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# Indigenous Wellbeing and Colonisation

## Editorial

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### Indigenous Health and Wellbeing in the Circumpolar North

Among countries in the circumpolar north<sup>1</sup> there are persistent and substantial differences in health and wellbeing. Norway, for example, was at the top of the global 2015 Human Development Index compiled by the United Nations, while Russia ranked just 50<sup>th</sup> (United Nations Development Programme 2015). In addition to differences in human development and wellbeing *between* countries, there are also significant regional and sub-population disparities *within* countries. One of the most enduring areas of inequality relates to the circumstances of Indigenous peoples. The recent Arctic Human Development Report (AHDR-II) underscored the disproportionate burden of preventable death and disease borne by Indigenous peoples in the region. However, other than urging policymakers and health service providers to monitor and pay attention to the issues, it did not make any clear recommendations on actions to address the situation, either regionally or within specific countries (Nymand Larsen & Fondahl [eds.] 2014).

At the same time the AHDR-II also highlighted the extraordinary resilience and rich cultural knowledge systems of Indigenous communities. Indigenous peoples are at the forefront of changes which have seen increased participation in local decision-making and governance,

along with greater control and ownership of resources. As the countries of the north struggle to adapt and respond to the challenges of climate change, they are beginning to recognise the importance of Indigenous knowledge and the potential for it to contribute to national and regional advancement (Nymand Larsen & Fondahl [eds.] 2014; Smith & Sharp 2012; Berkes 2012). Indeed, reports like the AHDR-II reflect a broader global shift towards an increasing recognition of how Indigenous peoples can guide future adaptation to climate change (Parsons, Fisher & Nalau 2016). At the same time, having collectively contributed very little to the consumption patterns underlying “wicked” problems such as global warming, Indigenous peoples are often the first to experience the ill effects, in the north as well as in the south (Ford *et al.* 2014; Salick & Byg [eds.] 2007). A devastating example is the Alaskan Inupiaq people on the island of Shishmaref whose village is disappearing into the ocean due to erosion. Efforts to relocate them to a new location are also being thwarted by melting permafrost (Marino 2015).

While there is incredible diversity across the world’s estimated 302 million Indigenous peoples (Hall & Patrinos 2012: 10–12), there is a common emphasis on the importance of sustaining cultural identity, knowledge and practices; of protecting spiritual and ancestral connections to place; of the inalienable right to self-determination; and the need to see wellbeing in its holistic, and collective dimensions (Cunningham & Stanley 2003; Kant *et al.* 2013). Many of these aspirations are embodied in the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP). Adopted by a majority of the world’s countries in 2007, including five of the eight countries of the circumpolar north,<sup>2</sup> UNDRIP is fundamentally a human rights instrument. Davis describes it as a non-binding declaration of the General Assembly that “provides a framework that states can adopt in their relationships with indigenous peoples and that may guide them in the development of domestic law and policy” (Davis 2016: 32). Articles 23 and 24 deal explicitly with the rights to equal health; the second section of Article 24 states that:

Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right. (UNDRIP §24)

### Efforts to Monitor and Advance Indigenous Health

The ability to monitor whether these health rights are being met in specific countries, let alone globally, is a major challenge given the Indigenous “data deserts” that exist in many regions. One study suggests that fewer than half

of the countries that have an Indigenous population collect Indigenous-specific data in the national population census (Kukutai & Taylor [eds.] 2016: 4). The lack of robust and relevant data on the circumstances of Indigenous peoples acts as a formidable barrier to implementing the sort of transformative change envisaged by instruments such as UNDRIP and the United Nations 2030 agenda for sustainable development (United Nations 2015).

The invisibility of Indigenous peoples in national data collections is not a new issue. The United Nations Permanent Forum on Indigenous Issues, the United Nations Special Rapporteur on the rights of Indigenous peoples, and numerous Indigenous advocacy agencies, academics, and communities, have all stressed the critical importance of disaggregated data on Indigenous peoples (Davis 2016; Kukutai & Walter 2015; Madden *et al.* 2016; Pettersen & Brustad 2013; Tebtebba Foundation 2006; Taylor & Kukutai 2015). In 2016 the forum recommended that states actively work with Indigenous peoples to develop key indicators to be included in the sustainable development agenda. Davis (2016: 31) notes that, despite these calls, serious challenges remain, and there are few global efforts to collect data in a way that enables regional comparisons. More recently, the call for “Indigenous data sovereignty” has shifted the conversation beyond data disaggregation to consider issues of data relevance, access, governance, ownership and control (First Nations Information Governance Centre 2017; Kukutai & Taylor [eds.] 2016).

Notwithstanding Indigenous “data deserts,” researchers, advocacy organisations and policy makers continue to make use of the data that are available to draw attention to the poor state of Indigenous health globally, and maintain pressure on governments to act. In 2016 an international research collaboration, led by prominent Aboriginal academic Ian Anderson, published the first major comparative study of Indigenous health indicators in *The Lancet* (Anderson *et al.* 2016). The study was a comprehensive analysis of Indigenous health in more than 20 countries and covered a diverse set of socio-economic characteristics, political arrangements, and colonial histories. The analyses clearly showed that inequities persist, with generally poorer social and health outcomes for Indigenous peoples relative to benchmark populations. The diversity of the circumpolar north was also evident. For instance, the life expectancy at birth of Inuit was 12.5 years less than for the Canadian population while the gap in life expectancy for Norwegian Sami was much lower at just 1.6 years (Anderson *et al.* 2016).

What reasons might account for the lack of major Indigenous health inequities overall in Scandinavia, compared to the large disparities observed elsewhere? This question is at the heart of an international comparative project “Indigenous Health in Transition (IHIT): A Longitudinal Study of Colonisation, State and the Health of Indigenous Peoples in Sweden,

Australia and New Zealand.” Led by the guest editors of this special issue, the project traces the history of colonisation and its links to Indigenous health, focusing on developments from 1850 to 1960. During this period Sweden, along with other Scandinavian countries, developed and implemented successful state-sponsored health services, programs and interventions. The result was a dramatic reduction in mortality from infectious and other diseases, leading to increased life expectancy overall. Other contributors to the general improvement in life expectancy were improvements in medicine, more health personnel including midwives and doctors, avoidance of the two world wars, and various health acts aimed at improving hygiene and sanitation (Baldwin 1999; Sundin & Willner 2007). Despite these population-wide benefits, the relationship between the Swedish state and Sami from the 1850s onwards was, at best, contradictory, and at times, overtly discriminatory. The egregious actions of the state included a state-run racial biological institute that heavily stigmatised Sami people and culture, and the alienation of large tracts of traditional Sami lands. The state also heavily circumscribed the parameters of Sami identity, with the result that many families and individuals of Sami ancestry have come to be defined out of the Sami population. The cumulative effects of colonisation during this period, and the Swedish state’s role in the Sami health improvement, begs further scrutiny.

### Addressing the Impacts of Colonisation

One of the key issues facing the IHIT project is how to develop theoretical models, conceptual frameworks, and measurement tools to make robust cross-national comparisons of the effects of colonisation on Indigenous health. Indigenous scholars, researchers and communities have long argued that colonisation and ongoing colonialism are at the heart of poor Indigenous health (Bastien *et al.* 2003; Czyzewski 2011); that alienation from land has led to physical and emotional illness (Walters *et al.* 2011); and that decolonisation needs to be taken seriously as part of the solution (Alfred 2009; Smith 1999; Walters *et al.* 2011). The 2015 United Nations report, *State of The World’s Indigenous Peoples*, acknowledges that the health of Indigenous people continues to be affected by the long-term impacts of colonisation (United Nations Department of Social and Economic Affairs 2015). However, while there is a broad consensus that colonisation has had profound and deleterious impacts on Indigenous cultures and lifeways, the relationship between colonisation and contemporary Indigenous health remains poorly articulated in many fields, particularly those that are dependent on quantitative analysis and statistical modelling (Axelsson, Kukutai & Kippen 2016).

In some fields and disciplines, notably historical trauma, Indigenous Studies, and History, much closer attention has been given to theorising, documenting, and addressing the impacts of colonisation on Indigenous wellbeing. The historical trauma literature, in particular, has been influential in highlighting the collective and intergenerational impacts of colonisation (Evans-Campbell 2008; Brave Heart *et al.* 2011). The term historical trauma refers to the cumulative emotional and psychological “wounding” experienced by individuals or entire communities and peoples, as a result of a traumatic experience or event. For Indigenous peoples, colonisation begat a long list of traumatic experiences including state-sponsored assimilation; the forcible removal of children from their families exemplified by Australia’s shameful “stolen generation;” and the large-scale sexual, psychological and physical abuses that were endemic in Canada’s residential schooling system. In the latter case, more than 150,000 First Nations, Métis, and Inuit children were forced to attend boarding schools, some of which were hundreds of miles from their home.

In Canada the Truth and Reconciliation Commission (TRC) has been working to try and heal the gaping wounds laid bare by revelations about residential schools, and the deeply fraught relationships between Aboriginal communities and the Canadian state. The TRC recognises that the “cumulative impact of residential schools is a legacy of unresolved trauma passed from generation to generation,” and that this trauma has had “a profound effect on the relationship between Aboriginal peoples and other Canadians” (Truth and Reconciliation Commission of Canada 2017). To achieve reconciliation the TRC is calling on “collective efforts from all peoples” and the “commitment of multiple generations” to make for a “better, stronger Canada.”

In Sweden, the Lutheran Church of Sweden has also taken steps to begin to repair its relationship with the Sami people. The church’s 1,100-page “White Paper” describes, from various perspectives, why and how the church served as an integral part of the Swedish state’s colonisation of Sápmi (Sami traditional land area) and the Sami people (Lindmark & Sundström 2016). The paper documents the Church’s involvement in the removal of sacred objects and places; its support for racial biology theory that marshalled pseudo-scientific methods to designate Sami people as a lower “race;” and a substandard residential school system that separated Sami children from their parents. The Archbishop Antje Jackelén admitted that the Swedish Church had exposed generations of Sami people to massive violation of human rights.<sup>3</sup>

An investigation has begun into the possibilities of establishing a truth and reconciliation commission in Sweden, spearheaded by Sáminuorra, the

Sami Youth organisation, the Sámedigge (Sami parliament), Swedish Discrimination Ombudsman (DO) and the Centre for Sami Research (CeSam)—Vaartoe at Umeå University in Sweden. An international meeting was held in Umeå in October 2016 where the aim, demands, authority and potential outcomes of such a commission were discussed. The meeting served as an opportunity to learn from TRC processes in other parts of the world, and to build global networks and stronger relationships with Indigenous leaders. It has not yet been decided whether there will be a future TRC in Sweden. It should be noted that neither Sweden nor Finland has yet ratified the ILO 169 that guarantees the rights of Indigenous peoples, despite issuing several supportive reports over the years. Norway and Denmark, on the other hand, ratified the convention in the 1990s.

### This Special Issue

This special issue focuses on colonisation and the links to health and well-being among Indigenous peoples in six different locations. Part of the motivation for this special issue is to bring colonisation more clearly into the frame of Indigenous health research in the circumpolar north, and to stimulate discussion about new directions in terms of theories, methods and policy approaches. In 2016 the editors edited a special issue of the *Journal of Population Research* which focused on the intersections between colonisation, history and Indigenous health in the specific context of population research. All of the papers were drawn from the CANZUS settler societies<sup>4</sup> (Ford, Vanderbilt & Berrang-Ford 2012) of Canada, Australia, New Zealand and the United States. This special issue of the *Journal of Northern Studies* provides a timely opportunity to expand the focus beyond the much-studied context of the CANZUS states to also examine the links between colonisation and Indigenous health in the circumpolar north. The interdisciplinary scope of the *Journal of Northern Studies*, and the emphasis on the northern environment, provides an ideal forum for such an exploration. The special issue comprises six papers, four from the north (Sweden, Norway, Greenland, Canada) and two from the south (Australia, Aotearoa New Zealand).

We begin in the south with a paper by demographer Ian Pool. His case study of the Māori population of Aotearoa New Zealand illustrates more broadly the negative impacts of colonisation on the health of Indigenous peoples. This case study centres on the processes by which colonisation derails normal demographic and health transitions, and how the effects of colonialism persist after the end of formal colonial rule. Continuing health deficits are linked to structural disadvantage whereby inequality is grounded in the social and political institutions of the hegemonic majority. The paper concludes by considering the challenge for colonised Indigenous peoples

of ongoing poor health and wellbeing outcomes, and lower life expectancy, and potential strategies to improve these measures.

The study by Ketil Lenert Hansen, Stephen James Minton and Tore Sørliie investigates the prevalence, settings and perpetrators of discrimination experienced by Sami and non-Sami living in mid and northern Norway. Norwegian policies of colonisation and assimilation—which included the banning of Sami languages and removal of Sami children to boarding schools—may be in the past, but their toxic legacy remains. The study finds that Sami respondents are much more likely than non-Sami to have experienced interpersonal (interaction between individuals) discrimination, and that this discrimination was mostly related to their ethnicity. Levels of discrimination are higher again for those with a strong Sami affiliation. There is increasing recognition that discrimination against Sami people is a serious social problem that must be addressed.

Peter Bjerregaard and Christina Viskum Lytken Larsen explore some of the ongoing deleterious mental-health effects of what was viewed as a “relatively benign” colonisation of Greenland. Historically, the Inuit in Greenland were not geographically displaced and were able to keep their language and many aspects of culture. However they suffered the cultural imposition of the colonising Danes and Norwegians, loss of autonomy, and large population losses through smallpox and other epidemics. Analysis of death registers and a recent population-health survey highlights the long-lasting effects of colonisation in Greenland, including high levels of alcohol abuse and suicidal ideation, and extreme rates of youth suicide.

Angela Mashford-Pringle reports on a Canadian qualitative study of perceptions by First Nations leaders, and federal and provincial government officials, of self-determination in four First Nations healthcare systems. Perceptions of self-determination differ between these groups. Government officials in the study view it as governance of administrative processes, albeit within strict government regulations and requirements. First Nations leaders perceive self-determination as choice, including autonomy of resource allocation and leadership development, and the freedom to use traditional medicines and provide other culturally sensitive health services. The First Nations communities in this study are progressing in self-determination in healthcare. This assists the process of decolonisation, and could facilitate self-governance in other First Nations institutions such as education and community development.

Anders Haglund and Per Axelsson examine regional healthcare developments in the three most northern counties of Sweden, an area recognised as Sápmi, the traditional Sami land. Based on analysis of extensive archival material from the county councils, 1863–1950, the authors show how region-

al healthcare development paid remarkably little attention to Sami people living in the area. Despite the fact that the “Sami shall remain Sami” mantra dominated Swedish national Sami policy during the period, it had little if any influence on regional public healthcare politics. No public healthcare facilities and no specific policies or directives aimed at improving access to healthcare for Sami people were set up by the county councils. In this administration, in the heart of their traditional area, the Sami people were made invisible.

Finally, a conceptual paper by Australian scholars Mark McMillan, Faye McMillan and Sophie Rigney explores the links between Indigenous peoples’ collective rights to health, nation-building and governance. This paper differs from the others in its explicit recognition of Indigenous voice, with the McMillans writing as Wiradjuri nation builders and citizens, and academics. Their paper traces the evolution of health rights in global instruments, from the narrow framing of health as an individual right, to health as a collective right under the auspices of the UNDRIP. In particular, Articles 23 and 24 provide critical links between self-determination and health. Like Aboriginal scholar Ngaire Brown (2013), the authors see self-determination as a cultural determinant of health, expressed in a holistic sense to incorporate cultural identity and autonomy. They argue that the rebuilding and strengthening of Indigenous political and cultural institutions cannot be achieved without first interrogating how colonisation continues to impact the physical, social and emotional wellbeing of Indigenous peoples. The paper concludes with a discussion of how a university-based course has interwoven concepts of Indigenous nation-building, culture and health to give practical effect to these theoretical concepts in the context of Aboriginal communities.

The field of Indigenous health is burgeoning. We anticipate that the articles in this special issue, together with the 2016 *Journal of Population Research* issue, will provide an important backdrop to future discussions and research in the circumpolar north and beyond.

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## NOTES

- <sup>1</sup> The circumpolar north comprises the world's eight northernmost countries (the Arctic Eight): Canada, Finland, Denmark (including Greenland and the Faroe Islands), Iceland, Norway, Russia, Sweden and the United States (Alaska).
- <sup>2</sup> The Russian Federation abstained from the General Assembly vote, while the United States and Canada, along with Australia and New Zealand, opposed it. The four countries later changed their position to support UNDRIP but only as a non-legally-binding document.
- <sup>3</sup> See: <http://fokus.dn.se/kyrkan-och-samerna/>; access date 10 March 2017.
- <sup>4</sup> The term *settler society* refers to those countries settled predominantly by European migration between the eighteenth and twentieth centuries, and is used to distinguish settler colonies from resource extraction colonies, such as India and parts of the Caribbean and Africa.

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