him he had a “worm infestation, probably from knocking around with Aboriginal people.” Bradley’s burst appendix required urgent medical attention, and according to Yanyuwa Elder Pyro Dirdiyalma, the rapid onset sickness was attributable to an act of sorcery against Bradley. Dismissive tendencies among healthcare providers characterize many of the historical accounts of local people’s interactions with the clinic in this remote township. Non-



FIGURE 2 Borroloola remote area health care clinic (Source: Author).



FIGURE 3 Borroloola renal unit (Source: Author).

Indigenous nurses at the clinic have been described as “cheeky” (rude or racist) and have at times spoken to people “as if they were stupid.”

Indigenous health clinics often have a fraught place within remote communities like Borroloola and can struggle to foster Indigenous community trust even in urban centers. Carlson and Frazer (2020, 88) have explored these relationships of trust, tracing the breach of trust as linked to experiences of intergenerational trauma related to past and present policies of removal and assimilation, racial discrimination, and a monocultural approach to health and well-being. These are read as harms that fracture relations of trust between Indigenous people and state-run health care services (Carlson & Frazer, 2020). Carlson and Frazer explain that from an Indigenous perspective, the spread of perceptions of trustworthiness or lack thereof can often be traced to localized relational encounters.

“Word spreads through family and community networks about whether particular health professionals are trustworthy or not” (Carlson & Frazer 2020, 93). Talk of mistrust has a profound influence on the nature of relations, which can turn tense and slip into unhealthy patterns of blame, suspicion, mistrust, judgement, and poor communication. Trust in health care services is a topic that has been

widely explored by Bury (2004), Carlson and Frazer (2020), Brownlie and Howson (2006), and Brownlie et al. (2008), and is reflected upon here in broad terms as a critical piece of the relational pact that accompanies care—whether as provided by outsider healthcare workers, or by kin.

Given the limitations of the remote area health care services in this community, there is a heavy reliance on medical evacuations out of Borroloola, a service provided by CareFlight NT, and the Royal Flying Doctor's Service. This is referred to locally as “the doctor plane.” The sudden and often unexpected nature of medical evacuation can cause communal distress as news or misunderstanding travels quickly throughout the community. This is illustrated by the instance in which Annie's son was taken away and later died in hospital, prompting her to ask the heartbreaking existential question, “why do our people die?”

In asking this question, Annie was drawing on several threads related to life and death in her community. Many of these do not have clear and present answers but gather to form a broader search for meaning around the following:

- Why people die away from their family and ancestral lands and waters?
- Why people die when they have sought medical assistance?
- Why so many people die, across age groups in this community?
- What is the cause of death in many of these instances?

For Yanyuwa, questions about illness and death are rarely left at the level of a clinical diagnosis or single cause. Instead, they are drawn into a wider search for meaning that reflects a cultural tendency to explain imbalance through reference to Law and relational frameworks. Annie's search for insight is an act of tracing connections across domains of life.

The 2021 Australian national census provides basic insights into the health status of people in the Borroloola community, according to Western medical diagnoses. This remote community is made up of 80% Indigenous residents (Australian Bureau of Statistics [ABS], 2021). It is a very young population, with around 25% of the total population aged between 10 and 24 (ABS, 2021). Less than 7% of people in Borroloola are aged over 65 (ABS, 2021). Kidney disease is reported among 3% of the population—relative to a national average of 0.7% (Devitt and McMasters for an account of the shocking rise in the number of Indigenous kidney dialysis patients in the Northern Territory between 1987 and 1993) (ABS, 2021). Diabetes and heart disease are also reported as well above the national averages. One of the few health conditions in Borroloola rated below the national average is that of “mental health conditions,” which are reported for only 2.8% of the population in Borroloola, compared to 8.8% nationally (ABS, 2021).

While we recognize the limitations of census-based health data, the patterns are widespread enough across Indigenous communities in the Northern Territory, as to warrant mention and to suggest patterns of a health crisis pertaining specifically to kidney disease, diabetes, and heart disease (Australian Government, 2024). Yet, this is only one part of the picture concerning health and well-being, ill-health, and the threat of illness in this Indigenous community (also Chenhall & Senior, 2018). Therefore, we must consider the culturally nuanced contexts in which Yanyuwa self-determine understandings of wellness and ill-health in this remote part of Australia. Starting with the Yanyuwa language, documented by Bradley in collaboration with Yanyuwa Elders, health is explored through the philosophy of meaning that shapes a Yanyuwa worldview, revealing relational ontologies as well as moral and cultural priorities (see Bradley with Yanyuwa Families, 2016, 2017).

While the Yanyuwa language is rich in its directional, ecological, and kincentric orientations, specifications around health and well-being as located in the individual body, are more oblique. In Yanyuwa there is no all-encompassing term that would align with a notion of “healthy,” and the following terms articulate a Yanyuwa linguistic framing and understanding of health and wellness:

Buluwarrinjarra – Feeling well, content, at ease, no stress



FIGURE 4 Yanyuwa family, including Jemima and Don Miller, photographed with two of their children (Source: Author). Such images, when looked upon by Yanyuwa today, are regarded as taken at a time when people were strong and healthy in the fullest sense of being on Country and with family. It also signals a time before families were heavily fractured by premature deaths and illness.

Yabilyabimantharra – Making/improving/building/mending/fixing/correcting/healing

Lumbu – Strong/healthy of both body and mind

Wirndalbirndal – Healthy, as indicated by hair as shiny, thick and healthy. This external display of health is attributed to the physicality of dugong hunters of esteem. Dugong fat is said to make skin and hair glisten.

Wardirrinjarra – Becoming unwell, worsening, tired feeling

Yabirrinjarra – Becoming well, getting better, being alert

Birrinbirrinnyi – Mentally unwell, naughty, disobedient, deaf, hard of hearing, mad

Yakayaka, yakiyakirrinjarra – Deaf, insane as a result of a fight, accident or the effects of sorcery

There is a strong leaning in the Yanyuwa language toward a sociality of health, which is indicated by the frequent association of health-related matters and ill health with the effects of sorcery, power, and a generalized sense of “things being right, or proper,” or aligned with a broader social contract of relations, and Yanyuwa Law (Figure 4; see Reid, 1983, for a discussion of sorcery and Yolngu theories of sickness, treatment, and Western therapeutics).

Expressions related to health and well-being are more commonly found in compound words. For example, the source of an individual’s well-being is reckoned through the stomach, which is also considered the center of one’s feelings. So, one would ask:

Wayi barra yinda? – How are you?

Depending on how you feel you might say:

jarna-yabirri ngarna-wurdu – (feeling good) “I am feeling goodness in my stomach,” or

jarna-wardirri ngarna-wurdu – (feeling not good) “I am feeling badness in my stomach”.



FIGURE 5 Dinah Norman a-Marrngawi photographed with her daughter Leanne and two sons, Jeffrey and Leonard, in the late 1970s (Source: Author).

Exhaustion from physical effort or extreme illness is measured in the chest through the *wurdula*—one’s heart, or one’s life spirit. In which case a person might say *jarna-wurdulanbayarra*—“my life spirit is falling.” This could mean being weak, being extremely ill, or sick. In times past, when a “traditional doctor” or “healer” (*mankarni*) was called to work on people who were unwell, they sometimes addressed this spirit through songs and massage. This was an action described as lifting the spirit up or cleaning the chest. A very healthy person could also be described as *ngar-ramilimili*, that is “warm chested,” as one for whom “the life spirit is strong.” It is this spirit that is attacked when sorcery is being talked about as inflicting illness or suffering upon a person.

Another way of expressing health is through the word *yanyka*. This word can mean personality, or the way a person looks. For example, a woman might say of a man *nya-yabiyanyka*—“he is looking good, his personality is strong and vibrant,” which also means that a person can fulfill all of their kinship requirements. For a woman one would say *a-yabiyanyka*. Bradley recalls conversations with Dinah Norman a-Marrngawi, who described her adult children, Leanne, Jeffrey, and Leonard, as *li-wardiyanyka* “they are not looking good, they do not carry themselves strongly, they are unable to fulfill normal obligations” (Figure 5). All three tragically passed away within a 3-year period, in their middle age.

ETHNOGRAPHIC ACCOUNTS OF HEALTH, SICKNESS, AND CAUSATION OF DEATH

In the following section we outline a series of ethnographic examples that introduce the reader to some aspects of Yanyuwa experiences with illness, causation of sickness, and threats to well-being.

Three pandemics

Yanyuwa have social memories attached to living through three pandemics: Covid (2020–2023), the Hong Kong Flu in 1969, and the Spanish Flu in 1919. For Yanyuwa, the COVID-19 pandemic was understood primarily as a “whitefella virus,” brought to Australia by tourists returning from overseas and the product of Western science. This perception was fueled by the fact that people now have widespread access to news media and were able to follow reporting on the origins of the virus in China, a loca-



FIGURE 6 A satellite image of the Flu Dreaming in the southwest Gulf of Carpentaria. (Source: Google Earth).

tion and cultural setting far from the Yanyuwa lifeworld. Graham Friday Dimanyurru, remarked, “That thing on the news they talkin about. They reckon that thing [virus] started off in a laboratory, in Wuhan. Gammin they been say it’s a man-made thing, yeah, they cooked it up and then it broked out of there.”

Of the threat to Elders and the need to care as a community, Warren Timothy explained local efforts, such as social distancing, to ensure that Elders (as a vulnerable population) were not exposed to the virus, “When the old people go to the shop, we just step back and they close the shop and let all the old ladies do their shopping. Gotta look after the old people, because they’re the ones get really sick with this virus.” Gloria Friday reiterated the collective urge to look after Elders, “...today there is only a few old people left and I just feel real broken up because they are special, very special...that’s where you’re going to find your culture and your health, and that’s your Law” (Norman et al., 2020, 2021). The benefits derived from social distancing were traced to the continued health and presence of Elders in this community. They are considered persons in possession of the most substantive body of knowledge related to Yanyuwa Law and their instructional importance in teaching mid and younger generations is regarded as unparalleled in this community.

The earlier Hong Kong Flu and Spanish Flu pandemics were very different experiences in terms of sickness, impact, and causation. Both were attributed to sorcery and the desecration of sacred sites. To the northwest of Borroloola lies the site of *Ngangkarrdila*, a place delineated by the presence of the Flu Dreaming (Figure 6). Dreamings are the ancestral beings that created patterns in the land and sea (Kwaymullina, 2005, 14). The Flu Dreaming is a location associated with the actions, intentions, and presences of ancestral beings that have left some form of mark or expression in situ. The root word of this place name is *ngangkarr*, the Yanyuwa word for sputum, nasal discharge, or snot. Just north of this site is another site called *Wurrwurr*, which literally means “cough” (Figure 6).

Yanyuwa Elder Old Tim Timothy Rakuwurlma described these places as follows: “Oh! Too dangerous, don’t go there, don’t touch that place, walk through that place and that sickness will come, just like a flu, people will get really sick, it is a place of a terribly bad sickness (*narnu-bulmunkurru*)” (Bradley ethnographic fieldnotes, 1985). The sites of *Ngangkarrdila* and *Wurrwurr* are associated with the Black-nosed Python Dreaming Ancestor. Power songs (*narnu-nyiri*) to spread the flu and to heal from the flu are also associated with this Dreaming.

The Spanish Flu, the earliest recorded pandemic experienced by Aboriginal people in this region, was, according to some Yanyuwa, associated with sorcery enacted at this site. Others explained it as

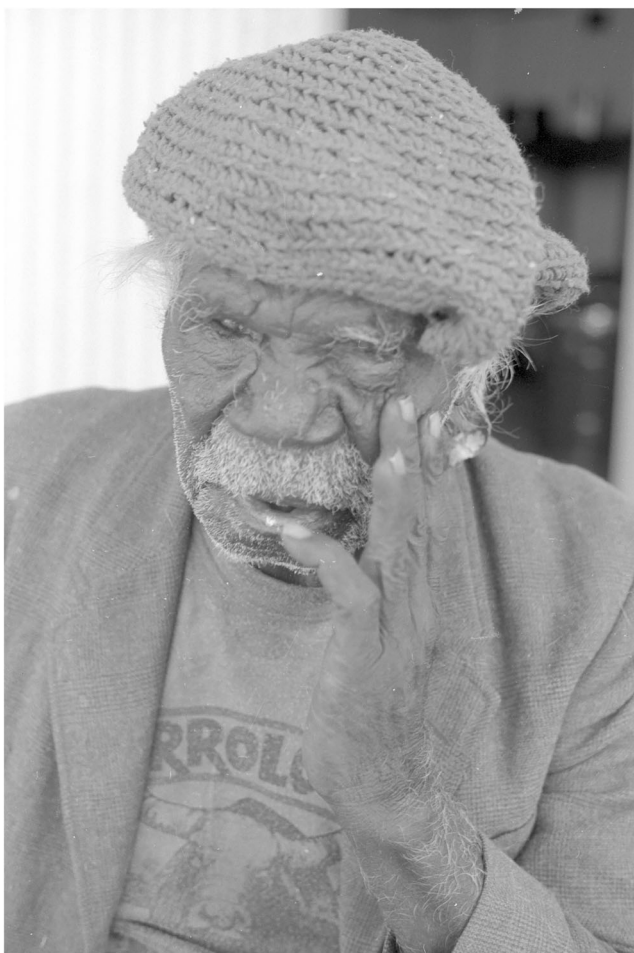


FIGURE 7 Old Tim Timothy Rakuwurlma, the holder of social memory of the Spanish Flu in 1919 (Source: Richard Baker).

the result of cattle breaking branches from the ironwood tree associated with the site. In 1985 Old Tim (Figure 7) spoke with Bradley about this early pandemic:

Just after the war [World War I] old people died from that flu, really bad flu, that flu came from jealous people, they hit that tree, that Flu Dreaming tree. A lot of them old Wurdaliya men died. Too much. That Flu Dreaming was their countryman.

The Flu Dreaming is located on Wurdaliya clan country. Given the close ties between clan groups and their ancestral lands and waters, it is a Yanyuwa understanding that any damage to this part of Wurdaliya country would cause the greatest suffering for its human Wurdaliya counterparts. In turn, it was primarily Wurdaliya Elders who died from this flu.

The Hong Kong Flu of 1969 was also associated with sorcery, introduced to the community by Aboriginal men who had come from another community for the Borroloola rodeo. They are said to have ensorcelled local Yanyuwa with illness because of jealousy. The Hong Kong Flu led to the death of many Elders and brought great fear and sadness to Yanyuwa families. Graham Friday Dimanyurru, recalls his memory of the Hong Kong Flu:



FIGURE 8 Eileen McDinny a-Manankurrmara, the key narrator of the Hong Kong Flu story (Source: Richard Baker).

... I was only 10 years old, just young fella. I still remember because I been see all the old people die... That Hong Kong flu was bad. I seen all my old people die. I remember I used to go with all them mob to that cemetery and bury all them old people. You know. Old people for all families, different families, kudardi [they all went].

The death and sickness that came with this flu was explained by Eileen McDinny a-Manankurrmara (Figure 8) as follows: “Rodeo time, a lot of strangers that year, they put that flu (through sorcery) in this country”. Eileen continues:

They were all there and they all died, the old men and women at camp on the east bank of the river... It was a long time ago, they died then. We were there cooking bush medicine for them... We used to lift them up and bathe them, one by one, we would wash them first, after washing them we made their beds for them and then helped them to sleep. We were there with heads bowed, praying for them, and we would sing for them, for those who were very sick.

... They all died, those old people. We couldn't cry because too many of them died at once, all of those men and women.

The attribution of blame in the case of the Spanish Flu and the Hong Kong Flu came through matters of Law and sorcery. There are key differences between Yanyuwa and Western frameworks for diagnosing and understanding illness: “Western medicine is primarily interested in the recognition and treatment of disease,” while Yanyuwa seek “to provide a meaningful explanation for illness and to respond to the personal, family and community issues surrounding illness” (Devaneson, 1985, 33).



FIGURE 9 Yanyuwa Law man, Leonard Norman Wungunya (Source: Author)

Leaving home to get advanced health care

Leonard had a toothache for years. It got worse, and his face swelled. His speech was impaired, and he started to carry a small handkerchief to cover his mouth. He was eventually diagnosed with advanced oral cancer. There were no treatment options available within the community and only limited treatment options in Darwin Hospital, 1100 km from Borroloola. He received intensive chemotherapy and radiation therapy in the more distant southern city of Adelaide. Posttreatment he was able to return to his community but was later sent back to Adelaide Hospital (2800 km from Borroloola) for mandibulectomy surgery, a procedure that involves removing part or all of the mandible and reconstruction of the jaw, to rectify bone damage caused by radiation therapy.

Leonard spent months in the big city hospital, travelling there with his wife. She was provided with temporary accommodation some distance from the hospital. Amanda Kearney (author) lived locally and for the duration of Leonard's time in hospital would visit daily to sit and talk with the couple, delivering home-cooked meals, magazines, and other simple items to make time in this strange place somewhat easier. Leonard's wife hated being alone at the accommodation and most often slept at the hospital on an uncomfortable bay window cushion with a scratchy cotton hospital blanket. She herself was diabetic and, rather worryingly, subsisted on hospital-provided sandwiches and tinned fruit for breakfast, lunch, and dinner. Leonard could not speak because of his surgery, and, to communicate, the couple passed notes to one another.

Leonard was a head Indigenous ranger in his community's Sea Ranger Unit and had passed through men's Law and ceremony befitting a senior member of this community (Figure 9). He was a man of great standing, kind, eloquent, educated, and firmly in possession of his ancestral Law.

The couple held close to one another in this strange, big-city place and relied on the telephone to stay in touch with family back in Borroloola. Once back home, and once Leonard had restored some of his ability to speak, he reflected on his own personal experience of being unwell and recovering from surgery in a strange city, “no one should sit down alone in a hospital, there has to always be someone there to look after you. Even now since this operation, I got mum across the camp, always someone there to look after you, my son here, my daughter, and big family, all here...it’s no good to be alone.” In-hospital patient care and the likes of company provided by Leonard’s wife are of critical importance for all Yanyuwa who leave their community for health care treatment. This role is referred to as being “*likili-nganji*”—a most necessary companion.

When Leonard passed away a year and a half later, it was a tremendous loss for everyone in his community. Of course, on the outside people say that Leonard died of cancer because he smoked too much, yet the “inside” explanation of his death, the sense-making around this terrible loss, was that he had experienced the effects of “breaking Yanyuwa Law.” His mother, Dinah Norman a-Marrngawi, and other relatives spoke quietly of the causation of his death. On this matter, they were beside themselves and recalled that it was during the holding of a high-level ceremony, *a-Kunabibi*, that a transgression of Yanyuwa Law occurred.

When one dances in *a-Kunabibi*, one must stay on the ceremony ground all night, and the sacred body designs that are painted on the body for the ceremonial performance must be faded by the morning. However, during the night a rumor came to the ceremony ground that Leonard’s then-wife was running around with another man. The rumor was false, but Leonard did not know that, and he left the ceremony ground still heavily decorated, and wearing the sacred body designs, he went down to his home, in the Yanyuwa camp, to see if the rumor was true. His decision to do this was considered a catalyst for his eventual illness and death, for it was believed that his choices had led to sorcery being enacted against him. Such an outcome registers as one of the most tragic outcomes of breaking Law, a Law that senior Yanyuwa contend finds ways and means to redress improper action, even many years later.

Kidney disease and dialysis dependency far from home

“I feel so sad. I feel lonely. I miss my grandkids, I miss my partner. I miss hunting, fishing, going out on various places. I miss Borroloola and my family” (Gloria Friday, interview 2020).

Gloria was diagnosed with kidney disease in her early 50s yet managed her condition for well over a decade with a strict adherence to a healthy lifestyle (Figure 10). She achieved this through personal discipline, and an overwhelming desire to stay with her family and in her Country, “I could have died long time ago but I’m a strong person and I’ve got family. That’s where you’re going to find your culture and your health, and that’s your Law” (Gloria Friday, interview 2017).

Gloria’s greatest fear was having to move away from home should the disease advance and require medical intervention. She maintained her closeness to home until such time as she reached the point of needing dialysis three times a week, at which point she was compelled to move to the city of Darwin. At the time (2015), the Borroloola health clinic did not have a renal unit, nor a renal nurse to allow people to reside close to home while receiving treatment. A renal unit came later but requires that patients self-administer their treatment. When Gloria had to move to Darwin, she would often express the depth of her homesickness and sense of social isolation. Living in Darwin, she found herself with no house and very little money and adhering to a dialysis schedule of three, 4.5-h sessions per week.

Community commitments, such as funerals or the annual rodeo, would often draw Gloria back to Borroloola, at great risk. In an interview with a local journalist in which she discussed the lack of dialysis



FIGURE 10 Gloria Friday in the peak of health before commencing dialysis, photographed here with author Amanda Kearney (Source: Author).

facilities in remote communities, Gloria explained how she managed these visits home, “I just go for a couple of days; I miss one dialysis, I come up to Darwin and empty fluid” (Ryan, 2019). The news report continued:

She could manage this as long as she did not drink too much fluid. If she did, and needed medical intervention, the situation was complicated by the fact that, as she explained, “the nurses [in Borroloola] want to have nothing to do with dialysis mob,” she said. “They’re very strict”. On this occasion, Friday said she was “overflowing with fluid.” She called Borroloola’s Community Health Centre for help. “And then [the person who answered the phone] said to me, ‘Well, I’m very sorry, we can’t do anything for dialysis patients.’ I said: ‘Why?’. She said: ‘You people ought to learn to look after yourself’. I said, ‘Look, that’s not fair, you should come and check me out anyway.’ That night, my life was threatening. I was short of a wind. And she wouldn’t come” (Ryan, 2019).

Eighty percent of dialysis patients in the Northern Territory are forced to relocate from remote communities to urban centers (see Devitt & McMasters, 1998; Dussart, 2009, 2010). Even if remote dialysis is available, for people who lack confidence or who have visual impairment (as Gloria did), self-dialyzing is not an option. Thus, they are left with little choice and face the reality that leaving behind Country and family has debilitating psychosocial effects. Gloria passed away in Darwin Hospital and was never able to return permanently to her family and home.

Renal matters are such in this community that many people who travel to Darwin for dialysis simply cannot sustain their lives there and choose to come home and die with their families (see also Devitt & McMasters, 1998). This was the case for Elder Billy Miller, who expressed to his sister Dinah Norman a-Marrngawi and John Bradley that all he needed was to be with family and make a few trips to Country.



FIGURE 11 Family members gather at the Borroloola cemetery (Source: Author).

Often as people's health declines, they express a strong urge to go bush, light a little fire, and sit and talk about how Country is peaceful and makes one feel good.

SEEKING EXPLANATIONS FOR ILLNESS AND CAUSE OF DEATH

When Gloria passed away in the Darwin hospital, people's tears communicated an even greater depth of sadness at the thought of her being alone in the city, without her trusted kin for care and company. In cases such as this, people understand the nature of the illness that has caused a person's death. Yet the disease is treated as one part of what ultimately ends life. Loneliness and isolation wrap around the experience and become the conditions that accelerate a tragic outcome.

Loneliness and isolation from kin and Country can be a catalyst for ill health and signs of a greater dysfunction caused by separation and disconnection. For Yanyuwa there is often also a direct association between the health of people and the health of relations, the health of Country (as ancestral lands and waters), and of nonhuman kin (Bradley, 1997). These associations are explored through the process of seeking explanations around the causation of illness and death. Sense-making occurs throughout the entire sequence of illness and death and in the aftermath during periods of heightened grief that coalesce around (Figure 11).

Bradley recalls, in the years he has lived and worked with Yanyuwa, many instances in which a direct correlation was traced between the ill health of a person and the ill health of their clan-based Country. For example, senior man Harry Lansen is said to have died because of the damage done to his conception site—the site of his *ardirri* (spirit child)—by local mining entity - McArthur River Mine. A spirit child comes from the Country of a person's senior paternal ancestors and begins the conception of a person ahead of their human form, entering a woman's body in anticipation of pregnancy and childbirth (Bradley with Yanyuwa Families, 2017, 399, 408). They reside within freshwater wells that are located across Yanyuwa Country, having been placed in these locations by Dreaming Ancestors. A person's *ardirri* remains deep within their bones. Damage to the place from which one's *adirri* originates is a direct harm to the self.

From the perspective of Yanyuwa Law, everything belonged once, and still does to some extent, to a moral order, inclusive of people, Ancestral Beings, lands and waters, the nonhuman, and the threads of kinship that hold these in relation. This order is upheld by specific types of interactions



FIGURE 12 Country such as this broken-down illegal crabber's camp on the McArthur River, are considered unhealthy. Often erected by non-Indigenous visitors to the region, they are littered with debris, neglected, and damaged. The neglect of Country is read as a "failure to care," evidence of disconnection and a disregard for Yanyuwa Law (Source: Author).

with ancestral lands and waters, including burning Country, visiting important places, singing song-lines, and maintaining an order of practice in how people interact with nonhuman species (Figure 12). The disordering of this reality has the potential to express itself in the overall health and ill-health of Yanyuwa people. For example, in 1980, 13 Yanyuwa men died from undiagnosed rheumatic fever. Bradley recalls that it was as if their hearts could not go on. From this profound loss came questions about Yanyuwa Law and the consequences of people not behaving properly. For Elders, the search for answers called for an exploration of threats to the integrity of Yanyuwa Law and Law-based misdemeanors.

ULTIMATE THREAT IS DISCONNECTION

In many Indigenous Australian contexts, terms that denote a particular type of interdependency as companionship reaching beyond that of "friendship" are common (see Sutton, 2009, 238). In the Yanyuwa language there is no term for the relationship that would be described as "friend," there are only kinship terms. Working with Warlpiri people, Musharbash (2017) explains a similar scenario, whereby being without relationships (socially and biologically determined kinship) and being alone is a state that people try to avoid at all costs. The Yanyuwa lifeworld is also illustrative of this relational practice, which is best described as kincentric in its focus.

Kincentricity ensures that all aspects of life can be configured through kin-based relations, clan linkages, and degrees of closeness to all Yanyuwa. Separation and isolation are dangerous states, resonating as they do with forms of strangeness and disconnection. Separation is an undercurrent in several of the ethnographic examples presented throughout this paper, ranging from the ensorcelling of sickness upon Yanyuwa people by jealous visitors, to the threat of isolation for Leonard and Gloria while seeking health care in locations far from home. So too, separation and disconnection inform the actions of non-Indigenous visitors to the region who have participated in foreign and damaging land use practices across Yanyuwa Country, for example, landscape clearing, open-cut mining, dredging, and polluting, as well as the introduction of feral species. These harmful actions have led to a degradation of the health and well-being of Yanyuwa ancestral lands and waters, the spaces in which people's spirit children reside. The ability to cause harm is directly attributable to a dispositional tendency that maintains a separation between people, the consequences of their actions, and the impact on the greater-than-human world (lands and waters).

One strategy for maintaining connection and ensuring the health of the kincentric order that underpins life for Yanyuwa is a practice referred to as “keeping company” (Kearney, 2022; see also Adgemis, 2017, 181; Bradley with Yanyuwa Families, 2017, 569). Keeping company is essential to maintaining health and well-being in stressful situations. Keeping company is associated with what Yanyuwa describe as *yumarra*, which translates to a form of age- and kin-based “most necessary companionship,” usually a sibling or cross cousin of the same sex (Bradley with Yanyuwa Families, 2017, 569). *Yumarra* are kin that one can trust at the deepest level; they are kin who will honor their obligations and provide care in the interest of mutual benefit. Relations that carry an obligatory nature, an ordained sense of importance, and necessary co-existence set into play relations of trust formed around a common goal; that is wellness through interconnected lives (Kearney, 2022). Relationships of this kind are displayed through the practice of accompanying and staying with *yumarra*, during extended hospital stays far from home. It is also the recognition of the broad-ranging health benefits that come from time with *yumarra* and kin that compels patients to train to self-dialyze, or, in Gloria’s case, to take calculated risks of absence from lifesaving health treatments to be with family.

A reliance on keeping company is crucial to supporting a person through periods of stress. Ristevski et al. (2020) and Cavanagh et al. (2016) have also studied the importance of family (trusted kin) as a support during times of stress, particularly induced by Indigenous health challenges, ranging from cancer diagnosis and treatment to survivorship. Disconnection from community and the epicenter of one’s cultural identity has the opposite effect of impeding good health, and “increases the risk for every kind of stress related disease, from depression to heart attack” (Fullilove, 2004, 14). As one part of the composite of keeping company and offsetting illness, Heil (2009) pushes for a more considered and culturally informed approach to what it means for Australian Aboriginal people to experience well-being (see also Heil & MacDonald, 2008). She makes the distinction that “Aboriginal people understand well-being in response to the quality of their relations with significant, mostly kin-related others.” This contrasts with “the neocolonial Australian nation-state” in which the emphasis is on “the well-being of people as individuals” (Heil, 2009; see also Chenhall & Senior, 2018).

With each generation of *yumarra*, there is an evolving field of new challenges that come with shifting realities in health and well-being, and the responsiveness that is called for with the company relation. This is an area for deeper consideration, as younger generations face the duty- and consequentialist-based ethics of keeping company with trusted kin who navigate a new and complex range of health challenges and illnesses at a younger age. In the Northern Territory, rates of diabetes and heart disease now compete with mental health conditions and substance use disorders as overwhelming emergent health challenges for younger generations (Australian Government, 2024). The specific demands that these illnesses make of the unwell, and their *yumarra* and company relations require close attention and consideration as part of a kincentric focus on the physical, social, emotional, cultural, and spiritual well-being for all parties in the relational bond, as individuals and families. Realizing this has the potential to shape and influence the provision of health care and extended care to family members, carers, and communities seeking to create safe spaces and in-community care options for young people.

WHAT DOES THIS MEAN FOR HEALTH AND MEDICINE

The experiences outlined in this paper are not unique to Borroloola, and similar accounts have been shared by Indigenous scholars, and anthropologists (see Best & Fredericks, 2021; Brady, 2003; Burbank, 2011; Carlson et al., 2020; Devitt & McMasters, 1998; Dudgeon et al., 2014; Glaskin et al., 2009; Lea, 2008; Mala & Trudgen, 2000). Integrating medical pluralism and kincentric care into approaches to health, well-being, and illness offers a pathway to more nuanced and meaningful cross-cultural understanding (Aspin et al., 2012; McGrath, 2008 outlines the benefits of kinship and family caregiving during end-of-life; Oliver, 2013; Saethre, 2007; Baer, 2008, for a caution on the impact of a dominative Western medical

system; McGrath et al., 2006; for a Canadian parallel, see Cohen-Fournier et al., 2021; for an illustration of pluralism in Indian medicine, see Sujatha, 2007).

Kincentric care emphasizes a holistic approach that considers the individual within the context of their relationships and community, while medical pluralism recognizes the diverse healing systems and practices used by individuals and communities, and the coexistence and utilization of multiple medical systems, including Western medicine (biomedicine) and “traditional or alternative therapies.” Left uncritiqued, the multiplying of options through a distinction of Western medicine on the one hand and traditional and alternative therapies on the other does reinforce, through the convention of a center and periphery, what Baer (2008) refers to as a dominative medical system. This can sustain separations and hierarchies of value attached to particular healing systems. This ultimately establishes Western biomedicine as the critical center and can lead to an oversight of the potential for medical syncretism, which Baer (2022) defines as the blending of different medical systems, their explanatory models, and their treatment strategies into new forms of healing, and which can occur over time in complex cultural contact zones.

Colonial histories and the ongoing structural violence of settler colonialism have, however, spurred relations of mistrust between Indigenous people and White services and service providers. While people will still seek out these services (Western medicine) within their community, such treatment cannot be disentangled from a broader perception of mistrust in systems that dominate and peripheralize Indigenous viewpoints and experiences. Not all interfaces with Western healthcare are bad, yet there is a sustained tension whereby mistrust of Western systems and processes, combined with Western medicines’ mistrust of Indigenous capacity to diagnose and treat illness, becomes both an obstacle and a determinant of health.

Medical pluralism, when combined with kincentric care, attends not just to treatment options and people’s choices in terms of what healing practices and therapies to engage in (e.g., funded accompaniment, on-Country dialysis—where people can receive dialysis treatments within their community and in close proximity to their homelands—and community-controlled services) but emphasizes a need to consider a person/community/environment in terms of an entire health and well-being paradigm. The convergence of medical pluralism and kincentric care is particularly relevant for Indigenous and marginalized communities, where healing practices and social connections based in trusted relational patterns and responsibilities play a significant role in overall well-being yet may take shape and expression through distinct modes of relational praxis and require specific conditions to enact.

Throughout this paper our aim has been to expand the range of possibilities for how health and well-being are narrated and made sense of among diverse human groups. We have utilized ethnographic accounts of health and illness in the interest of progressing discourse on medical pluralism. We have shared insights that speak to the importance of kincentric care and highlight the factors that intrude upon such provision of care. These findings contribute to medical anthropology because they demonstrate how health and illness among Yanyuwa are lived through relations of kin, Country, and ancestral Law, and are not reducible to biomedical categories alone. By foregrounding kincentric care, experiences of trust and mistrust, and plural explanations for sickness and death, we show that medical anthropology has a critical role in unsettling narrow biomedical framings and illuminating the cultural, social, and moral dimensions of health. In doing so, we argue that medical anthropology is uniquely positioned to amplify Indigenous perspectives, to attend to the consequences of disconnection, and to advocate for care models that can be supported by communities as well as institutions.

In closing, we return to Annie’s original question, why do our people die? and her search for meaning in terms of why people die away from Country, why death comes even when medical help is sought, why it cuts across generations, and why its causes are often unclear. We have not sought to provide straightforward answers, but rather to treat these questions as a generative moment for us to reflect on Yanyuwa experiences as linked to our central arguments about medical pluralism, kincentric care, and trust. Annie’s question is not only an expression of grief but also culturally meaningful efforts to trace imbalance across kin, Country, and Law. In this sense, they provide both an opening and a conclusion:

they are enduring prompts that call medical anthropology to recognize plural causations, to see trust and kinship as clinical infrastructures, and to take seriously Indigenous ways of making meaning in the face of uncertainty.

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REFERENCES

- Adgemis, P. 2017. "We Are Yanyuwa, No Matter What: Town Life, Family and Country." PhD diss., Monash University.
- Aspin, C., N. Brown, T. Jowsey, L. Yen and S. Leeder. 2012. "Strategic Approaches to Enhanced Health Service Delivery for Aboriginal and Torres Strait Islander People With Chronic Illness." *BMC Health Services Research* 12: 1–9.
- Australian Government. 2024. "Australian Institute for Health Welfare." Australian Government, July 2, 2024. <https://www.aihw.gov.au/reports/australias-health/indigenous-health-and-wellbeing>
- Australian Bureau of Statistics. 2021. "Borrooloola Census Data." Australian Bureau of Statistics, accessed May 12, 2025. <https://www.abs.gov.au/census/find-census-data/quickstats/2021/SAL70037>
- Baer, H. 2022. "Medical Pluralism: An Evolving and Contested Concept in Medical Anthropology." In *A Companion to Medical Anthropology*, edited by M. Singer, P. Erickson and C. Abadía-Barrero, 342–57. London: Wiley and Sons.
- Baer, H. 2008. "The Australian Dominative Medical System." *The Australian Journal of Anthropology* 19(3): 252–71.
- Best, O., and B. Fredericks, eds. 2021. *Yatdjuligin: Aboriginal and Torres Strait Islander Nursing and Midwifery Care*. Cambridge: Cambridge University Press.
- Bradley, J. 1985. Unpublished. Ethnographic Fieldnotes.
- Bradley, J. 1997. "Li-Anthawirriyarra, People of the Sea: Yanyuwa Relations With Their Maritime Environment." PhD thesis, Northern Territory University.
- Bradley, J. with Yanyuwa Families. 2016. *Wuka nya- Nganunga li- Yanyuwa li- Anthawirriyarra: Language for Us, the Yanyuwa Saltwater People Vol.1*. Melbourne: Australian Scholarly Publishing.
- Bradley, J. with Yanyuwa Families. 2017. *Wuka nya- nganunga li- Yanyuwa li- Anthawirriyarra: Language for Us, the Yanyuwa Saltwater People Vol.2*. Melbourne: Australian Scholarly Publishing.
- Brady, M. 2003. "Health Care in Remote Australian Indigenous Communities." *The Lancet* 362: s36–s37.
- Brownlie, J., A. Greene, and A. Howson, eds. 2008. *Researching Trust and Health*. New York: Routledge.
- Brownlie, J., and A. Howson. 2006. "Between the Demands of Truth and Government: Health Practitioners, Trust and Immunisation Work." *Social Science & Medicine* 62(2): 433–43.
- Burbank, V. 2011. *An Ethnography of Stress: The Social Determinants of Health in Aboriginal Australia*. New York: Palgrave.
- Bury, M. 2004. "Researching Patient-Professional Interactions." *Journal of Health Services Research & Policy* 9(1): 48–54.
- Carlson, B., and R. Frazer. 2020. "The Politics of (Dis)Trust in Indigenous Help-Seeking." In *Questioning Indigenous-Settler Relations*, edited by S. Maddison and S. Nakata, 87–106. Singapore: Springer.
- Carlson, B., T. Dunbar, R. D. Chenhall, and R. Bailie, eds. 2020. *Social Determinants of Indigenous Health*. London: Routledge.
- Cavanagh, B., C. Wakefield, D. McLoone, G. Garvey, and R. Cohn. 2016. "Cancer Survivorship Services for Indigenous Peoples: Where We Stand, Where to Improve?" *Journal of Cancer Survivorship* 10: 330–41.
- Chenhall, R., and K. Senior. 2018. "Living the Social Determinants of Health: Assemblages in a Remote Aboriginal Community." *Medical Anthropology Quarterly* 32(2): 177–95.
- Cohen-Fournier, S. M., G. Brass, and L. J. Kirmayer. 2021. "Decolonizing Health Care: Challenges of Cultural and Epistemic Pluralism in Medical Decision-Making With Indigenous Communities." *Bioethics* 35(8): 767–78.
- Devanesen, D. 1985. "Traditional Aboriginal Medicine and the Bicultural Approach to Health Care in Australia's Northern Territory." In *Alcohol and Drug Use in a Changing Society*, edited by K. P. Larkins, D. McDonald and C. Watson, 33–41. Canberra: Alcohol and Drug Foundation.

- Devitt, J. and A. McMasters. 1998. *Living on Medicine: A Cultural Study of End-Stage Renal Disease Among Aboriginal People*. Alice Springs: IAD Press.
- Dudgeon, P., H. Milroy, and R. Walker, eds. 2014. *Working Together: Aboriginal and Torres Strait Islander Mental Health and Wellbeing Principles and Practice*. Australia: Australian Government Department of the Prime Minister and Cabinet. Kulunga Aboriginal Research Unit.
- Dussart, F. 2010. "It Is Hard to be Sick Now: Diabetes and the Reconstruction of Indigenous Sociality." *Anthropologica* 52(1): 77–87.
- Dussart, F. 2009. "Diet, Diabetes and Relatedness in a Central Australian Aboriginal Settlement." *Health Promotion Journal of Australia* 20(3): 202–7.
- Fullilove, M. T. 2004. *Root Shock*. New York, NY: One World/Ballantine Books.
- Glaskin, K., M. Tonkinson, M. Musharbash, and V. Burbank, eds. 2009. *Mortality, Mourning and Mortuary Practices in Indigenous Australia*. London: Routledge.
- Heil, D., and G. Macdonald. 2008. "Tomorrow comes when tomorrow comes." *Oceania* 78(3): 299–319.
- Heil, D. 2009. "Embodied Selves and Social Selves: Aboriginal Well-Being in Rural New South Wales, Australia." In *Pursuits of Happiness: Well-Being in Anthropological Perspective*, edited by G. Mathews and C. Izquierdo, 88–108. New York: Berghahn.
- Kearney, A. 2022. *Keeping Company: An Anthropology of Being-in-Relation*. Abingdon, Oxfordshire: Routledge.
- Kwaymullina, A. 2005. "Seeing the Light: Aboriginal Law, Learning and Sustainable Living on Country." *Insights – Indigenous Law Bulletin* 6(11): 12–15.
- Lea, T. 2008. *Bureaucrats and Bleeding Hearts: Indigenous Health in Northern Australia*. Sydney: UNSW Press.
- McGrath, P. 2008. "Family Care Giving for Aboriginal Peoples During End-of-Life: Findings From the Northern Territory." *Journal of Rural and Tropical Public Health* 7: 1–10.
- McGrath, P., M. Patton, H. Holewa, and R. Rayne. 2006. "The Importance of the 'Family Meeting' in Health Care Communication With Indigenous People." *Australian Journal of Primary Health* 12(1): 56–64.
- Mala, D., and R. Trudgen. 2000. *Why Warriors Lie Down and Die*. Why Warriors Pvt. Ltd.
- Musharbash, Y. 2017. "Telling Warlpiri Dog Stories." *Anthropological Forum* 27(2): 95–113.
- Norman, D., J. Miller, M. Timothy, G. Friday, L. Norman, G. Friday, A. Friday, et al. 2021. "From Sorcery to Laboratory: Pandemics and Yanyuwa Experiences of Viral Vulnerability." *Oceania* 91: 64–85.
- Norman, D., J. Miller, M. Timothy, G. Friday, L. Norman, G. Friday, A. Friday, et al. 2020. "This Is Our Story: Yanyuwa Experiences of a Pandemic." *Oceania* 90(4): 34–40.
- Oliver, S. J. 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: 1–8.
- Reid, J. 1983. *Sorcerers and Healing Spirits: Continuity and Change in an Aboriginal Medical System*. Canberra: ANU Press.
- Ristevski, E., S. Thompson, S. Kingaby, C. Nightingale, and M. Iddawela. 2020. "Understanding Aboriginal Peoples' Cultural and Family Connections Can Help Inform the Development of Culturally Appropriate Cancer Survivorship Models of Care." *Global Oncology* 6: 124–32.
- Ryan, H. 2019. "This Kidney Patient Thought Her Life Was at Risk." Buzz Feed, May 23, 2019. <https://www.buzzfeed.com/hannahryan/dialysis-remote-communities-darwin-kidney-disease>
- Saethre, E. J. 2007. "Conflicting Traditions, Concurrent Treatment: Medical Pluralism in Remote Aboriginal Australia." *Oceania* 77(1): 95–110.
- Sujatha, V. 2007. "Pluralism in Indian Medicine: Medical Lore as a Genre of Medical Knowledge." *Contributions to Indian Sociology* 41(2): 169–202.
- Sutton, P. 2009. *The Politics of Suffering: Indigenous Australia and the End of the Liberal Consensus*. Melbourne: Melbourne University Press.
- Yanyuwa Families, J. Bradley, and N. Cameron. 2003. *Forget About Flinders: An Indigenous Atlas of the Southwest Gulf of Carpentaria*. Canberra: AIAS.

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