4/07

INDIGENOUS
AFFAIRS

SOCIAL SUFFERING

IWGIA

contents

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Cover photo: In March 2002 residents of Iqaluit demonstrated for increased spending on education, health, public housing and social services as a majority of the territory´s politicians prepared to vote themselves a richer pension plan. Photo: Kirsten Murphy, courtesy Nunatsiaq News

NEWS FROM IWGIA

In our last issue of *Indigenous Affairs,* we used this space to celebrate the adoption of the UN Declaration on the Rights of Indigenous Peoples last September. We called on states to take the necessary steps to follow through the commitments they have now made and ensure that the Declaration will be implemented. It is therefore with great satisfaction that we can report that the African Commission on Human and Peoples' Rights welcomed the adoption of the Declaration in a press release issued during its 42nd session held in Congo Brazzaville in November this year. The press release underlines the fact that the UN Declaration is in line with the African Commission's work on indigenous peoples' rights and states that the Declaration will be a valuable tool in the African Commission's continued efforts to promote and protect indigenous peoples' rights in Africa. We believe the message to be a powerful and important one at this point in time.

As this issue of Indigenous Affairs goes to print, the possibility of establishing an expert body on indigenous peoples' rights directly under the Human Rights Council is being debated in Geneva, and it is expected that the Council will take a decision on this over the coming days. IWGIA would like to take this opportunity to urge members of the Council to take positive action and establish a mechanism of their own that will maximize the Council's capacity to protect and promote indigenous peoples' human rights and move forward in terms of ensuring implementation of those rights.

From inside IWGIA we can report that we recently adopted a revised Information and Documentation Strategy which will guide our various publishing activities over the years to come. We are also in the middle of a longer process of revising and improving our website. Currently we prepare for our annual IWGIA Forum for members, which will take place on February 21 and 22 in Copenhagenand focus on indigenous peoples and climate change. We will look specifically at political and legal obstacles and restrictive regulations that can hinder indigenous peoples to respond and adapt to climate change. All IWGIA members are welcome to join us at this meeting.

Lastly, we would like to inform you of a new member of our Board following elections last October. We welcome Thomas Skielboe, and look forward to working with him. We would also like to express our pleasure at Maria Teresa Quispe's re-election, and look forward to continuing our cooperation with her.

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Jack Hicks

Recent decades have seen a disturbing increase in the rates of "social problems" in many indigenous societies around the world. Social pathologies such as alcohol and drug abuse, child neglect, sexual abuse, violence and suicide have reached crisis proportions in some places, and among the world's highest rates of diabetes are now being recorded in some indigenous communities.

In most cases these are fairly recent developments, often following the transition from a relatively autonomous way of life to life in settled communities where the state is able to directly and intensely impact on the lives of indigenous peoples. Between the past and the present lie historical processes of colonization, marginalization and coercive assimilation.

The lived reality of human suffering

"Social suffering" is a concept developed within medical anthropology that was first given wide exposure through a series of three powerful anthologies.[1] As Kleinman, Das and Lock wrote in the opening paragraph of their seminal volume, "Social suffering results from what political, economic and institutional power does to people and, reciprocally, from how these forms of power themselves influence responses to social problems. Included under the category of social suffering are conditions that are usually divided among separate fields, conditions that simultaneously involve health, welfare, legal, moral and religious issues."[2]

This concept can advance our understanding of the lived reality of human suffering by helping explain the suffering of individuals in the context of collective suffering, which is structured by the political, economic and institutional power relations in a society. It transcends the concept of "health" as it is commonly understood in non-indigenous societies, and gives meaning to suffering.

Indigenous pasts and indigenous presents

Indigenous peoples around the globe vary widely in both their historical experiences and present-day conditions, and the resulting patterns of social suffering are complex and varied. As Melinda Hinkson has noted[3], for indigenous peoples "the past adds up to a complex conjunction of trauma and ingenuity; distress and the will to survive; cultural continuities cut across by many transformations."

This perspective makes it possible for a researcher such as Philip May to contextualize suicide by indigenous (in this case American Indian) youth in a much deeper way than mainstream commentators do: "Very generally, adolescence is a time of trouble for all youths. But in many American Indian communities, it's compounded by limited opportunities, historical trauma and contemporary discrimination. The way the Lakota people and other Plains tribes have experienced history in the last 100 years has reduced the mental health factors that are available to them to cope."[4]

It is imperative that we not ignore history as indigenous people have experienced it, the resulting historical trauma, and present-day power relations and living conditions. The symptoms of social suffering should be understood not as individual "dysfunctional" cases but as a collective consequence of social structures which have been created by human agency and which can be changed by human agency. For example, my research on the topic of suicide has convinced me that far more effective suicide prevention is indeed possible – but only if the social determinants underlying the suicidal behaviour of individuals are addressed. All decisions to end one's life are ultimately taken by individuals, but no one individual's decision can really be understood outside of its social and political context.

At the same time, it is important that we avoid sweeping generalizations, and neither homogenize nor pathologize indigenous peoples. Some indigenous peoples have very high overall rates of suicide, while others have very low rates. There are many indigenous communities that are relatively happy and healthy, and many others that are not. (Given what some indigenous peoples have endured, it is a wonder that they are as healthy as they are today.) And within those communities there are people who are highly resilient, and others who are less so. These enormous variations among peoples, communities and individuals require far more attention than they currently receive.

Historic trauma and structural violence

This issue of Indigenous Affairs opens with an article by Canadian First Nations scholar Cynthia Wesley-Esquimaux, who introduces a concept that is key to understanding social suffering in many indigenous societies – the intergenerational transmission of historic trauma and grief. A leading trauma expert has written that, globally, "Childhood trauma, including

abuse and neglect, is probably the single most important public health challenge … a challenge that has the potential to be largely resolved by appropriate prevention and intervention."[5] Wesley-Esquimaux's article explains why this is particularly the case in many indigenous societies, how "a traumatic past has profound effects on the present", and how this understanding is critically important when designing measures to help families, communities and entire peoples heal the burden of the historical trauma they carry.

The article by Ida Nicolaisen reviews one of most urgent expressions of social suffering in indigenous communities today – the rapid rise in rates of diabetes among indigenous and other disadvantaged populations. It is a situation that requires urgent attention from and action by NGOs, governments at all levels, indigenous organizations and indigenous families.

The next two articles are powerful descriptions of two particularly harsh indigenous realities. Renée Sylvain argues that addressing the social suffering of the San in southern Africa requires the dismantling of "the social machinery of oppression" which first created, and now daily recreates, their suffering. Next an author who felt it necessary to remain anonymous for security reasons documents how the resettlement policies of the Lao People's Democratic Republic are a "legitimized form of violence" against the indigenous peoples of that country.

Jack Hicks then shows how rapid and recent has been the development of very high rates of suicide among the Inuit – especially the young Inuit men – of Greenland, Arctic Canada and Alaska. Inuit are at the cutting edge of negotiating and implementing self-government arrangements with the states into which they have been incorporated, and this article addresses the fact that their self-government institutions have so far failed to develop aggressive strategies to address this mounting tragedy.

Addressing social suffering - examples from Australia

The issue concludes with two articles on Australian Aboriginals. Melinda Hinkson provides a concise overview of the sweeping intervention in Aboriginal communities in the Northern Territory that was undertaken by the federal government in the summer of 2007. The intervention was launched by Prime Minister John Howard on the pretext of addressing high rates of child abuse in the Territory, and was described by Aboriginal leader Patrick Dodson as "sinister" and by Prof. Jon Altman as "ideological madness".[6] None-

theless it was supported by then-Opposition leader Kevin Rudd, whose Labor party defeated Howard's very conservative government in a general election just five months later. Rudd's new government is now engaged in reviewing – and hopefully rethinking – the intervention which, if nothing else, has focused national and international attention on the intense social suffering of Australian Aboriginals.

We wanted to conclude the issue on a hopeful note, and Penny Mitchell's article does just that. She describes and evaluates an inspiring community development process that has taken place in recent decades in the North Queensland community of Yarrabah. While the impetus for the process was an increase in suicides in the community, the Yarrabah experience is more than a "suicide prevention program". The article emphasizes the fact that real community empowerment and development is about on-going transformative processes rather than about discrete "programs".

It is almost beyond belief that governments continue to try and impose completely inappropriate measures such as Howard's unilateral, top-down intervention when success stories like that of Yarrabah can tell us so much about the spirit of respect and partnership that is required if indigenous children are to have futures that are brighter than their parents' pasts or presents.

Social suffering among indigenous peoples can and must be addressed and alleviated - not prolonged and intensified. In order to do so we must not deny history, the historical trauma that has resulted from that history or the structural violence that allows injustice to be reproduced each day.   ❑

Notes and references

1   Social Suffering (1997) eds. Arthur Kleinman, Vena Das and Margaret Lock; Violence and Subjectivity (2000) eds. Veena Das, Arthur Kleinman, Mamphela Ramphele and Pamela Reynolds; and Remaking a World: Violence, Social Suffering and Recovery (2001) eds. Veena Das, Arthur Kleinman, Margaret Lock, Mamphela Ramphele and Pamela Reynolds.; all published by The University of California Press.
2   Kleinman, Das, and Lock (1997), p. ix.
3   In 'In the name of the child,' her introduction to Coercive Reconciliation: Stabilise, Normalise, Exit Aboriginal Australia (2007) eds. John Altman and Melinda Hinkson, Arena Publications, p. 11.
4   "Indian reservation reeling in wave of youth suicides and attempts" (2007 June 9) Evelyn Nieves, The New York Times.
5   Bessel Van de Kolk, 'The developmental impact of childhood trauma', in: Understanding Trauma: Integrating Biological, Clinical and Cultural Perspectives (2007) eds. Laurence Kirmayer, Robert Lemelson, and Mark Barad, Cambridge University Press, p. 224.
6   It should be noted that there were also Aboriginal leaders who supported the intervention.

Cynthia C. Wesley-Esquimaux

THE INTERGENERATIONAL TRANSMISSION OF HISTORIC TRAUMA AND GRIEF

This paper proposes a model for studying the intergenerational transmission of historic trauma and grief, and examines the implications for individual and community healing in a contemporary context. It is based on a longer study prepared by the author in 2004 for the Aboriginal Healing Foundation, a body established and funded by the Government of Canada to address the impacts of emotional, physical and sexual abuse that were occurring at residential schools.[1]

The purpose of the study was to develop a comprehensive historical framework for indigenous trauma, beginning with contact in 1492, the date used to create a historic baseline. The primary focus throughout the original paper is on the period immediately after contact, but the question addressed is whether or not what is happening now, in contemporary societies, can be directly related to that much earlier timeframe by interpreting indigenous behaviours, beliefs and dysfunctional socio-cultural norms and symptomology through the lens of intergenerational transmission of unresolved trauma and mental/emotional grief responses.

Colonization and social disintegration

The study brings to light the brutal colonization of the Americas, which continues to be trivialized by many politicians in their official discourse of power. This discourse maintains the marginality of indigenous people and perpetuates the particularization of indigenous peoples' terrible experiences. Contact with colonizers changed everything for indigenous people on this continent. Resulting epidemics and displacement caused severe disorganization for indigenous societies. Traditional social structures, alliances and kinship ties were disrupted. Confidence in traditional leaders and healers was undermined. Those left alive in the aftermath of war and disease lost hope, and social disintegration followed. This "disease factor" differentiates the history of colonization of the Americas from other regions of the world. It explains why Europeans were successful in destroying civilization after civilization in the New World. As Ronald Wright (1992) proposes, "Europe possessed biological weapons that fate had been stacking against America for thousands of years. Among these were smallpox, measles, influenza, bubonic plague, yellow fever, cholera, and malaria – all unknown in the Western Hemisphere before 1492."

A traumatic past has profound effects on the present

According to many, colonialism belongs largely to the historic past and was replaced by inequality and domination in other forms. This study puts forward the proposition that the historical experiences of First Nation people(s), which disrupted the process of indigenous cultural identity formation, continue to loudly resonate in the present, and that the harm done in the past has continued to manifest inter-generationally into the present.

This is not to say that indigenous people have been programmed and doomed by their heredity. It has been well-documented in psychology literature that the development of collective memory is influenced by both heredity and environment in such a way that the two factors are inseparable (Gottlieb, 1983). It is more productive to think of the indigenous people's traumatic endowment as setting certain limits on their interaction with their social environment, mainly causing cultural discontinuities and creating a cultural cohort effect (a cohort here is a group of people who share similar socio-cultural experiences). Today's indigenous peoples' narrative of grief and their present reality confirm the past narrative of loss. In a sense, today's generations and their ancestors who lived centuries ago are the same cultural cohorts, connected by the nexus of past loss and present grief. Collective memories of the trauma, encoded by indigenous people centuries ago, have been stored in cultural memory repositories (stories, narratives and myths that also serve as memory cues) and, today, are being retrieved and reclaimed.

In other words, *"present"* indigenous communities are a direct legacy of their traumatic *"past"*. This is because it has been demonstrated that the "way" people remember their past and interpret those events as individuals and as a people contributes to continuing "dis-ease" in their communities, and more importantly, continues to affect the way they see themselves. It is not only direct traumatic experiences that can create negative effect, it is also *present interpretations* of past events that can continue to impact our lives.

Reframing memories as a first step to healing

HOW we remember things (our own lived experiences as well as historic events), and whether we can "reframe" those memories, has profound effects on

(above) Destruction of the sacred valley of the Lil'wat in British Columbia. Photo: Maria Helena Nyberg
(below) Lubicon children in Northern Alberta. Photo: Maria Helena Nyberg

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how they influence our present. Reframing is a mental process of examining or re-examining an event that occurred in the past, and placing it in another frame or context in your mind and in your community dialogue. A broader frame of reference can be created for you with the assistance of others. As an example, the contact period can be (re)contextualized by illustrations of what occurred, which we can then begin to integrate into our stories of self and come to understand in a different way, because we come to know that there were very specific circumstances that led to the "known" outcome. This is an important consideration for healing. Indigenous people were not socially weak, mentally passive or physically conquered, and they did fight to retain their lands. However, they were displaced and easily killed by the newcomers because they were weakened by forces they had no way of fighting, their populations were literally decimated by influenza, smallpox and other communicable diseases, and their societies left wide open to the invaders because disease did not pick and choose, it took everyone, warriors and children alike.   In the Americas, beginning in the late 1400s, indigenous peoples across the entire continent were subjected to *severely depressing experiences* generation after generation related to massive depopulation, unchecked murder and warfare, destroyed social structures and disempowered spiritual authorities and supports. The contagions that arrived with European explorers burned their way across the entire continent from the southern to the northern hemispheres over a 400-year period, killing up to 90% of the continental indigenous population and rendering indigenous people physically, spiritually, emotionally and psychically traumatized by what we now recognize as a profoundly deep and unresolved grief. The debilitating effect of grief was the result of unremitting losses that just kept happening, giving no respite in between little understood and horrific forms of death, because people were quite literally consumed by disease right before the eyes of their families and villagers. Today we can reframe our understanding of history to feel pride that any of us survived into the present at all: how strong our ancestors must have been to overcome that horrific legacy and enable us to be here today.

Otherness and the loss of a social self

Historic factors have strongly influenced indigenous peoples' locus of personal and social control, engendered a sense of fatalism and reactivity to historical and social forces, and adversely influenced their social relations. In the eyes of the non- indigenous population, indigenous people became silent, powerless constructions of "otherness", and this remains a place that

we are struggling to return from. This concept of "otherness" relates to a sense of separation and difference that is not positive. Yes, we have ourselves perpetuated the notion that we are in fact different and separate from the non-native population, and we are, but in another very real sense this has also created a barrier to or a banishment from that which is held to constitute normal, moral or social competency from within and outside of our traditions. In other words, cultural consensus (with society members sharing precisely the same cultural knowledge) is lost, and collective social action becomes more and more difficult to achieve, people are pushed into a marginal social sphere where disintegration or social disorganization becomes normative. When all the compartments of a social structure become damaged, a society can no longer exist ; it loses its social self, which is a group's cognitive, psychological, and emotional definition and understanding of its members as social beings. It encompasses self-understanding of the group's capabilities and limitations, strengths and weaknesses, emotions and cognitions, and beliefs and disbeliefs. On an individual level, the social self is acquired though a process of socialization. However, this process becomes disrupted and sometimes impossible when the socialized agents (parents, teachers, healers) manifest a profound sense of social worthlessness and inadequacy, and when social norms become discredited.

A Lil'wat family in Mt. Currie, British Columbia.
Photo: Maria Helena Nyberg

sociated with alcoholism, drug addiction, family disintegration and suicide. The dominant society perceives the passively aggressive group that resists assimilation as socially undesirable, as "invisible-by-necessity" and, thus, as needing the knowing (external) subject to represent it. The myriad effects of *historic trauma* have become deeply embedded in the worldview of indigenous peoples, together with that sense of learned helplessness. We can state unequivocally that historic factors destroyed indigenous peoples' locus of personal and social control, created an unhealthy reactivity to historical and social forces, and adversely influenced inter and intra group relations. Only by deconstructing historic trauma and (re)membering the past will indigenous and non-indigenous people be able to free themselves and each other from the oppositional realms they occupy in existing dominant and resistant cultural structures.

Learned helplessness and the need to deconstruct historic trauma

In addition to examining the concept of "otherness" and its effects, the reclamation of a personal and social locus of control is essential to the health and well-being of indigenous peoples. Socially-learned helplessness may become a prerequisite for social invisibility: people unable or unwilling to act according to dominant social standards and passively (instead of actively) resisting assimilation. There are many examples from different parts of the colonized world that show that acculturation (and a loss of the social self) is often as-

Overcoming social disorders

This study recognized and highlighted the inter-linkages between specific areas of historic impact and contemporary forces that were in operation and proposed a holistic model of understanding *historic trauma* that might be useful in designing practical teaching tools needed to re-tell and articulate First Nation history. In a (re)created history, native people – presently in the process of critiquing the dominant culture, and forging individual strengths and collective unity – will be able to reconstitute a cultural template using a defined rather than a supposed model of historic trauma. In order for indigenous people to devise culturally appropriate healing modalities that will help them overcome social disorders resulting from the historic trauma they experienced, a people-centred and a people-directed approach has to be adopted. The first step to initiate a meaningful healing process is to identify a focal problem that lies at the bottom of contemporary social difficulties in indigenous communities. Healing modalities can be devised and successfully implemented to help indigenous people negotiate and successfully

Lubicon cemetery with graves of youth who committed suicide.
Photo: Maria Helena Nyberg

practice their social and cultural knowledge in a contemporary world, and use their disastrous experiences of de-population and forced assimilation to their benefit. It is of vital importance for indigenous peoples' survival, in both a physical and cultural sense that, during times of change and possibility, they are able to create a new social formula from the conflicting cultural meanings that they were forced to internalize. Only then will they be able to resolve the tensions inherent in the task of reformulating their contemporary social and cultural identity. Hopefully, this will also disprove social judgements of indigenous people expressed by the non-indigenous population and change the dominant causal attributions of indigenous behaviour and indigenousness, eliciting a new cognitive appraisal, changing internalized cultural standards and opening avenues for self-actualization for indigenous people. For indigenous people, self-actualization means one simple thing: to become everything that they are capable of becoming.

In this regard, and certainly within the last fifty years, First Nations peoples have been witnessing a revival of indigenous strength and determination across Canada. The impetus behind this revival takes many forms:

- the restoration of traditional systems of belief and practice,
- the resurgence and reclamation of languages,
- the growth of a First Nation sense of national identity and the growing (re/de) construction of indigenous peoples' history by their own scholars.

For many centuries, indigenous people have been dispossessed, impoverished, ill and hungry. Researchers agree that people can recall more negative memories and more negative life events when they are depressed (Bower, Gillian and Monteiro, 1981). Only when such contextual cues are absent (as they may be in the changing social condition of indigenous people of today) can the tragic memory matrix be destroyed (Teasdale and Russel, 1983). In recent years, indigenous people have finally been given enough cultural space and freedom to enable them to analyze and integrate concepts of "loss" and "impermanence" on their own terms. Many are beginning to take the opportunity to inscribe a new relationship between themselves and the dominant culture and to create new and renewed links between themselves and their immediate world(s).

Creating a new cultural paradigm

As pointed out by Bandura (1977), children learn things vicariously by observing and imitating their parents. Children of traumatized parents may be assumed to have taken upon themselves some of the behaviours and emotional states of their parents. This matrix of unhealthy family relations frames the process of memory transmission and locates this social phenomenon on an individual level, thus affecting every person in indigenous communities and beyond. This is how universal trauma enters the lives of individuals. The goal of any healing process then is a recovery of awareness, a reawakening to the senses, a re-owning of one's life experience and a recovery of people's enhanced abilities to trust this experience. In a successful healing process, this will be coupled with the recovery of a social ability to create a new cultural paradigm, to bring order out of what has been chaos. The aim of a healing process is to recover a full person (culture) and to develop lost capacities for feeling and expression anew. The goal is to recover and reintegrate the past into the present. The aim of therapy then is to help traumatized people move from being dominated and haunted by the past to being present in the here and now, capable of responding to current exigencies with their fullest potential. The trauma thus needs to be placed in the wider perspective of a person's (or group's) life (van der Kolk, van der Hart and Burbridge, 1995). In the indigenous context, this "perspective" must be inclusive enough to encompass all the inter-connected elements of indigenous cultures and philosophies. One of several approaches that has been used in the treatment of post-traumatic stress disorder (PTSD), for example, is the testimony method in conjunction with supportive therapy. The testimony method involves asking people "to tell in detail the story of what happened to them. Many clinicians agree that having individuals tell the story of their traumatic experiences in a safe and caring interpersonal setting helps them to live better with traumatic memories." (Weine et. al., 1995:536-537) This re-telling and re-remembering helps remodel the past which, for trauma survivors, has been something akin to an inert, undigested foreign body carried with them. This is in line with Maslow (1954), who once said that the past was active and alive only insofar as it had re-created the person and had been digested into the present person. The person is alive only insofar as he or she has re-created and re-integrated the past.

Healing of aboriginal communities in Canada

The healing that is being undertaken through organizations such as Canada's Aboriginal Healing Foundation and at the community level is having a profound effect on the reconstitution and renaissance of indigenous societies. It is addressing awareness and the re-integration of the past. It is also through the youth that we can see the reconstitution of cultural domains, and the reclamation of indigenous consciousness and self awareness. We are hopeful that this coming generation will not have to carry forward the trauma that has been our historic legacy; the work that has been done on individual and collective levels has created a lightening of spirit that is reshaping the state of our cultures, personal mores and expectations and futures. Other researchers, such as Yellow Horse Brave Heart (1998, 1999) and her Lakota Takini Network, Brant-Castellano (2001), Mussel (2005) and McCormick (1995, 1997, 1998) have spoken and written eloquently about recovery from historic trauma and contemporary cultural wounding in ways that are accessible and useful to all indigenous people.[2] The contribution of this work, and the work of others, has ensured that access to education and the healing process has not only begun but that a new standard for living well as indigenous peoples and for inscribing a new and positive relationship with the world around us has been set. ❑

Notes

1   From the summary of the Final Report of the Aboriginal Healing Foundation, available at www.ahf.ca/publications/research-series

"Between 1800s-1990s, over 130 government-funded church-run industrial schools, boarding schools and northern hostels operated in Canada for Aboriginal children.

Many First Nations, Métis and Inuit children attending residential schools suffered physical, sexual and other abuses (i.e., loss of childhood, family, community, language and culture).

In 1996, the report of the Royal Commission on Aboriginal Peoples stressed the urgency of addressing the impacts of residential schools.

On 7 January 1998, the Minister of Indian Affairs and Northern Development issued a 'Statement of Reconciliation' and unveiled Gathering Strength – Canada's Aboriginal Action Plan.

The federal government announced a one-time grant of $350 million for community-based healing of the physical and sexual abuses that occurred in residential schools.

On March 31, 1998, the Aboriginal Healing Foundation was created. It was given a ten--year mandate: one year to set-up; 4 years to disburse the $350-million healing fund on a multi-year basis, and 5 years to monitor and evaluate the projects."

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Ida Nicolaisen

DIABETES

A SERIOUS THREAT TO INDIGENOUS PEOPLE

In November 2006, the first international conference on diabetes among indigenous peoples convened in Melbourne, Australia. Medical experts – indigenous and non-indigenous – expressed alarm at the fast spread of the illness among indigenous people worldwide, including children. Some of the hardest hit are the Australian Aborigines and Torres Strait Islanders, among whom prevalence reaches 44%. The message from the conference was clear. Professor Paul Zimmet, a leading expert, put it this way when talking about the situation in the Pacific: "Without urgent action there certainly is a real risk of a major wipe-out of [these] indigenous communities, if not total extinction within this century" (The Australian, November 13, 2006). It is time to wake up.

Diabetes is found in various forms: Type 1 diabetes occurs when the body cannot produce insulin but requires external substitutes to function. Type 2 diabetes implies that the body produces some insulin, but not enough to maintain normal blood sugar or glucose levels. A third form is a pre-diabetes stage likewise characterized by impaired glucose tolerance. Finally, pregnant women may develop so-called gestational diabetes. If untreated, as is often the case for indigenous mothers, the likelihood of the child becoming diabetic is increased dramatically. At the moment, the world is experiencing an explosion of type 2 diabetes due to changing lifestyles, with less physical work and changing food habits. Machines are replacing menial labor and we walk less than previous generations did. Children are driven to school, for example, rather than walking or taking the bike, and a lot of time is spent sitting in front of the computer or the TV set. In most parts of the world, the diet has changed as well, with an increase in diabetes in its wake. Not only has the consumption of snacks and soft drinks exploded, but new kinds of food are making inroads, some highly detrimental to health. Imported, poor food types are becoming common staples for many indigenous people, replacing traditionally home-grown crops or collected vegetables, fresh fish and game.
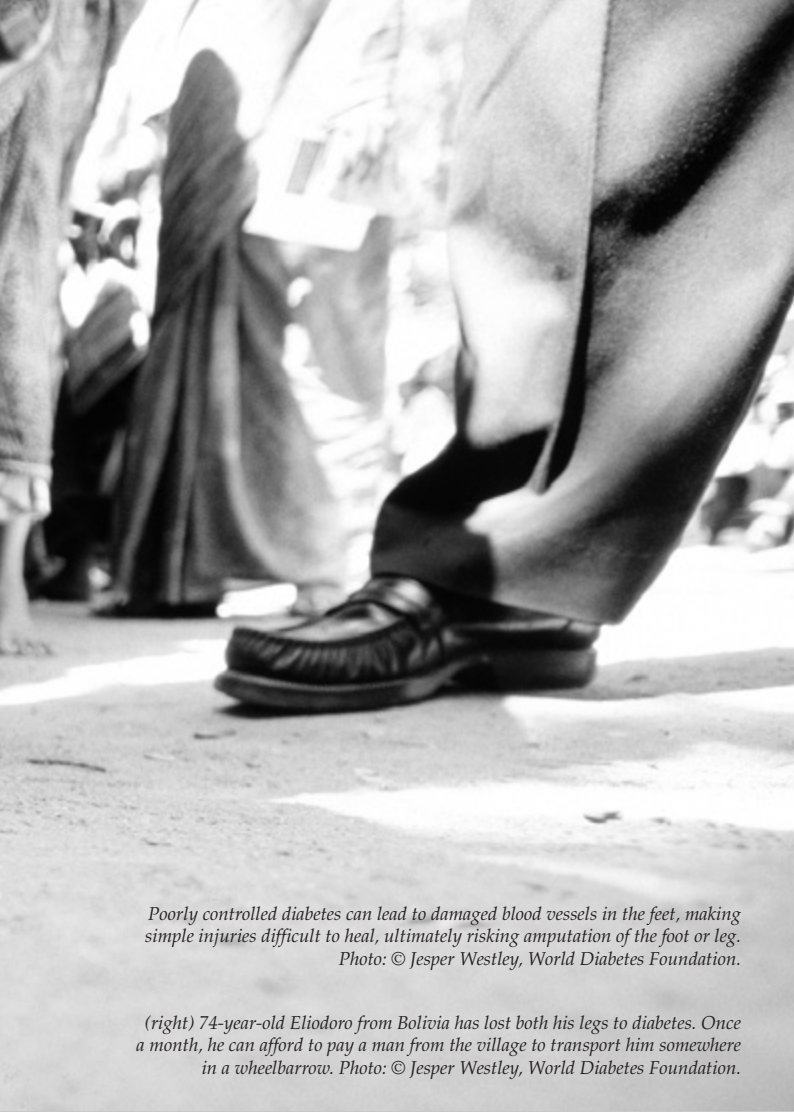
Poorly controlled diabetes can lead to damaged blood vessels in the feet, making simple injuries difficult to heal, ultimately risking amputation of the foot or leg.
Photo: © Jesper Westley, World Diabetes Foundation.

(right) 74-year-old Eliodoro from Bolivia has lost both his legs to diabetes. Once a month, he can afford to pay a man from the village to transport him somewhere in a wheelbarrow. Photo: © Jesper Westley, World Diabetes Foundation.

A disproportionate effect on indigenous peoples

Diabetes 2 is a worldwide health problem, as already noted. By 1994, around 100 million people had contracted diabetes. By 2007, the figure had grown to 246 million, while another 308 million have impaired glucose tolerance and are hence in transition from normality to diabetes, according to the World Diabetes Atlas 2006. The illness appears to affect many indigenous peoples disproportionately, as already mentioned. The prevalence is extremely high among Native Americans and Inuit, for example. It is as high as 16.5% among the Navaho, 38% among Pima Indians and 6.6% among the Inuit. The survey "Diabetes among Aboriginal (First Nations, Inuit and Métis) People in Canada: The Evidence, 2000" points to some very disturbing results. The total number of Aboriginal diabetics in Canada is unknown but can be inferred on the basis of self-reported national survey data and population numbers from the 1991 Aboriginal Peoples Survey (APS). The survey con-

cludes that: "From being a disease that was virtually unknown among First Nations, Inuit and Métis people thirty years ago, the prevalence of diabetes among First Nations is now at least three times the national average, with high rates occurring in all age groups. Diabetes in First Nations' communities is now considered an epidemic, and rates are continuing to increase. It is remarkable that rates appear to be higher on-reserve than off-reserve. Although much less is known about diabetes among Métis people, results from the Aboriginal Peoples Survey show rates well above the non-Aboriginal average. In the past, Inuit people have been the only exception to this pattern of high rates. However, more recent regional data indicate that this too is changing. Data available for some First Nations indicate a high prevalence of complications such as heart disease, hypertension, lower limb amputations, kidney disease and eye disease. There is particular concern regarding two groups within the First Nations population: children and women of childbearing age."

The very same picture emerges in other parts of the world. Wherever data are available they confirm

that diabetes is a major health threat to indigenous people. Pacific Islanders suffer highly from diabetes, as already noted. The latest figures indicate that 49% of the indigenous inhabitants on Nauru are diabetic or suffer from impaired glucose tolerance, while 22% are so on Tonga. It is also established that no less that 19% of the population of Katmandu in Nepal above the age of 40 have known or undetected diabetes, including the huge indigenous population of the city. Indian indigenous people are at high risk, as are the rest of the population in this vast country and medical findings in Latin America indicate a similarly sinister future for the indigenous population there.

Limited political attention

Despite the seriousness of the diabetes situation, its human costs and grave implications for social and economic progress, the epidemic has until recently attracted limited political attention. There may be several reasons for this but it seems that, in general, diabetes is not perceived as a threat to health. This is so despite the fact that diabetes causes hypertension, heart attacks, blindness, amputations and kidney failure. Most patients in need of dialysis are in fact diabetics. One reason that diabetes has not been considered a major health problem in Western societies may be because, if properly managed, most diabetics are able to live long and largely normal lives. In affluent societies where health services and insulin are readily available, the consequences of untreated diabetes such as blindness and amputations are not so frequent, adding to the invisibility of the problem.

There is growing political concern of the exploding human and social costs of the epidemic, however, and a realization that the situation is getting out of control and turning into a time bomb under existing health care systems. In developing nations, the focus of health politicians, planners and professionals is still largely on communicable diseases: tuberculosis, malaria and HIV/AIDS. The health care services are not geared up to coping with diabetes, moreover. All too often the illness goes undiagnosed until the damage is done and patients are losing their sight, have gangrene and need their feet amputated, are suffering from other serious complications or are simply left to die due to the unavailability of insulin. Few doctors or nurses are trained to deal with diabetes and awareness raising about the symptoms and prevention is limited or non existent.

This is the harsh reality facing many indigenous diabetics. To these fellow human beings, the illness has serious implications in terms of poor quality of life, but so it has also for their families. Most indigenous people are poor and without the means to pay for regular health services or manage the level of insulin in the unlikely case that this drug is available. All too many indigenous families are faced with grave economic problems if a member becomes diabetic. Lifelong treatment with insulin is costly and forces families to make painful economic choices, such as whether a diabetic child should be treated or another go to school and get an education, whether the family can invest to improve its economic situation or not. Should the breadwinner of the family fall ill, the social and economic consequences for the entire family may be no less than catastrophic.

Ways forward

Indigenous people have poor access to appropriate health services worldwide. Many still live in territories and lands that are difficult and costly to reach for national health services, or they are not targeted effectively because they are in city slums and/or are without the political clout to stand up for their equal rights to treatment on a par with other citizens. Moreover, where health services are provided to indigenous people by governments and NGOs, they seldom function in an optimal and culturally sensitive way. Modern health services are largely based on "Western" medical traditions and understandings of health and treatment of illness, but these notions and practices are not necessarily the same as those held by indigenous peoples. Health ministries, donor agencies and NGOs too often ignore the fact that cultural perceptions must be integrated into health planning and practical delivery of services. Indigenous peoples have alternative insights into and understandings of the constitution and workings of the human body and hence ideas of how this should be treated for good health. Indigenous conceptions are holistic in nature. In that sense, they comply with the action plans for diabetes prevention that diabetologists, the International Diabetes Association and some governments are promoting. Still, indigenous perceptions of the nature of the body may be entirely different from that of modern medicine, as may their explanations of appropriate cures, incorporating notions of the "hot" and the "cold", for instance, and of the well-being of the human soul or souls.

Indigenous peoples' perceptions and responses

Too little is known of how indigenous peoples in the developing world perceive diabetes and the proper

treatment of it. Presumably, few of them possess traditional terms for the illness, given the fact that indigenous diabetics display a set of symptoms that do not easily gel into a single diagnosis. Indigenous people in the industrialized part of the globe who are in contact with modern medical services, however, are increasingly aware that diabetes is a major risk to the health of their community. A draft Charter on Diabetes among Indigenous People was developed in 2006 by the Indigenous Population Subcommittee of the National Congress of American Indians. This underscores the following key issues for the indigenous population with regard to diabetes: loss of health attributed to Westernized, modern lifestyles, lack of confidence in or mistrust of the Western medical system, importance of faith, spirituality and spiritual healing, provision of quality diabetes education and the role of community action.

In some parts of the world, indigenous peoples are trying to address the epidemic. There are successful initiatives in North America and in the Pacific, for example. Some Pacific Islanders have gone back to growing and consuming traditional foods with positive results. This has happened in response to the steady and consistent erosion of the food security which many of them experienced. The resulting reliance on imported food brought with it an alarming rise in rates of non-communicable diseases, especially diet-related conditions such as obesity and type 2 diabetes. (Collins et. al. 1990;). Tonga is a particularly extreme example. Migration has been considerable during the past twenty years, and the remittances from those living overseas to families back home have increased the consumption of high-fat sausage, mutton flaps, chicken parts and corned beef amounting to some 56 kilos per person in 1999, at the expense of home-grown products and meat from traditional whaling. (Mike Evans, 2005). This picture is repeated all over the Pacific. In response to the deteriorating health conditions, Vanuatu has refused to be: "the dumping ground for food that has very low nutritional value" and Fiji has announced a ban on the import of mutton flaps from New Zealand because of the proven links to obesity and hence diabetes.

A need for culturally sensitive health programmes

It is vitally important that the World Health Organization, governments, development agencies, health planners and healthcare professionals take action now and address the diabetes epidemic among indigenous people. In doing so, the organizations must take into account the fact that an effective prevention of diabetes depends on the development of culturally sensitive health programmes in partnership with indigenous people. This can be done. A fine example is the health care system of Bhutan. This incorporates both Western medical practices and medicine along with traditional Bhutanese medicine, not only in health clinics but also in hospitals. Until now, WHO has worked only with a "Western model", as far as I know. WHO collaborates with countries by delivering a unified package of interventions composed of four approaches. These are: the development of a national plan and programme; working within a common surveillance system: promoting healthy lifestyles; and fostering clinical preventive approaches. Each has its own sub-components. Together, these components produce a planning model with stepwise interventions addressing the entire population and individuals at high risk. In my view, this approach needs cultural adjustments to ensure effective treatment and prevention of diabetes among indigenous people. It is high time the WHO, governments and donor agencies adopted more refined and culturally sensitive approaches to curb the epidemic, and that they and indigenous peoples themselves realized the urgency of the matter. The adoption in 2006 of the UN Resolution to designate an annual World Diabetes Day on November 14th should be a reminder to all that diabetes is a serious threat to world health in general – and to indigenous peoples in particular. ❑

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STRUCTURAL VIOLENCE AND SOCIAL SUFFERING AMONG THE SAN IN SOUTHERN AFRICA

Renée Sylvain

San children. Photo: Rockney Jacobsen

Only a small minority of the 100,000 San in southern Africa (Angola, Namibia, Botswana and South Africa) still have access to their traditional foraging territories. The majority lost their land first as a result of encroachments by Bantu-speaking herders and later as a result of European colonization. Most San are compelled to work as labourers on farms and cattle posts of dominant racial/ethnic groups. Others live in urban and rural squatters' settlements, where they eke out a living by working as casual labourers for members of dominant ethnic groups and rely on government welfare programs.

San are subject to unique and extreme forms of structural violence. Their choices and opportunities to flourish are limited by "insidious assaults on dignity", such as institutionalized racism and sexism (see Farmer, 1996 and 2003). They confront multiple and simultaneous unjust injuries caused by ethnic discrimination, racism, racialized sexism, exploitation, poverty and political violence. In what follows I describe how the collusion of physical and structural violence produces particular forms of social suffering that are often expressed through alcoholism, high risk behaviour, intergenerational alienation and violence among San.

Marginalization and assimilation in Botswana

In Botswana, San suffer as a result of land dispossession, poverty and historically deep servitude to the dominant Tswana ethnic group. These forms of deprivation are compounded by symbolic harms of stereotyping and cultural devaluation that result in their marginalization within the Tswana-dominated political system. Cultural devaluation is also expressed in Botswana's ostensibly non-ethnic, but largely assimilationist, poverty alleviation strategies that classify San as "Remote Area Dwellers".

Legal dispossession of the San began with the Tribal Lands Act (TLA) of 1968, and was accelerated by the Tribal Grazing Lands Policy (TGLP) of 1975. Under the TLA, San were not allocated land because their subsistence strategies were considered unsuitable for securing legal tenure (Suzman 2001:12). Under the TGLP, large tracts of land were allocated to non-San for cattle ranching (ibid). To address the impoverishment that followed land dispossession, the government of Botswana initiated a villagization scheme by which San could access development resources as "Remote Area Dwellers". Remote Area Dwellers in-

clude rural poor from any ethnic group, and so the poverty alleviation program fails to address the ways in which poverty among San is associated with racial/ethnic discrimination.

The recent forced relocation of G/ui and G//ana San from the Central Kalahari Game Reserve (CKGR) illustrates how racial/ethnic stigmatization makes San particularly vulnerable to assimilationist policies and development aggression. The CKGR was established in 1961 to protect the local ecosystem and to provide San with land on which to forage. In the mid-1980s, the government revised its policies; development inside the Reserve was frozen, and San were relocated to settlements outside the Reserve. Official reasons for the relocations included: protecting local wildlife, developing the tourism potential of the Reserve and "developing" the San into "modern" citizens – defined largely in terms of national Tswana political values.

Between 1997 and 2002, approximately 2,000 San (and Bakgalagadi) were moved from the Reserve to the settlements of New Xade, Kaudwane and Xeri. Relocation was initially achieved through a combination of incentive packages and intimidation. By 2005, efforts to remove San who were resisting relocation became more coercive: San who were suspected of hunting illegally in the Reserve were allegedly assaulted and tortured by police and wildlife officials (Hitchcock et al 2006:15).

In the settlements, San remain highly dependent on government welfare programs, and are marginalized by members of dominant ethnic groups who have moved into the settlements, taken over local resources and are selling alcohol to San (Hitchcock et al 2004: 172). The South African newspaper, the *Mail & Guardian* has described New Xade as a "wasteland" of poverty, drunkenness and despair. The relocations also dramatically increased the vulnerability of San women and children to poverty and violence: San women's economic security was undermined, especially since the incentive packages were directed toward San men, whom officials took to be the household heads. San women and children in the settlements are also frequent targets of sexual assault by non-San men (Hitchcock et al 2004).

The consequences of land loss involve more than the loss of access to resources. San who are dispossessed and relocated lose autonomy, dignity, social cohesion and thus also economic and psychological security. They lose the ability to develop and maintain a fulfilling social and cultural life of their own. Material, emotional and social deprivation result in a complex combination of physical and psychological suf-

fering. San in the settlements explain that their health is suffering because they are unable to eat game meat, and the maize porridge they are obliged to eat makes them sick. In this case, health problems are not only due to the low nutritional content of maize porridge; San claim that their inability to hunt deprives them of opportunities to engage in emotionally satisfying activities central to their social world. San also claim that their health suffers because of "air pollution", caused by the high concentration of people, cattle and vehicles (Ingstad and Fugelli 2006:68). Living in crowded conditions also causes San to feel imprisoned. Such feelings of confinement are amplified by their sense of political marginalization and powerlessness. As one San man explained: "The most painful thing is that we … do not control things that are said to be ours, which causes bad health. The government is controlling our life, yet there is no [San] in that government. It is very painful." (cited in Ingstad and Fugelli 2006:68)

On December 13, 2006, the High Court of Botswana ruled the relocations unconstitutional. However, the ruling did not secure San rights to water or access to services inside the Reserve. It remains to be seen whether the San who return to the CKGR will simply be moving from one rural wasteland to another.

Militarization and relocation in Angola and South Africa

San in Angola have endured close to three decades of civil war, and continue to suffer the effects of political violence, militarization and displacement. From the 1970s to the 1990s, large numbers of Angolan San fled to Namibia, Botswana and Zambia. Since the 2002 ceasefire agreement, more information about San who remained in Angola is becoming available. A recent assessment found that Angolan San are facing severe food insecurity and widespread discrimination, and suffer from poor health and a lack of access to medical services (Pakleppa and Kwononoka 2003).

Large-scale population displacement caused by the conflict led to the encroachment of Bantu-speaking people into San territories, undermining San land rights (Pakleppa and Kwononoka 2003:7). San are also among the four million internally displaced people in Angola, and so they have been deprived of secure access to a means of livelihood. The resettlement of internally displaced people, the return of approximately 400,000 refugees and the demobilization of 80,000 soldiers is contributing to competition for land and resources, which will continue to threaten food

security until resettlement and aid programs can be effectively implemented (ibid).

San face additional threats to their health and food security. Reports claim that food aid is not reaching San communities because members of dominant Bantu-speaking groups are withholding distribution from the San, and using it to keep them in conditions of deprivation and dependency (Hitchcock et al 2006: 31). San communities in Angola also suffer from a high prevalence of malnutrition and preventable and infectious diseases (Pakleppa and Kwononoka 2003:21). Although delivery of aid and medical services is impeded by landmines and a war-torn infrastructure, San access to medical care is further limited by racial/ethnic discrimination. San report that clinic staff ignore or insult them, and provide only substandard care to San patients (ibid).

San social relationships were deeply affected by the war and displacement, and were particularly damaged by experiences of combat (Pakleppa and Kwononoka 2003:25). San men fought on both sides of the conflict, and San communities report that returning San soldiers drink more heavily, beat their wives and fight with each other (ibid).

Among the San who left Angola during the war were about 6,000 !Xun and Khwe, who were recruited first by the Portuguese Security Forces in the 1960s and then by the South African Defense Force (SADF) in the 1970s to fight against liberation movements in Angola and Namibia. After Angolan independence in the mid-1970s, they were relocated to northern Namibia. Following Namibian independence in 1990, 500 !Xun and Khwe soldiers, along with 3,500 dependents, were relocated to the Schmidtsdrift army base in South Africa.

Frustration, despondency, drinking and violence dominate life at Schmidtsdrift. Ten years of living in a tent city, tensions between the !Xun and Khwe communities, unemployment and traumatic experiences of war contribute to widespread alcohol abuse and violence (Robbins et al 2001). War-related traumas suffered by San soldiers included coercive recruitment, as the SADF took advantage of poverty and displacement or simply forcibly conscripted San men. San ex-combatants addressed the South African Truth and Reconciliation Commission to draw attention to the brutality and unique forms of racism they experienced in the military: stereotypes of San with animal-like tracking and hunting instincts were widely used to promote the use of San soldiers in bush warfare during apartheid (Lee 1986).

Although the San have been officially granted title deed to a new farm, Platfontein, in South Africa, and

are in the process of relocating, it is unlikely that land rights alone will be sufficient to address the injuries that !Xun and Khwe have suffered. A recent study points out that alcohol abuse and episodes of violence "cannot be ascribed to individual pathology", but are better understood as expressions of collective trauma "that could eventually undermine efforts to create a cohesive and empowered community" (Robbins et al 2001:23).

Discrimination and exploitation in Namibia

The case of the San in the Omaheke Region of eastern Namibia vividly illustrates the suffering that results from landlessness, racism and forced labour. As a result of first German (1885-1915) and then South African (1920-1990) colonial rule, the Omaheke San were completely dispossessed of their foraging territories and were incorporated into the political economic system at the lowest level of the local ethnic labour hierarchy.

Approximately one-half of the 7,000 San in the Omaheke work on white-owned cattle ranches. Others work as casual labourers on the cattle posts of Hereros and Tswanas. Smaller pockets of San live in government resettlement camps, and there are growing communities of San living in squatters' settlements along the fringes of urban areas.

On the white farms, San workers receive monthly wages and weekly rations. But San farm workers earn less than half what non-San farm workers receive (Sylvain 2005). San women working in the farmers' homes are paid less than one-fifth what domestic workers from other ethnic groups receive (ibid). Since the wages and rations received are inadequate to support a family, many San are compelled to purchase necessities at the farm store on credit, and so they become tied to the farms by a system of debt-bondage.

Racial stereotypes often serve to rationalize wage discrimination. Farmers claim that San are too primitive to understand the value of money, and that they are unreliable workers: as former foragers they are "instinctually nomadic", and prone to absconding from service. White farmers also claim that San women are lazy, promiscuous, and that "all they do is breed".

On Herero and Tswana cattle posts, San workers are paid minimal cash wages, and often only homemade beer for their labour. When the San are paid in cash, often the only item they can afford to buy on the cattle posts is homebrew. San children, especially young girls, are sometimes "adopted" by Herero and

Tswana families as servile household members. These girls are caught in a system of child slavery and report that Herero men use them for sex.

After several generations of life as an ethnic underclass, San social relationships have adapted to reflect broader power asymmetries and the values of dominant groups. San men are treated as the breadwinners and household heads, and so women are subordinated to their menfolk. San men are increasingly willing to resort to violence, and beat their wives, in order to assert their authority. To cope with hardship and boredom, they drink heavily on the weekend, which usually results in fighting. Since most San on the farms or cattle posts are kin, the fighting is a form of domestic violence, and is especially traumatizing to San.

Addiction and affliction

The former "black" township of Epako, four kilometers east of the town of Gobabis in the Omaheke Region, provides an example of conditions in an urban setting where San live in close proximity to members of other ethnic groups, and where alcohol dominates the economy and social environment.

Residents of Epako are mostly "black" Africans – Damara, Herero, Tswana and Ovambo – but there is a growing community of San who "squat" in improvised shacks along the edges of the township. Just after Namibian independence, one of the only ways to make money in the township was to establish "cuca shops", where homebrew is made and sold. Tswana and Herero women, and Ovambo men, quickly cornered the market for illicit brewing, since they had access to the cash needed to purchase supplies. They now generate income by selling homebrew to San, who buy the inexpensive beer to "kill the hunger". Here, San continue to live in servitude, since many are often in a state of debt-bondage to cuca-shop owners, who encourage the San to drink on credit. Young San men are being drawn into the gang life associated with the cuca shops, while young San women engage in sex work to pay off drinking debts. Involvement in gang life among San men is contributing to intergenerational alienation and conflict. One San woman described the problem this way:

Your own child that you took care of is going to be with the other boys [the gangs], *and then he is going to make a mess of you. If my grandfather goes to get his pension, on the way, even my own son will rob him. We did not grow up like that. There is no respect … The adults are afraid of their children. If they say anything, they will be beaten* (Sylvain 2006:141).

The increasing level of alcohol abuse among San not only damages intergenerational relationships, it also poses serious health risks. Alcohol consumption and associated high-risk behaviour increases the risk of HIV infection (see also Lee and Susser 2006).

The HIV rate among San in southern Africa is believed to be lower than the general population (Lee and Susser 2006). But this is changing as more San are pushed into urban and rural slums, where involvement in sex work, and the prevalence of rape, increase vulnerability to HIV infection, especially among San women. Although San women are sexually assaulted by San men, San women claim that they are most commonly attacked by non-San men. Event assaults such as rape are embedded in broader systems of structural violence, such as poverty, racism and sexism (see Farmer 2003). The physical and psychological injuries suffered as a result of traumatic events are compounded and extended by systemic assaults on health and dignity.

The health of the San is directly connected to their marginalization and poverty. The primary ailments in most San communities in southern Africa are tuberculosis, malaria, HIV/AIDS and malnutrition. Tuberculosis is a particularly severe problem, since it is most easily transmitted in the over-crowded and unsanitary conditions in which they live. San living on farms or in remote settlements find it difficult to travel the long distances to clinics and hospitals, and so are often unable to access medical services. Difficulties in accessing medical care also prevent San from completing a course of treatment, which is now contributing to greater vulnerability to multi-drug resistant tuberculosis.

Under apartheid in Namibia and South Africa, whites had access to high-quality medical care, while medical services for Africans were under-funded and substandard (Daniels 2004:51). This disparity continues today, although it is slightly less racialized. Now those without sufficient cash to access high-quality medical care in private clinics must seek medical attention in the under-funded state hospitals and clinics. In these hospitals and clinics, many San face discrimination by non-San medical staff, who regularly deny medical attention to San patients. Racial/ethnic discrimination also threatens to contribute to the spread of HIV/AIDS among San. Many San claim that they are not informed of their HIV status by clinic staff. Distrust of medical staff, and the costs associated with accessing medical care, has compelled the San to seek treatment from evan-

gelical and fringe churches, which claim to be able to cure AIDS through prayer.

Conclusion

San suffering is due to historically deep race, ethnic, gender and class inequalities, and widespread patterns of cultural disrespect. The San suffer collectively, as individuals who share experiences of group-specific harm, and they suffer socially; their relationships with each other are damaged by dispossession, deprivation, marginalization and stigmatization. This is particularly harmful to San because their cultural traditions, and their current adaptations to hardship, involve deep emotional investments in relationships with family and friends. San themselves understand their suffering as a consequence of social forces beyond their control, and consistently emphasize the connection between individual and community health. One San healer in Botswana explained: "*People with a healthy body are people who stay with others harmoniously, without quarrels, in good cooperation with each othe*r" (cited in Ingstad and Fugelli 2005:71).

Addressing social suffering requires dismantling "the social machinery of oppression". Thus it is not only San relationships that must be rehabilitated; San relationships with non-San must also be redefined. Numerous non-government organizations, such as the Working Group of Indigenous Minorities in Southern Africa (WIMSA), the South African San Institute and First Peoples of the Kalahari (FPK), are working to secure rights for San. Among the priority rights are land rights, social and economic rights, including the right to medical care and right to a means of livelihood, the right to culturally appropriate and self-directed development, and the right to political representation. These rights are crucial to establishing the conditions in which San can flourish, materially, emotionally and socially. ❑

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DEVELOPMENT-INDUCED RESETTLEMENT AND

SOCIAL SUFFERING IN LAO PDR

Lahu forced resettlement huts.

Tarieng children working for an Unexploded Ordinances (UXO) scrap collector. Sanxay district, Appateu province, 2005.

This article is based on extensive research on re-settlement throughout Laos from 2000 to 2006 and analyses the trauma and social suffering engendered by the resettlement of indigenous communities as a form of violence legitimized both at national and international level as a development strategy targeting indigenous peoples.

The Lao People's Democratic Republic (Lao PDR) is located in the heart of the Indochinese Peninsula, bordered by Burma and China to the north-east, Vietnam to the east, Cambodia to the south and Thailand to the west. Laos is a mosaic of numerous ethnic groups, of which 49 have been officially recognized. They belong to four ethno-linguistic superstocks: the *Austro-Asiatic*, *Tai-Kadai*, *Tibeto-Burmese* and *Hmong-Iu-Hmien*. The Lao PDR make up about half of the population and are both culturally and politically dominant, which is reflected in the official designation of all citizens as "Lao". The other 50% of the population are usually called "ethnic minorities" and are considered Laos' indigenous peoples.

Since the end of the centralized socialist period and the introduction of the New Economic Mechanism in 1986 characterized by an opening up of the economy to bordering countries and the world market, the indigenous peoples of Laos have been facing increased social and economical pressures from the State to integrate into the mainstream society. One strategy employed by the State is resettlement. As in other Asian countries, the resettlement of indigenous communities takes place in the context of development and is aimed mostly at the sedentarization and regrouping of populations that are geographically and culturally marginal.

The official discourse justifies the resettlement policy with a general ideology of modernization based on an outdated cultural evolutionist theory,

with the need for nation building and maintaining national security. The relocation of villages from the highlands to the lowlands, or within the highlands in particular, is linked to strategies to reduce shifting cultivation, eradicate opium production, improve access to government services and consolidate villages into larger, more easily administered units. It is ostensibly aimed at contributing to the development of the target population. But resettlement is also a tool that enables increased surveillance and control of indigenous communities, who are labelled as suspect, animist and backward peoples, and their integration into the Lao nation.

Far from achieving its official objective of providing remote populations with access to basic services such as health, education, water or electricity, and guaranteeing them a better livelihood, resettlement in many cases causes increased poverty and food insecurity and leads to high mortality rates. As a result, the issue has raised concerns among a number of government agencies, donors and international organizations.

Resettlement as a form of social suffering

The concept of social suffering introduced by Kleinman in the American literature "results from what political, economic and institutional power does to people, and reciprocally from how these forms of power themselves influence responses to these social problems".[1] The diverse forms of social suffering emerge from "everyday violence". As underlined by Scheper-Hughes & Bourgois,[2] structural inequalities and power relations are naturalized by our categories and our conceptions of what violence is; in fact, violence is also part of the normative fabric of the social

and political life. Most of the violence does not result from deviant or disapproved acts but consists of conducts that are socially allowed, encouraged or ordered as a moral right or a duty. Such violence is instead defined as a virtuous action serving social, economic and political normative conventions. Social violence occurs when everyday life, for those subjected to economic and political power, does violence to their bodies and moral experience.[3] As pointed out by Scheper-Hughes & Bourgois: *"Revolutionary violence, community-based massacres, state repression are often painfully graphic and transparent. The everyday form of infant mortality, slow starvation, disease, despair and humiliation that destroy socially marginalized humans with even greater frequency are usually invisible or misrecognized".*[4] We have to understand violence as including all forms of the "processes of control"[5] that endanger elementary human freedoms and individual and collective survival.

The resettlement of non-Lao communities in Laos should therefore be understood as a form of violence. Despite growing evidence of the disastrous impact on the resettled people, resettlement is legitimized by the State and sanctioned by the international community as a development strategy. This can be explained by analyzing development as a hegemonic discourse spread by multilateral institutions and adopted by national governments. Indigenous peoples are labelled as "poor" and targeted by poverty alleviation programs, presumably for their own good. As experiences have shown, wrongly informed and misguided policies can have serious consequences as they may legitimize destructive interventions – and thus be understood as a form of violence. As Scheper-Hughes & Bourgois put it: *"Collective denial and misrecognition are prerequisites for mass violence and genocide."*[6]

Violence finds its climax in cases where resettlement is implemented under threat of machine gun. In the case of the three Lahu communities of Viengpoukha district, who were forced into military trucks, without prior notice, with no possibility of contestation, and without the possibility of ever returning home, resettlement constitutes a form of extreme violence. Their belongings, animals, houses and lands were confiscated and usurped in the name of a kind of development that aims to control and assimilate a nomadic people perceived as suspect and potentially dangerous because of the periodical appearance of messianic figures within the group and also because

Morning after transportation of housing materials in Sanxay district, Attapeu province.

of their proximity to the Lahu National Liberation Army in Burma. The Lahu people is also more versed in gathering forest products than in agricultural production, thus constituting the antithesis of the Lao civilisation ideal.

Scope of resettlement in Lao PDR

At the beginning of the 1990s, the Lao government planned to sedentarize and rehabilitate 180,000 households, totalling 1.5 million people, of which 60% were to be resettled by the year 2000. Resettlement is not an official policy but a strategy by which to achieve development goals, first introduced during a symposium held at the Ministry of Agriculture and Forestry in 1991. The idea was to reorganize production and social conditions in the uplands and establish permanent settlement. Recent studies have also revealed the existence of resettlement plans in the Five Year Plans of 2001-2005 and 2006-2010. For the 2001-2005 Five Year Plan, a study conducted in 16 districts revealed that 457 villages out of 1,415 villages and a total of 98,660 people (23% of the entire population of those

districts) were included in resettlement plans. 28,010 people have effectively been resettled and 70,659 more are included in the resettlement plans for 2006-2010. Still more resettlement is planned, mainly in the country's 48 poorest districts, as targeted in the National Growth and Poverty Eradication Strategy. It is estimated that 683 villages, with a total of 164,285 people, will be resettled during the 2006-2010 Five Year Plan.

The irrelevance of the dichotomy of involuntary and voluntary resettlement

The distinction between "voluntary" and "involuntary" resettlement makes no sense in the Lao context.[7] Baird and Shoemaker assert that

"the terms 'voluntary' and 'involuntary' fail to adequately describe the decision-making process or local context that results in the movement of communities and people in Laos. More accurate terms of definition might be 'villager-initiated' and 'externally-initiated' or 'coerced' resettlement, but even

Old Khamu Rok couple leaving their village in Nalae district. Louang Namtha province, 2004.

these cannot represent the complex situations that often develop. It is clear, however, that almost all of what is classified as voluntary resettlement in Laos is, in reality, not villager-initiated. Despite claims that there is no involuntary resettlement in Laos, it often takes place after a number of escalating steps that are designed to fundamentally influence or coerce villagers to agree to the resettlement option". [8]

Extensive research throughout Laos has allowed a fair amount of evidence to be gathered with regard to State pressure on upland communities to resettle in the lowlands. Party meetings, a military presence in communities targeted by resettlement plans, threats, the dismantling of public infrastructure such as water systems and service delivery at village level, orders to resettle from Party authorities, removal of village administrations and the official stamp pads used for stamping documents that symbolize the leg-

acy of a settlement school, erasure of the village name on official lists, etc., are among the methods used to convince or force communities to implement the resettlement planned by the State.

Consequences of resettlement

The first impact of resettlement is usually the reception of the resettled by the already established population. Psychological harassment, disobliging comments, threats, vandalism, stealing and killing of animals, destruction of belongings, even gunshots and other forms of pressure are issues that newly resettled people have to face on a daily basis. In many cases observed, the pressures exerted by the host population, who often – and rightfully – claim the ownership of the land and resources promised to the resettled communities, have necessitated the intervention of the local authorities. The reality is far from the equality rhetoric promoted by the regime: the resettled are not welcome in the plains and resettlement increases conflict over resources.

The major consequence of resettlement is an increase in mortality rates among all resettled villages throughout the country. A study conducted by an NGO in Northern Laos confirmed extremely high mortality rates, in some cases up to 20%. The study compared mortality rates in five villages originally located in the plains, which showed an average of 0.78%, and in 15 mountain villages, which had an average rate of 2.32%, with the mortality rate in 17 resettled villages, where the rate was 3.99%, thus significantly higher. The main causes of death are malaria, cholera, diarrhoea and other infections. The results clearly show that even though mortality rates in mountain villages are considerably higher than in plains villages, they are still much lower than in resettlement sites.[9] Access to clean water remains a major problem in resettled communities, especially during the first years following resettlement.

In theory, some resettled communities have gained better access to modern medicine in State or private clinics but, in reality, the language barrier often prevents non-Lao from using public health services. All indigenous communities rely on traditional healing systems. Shamans and healers are usually referred to in case of illness, which is believed to be caused by malevolent spirits and is treated by sacrifices and the use of traditional medicine (herbal potions, animal parts, amulets, and so on). But the victims of resettlement are often the elders, bearers of the knowledge that can save life. Their death – and with that, the col-

Resettled Brau woman. Phouvong district, Attapeu province, December 2005.

lective loss of knowledge - as well as the lack of access to traditional herbal medicine, is yet another aspect of the fundamental disruption of the socioeconomic and cultural reproduction process of resettled communities.

Khamu Rok people resettled in the Namtha River valley in Nalea district explain diseases that overwhelm their communities with the fact that their souls remain in the mountains, in their old land. Elders fear being taken by the *pryyong*, mythical Naga snakes that haunt forested areas in the lowlands, and this belief is shared by many Mon-Khmer speaking groups around the country.

Food insecurity

Resettlement also directly jeopardizes the food sovereignty of resettled populations. In fact, one of the main consequences of resettlement to the lowlands is land and resource shortage for the resettled communities, due to the inadequacy of the resettlement site. This situation results in conflicts between the local population and the resettled communities over water, land and other resources. Many resettled communities that were previously self-sufficient now face food insecurity and famine and depend increasingly on neighbouring communities and the State for survival. This contributes to making the population more docile. The right to food, a fundamental right guaranteed by the Universal Declaration of Human Rights (article 25), is violated. The UN Committee on Economic, Social and Cultural Rights defines it as: "*The right to adequate food is realized when every man, woman and child, alone or in community with others, has physical and economic access at all times to adequate food or means for its procurement*" (para. 6). According to Jean Ziegler, the UN Special Rapporteur on the Right to Food: "*The right to food is the right to have regular, permanent and free access, either directly or by means of financial purchases, to quantitatively and qualitatively adequate and sufficient food corresponding to the cultural traditions of the people to which the consumer belongs, and which ensures a physical and mental, individual and collective, fulfilling and dignified life free of fear.*"[10]

A new regulation promulgated in 2005 by the Ministry of Agriculture and Forestry forbids the free roaming of buffalos and cattle in sub-urban areas. This measure was primarily designed to protect cashcrop fields. It further weakens resettled communities facing a lack of access to land and resources, however, and for whom large livestock, as everywhere in rural Laos, has been the main form of saving for emergency situations.

Proletarianisation of swidden cultivators

Faced with a lack of opportunities in terms of re-establishing a land-based livelihood in the resettlement site, one of the only alternatives is wage labour, working for Lao communities or for private, often foreign, companies. Economic development in most cases remains an illusion because land is scarce, and resettled communities usually have to rely on themselves since government assistance is insufficient or entirely absent. Having become landless peasants they have no choice but to join the ranks of an emerging proletariat. Aside from daily wage labour, the only alternatives enabling the survival of the resettled are prostitution, illegal work in neighbouring countries or trafficking of all kinds of legal and illegal goods. While, traditionally, children contribute their labour during crucial stages in the annual agricultural cycle or for domestic tasks within their own family, resettlement encourages child labour outside their own household.

Loss of assets

All resettled communities face loss of their assets within a short time. Transportation of material and belongings, loss of assets in the old village, difficulty of the transition toward wet-rice cultivation, diseases and death all contribute to the impoverishment of the resettled people. The relocation costs, including labour input, the building of a temporary shelter, transporting belongings, house construction, etc., have been estimated to amount to around 15 millions kip (US$1,500) per household.[11] In areas where land is scarce, the original communities demand a "fee" from those who have been resettled. The idea has even been adopted by a governor in Northern Laos who became well-known for ransoming resettled households, demanding a pig and a bottle of alcohol and some cash for being allowed to have a meeting with him, at the end of which they were not even sure they would get authorisation to settle in the respective district.

Finally, even just the labour input required by the communities to build community infrastructure in the resettlement sites, in the context of internationally sponsored community development projects, poses a heavy burden on communities. In the case of Homechaleurn village, in Nalae district, Louang Namtha province, the 48 households had to provide 7,782 labour units, that is 409 labour units per month, between the resettlement in December 2004 up to July 2006. That meant 8.5 days of labour per household per month in order to build two schools, one gravity water system and a road to the village. This labour

input had to be provided on top of all the work resettlement demanded at the household level, such as transportation, house building and regular agricultural and gathering activities.

Gender

In Mon-Khmer speaking communities, women are traditionally in charge of key economic activities such as the selection of the indigenous upland rice varieties to be planted or collection of wild food products. Resettlement to the lowlands makes much of the women's knowledge obsolete, but at the same time drastically increases their work load. Being in charge of collecting the daily firewood, fetching water and gathering forest food products, they are the first to be affected by increased competition over resources due to resettlement. The emergence of prostitution, increasing alcoholism and drug abuse that are symptomatic of individual difficulties and social disruption after resettlement also increase women's vulnerability. The poorest communities often become places where local civil servants and Chinese or Vietnamese traders come to have sex. In some cases, visitors take advantage of the traditional hospitality of some ethnic groups. In general, resettlement has increased the risk of HIV and other sexually transmitted diseases.

Drug abuse

In government rhetoric, development programs and resettlement were supposed to put an end to opium production and consumption. However, both continue and the cultural and psychological traumas have contributed to an increase in drug consumption. What is worse, opium eradication orchestrated by the State and sponsored by some international donors not only deprives the shifting cultivators of their most important source of income and of an efficient medicine against diarrhoea and other diseases but fosters the emergence of a much more harmful substance: the so-called amphetamine-type stimulant (ATS), which is now the only drug available. Social suffering is worsened by the social damage incurred by changing forms of drug abuse. The performance-enhancing drug ATS has become a real social evil, with murders, rapes and social chaos having become the daily burden for a population already exhausted by resettlement.

Social disruption

Resettlement not only has an impact on individuals but on the social fabric of communities. General hard-

ship, competition over resources and capital, social adversity and exploitation by original populations in the resettlement sites lead to more entrenched forms of social suffering manifested in a loss of dignity, communality, mutual assistance and egalitarianism.[12]

The impact of resettlement is already felt before the actual resettlement starts. The wealthiest households (the ones that can afford to buy land in the lowlands) often leave the communities early on. The emigration of these households destabilizes traditional labour exchange and seasonal mutual assistance systems. The actual resettlement usually involves the poorest sections of the communities, those who cannot settle in a place in the lowlands of their own choice because land has become a commodity that they cannot afford to buy. This phenomenon of fragmentation of communities leads to increased dependency on State institutions in charge of conflict resolution, service delivery and welfare.

Cultural impact

When smaller indigenous communities are resettled, they are often consolidated into large multiethnic settlements. Speaking mutually unintelligible languages, the Lao language becomes the lingua franca, and this leads to a loss of indigenous languages and identity.

Furthermore, resettlement hinders the conducting of essential community rituals linked to the land or ancestral spirits. Traditionally, every year, before the beginning of the agricultural cycle, a community ritual is implemented in the sacred forest and conducted by leaders of the founding lineage. The ritual is conducted to reassert the integrity of the land and its boundaries, to ensure a good harvest, the health of the people and their domestic animals, as well as security during the production cycle and permission from the spirits to use the land and other resources. Customary institutions that have evolved over centuries to manage and preserve natural resources are made obsolete after resettlement. However, the cultural impact of resettlement goes far beyond this. It includes a loss of fundamental symbolical values as reflected in traditional architecture. In traditional villages, the organization of public spaces as well as the architectural style of houses all reflects the identity of the inhabitants and is designed on the basis of cosmological models. In resettlement sites, a community is divided into nuclear houses in lowland Lao style stretched along a road, which not only affects social interaction and organization but the fundamental cultural reproduction of the communities.

Discrimination and control

Resettlement is a violation of fundamental human rights. Freedom of movement is included in the Universal Declaration of Human Rights. Article 13 guarantees that: "*Everyone has the right to freedom of movement and residence within the border of each State*". The same right is guaranteed by the United Nations International Covenant on Civil and Political Rights (ICCPR), article 12: "*Everyone lawfully within the territory of a State shall, within that territory, have the right to liberty of movement and freedom to choose his residence.*" Laos has signed (but not yet ratified) the Covenant. Both articles guarantee the right for everyone to move, but also the right to stay. Within the resettlement process both rights are violated. Resettlement both denies the indigenous peoples the right to stay on their ancestral lands, and alienates their freedom of movement.

Although Laos has signed the International Convention on the Elimination of all forms of Racial Discrimination (ICERD), development-induced resettlement in Laos affects exclusively indigenous communities. Also, in some areas, Lao farmers who are practising swidden cultivation, which the government intends to eliminate, do not face the same restrictions as the indigenous people do.

Officially presented as a development strategy for indigenous communities, resettlement is a legitimized form of violence that generates increased mortality and morbidity, poverty, marginalisation, food insecurity, social anomalies, disintegration, discrimination, loss of dignity and violation of basic human rights, all implying or constituting forms of social suffering.

Despite the undeniable evidence of its disastrous consequences, resettlement and village consolidation is currently still ongoing and sanctioned by a number of international agencies. This allows the Lao State to achieve its all too obvious real agenda in the name of development: establishing control over indigenous communities, who are being spatially, economically, culturally and politically integrated into the Lao nation, and the appropriation of their ancestral land and resources.   ❑

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The author, who has chosen to remain anonymous for security concerns, has been involved in research on resettlement and ethnic-related issues since 1999.

Jack Hicks

THE SOCIAL DETERMINANTS OF ELEVATED RATES OF SUICIDE AMONG INUIT YOUTH

KALAALLIT NUNAAT
GREENLAND

It has not always been the case that the world's Inuit population has suffered from the tragically high rates of death by suicide that they experience today.

The 150,000 Inuit alive today are an indigenous people inhabiting Greenland, the Arctic regions of Canada, the north and west coasts of Alaska, and the Chukotka peninsula in the Russian Far East. A maritime people, Inuit traditionally relied on fish, marine mammals and land animals for food, clothing, transport, shelter, warmth, light and tools. Until fairly recent times, there was a remarkable cultural homogeneity across their homelands, but that began to change as the four states in which Inuit now find themselves[1] consolidated their grips over their Arctic regions.

Beginning in the 1950s, governments across the Arctic subjected Inuit to intense disruptions of the lifeways they were accustomed to. The details varied considerably across the region, but the fundamental economic, political and social processes of incorporation and sedentarization were similar. These processes of incorporation and sedentarization also took place at somewhat different times in different parts of the Arctic, and had somewhat divergent outcomes.[2]
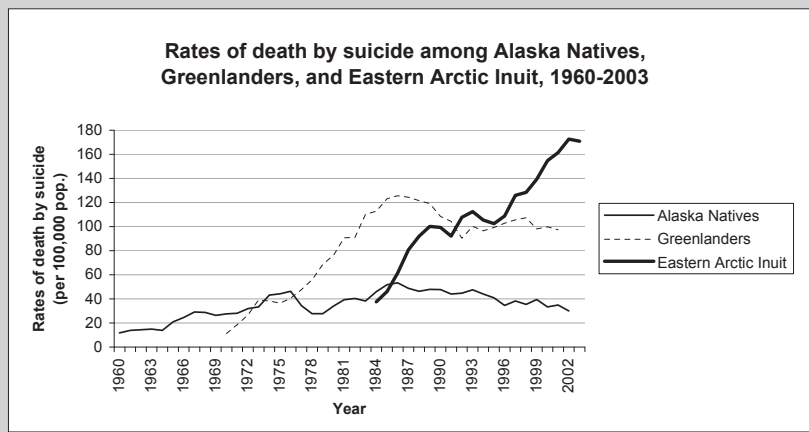
A transition in suicide patterns

The earliest existing data on suicide among Inuit comes from Greenland. Writing in 1935, Dr. Alfred Berthelsen calculated an annual suicide rate of just 3.0 per annum per 100,000 population for the period 1900 to 1930.[3] (By comparison, the most recent suicide rate for Denmark is 13.6 per 100,000, 11.6 for Canada and 11.0 for the USA.) He concluded that the few suicides occurring in Greenland at that time were all the result of serious mental illnesses. As late as 1960 there was still the occasional year when there were no recorded suicides by Greenlanders.

The transition from the "historical pattern of suicide by Inuit" to the "present-day pattern of suicide by Inuit" was first documented in North Alaska by psychiatrist Robert Krauss. In a paper presented at a conference in 1971, he noted:

In the traditional pattern, middle-aged or older men were involved; motivation for suicide involved sickness, old age, or bereavement; the suicide was undertaken after sober reflection and, at times, consultation with family members who might condone or participate in the act; and suicide was positively sanctioned in the culture.

In the emergent pattern, the individuals involved are young; the motivation is obscure and often related to intense and unbearable affective states; the behaviour appears in an abrupt, fit-like, unexpected manner without much warning, often in association with alcohol intoxication; and unlike the traditional pattern, the emergent pattern is negatively sanctioned in the culture.[4]

This suicide transition among Inuit was experienced first in North Alaska in the late 1960s, then in Greenland in the 1970s and early 1980s, and then again in Canada's Eastern Arctic[5] in the late 1980s and through the 1990s.[6] Each time the transition occurred, it resulted in a higher overall rate of death by suicide.

The temporal sequence in which the "regional suicide transitions" occurred is noteworthy, as it mirrors – roughly one generation later – the processes of "active colonialism at the community level". (We need to differentiate between "active" and "passive" colonialism as some Inuit populations had been colonized for several generations – but in those cases the colonial powers had not attempted to substantially reorgan-

Rates of death by suicide among Alaska Natives, Greenlanders, and Eastern Arctic Inuit, 1960-2003

(right) Upernavik (meaning "Springtime Place"), a town of 1,200 in north Greenland. Photo: Jack Hicks

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ize Inuit society as they depended on the persistence of the communal mode of production to ensure a supply of marine mammal products, fox pelts, etc.) One of the positive aspects of state intervention in Inuit life was the rapid decline in the incidence of tuberculosis. We can therefore use the decline in tuberculosis incidence as a historical marker of the early years of "active colonialism at the community level". The historical sequence in which Inuit infectious disease rates *fell* (as a result of the introduction of Western medicine) was the same order in which Inuit rates of death by suicide later *rose* across the Arctic.
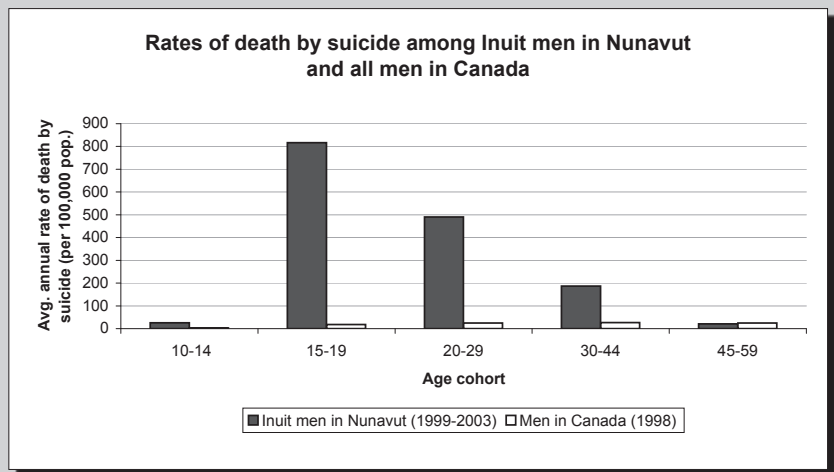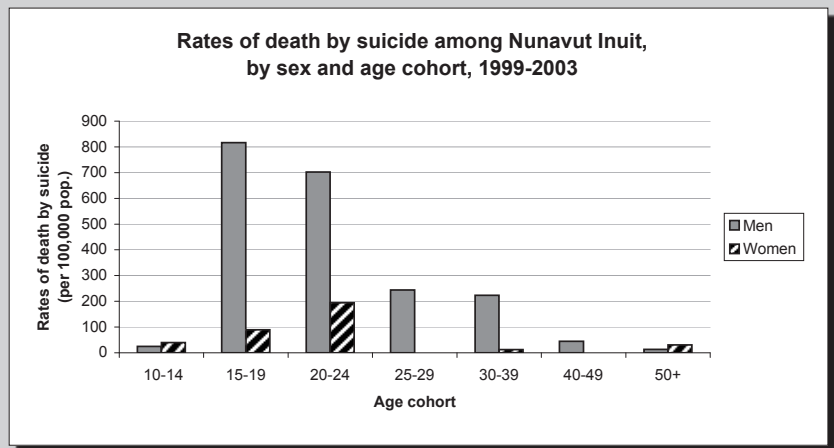
What the basic statistics tell us

Even though the existing data on suicide among Inuit is quite limited, the basic statistics we do have can tell us a fair amount about what has happened and what is happening.

In each jurisdiction for which data is available,[7] suicides first increased dramatically among young men. For Greenland, Dr. Peter Bjerregaard has shown that suicide began to increase among men born after 1950 – the very year in which the Danish state initiated an intensive programme to turn Greenland into a "modern welfare society"… a process in which Greenlanders had very little say.

Today, suicide rates among Inuit are several times higher among young men than they are among women of the same age, older men and women; and many times higher than among their peers in "mainland" Denmark and "southern" Canada and the US. It is difficult to find words that adequately describe the amount of suicide-related pain and trauma that has been suffered in Inuit communities in recent years.

In each Inuit jurisdiction, there are some subregions that developed and sustained far higher rates of suicide than others. In Alaska, the Northwest

Rates of death by suicide among Nunavut Inuit, by sex and age cohort, 1999-2003

Rates of death by suicide among Inuit men in Nunavut and all men in Canada

Rates of death by suicide among Nunavut Inuit, by region and sex, 1999-2003
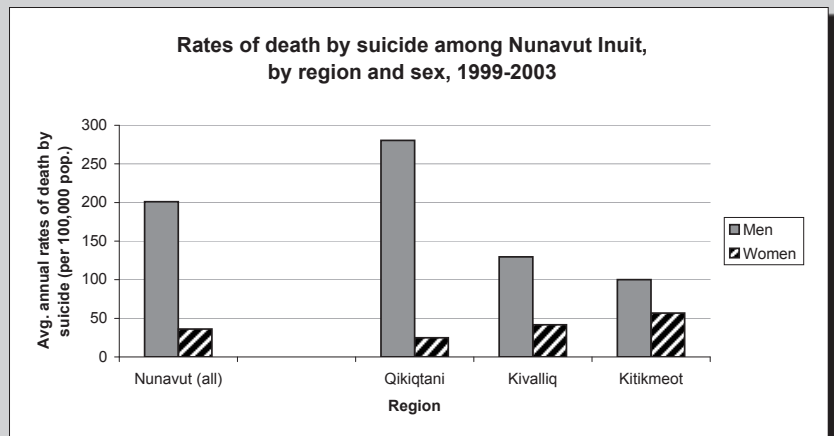
Coast has by far the highest rates. In Greenland, the suicide rate among young Inuit men peaked first in Nuuk in the early 1980s, then along the rest of the west coast in the late 1980s, and finally on the east coast in the early 1990s. Suicide by young men in East Greenland reached a rate of 1,500 per annum per 100,000 population, surely one of the highest suicide rates ever recorded anywhere on earth, before finally beginning to decline. In Nunavik (the Inuit part of northern Quebec), the Hudson coast has suffered from a much higher suicide rate than the Ungava coast, while in Nunavut the Qikiqtani (formerly Baffin) region has a markedly higher suicide rate than the two mainland regions.

Members of the Kanguit Healing Circle, a group of residents in Cape Dorset, Nunavut, who offer counselling to other community residents. Photo: Jack Hicks.

The community of Clyde River (Kanngiqtugaapik), an Inuit community of 820 on the east coast of Baffin Island, in the Canadian territory of Nunavut. Photo: Jack Hicks.

Boys in a boarding home in Tasiilaq, East Greenland. Children from small settlements stay in boarding homes while attending school in the larger towns in Greenland. Photo: Jack Hicks

Bent B. Kristiansen, the Vice-Mayor of Ilulissat: "Suicide prevention is our Council's number one priority. … We know that we can't prevent ALL suicides, but we believe that intervention can sometimes prevent a difficult time in the life of a troubled person from escalating into a tragedy." Photo: Jack Hicks.

Simultaneously, there are places in the Arctic where suicide rates are *decreasing* – those sub-regions of the Inuit world that have experienced the most "development" in recent decades. In Greenland, suicide rates among young men in Nuuk have declined significantly over the past 25 years while they have remained stable on the rest of the west coast and risen considerably in East Greenland. A similar shift appears to be underway in Alaska, where the suicide rate among Alaska Natives residing in "urban Alaska"[8] is now less than a third that of Alaska Natives residing in "bush Alaska".

Exploring *why*

These statistics are really nothing more than "body counts" that tell us very little about *why* these people chose to end their lives. In order to develop more effective suicide prevention strategies, we would ideally like to know the rates and patterns of family history and early childhood experiences; mental disorders;

medical history; education history; work history; relationship history; substance use/abuse; engagement with the justice system; availability of, access to and use of health care services; and other factors that may have played a role in the suicidal behaviour of these persons. We would also like to know about the presence or absence of a number of protective factors.[9]

An important body of research exists on mental health in Greenland. In a recent article, the two leading figures in health research there in recent decades – Drs. Peter Bjerregaard and Inge Lynge – added the observation that "Suicidal thoughts occur more often in young people who grew up in homes with a poor emotional environment, alcohol problems and violence. … the socioeconomic and structural features of the home were less important than the emotional environment for the development of personality disorders. A logical sequence of transgenerational events would be that modernization leads to dysfunctional homes due to poor parental behaviour (alcohol and violence). This in turn results in suicidal thoughts, suicides and also substance

abuse among the children of those parents."[10] These conclusions are entirely consistent with the results of research on suicidal behaviour elsewhere in the world.[11]

The Ph.D. project of the Dutch researcher Markus Leineweber also contributed to our understanding of suicide in Greenland.[12] Leineweber worked with death certificates and police reports for deaths occurring between 1993 and 1995 that were deemed by the authorities to have been suicides and, where possible, he obtained limited amounts of additional data on the deceased. His conclusion was that frequent conflict within the family and with friends, a recent life-threatening experience, expressing suicidal intentions and the acute abuse of alcohol could be identified as the most common characteristics among Greenlanders who ended their lives by suicide.

An equally important body of research has been accumulated in Nunavik by Dr. Laurence Kirmayer and his colleagues at McGill University.[13]

The impact of adverse childhood experiences

There is also a vast array of research on mental health that is of relevance to Inuit insofar as Inuit are "people" like everyone else, in addition to being members of a specific indigenous group.

Of particular relevance to the Arctic at this moment in history is the developing literature on the negative impact of what are termed "adverse childhood experiences". In short, early childhood experiences – both positive and negative – can significantly impact on the physical, mental, behavioural and economic well-being of both the child and of the adolescent and adult (s)he grows up to be.

Researchers have documented the profound impact that adverse childhood experiences – emotional, physical and sexual abuse; neglect or otherwise problematic parenting; substance abuse within the family; violence within the family; etc. – can have on a person's mental and emotional health as an adult. They found a "strong, graded relationship" between adverse childhood experiences and an array of negative outcomes later in life, meaning that experiencing a range of such negative experiences has a cumulative effect which makes it much more likely that a range of mental and emotional problems will arise.[14] There are a number of other studies that support the hypothesis that adverse childhood experiences have a strong impact in mental health during a person's adolescent and young adult years as well.[15]

The impact of *positive* early childhood experiences has also been demonstrated, by evaluations of a range of early childhood intervention programs. Some have been shown to provide at-risk children with both a better start in life and better mental health outcomes later in life.

Emergence of a new 'life script'

The Australian psychiatrist Robert Goldney has suggested that all human societies are likely to suffer a "base rate" of suicide in the range of 5 to 10 per annum per 100,000 population as a result of biological and other factors that are simply a part of the human condition.[16] The difference between the "base rate" and rates that are significantly higher than the "base rate" is, he believes, primarily the result of social determinants.[17]

The only logical explanation for the dramatic increase in suicide rates among Inuit living in different regions of the Arctic, with similar outcomes among the sexes and age groups, at different and distinct time periods, is that a similar "basket" of social determinants has impacted heavily on Inuit societies at different times across the different regions and sub-regions. The manner in which Inuit in different regions of the Arctic in recent decades experienced history several decades ago may have had significant impacts upon the mental health of their children, the next generation of young Inuit, who in some cases were the first Inuit to grow up in settled communities.

The fact that suicide rates among young Inuit men residing in the most developed areas of the Arctic (Nuuk in Greenland and the cities in Alaska) have *fallen* in recent decades suggests that this "basket" of social determinants is still at work, and that it continues to change over time.

It may be that young men who have grown up in these new conditions – stronger health care systems, higher rates of school success, higher employment rates, more role models, generally better living conditions – both get a better start in life and have a greater chance of becoming happy, successful adults. In effect, a new "life script" may have come into existence in urban areas across the Inuit world. In the "olden days", boys grew up seeing the adult men around them being busy and productive, being good husbands and parents, and taking pride in their various accomplishments. The opportunity to grow up seeing – and to be parented by – adult men who are happy and successful is not uncommon in the Arctic, but socioeconomic circumstances result in the opportunity being greater in some places than in oth-

ers. The young Inuit men at greatest risk appear to be those who are situated somewhere between the historical Inuit "life script" and the emerging urban Inuit "life script", in communities and families where unemployment and social dysfunction are more common.

We are also living in a time of increasing social differentiation among Inuit, a process that has a mental health component to it. In Nunavut, for example, some young Inuit find themselves living in a world of almost limitless opportunity while the daily reality of other young Inuit is one of historical traumas being transmitted through their family and community, overcrowded housing, a weak school system with a 75% drop-out rate, limited employment opportunities, sociocultural oppression,[18] and drifting through their teenage years stoned on marijuana.

And while the settlement of Inuit land claims and the establishment of regional public governments that Inuit effectively control have gone a long way to redressing the power imbalance that scarred several generations of Inuit, this kind of healing does not happen overnight. "There is still a lot of bitterness toward the government here," the Mayor of a Nunavut community was recently quoted as saying. "It's passed down from generation to generation."[19]

Challenges of suicide prevention

Robert Goldney's suggestion that any society's suicide rate is a combination of a human "base rate" and the result of social determinants specific to that society can help us develop a clearer picture both of what is happening in Inuit society and what might be done to positively impact on it in terms of mental health outcomes.

Inuit take their lives for the same reasons that other people commit suicide – *plus some other reasons specific to Inuit societies as they exist today.* The challenge of suicide prevention in the Inuit regions, then, can be seen as the same challenge that all peoples on the planet have PLUS the challenges that are unique to the social determinants underlying elevated rates of suicide among Inuit youth.

If one were to pose the fundamental question, "Why are Inuit societies generating such a high proportion of suicidal young people?", "high rates of adverse childhood experiences" would have to be among the answers. For 50 years now the Arctic has been a rough place to be a child. In the Canadian Arctic, the generation of Inuit who first began to display elevated rates of suicidal behaviour was the first generation to grow up in settled communities – at a time when the communities were raw and rough, when substance abuse was

just beginning to ravage families, and when discrimination was an everyday fact of life. Some families had the coping skills and resiliency required to protect their children from these social forces, but others did not. Similarly, some people who suffered during those years have since healed – but many others are passing their historical trauma on to their own children..

That being said, we must keep in mind a caution expressed by Laurence Kirmayer: "The location of the origins of trauma in past events may divert attention from the realities of a constricted present and murky future; which are the oppressive realities for many aboriginal young people living in chaotic and demoralized communities."[20] Weak health and education systems, poverty, high rates of all kinds of violence, high rates of substance abuse and generally poor living conditions also help answer the question.

Time to get serious about suicide prevention

Quite a lot – but by no means enough – is known about the effectiveness of various types of suicide prevention strategies.[21] There is a voluminous literature available for the medical/academic researcher, the government program manager and the average person who wants to help make a difference. The websites of the World Health Organization, the public health authorities in different countries, and myriad suicide prevention organizations all share hard-won insights. Examples of "good practice" abound; one of them – the community development process that has taken place in the Aboriginal Australian community of Yarrabah – is described in this magazine. We cannot hope to prevent *all* suicides, but there is abundant evidence that we can prevent *some* suicides – perhaps even *many* suicides.

Given the severity of the suicide crisis in Inuit communities today and the fact that it has been developing for several decades, it is both remarkable and appalling how long it has taken the public governments in the Arctic to take concerted action to prevent suicides from occurring.

Alaska took the lead, with a report issued by a Special Committee of the State Senate (chaired by Iñupiat State Senator Willie Hensley) in the late 1980s, a grants program that sought to provide communities with the resources and support required to try community-based projects they felt would make a difference, a program to train mental health para-professionals to work in their home villages, the formation of a multisectoral Statewide Suicide Prevention Council and, most recently, the development of an Alaska Suicide Prevention Plan.

Despite two decades of very high suicides rates, Greenland did not really begin to take suicide prevention seriously until 2003 – when Health Minister Asii Chemnitz Narup saw the need to move beyond scattered interventions and develop a coherent strategy along the lines recommended by the World Health Organization.

A multisectoral *Isaksimagit Inuusirmi Katujjiqatigiit* (Embrace Life Council) based loosely on the Alaskan model was formed in Nunavut in 2004, and has received substantial financial support from the fledgling Government of Nunavut (GN). Also in 2004, the GN publicly committed itself to preparing "a suicide prevention strategy with a focus on wellness". However, no work was done to develop such a plan until January 2007 when Nunatsiaq News – the more serious of the territory's two weekly newspapers – began asking embarrassing questions about the GN's failure to deliver on its promise. A bland, safe[22] and utterly uninspired "strategy" was quickly whipped up, with a modest "to do" list that could have been completed already if the government had actually set out to do so back in 2004. The GN official who co-ordinated the development of the strategy said that she was not surprised by complaints about the speed and direction of the government's efforts: "I understand that, but at the same time you have to be what I'd call the parent. Sometimes a toddler really wants something but it might not be the best thing for her at that time."[23]

More – far more – can and should be done to try and prevent suicidal behaviour in Inuit communities. The quote with which I opened this article suggested that "mainland" Canada, Denmark and the United States simply would not tolerate suicide rates comparable to those of their Inuit populations – that national emergencies would be declared. Unless appropriate and concerted efforts are made, it is entirely possible that Inuit suicides will remain at or near their current rates for the foreseeable future. It is high time public health emergencies were declared in and by the Inuit regions themselves, and that all levels of governments in those jurisdictions should aspire to becoming world leaders in culturally-appropriate suicide prevention. ❑

Notes and references

1   Russia in the case of the Inuit of Chukotka; the United States of America in the case of Alaskan Inuit; Canada for Inuit ranging from the Inuvialuit of the Mackenzie Delta region right across to the Inuit living on the Labrador Coast; and, Denmark in the case of Greenlanders.

2   See: Csonka, Yvon, 2005: Changing Inuit historicities in West Greenland and Nunavut. *History and Anthropology* 16, no. 3 (2005), pp. 321-34.

3 Bertelsen, Alfred, 1935: Grønlandsk medicinsk statistik og no-sografi I: Grønlands befolknings-statistik 1901–30. *Meddelelser om Grønland* 117, no. 1 (1935), pp. 1–83.

4 Krauss, Robert F. , 1971: Changing patterns of suicidal behaviour in North Alaska Eskimo. *Transcultural Psychiatric Research Review* 9 (1971), pp. 69-71.

5 The term "Eastern Arctic" here refers to Nunavik (Northern Quebec) and the Qiqiktani (formerly Baffin) region of Nunavut. The Kivalliq (formerly Keewatin) and Kitikmeot regions of Nunavut are the "Central Arctic", and the Inuvialuit region is the "Western Arctic".

6 The term "Greenlanders" as employed in this article technically refers to "persons born in Greenland". Most of the statistical data on rates of death by suicide among Greenlanders used in this article were developed by Dr. Peter Bjerregaard of Denmark's National Institute of Public Health, from raw data obtained from Greenland's *Embedslægeinstitutionen* (Chief Medical Officer) and Statistics Greenland. The statistical data on rates of death by suicide among "Alaska Natives" were obtained from the Alaska state government's Division of Vital Statistics. It is unfortunately not possible to "unpack" statistics aggregated for "Alaska Natives" to obtain data specific to the state's Iñupiat and Yu'pik populations. The statistical data on rates of death by suicide among Inuit in the different regions of Arctic Canada were developed by the author, from raw data obtained from a variety of official sources.

7 No reliable data are available for the Inuit of Chukotka.

8 Defined as Anchorage, Kenai Peninsula Borough, Mat-Su Borough, Fairbanks Borough and Juneau.

9 The *Qaujivallianiq Inuusirijauvalauqtunik* (Learning from lives that have been lived) suicide follow-back study currently in progress in Nunavut is designed to obtain this kind of richer data. The study is being conducted by the McGill Group for Suicide Studies (www.douglasrecherche.qc.ca/suicide/) in collaboration with a number of organizations in Nunavut, with funding provided by the Canadian Institutes of Health Research.

10 Bjerregaard, Peter, and Inge Lynge, 2006: Suicide – a challenge in modern Greenland. In *Archives of Suicide Research* 10 no. 2, pp. 209-20.

11 That being said, it should be noted that different people take their lives for different reasons. Just as some children who grow up in deeply dysfunctional homes survive and thrive later in life, some children who grow up in stable and happy homes and who experience few adverse childhood experiences die by suicide later in life. This is important to keep in mind when discussing suicide in a society such as that of the Inuit, who have been deeply traumatized by several decades of high suicide rates. One cannot assume that any one suicide is rooted in childhood trauma.

12 Leineweber, Markus, 2000: Modernization and mental health: Suicide among the Inuit in Greenland. Ph.D. Dissertation, University of Nijmegen. 48 pp.

13 Working Papers are available at www.mcgill.ca/tcpsych/research/cmhru/working-papers/

14 Their data comes from about as non-Inuit a source as one can imagine – a retrospective cohort study of 9,460 adult "health maintenance organization" members in a primary care clinic in San Diego, California who completed a survey addressing a variety of health-related concerns which included standardized assessments of lifetime and recent depressive disorders, childhood abuse and household dysfunction – but there is no reason to suspect that their findings do not apply to Inuit as much as they do to any other population. See: Anda, Robert F., et al., 2006: The enduring effects of abuse and related adverse experiences in childhood. In *European Archives of Psychiatry and Clinical Neuroscience* 256 no. 3, pp. 174-86; Chapman, Daniel P., et al., 2004: Adverse childhood experiences and the risk of depressive disorders in adulthood. In *Journal of Affective Disorders* 82 no.2, pp. 217-25;

Dube, Shanta R., et al., 2001: Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span. In *Journal of the American Medical Association* 286 no. 24, pp. 3089-96, and others. See also the work of Michael De Bellis on "developmental traumatology", such as The Psychobiology of Neglect. In *Child Maltreatment* 10 no. 2 (2005), pp. 150-72.

15 "The public health impact of childhood adversity is evident in the very strong association between childhood adversity and depressive symptoms, antisocial behavior, and drug use during the early transition to adulthood." Schilling, Elizabeth A., et al., 2007: Adverse childhood experiences and mental health in young adults. In BMC Public Health 7 no. 30.

16 Goldney, Robert W., 2003: A novel integrated knowledge explanation of factors leading to suicide. In *New Ideas in Psychology* 21, pp. 141-6.

17 We should, however, keep in mind that *all* suicides occur within *both* (A) a medical context (i.e. the complex biological interactions taking place within the brain of the victim); and, (B) the social context within which the victim developed, and then lived his/her life.

18 See: Sullivan, Alice, and Christine Brems, 1997: "The psychological repercussions of the sociocultural oppression of Alaska Native peoples", *Genetic, Social, and General Psychology Monographs* 123 no. 4, pp. 411-40.

19 Belkin, Douglas, 2007 October 12: Dissenters in Canada's Arctic: Government move to beef up military makes Inuit wary. *The Wall Street Journal.*

20 Kirmayer, Laurence J., et al., 2003: Healing traditions: Culture, community and mental health promotion with Canadian aboriginal peoples. In *Australasian Psychiatry* 11 suppl., pp. 15-23. See also: Kirmayer, Laurence J., et al., 2007: *Suicide Among Aboriginal People in Canada*. Report prepared for The Aboriginal Healing Foundation. www.ahf.ca/publications/research-series

21 See, for example: Hawton, Keith, ed., 2005: *Prevention and Treatment of Suicidal Behaviour: From Science to Practice*. Oxford: Oxford University Press. 379 pp.; Mann, J. John, et al., 2006: Suicide prevention strategies: A systematic review. In *Journal of the American Medical Association* 294 no. 16, pp. 2064-74; and, Taylor, S.J., et al., 1997: How are nations trying to prevent suicide? An analysis of national suicide prevention strategies, In *Acta Psychiatrica Scandinavica* 95 no. 6,, pp. 457-63.

22 No suicide prevention strategy in Nunavut should be taken seriously if it fails to include an evaluation of the adequacy of the counseling resources available to the residents of Nunavut communities and the support provided by the territorial government to the grassroots suicide prevention committees that exist in many communities – and an evaluation of the impact of the strategy itself.

23 Harding, Katherine. (2007 July 16) Nunavut reeling from soaring suicide rate. *The Globe and Mail.*

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A "NATIONAL EMERGENCY" IN AUSTRALIA:
THE HOWARD GOVERNMENT'S INTERVENTION IN NORTHERN TERRITORY ABORIGINAL AFFAIRS

Melinda Hinkson

Kava has now been banned by an emergency measure. The licensed sale of kava was introduced in the 1970s as a less harmful alternative to alcohol. Photo: Jon Altman

On 21 June 2007, Australian Prime Minister John Howard and Minister for Indigenous Affairs Mal Brough declared a "national emergency" in respect of widespread allegations of child sexual abuse in Australia's Northern Territory (NT), which is home to about 15 per cent of Australia's Indigenous population and includes some of the most remote and traditionally-oriented communities in the country.[1] Their reference point was the recently released report of the Northern Territory Board of Inquiry into the Protection of Aboriginal Children from Sexual Abuse, *Ampe Akelyernemane Meke Mekarle, Little Children Are Sacred*,[2] which found child sexual assault to be widespread throughout Aboriginal communities, and made 97 recommendations for a comprehensive response.

The sheer scale of the measures foreshadowed by the Prime Minister took many in Australia by surprise – taken together they constituted a governmental intervention unmatched by any other policy declaration in the last 40 years of Aboriginal affairs.

Since the passing of the *Aboriginal Land Rights Act* in 1976, over half the Northern Territory has been returned to Aboriginal traditional owners. Under this legislation, traditional owners hold freehold title to their lands and the right to control who enters that land through a permit system. These rights were recognised as part of a broader policy of self-determination that framed Indigenous policy in Australia from 1972 until Prime Minister Howard declared the end of self-determination with the abolition of the Aboriginal and Torres Straight Islander Commission in 2004.

In the name of protecting children, the Commonwealth announced it would introduce the following measures, which would apply to all people living in 73 prescribed remote Aboriginal communities in the Northern Territory:

- widespread alcohol restrictions;
- welfare reforms to stem the flow of cash going toward substance abuse and to ensure that funds meant for children's welfare are used for that purpose;
- enforce school attendance by linking income support and family assistance payments to school attendance and providing meals for children at school at parents' cost;
- introduce compulsory health checks for all Aboriginal children to identify and treat health problems and any effects of abuse;
- compulsorily acquire these townships, most of which are held under Aboriginal freehold title, for a leasehold period of five years, possibly without payment of just terms of compensation;
- increase policing levels, including requesting secondments from other jurisdictions to supplement Northern Territory resources;
- require intensified on-ground clean-up and repair of communities to make them safer and healthier by marshalling local workforces through work-for-the-dole;
- improve housing and reform community living arrangements, including the introduction of market-based rents and normal tenancy arrangements;

Fishing in a billabong, Arnhem land. Photo: Tony Griffiths

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- ban the possession of x-rated pornography and introduce audits of all publicly funded computers to identify illegal material;
- scrap the permit system (which had been introduced with the recognition of land rights to allow traditional owners to determine who could enter their lands) so that permits would no longer be required for common areas within townships, road corridors and airstrips for prescribed communities on Aboriginal land; and
- appoint managers for all government business in prescribed communities to override the decision-making powers of Aboriginal community-based organisations and their elected Aboriginal Boards.[3]

The police and army would be mobilised to help facilitate the implementation of these "measures". Doctors and other professionals would be encouraged to "volunteer" their time and expertise to the cause. This was part of a wide-ranging program in which the government planned to "stabilise, normalise and exit" remote Northern Territory Aboriginal communities, and its intervention would commence immediately.

In the three months that have passed since the national emergency declaration, the various planks of the government's initiative have undergone considerable modification. Indeed, it was clear from the outset that the dramatic announcement by Howard and Brough on June 21 was made prior to the detail of many of the interventions being worked out. It is indeed noteworthy, given the stated need for urgent action, that three months on not one arrest has been made, not one referral to the authorities in relation to child sexual abuse allegations from across the 73 prescribed communities.

Complex legislation passed in no time

On August 7, the Federal government introduced three Bills containing the "emergency response" legislation into the House of Representatives of the Australian Parliament. Five hundred pages of hastily compiled and complex legislation passed through the House with the support of the opposition Labor Party on the same afternoon as it was tabled. In response to widespread calls for some semblance of decency in the treatment of legislation with such far-reaching consequences (but against the wishes of the Minister), the government assented to holding a one-day Senate enquiry on 10 August. Reflecting the breadth and depth of concern for the issues under consideration,

154 submissions were received by the committee in the 48 hours between the announcement of the enquiry and its sitting. The committee sat on a Friday and tabled their report the following Monday. The majority report recommended that the legislation be passed but that progress on its implementation be reported at 12-monthly intervals and a review conducted at the end of the first two years. The legislation passed the Senate on Friday 17 August – without even these minor amendments.

A convenient opportunity for the government to act on its wider aspirations

It was not until the three Bills were tabled in parliament that the extent of the government's intentions became fully apparent. A number of commentators observed soon after the June 21 announcement that there was a clear political intent in the measures that went well beyond what might be credited as a genuine desire on the part of the Commonwealth to tackle child sexual abuse. The plan to amend the *Aboriginal Land Rights Act*[4] in order that the Commonwealth could take control of communities, including compulsory acquisition of leases to towns for five years and the abolition of the permit system, suggested that the response to *Little Children Are Sacred* was being used as an opportunity by the government to act on its wider aspirations, more particularly to undermine the kin-based forms of ownership that characterise Aboriginal land title and substitute these with individual forms. Child sex abuse, noted some prominent Aboriginal commentators, was being used as a "Trojan horse" for undermining land rights.[5]

With the tabling of the legislation, it became clear that this revolution in Indigenous affairs would indeed be profoundly far-reaching in its consequences. The passing of this legislation enables the government to:

- control the way *all* Aboriginal people living in prescribed townships in the Northern Territory can spend their welfare payments (with no provision for exemption). Goods and services to be controlled include alcohol, pornographic material, gambling and tobacco;
- confer new powers on police to enter private properties without warrant to pursue a person believed to be affected by alcohol;
- require detailed records be kept for three years about all users of all computers purchased with government funds; and,

- direct courts to no longer take customary law or cultural practices into account in setting bail conditions or sentencing.

The legislation also confers on the Commonwealth the power to:

- vary or terminate or unilaterally alter existing funding agreements with community organizations;
- direct persons to undertake specified tasks at the instruction of new government business managers through the work-for-the-dole (work for welfare entitlements) scheme;
- direct government-funded assets to be used for specific tasks;
- gain oversight of local governance processes, including having a representative attend meetings of members of any government-funded organization and to sack employees of government-funded bodies;
- supervise and control community government councils;
- assess the operations of community-managed stores and, if deemed substandard, appoint new managers; and,
- a right to exclude any person, including a traditional owner of that land, from township land that was to be unilaterally leased by the Commonwealth for five years (see comment 3).[6]

Aboriginal people's calls for help ignored

At the outset, there seemed to be a double paradox in the government's announcement that urgent action would be taken. Firstly, for many years Aboriginal people have been appealing to governments to help turn around the escalating social crisis experienced in many communities. The symptoms of this crisis are familiar – substance abuse, poor health conditions, dilapidated and overcrowded housing, domestic violence, high levels of unemployment, social malaise. It is a crisis that many observe has been compounded by the Howard government's 11 years in office. But rather than respond to Aboriginal people's calls for help, the government chose to take action unilaterally, without consultation, in a campaign led by military personnel. It was a response that denied the hard work that Aboriginal people themselves were undertaking.

The second aspect of the paradox is perhaps a little less obvious. The communities in question are organ-

ised around broad extended family networks. In these kin-based societies, children grow up being cared for intensively by siblings, cousins, grandmothers, aunts and uncles as they move frequently between households and, indeed, townships, in and out of the care of various relatives in a way that can be bewildering to observers from nuclear family backgrounds. The government's application of punitive measures to *all* Aboriginal people – including controlling the way people spend their welfare payments to ensure children are looked after – ignores the fact that for most Aboriginal people in this region *care of family* is the defining principle of their lives. Rather than acknowledge this set of values as the norm and see the crisis gripping such places in terms of a disruption to that norm, the government's 'emergency' typecasts all remote living Aboriginal people as irresponsible and incapable of looking after their children.

A strategically important move for the government

Painting a picture of dysfunction and pathology as the norm in remote Aboriginal Australia is a strategically important move for the government – it not only legitimises the actions of the emergency intervention but also of the government's wider aims in Indigenous affairs. For it was clear very soon after the emergency was announced that this intervention was about much more than child sexual abuse.

Legal experts have argued that there is ambiguity in the legislation over reference to "just terms" compensation that might be paid to traditional owners for the compulsory leasing of their land. Questions have also been raised as to whether the government intends to pay compensation or would seek to offset this with the delivery of services usually funded as citizen entitlements (such as the maintenance of roads and provision of basic infrastructure). Yet such debate overlooks the possibility that, for traditional owners – for whom land provides the anchorage and inspiration of their very identity – no amount of compensation might be regarded as "just". In this regard, the government's approach illustrates an utter failure to comprehend that Aboriginal people hold land to be valuable in radically different terms to the economic.

A radical shift in Indigenous affairs

There are a number of initiatives that are likely to receive widespread support from Aboriginal residents

of the towns in question – especially increased police numbers, increased support for child and family health, improved housing and infrastructure, and improved quality of goods and management of community-managed stores. But, as suggested by the scope of the legislation and statements made by the Minister subsequent to its tabling, this intervention is about much more than "fixing" existing conditions. At the heart of the government's coercive approach lies a clear intent: to bring to an end the recognition of, and support for, remote living Aboriginal people pursuing culturally distinctive ways of life.

Evidence of this intent can be observed clearly in a number of the measures, especially those concerning welfare reform and land tenure reform. Applying new controls to the welfare payments of *all* Aboriginal residents of remote townships treats *all* parents and carers as if they are irresponsible. Moreover, the quarantining of welfare monies will not just alter the Aboriginal people's spending patterns, it will place limits on *where* they can spend their money, potentially curtailing the high levels of mobility that characterise the rhythms of daily life in these parts of the Northern Territory as people travel continually to attend to kin, ceremony and country.

While the emergency response was hastily conceived, and needed broad ranging and complex legislation to back it up, the government's intentions were stated at the outset: in the words of the minister this was an intervention to "stabilise, normalise and exit" remote NT communities. Jon Altman and I employed these terms as the sub-title for a new book *Coercive Reconciliation* that brings together essays by Aboriginal leaders, academics and social commentators as the first comprehensive critical response to this intervention because we feel that they indicate a radical shift in Indigenous affairs. Any doubt that this was the case was dispelled in statements made by John Howard at the end of August, when he told residents of Hermannsburg that "whilst respecting the special place of indigenous people in the history and life of this country, their future can only be as part of the mainstream of the Australian community".[7]

Normalising the Aboriginal population

If the circumstances of remote communities are viewed as pathological or dysfunctional, then the Prime Minister's singular vision of Aborigines entering the mainstream appears perfectly reasonable. If Aboriginal people's cultural difference is to blame for the circumstances they find themselves in – and much has been said in the mainstream Australian media to

suggest this is the case – then ending support for culturally different practices and values is clearly necessary. Minister Mal Brough argues that a large part of the problem is that Aboriginal people have been "locked into communal land ownership". He suggested that ownership of land needed to be properly mixed with economic opportunity: "If we get that balance right, people will flourish."[8] He has directed the courts not to take customary law or cultural practices into account in sentencing procedures. In this sense, the intervention is aimed at nothing short of the production of a newly-oriented "normalised" Aboriginal population – one whose concerns with custom, kin and land will give way to the individualistic aspirations of private home ownership, career, self-improvement. From this perspective, bringing to an end wider Australia's recognition of customary law and communal land ownership, support for outstations and programs such as bilingual education is simply part of a process of helping Aboriginal people along the road to "normalisation".

Of particular concern since the passing of the emergency legislation has been the government's announcement that it will abolish the Community Development Employment program (CDEP). CDEP is a community development program that has operated in remote Aboriginal communities since 1977. It has multiple objectives, including community development, employment creation, income support and enterprise assistance. In recent years, CDEP has come under attack as a form of "passive welfare", and a barrier to Aboriginal people entering the "real economy". Under the terms of the intervention, the government declared that CDEP positions would be replaced with "real jobs, training and mainstream employment programmes".[9] But the reality is that there are very limited employment opportunities in remote Australia. CDEP delivers not only employment but also myriad services both within the prescribed communities and to the hundreds of smaller outstations that exist on Aboriginal lands. The abolition of CDEP will ensure the demolition of some highly innovative enterprise, and will put several thousand Aboriginal people in the Northern Territory out of work.[10]

Undermining cultural redevelopment

There are many things that get overlooked in the government's mainstreaming vision – not least the aspirations of Aboriginal people themselves. While there is some diverse opinion surrounding the intervention, Aboriginal people in the communities in ques-

tion are beginning to make it clear that, as far as they are concerned, any vision for the future must retain the foundations of their cultural identity at its core.

As Valerie Napaljarri Martin, a senior Warlpiri woman from the central Australian township of Yuendumu, put it recently: "Without our cultural side, the country, the ceremony, the sacred sites that we are connected to, the land – absolutely we are nothing. Our dignity is going to be taken away and our rights. We are nothing then."[11]

The government's vision also ignores the fact that Aboriginal people in the NT have been responding to the circumstances of post-colonial life for decades. It has been a slow and at times painful process, and by no means always successful. Yet history suggests that cultural redevelopment will only ever be successful where the people in question are centrally involved in determining the manner and pace of change.

Over the past thirty years, the transformations in remote Indigenous communities have been profound. Much dynamic activity has occurred around the development of community-based enterprise – in the arts, media production, youth programs, tourism, natural resource management.[12] A number of these programs have grown as a direct response to problems of substance abuse and disaffected youth. Rather than locking people into some form of separatist way of life, as some commentators suggest,[13] these enterprises have opened up the interface between Aboriginal communities, the wider Australian society and, increasingly, a global arena. It is in such activity that people develop a new sense of self-worth and begin to imagine positive futures for themselves and their families. This is cultural redevelopment at work. This is how hope is fostered. Many have observed that the implementation of the government's vision will ensure the demolition of some highly innovative enterprise, and bring to an end the only employment prospects for several thousand Aboriginal people. It will also kill hope.

Is there anything positive to be found in the intervention? There is certainly optimism among Aboriginal people and their supporters that the circumstances of Aboriginal people living in the Northern Territory have become visible in the mainstream media in a way that is unprecedented, and there appears to be willingness on the part of government to make a considerable investment of funds to tackle Aboriginal disadvantage. The current focus provides a unique opportunity to regenerate debate and bring fresh thinking to bear on Indigenous policy in Australia.

The destruction promised by the current course of action also raises the question of what kind of Australia will be bestowed on future generations. Will it be one where "normalised" individuals pursue the questionable "equality" of neo-liberalism – the only choice as the government sees it – or one in which Aboriginal people are given the space and support to pursue their diverse aspirations and to sustain the fundamentally different values that anchor who they are? ❑

Notes and references

1 Under Australia's federal system, there are six States and two Territories. The Northern Territory covers nearly 20 per cent of the continent but only has a population of 200,000. In 1978 it became self governing and it has its own legislative Assembly, but under s.122 of the Australian Constitution it remains under Commonwealth control.

2 This report commissioned by the NT government was undertaken by a team headed by Pat Anderson, an Aboriginal health professional and Rex Wild QC; the report found evidence of significant child sexual abuse and made 97 recommendations for considereation by the NT government

3 Hon Mal Brough media release, 21 June 2007

4 Iconic federal law that has been passed in 1976 and that saw half the NT (about 600,000 sq kms) returned to Aboriginal inalienable freehold ownership by 2007.

5 See Turner, P. and Watson, N.2007: The Trojan horse. In Altman, J. and Hinkson, M. (eds) *Coercive Reconciliaition: Stabilise, Normalise, Exit Aboriginal Australia*, Melbourne: Arena Publications.

6 Summary compiled from Department of Parliamentary Services, *Families, Community Services and Indigenous Affairs and Other Measures Bill 2007*, Bills Digest No. 21, 2007-08, Canberra, Parliament of Australia.

7 *The Australian*, 29 August 2007.

8 Hon. Mal Brough at the National Press Club, Canberra, 15 August 2007, transcript of question and answer session available at http://www.theage.com.au/news/national/questions-and-answer-session/2007/08/15/1186857591353.html

9 Hon. Mal Brough media release, 23 July 2007.

10 See Altman, J. 2007: *Neo-paternalism and the destruction of the CDEP*, available at http://www.anu.edu.au/caepr/topical.php#0753

11 *The Australian*, 8 October 2007.

12 Some of which is described in the book *Coercive Reconciliation: Stabilise, Normalise, Exit Aboriginal Australia*, edited by the author and Jon Altman.

13 See for example, Hughes, H. 2007: *Lands of Shame: Aboriginal and Islander 'Homelands' in Transition*, Sydney: Centre for Independent Studies.

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Penny Mitchell

FINDING ANSWERS TO SUICIDE WITHIN ABORIGINAL COMMUNITIES:

THE YARRABAH STORY

Yarrabah is a small community in far North Queensland Australia. Like many Aboriginal communities in Australia and America, the people of Yarrabah experienced an epidemic of suicide in the 1980s. A sudden end to the epidemic in the late 1990s has been attributed by some to the success of a suicide prevention program called the Yarrabah Family Life Promotion Program. The apparent success of this program may tempt health workers and policy makers to study the features of this program and attempt to replicate it in other Aboriginal communities. The range of suicide prevention strategies employed - including suicide prevention training for community members, a 24-hour Crisis Centre / Safe House, a telephone crisis line, one-on-one counselling, workshops on family life development and networking among community organizations – are relatively portable and seem relevant to a wide range of settings; why not just package them up into a manualised program and disseminate it as widely as possible? This approach to dissemination of health programs often fails because it does not recognize the fundamental importance of the community development process in enabling a community to develop, implement and maintain such programs. In their comprehensive study of the historical, cultural and symbolic context of sui-

cide among indigenous communities in North Queensland, Ernest Hunter, Joseph Reser, Mercy Baird and Paul Reser provide a detailed account of how one Aboriginal community searched deep within itself to find its own answers, and they explain how this process is absolutely critical to the development of effective solutions. The Yarrabah story has important lessons to contribute to our understanding of the process of community engagement and empowerment around the problem of suicide.

The history of Aboriginal suicide in Yarrabah

The Yarrabah area was originally inhabited by the Yindinjdji. An Anglican mission was founded in 1892, imposing a ban on all traditional activities (The State of Queensland, 2007). The community is not a natural grouping within the Aboriginal population of North Queensland. The township was formed through "the forced co-location of disparate Aboriginal groups, including the relocation of children of mixed descent who had been removed through state-sanctioned abduction from their families and communities elsewhere in Queensland" (Hunter et al, 1999: 57). It was not until the 1960s and 1970s that Yarrabah was slowly provided

Creating Futures: Influencing Social Determinants of Mental Health and Well-Being in Rural, Indigenous and Island Peoples. Conference held in Cairns in September 2006.
Photo: Jack Hicks

with the infrastructure and services available to nearby non-indigenous communities. The town was fully electrified in 1965 and a hospital was built in 1963. Residents obtained greater freedom and autonomy when a sealed road to the nearest city, Cairns, 40 km away, opened in 1972. Government administrators gradually moved out of the community in the following years; however community self-management did not begin in any real sense until the mid to late 1980s. Today 3,000 people, almost all Aboriginal, live in the community.

The first confirmed suicide of an Aboriginal person in Yarrabah occurred in 1974 and, although there were numerous suicides in nearby Palm Island in the 1960s and 1970s, suicide did not become a common occurrence in Yarrabah until the mid 1980s. The suicide epidemic in Yarrabah has been described as occurring in three distinct waves. Three deaths occurred in the mid 1980s, nine in the early 1990s, and eight more in the mid 1990s. There were no deaths from suicide in 1997 or 1998.

The Yarrabah Family Life Promotion Program

The Yarrabah Family Life Promotion Program was formally initiated by the Yarrabah Community Council in late 1995 with a grant of $50,000 from the State Government, and funding from the Community Development Employment Program (CDEP) to employ two workers called Family Life Promotion Officers. In mid 1996, a life-long resident of the community, Mercy Baird, was commissioned to undertake community consultations and produce a five-year plan for the program. The priorities identified by the community were: family life skills; culturally appropriate services; education and training; and other projects. A clear Mission Statement for the Family Life Promotion Program was also formalized.

The Program has evolved consistently towards a comprehensive approach based on a social understanding of health that emphasizes risk and protective factors operating at the community as well as the individual level. Specific strategies implemented under the Program include:

- education and training programs for individuals and families to empower them with the knowledge, skills and understanding to deal with the suicide problem from a holistic healing perspective;
- crisis intervention including a Crisis Centre/ Safe Place that provides short-term (24-hour) support during crises, and a Telephone Crisis Line;

- one-on-one counselling, grief and loss counselling, and family support groups;
- postvention, including information and self-awareness programs for survivors of suicide and those who are at risk;
- promotion of healthy family life through workshops on parenting and personal relationship development; and
- networking and coordination with community agencies to encourage and support all people in the community, and especially youth at risk, to be involved and participate in sporting, recreational and cultural activities, to promote unity amongst family and the community.

The abrupt end to the epidemic of suicides after the initiation of this program is remarkable. But no less remarkable is the fact that a program of this sophistication was able to become established and survive past the start-up phase. Key problems experienced early in the life of the program included: an excessive and rapidly escalating workload for the two Program Officers; a lack of protocols to ensure provision of adequate and timely back-up to the officers by other professionals when needed; as well as transport and worker safety issues. The workers experienced burn-out and there was a high turnover of staff. However, with persistence, and through the active involvement of a highly engaged community network, stability was achieved and protocols were developed for responding to crises which specified the roles of other services such as the hospital and the police, as well as family and friends.

Many similar community-based programs fail to survive these common start-up difficulties. How did the Yarrabah community manage to carry it off? To understand this we need to look behind the surface of the program itself, to the history of its development and the evolution of structures and processes within the community that act as foundational supports. From the detailed chronological account provided by Hunter et. al., at least seven key factors can be discerned.

Owning the problem and seeking solutions within the community itself

The central theme in Hunter et al.'s account of the Yarrabah experience is the absolute necessity of the community "owning the problem and seeking the core elements to solutions within the community itself". This is particularly critical in indigenous communities where the social and cultural factors that have led to increased risk of suicide are, in large part, due to historical factors that have removed or actively suppressed self determination over a long period of time, leading to chronic feelings of helplessness and hopelessness at an individual and community level. The implication is that solutions brought in by outsiders cannot address these fundamental predisposing risk factors.

Hunter and colleagues also show how suicide, particularly by hanging, has become incorporated into the contemporary culture of some indigenous communities as a symbol of, and response to, ongoing dispossession, social inequality and injustice. The "enculturation" of suicide in this manner further indicates the fundamental importance of indigenous communities developing their own cultural counter-response. Hunter and colleagues present convincing evidence that the Yarrabah community was highly engaged in the task of identifying and developing its own solutions.

The terms "community engagement" and "community ownership" are often used interchangeably but it can also be helpful to understand ownership as a separate phenomenon or process that begins early in a successful community development process, and which facilitates engagement and empowerment in the medium to long term. Hunter et al. see community ownership as a political commitment to action that is widely shared across the community. They provide convincing evidence that the Yarrabah community owned the problem in a very deep sense.

The authors describe how the Yarrabah community progressed through a series of stages before entering into a state of full ownership of the suicide problem. Full ownership is seen as stemming from an understanding that lasting solutions can only be found within the community itself and manifests as a widely shared political commitment to action. The process was slow, and accompanied by much pain and grief over a long period of time. A stage of "consternation and confusion" turned into a feeling of "resignation and rejection" but there was also an increasing level of critical reflection, a "looking in" to identify causes and solutions within the community and a "looking around" at broader, related social issues.

Eventually, after considerable critical reflection, the community came together in a number of meetings to talk and identify solutions. A stage of "commitment and collaboration" was being reached. There was a sense of shared realisation that the problem had to be addressed by the whole community working together. Following this, Yarrabah moved on to a phase of "persistence and planning", focusing on building sustainable structures for social, emotional, cultural and spiritual well-being.

Democratic, community-controlled decision-making structures

The process of community empowerment that took place in Yarrabah was associated with the growth and formalization of structures for community self-management, which have developed gradually since the mid 1980s.

Originally established as an Anglican mission in 1892, the Federal Government took over running of the mission in 1960. In 1965, an Aboriginal Council was established which acted only as an advisory body and reported to the Federal Government Department of Aboriginal and Torres Strait Islander Affairs (The State of Queensland, 2007). In 1984, Queensland established a system of community-level land trusts to own and administer former reserves under a special form of title called a Deed of Grant in Trust (DOGIT). Local Community Councils in DOGIT communities are able to make by-laws, appoint community police, and are responsible for maintaining housing infrastructure, the Community Development Employment Program, licences and hunting and camping permits (The State of Queensland, 2007). Yarrabah became a DOGIT community in 1986, and the Yarrabah Community Council was established as a vehicle for the exercise of democratic community-based decision-making.

Hunter et al. observe that citizens' perceptions and acceptance of their civic responsibilities increased when formal democratic decision-making structures and processes were made accessible to them. For example, when the Federal Government owned the housing at Yarrabah, people took little pride or interest in trying to maintain their overcrowded and rapidly deteriorating houses. When buildings needed repair, residents would wait passively for the government to fix them. Decades of missionary then government intrusion and control had led to the entrenchment of a culture of institutional dependency in many indigenous communities such as Yarrabah. However, as departmental responsibility decreased and community control increased, people gradually began to take a more active interest and involvement in community issues such as housing, health services, alcohol use, interpersonal violence and suicide.

A social-historical understanding of health

Throughout the mid to late 1980s, as the first wave of suicides occurred in Yarrabah, a number of health professionals and students completed studies into the health problems of the Yarrabah community. These researchers noted the extremely poor and overcrowded housing conditions as one of the greatest obstacles to improved health. As a Director of Nursing wrote in 1987, "It does not matter if the problem is one of parental neglect, continual sickness, truancy, child abuse, incest or alcohol or drug abuse, it always has the same roots in the overcrowded housing situation. Sometimes families have to be broken up because they simply have nowhere they can live together" (Hunter et al, 1999; 62).

Hunter et al. also note historical factors which they believe exacerbate social tensions, poor social connectedness, and interpersonal violence in communities such as Yarrabah. Development of an understanding of the socio-historical roots of contemporary health problems was a necessary precursor to the community eventually taking responsibility for addressing their own health problems, including suicide.

A comprehensive Primary Health Care Approach

Based on the findings of the social research, which emphasized the socio-historical factors underlying the poor health of the Yarrabah population, a "Proposed Health Care Plan for Yarrabah Community Council" was completed in 1988. This Plan identified a set of core problems, and called for the setting up of a community-based health committee to work towards establishing an independent and integrated health care system based on the World Health Organisation's principles of Primary Health Care (World Health Organisation, 1978). The Yarrabah Health Council was duly formed in 1988. Along with the work of the Yarrabah Community Council, the Primary Health Care approach to health service development adopted by the Yarrabah Health Council provided a valuable conceptual and practical framework for supporting a range of community-initiated responses to the suicide problem at Yarrabah.

In 1996, a five-year development plan was produced for Yarrabah by external consultants who noted that existing services remained limited and tended to operate in isolation from each other. Consistent with the "Proposed Health Care Plan for Yarrabah Community Council" produced a decade earlier, the consultants recommended that a clear network be established between service providers.

Hunter et al. note that efforts to expand and improve the primary health care system at Yarrabah, and to achieve greater community control, are ongoing and that this process has been facilitated by the mobilisation of the community around the issue of suicide.

A focus on community risk rather than individual risk

Early actions directed towards suicide prevention focused at the individual risk level, including efforts to provide a visiting psychiatric service, were largely ineffective. Through a process of trial and error, Yarrabah citizens and organisations eventually came to focus more strongly on interventions that addressed community-level risk factors. Hunter et al. note two main advantages of the community-level risk approach. First, this approach acknowledges and addresses the underlying causes of self-harming behaviour in Aboriginal communities. Second, it provides a conceptual and practical framework that accommodates the involvement of ordinary community members in a way that the individual risk focused approach does not.

Toward the end of the second wave of suicides that swept through Yarrabah, a more cohesive sense of "community ownership" of the suicide problem began to crystallize A series of community meetings was held in 1993 and 1994 to discuss the suicide problem and review current responses. These meetings were increasingly organised through cooperation between the Yarrabah Health Council, the Yarrabah Hospital and the Yarrabah Community Council. At the first meeting, community members attending decided that the way attempted suicides were currently being handled was not acceptable (too many admissions to hospital in Cairns), and that local health workers would be in a better position to respond appropriately if they were provided with adequate training and support. At subsequent meetings, community members talked about a range of other related social issues that could be contributing to the suicides in the community, such as authority over children, the situation at the school, and local economic issues. Pressure was put on the Health Department for the provision of specific training in "suicide prevention". Funding was eventually obtained from the Health Department and training in counselling was organised, provided by the Aboriginal Studies Program at Curtin University. Attendance was open to everyone. The course focused on historical traumatisation and "cultural healing".

Development of knowledge and skills

The story of Yarrabah shows that the capacity of the community to identify causes and solutions was associated with a long process of study and reflection. Knowledge was initially generated by a series of studies on health and social issues affecting the Yarrabah community by researchers and health professionals from outside the community. Over a period of time, community members reflected on this research, as well as their own experience, and were able to begin to make sense of the suicide issue. Eventually, the community began to commission research into specific issues that they needed more information on, in order to inform decision-making and planning. On several occasions, the Yarrabah community also sought training in specific suicide prevention skills that they believed were needed by community members, such as crisis intervention and counselling.

Time

Securing the engagement of a significant number and cross-section of people in a community requires a considerable length of time. As already noted, Hunter et al. describe how the Yarrabah community had to pass through a series of stages before they developed an understanding of what was happening in the community and came to realise the need to work together for common goals.

Conclusions

The major concern of Hunter et al. in their historical analysis was to document the wider social changes within which the Yarrabah Family Life Promotion Program is embedded and demonstrate their critical importance for understanding the decline in suicides that has occurred in Yarrabah. Not only do these wider social changes provide a structural base that supports the existence and effective functioning of specific prevention programs and activities but it is also likely that these wider social changes have contributed directly to the decline in suicides through enhanced community empowerment, connectedness and well-being.

The Yarrabah story provides rich insight into the reasons why interventions grounded in a true or "structural" community development process are more likely to be effective than interventions that operate in isolation from the community, or which involve primarily "instrumental" community participation. Two main features of the process stand out.

Community ownership

The Yarrabah story demonstrates the way in which community ownership of problems and solutions

works to generate and sustain practical support for effective interventions and directly enhances community well-being. The meaning of the concept of community ownership, and practical evidence of its benefits, are illustrated in several ways.

First, the problem of suicide was owned by the community in that the community came to an awareness of the problem on its own, rather than being told by outsiders that it was a problem. Second, as the community developed awareness of the problem, different groups gradually developed a shared political commitment to addressing the problem, and began to work together to seek solutions within that community. This included approaching outsiders to assist in the development and implementation of the kinds of solutions identified. Finally, following ownership of the problem and development of shared commitment to action, interventions and activities were formulated, initiated and driven from within the community involved, rather than by outsiders. The community development process at Yarrabah was consistently driven from the inside. At all times, it was locals who came up with ideas about what the community needed to do. With experience, it became apparent that some of these solutions were not the most appropriate, but these experi-

ences contributed to the community's own learning process.

Social structures

A second critical component of the wider social changes that took place in Yarrabah was the development of formal structures capable of supporting processes of debate, discussion and decision-making. The community development process that took place in Yarrabah occurred in association with the growth and formalisation of clear structures for community self-management, especially the Yarrabah Community Council and the Yarrabah Health Council. The growth of these organisations was stimulated by, and in turn supported, further increases in community empowerment. Features of these organisations that appeared to be critical to their capacity to facilitate community development include their democratic control by the community, their significant decision-making powers with respect to the management of services in the community, and their role in creating opportunities for community members to participate in discussing problems and finding solutions. The existence of "opportunity structures" that support meaningful participation in com-

Members of the Yarrabah Men's Health Group. Photos: Jack Hicks

munity has long been observed as critical to the problem of suicide and its prevention (Giddens, 1978).

Implications for practice

What are the major implications of the Yarrabah experience for practitioners wishing to enhance community development practice? When the findings of the study by Hunter et al. are examined alongside those of the evaluations of community development projects funded under Australia's National Youth Suicide Prevention Strategy (see Mitchell 2000b), the limitations of conventional "instrumental" or "top-down" approaches to community development become painfully apparent.

Community development initiatives that involve outsiders working to promote community engagement with a particular issue are at a distinct disadvantage in the community ownership stakes because they tend to ignore or deprioritise other issues that the community may have previously prioritised. This can have the effect of alienating people who have identified or have been working on other issues, and is particularly problematic in small rural communities where human resources are scarce. Such "top-down" community development initiatives also tend to rely heavily on a limited range of strategies prioritised by project managers who rely on their expertise to make such judgments. Time limitations around most community development "projects" also limit the ability of projects to identify and properly test locally derived solutions.

The critical importance of ensuring genuine community ownership of problems and programs does not mean that governments and authorities do not have an important role to play in community development. Rather, the problems associated with conventional approaches to community development suggest that the role of government should be responsive rather than proactive, and facilitative rather than directive. This point has been observed repeatedly in community development literature. A responsive and facilitative approach is difficult, however, particularly within dominant policy and funding frameworks that focus strongly around particular problem categories or silos, such as suicide, or drug and alcohol misuse, or child abuse. This categorical approach to funding seriously limits local discretion and control over the distribution of resources and their ability to address underlying social factors (Buchanan, 2000).

The Yarrabah experience also demonstrates the importance of organisational structures capable of sustaining ongoing community participation in the full range of decisions that affect community well-being. Development of such organisational structures is generally a task that is beyond the ability or responsibility of small, time-limited community development projects funded by particular government departments in order to address particular social or health problems such as suicide. It can only be accomplished through a sustained whole-of-government commitment to the development and maintenance of infrastructure.

In conclusion, an important role for government in community development is to develop policy and administrative frameworks that facilitate increased local control over the allocation and management of resources for services and programs, and the development of organisational structures capable of supporting democratic participation. Increased intersectoral collaboration by all levels of government is essential. ❑

This article is a brief version of a longer article by Penny Mitchell published in Australia's Youth Suicide Prevention Bulletin No.4 in 2000. It reviews findings from a study conducted by Hunter, Reser, Baird and Reser (1999) on suicide among Aboriginal people in North Queensland, Australia.

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IWGIA – INTERNATIONAL WORK GROUP FOR INDIGENOUS AFFAIRS

IWGIA's aims and activities

The International Work Group for Indigenous Affairs - IWGIA - is a non-profit making, politically independent, international membership organization.

IWGIA co-operates with indigenous peoples all over the world and supports their struggle for human rights and self-determination, their right to control land and resources, their cultural integrity, and their right to development. The aim of IWGIA is to defend and endorse the rights of indigenous peoples in concurrence with their own efforts and desires. An important goal is to give indigenous peoples the possibility of organising themselves and to open up channels for indigenous peoples' own organizations to claim their rights.

IWGIA works at local, regional and international levels to further the understanding and knowledge of, and the involvement in, the cause of indigenous peoples.

The activities of IWGIA include: publications, international human rights work, networking, conferences, campaigns and projects.

For more information about IWGIA's activities, please check our website at: www.iwgia.org

Publications

IWGIA publishes a yearbook, *The Indigenous World/ El Mundo Indígena*, and a journal *Indigenous Affairs/ Asuntos Indígenas*. Furthermore, a number of books thematically focussing on indigenous issues are published each year.

Suggestions for and contributions to IWGIA's publications are welcome and should be submitted to the editors in charge.

INDIGENOUS AFFAIRS 3/07 - MIGRATION

Alejandro Parellada &
Alvaro Bello M. (eds.)

The articles in this issue of Indigenous Affairs bear witness to various aspects of the phenomenon of indigenous peoples' migration. Above all, they offer an insight into the way in which indigenous people around the world experience their migration and shed light on its root causes. The global scene of deterritorialized communities and the constant re-creation of identities is examined, and it becomes clear how migration concerns not only individuals, but whole communities and ethnic groups that have accepted migration as a way of surviving.

IWGIA – 2007
ISSN 1024-3283 – 52 pages – maps – photos – (also available in Spanish)

MARCANDO TERRITORIO
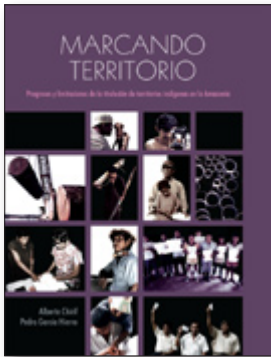
Alberto Chirif & Pedro García Hierro

PROGRESOS Y LIMITACIONES DE LA TITULACION DE TERRITORIOS INDIGENAS EN LA AMAZONIA

Anthropologist Alberto Chirif and lawyer Pedro García discuss the important gains made by the Amazonian indigenous movement in terms of the legalisation of their territories. But they also question the territorial control (or loss thereof) that indigenous communities have actually experienced in recent years. This book endeavours to 'think outside the box' and turn the problem of indigenous territoriality on its head so as to look at it from a completely new perspective.

IWGIA - 2007
ISBN 97-88791563393 – 344 pages – maps – (only available in Spanish)
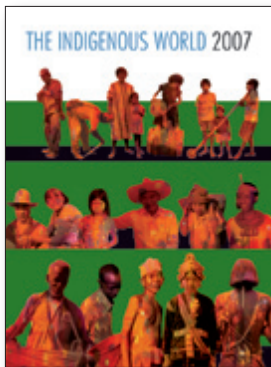
THE INDIGENOUS WORLD 2007

Sille Stidsen (ed.)

This Yearbook covers the period January-December 2006. IWGIA's Yearbook is issued every year in April-May. With contributions from indigenous and non-indigenous scholars and activists, its purpose is to provide an update on the state of affairs of indigenous peoples worldwide.

The Indigenous World is a source of information and an indispensable tool for those who need to keep abreast of the most recent issues and developments within the indigenous world.

IWGIA - 2007
ISBN 9788791563232 – 594 pages – maps – (also available in Spanish)

INTERNATIONAL WORK GROUP FOR INDIGENOUS AFFAIRS