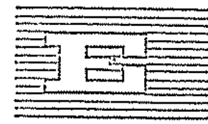

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STUDY OF THE PROBLEM OF DISCRIMINATION AGAINST INDIGENOUS POPULATIONS

Final report (last part) submitted by the Special Rapporteur,
Mr. José R. Martínez Cobo

CONTENTS

Chapter				Paragraphs	Pages
XI	Health, medical care and social services			1 - 173	3
	A.	The right to health services, medical care and other related social services		1 - 79	3
		1.	Preliminary remarks	1 - 19	3
			(a) The recognition of these rights	1 - 9	3
			(b) Problems of implementation	10 - 19	5
		2.	The failure to provide equal access to health services for indigenous populations	20 - 41	6
		3.	The impact of *de facto* discrimination on indigenous health	42 - 59	13
			(a) Preliminary remarks	42 - 44	13
			(b) Information available	45 - 59	13
		4.	*De jure* discrimination related to health, medical and social services	60 - 79	23
			(a) Preliminary remarks	60 - 61	23
			(b) Restrictions on the sale or the consumption of alcoholic beverages	62 - 75	23
			(c) Restriction of services to recognized or registered members of indigenous groups	76 - 79	27

GE.83-16683

	Paragraphs	Pages
B. Special considerations in providing health services to indigenous populations	80 - 113	29
1. Preliminary remarks	80 - 82	29
2. The importance of the socio-cultural factors	83 - 107	29
(a) Traditional practices and beliefs	83 - 93	29
(b) Alcoholism	94	32
(c) Nutrition	95 - 107	35
3. The relevance of the physical environment	108 - 113	39
C. Special measures taken by Governments	114 - 173	41
1. Preliminary remarks	114 - 115	41
2. Available information on measures adopted	116 - 145	41
3. The importance of training programmes	146 - 161	54
(a) Preliminary remarks	146 - 147	54
(b) Examination of available information	148 - 161	55
4. Programmes to combat alcoholism	162 - 167	58
5. Special measures to combat dietary deficiencies	168 - 173	60

XI. HEALTH, MEDICAL CARE AND SOCIAL SERVICES

A. The right to health services, medical care and other related social services

1. Preliminary remarks

(a) The recognition of these rights

1. The right to an adequate standard of health and medical care as well as the right to social security have received international recognition in several international instruments on human rights adopted by the General Assembly of the United Nations or by United Nations specialized agencies.

2. Regarding the right to an adequate standard of health, the Universal Declaration of Human Rights provides:

"Article 25

"1. Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

"2. Motherhood and childhood are entitled to special care and assistance. All children, whether born in or out of wedlock, shall enjoy the same social protection."

The International Covenant on Social, Economic and Cultural Rights stipulates:

"Article 12

"1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

"2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:

"(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

"(b) The improvement of all aspects of environmental and industrial hygiene;

"(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;

"(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness." 1/

1/ In article 7, States parties to the Covenant recognize the right of everyone to the enjoyment of just and favourable conditions of work "which ensure, in particular: ... (b) safe and healthy working conditions".

3. As far as the right to social security is concerned, the Universal Declaration of Human Rights declares:

"Article 22

"Everyone, as a member of society, has the right to social security and is entitled to realization, through national effort and international co-operation and in accordance with the organization and resources of each State, of the economic, social and cultural rights indispensable for his dignity and the free development of his personality."

The International Covenant on Social, Economic and Cultural Rights provides:

"Article 9

"The States Parties to the present Covenant recognize the right of everyone to social security, including social insurance."

4. In addition to attributing these rights explicitly to "everyone", both texts interdict "distinction" (Declaration) or "discrimination" (Covenant) of any kind based on criteria such as "race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status". These interdictions are contained in the respective article 2 of both texts.

5. The International Convention on the Elimination of All Forms of Racial Discrimination includes "the right to public health, medical care, social security and social services" among the economic and cultural rights in regard to which States parties to the Convention have undertaken to prohibit and eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour or national or ethnic origin, to equality before the law (articles 2 and 5 (e) (iv)).

6. ILO Convention No. 107, concerning the Protection and Integration of Indigenous and Other Tribal and Semi-Tribal Populations in Independent Countries (Indigenous and Tribal Populations Convention, 1957) provides, as regards the right to health:

"Article 20

"1. Governments shall assume the responsibility for providing adequate health services for the populations concerned.

"2. The organisation of such services shall be based on systematic studies of the social, economic and cultural conditions of the populations concerned.

"3. The development of such services shall be co-ordinated with general measures of social, economic and cultural development."

Concerning the right to social security, it states:

"Article 19

"Existing social security schemes shall be extended progressively, where practicable, to cover:

"(a) wage earners belonging to the populations concerned;

"(b) other persons belonging to these populations."

7. It may be noted in closing this aspect that the Convention on the Prevention and Punishment of the Crime of Genocide declares in article II, which defines genocide, that:

> "In the present Convention, genocide means any of the following acts committed with intent to destroy, in whole or in part, a national, ethnic, racial or religious group, as such;
>
> "...
>
> "(c) Deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part;
>
> "...".

8. The right to an adequate standard of health, medical care and social security services is also recognized at the national level. Thus, in some countries 2/ the constitution stipulates that ensuring and protecting the health and welfare of citizens or of all inhabitants are functions and obligations of the State. These provisions have to be read in conjunction with other constitutional provisions prohibiting discrimination on the ground of race, colour, language, religion, national or other origin or other status, *inter alia*. It is clear then that these services are to be made available on a non-discriminatory basis.

9. In all countries covered, there are important statutory and regulatory provisions governing health and medical services and associated social services, generally within social security schemes for workers.

(b) Problems of implementation

10. Despite international and national recognition of the right to adequate health and medical care on a non-discriminatory basis, in most countries indigenous peoples, in so far as they form part of the rural population and have special health problems, do not have equal access to facilities and services. While both private and public services are available in urban areas (although, it is true, in most instances, only to those who can afford them) those same services are often not readily available or are unavailable at any price in the rural areas where most indigenous people live. Many arguments have been advanced to explain this imbalance. For economic as well as political reasons, Governments tend to give priority to health and other services in urban areas. Urban forces are more likely to command attention.

11. It is politically less essential and economically more costly to provide the same level of care in sparsely populated areas. Similarly, private institutions are not particularly attracted to rural areas because of the limited returns on their investment. Medical personnel are further discouraged from practising in rural areas because of the lack of facilities for their families, the lack of opportunity to maintain contact with professional developments and the absence of proper equipment and appropriate support staff for professional work. The unavoidable changes in cultural environment are not infrequently invoked as an additional deterrent.

12. Rural inhabitants who have come to live in urban centres tend to find space only in the shanty towns encircling these centres and swell the numbers of unqualified personnel in public and private employment, if they are lucky enough to find any gainful employment. It is even more difficult for rural inhabitants to move exclusively so as to receive medical attention in the urban centres.

2/ For example Bangladesh, Brazil, El Salvador, Ecuador, Guatemala, Honduras, India, Pakistan and Venezuela.

13. The constitutional and statutory mandate calling for non-discriminatory health and medical services has been implemented through plans for the transfer of urban services and personnel, without changes in organization and training, to areas outside the urban centres. The result has been that the effectiveness of the health and medical services that reach rural and indigenous populations in the countryside is seriously reduced.

14. In the cities, such personnel and services are naturally geared to deal with the needs of the urban dweller within his socio-cultural and physical environment. Urban services and personnel are therefore not attuned to the different situation and needs of the rural recipient of the services concerned. These services must therefore be tailored and personnel trained to adjust and adapt to the different socio-cultural and physical environment prevailing in the rural areas. The mere transfer of urban services and personnel to rural areas, even if unrestricted, is therefore inadequate.

15. It has been stated above, however, that many health and medical personnel are not attracted by practice in the rural areas, because of the shortage of necessary facilities and equipment and appropriate support staff. Those who do go to rural areas are inappropriately trained and ill prepared and existing schemes are not adapted to the rural situation and needs, with the result that inferior health and medical services are made available to rural and indigenous populations. In order to adapt these services, plans and personnel to indigenous populations, programmes and schemes must be suitably oriented, personnel must be appropriately trained and prepared and equipment must be suited to the different conditions existing in the area. Unless these changes are incorporated in the system it will not serve its purpose. What is appropriate and effective for some people is not necessarily appropriate and effective for others with different needs and in a different environment.

16. Mortality and morbidity rates and life expectancy figures are among the most accurate criteria for assessing the suitability of health and medical services.

17. It is an established fact, that in all countries the mortality rates, and particularly the infant mortality rates, are higher and that life expectancy is lower for rural and indigenous populations than for urban inhabitants in general. This indicates that health services and personnel for rural populations groups are inadequate.

18. Thus a pattern of conduct amounting to a failure to provide adequate health and medical services for rural populations emerges which, if continued, could become *de facto* discrimination. Only specially devised positive government programmes can correct this imbalance, which is further accentuated by the dearth or outright absence of private initiative in rural areas which have been neglected to a greater or lesser degree for far too long.

19. The present chapter attempts to deal with these matters in the light of very fragmentary and incomplete information which, in the case of some countries, was almost non-existent. The information on social security matters did not give rise to any cogent discussion and is only presented here in the few instances in which an explicit reference was made to it in the information supplied for the purposes of the present study.

2. The failure to provide equal access to health services for indigenous populations

20. Although the reasons may vary and the situation is not necessarily the desired result of a deliberate course of action, it may be said that most nations in which indigenous populations live today have failed to provide them with health services

that are equal to those available to the rest of the population. This is true, even in States which have allocated more funds to this area and in which indigenous populations may, in effect, enjoy better health services than their counterparts in other countries. The information from governmental and non-governmental sources contained in the following paragraphs shows that these circumstances are generally recognized and provide examples of the type of inadequacy which may exist in the provision of this kind of service.

21. The failure to provide adequate health and medical services to rural and indigenous populations in particular is recognized everywhere.

22. In general, the three main reasons for this situation are the isolation or sparsity of indigenous settlements, imbalance in the distribution of medical personnel and services between urban and rural areas and the conditions of poverty in which indigenous populations are incorporated into a market economy and which means that they lack the economic power for adequate services. It must be noted, though, that these circumstances frequently coincide in different degrees of intensity.

23. Several Governments and non-government services refer in particular to the relative isolation or sparsity of indigenous settlements. Thus, the Government of Canada, recognizing the shortcomings of health and other services among native communities, has stated:

> "The isolation of most native communities poses a severe obstacle to health care. Public health care is often inadequate and little has been done in the field of mental health or family planning programs. Few programs exist which successfully surmount the cultural and language barriers in remote regions."

24. The relative isolation of the indigenous population of Costa Rica is also cited by the Government as the principal reason why Indians do not enjoy equal access to public and private health facilities or other social services. It notes, however, that Indians now inhabit isolated and rather unproductive areas because they have been displaced, despite the existence of laws which should protect Indian lands.

25. The Government of Panama reports that "geographical remoteness, defective methodology and lack of material resources are major obstacles to the conduct of health programmes."

26. Similarly, according to the Government of Denmark, it endeavours to provide the population of Greenland with treatment of the same standard as that received in Denmark, but "the simple fact that Greenland is sparsely populated makes it difficult fully to live up to this target." 3/

27. Despite the existence of various government health services which are open to all citizens, the Government of Australia reports that aboriginal health remains a major problem:

3/ Information furnished on 21 May 1981.

"... Many Aboriginals display a stoic endurance of poor health rather than positive concern for good health, particularly the good health of children. Aboriginals are often reluctant to attend clinics and hospitals, and are deterred by the administrative requirements of schemes such as the Subsidised Health Benefits Plan. Poor nutrition, ignorance, apathy, and all the concomitants of the depressed socio-economic circumstances in which many Aboriginals live tend to lower their resistance and encourage the spread of disease. In addition, many Aboriginals live in rural or remote areas where it is difficult to provide normal community health services. In such areas serious illness necessitates evacuation to a hospital, and this is often resisted or resented by the Aboriginal community."

28. According to an official source, there is no adequate medical coverage for the majority of the population of Bangladesh, and in rural areas, medical care is available to no more than 25 per cent of the inhabitants.

29. In the information concerning other countries more emphasis is placed on the unequal distribution of medical personnel and services which are concentrated in urban centres.

30. Thus, according to one source, about half of Burma's doctors practice in Rangoon and Mandalay, and most of the remainder are in the larger towns. Few physicians are available in rural areas and villagers have to travel to urban centres for modern medical care or depend on medical assistants at rural health centres or traditional practitioners. The situation with regard to dentists is more serious: in 1971, there were believed to be only 26 dentists in the entire country. 4/

31. A similar maldistribution of medical personnel is reported to exist in Indonesia, where in the early 1970s one-fourth of all practising doctors were concentrated in Djakarta, and most of the rest were located in other major urban areas, so that effective ratios ranged approximately from one doctor per 5,000 Djakarta to one doctor per 200,000 in Bali. In some rural regions, moreover, there were no doctors at all, and medical care of all kinds was left exclusively in the hands of about 50,000 traditional _dukuns_. 5/

32. One source maintains that health care and other social services are not readily available in rural areas of Paraguay:

"Public health, sanitation, and welfare programs made some progress during the 1960s, but in 1971 their principal impact had not yet reached beyond Asunción and a few of the larger towns. There were practical difficulties to be met in bringing the benefits of these programs to the scattered rural majority of the population. In addition, country people

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4/ John W. Henderson and others, _Area Handbook for Burma_, Washington, D.C., 1971, pp. 96-97.

5/ John W. Henderson and others, _Area Handbook for Indonesia_, The American University, Washington, D.C., 1970, p. 177.

were distrustful of those medical and dental services available to them, and participation in the national social insurance program was mandatory only for the predominantly urban wage-earning sector of the labor force."

"...

"The fragmentary statistics available indicate that during the 1960s at least three-fourths of the doctors, dentists, and graduate nurses were located in Asunción. Most of the laboratory personnel worked in the capital city, and social service personnel were assigned only in Asunción and in a few of the health centers in the larger towns. There were pharmacists in most of the interior, where they provided the permanent staffs of the health posts and units." 6/

33. The Anti-Slavery Society has reported that in Paraguay the geographical distribution of medical and hospital facilities is unfavourable to the regions inhabited by the majority of the indigenous populations and that "the health situation is ... obviously worse for the Indians than for the rest of the population ..."

34. In its opinion, the health situation of the Indian is more the result of inferior housing, nutrition and labour conditions than the lack of medical services. However, it asserts that the extremely bad health situation of the Aché Indians living in the Colonia Nacional Guayaki is partly due to deliberate withholding of medical care.

35. Available figures for Guatemala show that physicians are concentrated primarily in the capital and that the central Government's <u>per capita</u> expenditures on health services are much higher in Guatemala City than in rural areas:

"The ratio of physicians to population is one to 5,000. This figure, however, is highly misleading since 82% of the MDs practise in Guatemala City. Thus the ratio for rural Guatemala is one MD per 17,000 people, though rural MDs generally practice in the town centers and are not readily available to the majority of the rural population. It is estimated by some that, '... a minimum of three million persons in the rural areas have no ready access to a MD.'

"The [central] government's <u>per capita</u> expenditure in the health sector varies from one department to the next with the <u>per capita</u> expenditures for Guatemala City being at least six times higher than for the various Highland departments. There are efforts to overcome this maldistribution and to get physicians out to the rural areas as a three month obligatory service by last year medical students as well as an attempt to establish a six month rural obligatory service for interns. Though these are commendable efforts, they do not really begin to meet the real health needs of the people in the Highlands. It must also be

6/ Thomas E. Weil and others, <u>Area Handbook for Paraguay</u>, The American University, Washington, D.C., 1972, p. 65.

mentioned that a number of rural government centers and puestos de salud - though staffed by physicians and nurses - often do not have medicines necessary for treatment and in many towns where there are government health posts there are no pharmacies." 7/

36. Official estimates show that some 96.5 per cent of the indigenous people in Mexico who live in small rural towns or in marginal neighbourhoods do not have basic sanitary services such as potable water, sewerage and sufficient living space. Running water, gas and other urban services are practically unknown among the indigenous population. Most Indians are not covered by social security since they are either independent or temporary workers. Therefore, they depend on the medical posts established by the Secretaría de Salubridad y Asistencia and Instituto Nacional Indigenista. The Government has stated, however, that its medical services have never reached all of the indigenous population and that some 53 per cent of that population (as of 1977) had more inhabitants per doctor and higher general mortality rates than the rest of the population. 8/

37. In its report to the VIII Congreso Indigenista Interamericano, the Government of Bolivia recognized that health care for the indigenous population was still in the initial stage since there were insufficient funds to provide care in rural areas. Though in some areas medical posts have been established in recent years, there are not enough doctors or paramedical personnel to man the rural health centres. The Government has attempted to remedy this situation by requiring that each doctor spend a year in rural service before receiving his degree, but this and other measures have not been successfully enforced. 9/

38. This lack of qualified medical personnel often seems to be compounded by the lack of qualified pharmacists in rural areas. Further, the circumstances under which drugs are distributed in the rural areas of many countries constitute a health hazard. As an example of the global situation, it may be useful to quote here what has been stated about Bolivia:

"In the Altiplano towns, and occasionally in the cities as well, the pharmacy may represent a hazard as well as a cure. Most drugs are available without prescription, and the druggist may also

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7/ Kris Heggenhougen, "Health care at the edges of the world - Indian campesinos as health workers in the Guatemalan highlands", in Actas del XLI Congreso Internacional de Americanistas, Mexico, 2-7 September 1974, vol. III, Mexico 1976.

8/ "Informe Nacional de México" VIII Congreso Indigenista Interamericano (Mérida, Yucatán, Mexico) 17-21 November 1980, OAS doc. No. OEA/Ser.K/XXV.1.8, CII/doc.8, 12 November 1980, Original: Spanish pp. 17-18.

9/ "Informe Nacional de Bolivia", VIII Congreso Indigenista Interamericano (Mérida, Yucatán, Mexico), 17-21 November 1980, OAS document No. OEA/Ser.K/XXV.1.8, CII/doc.7, 12 November 1980, Original: Spanish, p. 38.

be a traditional practitioner. In the La Paz press a regularly carried advertisement concerns a product guaranteed to restore male virility. In the towns, sophisticated but little-tested European drugs are available and the prescribed doses are given in languages certainly meaningless to the druggist as well as to the purchaser who, as often as not, is illiterate. The druggist has often received some training, however, and the products sold are frequently of value. Hazardous as they sometimes are, the village store products probably save many more lives than they destroy." 10/

39. Other services such as potable water, sewerage and refuse collection are in general also seriously inadequate in rural areas. To illustrate this situation, the following statement relating to Bolivia is quoted but it should be emphasized that a similar situation prevails in many other countries:

"In the early 1970s the water and sewerage systems were seriously deficient. Virtually all of the rural and most of the urban populations had direct access to neither, and OAS had estimated that 15 per cent of the country's disease could be attributed to unsafe water. According to official data, in 1969 about 34 per cent of the urban population was served by water systems, and about 21 per cent had sewerage outlets. In rural areas, service in both was virtually nil.

"...

"Water, sewerage, and refuse collection are conveniences available only in the larger urban communities. Only a small proportion of the farm population has provided itself with latrines, and few public facilities are available in cities and towns.

"The best sewerage is provided in Santa Cruz, where a model system was installed in 1970 with IDB assistance. There are no sewerage mains other than those in La Paz and the department capitals, and the manual for public health doctors noted that in the late 1960s no more than 4 per cent of the rural population had any installations for the disposal of human wastes.

10/ Thomas E. Weil and others, Area Handbook for Bolivia, The American University, Washington, D.C., 1974, p. 180.

"Refuse collection in the larger urban localities is generally satisfactory, although it is in some part accomplished by private contractors. In towns and villages much of the refuse is simply thrown into the street, where it is devoured by dogs and pigs. In general, economic imperatives are such that very little trash and garbage are generated. Empty tins, bottles, and cartons find ready use, and animal excrement is used for fuel or fertilizer." 11/

40. The lack of sufficient resources to pay for adequate medical services is underlined in other countries. Thus, in the United States, although the Government has noted that the Indian Health Service provides free medical preventive and curative services and has asserted that "few other citizens of the United States have similar opportunities", it has been affirmed that the statement is misleading and that Indians actually have inferior health services.

41. In fact, a publication contains the following statements:

"It is a distortion to say that few other citizens of the United States have similar opportunities for health services. Although there are many problems in the health delivery system, most Americans can afford minimal health services and virtually all employed Americans have some form of health insurance. The Indian unemployment rate is high; physical conditions of living are bad, and disease is rampant. Many Indian Health Service hospitals are antiquated and inadequate.

"Most Indian Health Services hospitals are understaffed having neither enough doctors nor nurses to provide adequate coverage. The shortage of nurses sometimes approaches dangerous levels. The statement that 'indigenous personnel living in non-reservation areas avail themselves of existing medical and health facilities in the same manner as other citizens' is also exceedingly misleading. A very high percentage of these 'personnel' are poor and cannot afford private medical care. Almost without exception public medical care in the cities of the United States is extremely substandard compared to the rest of the world.

"It is also worth noting that many of these people living in poverty in the cities are there because they are induced to move there by the Federal Government". 12/

11/ Ibid.

12/ American Indian Law Newsletter, vol. 7, No. 11, Special Issue containing the American Indian response to the response of the United States of America, p. 24.

3. The impact of de facto discrimination on indigenous health

(a) Preliminary remarks

42. The effects of de facto discrimination or inequalities in the provision of services or facilities can be more devastating in the area of health than in any other. The lack of adequate health and medical care and related social services is reflected in life expectancy figures, infant mortality rates and other demographic information. In general terms, life expectancy is lower and infant mortality higher outside the urban areas. This is generally due to the fact that health and sanitary conditions are worse in the rural areas. In most countries, the unfavourable situation is further accentuated among the indigenous populations, because health and sanitary conditions in the areas they inhabit are even worse than elsewhere.

43. Governments are generally aware of the gravity of health problems in rural areas and particularly among indigenous populations, even without the aid of fully dependable statistics. Reliable official statistics on indigenous populations or, in general, on rural inhabitants were totally unavailable or explicitly not very reliable for many of the countries included in the study. The difficulty in gathering statistical data on scattered and sometimes mobile populations, as well as the paucity of funds generally devoted to that purpose, explain in part the non-existence or lack of reliability of such information. In any case, whenever information was available in the form of mortality and morbidity rates and on the incidence of nutritional deficiencies in indigenous peoples, it was impossible to compare the data from country to country and even, within countries, from region to region, either because of the different approach taken in gathering the data or because of the differences in the periods covered. In consequence, statistical data have been included only in the few cases where they seemed to be beyond serious dispute. No attempt has been made to draw any conclusions of a comparative scope. It is clear though, that mortality and morbidity rates are higher and that life expectancy is lower for indigenous populations than for the other population groups in all countries covered by the study, even as compared with other rural (non-indigenous) population groups.

44. In the paragraphs below, governmental and non-governmental sources are cited as evidence of the effects on the indigenous population of unequal or inadequate provision of health and medical facilities and related services.

(b) Information available

45. According to a non-governmental organization, the morbidity rates of isolated communities in Indonesia are higher than those of society as a whole, but the same report remarks that isolated groups living as nomadic farmers (with hunting and gathering activities supplementing their protein intake) often have a better balanced diet, and consequently better health, than non-tribal peasants in the same area. 13/

13/ Information furnished on 23 September 1976 and 24 April 1977 by the Anti-Slavery Society.

46. Noting the difficulty in providing statistical data, the Government of Costa Rica points to high mortality rates and serious deficiencies in health measures and nutrition among the indigenous population:

> "It is difficult to provide statistical data on health, dietary and nutritional patterns, but we are aware that there are serious difficulties in these areas: poor food, lack or misuse of latrines, nutritional deficiency.
>
> The morbidity and mortality rates of the indigenous segments of the population are the highest in the country, since they are a marginal group compared with the non-indigenous inhabitants, and their coverage by the national health programmes is therefore envisaged. These problem areas are affected by lack of communication through the indigenous languages, inaccessibility of the regions they inhabit and other factors. It should be noted that there is no specific census for the indigenous segments of the population."

47. According to an official statement, the infant mortality rate among the Amazon Indians of Brazil was reduced from 183 to 87 per thousand in the period 1973-1977. The latter figure would place the Amazon Indian in a situation comparable to that of the inhabitants of the predominately rural and impoverished north-eastern region of Brazil. Both regions compare unfavourably, though, with other areas. 14/

48. On the basis of official data, one writer has found that "Indians in Guatemala had a life expectancy about 11 years shorter than did Ladinos [non-indigenous population] at birth (38.34 and 49.66 respectively) as well as about 9 years shorter at age five (46.84 and 56.04 respectively)". These differences were attributed to the standard of living as well as the fragmentary nature of the data. 15/ Another author comments on some of the factors which contribute to higher mortality rates among the indigenous population of Guatemala:

> "As in most developing countries 'morbidity and mortality' are associated with enteritis and other diarrhetic illnesses, respiratory infections, pneumonia and infectious diseases of early childhood such as measles and whooping cough, a great number of which can be easily recognized and treated by people with far less training than a physician.
>
> "The basic underlying contributory factor is 'malnutrition'. The Nutritional Institute of Central America and Panama (INCAP) [has stated] that more than 70 per cent of all Guatemalan children under five years old were malnourished. The death rate of children under five is one of the highest in all Latin America totaling approximately 50 per cent of all deaths.

14/ "Informe da Ação Indigenista Brasileira", VIII Congreso Indigenista Interamericano (Mérida, Yucatán, México), 17-21 November 1980, OAS Doc. No. OEA/Ser.K/XXV.1.8. CII/doc.5. 14 November 1980, Original: Portuguese, pp. 25-26.

15/ N.L. Whetten, Guatemala, The Land and the People, New Yale University Press, 1961, p. 215.

"Only 43 per cent of the urban and 0.6 per cent of the rural population has piped water and thus it is evident that lack of public sanitary facilities as well as malnourishment are underlying causes of the high rates, and the types of morbidity and mortality.

"These statistics are much more drastic when considering just the Highland rural areas. The infant mortality rate, for example, is even higher in the rural areas than the large number officially recorded since in a great number of Highland communities the birth of a child is not recorded until it is at least 15 days old and should it die before that time no record is made either of the birth or of the death. The infant mortality rate is 50 per cent or more in many communities." 16/

49. Mortality and death rates are higher among the indigenous than among non-indigenous segments of the population of Bolivia, particularly because of the prevalence of diseases such as whooping cough and measles among infants. The Government has recognized that maternal and infant care and other health services have not reached the indigenous population and that traditional medicine predominates in the rural environment. 17/ Another official report has stated that the social security system does not cover the rural worker, but that such coverage is contemplated. Malnutrition is another major problem among the rural population:

"In urging the public health authorities to expand their studies in nutrition, a La Paz newspaper in 1971 attributed many of the country's social and economic problems to quantitative and qualitative food deficiency and estimated that two-thirds of the population suffered from some degree of malnutrition. The proportion seems excessive, but malnutrition is known to be widespread, particularly among children. A 1965-68 Government survey found that 38 per cent of the rural children under the age of 15 suffered malnutrition of the first grade (10 to 25 per cent under normal weight), 17 per cent suffered second grade malnutrition (25 to 40 per cent under weight), and 4 per cent suffered malnutrition of the third grade (40 per cent or more under normal weight)." 18/

50. Peru, which has a large indigenous population, has a high infant mortality rate owing to preventable disease, malnutrition, the lack of proper sanitation measures and medical attention:

"The country is still in the stage where preventable diseases represent an important health problem. Malnutrition, another standard index of poor health conditions, is widespread. A high potential rate of natural increase - the birth rate is close to 4 per cent - is countered by the great number of deaths among infants and young children. Figures on the average lifespan are not available, but presumably the life expectancy

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16/ K. Heggenhongen, op. cit., p. 305.

17/ Informe Nacional de Bolivia, op. cit., p. 38

18/ Weil and others, Area Handbook for Bolivia, op. cit., p. 166.

is comparatively low, especially in the Sierra. In general, information is incomplete, as reporting facilities are not well developed in many areas, in itself an indication of conditions. According to official estimates, medical certificates are issued for only 33 per cent of the births and 44 per cent of the deaths.

"During the last decade the death rate has been estimated at between 11 and 12 per 1,000 inhabitants. Although deaths among those over 50 years of age account for 25 per cent of the total, those among children under 5 account for 52 per cent. Infant deaths alone amount to approximately one-third. The national infant mortality rate is close to 100 per 1,000, but variation from region to region is considerable. In Lima the rate is approximately 67 per 1,000, but in some rural areas it goes as high as 200 per 1,000. The nature of the care given to mother and child is a key factor.

"Outside the Lima and Arequipa areas, most women continue to have their babies at home, and a medical doctor is in attendance in only a small minority of home births. Midwives are called in the majority of cases, but rather frequently women give birth completely unattended. In these instances, programmes of parental care are seldom practices and delivery techniques are unsanitary. After birth many infants, especially in rural areas, are constantly exposed to an unhealthful physical environment. The maintenance of personal hygiene is often casual. The available water supply may be contaminated. After weaning, milk is more often than not absent from a diet which differs very little from that of adults." 19/

51. The Anti-Slavery Society has reported alarming infant mortality rates among various Indian groups in Paraguay:

"Infant mortality: Paĩ-Guarani 50 per cent before the age of 2 years; Puerto Casado (zone of about 1,500 Indians in the Chaco): Over 50 per cent; Ayoreo of El Faro Moro: 21 per cent until the age of 5 years (not counting babies who died shortly after birth). These figures, from groups who are not in extreme situations, must be compared with the infant mortality rate of the non-indigenous population of Paraguay, which is 91 per thousand." 20/

52. The same organization cites tuberculosis as one of the major health problems among Paraguayan Indians:

"TB: One of the greatest health hazards in indigenous groups, usually explained by poor housing, lack of nourishment, and perhaps also alcoholism. There are few exact statistics, but observers agree that TB is more widespread among Indians than among non-Indians. Among the inidgenous inhabitants of the Mennonite zones in the Chaco, PPD tests had positive results for 50 per cent - compared with only 10 per cent among the white Mennonites of the same zones." 21/

19/ Erickson and others, Area Handbook for Peru, the American University, Washington D.C., p. 51.

20/ Information furnished on 3 September 1976.

21/ Ibid.

53. Serious nutritional deficiencies among Paraguayan Indians are directly related to high infant mortality and tuberculosis. A detailed nutrition study exists on the indigenous population of Misión Santa Teresita and Filadelfia of the Western Guaraní and Nivaklé ethnic groups, which can be considered to be an unusually well situated section of the Indian population. The study was written in 1965, but the comparison between indigenous and non-indigenous nutrition still appears to be relevant today.

	Daily intake for the indigenous population	Daily intake for the non-indigenous population in the same zone (excluding Mennonites)
Calories:	less than 1,700	2,350
Calcium:	176 mg.	516 mg.
Phosphorous:	722 mg.	1,026 mg.
Proteins:	59.3 g.	63.4 g.
Oils and fats:	38.9 g.	54.3 g.
Vitamin A:	132 mg.	810 mg.
Vitamin C:	25 mg.	366 mg.
Thiamine:	0.72 mg.	1.39 mg.
Riboflavin:	0.82 mg.	1.28 mg.

The comparison shows remarkably better nutrition for the non-indigenous population. It must be noted that the Indians in question are no longer very dependent on their traditional economic activities, but are mainly labourers working for the non-indigenous population. This example, the best documented to hand, is not the only one: Mr. John Renshaw notes "some nutritional deficiencies, anaemia, and possibly protein shortages" among the Ayoreo of María Auxiliadora in the Chaco in 1975. It must be noted that this deficiency is not due to traditional eating habits of the Ayores, as these provided a well-balanced diet. About the Indians of Puerto Casaco, Mr. Renshaw writes: "All the population appears undernourished, even the young and the elderly who are fed by the mission.". As for the Paĩ, Proyecto Paĩ-Tavyterã stated in 1975 that the high percentage of pulmonary TB among the Paĩ-Tavyterã is closely linked to intense deterioration of the nutritional system ... The most frequent diseases of nutritional origin are malnutrition and avitaminosis. 22/

54. Although no separate statistics are kept on the Lapps, the Government of Finland has reported that their health, dietary and nutritional patterns "differ to some extent from those of the other population due to the fact that they are still, more than others, living on the basis of natural economy". The Government has also declared that the mortality rate of the Lapps is "somewhat higher than that of the other population".

22/ Ibid.

55. In the United States, one study shows important dietary deficiencies among Indian children and a higher infant mortality rate than among non-Indians:

> "Poverty spawns squalid living conditions and a multitude of manifestations of ill health. Nowhere is this more tragic in America than among the Indian children from conception to school age. Studies in South Dakota and Arizona specify some of the consequences of poverty on the health of Indian children. Of 190 Pine Ridge children who were born in 1964 and tested, 40.5 per cent had hemoglobin determinations below 10 grams, and 15.8 per cent had determinations below 8 grams before the age of two. In Arizona, at Tuba City Hospital, of 676 Indian children below the age of 4 discharged during the 10-month period in 1967, 44 suffered from malnutrition, 38 had iron deficiency anemia, 13 under 1 year manifested marasmus and 8 had incurred kwashiorkor. Of 1,591 Indian children 5 years or older who were discharged, 44 suffered from anemia and 2 from malnutrition. Of 4,335 Indian admissions in a 5-year study, 616 suffered from malnutrition, 44 had incurred kwashiorkor or marasmus, and 572 were small for their age. And at Window Rock, Arizona, 20 per cent of the Indian children hospitalized evidenced malnutrition and 10 per cent of those under 4 suffered iron deficiency anemia. Ten per cent of the Window Rock women tested had iron deficiency anemia, portending the continuation of the cycle.
>
> "The death rate for Indian children under 14 is almost two and one-half times that for all American children under 14, and in every category of medical illness studied for the White House Conference on Children in 1970, Indians (grouped with Alaskan natives) had a higher death rate. As for Indian survival generally, a larger percentage die in their teens, twenties, thirties and forties than is true for the rest of the population, and Indian life expectancy over-all is 44 years. But although the Indian must contend with earlier death and more diseases, he has little or no life or health insurance and in most cases is in debt for medical services already rendered." 23/

56. Although there is a stable Indian population growth rate in Canada, a non-governmental organization has declared that Indian mortality figures are significantly higher than those of the remainder of the population:

> "This population increase has taken place in spite of mortality figures which are higher than for the rest of Canada according to figures provided by the Department of Indian Affairs Statistics Division and Statistics Canada. Based on mortality figures for registered Indians available from six provinces and the two territories, their mortality rate was 8.32 per 1,000 in 1973, compared to 7.42 per 1,000 for other Canadians. Infant mortality was four times higher among Indians, 62.12 per 1,000, compared with 15.3 for all infants in Canada. There was a higher incidence of violent deaths among Indians than among non-Indians in 1973, these occurring 3 to 6 times more often among people in the 20-39 age group. Deaths by homicide, suicide and accidents of all kinds occurred on an average of about 2.8 cases per 1,000, as compared to .74 per 1,000 for other Canadians." 24/

23/ Gerald S. Nagel. "Economics of the Reservation", in Current History, December 1974, p. 248.

24/ National Indian Brotherhood, Statistical Survey, Economic and Social Conditions of Canadian Indians. Appendix B, Presentation of George Manuel, President of the National Indian Brotherhood to the Mackenzie Valley Pipeline Inquiry. Yellowknife National territories, 13 April 1976, p.l.

57. The Government of Canada has also recognized the relationship between poor health conditions and high mortality rates among Indians:

"The situation remains that health conditions among native people are generally poorer than among the white population. Thus the infant mortality rate in 1968 was 21 per 1,000 live births for all Canadians, 49 per 1,000 for Indians and 89 per 1,000 among Eskimos. However, the mortality rate had declined over the previous decade: for Indians it had declined from three times the national average to just over twice the rate. There is also a higher than average mortality rate in the 20-23 years age group and a much higher incidence of death and injuries from accidents associated with violence or severe climatic conditions."

58. In Canada, despite increased and improved medical and health services rendered to indigenous populations on reserves, the situation in 1981 was still far from satisfactory, since according to an official publication: 25/

"In 1961, life expectancy for Indians under one year was approximately 10 years less than that of the national population, although for Indians surviving to middle age, additional life expectancy was only slightly below the national. By 1971, both Indian and national populations had increased their life expectancies, although the gap between the two populations remained the same Indians surviving to 80 years had a greater additional life expectancy than the national population, suggesting that:

- health conditions are improving for Indians but are still significantly below national levels

- high infant and youth mortality appear to be the major reasons for lower Indian life expectancy.

Death rates for Indians, despite improvements over the past 10 to 20 years, remain well above the national average. For all age groups (except those over 65, where the Indian rate is only slightly higher than the national), Indian death rates range from 2 to 4 times the national average.

The leading causes of perinatal (foetal deaths of 28 or more weeks' gestation plus infant deaths under 7 days of age) and neonatal mortality (deaths under 28 days of age) for both Indian and national populations are complications at birth and congenital anomalies, accounting for more than 75 per cent of perinatal and neonatal deaths.

A larger proportion of post-neonatal mortality (deaths from 1 month to 1 year) in the Indian population is attributed to respiratory ailments and infectious or parasitic diseases, reflecting poor housing, lack of sewage disposal and potable water, as well as poorer access to medical facilities.

25/ Department of Indian and Northern Affairs Canada. Indian conditions. A survey. Published under the authority of the Minister of Indian Affairs and Northern Development, Ottawa, 1980, pp. 15-20.

Lowered perinatal and neonatal mortality has kept pace with national improvements, although the Indian rate is currently approximately 60 per cent higher than the national.

Post-neonatal mortality nonetheless has shown great improvements for Indians, plummeting from 6 times the national rate in 1963 to approximately twice the national rate in 1977.

Accidents, violence and poisonings account for over one-third of all deaths among Indians compared with 9 per cent in Canada as a whole.

Respiratory and digestive system diseases have decreased significantly as causes of death and, in the Indian population, are now comparable to the national rates.

Indian rates of death from cancer and circulatory diseases are less than half the national rate.

The number of Indian deaths due to suicide per 100,000 population is almost 3 times the national rate. Suicides account for 35 per cent of accidental deaths in the 15-24 age group and 21 per cent in the 25-34 age group.

The over-all rate of violent deaths for Indians is more than 3 times the national average. These deaths may be comparable in non-Indian rural and remote populations where there is:

- greater use of firearms for hunting

- substandard housing and heating systems

- inadequate fire-fighting equipment

- poor access to medical assistance.

Violent deaths among Indians are higher than in the national population at all age levels. With the exception of those over 65, violent deaths among Indians range from a low of 3 times the national rate in the 5-14 age group to a high of between 4 and 5 times the national rate in the 15-44 age group.

For Indians 1-14 years, burns, drowning and motor vehicles accounted for 69 per cent of accidental deaths.

For Indians 15 years and older, the leading causes were motor vehicle accidents (29 per cent), drowning (10 per cent) and firearms (9 per cent).

Indians use hospitals about 2 to 2.5 times more than the national population, but on the average stay less time (7.3 days compared to 9.1).

The high incidence of respiratory ailments, infectious and parasitic diseases and digestive disease may reflect poor or unsanitary housing and living conditions.

The high incidence of childbirth complications may indicate malnutrition and lack of prenatal care.

The high accident rate may reflect the hazards of a rural and remote life style, which includes high use of firearms for hunting, higher fire risk and poorer access to medical facilities."

59. There is very little information on off-reserve health conditions and services. Among the data appearing in the same publication some refer to the implications of life off-reserve and others to hospitalization rates in British Columbia as follows:

"OFF-RESERVE: IMPLICATIONS

"A significant proportion (almost one-third) and an increasing number (almost 80,000) of Indians fall outside the program jurisdiction of Indian Affairs by virtue of living off reserves.

"Migration off reserves, in particular among young entrants into the labour force, will likely continue at high levels as long as employment opportunities on reserves remain poor.

"Improvements in the employability of Indians, such as better education and better skills in English or French in the absence of other on-reserve improvements (e.g. employment opportunities on reserve, effective band government, urban access), will encourage further off-reserve migration.

"Since conditions for Indians off reserves in terms of education, employment, income and housing appear to be only modestly better than for Indians on reserve, poor on-reserve conditions appear to be the major factor in migration off reserves.

"The contrast between Indian and non-Indian living conditions is sharper and more apparent in urban centres."

"HOSPITALIZATION

B.C. Off-Reserve Indians Compared to Provincial Rate

1971

"INDIAN RATE (PROVINCIAL RATE = 1)

AGE (Years)	MEN	WOMEN	TOTAL
15-24	3.64	2.45	2.82
25-44	5.19	3.96	4.30
45-59	4.78	2.94	3.86
15-59	3.97	3.21	3.48

"Source: W.T. Stanbury, Success and Failure: Indians in Urban Society, U.B.C. Press, c1975, p. 362.

"In Stanbury's sample, one-third indicated they had, in their own perception, been ill in the previous 12 months. More women (42 per cent) reported illness than men (27 per cent).

"The healthiest off-reserve Indians in B.C. were those living in prisons! Only 12 per cent of this population indicated they had been ill in the previous 12 months.

"Indian women off reserves visited doctors an average of 6.14 times a year compared with 3.34 times for the men in the Stanbury sample, with higher rates for the elderly, the lower educated, and those living in smaller centres.

"Medical insurance was held by 82.7 per cent of the B.C. sample of off-reserve Indians. Those without insurance averaged 2.74 visits to a doctor per year, while those with insurance had an average of 5.02 visits per year." 26/

26/ Ibid., pp. 144 and 147.

4. De jure discrimination related to health, medical and social services

(a) Preliminary remarks

60. In a number of countries considered in the present study, there are laws in the area of health and social services which specifically provide for unequal treatment of indigenous people as compared with the non-indigenous population, or of some indigenous groups as compared with other segments of the indigenous population. These laws may, of course, not be qualified as discriminatory unless they create clearly unfavourable distinctions which are arbitrary, invidious or unjustified with regard to the groups concerned. Special measures designed to protect or aid disadvantaged groups, it must be borne in mind, would not be classified as discriminatory so long as they do not continue in effect longer than necessary.

61. The following subsections consider two types of laws which affect indigenous populations in several countries and which have been called discriminatory. They deal with legal provisions explicitly establishing restrictions, limitations or prohibitions for indigenous people that do not apply to non-indigenous people and with the explicit restriction of health, medical and social services to certain segments of the indigenous population while other segments of those populations are ignored.

(b) Restrictions on the sale or the consumption of alcoholic beverages

62. A few countries report that legal provisions on the sale or consumption of intoxicating beverages and other toxic substances apply equally to all segments of the population, whether they are indigenous or non-indigenous.

63. While in Bangladesh there is a general prohibition in this respect since, according to information provided by the Government, in that country, "intoxicating beverages, use of drugs and narcotics, etc., are prohibited by law and the prohibition is applicable to all citizens alike", the Government of Finland has stated that in that country "there are no special restrictions on the possession or consumption of intoxicating beverages and other toxic substances that would be imposed only on the Lapps". Similarly, the Government of Mexico has indicated that there are no prohibitions or restrictions on the possession or consumption of intoxicating beverages or drugs that do not apply to the population as a whole. 27/

64. In those countries where special restrictions, limitations or prohibitions do apply, they appear to be based on special areas, 28/ special population groups, 29/ special persons, groups or areas, 30/ or special persons, gatherings or places under given circumstances. 31/

27/ It would seem that a very similar situation prevails in Argentina, Bolivia, Chile, Colombia, El Salvador, Guatemala, Honduras, Nicaragua, Panama, Peru and Venezuela.

28/ As in Australia, Costa Rica and Denmark.

29/ As in Brazil.

30/ As in Malaysia.

31/ As in New Zealand.

65. With regard to those countries in which the restrictions, limitations or prohibitions apply in specified areas, the Australian Government has stated that "Western Australian legislation restricting the supply of liquor to Aborigines on reserves, namely section 130 of the Liquor Act 1970, was repealed by section 32 of Act No. 76 of 1972 of Western Australia". It noted that restrictions on the consumption of liquor on reserves still existed in the mid-1970s in the Northern Territory and the States of Queensland and South Australia.

66. During his official visit to Australia (June 1973) the Special Rapporteur was told in Maningrida (Northern Territory), by members of the local Aboriginal Council, that control of alcoholic beverages was used by the police as a pretext to search Aboriginal persons' baggage whenever they returned to Maningrida from a visit to other localities. Non-Aboriginals, they said, were not subjected to this search. They communicated their desire to have this practice discontinued, as, in their words, they rejected the idea of being "second class citizens".

67. In this respect the Government states (1975):

> "The practice of police searching Aboriginals' baggage for liquor was commenced at the request of the Maningrida Aboriginal Council, and could be revoked by the Council. Some people at Maningrida, including some members of the Council, did not approve of the Council's decision. Some other communities have considered attempting to control the importation of liquor in this way, but the practice is not widespread."

68. In order to prevent alcoholism and the exploitation of Indian communities by outsiders who promote the sale of alcoholic beverages, the Government of Costa Rica has prohibited the sale of alcoholic beverages in Indian reservations by Decree 5904-G as modified by Executive Decree 6036-C:

> "Article 6 - No person or institution may establish, _de facto_ or _de jure_, bars, or sell alcoholic beverages, within indigenous reservations. This law cancels the existing possession or concession of licences for domestic and foreign liquors and the transfer of liquor licences within the reservations."

69. According to the Government of Denmark the sale and serving of alcoholic beverages in Greenland is limited by a system of rationing which went into effect on 1 August 1979 and was amended in October 1979. Authorizations for the purchase of alcoholic beverages are allocated on the basis of age or conviction for certain criminal offences, rather than membership of an indigenous group. However, on the recommendations of some municipal councils rationing is more rigorously applied in certain areas. 32/

70. An example of application to specific population groups only is to be found in Brazil which, in its special protective legislation, distinguishes between "tribal groups" or "non-integrated Indians" and those who are considered "integrated" into society. Article 58 (III) of Act No. 6001 provides the following:

> "The following constitute crimes against the Indians and native culture:
>
> "...
>
> "III. To foster by any means the use and spread of alcoholic drinks in tribal groups or among non-integrated Indians. Penalty: Six months' to two years' imprisonment."

32/ Information furnished on 21 May 1981.

71. A wider range of possibilities including persons, communities or areas is provided by the Aboriginal Peoples Ordinance of Malaysia which gives the appropriate Minister broad regulatory powers to prohibit or restrict the sale of alcoholic beverages or an indigenous person, community, area or reserve, as follows:

"The Minister may make regulations for carrying into effect the purpose of this Ordinance and in particular for the following purposes:

"...

"(m) prohibiting either absolutely or conditionally the sale or gift of any intoxicating liquor as defined in any written law relating to excise for the time being in force in the States of Malaya or any part thereof to any specified aborigine or aboriginal community or within any aboriginal area, aboriginal reserve or aboriginal inhabited place;"

72. According to the Government of New Zealand, the general prohibition of the sale of liquor to Maoris no longer exists, but there are still certain legal restrictions under the Maori Welfare Act of 1962 which are intended to control excessive drinking. These restrictions apply to individuals, certain kinds of gatherings or licensed premises under certain circumstances.

"... the Maori Welfare Act 1962 made provision for the appointment of Maori wardens with certain powers to control drinking by Maoris. The Act and its amendments provide that the Maori wardens must be Maoris. They are appointed by the Minister on the nomination of a District Maori Council and are responsible to that Council. Maori wardens are authorised to enter licensed premises (i.e. licensed to sell liquor) and to warn the licensee or any of his servants to abstain from selling or supplying liquor to any Maori who, in the opinion of the warden, is in a state of intoxication or is violent or quarrelsome or disorderly, or is likely to become so. It is an offence to disobey a warden. The warden may also order a Maori to leave licensed premises if he appears to be intoxicated, violent, quarrelsome or disorderly. If the Maori refuses to leave the premises he commits an offence against the Act and the warden may request a member of the Police Force to expel him. The Act also provides that drinking or having possession of liquor at a Maori gathering is an offence unless a Maori Committee appointed under the Act has issued a permit for liquor to be consumed at the gathering. But only the Maori Committees are empowered to lay charges under the Act, and before dealing with an offender a Committee must give him the option of having a penalty imposed by the Committee after a hearing and the giving of his defence, or having the matter dealt with in the Magistrate's Court. If a penalty is imposed by the Committee the Act provides for that penalty to be enforced by the Magistrate's Court in the event of non-compliance by the offender. The Act provides that no person shall be punished for the same offence by both a Maori Committee and a Magistrate's Court. Penalties imposed by Committees are limited to a fine not exceeding $40.

"The general effect of this legislation is to provide a more preventive system in relation to drunkenness or likely drunkenness than exists under the general law (such as the provisions in the Police Offences Act regarding intoxication) applicable to all persons." 33/

73. The Government adds that in the early 1970s, during a review of legislation affecting Maoris,

"the Government proposed to repeal these provisions in the Maori Welfare Act and to do away with the powers of Maori wardens and Maori Committees, having regard to the fact that the legislation could be considered discriminatory. There was, however, an immediate reaction from Maori organisations throughout the country. The organisations argued that the legal provisions should remain in force, on the grounds that the excessive use of alcohol was a social problem amongst their people and that, although the situation was improving, they felt that it was not yet time to remove the special provisions. They pointed out also that although the legislation applied only to Maoris, the powers accorded by the Act are in the hands of Maoris. They considered that it was better that this problem should continue for the meantime to be handled by the people themselves. The legislation remains in force, but the provisions referred to are to be reviewed from time to time with a view to repeal when they are no longer necessary."

74. Although this legislation apparently represents the wishes of the Maori community for protective legislation in this area, the system has been criticized on the ground that criminal liability depends in some cases upon the race of the defendant and some objection has been made to the existence of a special tribunal and enforcement agency.

75. The Government has replied to these objections as follows:

"... While it is realised that this legislation could possibly be described as discriminatory, it should be noted that it was originally passed at the request of Maori leaders who felt that the Maori people as such should have some modest form of control over their own communities. At that time, most Maoris actually lived in Maori villages and the legislation played quite an important part in social control. ... [Some] years ago the then Minister of Maori Affairs suggested that the time had come when the legislation should be repealed, especially in view of the fact that so many Maoris now live in urban areas. However, there was a strong objection from the Maori people to this proposal. They felt that the misuse of alcohol was still a problem amongst their people and they wanted to continue at least for the present some form of internal control. The jurisdiction of the Maori committees to hear offences is being reconsidered at the present time and will be discussed with the Maori organisations."

33/ The Government states that "before the arrival of Europeans in New Zealand the Maoris had no form of alcohol or drugs. However, in some sections of the Maori community the excessive drinking of alcohol later became and, to a lessening degree, still remains a social problem." It was to meet this situation the Government states, that the Maori Welfare Act 1962 made provisions for the appointment of Maori wardens with certain powers to control drinking by Maoris that are described by the Government in its information.

(c) Restriction of services to recognized or registered members of indigenous groups

76. Another type of de jure discrimination is the legal or administrative distinction which denies eligibility for special governmental services to members of indigenous groups who do not live on reservations or reside in isolated areas. The question is whether such distinctions have a rational purpose which outweighs the right of an indigenous citizen to live off the reservation or in an urban area.

77. The Government of Canada recognizes that under the present system many Indians are ineligible for various health and social services:

> "The most serious gap in health service relates to eligibility under the Medical Services Branch, which is designed to cover mainly Eskimos and registered Indians living on reserves or in isolated areas who cannot provide for themselves. This excludes Indians with adequate income, enfranchised Indians, Métis and Indians living off the reserve. The Métis and non-status groups suffer from this arrangement in that some provincial authorities still regard them as Indians, a federal responsibility - most live like the poorest group of registered Indians and are left without services. Similarly the off-reserve Indians are expected to qualify for the common social services of the community after one year's residence, but since many live in squatters' fringe areas and are not absorbed into the community their needs tend to be ignored and neglected."

78. Eligibility for federal health services for indigenous people in the United States depends on whether a person is classified as a federally recognized Indian, as explained in the following statement made at a non-governmental conference:

> "... federally recognized Indians are entitled to comprehensive health benefits (medical and dental care); this program is administered by the Indian Health Service, located in the United States Department of Health, Education and Welfare (HEW). Prior to the establishment of HEW in 1955 the Bureau of Indian Affairs administered the Indian Health Service. Non-federally recognized Indians constitute the majority of the United States Indian population; they include those in urban and rural areas and those who had signed treaties with the state governments. State governments are responsible for providing health services for these Indians, and in many instances health benefits are inadequate." 34/

79. Other Indians in the United States, particularly those who live off the reservations and in urban areas, have been excluded from federal health services by administrative decisions or regulations, as described in the following excerpt from an indigenous publication:

> "The shortage of funds, facilities, and personnel has caused HEW to refuse services to certain groups of people who believe they are entitled to services - especially the group known as 'urban Indians'. Removed from the health facilities on the reservation, poor as they may be, and unable to pay the costs of medical care in the cities, urban Indians often find themselves in chronically poor health in the city environment.

34/ North American Conference on the Protection of Human Rights for Indians and Inuits, Wingspread Conference convened by the Commission to Study the Organization of Peace and the Johnson Foundcation, 2-4 November 1973.

"To remedy the discrimination against them by IHS's master agency, the Department of Health, Education and Welfare (HEW), the National Indian Youth Council has instigated two class-action suits against the department in Albuquerque, New Mexico on behalf of the 440,000 urban Indians in the U.S.

"One suit, a civil suit entitled Lewis v. Weinberger, seeks to 'compel the defendants to treat Indians eligible to receive medical services' in line with the Snyder Act of 1921, and 'to give all such Indians equal considerations for services provided through the expenditure of contract health care funds.' Other suits are designed to force IHS to rewrite its regulations to remove current limitations. The cases are expected to be heard by District Judge Howard C. Bratton this June.

"The IHS now provides services via 51 hospitals, 86 health centers (including 26 in schools) and several hundred other 'health stations' across the U.S. Only persons 'residing on or near reservations' are deemed eligible for treatment." 35/

35/ "Newly passed Indian Health Act could signal better programmes", in Akwessasne Notes, vol. 7, No. 2, 1975, p. 37.

B. Special considerations in providing health services to indigenous populations

1. Preliminary remarks

80. In the provision of health, medical and other social services, Governments must give special consideration to the particular socio-cultural and physical environment of indigenous populations. Like other segments of the population of certain countries, indigenous peoples have special health care needs and problems which reflect their basic concepts and way of life. The fact that distinct health problems exist has been well stated by the Secretary for Health in the Northern Territory Government of Australia: "... our country is a land of contrast, on the one hand the affluent world of non-Aboriginals with near perfect environmental conditions strives for immortality while beset by new enemies such as alcohol and drug abuse, the internal combustion engine, pace diseases like hypertension, coronary occlusion, and mental breakdown, while on the other hand the Aboriginal world represents very much a nineteenth century picture where many of the early health battles still remain to be fought ..." 36/ The first step towards the establishment of effective health and medical services among indigenous peoples is the realization that a distinct battle is being fought. Such programmes will be successful only to the extent that they are responsive to special health problems in the context of the physical environment and the socio-cultural needs of the population concerned.

81. Practical considerations aside, a policy which consistently ignores the special health care needs of the indigenous population might well be defined as discriminatory. Furthermore, practice has shown that the imposition of the health service concepts and methods of another segment of society which show no regard for those of the indigenous population provokes resistance and misunderstanding and may well violate international norms for the safeguarding of cultural rights.

82. Subsection B considers the relevance and need to take account of socio-cultural factors such as traditional medicine and other beliefs and customs which have a bearing upon health care. It also discusses available information on special problems such as alcoholism and dietary deficiencies. The relationship of the physical environment to special health problems among indigenous peoples is treated in subsection C below.

2. The importance of the socio-cultural factors

(a) Traditional practices and beliefs

83. The existence of traditional health practices and beliefs among indigenous populations is an important factor which must be taken into account. The imposition of modern practices and wholesale rejection of traditional medicine has been one of the most serious shortcomings of governmental health and medical care programmes and reflects a bias against indigenous culture. In order to be responsibe to indigenous health and medical needs, modern practices must be acceptable to those populations. It is clear that traditional practices which are found to be effective must be supported and encouraged. It is also clear that in many instances modern medical practices will enhance some aspects of traditional medical care. Modern practices are at times found to be lagging behind traditional practices and require renewed impetus and orientation to become more effective.

36/ Cited by Elizabeth Adler and others in Justice for Aboriginal Australians, report of the World Council of Churches team visit to the Aborigines, 1981, p. 36.

84. The importance of traditional practitioners is evident in the fact that still today 90 per cent of the childbirths in the world are assisted by traditional medical or paramedical practitioners. Many of the modern medicines (quinine compounds, curare, penicillin, etc.) were derived from substances that have been applied in curative and preventive practices for centuries upon centuries by indigenous people or were developed on the basis of such substances.

85. Obviously practices that are found to be harmful in themselves or in the specific socio-cultural context, be they traditional or modern, should be abandoned or de-emphasized. Positive and useful aspects of both medical practices must be emphasized and fully applied.

86. In their endeavours to bring the same primary and basic health and medical care to indigenous peoples as to other segments of the country's population, the appropriate elements of traditional indigenous medical practices and those of modern scientific medicine must be combined and harmonized in such a way as to achieve the utmost effectiveness.

87. A study prepared under the auspices of the World Health Organization underlines this problem and recommends a greater focus upon traditional medicine:

> "There are those who take a hostile attitude towards traditional medicine, and those who, without reservation, accept all things handed down by tradition. Both of these attitudes are indeed wrong. The more realistic tendency which is emerging is discriminating and discards the crude and harmful practices while retaining the refined and useful methods for further development and application. The same applies to the clinical approach to modern scientific medicine, particularly in the developing countries, where not infrequently technical bias makes it incomplete and indeed potentially harmful because it pays little or no heed to socio-cultural factors, and focuses mainly on laboratory diagnosis.
>
> "The belief that illness arises from supernatural causes and indicates the displeasure of the ancestral gods and evil spirits, or is the effect of black magic is still held by many communities in Africa, Asia and the developing world, and, to some extent, this is true also of the industrialized countries. It is therefore wrong to attribute magical, irrational and superstitious ideas to any group of countries or level of industrial or educational development. The evidence is that the two approaches to health care are complementary, and that with the swing of the pendulum greater attention should be paid to the traditional practices which bring comfort to very large numbers of people everywhere." 37/

88. By its very nature, medical treatment is difficult to apply. The co-operation of the patient in the healing processes used is essential. Accordingly modern health and medical practices must be seen to be compatible with indigenous culture. Some aspects of this problem have been recognized in a study focusing upon Mexico but which would apply, *mutatis mutandis*, in all countries:

37/ Dr. R.H. Bannerman, "Traditional Medicine in Modern Health Care Services", paper prepared under the auspices of the World Health Organization, February 1980, p. 1.

"Acceptance of modern medical practices depends to some extent on their ability to be incorporated into Indian theories of illness. Many patented and commercial medicines and some modern treatments by physicians have been interpreted as being within the hot-cold conception of disease and the maintenance of equilibrium within the body and incorporated into folk medicine. Other practices have been rejected because they conflict with prevailing beliefs. Indians who believe that disease is caused by supernatural forces or violations of the hot-cold principle cannot accept the modern belief that disease is caused by germs.

"Folk medicine is practised especially in rural areas. From an Indian and *mestizo* viewpoint, physicians are ignorant of many of the diseases, such as bewitchment and evil eye, which threaten the health of the individual. When physicians find nothing wrong with individuals who believe themselves to be suffering from these maladies, some rural dwellers question the powers of modern medicine. On the other hand, if traditional medicine fails to cure an illness, the aid of a physician will often be sought. However, the greater expense of modern health care usually limits its use to the most serious illnesses." 38/

89. Closely related to the failure to consider traditional practices and beliefs is the lack of attention to more general cultural differences which may create psychological barriers to the acceptance of governmental services. This type of culture shock experienced by Australian Aborigines is described by a Mission of the World Council of Churches:

"Aborigines do not find existing health care relevant to their needs. Before the Federal Department of Aboriginal Affairs (DAA) was established in 1968 little recognition was given by the State Governments to the special health needs of Aborigines. But since then, large sums have been provided by DAA for Aboriginal health care. Aware that these programmes are now in operation we asked Aboriginal communities what the problems were with the kind of health services provided. The answers were:

- "Aboriginal people feel insecure in clinics and hospitals where they are taken care of by all white staff. They would rather not receive any treatment than go to such places and are also afraid of interference in their personal lives (e.g. by family planning). Some told stories of nurses taking away their children;

- "The approach to health care for Aboriginal people has generally been a technical one - enlarging health care facilities, building bigger and more specialized hospitals in predominantly white cities and towns. The atmosphere in such institutions is impersonal. Aboriginal patients are put in an alien environment, often far away from their families and communities. Diseases and sickness are treated but there is little consideration of the economic, political and cultural situation in which the Aboriginal victims live;

- "What is resented by Aborigines is the *de facto* application of the concept of assimilation. They are expected to get used to the health facilities of white Australians." 39/

38/ John Morris Ryan and others, *Area Handbook for Mexico*, The American University, Washington D.C., 1974, p. 145.

39/ Adler, and other, *op. cit.*, pp. 36-37.

90. In this connection it might be relevant to mention here that in the hospital at Comback near Kuala Lumpur in Malaysia, devoted to care for Orang Asli patients, provision is made for extra beds, so that patients may be accompanied by those close relatives accepted by the hospital to keep them company and comfort them during their stay in the hospital. This seems to go at least part of the way towards offsetting reluctance to accept hospitalization because of separation from family and community. The relatives stay in the hospital with the patient and can cook, and engage in other permitted activities to keep themselves while there, as long as they do not interfere with the required treatment and usual hospital routine.

91. Other factors can hamper progress in the areas of health and sanitation. In Brazil, for example, in small villages where privies had been installed, Indians complained of their smell, of the mosquitos attracted to them, or that children could fall into them. Public health authorities must consider these reactions in their planning. In smaller villages the traditional way of defecating at the edge of the jungle may be more practicable. Another example is the difficulty sometimes encountered in the use of a new potable water supply. Though wells were sunk in some Brazilian villages, the inhabitants continued for some time to bring water from their traditional source - a nearby river, which was heavily polluted and the cause of dysentry. 40/

92. Going to the river may have important socio-cultural functions which could be maintained by the establishment of a public fountain or well in larger villages, which would provide an opportunity for fulfilment of the needs and functions not specifically concerned with the consumption of water.

93. Another related problem is the unhealthy situation to which people have grown accustomed and to which they must be sensitized before public health programmes will be successful. A Canadian author reflects upon whether appropriate perception of many health problems exists:

> "... To what extent, for example, are the Indians trained to identify a health problem? We must remember that these people live in situations of extreme privation. Diseases such as impetigo and lice are so prevalent and so much a part of daily life that they might not be perceived as requiring special attention. Obviously, the provision of publicly paid medical treatment is of little value to people who are not sufficiently sensitive to the circumstances when they could request such treatment." 41/

(b) Alcoholism

94. In some countries, alcoholism is recognized as a major problem among the population at large, including the indigenous peoples. It has been pointed out, however, that different socio-cultural factors should be taken into account in responding to this problem among different population groups. In Canada, for example,

> "Most Indians drink. As do most Canadians. Drinking is an acceptable social custom and a majority of the adult population drinks - about 70 per cent in both cases.

40/ International Committee of the Red Cross, Draft Programme of Red Cross Medical Assistance to the Indian Population of the Brazilian Amazon River (Geneva, May 1972), p. 40.

41/ Canadian Civil Liberties Education Trust. Indian Life and Canadian Law. A report on the Ontario North, 1973, p. 16.

"Among Indian people there appears to be less social control to inhibit excessive drinking with proportionately less ostracism from the group as a result of arrest, conviction and detention for liquor infractions. While the use of alcohol serves to provide an escape mechanism from present problems and circumstances, there is also some evidence that in terms of social acceptance it enhances the offender in the eyes of his colleagues.

"While intoxicated, the behaviour of Indian people is basically the same as that found in other groups of the population. Whatever differences do occur appear to be the result of sociological factors and not racial ones.

"Lone drinkers are rather rare, and individual addicted drinkers may be less common among Indian people than among other groups. In some Indian groups, drinkers seem to have formed a social solidarity in the presence of white society.

"There is some evidence that there may be two groups of drinkers in the Indian population - 'anxiety drinkers' and 'recreational drinkers'. The first tends to be younger, better educated and suffering from the tensions of severe problems of adjusting to white society. The second group tends to be older, less well educated, less involved in comtemporary industrial society, and not particularly affected by acculturation problems.

"In short, drinking is an accepted social custom among Indian people. They are not different from whites in most respects. Those differences which are apparent seem to be the result of social factors, not racial factors.

"In this part we will summarize five theories about social factors which appear to be associated with alcoholism and violence, and point out the implications of these theories for action programmes.

Acculturation

"One theory holds that Indian people are experiencing a great deal of difficulty in adjusting to the larger society. They are caught between two life styles, one their own traditional way of life and the other a more technological and urban life style. The traditional way of life is downgraded: the technological-urban life style is out of reach.

"It is theorized that this problem of adjustment is at the root of many of the problems facing Indian people - family disorganization, lack of attainment in education, violence, suicide and alcoholism.

"To the extent that this theory is useful it means that a major challenge is to ease or buffer the transition from one lifestyle or culture to another. This in turn means that: (1) traditional culture must not be downgraded, but rather be a source of pride and identification; and (2) Indian people must obtain the skills to survive and compete in a technological-urban society.

Abbreviation

"Another theory suggests that the lives of many Indian people are without meaning - it is a frustrating and purposeless existence for many. They do not have jobs; they have little that is within reach; they are estranged from the larger society; they do not like what they see in their own way of life.

"To the extent that this theory holds, it means that the active participation and involvement of Indian people in every aspect of life of the larger society must be encouraged. It also means that Indian communities should be enriched and diversified to enhance opportunities within their own society.

Discrimination

"A third theory is that white attitudes towards Indians are discriminatory, and that these prejudices and biases become self-fulfilling prophecies. Whites expect Indians to drink, treat them as if they do, and encourage them to do so.

"White attitudes can also be part of a vicious circle. The white won't hire an Indian because he drinks, and that is why he drinks. He wants to work, but he can't get a job; he is ashamed of being on welfare, being unable to provide support for his family, etc. All of this makes the Indian loathe himself and eventually turn to alcohol.

"To the extent that this theory is true, much can be done to alleviate the present situation by changing white attitudes and practices. Whites must come to understand Indian people, think of them positively and come to value their contribution to Canadian society.

Inadequate community structures

"A fourth theory is that Indian communities are more loosely controlled than white communities, that an Indian person will not intervene in the affairs of another Indian person, and that Indian communities are more tolerant of deviant behaviour. Community control is weak and there is little enforcement in Indian communities.

"To the extent that this theory is true, the early identification and development of Indian community leaders is crucial. Attention must also be given to other aspects of social control and law enforcement in Indian communities.

Inadequate social services

"A final theory holds that adequate social services are unavailable to Indians. The social services that do exist tend to alienate or close out Indian people, thus leaving them without basic services or emergency care. There are few social institutions to which the Indian person can turn for help when he needs it.

"To the extent that this theory holds true we must improve services to Indian peoples. Not only are more services needed, but they must develop an open and healthy relationship with Indian people. It is no use having more services if Indian people do not know about them, do not want to use them, or are afraid to do so. More attention must also be given to preventative services of all kinds.

Concluding comment

"In this part we have sketched the outlines of some of the theories which have been used to explain violence and alcoholism amongst Indian people. The

problems experienced by Indian people have many aspects - any attempts to deal with them must also be multifaceted and a whole range of programmes and changes must be instituted simultaneously." 42/

(c) Nutrition

95. In many instances the nutritional habits of indigenous populations before intercultural contacts have been found to be much more balanced than those practised after such contacts. Today, however, as with non-indigenous groups, socio-cultural factors must also be considered in seeking an answer to nutritional deficiencies among indigenous populations. Malnutrition is not only the result of poverty. Eating habits, religious beliefs and taboos, the use of certain drugs, as well as the replacement of more healthy, traditional food sources with modern processed foods, all have an impact. Likewise, modification of the physical environment may, and often does, affect traditional food supplies and produce nutritional deficiencies. Some of these problems are illustrated in the following paragraphs.

96. It has been written that in Burma nutritional defects stem more from dietary practices than from a shortage of food:

"... The highly polished rice that is preferred and is a mainstay of the daily fare loses most of its vitamin and mineral content in the milling process. Although most curries contain some meat, fish, or eggs, the individual portion does not supply adequate quantities, and there is a marked deficiency in protein intake of most people. Much of this lack has a monetary basis, but much is caused also by the Buddhist aversion to taking life of any kind. This is reflected in the unpopularity of beef and mutton. Seafood is an essential ingredient of ngapi, but professional fishermen are usually non-Buddhists and are looked down upon because they destroy life. Fresh fruits and vegetables are important dietary elements, but they cannot make up for other deficiencies. The few analyses of the diet that have been made indicate that a large proportion of the people are undernourished, the major nutritional problems relating to deficiencies in iron, iodine, thiamine, and riboflavin." 43/

97. A nutritional survey among the Eskimos of Canada has found processed foods to be an unacceptable substitute for the traditional diet:

"... On 13 February 1972 an overdue study of nutrition in the North was begun by an eight-man team led by André Beaulieu of St. Romuald, Quebec, under the auspices of Nutrition Canada. The nutrition problem in the North is due largely to the introduction of southern foodstuffs into the diet of native peoples. The dangers of industrial techniques of food preservation - techniques which systematically rob natural foods of their organic vitamin and mineral content - is pointed to by many nutritionists.

"Refined sugar and bleached flour, staples of the northern diet, have little nutritional value. The results are disastrous. Bryan Pearson says: 'Many youngsters in Frobisher Bay live exclusively on a diet of potato chips and pop ... The hospital is full of kids with respiratory disease'."

42/ While People Sleep: Sudden Deaths in Kenora Area. (Published and copyright Grand Council Treaty No. 3, Kenora, Ontario, 1973, pp. 17-19).

43/ Henderson and others, op. cit., p. 89.

"In 1965, pneumonia accounted for 31 per cent of the infant deaths in the Northwest Territories. In 1947 the Inuit death rate from tuberculosis was 700 per 100,000 population.

"The danger in imported foodstuffs is shown in a scientific study of the energy budget of a hunting village on southern Baffin Island by William B. Kemp. The study is important because it shows that if native peoples can pursue an economy based partly on wage-earning and partly on hunting, they can maintain themselves at a level considerably above subsistence. In the study, Kemp examines the nutritional input of the people in detail and makes these observations:

'The data on food input support the general finding from other areas that show the Eskimo diet to be high in protein. At least in this Eskimo group, even though imported carbohydrates were readily available and there was money enough to buy imports almost *ad libitum*, the balance was in favour of protein.

'Over the 13-month period the villagers acquired 44 per cent of their calories in the form of protein, 33 per cent in the form of carbohydrate and 23 per cent in fat. Almost all the protein (93 per cent) came from game; 96 per cent of the carbohydrate was store food. The figures suggest how nutritional problems can arise when hunting declines. As store food calories take the place of calories from the hunt, the change frequently involves increased flour consumption and consequently a greater intake of carbohydrate'." 44/

98. The Government of Costa Rica has reported that nutritional deficiencies result in the indigenous diet when basic vegetables are replaced by processed foods. Another example given by the Government is the substitution of new alcoholic beverages for the traditional Indian *chicha*:

"For thousands of years one of the festive beverages *par excellence* among the aborigines has been *chicha*, usually made from fermented maize. It is nutritious, of high caloric value and rich in vitamins. Apart from its nutritional value, its preparation is imbued with traditions of deep telluric significance and its distillation involves a process of community and spiritial association.

"It is harmless, even when drunk in large quantities; it causes a kind of seasickness but not drunkenness. Now, however, the traditional *chicha* has been replaced by ruinous alcohol, rum, whisky, *guaro*, etc., resulting in the loss of an ancient tradition, of a source of income, of spiritual togetherness, of many nutritional elements, and, on the other hand, in acquisition of the alcohol habit, which most often leads to chronic alcoholism, break-up of the family, extreme poverty, etc. Paradoxically, the law encourages the sale of alcohol and forbids the preparation of *chicha*."

99. The Government of Denmark has noted that in Greenland traditional food items forming part of the indigenous diet are being replaced by "Substandard" European foodstuffs. The state of nutrition in some types of Greenlandic communities was

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44/ Robert Davis and Mark Zannis, *The Genocide Machine in Canada*, Black Rose Books, Montreal, 1973, p. 117.

investigated in 1974. Part of the indigenous population lives, to a great extent, on traditional food items, i.e., fish, marine mammals, such as seals and whales, and sea birds, and there is an increasing tendency for smaller communities to rely more on the traditional food. Since such food is healthy and cheap compared to imported European foodstuffs, it must be considered convenient and appropriate in every respect to live on such food. There is, however, hardly any doubt that some people living at a lower social level are eating substandard European food with a large carbohydrate content, and that this is detrimental to their health, and in particular to their teeth; there is no indication, however, that such developments depend on race. 45/

100. The Government of Colombia has pointed to the use of drugs, either as a stimulant or as a religious practice, as one of the causes of malnutrition among the indigenous population:

"The indigenous person, lacking economic resources, influenced by daily contact with civilization and consuming a diet of limited nutritional value, is a prey to disease and ages prematurely, despite ingenious and sometimes effective therapeutic practices. In this process of physical disintegration, an important factor is the consumption of hallucinogenic and narcotic substances which are harmful to bodily health but at the same time maintain physical strength without a feeling of exhaustion. The use of coca, yopo and other such substances has functions associated with religious practices, but it also enables the Indian to consume little food while working for long and exhausting periods. The increasingly alarming result of this situation is the general under-nourishment of indigenous groups."

101. According to the Government of Malaysia, food taboos affect the diet of the Orang Asli:

"(2) One factor of considerable importance among Orang Asli groups is that of food taboos. These are complex and widespread. In respect of the Orang Asli affected by them, the following generalization can be made:

"A. Adult men and women past normal childbearing age - Hardly affected

"B. Children below puberty - Significantly affected

"C. Pregnant and nursing mothers - Considerably affected.

"(3) It has been observed that the incidence of taboos in regard to food and the degree to which these are faithfully observed has decreased over the past 15 years or so and will no doubt do so further in the future. It is interesting to note that over the past 15 years the Orang Asli have come into contact with many new types of foods which, apart from fish and meat, in general do not come under any taboos. This in itself will probably lead to a further weakening of the food taboo system."

102. Religious and social ideas may influence dietary practices, as one author has noted in Sri Lanka:

"Although vitamin and protein-rich foods are plentiful, tradition dominates the average family's choice of diet, and malnutrition, caused by a

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45/ Information furnished on 21 May 1981.

deficiency of iron and protein in the diet of many segments of the population, is fairly widespread. Many families who could supplement their diet by fish do not do so because fishing is commonly associated with low caste occupations or because their religion prohibits the consumption of fish or meat ..."

103. Where indigenous peoples depend upon their environment for a significant portion of their food supply, changes provoked by industrial development, hydro-electric or even certain conservation projects may lead to nutritional deficiencies. The Government of Canada has stated that mercury poisoning of fish from industrial wastes was causing serious concern in Manitoba and north-western Ontario where fish is essential to the native diet.

104. It has been reported that indigenous communities in the United States have also been affected by mercury poisoning of plants and fish.

105. Information gathered during the Special Rapporteur's visit in 1976 to Canada and the United States of America showed that in both countries industrial waste is dumped into rivers and absorbed by plants, eaten by fish, and passed on to humans who eat them in turn. Waste containing mercury which is dumped in waterways is extremely dangerous. The mercury becomes more concentrated as it is passed up the food chain to man. Indigenous communities that make their living by fishing are the newest victims in Canada and the United States.

106. Symptoms of the Minimata disease 46/ are being found among the indigenous people of Canada and the United States in several areas of both countries. Research has shown that the disease could be spreading to many other parts of the country. Indigenous organizations demanded action by federal and local governments but all that was accomplished was the posting of signs warning "natives" not to fish. In this regard, it must be noted, that they cannot simply stop fishing, as it is their traditional occupation and the only means of livelihood for themselves and their families. Strong action by federal and local authorities is needed to stop these very dangerous practices.

107. It has been written that the massive flooding required by the James Bay Hydroelectric Project in northern Quebec would upset the ecological balance of the land, seriously impairing the livelihood of some 8,000 Indians who depend on hunting and fishing. In Paraguay the creation of new pasture land has led to the clearing of extensive areas of tropical forest on which the Aché Indians, who are hunters and gatherers, depend for their subsistence. Conservation measures may have a similar impact. According to the Government of Canada, Indians have protested against interference with their traditional hunting and fishing rights through control procedures under the Migratory Birds Convention Act, maintaining that fish and game are necessary for their food supply whereas the law is meant to ensure the pleasure of sportsmen. 47/ Likewise, the Indians of Manitoba have protested the prohibition of Seneca root gathering in the Riding Mountain National Park.

46/ In the 1950s over 10,000 people in Minimata, Japan, were maimed, blinded and killed by mercury poisoning. The Japanese island gave its name to this dread disease, Minimata, which attacks the central nervous system and is passed on from generation to generation. There is no known cure.

47/ See also resolution 77-17 of the First Inuit Circumpolar Conference, Barrow, Alaska, 13-17 June 1977 (E/CN.4/Sub.2/476/Add.5), annex I, p. 10.

3. The relevance of the physical environment

108. The concentration of indigenous peoples in rural, and sometimes isolated areas, gives rise to additional factors associated with the environment which must be considered in planning health and medical services. Perhaps the most unique situation is that of groups or communities so isolated from the rest of society that they have developed no immunity to a number of diseases that are relatively common in the world at large. As history has shown, the introduction of new diseases by mere contact, but particularly by the influx of immigration may have a particularly severe effect on indigenous populations to the point of devastating entire communities.

109. The statements made by a Mission of the International Commission of the Red Cross with regard to indigenous populations in the Amazon basin in Brazil are equally applicable to isolated populations elsewhere:

"The rapid decline of Indian populations already contacted is due to disease: this is by no means surprising. Any isolated group would have a low resistance to infection agents which are normally absent in its natural habitat.

"Even diseases that are regarded as relatively mild in Western countries can cause an incredibly large number of deaths. Poor health, due to malnutrition, for example, would also favour the fatal outcome of a disease. For all the reasons mentioned, we are convinced that it is only after having carried out an initial immunization campaign that any kind of long-term assistance in other fields can be given with any chance of success ..."

110. All sources available for the study agree that, broadly speaking, indigenous peoples are particularly affected by certain types of health problems, such as parasitic, respiratory and deficiency diseases. All of these are related, in turn, to the physical environment - inadequate housing and clothing, poor drinking water and sanitary conditions, lack of land or loss of traditional food supplies, etc. The problem of health is closely linked to the general problem of the conditions of poverty in which indigenous populations live in most societies and their limited access to the services made available to them. This demands a holistic approach in the search for solutions.

111. As previously stated, the lack of sanitation programmes and facilities in rural areas is a cause of many of the health problems faced by indigenous peoples. The following excerpt shows how poor sanitation in a small community in Canada has affected the water supply and health of the indigenous population. It is given as an illustration of conditions that are common everywhere:

"Poor sanitation is also a contributing cause of disease in the North. As the wage-welfare system forces native peoples into settlements, and off their familiar land, sanitation becomes a problem. When the people lived nomadic life following the game, human wastes did not concentrate in dangerous levels at any one spot. In today's circumstances, sanitation became a particularly knotty problem in the North.

"As extractive industries bring a temporary influx of people and as the natural increase of native populations in the new settlements continues, the problems will increase. An object lesson of the gargantuan proportions which could result can be seen in the example of settlements a little further south in the middle-North.

"Blanc-Sablon is a town on the Quebec-Newfoundland border with a population of 250, one half of whom are Indian. Each year, the run-off from the spring thaw and autumn rains overflows cesspools into the drinking water. In 1971, 35 per cent of the town's population was treated for gastro-enteritis. In April, three infants died.

"While Blanc-Sablon has no revenue to build proper sewers or water treatment facilities, the provincial government 'has no authority' to deal with what is a municipal matter.

"Similarly, at Ironside, Quebec, the entire underground water table has been contaminated. Dr. Victor Goldbloom, Quebec Minister of the Environment, suggested that the only way to get non-polluted drinking water for the several hundred residents of this community may be to move them out.

"A 1969 Quebec Department of Health survey classed 49 of 164 communities as having 'bad quality' drinking water and 57 with a supply considered doubtful." 48/

112. Clothing and housing form part of the physical environment which has a direct impact on health. Many indigenous peoples suffer from sickness and disease associated with inadequate clothing and housing, combined with or exacerbated by inadequate hygiene and health practices. The following comments with respect to the indigenous population in the United States of America are relevant today and are applicable, broadly speaking, to most of the rural indigenous populations throughout the world.

"... The Aboriginal dwelling is almost always damp, insufficiently ventilated, overcrowded and devoid of the most rudimentary sanitary facilities, all of which factors strongly favour the spread of respiratory and digestive diseases, malaria, etc. Clothing is usually inadequate both for protection against the severity of the climate and from the point of view of personal hygiene. This latter factor, combined with unhealthy housing, encourages the spread of skin and parasitic diseases. 49/

...

"It would be fair to say that as a rule the Indians' clothing is insufficient to meet the needs of physical protection and insufficient also with regard to the demands of hygiene. The Indian has seldom more than two garments in the year, and generally they are shabby and full of patches." 50/

113. In rural areas with insufficient medical and veterinary services, contact with animals may be a major source of contagious diseases. The Mission of the International Commission of the Red Cross noted, for example, the role of the dog as a carrier of disease in indigenous villages in Brazil:

"Many Indian villages are full of dogs, and this is no doubt an important factor in the spread of a number of diseases. Not only rabies, but also dracontiasis, larva migrans, leishmaniasis, both cutaneous and visceral, leptospirosis, paragonimiasis, salmonellosis, strongyloidiasis, toxoplasmosis and American trypanosomiasis (Chaga's disease) can all be transmitted through dogs, and possibly, also tuberculosis in areas of high infection prevalence."

48/ Robert Davis and Marl Zannis, *op. cit.*, p. 118.

49/ International Labour Office, *Indigenous Peoples*, Geneva, 1953, p. 90.

50/ *Ibid.*, p. 144.

C. Special measures taken by Governments

1. Preliminary remarks

114. The two basic shortcomings in the provision of health and other services to indigenous peoples are accessibility and adaptability. Health services normally available to other sectors of the population are inaccessible to indigenous peoples either for economic reasons or because they are too remote as explained above. When those facilities are accessible, the personnel is often not equipped, either culturally, psychologically or professionally, to deal with the special health problems related to the socio-cultural and physical environment of the indigenous population.

115. Some governments have become more attuned to these problems in recent years. Special budgetary allocations are being made for programmes that are intended to provide health and medical services for the rural and indigenous populations. Regional or local hospitals and health centres have been established in rural areas; health outposts, or dispensaries have been set up in isolated areas and medical missions are visiting those regions on a more regular basis. Measures have been taken to provide special training for indigenous medical and health workers and to involve the community in health programmes. Health education is receiving renewed emphasis, as are sanitation and immunization campaigns, including the vaccination of animals. Examples of special measures adopted by some governments are given in the following paragraphs. Other measures related to training, alcoholism and nutrition are discussed briefly in separate subsections.

2. Available information on measures adopted

116. There are countries for which no information is available at all, while for other countries only limited information on specific action taken or contemplated was provided for the purposes of the study. More substantial data were available only for a few countries, and it is this information that is outlined in the following paragraphs.

According to a publication, the Government of Peru has taken steps to lower the cost and improve the distribution of pharmaceuticals in rural areas:

> "Some activity is also being carried out in the distribution of medicines. Through a series of legal depositions, nationally produced pharmaceuticals have been reduced in retail price by 20 per cent, and foreign-produced pharmaceuticals, by from 10 to 70 per cent. Popular pharmacies (*boticas populares*), where medicines can be obtained at still lower prices are maintained by the ministry in areas where commercial pharmacies are limited or non-existent.". 51/

51/ Erickson, and others, *op. cit.*, p. 162.

117. The Government of Paraguay has announced that it is planning to establish a department of Indian health to carry out studies and provide direct medical services to the indigenous population. 52/

118. According to non-governmental sources, Burma had more than 600 rural health centres in operation by 1966. Each centre was responsible for medical services within approximately 15 village tracts, covering a population ranging from 15,000 to 40,000. These centres were headed by either a doctor or a public health assistant with quasi-medical training. As time permitted, the health assistant also visited the countryside. Medical missions have been set up among the forest-dwelling tribes of the Kachin and Kayah states. In the former, there are three dispensaries and a hospital staffed by aborigines. In indigenous villages, the services of aboriginal medicine men and midwives are employed. In Kayah state and the Chin Hills, dispensaries are run by religious missions, and maternity and child welfare societies, located at the edges of the forests, are staffed by qualified health visitors and midwives. Karen nurses and midwives are found in nearly all government hospitals in Burma. 53/

119. According to an official report, the Government of Chile extends medical and health care to the indigenous population in rural areas by means of rural health centres provided for in the budgets of regional development programmes. These centres have special services for mothers and infants, including the distribution of foodstuffs and milk. By 1978, 70 such centres had been inaugurated in the region with the largest indigenous populations and were functioning as a part of the Department of Rural Health of the Ministry of Health. 54/

120. The Government of Colombia sends health brigades to Indian communities to provide medical services and vaccinations and to work in nutrition and sanitation. At the same time, first aid stations are set up with State funds or funds made available by the community itself. These stations are run by an indigenous person who has been trained for the purpose. 55/

121. The Government of Norway has drawn attention to the special schemes for Lapps:

> "Attention is drawn to the special schemes for Lapps wishing to study medicine applicable in respect of those admitted to the medical faculty in Bergen or Tromsø. In recruitment to the School of Nursing in Hammerfest, it is always sought to include some Lapp speaking pupils in each group, although this has not always proved feasible.
>
> "Otherwise it cannot be said that any special measures have been put into effect."

52/ "Informe Nacional del Paraguay", VIII Congreso Indigenista Interamericano (Mérida, Yucatán, México), OAS doc. No. OEA/Ser.K/XXV.1.8, CII/doc. 4, 12 November 1980, Original: Spanish, p. 27.

53/ Henderson and others, op. cit., pp. 94-97, and ILO, Indigenous Peoples, Geneva, 1953, pp. 535 and 273.

54/ "Informe Nacional de Chile", VIII Congreso Indigenista Interamericano (Mérida, Yucatán, México), 17-21 November 1980, OAS doc. No. OEA/Ser.K/XXV.1.8, CII/doc. 11, 12 November 1980, Original: Spanish, p. 11.

55/ "Recuento Histórico de la Politica Indigenista en Colombia. Informe Nacional", VIII Congreso Indigenista Interamericano (Mérida, Yucatán, México), 17-21 November 1980, OAS doc. No. OEA/Ser.K/XXV.1.8, CII/doc. 10, 12 November 1980, Original: Spanish, p. 28.

122. It has been reported that the following measures have been taken on behalf of the rural and indigenous population in Bangladesh:

> "The creation in the country of an integrated system of medical institutions and services is one of the most important public health problems. The rural medical complex is to become the basic unit in the system of medical institutions. Each such complex is to comprise a rural health centre with a 25-50 bed hospital and associated union sub-centres. Health centres are being established in every rural region (Tkhana), and each one is expected to provide medical care for up to 50,000 rural inhabitants. The sub-centres are being established in areas within the jurisdiction of the lower local councils and are called upon to provide services to several villages with up to 12,500 inhabitants.
>
> "The national programme for the development of public health services calls for the organization in the country of 356 regional medical complexes, which would combine 3,698 rural sub-centres. According to data for 1973, there were 150 rural sub-centres in Bangladesh. It is proposed to establish a further 206 centres during the first five-year plan, i.e. by July 1978. The programme for the development of rural sub-centres is to extend over a period of 15 years.
>
> "The Government of Bangladesh is seeking to place the entire system of medical services, including the birth control programme and the campaign against epidemic diseases, under unified administrative control. It will be necessary to combine all three branches of the public health service at the rural health centre level. It is also considered that, at this stage in the development of the medical services, the main concern of public health bodies should be the family and the rural community, rather than individual patients."

The Government has reported that, although it has not yet managed to work out a single integrated social security scheme for the entire population or for any sector of it, sectional security measures exist for the indigenous and tribal population. The employed population, mostly indigenous, is covered by statutory old age protection, and by the Workmen's Compensation Act against industrial injuries. Legal provisions for health, sanitation and children's education exist in some areas. Maternity benefits with post-natal and pre-natal care are also available at the cost of the employer.

123. In Canada, governmental health care programmes for indigenous peoples are characterized by their flexibility. The Government employs a system of direct services and grants as well as arranging for care on a fee-for-service basis with independent practitioners and medical care insurance plans. The Government of Canada has provided the following description of its medical care services for indigenous peoples:

> "The Medical Services Branch of the Department of National Health and Welfare undertakes to see that health care is provided for Indians and Eskimos. It arranges where possible to have provincial and local services extended to Indians and Eskimos, through the payment of grants, and it provides direct service where no other is available. The annual

appropriation for 1973-74 from Parliament is approximately $35,000,000. In 1970-71 Medical Services operated 13 hospitals, 24 clinics, 57 nursing stations and 91 health centres, chiefly in the northern part of the provinces and in the territories. It directly employed 920 nurses, 30 dentists, 200 doctors and a number of public health personnel. In addition, the majority of professional medical services were provided by medical personnel working on a fee-for-service basis, i.e. although there are only 30 dental officers employed by the Medical Services in the field, there are approximately 700 dentists who work on a fee-for-service basis. The inidgenous people are strongly urged and assisted financially to enrol under provincial medical care insurance plans. Where they cannot individually afford such insurance, the Medical Services Branch pays on their behalf. In some cases Bands have contributed toward hiring physicians' services from their own communal funds. The International Grenfell Association provides needed health and social services in Northern Labrador.

"Getting specialist services for the remoter areas poses particular problems. Medical Services attempts to meet this by arranging with specialists' associations for visiting services and some, notably the pediatricians and ophthalmologists, have responded generously. Some provincial departments make the services of their peripatetic specialists available on a routine basis. Efforts have also been made to interest university schools of medicine in federal work in remoter areas as a part of medical training and experience. Federal financial assistance to participate in such programs has been extended to 11 major universities.

"However a system of regular free transportation to treatment centres by air is in operation, and along the north-eastern coast the Eastern Arctic Patrol carries out regular medical mission services. Also in the North a broad immunization and TB X-Ray program has brought good results. Tuberculosis is now ranked ninth instead of first as cause of death among northern residents."

124. The Government of Canada has stated that general social security benefits and other related services are available to indigenous peoples:

"All Indians and Eskimos are eligible to receive Canadian social security benefits; these include Family Allowances and Old Age Security pensions which are administered and financed by the federal government, and, where applicable, supplementary Old Age Assistance, Blind Persons' Allowances and Disabled Persons' Allowances which are financed jointly by federal and provincial governments and administered by the provinces.

"Such provincial programs as the Ontario Mothers' Allowances and Assistance to Widows and Unmarried Women, and the Quebec Needy Mothers' Allowance are payable to Indian women as well as whites.

"Rehabilitation and protection services include provisions for the maintenance of Indian children who are in the care of public or private child welfare agencies. Where the services of a child welfare agency are not available, Indian Affairs personnel place such children and arrange for foster home payments. In some provinces, maintenance is also paid on behalf of children committed by courts to training schools or correctional institutions.

"Adults who need institutional care because of senility or chronic illness receive such care and maintenance. In addition, public assistance under the nation-wide Canada Assistance Plan is provided to native people who for physical or social reasons cannot meet their basic minimum needs for food, shelter and clothing. Regrettably, the lack of employment and training has led to many native communities existing almost entirely on this public assistance, creating an unhealthy dependence at a subsistence level."

125. The Government of New Zealand has stated that it has a very comprehensive social security system which covers all its citizens:

"New Zealand has long enjoyed one of the most complete social security systems in the world. A great deal of material could be supplied about the New Zealand system, but in brief it may suffice to say that all social security benefits are available to all citizens regardless of race, and that these benefits include medical benefits, and the right to free treatment in public hospitals and to free medicine supplied on the prescription of a medical practitioner. So far as medical benefits are concerned, the system provides for prescribed fees, part of which are payable by the patient and the balance by the State. By far the greatest proportion of hospital beds in New Zealand is in public hospitals; these are situated in all the main cities and in some of the more isolated rural areas. Free ambulance services are available in almost every part of New Zealand. There are medical practitioners within reasonably easy reach of practically the whole population. In addition, the Health Department stations public health nurses in the more isolated districts. These nurses provide a free service and pay particular attention to the needs of isolated Maori families. All parts of the country have maternity hospitals within a reasonable distance. An active and wide-spread voluntary organization supported by the Government - the Plunket Society - makes a special point of assistance to young mothers and its services are much used throughout the country."

126. The Government of Australia reports that it has been concerned for many years with aboriginal health. Though services provided by the State department of health are available to Aborigines, special measures are taken by Commonwealth and State officials who meet annually to co-ordinate their programmes and policies. An annual budget is made available for aboriginal health, and the Commonwealth provides grants to the states for special aboriginal health programmes. According to the Government, these programmes have contributed to the improvement of rural health services in areas with high aboriginal populations by allowing for the establishment of hospitals, dental clinics, nursing homes, rural health centres, the training of community health nurses and the provision of supplementary food assistance for children and expectant mothers.

127. The Government further reports that, through direct grants, the Commonwealth Government also supports voluntary organizations engaged in aboriginal health work. Special encouragement has been given to the Aboriginal Medical Service, an aboriginal organization which began in an inner-city area of Sydney in 1971. According to the Government, it now retains a full-time medical officer, plans to employ a second, and is extending into nutritional and health education programmes in New South Wales.

128. In 1975, the Government began to provide funds to the Aboriginal Medical Service in Redfern to reimburse pharmacies for the prescription costs of needy patients; a grant has also been provided for the purchase of the premises of that organization. Similar aboriginal medical services have been set up in Melbourne and East Gippsland (Victoria) in Perth (Western Australia), Brisbane and Townsville (Queensland). The Commonwealth also supports the Institute for Aboriginal Development in Alice Springs, which works on health education in aboriginal communities, and other groups dealing with family planning and nutrition.

129. The Government has undertaken a campaign to improve aboriginal health, including an offensive to eliminate leprosy, hookworm, and tuberculosis, and to reduce infant mortality. In addition, proposals are under consideration for the establishment of a national advisory body on aboriginal health, and an Aboriginal Health Section within the Commonwealth Department of Health. Also under discussion are the means of strengthening the services available in rural areas and the training of aboriginal health workers. Other measures taken by the Government include nutritional surveys, dietary supplement programmes, health education, immunization programmes, the provision of basic sanitary services, special measures to control leprosy and prevent malaria, and general programmes to prevent and control animal diseases.

130. A Mission from the World Council of Churches reports that 19 health centres exist in Australia. According to the Mission, they provide an alternative health service "appropriate to the needs of the Aborigines" for the following reasons:

> "they are designed and controlled by Aboriginal people themselves;
>
> "they create the atmosphere in which the Aborigines can feel at ease, where they meet their own people, find doctors in whom they can trust because they know the traditional culture and personal predicaments;
>
> "they serve the Aboriginal communities and their problems rather than just the individual patient. They help to strengthen confidence, self-respect and have become centres of social and cultural significance to the Aboriginal community;
>
> "they work along the lines of health services which the World Health Organization regards as effective in Third World countries. They spend less money and serve more patients than state institutions: $10.00 to $15.00 per patient compared with $40.00 to $50.00 per patient in a State run hospital." 56/

131. The Government of Denmark has described as follows the health and social services available to the indigenous population of Greenland:

56/ Elizabeth Adler, and others, op. cit., pp. 37-38.

"The Health Service in Greenland is operated by the public authorities exclusively, and any and all services, including ... medicines, bandages and other facilities are free of charge for all permanent residents. Everybody - indigenous and non-indigenous - thus has equal possibilities of obtaining assistance from the Health Service.

"[Efforts are made] to furnish the Greenland population with treatment of the same standard as in Denmark; but the simple fact that Greenland is extremely sparsely populated makes it difficult fully to live up to this target.

"In all towns in Greenland [there is] a hospital with one or more medical officers, depending on the number of inhabitants within the area concerned...

"These hospitals [provide both out-patient services] (general practitioning) and hospital services as such.

"In settlements the population has regular access to doctors [who travel] regularly within their respective districts.

"In addition, in settlements with less than ... 70 inhabitants, a drug-store-keeper is employed [who] can hand out medicines, following a telephone contact with the doctor - if appropriate.

"In large settlements a Greenlandic health-service assistant is employed, who is in a position to undertake independent treatment of minor cases, and who will consult the doctor on any more important problem.

"Patients who cannot be treated in the settlements are taken to the hospital in town, at the expense of the Health Service, most frequently by ship, in urgent cases a helicopter is used however." 57/

132. Brazil has developed a system of health outposts ("postos") to provide medical care for indigenous peoples in isolated jungle areas. According to one author who has described this programme as it operates in the Xingú National Park, the assistance includes disease and epidemic control, as well as measures to increase food resources and enrich the Indians' diet. Indigenous people normally go to the outpost for care, but the medical team from the post will go into the village in the case of an epidemic or a patient who is too ill to be moved. If specialized care is needed, patients are sent to regional hospitals or to São Paulo. The post also engages in health education programmes, and as part of its preventive measures, controls the entry of non-indigenous people into the area.

133. In a recent report, the Brazilian Government published the following statistics which describe the health services provided to indigenous populations:

57/ Information furnished on 21 May 1981.

"In addition to its arrangements with various bodies, FUNAI furnished direct help to indigenous communities, using 17 mobile health teams, 11 'Indian homes', 78 infirmaries established in indigenous stations, the Indian Hospital on Bananal Island, the Chácara-Ambulatorio (a health station at Cuiabá), 781 beds, and 259 personnel (17 doctors, 12 dentists, 13 nurses, 185 infirmary assistants and 32 other specialists). Altogether, there were about 371,000 medical, dental or nursing consultations.

"Through this system, epidemiological control of contagious diseases was effected, in part with the co-operation of the various interested bodies with which there were arrangements.

"In the campaign against malaria and chagas' disease, 27,765 houses in the North, North-East and Central-East regions were fumigated.

"By the end of 1978, some 109,000 doses of vaccine against tuberculosis (hypodermic BCG) had been administered, as well as 223,000 doses of vaccines against diphtheria, tetanus, whooping-cough, measles, yellow fever, meningitis, and infantile paralysis, thus immunizing about 80,000 indigenous people.

"Under an agreement with the National Food and Nutrition Institute (INAN), about 19,000 Indians benefited from food supplements for children under 6 years of age, pregnant women and wet-nurses.

"Through FUNRURAL, Indians were given medical care or were hospitalized in 173 hospitals throughout Brazil, and some 1,135 Indians over 60 years of age were given pensions.

"CEME, the pharmaceutical plant, provided FUNAI and religious missions with more than 2 million medicinal units from its production line.

"As regards basic sanitation, various communities were helped by the digging of wells and earth latrines and by health-education talks, resulting in a decrease in gastro-intestinal and parasitic diseases ...

"With the aim of preserving the indigenous groups and harmonizing their contact with the advancing elements of national expansion, between 1974 and 1978 FUNAI carried out attraction activities with the following indigenous groups:

AMAZONAS: Waimiri/Atroari, Marubo, Meyuruna, Kanamari and Yanoama;

PARÁ: Parakañ, Araras, Assurimi and Arawetê;

MARANHÃO: Guajá;

T.F. RONDONIA: Karipanas, Zoró, Surui and Rru-Eu-Wau-Wau;

ACRE: Machineri;

T.F. RORAIMA: Yanoama;

MATO GROSSO: Massacá and Krenakarore;

GOIÁS: Avá-Canoeiro.

"In the period in question there was a perceptible decrease in general and mother and child mortaility, thanks to the work carried out in collaboration with various public and private bodies." 58/

134. Federal health care services for Indians in the United States are administered primarily through the Indian Health Service, which is described in the following excerpt from an official report:

"The Indian Health Service (IHS) of the Department of Health, Education, and Welfare is the primary federal health resource for approximately 760,000 Indians and Alaska Native people living on or near Federal Indian reservations or in traditional Indian country such as Oklahoma and Alaska. It provides a comprehensive program of preventive, curative, rehabilitative and environmental services. The Service also provides limited assistance to approximately 274,000 of the 507,000 urban Indians to enable them to gain access to those community health resources available to them in areas where they reside.

"Indian health advisory boards have played an important role in developing IHS policy and allocating resources. Tribes also have been actively involved in program implementation. As a result of new laws enacted in the last five years, the number of tribes managing health services has increased. The scope of tribally managed activities is broad, ranging from the provision of outreach services in the community to the planning, construction, staffing and operation of health care facilities.

"The Indian Health Care Improvement Act, which authorizes higher resource levels for a seven-year period, beginning in Fiscal Year 1978, seeks to increase the number of Indian health professionals for Indian communities. It also authorizes IHS to set up programs with Indian urban organizations to improve Indians' access to health services.

"Indian Health Developments

"The health of Indian people has improved significantly. This gain is due, in part, to the over-all expansion of health service and the construction of better health care and sanitation facilities. Since 1955, hospital admissions have more than doubled; outpatient visits increased seven-fold and dental services six times. Partly as a result of the increased use of hospitals, the infant mortality rate has been reduced by 74 per cent and the maternal death rate by 91 per cent. During the same period, the death rate for influenza and pneumonia dropped 65 per cent; certain diseases of early infancy, 72 per cent. Tuberculosis, once the great scourge of the Indians, in 1955 struck eight out of every 1,000; now it strikes fewer than one. An Indian child born today has a life expectancy of 65.1 years, an increase of 5.1 years over a child born in 1950. Progress and improvements do not mean that the United States has succeeded in raising the health status of Indians to the high level that it seeks. Further efforts will be required." 59/

58/ "Informe da Acão Indigenista Brasileira. Informe Nacional", op. cit., pp. 28-29.

59/ Report prepared by the United States Commission on the Conference on Security and Co-operation in Europe for the European Review Conference in Madrid (November 1980), pp. 157-158.

135. Indigenous people are covered under the general Social Security Act of the United States and some special social services are available to them through the Bureau of Indian Affairs:

"The major participation by the States in this function was precipitated by the passage of the Social Security Act in 1935.

"The categorical aid programs under Social Security (Old Age Assistance, Aid to Blind, Aid to Families with Dependent Children, and Aid to Permanently and Totally Disabled) are administered through the States for all of their citizens including their Indian citizens both on and off Federal reservation. Over 81,000 (17 per cent of the reservation total of 488,083) Indians living on reservations as of June 1971 were receiving categorical aid assistance.

"Many Indian families are in need of assistance who do not qualify for one of the categorical aids. Assistance provided to this group by the BIA is called General Assistance. States and localities also provide general assistance to needy persons not eligible for the categorical aids.

"The BIA provides foster home care for Indian children on reservations in 12 States: Alaska, Arizona, Iowa, Minnesota, Mississippi, Montana, Nevada, New Mexico, North Carolina, North Dakota, South Dakota and Wyoming. In other states foster home care is provided by state welfare departments to Indian children needing such care, including those living on reservations, on the same basis as for non-Indian children.

"It is the general position of the Bureau that insofar as possible Indians should have the same relationship to public welfare agencies as non-Indians, and that public welfare agencies should have the same responsibility for providing services and assistance as they have for non-Indians in similar circumstances." 60/

136. Mexico has increased the availability of health and medical services in indigenous communities by giving elementary medical training to health workers recruited from their own communities. These locally trained persons staff some 567 medical posts, with the backing of doctors who are stationed in co-ordinating centres. Attention given at the posts includes minor surgery, dental work, laboratory tests, treatment for parasites, diagnoses, pre- and post-natal care for mothers and children, and first aid. 61/

137. Preventive measures are taken. Immunization campaigns against polio, tuberculosis, diphtheria, measles, tetanus and other diseases have been undertaken by the Secretaría de Salubridad y Asistencia and the Instituto Mexicano del Seguro Social. The health workers at the medical posts played a particularly important role in educating the indigenous population with regard to these campaigns. 62/

60/ Theodore W. Taylor, "The States and Their Indian Citizens", United States Department of the Interior, Bureau of Indian Affairs, Washington D.C., 1972, p. 2.

61/ "Informe Nacional de Mexico", VIII Congreso Indigenista Interamericano (Mérida, Yucatán, México) 17-21 November 1980. OAS doc. No. OEA/Ser.K/XXV.1.8, CII/doc. 8, 12 November 1980, Original: Spanish, p. 31.

62/ Ibid., p. 32.

138. In 1979, eight Mobile Health Units entered into action in several Mexican states with a high concentration of indigenous peoples. Each unit has a general surgeon and a dental surgeon with their assistants and the driver. They visit communities along established routes, providing medical assistance and encouraging preventive measures in sanitation and education. 63/

139. Between 1979 and 1980, the Instituto Mexicano de Seguro Social and COPLAMAR established 2,105 rural medical units and 54 rural hospitals which provide free medical services. Those communities where such units are established, however, are requested to undertake work projects which benefit the community as a whole. 64/

140. In parallel action, the appropriate offices of the Co-ordinating Centres have made significant progress in sanitation. Potable water supplies have been increased and protected; washing places, baths, showers and toilets have been supplied; septic tanks and drains have been built. Improvements in housing have been encouraged, particularly the provision of latrines and windows. A special programme for the improvement of rural dwellings is designed to contribute to better sanitary conditions. It will include about 250 villages within the areas of the medical units. State agencies will provide technical advice and materials; the interested communities will supply the labour. 65/

141. The Instituto Indigenista Mexicano is also active in the area of health and medical services. During 1977, its medical centres provided the following services:

"General medical care

General medical care	385 220
General consultations including those for children	320 936
Minor surgery	5 584
Dental care	5 016
Laboratory tests	4 318
Antiparasitic treatment	44 933
Forensic medicine and hospitalization	4 433

63/ Ibid.

64/ Ibid., p. 33.

65/ Ibid., p. 33-34.

"Mother and child care

Total cases	16 409
Pre-natal examinations	9 759
Post-natal examinations	4 997
Childbirths	1 653

"Infirmary activities

Total cases	248 520
Injections	197 662
Cures	42 923
Venoclyses 66/	7 935"

142. The Instituto Nacional Indigenista participates in campaigns to vaccinate cattle and other animals in indigenous communities and advises other governmental bodies on measures to maintain ecological balance in interethnic zones.

143. The Government reports that the Institutio Nacional de la Nutrición has been carrying out studies for 20 years in rural and urban areas of the country and a number of governmental offices (Secretaría de Salubridad y Assistencia, Desarrollo Integral de la Familia, Companía Nacional de Subsistencias Populares, Instituto Mexicano del Seguro Social, Instituto Nacional Indigenista) have undertaken programmes related to nutritional education.

144. In Malaysia, the Department of Orang Asli Affairs has primary responsibility for implementing medical and health services among the Orang Asli. Some of its programmes are noted in an official source:

> "(a) A 450 bed hospital at Gombak 12 miles from Kuala Lumpur providing medical treatment for Orang Asli. This hospital contains 13 wards, maternity, x-ray, laboratory, dispensary, out-patient, dental and paediatric facilities, in fact all normal hospital facilities except those for surgery cases which are referred to Kuala Lumpur General Hospital or the University Hospital forming part of the University of Malaya. The hospital is also a recognized training school for Assistant Nurses.

66/ *Ibid*.

"(b) A system of 140 deep jungle medical posts providing out-patient treatment for deep jungle Orang Asli.

"(c) A comprehensive paramedical service enabling all Orang Asli locations to be visited regularly by departmental medical staff.

"(d) A dental service for Orang Asli which places emphasis on preventive dental care for Orang Asli school children.

"(e) A TB Eradication Campaign which carries out a continuous x-ray programme in all Orang Asli areas by means of mobile miniature mass x-ray machines. These machines are sent by road, boat, and helicopter to cover even the most inaccessible areas. Treatment for TB patients is carried out at Gombak Hospital.

"(f) A Malaria Eradication Campaign carried out in conjunction with the National Malaria Eradication Programme for all deep jungle Orang Asli.

"(g) A 'Flying Doctor Service' and a Medical Evacuation Service to cater for deep jungle Orang Asli areas inaccessible by road or boat and only accessible by air. The Royal Malaysian Air Force provides helicopters for seven days flying per month to take departmental Medical Officers, Dental Officers and Nurses to visit deep jungle locations. Seriously ill Orang Asli are lifted by helicopter from deep jungle locations to Gombak Hospital. In 1972, 343 seriously ill patients were [treated in this way]."

145. During his official visit to West Malaysia in June 1973 the Special Rapporteur was able to appreciate first hand the excellent health and medical facilities and services established for the Orang Asli. He personally toured the hospital at Gombak and the medical and paramedical clinics and laboratories at the different Orang Asli posts visited. He was assured that these facilities and services were constantly being improved upon in an unrelenting effort to maintain their standards at the highest level possible in each locality. He understood that medicines were available free of charge at all posts.

3. The importance of training programmes

(a) Preliminary remarks

146. The difficulty of attracting adequate numbers of qualified medical personnel to rural areas presupposes an approach to health and medical services which, while creating conditions that would make indigenous programmes and areas more attractive to medical personnel, would also take maximum advantage of local human resources. In some cases quicker, and, in the long run, better results may be obtained by providing the necessary training in basic medical and health services to those already active in that area in rural communities, such as indigenous practitioners and midwives. A strong argument for the incorporation of local healers is made in the following excerpt from a study prepared under the auspices of the World Health Organization:

> "National health planning is defective in many countries and the small number of professional groups, relatively ineffective in the rural areas where their services are most needed, are in the main unwilling to delegate responsibility and to allow non-professional health workers to take over parts of their professional roles. In some communities, non-professionals are accepted unwillingly, the health services not utilized, and health personnel responsible for primary health care are inadequately trained for the work which needs to be done. The end result is that the return for the resources and human effort is poor and well below expectation, but it must be remembered that the professional health worker has invariably been trained in a scientifically oriented medical school, but works in communities that are essentially rural, traditional in outlook and with very different cultural backgrounds.
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> "Traditional medicine is an established part of culture, though in some countries the systems of care and prevention may not be as well developed as in China and other Asian countries. Some countries have retrained indigenous traditional healers for work in the general health systems and have established departments for traditional medicine in the ministries of health and the universities.
>
> "...
>
> "Many public health administrators now concede the fact that traditional healers have a role to play in formal health services, and certain countries now consider the concept of integration a reality that could be achieved in the foreseeable future. In China and India, traditional systems of medicine have already been recognized, legalized and well developed as separate systems in their own rights." 67/

67/ Bannerman, *op.cit.*, p.2.

147. Simultaneously with the training of those already involved, programmes should be initiated to attract members of indigenous communities to careers in medical and health services at all levels, from doctor to health assistant. Professionals of local origin are more likely to be successful in introducing modern methods and technology in a way compatible with the socio-cultural environment. Recruitment and training of indigenous medical and health professionals is, however, not a simple task. Participants in an international conference have identified several problems in this area which are applicable to the situation in many countries:

> "First, young Indians have little incentive to choose a medical career because of the lack of role models. There are few Indian doctors. Second, Indians attending college are not counselled to take the science courses required for admission to medical schools. As a consequence many potential medical doctors are not recruited. Third, Indians fear that professional training in medicine (also in law) causes the Indian to lose his or her cultural identity. Fourth, a related concern is that an Indian with a medical degree will prefer to practice in areas where earnings will be higher, rather than return to the Indian community. Fifth, Indians are concerned that standards of the non-Indian dominated medical profession are not entirely applicable in the cultural context of the Indian. Definitions of Indian health and illness must be developed and distinguished from those applied to persons in non-Indian communities. For example, the application of the non-Indian standard of mental retardation to the Indian would be inappropriate. Although many Indians work as doctor's assistants, orderlies, nurses and volunteers in hospitals and health centers, participants generally agreed that additional paramedical personnel must be trained." 68/

(b) Examination of available information

148. It seems that in most countries covered by the study there are arrangements for training indigenous people as medical or paramedical personnel or instructing indigenous or non-indigenous people specifically for work among the indigenous populations.

149. The Government of Finland has explicitly stated, however, that no arrangements have been made with regard to the special training of indigenous or non-indigenous medical or health personnel to work among the Lapps.

150. The Government of Denmark has provided the following information on the participation of Greenlanders in local health services, which it describes as of increasing importance:

> The Greenlanders' participation in the health service in Greenland is, also in respect of personnel, of ever increasing importance. Although to date only a few Greenlandic doctors have been trained, the function of midwife has for many years been fulfilled to a very large extent by indigenous midwives; indeed almost all midwife posts in Greenland are

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68/ North American Conference on the Protection of Human Rights for Indians and Inuits, op.cit., pp. 8-9.

now occupied by fully trained indigenous midwives. There are also special jobs for "fødselshjaelpersker" (childbirth helpers, midwife assistants) (an old specifically Greenlandic class of training) and health service assistants (new training in Greenland), designed, inter alia to concentrate on health service work in the small and often relatively isolated settlements in Greenland. In cases of a more complex character they will often co-operate - over the telephone - with the district medical officer. In this connection, it is considered appropriate to mention that the Ministry has started a special Greenlandic education and training course for clinical secretaries and assistants, and a special training and education course for X-ray assistants, as a supplementary training for health service assistants. Moreover, a special Greenlandic course for dental care assistants has been established, with a view to attaining a much needed promotion of dental prophylactic work for the Greenlandic population. 69/

151. In Burma, Karen nurses and midwives are found in nearly all government hospitals. In Kachin State, a hospital and three dispensaries are staffed by Aborigines. In indigenous villages the services of aboriginal medicine men and midwives are employed. 70/

152. The Government of Brazil states that members of the indigenous communities served by the medical post system are trained as auxiliaries to paramedical personnel and the teachers who work in health education. 71/

153. According to the Government of Costa Rica, the training of Indians as paramedical personnel and health workers began a few years ago with a small number of individuals. Recently it has been carried out more systematically with the support and direction of the Comision Nacional Indigenista (CONAI).

154. Bilingual teachers and health workers have made an important contribution to isolated areas of Peru. The health workers and teachers with special training teach the basic elements of personal hygiene, treatment of the most common tropical diseases and sanitation measures such as boiling drinking water, the use of latrines, the disposal of wastes and cleanliness in the home. Some communities have established their own health posts.

155. Since the establishment of the Instituto Nacional Indigenista, the Government of Mexico has carried out training programmes for local paramedical personnel including midwives and practitioners of traditional medicine. Other training programmes for local health workers are maintained by the Secretaría de Salubridad y Asistencia and the Instituto Mexicano del Seguro Social. Additional plans have been made for programmes which will combine traditional indigenous medicine and Western medicine and to train medical personnel for their work among indigenous cultures.

69/ Information provided on 21 May 1981.

70/ See para. 118, above.

71/ "Informe da Acão Indigenista Brasileira, Informe Nacional", op.cit., p.13.

156. The efforts of the Government of Indonesia to utilize the services of local midwives and folk practitioners are described by an independent author:

> "Assistance in childbirth traditionally has been given by a dukun, who might be a specialist or, more commonly, one who combines general folk medicine with midwifery. In the person and practice of these dukuns, modern medical practices probably collide with the traditional more significantly than in any other aspect of medical care. As highly respected members of the local community and, in the absence of doctors, they are in a unique position to impede or to further the expansion of national health programmes. Accordingly, the government has attempted to enlist their co-operation by giving them status through official recognition and licensing and by providing considerable amounts of training in modern medical practice." 72/
>
> ...
>
> "With the assistance of UNICEF, another programme has been established to increase the competence of dukuns and to co-ordinate their efforts with the national health improvement campaign. Trained rural nurse-midwives of the Public Health Service are required to set aside one day a week to conduct classes for all dukuns in their areas. When these trainees have attained certain minimal levels of understanding and proficiency, they are presented with a UNICEF midwifery kit and other essential equipment.
>
> "The beneficial effects of this programme extend far beyond the simple one of improving the quality of services performed by the dukun in local communities." 73/

157. The Government of Malaysia has taken special measures to train Orang Asli as health workers and medical personnel. The Department for Orang Asli Affairs established an Assistant Nurses Training Centre for this purpose at the departmental hospital. According to the Government's report, some 250 Orang Asli medical staff had been trained by 1974. Additionally, members of the Field Medical Staff who enter the medical division of the Department are specially trained to work in rural and jungle areas. Hospital and jungle medical posts are rotated every 3 to 4 months, and health workers as well as medical personnel participate in training programmes in rural health.

158. The Government of Canada reports that native workers are being trained with good results in the fields of preventive medicine and public health. Some serve as community health workers under the Medical Services Branch and others as liaison officers with Indian bands. In-training programmes for native workers are sponsored at some of the larger hospitals in the North, and more Indians are being employed as welfare administrators. At the same time, an increasing number of bands are administering public assistance programmes among their members, thus eliminating some of the problems in communication caused by cultural factors.

72/ John W. Henderson and others op.cit., p.179.

73/ Ibid., p.180.

159. Nurses who attend the New Zealand Post Graduate Nursing School and plan to work in public health are given a series of lectures on Maori society and attitudes to assist them in their treatment of patients. The Government of New Zealand reports that many Maoris are doctors, dentists and nurses. To ensure a steady supply of Maori and Polynesian doctors, at least four places per year are reserved at the Otago Medical School for Maoris and other Polynesians.

160. With regard to the training of indigenous medical personnel and health workers the Government of the United States of America has declared that:

> "More than half of the employees of the Indian Health Service of the U.S. Public Health Service are of Indian descent and they include physicians, dentists, professional nurses, engineers, and health educators. Many others have been trained by the Public Health Service as practical nurses, sanitarian aides, laboratory and dental technicians and dental assistants, and community health aides. In addition, many tribes supply funds for medical care and other health services for their people. Tribal health Committees work actively with Indian health staff in planning health services."

161. It has been commented, however, that the above estimate does not represent a true picture:

> "The statement that 'more than half of the employees of the Indian Health Service of the United States Public Health Service are of Indian descent and they include physicians, dentists, professional nurses, engineers and health educators' is a gross and deliberate distortion. The Federal Trade Commission would immediately bring sanctions against a private company using such misleading innuendo in its advertising. In fact, almost all of the more than half are employed at the lower grades of the pay scale, not the higher grades as the statement implies. The 'physicians' just barely justifies the plural, there being in actual fact only two. There are no Indian dentists employed in the Indian Health Service." 74/

4. Programmes to combat alcoholism

162. It would seem that in most countries the general programmes to control and combat the incidence of alcoholism apply unchanged to all segments of the population, regardless of their different socio-cultural backgrounds and whether or not they are indigenous.

163. Any effective health programme must be tailored to respond to the needs and problems of the group for which it is designed. The fact that alcoholism might have socio-cultural roots, as discussed above, 75/ would suggest that programmes to combat alcoholism in society at large may not be fully relevant in the context of groups with special cultural backgrounds. This is considered to be the case of

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74/ American Indian Law Newsletter, op.cit., p.25

75/ See para. 94, above.

indigenous populations in culturally conflictive societies. The failure to recognise that a different approach is needed explains why it has been said that government-styled programmes in the United States cannot help Indian alcohol abusers effectively, and that tribal medicine and traditional spiritual activity are of greater value. Others have complained that government programmes only treat symptoms and not causes.

164. According to information furnished by the Government of the United States, the Bureau of Indian Affairs, the Indian Health Service and various tribal governments have programmes to combat alcoholism. Another source 76/ has stated that the United States Government has set up a special native desk within its National Institute of Alcohol Abuse and Alcoholism. Some 7 million dollars are expended annually and 140 projects serve both urban and reservation Indians. The one at the University of Utah trains personnel for 114 community programmes in 25 western states and involves 165 persons who alternate between classwork and filed assignments. Three-fourths of the participants are rural or reservation Indians who are taking classes leading to certification. Still another source 77/ is critical of the lack of funding and general efficacy of some of these programmes: "Although the problem of alcohol among American Indians is legend in western culture, few alcoholism programs have been funded and the ones in existence are in danger of dying unless new legislation is passed. Such programs are of very recent origin; they have in general been sparingly funded, and though it is true that they combat alcoholism, evidence is so far lacking that they are in any cases winning the battle."

165. The Government of Mexico has stated that it is carrying out a pilot research programme into rural alcoholism in the area of San Felipe del Progreso, in the State of Mexico. Sponsored by the Instituto Nacional Indigenista and the Centro Mexicano de Estudios de Farmacodependencia, the programme will involve not only anthropological and medical research, but preventive, educational and rehabilitative measures.

166. Reference has been made above, regarding New Zealand, to the Maori Welfare Act 1962 and its amendments which provide for the appointment of Maori wardens with certain powers to control drinking by Maoris. The Maori wardens must be Maoris, are appointed by the Minister on the nomination of a District Maori Council and are responsible to that Council. Maori wardens are authorized to enter licensed premises (i.e. licensed to sell liquor) and to warn the licensee or any of his servants to abstain from selling or supplying liquor to any Maori who, in the opinion of the warden, is in a state of intoxication or is violent, quarrelsome or disorderly, or is likely to become so. It is an offence to disobey a warden. The warden may also order a Maori to leave licensed premises if he appears to be intoxicated, violent, quarrelsome or disorderly. If the Maori refuses to leave the premises he commits an offence against the Act and the warden may request a member of the Police Force to expel him. The Act also provides that drinking or having possession of liquor at a Maori gathering is an offence unless a Maori Committee appointed under the Act has issued a permit for liquor to be consumed at the gathering. 78/

76/ Alcoholism under attack, Akwesasne Notes, vol.6, No. 1, 1974, p.29.

77/ Burnette and Koster, The Road to Wounded Knee, Bantam Books, New York, 1974, pp. 86-87.

78/ See para. 72 above.

167. It has also been indicated above that the New Zealand Government has stated that this legislation established for Maoris is a systematic way of responding to drunkenness that is more preventive than the one existing under general law provisions applicable to all persons (Maoris and non-Maoris), such as the provisions in the Police Offences Act regarding intoxication. 79/

5. Special measures to combat dietary deficiencies

168. Some efforts to prevent dietary deficiencies through health education, food supplements for mothers and infants, school lunch programmes and environmental protection have been mentioned in previous sections. In some countries additional measures have been taken or are proposed and they deserve consideration here. Most are related to the development of alternative sources or supplies. The report of the ICRC Medical Mission to Brazil, for example, stated that in order to run a valid nutritional programme for Indians with any reasonable hopes for results, it should be combined with an agricultural scheme. It has been explained that this suggestion would entail the entire gamut of agricultural development projects, but in particular, the introduction of new crops, hybrids, or special fertilizers which would help to correct identifiable nutritional deficiencies among any indigenous community.

169. In Malaysia, the Department for Orang Asli Affairs provides funds for the construction of fish ponds, provision of cattle, goats and poultry, distribution of improved seed for traditional crops and the introduction of new crops among the Orang Asli. The Government of Malaysia has stated its belief that the problems of health, education, and social and economic development must be dealt with simultaneously.

170. On the other hand, the provision of new food sources may simply require the modification of certain conservation laws or the opening of new areas to exploitation by indigenous peoples. In Canada, where commercial fishing had ended in certain lakes, a "Fish for Food" programme was initiated. Some traditional sources need nothing more than revitalization. According to information furnished by the Government the Indians of the Grassy Narrows Reservation in Canada have asked the Government for aid in reviving winter trapping as a food source. The same Indians also requested government funds for the establishment of a grocery co-operative which would purchase in bulk from wholesalers and pass on the savings to Indian co-op members.

171. One approach has been the introduction of specially enriched foods such as incaparina, a high vitamin and protein meal developed by the Institute of Nutrition of Central America and Panama (INCAP) in the 1960s. Incaparina can be produced commercially from locally available products anywhere in the world, modified to suit differing tastes, and sold at very low cost.

79/ Ibid.

172. Government price subsidies for certain basic foodstuffs may be another answer. According to one source, the National Production Council of Costa Rica has subsidized the price of fish in order to encourage people to take advantage of this important source of protein. Although fish consumption reportedly increased as a result, it was noted that traditional beliefs about easy fish spoilage deterred wider consumption. In addition to providing price subsidies, some countries sell and distribute basic foodstuffs in order to prevent speculation and to ensure adequate distribution in isolated areas.

173. The importance of research into the nutritional deficiencies of particular groups is often overlooked. The Government of New Zealand reports that nutritional surveys of the Maori population are carried out from time to time, and a study of the dietary deficiencies of Maori mothers is being conducted under government sponsorship at the National Women's Hospital in Auckland.