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# The field of Indigenous health and the role of colonisation and history

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With few exceptions, Indigenous peoples around the world continue to experience significantly poorer health outcomes than their non-Indigenous counterparts. Although the magnitude of Indigenous/non-Indigenous health disparities varies significantly across time and place, there is a general consensus that Indigenous people suffer higher suicide rates, higher mortality for infants, children and mothers and carry a heavier infectious disease burden (Gracey and King 2009).

Building on the seminal work of Kunitz (1994) researchers over the last decade have made a concerted effort to identify the scale and nature of Indigenous health inequities and suggest steps for action. In 2006 *The Lancet* commissioned a pioneering series of articles on Indigenous health in different continents including Africa and South America (Anderson et al. 2006; Montenegro and Stephens 2006; Ohenjo et al. 2006; Stephens et al. 2006). Until then most of the Indigenous health research had focused on the situation of peoples in the wealthy developed settler states of Canada, the United States, New Zealand and Australia (the so-called CANZUS group; Meyer 2012). In their paper, ‘Disappearing, displaced, and undervalued: a call to action for Indigenous health worldwide’, Stephens et al.

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(2006) challenged the intervention focus of Indigenous public health policies and argued that Indigenous health inequities needed to be seen in a broader socio-political context that included ongoing colonialism, land appropriation, and displacement. Questioning the relevance of ‘top-down’ international policies such as the Millennium Development Goals, they also called for a new policy approach that incorporated Indigenous knowledge and values, and the meaningful participation of Indigenous peoples. Subsequent papers, including a second set of *Lancet* articles (Gracey and King 2009; King et al. 2009), expanded on these themes, with a 2009 editorial supporting a rights-based approach to addressing health inequities, consistent with the United Nations Declaration on the Rights of Indigenous Peoples<sup>1</sup> (United Nations 2007).

In a forthcoming paper, a global collaboration led by the Lowitja Institute further extends the field of global Indigenous health with a unique comparative analyses of the health and social status of Indigenous and tribal peoples. This paper provides a comprehensive analysis of Indigenous health in more than 20 countries covering a diverse set of socio-economic characteristics, political arrangements, and colonial histories. The analyses clearly show that inequities persist, with generally poorer social and health outcomes for Indigenous peoples relative to ‘benchmark’ populations (Anderson et al. 2016). The collaboration underscores the importance of data disaggregation for Indigenous peoples, as well as their active participation in decision making—a theme that has been taken up by both the United Nations Permanent Forum on Indigenous Issues (2015), the Special Rapporteur on the Rights of Indigenous Peoples (Corpuz 2015), Indigenous communities (First Nations Governance Information Centre 2014) and researchers (Kukutai and Walter 2015; Madden et al. 2016; Taylor and Kukutai 2015).

Establishing that health gaps exist is clearly important for inequities to be addressed. However, to achieve equitable health outcomes for Indigenous peoples, it is also important to understand how health disparities have arisen and endured. A number of scholars, many of whom are Indigenous, have called for the effects of colonisation and colonialism to be incorporated into epidemiological and demographic analysis (Czyzewski 2011; Durie 2003; Elias et al. 2012; Indigenous Health Group 2007; King et al. 2009; Lawson-Te Aho and Liu 2010; Reading and Wien 2010; Stephens et al. 2006; Wilson and Barton 2012). Czyzewski (2011), for example, argues that colonialism should be treated as a distal determinant or

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<sup>1</sup> Articles 23 and 24 of the United Nations Declaration on the Rights of Indigenous Peoples are of particular relevance to a rights-based approach to Indigenous health. Article 23 states: ‘Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions’. Article 24(1) states: ‘Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services’. Article 24(2) states: ‘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’.

underlying 'cause of causes' of Indigenous health. More specifically she sees colonialism as:

the guiding force that manipulated the historic, political, social, and economic contexts shaping Indigenous/state/non-Indigenous relations and account for the public erasure of political and economic marginalization, and racism today. These combined components shape the health of Indigenous peoples (Czyzewski 2011, p. 4).

The response from within 'mainstream' research on Indigenous health and population research has been variable. While there continues to be a proliferation of research on the contemporary health outcomes of Indigenous peoples, colonisation or colonialism rarely figure as part of the explanation. On the rare occasion that colonisation is mentioned, it is usually situated as an historical event rather than an ongoing process that continues to impact negatively on Indigenous health outcomes.

In the field of population research, and especially in demography, colonisation is even less visible, either as a background variable, or as a causal mechanism. This is not to imply that demographers have no interest in Indigenous population health; to the contrary. Dating back to at least the 1970s, one can find a plethora of demographic studies examining the impact of European contact on Indigenous survivorship and survival, particularly in the Americas and Pacific (see, for example, Cook 1998; Cook and Borah 1971; Dobyns 1983; Pool 1991; Rallu 1991). With some exceptions (Pool 1991, 2015; Stannard 1989; Thornton 1987), these studies have tended to have a narrow epidemiological focus on quantifying the impacts of disease on Indigenous 'virgin soil' populations (Crosby 1976; for a critique, see Kunitz 1994).

In more recent times governments in the CANZUS states have invested substantial time and resources in monitoring the wellbeing outcomes of Indigenous peoples vis-a-vis 'Closing the gaps' (Australian Government 2009; Te Puni Kōkiri/Ministry of Māori Development 2000). Critics argue that this form of 'postcolonial demography' has largely been geared towards meeting the needs of government rather than the needs of Indigenous peoples and communities (see, for example, Altman 2009; Kukutai and Taylor 2013; Prout 2012; Taylor 2008). By focusing policy interventions solely on individual-level behaviour change rather than underlying power inequalities, contemporary forms of inequality are decoupled from the unequal institutional arrangements that structure the relationship between Indigenous peoples and the State, itself a product of colonialism.

In light of these critiques, part of the motivation for this special issue is to bring colonisation more clearly into the frame of Indigenous population research in order to stimulate discussion about new directions in terms of theories, methods and policy approaches. In so doing we bring together contributors from health, history, Indigenous studies, demography and other social sciences to discuss the role of colonisation and history in shaping contemporary Indigenous health outcomes.

The papers selected for this special issue have been drawn from an international workshop 'Colonisation, Indigenous Health and History' held in Stockholm in June 2015. The workshop assembled a group of 30 scholars to explore how colonisation

should be defined, measured and evaluated for population-health research. The workshop emphasised interdisciplinarity and the participation of Indigenous researchers. Papers addressed one or more of the following themes:

- Theorising and defining colonisation for health/population research;
- Longitudinal and intergenerational studies of Indigenous health;
- Comparative approaches to understanding the relationships between colonisation and Indigenous health;
- The impact of colonisation on reproduction, survival, or mobility as it relates to individuals, the family/household and other meaningful social units (e.g. tribes).

The first paper in this special issue, by Kalinda Griffiths, Clare Coleman, Vanessa Lee and Richard Madden, is a literature review that explores the relationship between colonisation, social justice and health for Indigenous Australians. The paper notes the health and mortality disparity between Australia's Indigenous and non-Indigenous population, and the recent introduction of the Federal 'Closing the Gap' strategy to decrease the socio-economic disadvantage, social injustices and health inequalities experienced by Indigenous Australians. The literature shows that researchers and others need to take account of Indigenous definitions of health in addition to those employed by the prevailing culture. Indigenous Australians take a more holistic view of health, which includes not just the health and wellbeing of the individual, but also that of spirit, culture, land and community. Other themes discussed include the causes and consequences of intergenerational trauma.

The paper by John Reid, Golda Varona, Martin Fisher and Cheryl Smith focuses on the relationships between culture, material wellbeing and land loss within the Ngai Tahu (tribe) in Aotearoa New Zealand. In 1996 Ngai Tahu was one of the first tribes to receive compensation from the Crown for historical grievances relating to the unlawful taking of their lands and resources. While much is known about the impact of the loss of land on economic wellbeing, the impacts of land loss on cultural wellbeing are poorly understood. Reid's paper uses a mixed methods approach that combines tribal data from the population census, the inaugural Māori Social Survey Te Kupenga and qualitative interviews with 80 Ngai Tahu tribal members. While official data show that the material wellbeing of Ngai Tahu has improved since the 1990s, the qualitative narratives about *whānau* (family) suggest that land loss has had a range of negative cultural and psychological impacts. Nonetheless, *whenua* or land/place continues to be a core part of Ngai Tahu culture and identity. The authors call for the development of more nuanced measures for assessing the quality of relationships within and between *whānau* and *whenua*.

There have been few longitudinal studies of Indigenous health due to the lack of sources available. Janet McCalman and Len Smith's paper uses historical analysis and the Koori Health Research Database (KHRD) to trace the Aboriginal population of what is now the Australian state of Victoria, and the calamitous effects of British colonisation on that population. The KHRD comprises an individual-level longitudinal reconstitution of the Victorian Aboriginal population from the 1840s—just after colonisation began—through to 1985. Data are drawn from

detailed Aboriginal family histories, and historical records of the colonial state. The authors conclude with a paradox. While the reserves established in the second half of the nineteenth century to confine and control the surviving population contributed to the ruin of Aboriginal health and wellbeing, they did allow families to retain some connection to their Indigenous culture and history.

Chris Andersen's study raises the vexed question of how Indigenous populations should be defined for the purposes of data collection, and health and other research. The author argues that allowing self-identification as 'Métis' in the Canadian census perpetuates the colonial nature of Canada's official statistics, and legitimises this definition of 'Métis' when other delineations would better reflect the Métis nation over time and provide a basis for more-accurate population statistics. With this in mind, Andersen suggests how the census question can be reframed. This discussion is highly relevant for other post-colonial regimes contending with how to identify Indigenous peoples in official data collections.

The final paper, by Yin Paradies, addresses the question: how do colonial processes contribute to health inequalities between Indigenous and non-Indigenous populations in settler states such as Canada, Australia, New Zealand and the United States? The author explores colonial and contested definitions of indigeneity, and the effects of historical trauma, racism and the colonial mentality on continuing health and other disparities. He concludes with a discussion of what constitutes decolonisation, and whether it can lead to improved health outcomes while 'preserv[ing] cultural distinctiveness beyond health and social disadvantage'.

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