CHAPTER V

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CHAPTER V

HEALTH

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The United Nations Declaration on the Rights of Indigenous Peoples states that "Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right",[2] thus affirming the basic human right to life and health that is guaranteed under international human rights law. It also goes on to state, "Indigenous peoples have the right to promote, develop and maintain their institutional structures and their distinctive customs, spirituality, traditions, procedures, practices and, in the cases where they exist, juridical systems or customs, in accordance with international human rights standards".[3] This implies a greater obligation of states to uphold not only the indigenous individual's right to health but also the collective right of indigenous peoples to maintain and use their health systems and practices in pursuit of their right to health. The Declaration further specifies, "Indigenous Peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services".[4] The Declaration thus establishes a framework for addressing the health situation of indigenous peoples that includes the obligations of states both to provide accessible, quality health care to indigenous peoples and to respect and promote indigenous health systems, each of which must be fulfilled in order to ensure the health of indigenous peoples.

The commitment of United Nations Member States to the Millennium Development Goals (MDGs) is an important step forward in improving the health of millions of people who live in poverty around the world. However, by failing to ground the goals in an approach that upholds indigenous peoples' individual and collective rights, the MDGs fall short in addressing the health disparities that persist between indigenous peoples and other poor, marginalized groups. By advancing the dominant paradigms of health and development rather than an approach based on individual and collective human rights, the MDGs also promote projects that are potentially detrimental to indigenous peoples, and which violate their rights to their collective land, territories and natural resources. Moreover, because the cultures and worldviews of indigenous peoples are not taken into account in the formulation of the MDGs, the goals do not consider the indigenous concept of health, which extends beyond the physical and mental well-being of an individual to the spiritual balance and well-being of the community as a whole. To improve the health situation of indigenous peoples, there must thus be a fundamental shift in the concept of health so that it incorporates the cultures and world views of indigenous peoples as central to the design and management of state health systems.

The indigenous concept of health and health systems

National, regional and international health institutions have typically defined health as the biological, physical and mental well-being of an individual. The World Health Organization (WHO), for example, defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".[5] However,

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[1] Written in collaboration with the Center for Indigenous Peoples' Autonomy and Development (CADPI).

[2] United Nations Declaration on the Rights of Indigenous Peoples, Article 24.2.

[3] Ibid., Article 34.

[4] Ibid., Article 24.1.

[5] Constitution of the World Health Organization (1946), 1.

WHO has begun to debate this definition and to consider the possibility of incorporating a cultural aspect into its concept of health.[6] Many organizations that promote health are thus beginning to recognize that the conventional definition is insufficient to capture the full meaning of health in societies that are diverse in their cultures, religions and forms of social organization.

the indigenous concept of health articulates physical, mental, spiritual and emotional elements, from both individual and communal points of view

For indigenous peoples, health is equivalent to the "harmonious coexistence of human beings with nature, with themselves, and with others, aimed at integral well-being, in spiritual, individual, and social wholeness and tranquillity".[7] The indigenous concept of health articulates physical, mental, spiritual and emotional elements, from both individual and communal points of view, and involves political, economic, social and cultural aspects. It is shaped by indigenous peoples' historical experiences and worldviews, and is expressed in the rules and norms that are applied in the community and practised by its members. To promote health and prevent illness, an indigenous community seeks to recuperate and maintain its interior and exterior equilibrium, including the harmony between community members who are sick and the world around them.

Traditional health systems in indigenous communities are complex and quite structured in their content and internal logic. They are characterized by a combination of practices and knowledge about the human body, and coexistence with other human beings, with nature and with spiritual beings. They involve all aspects of health promotion, prevention of illness and treatment and rehabilitation, but differ from most Western health systems in that they take an integral or holistic approach.[8] Many indigenous families address illness with a variety of approaches and practices, using either traditional or Western medicine, or a combination of the two. If treatment administered in the home proves insufficient, the choice is made—often by a woman, who is the primary decision-maker in this arena—as to whether to send the sick person to a practitioner of traditional or of Western medicine. In the absence of state health systems that incorporate the philosophies and practices of both traditional and Western medicine, the choice becomes polarized between the two systems, often to the detriment of the sick person.

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[6] In its Session 101 in January 1998, the WHO Executive Board was requested to amend the WHO definition of health to include the concept of spirituality. WHO considers spirituality, religiousness and personal beliefs as three of the areas by which to analyze the quality of life of an individual. See WHO (1998).

[7] Health Workshop, Guaranda, Bolívar, Ecuador, 1995.

[8] It is important to present working definitions of the terms "Western" and "traditional" medicine. Western medicine, also called Occidental medicine, biomedicine, conventional, allopathic, or orthodox medicine, is a system of medical practices that use an approach of treating illness through remedies that produce effects that oppose the symptoms of the illness. The Pan-American Health Organization (PAHO) has defined traditional medicine and indigenous health systems to "include the entire body of ideas, concepts, beliefs, myths, procedures and rituals (whether explainable or not) connected with the maintenance of health or health restoration through the treatment of physical and mental illness or social imbalances in a particular individual, community, or people. This body of knowledge, grounded in the people's cosmic visions, explains the etiology, nosology and procedures for the diagnosis, prognosis, cure, disease prevention, and health promotion". See PAHO (1997).

Tuberculosis in indigenous and non-indigenous populations

Tuberculosis, a disease that primarily affects people living in poverty, affects at least 2 billion people in the world, according to 2008 statistics. As a result of poverty and associated issues, tuberculosis continues to disproportionately affect indigenous peoples around the globe. Indigenous peoples are at an increased risk of suffering from tuberculosis. Whilst programmes have been designed to combat tuberculosis, they often do not reach indigenous peoples because of issues related to poverty, poor housing, a lack of access to medical care and drugs, cultural barriers, language differences and geographic remoteness.

The statistics surrounding indigenous people in the context of tuberculosis indicate that

- in Canada, in 2006, the First Nations tuberculosis rate was 27.4 per 100,000, or 35 times higher than among the non-aboriginal population born in Canada. Tuberculosis is a particular threat to the Inuit in Canada, where the rates are 121 per 100,000, or just over 150 times higher than the non-aboriginal population;[9]
- in New Zealand, the ratio is 21.1 among Pacific Islanders and Maoris, making them at least 10 times more likely to contract tuberculosis than other people living in New Zealand;[10]
- in Kalaallit Nunaat (Greenland) the tuberculosis rate was 157 per 100,000, making them 45 times more likely to get active tuberculosis than the Danish population.[11]

Health and the collective rights of indigenous peoples

International human rights instruments such as the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination against Women and the Convention on the Rights of the Child have traditionally provided the legal framework for the foundation of international human rights, including the right to health. These instruments include provisions for the right to life and for the "right of everyone to enjoy the highest attainable standard of physical and mental health",[12] with some specifically recognising the rights of individuals from marginalized populations, including indigenous peoples and ethnic minorities.

In the case of indigenous peoples, the right to health should not be conferred only on individuals, but should also be applied at the collective level. Until recently, however, few legal instruments had incorporated the concept of collective rights. In the same way that the establishment of individual rights has advanced over time, a set of collective rights is never beginning to be articulated at the international level, such as the approval of the Declaration on the Rights of Indigenous Peoples by the United Nations General Assembly.[13] This is perceived by indigenous peoples as a human rights instrument which, in time, will increase the political will of states to build new relationships with indigenous peoples, and to confront the exclusion to which they have been subjected.

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[9] Public Health Agency of Canada (2006) and Statistics Canada (2006).

[10] Das, Baker & Calder (2006).

[11] Skifte (2004).

[12] International Covenant on Economic, Social, and Cultural Rights, Article 12.1.

[13] The Declaration was adopted by the newly established Human Rights Council in June 2006 and, on 13 September 2007, by the United Nations General Assembly.

In accordance with the international human rights instruments that provide for the right to health, most initiatives that seek to improve the health of poor and marginalized populations focus primarily on increasing access by individuals from those populations to state health systems. Indeed, full access to quality health care is a human right of all individuals, and it is therefore critical to ensure equal access to health care, including through efforts to eliminate the discrimination and marginalization faced by indigenous peoples. However, to address the root causes of indigenous peoples' health problems, there must also be full recognition and exercise of indigenous peoples' collective rights to communal assets and self-determination.

Gap in life expectancy between indigenous and non-indigenous people (in years)

Guatemala	Panama	Mexico	Nepal	Australia	Canada	New Zealand
13	10	6	20	20	7	11

Source: Hanemann (2006), 5 & Health Canada (2007).

Many of the most urgent health challenges faced by indigenous peoples, such as illnesses from pesticides and extractive industries, malnutrition, diabetes and HIV/AIDS, stem from the contamination and depletion of their land and natural resources, and from their forced displacement from their territories. The right to collective land, territories and natural resources is thus an essential component that lays the foundations for improving the health of indigenous peoples. In addition, the rights to preserve, practise and transmit traditional knowledge and to maintain cultural, spiritual and social beliefs and institutions are integral to ensuring the health of indigenous communities. Many mental health issues such as depression, substance abuse and suicide have been identified as connected to the historical colonization and dispossession of indigenous peoples, which has resulted in the fragmentation of indigenous social, cultural, economic and political institutions.

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Similarly, the right to self-determination with respect to health implies creating conditions for the full and effective participation of indigenous communities in the design and management of health systems, in addition to adherence to the principle of free, prior and informed consent in the planning and implementation of health and development programmes and projects.[14] Furthermore, there must be a commitment to building the human resources necessary for the participation of indigenous peoples in health policy and management, as well as training non-indigenous health professionals in the cultures and languages of indigenous peoples. Finally, it is essential to recognize that the health situation of indigenous peoples is linked to the sustainable human development of

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[14] For more on the concept of free, prior and informed consent, see UNPFII (2005).

indigenous communities in all aspects, which includes issues of education, political participation, environment and economic development; efforts to improve the health of indigenous peoples must therefore involve a multi-sectoral and multidisciplinary approach.[15]

Over the course of the last decade, some international and regional health initiatives have begun to pay greater attention to the specific needs of indigenous peoples, many of which were precipitated by the first International Decade of the World's Indigenous Peoples (1995-2004) proclaimed by the United Nations General Assembly. WHO, for example, has various initiatives administered by their Health and Human Rights Team that focus on improving the health of indigenous peoples, and the World Health Assembly (WHA) has passed a number of resolutions affirming its intention to tackle health disparities between indigenous and non-indigenous populations.[16] In addition, WHO has urged member States to "develop and implement, in close cooperation with indigenous people, national plans of action or programmes on indigenous people's health which focus on ensuring access of indigenous people to health care."[17] The Pan-American Health Organization (PAHO) has been one of the institutions most attuned to the demands of indigenous peoples. In 1993, within the framework of the United Nations International Year of Indigenous Peoples, PAHO held a meeting on the health of indigenous peoples.[18] The recommendations of that meeting were approved by the PAHO Directing Council as Resolution V, "Health of Indigenous Peoples", and secured a commitment from member Governments, at least at the policy level, to grant priority to improving the health of indigenous peoples while respecting their ancestral culture and knowledge.[19]

Core elements of PAHO Resolution V

- Promoting the participation of leaders and representatives of indigenous peoples and their communities in the formulation of health policies and strategies and the development of health and environmental activities directed at their people;
- Strengthening the technical, administrative and management capacity of national and local institutions responsible for the health of indigenous peoples, with particular attention to the need to overcome the lack of information;
- Ensuring greater access by indigenous peoples to quality health services;
- Facilitating inter-sectoral actions (government, non-governmental, universities, research centres and indigenous organizations);
- Promoting the transformation of health systems and supporting the development of alternative models of care, including research and certification of traditional medicine;
- Promoting programmes in disease prevention and health promotion to address the problems most relevant to each country; and

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[15] This has been recognized by the Pan-American Health Organization. See PAHO (2003), 7.

[16] WHA (1994-2001). Resolutions 54.16, 53.10, 51.24, 50.31, 49.26, 48.24, and 47.27.

[17] WHA Resolution 51.24, International Decade of the World's Indigenous People, (1998), 1.

[18] The meeting was held in Winnipeg in April 1993, with the participation of indigenous peoples from the Americas and functionaries of WHO, Ministries of Health, and non-governmental organizations.

[19] PAHO Resolution V also includes the adoption of Document CD37/20, creating the PAHO Health of the Indigenous Peoples of the Americas Initiative.

- Forming reciprocal information and collaboration networks between organizations and institutions.

Source: PAHO/WHO Resolution V "The Health of Indigenous Peoples", adopted at the Fourth Plenary session, 28 September 1993.

In addition, WHO, along with the specialized agencies of the United Nation system and international development institutions such as the World Bank, has begun to recognize that "when we marginalize indigenous peoples, we cut off a vast body of knowledge that is of great value to humanity."[20] This has spawned a number of efforts to support the preservation of indigenous knowledge with respect to traditional medicine and healing practices. Programmes such as UNESCO's Local and Indigenous Knowledge Systems Programme may not have an explicit health focus but, by focusing on sustainable development and resource management, they work on preserving and promoting the use of traditional knowledge, which is integral to indigenous health systems. In 1997, WHO established a programme on traditional medicine with the objective of interesting governments of member countries and other health institutions in supporting traditional health agents, and has since focused on supporting the development of national policies related to the practice of traditional medicine, advocating for the rational use of traditional medicine based on international standards, and developing technical standards and methodologies for research into traditional medicine therapies and products.[21]

Based on reports on the health of indigenous peoples and to follow up from the work initiated through Resolution V, PAHO approved Resolution VI, calling on member States to intensify their efforts to identify and eliminate the inequities in the health status of indigenous peoples. One of their strategic goals is to create an inventory of the region's best practices in incorporating indigenous perspectives and practices into health systems.[22] Various regional initiatives have followed, including the support of the United Nations Population Fund (UNPFA) for summits and associations of indigenous women that address health in Latin America and the Caribbean[23] and efforts by both UNIFEM and the United Nations Inter-Agency Support Group on Indigenous Peoples' Issues to convene indigenous women to discuss how to incorporate the demands of indigenous women into United Nations initiatives related to the MDGs.

The current health situation of indigenous peoples

Indigenous peoples suffer from poorer health, are more likely to experience disability and reduced quality of life and ultimately die younger than their non-indigenous counterparts. PAHO has stated that "the present epidemiological profile of the indigenous population is associated with high poverty indices, unemployment, illiteracy, migration, exclusion from the mainstream society, lack of land and territory, destruction of the ecosystem, alteration of the dynamic of life, and unmet basic needs".[24] Circumstances of extreme poverty are significantly more prevalent among indigenous peoples than non-indigenous groups, and are rooted in other factors, such as a lack of access to education and social services, destruction of indigenous economies and socio-political structures, forced displacement, armed conflict and the degradation of their customary lands and waters. These forces, which are inherited from colonization, are all determined and compounded

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[20] WHO (1999), Statement by WHO Director-General, Gro Harlem Brundtland.

[21] WHO (2002), 5.

[22] See PAHO (2006).

[23] See UNFPA (2006) and Box on page 180, this chapter. UNFPA also makes efforts to consider gender mainstreaming and cultural sensitivity in all of its initiatives. See http://www.unfpa.org/culture/rights.htm and http://www.unfpa.org/gender/index.htm

[24] PAHO (2003).

by structural racism and discrimination, and make indigenous women and children particularly vulnerable to poor health.

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The impact of these phenomena is that indigenous peoples experience disproportionately high levels of maternal and infant mortality, malnutrition, cardiovascular illnesses, HIV/AIDS and other infectious diseases such as malaria and tuberculosis. Indigenous women experience these health problems with particular severity, as they are disproportionately affected by natural disasters and armed conflicts, and are often denied access to education, land, property and other economic resources. Yet they play a primary role in overseeing the health and well-being of their families and communities. In addition, as the incidence of other public health issues such as drug abuse, alcoholism, depression and suicide increases, urgent and concerted efforts are needed to improve the health situation of indigenous peoples.[25]

Health disparities from an epidemiological perspective

All around the world, there are health disparities between indigenous and non-indigenous populations in the incidence of virtually every health condition, from infectious diseases such as HIV/AIDS, malaria and tuberculosis to cardiovascular disease, diabetes, cancer and respiratory diseases. Moreover, many of the most widespread causes of mortality among indigenous children are preventable, such as malnutrition, diarrhoea, parasitic infections and tuberculosis. Box V.3 gives an example of the health disparities between indigenous and non-indigenous populations in Venezuela.

The health situation in Amazonas state, Venezuela

Although Venezuela is a middle-income country, health indicators in Amazonas state, which is home to twenty distinct indigenous peoples, are significantly lower than in the rest of the country. Living in areas short of infrastructure, indigenous peoples are disproportionately affected by malnutrition and infectious diseases. Consequently, the infant mortality rate in Amazonas state is 43.9 per 1,000 births, compared to the national average of 19 per 1,000 births, and between 76 and 250 per 1,000 births in the Yanomami population. In 2001, the rates of diarrhoea-related diseases, pneumonia and tuberculosis in Amazonas state were double the national rates. In 2004, the malaria incidence was 70 times higher than the national average, standing at 87.7 cases per 1,000, compared to 1.2 per 1,000, making malaria the main cause of morbidity and the seventh cause of infant mortality. The indigenous municipalities of Atabapo, Autana and Manapiare were the most affected, with the highest malaria rates in Venezuela.

Source: The Indigenous World 2004 (2004), 137-138.

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[25] PAHO (2006), 3.

Poor nutrition is one of the health issues that most affects indigenous peoples around the world. In addition to circumstances of extreme poverty, indigenous peoples suffer from malnutrition because of environmental degradation and contamination of the ecosystems in which indigenous communities have traditionally lived, loss of land and territory, and a decline in abundance or accessibility of traditional food sources. These changes in traditional diet, combined with other changes in lifestyle, have resulted in widespread malnutrition among indigenous peoples. The World Bank has reported that "the rate of stunting [height/age] for Guatemala overall is 44 percent, but for indigenous children the rate is 58 percent, higher than either Yemen or Bangladesh, and almost twice the rate for non-indigenous children. In Ecuador, chronic malnutrition is more than twice as high in indigenous as compared to non-indigenous communities".[26] In El Salvador, an estimated 40 per cent of indigenous children under age five are malnourished, compared to the national average of 23 per cent, and in Honduras an estimated 95 per cent of indigenous children under age 14 suffer from malnutrition.[27]

However, this malnutrition manifests itself differently depending on the local circumstances. Whilst in some parts of the world malnutrition affects maternal and infant health and child development, in other regions it contributes to an increasing prevalence of non-communicable diseases such as obesity, diabetes and cardiovascular disease among indigenous peoples. In the State of Arizona in the United States, for example, the Pima Indian tribe has the highest rate of diabetes in the world, as "some 50 per cent of the Pima between the ages of 30 and 64 have diabetes."[28]

Indigenous people and diabetes

Indigenous people are particularly vulnerable to diabetes due to a combination of environmental, genetic and socio-economic factors. The contamination and destruction of natural habitats and the disappearance of wildlife plants and animals have resulted in the erosion of traditional food systems and decreased food security. This has led to increasing reliance upon imported processed foods that have little nutritional value but are often high in sodium and fat, causing obesity and diabetes.

The genetic selection processes that may have been advantageous when food was in short supply and had to be obtained through hard physical effort make indigenous people highly vulnerable to diabetes at the time of the rapid transition to a high-calorie diet and low levels of physical activity. The situation is aggravated by indigenous peoples' lack of access to health care. Most indigenous people are never diagnosed or treated for diabetes. Others are diagnosed too late to prevent the dramatic impact of the disease on the eyes, kidneys, nerves and circulation.

Because of economic constraints and lack of knowledge about healthy eating, many families choose affordability over nutritional value. In Tonga, for example, traditional low-fat sources of protein, such as fish, cost between 15 per cent and 50 per cent more than either lamb flaps or imported chicken parts. The local taro plant costs more than imported starches such as bread and rice. Thus, "not only are the health consequences of these imported foods detrimental, but the availability of these cheap imports is also constraining the development of domestic markets".

There is little research into diabetes prevalence in indigenous populations. However, available health statistics indicate that, in some indigenous communities, diabetes has reached epidemic proportions and

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[26] Hall and Patrinos (2006), 14.
[27] PAHO (2002a), 181.
[28] PAHO (2002), 182.

places the very existence of indigenous groups at risk. In the Pacific, diabetes is present in 44 per cent of the Torres Strait Islanders of Australia, 28 per cent of the residents of the Kingdom of Tonga and 22 per cent of the residents of Nauru. In Australia, the estimated number of indigenous adults with type 2 diabetes is up to four times higher than that of Australians of European descent, and ten times higher than the national prevalence among 25- to 50-year-olds. In other areas of the world, diabetes prevalence is also high among Native North Americans, Inuit people of the Canadian Arctic and Greenland, and indigenous people in Asia. In Canada, diabetes prevalence among certain aboriginal peoples is three to five times higher than that of the general population in the same age group. Worldwide, over 50 per cent of indigenous adults over age 35 have type 2 diabetes, and these numbers are predicted to rise.

It is essential to recognize the severity of diabetes in indigenous people. A number of successful initiatives have been undertaken in order to protect traditional food systems in the Pacific region. Vanuatu declared 2001 as Yia Blong Aelan Kakae, or the Year of Island Food, to encourage the revival of traditional methods of food cultivation and consumption. Fiji banned the import of lamb flaps from New Zealand because of the proven links with obesity. Such initiatives need to be supported with research that will foster a better understanding of diabetes in indigenous communities. Furthermore, it is important to step up efforts to develop culturally appropriate methods of education, prevention and care within indigenous populations as part of broader efforts to improve the health of indigenous communities around the world.

Sources: International Diabetes Federation (2007); World Health Organization (2001); Nicolaisen (2006).

Infant, child and maternal mortality rates are good indicators of the general health status, as they are affected by a range of factors, most important of which are malnutrition and poor access to health care, which are preventable. Although the gap has narrowed in recent decades in most countries that collect disaggregated data, these rates continue to be significantly higher among indigenous peoples, compared to the non-indigenous populations. Child mortality (years 1-4) rates in 2005, for example, were twice as high for American Indian and Alaska Natives than for the total population in the United States,[29] while in Australia for the period 1999-2003, the indigenous infant mortality rates were almost three times that of non-indigenous infants, and child mortality twice as high.[30] Infant mortality rates in New Zealand are 1.5 times higher for the indigenous Maori than for non-Maori, whilst similar trends are visible in Canada.[31]

In Latin America, where disaggregated data is readily available, indigenous infant mortality rates are always higher than those of the total population, ranging from 1.11 times higher in Chile to 3.09 times higher than the general population in Panama.[32] "In Bolivia, Ecuador, Guatemala, México and Panama, which have collected information on ethnic group and mother's area of residence (i.e., urban vs. rural), infant mortality rates are consistently higher among rural indigenous populations than among their non-indigenous rural peers as well as among urban indigenous populations".[33]

Where disaggregated data is unavailable, it is sometimes helpful to look at regional differences, and the regions where indigenous peoples predominantly live tend to fare worse than other regions. In Ratankiri, the northeast

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[29] DeVoe, J.F. and Darling-Churchill, K.E. (2008), 34.

[30] Trewin, D. & Madden, R. (2005), 88.

[31] Although these differences in these rich countries are striking, the gap has narrowed substantially in recent years.

[32] ECLAC (2007) 190.

[33] PAHO (2007) 32.

province of Cambodia, the infant mortality rate was reported estimated at 187 per 1,000 births, compared to the national rate in 1999 of 86.[34] Maternal mortality rates tend also to be higher than those of the general population. "In Viet Nam, access to maternal health care services ranges from 90 per cent in urban areas to as low as 20 per cent in remote areas of the Central Highland and Northern Uplands regions inhabited by indigenous peoples".[35] Similar trends have been recorded throughout Latin America[36] as well as in the richer developed countries.

The health gap in developed countries

The health of indigenous peoples in First World countries, measured by life expectancy, is significantly worse than that of the mainstream populations of those countries.

Broadly speaking, New Zealand, the United States and Canada saw major health improvements for indigenous populations up to around the 1980s, leading to an appreciable narrowing of the gap in life expectancy between indigenous and mainstream populations. However, between the 1980s and the end of the century, a slowing or stalling of indigenous health improvements measured by life expectancy meant that the gap failed to close significantly (Canada) or even widened (New Zealand and the United States).

Source: Griew, R. (2008), 41.

> because indigenous peoples are essentially invisible in the data collection of many international agencies and in most national censuses, the disparities in their health situation as compared to other groups continue to be obscured

A recent conference on diabetes among indigenous peoples noted that "poverty and the associated poor quality diet, physical inactivity, overcrowded living conditions, psychosocial stress, and high burden of infectious disease interact to increase the risk of these chronic conditions from early life".[37] At the same time, it has also been demonstrated in some parts of the world that "the heavy reliance on traditional, locally available foods seems to reduce the risk for certain health problems".

Lack of disaggregated data and of culturally relevant indicators

Although the above statistics provide a general picture of the health gap between indigenous and non-indigenous populations around the world, precise and comprehensive data are still extremely difficult to obtain. In fact, because indigenous peoples are essentially invisible in the data collection of many international agencies and in most national censuses, the disparities in their health situation as compared to other groups continue to be obscured. The lack of data means ongoing shortcomings in plans, programmes and policies that

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[34] UNICEF (2003) 9.

[35] UNICEF (2003) 10.

[36] See for example PAHO (2004).

[37] International Diabetes Federation (2006), 2.

seek to improve global health, including efforts to achieve the MDGs, which are based on averages instead of disaggregated data. Similarly, even when indigenous peoples appear in health data, they are often conceived of as a percentage of a national population, which UNICEF has noted "can be misleading in as much as the distribution of certain indigenous peoples does not correspond to national boundaries. As an illustration, the Quechua in South America are found in significant numbers in six countries and the Fulani of West Africa extend across eight countries".[38] PAHO has thus continually stated that "the lack of vital statistics or breakdown by ethnic groups, gender, and age makes the generation of policies and managerial processes based on evidence more difficult, which, in turn, jeopardizes the formulation of priorities and appropriate monitoring and evaluation systems for indigenous populations".[39]

In order to design public policies aimed at improving the health situation and related conditions of poverty and discrimination faced by indigenous peoples, it is necessary to collect disaggregated data, to develop culturally relevant indicators of health and well-being rooted in the world views of indigenous peoples, and to advance methodologies for conducting research into indigenous peoples. Moreover, indigenous peoples must have full and effective participation and take leadership roles in the collection, processing, reporting and use of information that guides decision-making in health policies and programmes.

In the international arena, and especially in the United Nations system, there has been increased recognition of this need for improved data collection.

Aboriginal health indicators in Canada

The Assembly of First Nations (AFN) represents over 630 communities in Canada. Since its charter was adopted in 1985, it has lobbied for the rights of indigenous peoples, setting policy objectives, conducting research, and negotiating with the state on issues such as treaty rights, economic development, culture and language, education, health, housing, justice, and environment.

AFN's research and policy development on the health of indigenous peoples complements the First Nations Regional Longitudinal Health Survey (RHS), which was initiated in 1997 as the most extensive national health survey on indigenous peoples and the only national research initiative controlled by indigenous peoples. It was stewarded by the National Aboriginal Health Organization and governed by the First Nations Information Governance Committee, comprising First Nations regional health coordinators from ten regions across Canada. The RHS was based on the principles of Ownership, Control, Access and Possession (OCAP) to ensure self-determination over the data collection process. The survey used the framework of holistic health and gathered information on areas such as demographics, languages, culture and religion, education, employment, water quality, food and nutrition, community development, housing, physical activity, health conditions, HIV/AIDS, diabetes, drug and alcohol use, and suicide attempts.

In 2005, the National Chief of the AFN proposed that all governments in Canada work toward "Closing the Gap" between indigenous and non-indigenous populations in health and well-being. AFN thus devised a "Closing the Gap Reporting Framework" of indicators, and a First Nations Holistic Policy and Planning Model, which guides policy interventions and the development of performance indicators.

AFN's indicators of well-being are linked to each of the core issues in the holistic health model, which is based on the following principles:

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[38] UNICEF (2003), Innocenti Digest, No.11, 8.

[39] PAHO (2006), 3.

- Holistic focus on determinants of well-being
- Individual placed in the context of the community
- Governance as its underpinning, including self-government, fiscal relationships and capacity building
- Premised on the components of the Medicine Wheel, with the four directions articulated as spiritual and social, cultural and physical, emotional and environmental, and economic and mental
- Inclusive of the four cycles of the lifespan (child, youth, adult, elder)
- Inclusive of the three components of social capital (bonding, bridging, linkage)

The indicators include the following categories: health care; education/lifelong learning; housing; community control over services/community relationships; economic development; environmental stewardship; social services; justice; lands and resources; language/heritage/culture; employment; gender; on/away from reserve and urban/rural.

Sources: Assembly of First Nations Canada (2004), (2005) and (2006), 6.

Even where the political will exists to generate disaggregated data, however, the mechanisms and methodologies for collecting data that both give greater visibility to indigenous peoples and incorporate their participation are still lacking. The Permanent Forum on Indigenous Issues has been promoting processes to define indicators of well-being. Organizations such as the International Indigenous Women's Forum/Foro Internacional de Mujeres Indígenas (FIMI)—a network of indigenous women who facilitate the participation and advocacy efforts of indigenous women in the international arena—has called for the development of analytical paradigms, research methodologies and training programmes that can strengthen the capacity for relevant and useful data to be collected from indigenous women.

Health outcomes influenced by structures inherited from colonialism

Many illnesses that have a disproportionate impact on indigenous peoples, especially problems of mental health, are related to the colonialist and racist structures that cause indigenous communities to be some of the poorest and most marginalized in the world. Not only have indigenous peoples experienced a collective history of genocide, dispossession and dislocation, manifestations of these violent forces persist today in the form of development aggression, forced displacement and economic exploitation. WHO has noted that "whatever the reasons—war, development, or lack of economic opportunity—the psychological consequences of dislocation are serious and often result in high rates of distress".[40] In addition, most armed conflicts around the world are being waged on indigenous peoples' territories, which contain most of the remaining sources of mineral wealth, water and biodiversity.

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[40] Cohen (1999), 9.

Environmental contamination and degradation

Environmental contamination and degradation are often the direct result of violations of the collective rights of indigenous peoples and the continuation of colonial tendencies to exploit indigenous peoples' land and resources. The environmental contaminants from sources such as mining, oil and gas industries, as well as climate change and resource depletion have serious health consequences for local indigenous communities, and neither governments nor transnational corporations seeking profit in these industries share the values of conservation and sustainability practised by indigenous peoples for thousands of years. In some regions such as the Arctic, the contaminants do not even originate in the region; rather, "environmental contaminants such as mercury, other heavy metals, PCBs, DDT, dioxins and other organ chlorines mainly originate in the mid-latitude industrial and agricultural areas of the globe but have migrated to the Arctic via atmospheric, river and ocean transport. Their subsequent bio-magnification in the Arctic food-webs and appearance in subsistence foods such as fish, waterfowl, marine and land mammals, and in the indigenous people who rely on these foods, is of great concern to Arctic residents. Potential human health effects include damage to the developing brain, endocrine and immune systems".[41]

> contaminants from sources such as mining, oil and gas industries, as well as climate change and resource depletion have serious health consequences for local indigenous communities

Use of pesticides and the health of indigenous peoples

In 1997, the University of Arizona conducted a study into the health effects of industrial agricultural pesticides in the homeland of the Yaqui people in Sonora, México, who share a common territory between the United States and Mexico. Yaquis living or working near the fields are exposed to frequent aerial spraying of pesticides. For some, their only source of water is contaminated irrigation canals. They carry poisons home in pesticide-soaked clothing, spreading the contamination to their families. The study detected high levels of pesticides in the cord blood of newborns and in mothers' milk and found birth defects, learning and development disabilities, leukaemia and other severe problems in children, along with cancer and other illnesses among family members of all ages. Deaths from acute pesticide poisoning are increasing. U.S. tribal communities are also affected by contamination passed on through the food chain and the natural environment. Dangerous pesticide use in the United States has increased 33 times since 1945.

Source: Guillette, Elizabeth et al. (1998), 347-353.

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[41] Statement by Alan J. Parkinson from the Arctic Investigations Programme (2006).

Mental and behavioural health issues

Another serious concern in indigenous communities is mental and behavioural health issues such as alcoholism, drug abuse, depression and suicide, particularly among indigenous youth. These have all been linked to past and current experiences of colonization as a clear "psychopathology" and are exacerbated by conditions of poverty and marginalization.[42] A WHO report stated the following:

> *Mental health must be considered as being deeply enmeshed with economic and political concerns such as poverty, hunger and malnutrition, social change, and violence and dislocation… Furthermore, mental, social and behavioural health problems cannot be assessed in isolation from one another, because they "represent overlapping clusters of problems that… interact to intensify each other's effects on behaviour and well-being"… From this perspective, social pathologies (e.g., substance abuse and violence), health problems, (e.g., heart disease and depression) and social conditions (e.g., poverty) are interrelated to such an extent that it is impossible to differentiate one problem clearly from another.*[43]

In addition to this interrelation, which complicates diagnosis of mental health issues, some Western methods of diagnosis are insufficient within the context of contemporary multicultural, multiethnic societies. Because social and cultural contexts determine the manifestations and symptoms of mental health illnesses such as depression, the methods of diagnosis are culturally constructed.[44]

Suicide

Youth suicide affects societies around the world. The issue has been a particularly painful and sensitive topic for a number of indigenous peoples, which have experienced disproportionately high rates of youth suicide.

Youth suicide in indigenous communities takes place in the context of contemporary discrimination and marginalization and historical trauma related to colonization, assimilation and loss of traditional livelihoods. During the 19th and 20th centuries, for example, some States implemented policies intended to destroy indigenous cultures, and which isolated children from their families and forcibly stripped them of their traditions, language and religion. Although the reasons for youth suicide are complex and difficult to define, such interference with, and destruction of, cultural structures has caused stress throughout subsequent generations that is generally considered to contribute to suicidal behaviour. Indigenous youth today face the challenge of striking a balance between their place within their indigenous community and within the mainstream society of the country and may feel marginalized from both, resulting in a sense of social isolation.[45] This isolation, compounded by contemporary manifestations of discrimination, such as disproportionately high levels of poverty and unemployment, may contribute to the high rates of suicide experienced by certain indigenous tribes or peoples.

In Australia, death from self-injury is higher amongst indigenous youth than among the overall Australian youth population. In 2005 the death rate from self injury for young people aged 15–24 years was 10.4 for the

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[42] Cohen (1999), 12.
[43] Cohen (1999), 11 citing Desjarlais et al. (1995).
[44] Cohen (1999), 12.
[45] Center for Disease Control (2007)

total Australian population and 17.6 for the Indigenous Australian population.[46] In the United States, suicide rates for American Indian and Alaska Native youth are significantly higher than the national average for other population groups. For 5 to 14 year-olds, the suicide rate is 2.6 times higher than the national average. The disparity grows larger in the later teenage years and into young adulthood. The suicide rate for American Indian and Alaska Native youth aged 15 to 24 is 3.3 times higher than the national average.[47] In the state of Alaska, a study conducted by the Alaska Statewide Suicide Prevention Council found that, although Alaska Natives comprise 16 percent of the state population, they accounted for 39 per cent of suicides between 2003 and 2006. The disparity was even greater for Alaskan youth 19 years and younger where, since the early 1990s, Alaska Natives accounted for 19 per cent of the youth population and 60 percent of the suicide deaths in that age group.[48]

In Canada, while there is a great deal of variation among First Nations communities, overall suicide rates are 5 to 7 times the rate for Canadian youth overall: 126 per 100,000 for First Nations male youth aged 15-24, compared to 24 per 100,000 for Canadian male youth as a whole, and 35 per 100,000 for First Nations female youth, compared to 5 per 100,000 for Canadian female youth.

Suicide rates have also been disproportionately high among certain communities of Inuit peoples. One researcher has correlated suicide rates among Inuit peoples in Alaska, Nunavut and Greenland with the period when governments encouraged them to move from their traditional territories to villages and towns. The trend began in north Alaska in the 1960s, Greenland in the 1970s and Nunavut in the 1980s.[49] Today, suicide rates among Inuit are the highest in Canada, at eleven times the national average".[50] In Greenland, suicide rates by young men in East Greenland reached a rate of 1,500 per annum per 100,000 in the 1990s, before beginning to decline.[51] These figures contrast starkly with historical records, which indicate that Inuit suicide rates were traditionally low. The earliest existing data on suicide among Inuit comes from Greenland, and indicates a low annual suicide rate of 3.0 per year from 1900 to 1930. [52] Records for Nunavut suggest that there was only one suicide in the region during the entire 1960s. [53]

In Latin America, suicide rates have risen dramatically within some indigenous peoples that are facing severe disruptions to traditional ways of life, including "rapid sociocultural change, disturbances in traditional social life, progressive dismantling of extended family structure, and forced relocation to reservations." [54]

In Brazil, the Kaiowa, with some 30,000 people, have seen hundreds of young people take their lives in the last two decades as the tribe has fought to keep loggers and farmers off its land.[55] Data collected by the Brazilian Ministry of Health on suicide trends and characteristics in two Guaraní communities from 2000 to 2005 suggests that the suicide rate among Guaraní was 19 times higher during this time period than the national rate in Brazil and that suicides disproportionately affected Guaraní adolescents and young adults. [56]

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[46] Australian Research Alliance for Children and Youth (2008), p.60.
[47] Carmona (2005)
[48] Alaska Injury Prevention Center, Critical Illness and Trauma Foundation, Inc. & American Association of Suicidology (2006), p. 12.
[49] Canadian Press (2008)
[50] Health Canada (2008)
[51] IWGIA (2007)
[52] IWGIA (2007)
[53] Health Canada (2008)
[54] Center for Disease Control (2007)
[55] New York Times (2004).
[56] Center for Disease Control (2007).

In Colombia, at least 15 youth from the Embera, Wounaan, Katio and Chami peoples committed suicide between 2003 and 2004. Given the tribes' population of some 3,000 individuals, "the yearlong spate of deaths adds up to a suicide rate of 500 per 100,000 people. The overall suicide rate in Colombia was 4.4 per 100,000 in 2003, according to government statistics."[57] The suicides took place at a time of extreme change, during which settlers depleted the jungles of animals that the indigenous peoples once hunted, forcing the once-nomadic Embera to form permanent communities and turn to farming. Their traditional lives have also been greatly impacted by guerrilla and paramilitary activity.[58]

The problems faced by adolescents are often further compounded by the lack of resources available to assist them. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health has reported discrimination in access to and treatment in, health care and support services, stating that "[I]ndigenous populations are frequently ignored, with no specialist development of psychiatric and support services despite acute needs that are manifest in increasing suicide rates…".[59]

The erosion of traditional resources and authority frustrates the ability of traditional governments to make available the culturally appropriate services most needed by indigenous adolescents. This is extremely significant as suicide rates have been found to be negatively associated with integration of traditional culture in several Native American peoples and degree of self-government among Native Canadians.[60] Similarly, although a study of suicide risk among indigenous Sami in Arctic Norway found an increased risk of suicide for the Sami in comparison with the rural population of Arctic Norway as a whole, it found no increased risk of suicide among reindeer herding Sami males. This finding may be due to the significance of reindeer herding as a traditional, culturally significant occupation among the Sami in Norway. Today, Sami in Norway who are involved in reindeer herding occupy a unique cultural position and have a strong ethnic identity and high status within the Sami culture.[61] In this regard, improvements in the enjoyment of human rights by indigenous peoples, including the rights to self-governance, culture and land rights, and improved access to resources and reduction in poverty may be expected to decrease the disproportionately high youth suicide rates faced by some indigenous tribes or communities.

At the same time, some mental health problems may be perceived differently in indigenous communities that have a collective sense of loss of their cultures, territories, or social structures. One study on alcoholism and depression in an indigenous community in the United States noted that "depression… can be a positive expression of belonging.… To be sad is to be aware of human interdependence and the gravity of historical, tribal, familial and personal loss. To be depressed, and that includes tearfulness and sleep and appetite disturbances, is to demonstrate maturity and connectedness to the Indian world".[62]

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[57] New York Times (2004).
[58] New York Times (2004).
[59] Hunt (2005), para 12.
[60] Silviken, Haldorsen & Kvernmo (2006)
[61] Silviken, Haldorsen & Kvernmo (2006)
[62] Cohen (1999), 14, quoting O'Nell (1993).

Applying culturally adapted strategies to prevent suicide

In 2002, suicide was the second leading cause of death among Maori youth aged 15 to 24. In that same year, young Maori males were almost 3 times as likely (43.7 vs. 18.0 per 100,000), and young Maori females twice as likely (18.8 vs. 9.1 per 100,000), to die by suicide than non-Maori youth. In addition, for every suicide, there are around eight times as many hospital admissions for attempted suicides and self-injury. Many factors are attributed to the disproportionate rate of suicide among Maori youth, including poverty and higher exposure to the welfare system, cultural alienation, drug and alcohol abuse, and high rates of family and community violence.

The New Zealand Ministry of Health has developed a comprehensive strategy in conjunction with the Ministry of Maori Development and the Ministry of Youth Affairs that departs from the cultures and world views of Maori communities. The plan includes the goals of strengthening collective identity, increasing the role of Maori youth in the development of their communities, supporting cultural development, increasing access to mainstream services, and conducting further research into the underlying causes of suicide among Maori youth. Within these goals, the plan recommends a variety of strategies, including promotion of the Maori concept of health and well-being, focusing on community support systems and collective practices, reviving cultural practices to reinforce the cultural identity of Maori youth, connecting youth to elders, and fostering greater dialogue around the forces that affect Maori communities, such as unemployment, racism, abuse and breakdown of traditional social and cultural institutions.

Sources: Canterbury Suicide Project (2007) and Lawson-Te Aho (1998).

Multi-sectoral plans such as the one developed by the New Zealand Ministry of Health involve a number of actors in diverse settings and therefore require a real commitment of resources and full recognition of the capacity of indigenous peoples to lead efforts to improve the health of their communities. For governments to undertake such efforts, there must be full willingness to identify and address the underlying causes of mental health issues in indigenous peoples, and to transform structures inherited from colonization that perpetuate violations of the collective rights of indigenous communities.

Violence against indigenous women

One health problem that indigenous women are disproportionately afected by is violence, ranging from domestic violence to rapes perpetrated because of militarization and armed conflict, to economic violence through policies of neoliberalism, to violence against women through their forced displacement from their ancestral lands.[63] It is inextricably linked to violations of the collective rights of indigenous peoples and colonization, because indigenous women play a central role as bearers of collective traditional knowledge and as stewards of the collective ancestral lands, waters and other natural resources. In this sense, "indigenous traditions and indigenous women themselves identify women with the Earth and therefore perceive degradation of the Earth as a form of violence against women. This conviction is more than a metaphorical allusion to Mother Earth. It is rooted in indigenous cultural and economic practices in which women both embody and protect the health and well-being of the ecosystems in which they live."[64]

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[63] For an in-depth discussion of violence against indigenous women, see International Indigenous Women's Forum/Foro Internacional de Mujeres Indígenas (2006).

[64] International Indigenous Women's Forum/Foro Internacional de Mujeres Indígenas (2006),16.

Umoja: Combating violence against indigenous women in Kenya

Umoja, which means "unity" in Swahili, is an independent, women-run village for survivors of gender-based violence in Kenya. Founded by Rebecca Lolosoli, an indigenous Samburu woman, and 15 other women, Umoja serves as a place for women who have been forced to leave their communities after bringing "shame" on their families for having been raped by British soldiers stationed on their ancestral lands. After being granted a neglected field of dry grassland by the local District Council, the women collectively filed a lawsuit against the British military for the rapes of over 1,400 Samburu women during the 1980s and 1990s. The women of Umoja have since participated in human rights training sessions led by Rebecca Lolosoli, actively took part in local government, and organized to demand an anti-violence unit within the local police force.

As part of their anti-violence strategies, the women of Umoja have also developed systems of resource sharing and collective means for promoting women's economic independence, which they see as integral to women's ability to be independent from abusive men. Moreover, while they draw heavily on their traditions and cultures in their strategies to combat violence, they have also used economic independence to avoid the pressure to submit their daughters to female genital mutilation and marry them off at a young age. Instead, they ensure that their daughters attend school and draw on the parts of their culture that empower them rather than those that are used to limit their choices as women.

Source: International Indigenous Women's Forum/Foro Internacional de Mujeres Indígenas (2006), 45-46.

Barriers to accessing health services

Indigenous peoples' lack of access to adequate health care manifests itself in a variety of ways. There are practical obstacles such as geographical distance or seasonal isolation, and "although health care services are largely free to indigenous peoples, the real cost of care, including the out-of-pocket costs of transportation, food, accommodation, family care, medication, and loss of workdays, poses a threat to health care access".[65] When affordable health services do exist in indigenous communities, they are often of lower quality than the services that are available to the non-indigenous population.

Moreover, expressions of racism and other forms of discrimination are widespread, creating an even greater barrier to indigenous peoples' access to health services, even when full access to quality health care based on Western medicine is possible. This is because most state health systems are not culturally sensitive, and their services and management do not reflect the socio-cultural practices, beliefs or visions of the indigenous communities. The Pan-American Health Organization has noted

> *Cultural barriers present the most complicated challenge because there is little understanding of the social and cultural factors deriving from the knowledge, attitudes, and practices in health of the indigenous peoples. The bias towards Western medicine and intervention can be offensive or inappropriate for practitioners of traditional medicine. Finding health staff that speak and understand indigenous languages is difficult, and poor communication between providers and clients at all levels compromises access to quality care. Moreover, indigenous people are often*

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[65] PAHO (2006), 3.

> *discriminated against in health centres by non-indigenous staff and both fear and distrust caused by the attitudes and behaviours of health care workers prevent indigenous people from seeking the health care they need.*[66]

These factors are even more acute for indigenous women, many of whom face multiple layers of discrimination based on the fact that they are poor, women and indigenous.

Lack of recognition of, or support for, indigenous health systems

Another fundamental aspect in the status of indigenous peoples' health is that most national governments do not provide technical or financial support to indigenous health systems, nor do most state health systems recognize, respect or incorporate the abundance of knowledge and experience of traditional medicine. Thus, because state health systems neither incorporate the indigenous concept of health nor work in harmony with traditional health systems, indigenous communities are marginalized, and health disparities between indigenous and non-indigenous populations persist.

most national governments do not provide technical or financial support to indigenous health systems

Treating HIV/AIDS with traditional medicine in Senegal

Indigenous peoples are particularly susceptible to contracting HIV because of their situations of poverty, unemployment, and vulnerability to violence and displacement. Yet, there are few efforts that address HIV/AIDS among indigenous peoples. Traditional treatments for HIV are widespread in indigenous communities, however, and, if recognized and supported, they are promising practices for combating the illness among all populations.

French doctor and academic Yvette Parès trained for 15 years under African traditional healer Dadi Diallo, and in 1980 founded the Keur Massar Leprosy Treatment Center outside Dakar.[67] The center uses traditional therapies to treat a wide range of illnesses, including leprosy, tuberculosis, malaria and HIV/AIDS. The treatments are based on the indigenous concept of health, which sees the therapist as a spiritual mediator who stimulates the healing forces of the sick person rather than trying to cure the disease through a cocktail of synthetic drugs. Keur Massar's traditional healers have succeeded in developing treatments for HIV/AIDS that have the benefits of being non-toxic, of addressing secondary infections such as tuberculosis, and of being formulated with natural plant components that do not require the support of rich nations in order to be synthesized. Parès has noted, "In addition, traditional medicine does not attack a pathogen in only one way, but through a combination

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[66] PAHO (2006), 4.

[67] For a detailed account of Parès's work in Senegal, see Parès (2004)

of active substances… from several different plants or roots, sometimes as many as 50. Where modern medicine is analytic and attacks the problem with a single molecule, traditional medicine attacks it on several fronts. This prevents the development of resistance to the combined action of all these plants."[68]

Indigenous knowledge and community-based medical practices have already played a significant role in treating AIDS patients, as traditional medicine, such as that practiced at Keur Massar, is more accessible, affordable, and culturally appropriate than most current Western treatments for HIV/AIDS. Further research should be conducted to determine its potential to treat or cure the illness, and both governments and international agencies should recognize the need to incorporate indigenous knowledge into efforts to fight the HIV/AIDS pandemic.

The advancement of indigenous peoples' individual and collective rights at the national and international levels opens up possibilities of reorganising health services so that they are more culturally relevant. This process of reorganization must, however, be carried out in a participatory fashion that is oriented toward the empowerment of indigenous communities within the framework of their own plans for self-government and integral community development.[69]

As part of its Health of Indigenous Peoples Initiative, PAHO uses a socio-cultural analysis approach to harmonize indigenous health systems with state health systems based on allopathic medicine. PAHO notes

> *This approach seeks to encourage recognition, respect and an understanding of the social and cultural differences between peoples, their knowledge and their resources to improve health strategies by incorporating their perspectives, medicines and therapies into the national health systems. This process requires the application of a legal framework that facilitates social participation, indigenous practices, and the protection and conservation of indigenous knowledge and resources. It similarly requires the generation of knowledge and paradigms that expand conceptual frameworks and facilitate an understanding of indigenous knowledge and its incorporation into the training and development of human resources.*[70]

Within indigenous contexts, however, illnesses are not just epidemiological and mental health sicknesses identified by Western medicine, but also those that have direct relationships with indigenous beliefs and world views. Some indigenous beliefs hold that illnesses may come from supernatural figures, from other humans who know how to manipulate supernatural forces, or from imbalances produced in nature by humans, any of which can be cured by spiritual mediators who maintain contact with the supernatural world.[71] Some communities believe that many illnesses have a spiritual character that can be understood only by the indigenous prophets, shamans, healers and other health agents who understand the spiritual past and present of the communities in which they live. Community ceremonies and rituals are believed to protect or restore harmony within and among individual members of the community, families, nature, and the ancestors and gods.[72] Western medicine does not recognize traditional healing techniques such as song and dance, or traditional training methods for medical practitioners, such as dreams, yet these practices are viewed as integral to the prevention, diagnosis and treatment of illnesses in indigenous health systems.

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[68] French Ministry of Foreign Affairs (n.d.)
[69] Cunningham (2002), 38.
[70] PAHO (2002b), 9.
[71] Cox Molina (2003), 42.
[72] Cox Molina (2003), 44.

Grisi siknis in Nicaragua

For centuries, grisi siknis (also called pauka alkan) has been a syndrome that occurs occasionally in the Miskitu communities of the Caribbean Coast region of Nicaragua. The first case recorded by Europeans was in 1881, in which most of the victims were young women, with some rare cases in men. The symptoms observed included a loss of senses, believing they had had sexual relations with spirits, and people running from their houses. The syndrome has an epidemic pattern; it is highly contagious and can affect a large number of people within a specific community simultaneously. According to the indigenous Miskitu and Mayangna worldview, a lack of happiness and socio- environmental well-being is related to being "sick". Based on this life philosophy, the grisi siknis is considered a state of illness. In the Miskitu culture, there are spirits in the forms of elves, mermaids, spirits of the dead and the owners of the mountains, rivers and hills. They are part of the way of life of the communities with whom they coexist. There are several reasons that this co-existence is broken and causes the imbalance. When this happens, the spirits cause sickness. Only traditional healers can cure grisi siknis.

Source: Davis (2006)

Intercultural health systems

In most state health systems, the cultures and world views of indigenous peoples are ignored, dismissed or actively opposed. Instead, most states promote monocultural health systems based exclusively on Western medicine, which do not fully reflect the multiple cultures and ethnicities of that state. This monoculturalism marginalizes indigenous peoples, denying them access to basic health services and devaluing their traditional health systems. In order to evaluate the extent to which governments are meeting the health needs of indigenous peoples, the degree to which indigenous health systems are respected and integrated into the state health systems must thus also be examined. Most health systems can be classified as monocultural, multicultural or intercultural.[73]

Monocultural health systems are based on a concept of society being homogeneous, and privileging the dominant national culture over all other cultures. There may be nominal acknowledgement of ethnic, linguistic or cultural diversity but the design of policies and programmes, including the allocation of resources, does not adequately reflect this reality. For example, in monocultural systems, data collection is not attuned to ethnic or cultural differences and may not identify health issues that are determined by gender, socio-economic class or ethnicity. Furthermore, the education of health practitioners is based on a biotechnological approach and ignores the contributions of indigenous cultures. Few health personnel are qualified to work in multiethnic contexts and the development and distribution of human resources is not culturally relevant. In these monocultural health systems, decisions are centralized at the top, without the systematic participation or consultation of indigenous communities.

Multicultural (or pluricultural) health systems, in contrast to monocultural ones, welcome and promote the presence of different cultures in society, including their respective beliefs, customs, practices and ways of life. This degree of recognition of diversity is still insufficient if it fails to ensure equality among those cultures or to promote mutual learning.

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[73] For a classification and description of monocultural, multicultural and intercultural systems, see Cunningham (2002).

Interculturalism goes beyond merely recognising the existence of different cultures to seeking exchange and reciprocity in a mutual relationship, as well as in solidarity, among the different ways of life. Interculturalism is thus a concept that refers to communication and action among people of different cultures, and involves "interaction… putting in contact elements of different cultures and peoples and overcoming barriers between peoples, promoting a dialogue focused on the pursuit of mutual acceptance and reciprocity".[74] Intercultural health systems not only improve the quality of the health services for marginalized populations, but also promote greater horizontality, respect and solidarity between cultural health knowledge and procedures within the context of national society. In practice, this implies that both Western and indigenous health systems should be practised with equal human, technological and financial resources, with spaces for exchange of knowledge, methodologies and practices that ensure the ongoing development of both systems.

Alternative approaches

The main approaches used in different countries to find intercultural health models have been as follows:

> intercultural health systems not only improve the quality of the health services for marginalized populations, but also promote greater horizontality, respect and solidarity between cultural health knowledge and procedures within the context of national society

The promotion of the use of medicinal plants approach has been generalized. It has been implemented in response to WHO guidelines in terms of giving priority to the use of medicinal plants, assuring their scientific validation. Generally, this has served as a first step in the efforts to find an intercultural health model. This has been combined with the organization of traditional therapists and the delivery of both health systems in the same facilities. A review of the different experiences shows that emphasis has been placed on carrying out studies to "scientifically" validate the plants that are used in the communities, thereby concurring with the position of WHO. A growing tendency to legalize the use of medicinal plants can be noted, although very often, laws fail to recognize the property rights of indigenous peoples—those who carry their ancestral knowledge with them. They become reduced to marginal actors in implementation of the norms.

One limitation to this approach is that it does not value the intangible knowledge that accompanies the use of medicinal plants in the practice of community health. The activities of cutting and using these medicinal plants in the communities are accompanied by ceremonial activities and norms linked to other elements of the surroundings, the stars, spirits and other things. In other cases, each plant has a spiritual owner from whom permission is solicited in order to use it, and so on. These aspects are obviated once the use of medicines based on medicinal plants is validated and generalized, as when, in some cases, medicines derived from medicinal plants are being offered in response to requests from health units.

Joint delivery of official and indigenous medicine in the same health facilities. Various countries have adopted another modality by which to organize their

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[74] R. Moya, cited in Cunningham (2002), 9.

intercultural health systems, delivering Western and indigenous health services through the same assistance center. In the Ecuadorian case, the goals set out for this modality were to a) link indigenous and Western medicine by treating both the indigenous and non-indigenous population, b) deliver health services in harmony with the world vision of different peoples, and c) recover and re-validate indigenous medicine and the role of its representatives.

The Jambi Huasi clinic in Ecuador

In 1994, a local organization established the health clinic *Jambi Huasi* ("Health House" in Kichwa), designed to meet the health needs of the indigenous peoples living in the Andean city of Otavalo. Over 1,000 people come to the clinic seeking health care every month. *Jambi Huasi* offers care using both Western and indigenous traditional medicine, and while it focuses on family planning and reproductive health services, it also offers traditional healing with native plants, as well as general medicine and dentistry. In addition to direct health care services, the clinic also conducts outreach and educational programmes, and all of its services are rooted in an understanding of the culture, language, customs and values of the local indigenous communities. The staff includes indigenous doctors, other health practitioners trained in working with the local population, and a full-time specialist in communication and education.

While *Jambi Huasi* started out by concentrating on meeting the health needs of the local indigenous communities, it has since grown into a care facility for other populations as well. In addition, it has now branched out into developing programmes focused on gender, discrimination, and violence, and programmes focused on youth and adolescents. *Jambi Huasi* has been supported by the United Nations Population Fund (UNFPA), which recognizes it as having the potential to influence national health policy.

Source: UNFPA (2006).

People are offered the choice of using both health systems as they share the same health infrastructure. Referrals between both systems take place within the same health unit in accordance with the diagnosis. Western doctors are trained to diagnose cases whereby referral to indigenous medical practice is required. One of the most developed areas within this concept has been the institutionalization of traditional births, for which rural doctors have been trained and health units have been oriented.[75] In many cases, the presence of traditional midwives is accepted. This has contributed to reducing maternal mortality rates. Among the lessons learned is that these experiences facilitate the access of non-indigenous people to the indigenous health system and facilitate a "dialogue of wisdoms" between men and women practitioners in the health systems.

The complementarity approach between the indigenous and official health systems. Intercultural health experiences have led to mechanisms for coordination between indigenous and official health systems even where they do not share the same facilities. The coordination is based on referral and counter-referral agreements. The lessons learned are that promoting indigenous medicine enhances the self-esteem of its practitioners and strengthens indigenous identity. Moreover, it responds to social-cultural illnesses because it facilitates complementary therapy for patients. In addition, it increases community members' confidence in the official health system because they see that their beliefs are respected. It also facilitates relations of respect on the part of staff from the official health system because they get to know and understand indigenous health concepts and practices.

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[75] This has been documented in experiences in México (e.g., the intercultural hospital in Cuetzalan, Puebla), Ecuador, Bolivia and Chile.

Promotion of intercultural health in laws, public policy and state programmes. Intercultural health aim to influence laws and public policy so that they can transform health systems, and there are some experiences where this has been the main emphasis. These experiences combine some of the above-mentioned approaches; they are also aimed at changing power relations within health ministries—whether through decentralization, promotion of national laws and programmes, gathering of data with information ethnically disaggregated, or establishing more inclusive forms of participation of indigenous communities and peoples.

Another method has been applied in countries such as Ecuador, Bolivia and Venezuela, where vice-ministries or National Commissions of Indigenous and Intercultural Health have been created. These entities have promoted indigenous health either as a cross-cutting axis or as a specific programme. In the case of Nicaragua, the 1987 approval of an autonomous regime for indigenous peoples and ethnic communities legally transferred the administration of health services to the autonomous regional authorities.[76] This approach enabled indigenous organizations and authorities to take the lead in a large number of political initiatives. The generally held stigma and perception of incapacity in relation to indigenous peoples changed. The channelling of public resources to indigenous programmes improved. Administrative and management experience was gained at different levels, and this reflected positively in other areas of work.

Addressing social health determinants. Another approach being promoted in the delivery of health services to indigenous peoples recognizes that to achieve structural changes, it is necessary to respond to the specific factors determining the health of indigenous peoples.[77] Social determinants of health can be grouped into the following categories: socio-economic circumstances, physical circumstances and environment, infant development, personal health practices, the individual capacities and skills of those in power, and investment in biological and genetic research and health services. These social determinants of health deal with the life and work circumstances of people and their lifestyles. They deal with how social and economic policies impact on the lives and health of individuals.

Some common measures applied in the identified approaches have been a) education of official health staff about cultural diversity and indigenous rights. b) coordination with traditional women and men therapists, especially midwives, c) discussion around indicators, especially regarding ethnic disaggregation, and the inclusion of social illnesses in health records, and d) efforts to improve forms of community participation, and decentralization of services.

Prerequisites for introducing intercultural health systems

All these experiences tell us that intercultural health systems must be based on building the autonomy and ensuring the empowerment of indigenous peoples, which derive from the full recognition and exercise of rights of indigenous peoples. The framework for an intercultural system therefore includes self-determination; sovereignty over land, territory and natural resources; full and effective participation in decision-making arenas (including processes based on the principle of free, prior and informed consent); the recognition of indigenous

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[76] In 1987, a new Political Constitution was approved in Nicaragua. The collective rights of indigenous peoples and ethnic communities were recognised, and the region where they live and what amounts to 50 per cent of the national territory was divided in two Autonomous Regions. The same National Assembly approved an Autonomy Statute that defined health administration as a responsibility of the autonomous authorities. As a result, the Regional Autonomous Councils have defined an Intercultural Autonomous Health Model that has also been recognised in the General Health Law (2003), the General Health Plan (2005), and National Health policies.

[77] See WHO/CSDH report (2008). In its fifth meeting, in Nairobi in June 2006, the WHO Commission on Social Determinants of Health (CSDH) committed itself to making health for indigenous peoples a specific area of its work.

health definitions and norms; and the recognition and protection of collective traditional knowledge. Based on this framework, intercultural health systems can be more relevant to the socio-cultural realities of indigenous peoples, and better suited to their aspirations for development and autonomy.

Conceptually, there are four fundamental prerequisites that must be present in order for an intercultural health system to exist. First, there must be a fundamental respect for human rights as codified in international human rights instruments and international law. Second, there must be recognition of indigenous peoples, because if states do not acknowledge the existence of indigenous peoples, it is not possible to develop policies that respond to their health capacities and needs. Often indigenous peoples are included in broader categories such as "vulnerable groups" or "the poor", obscuring the particularities of their situation. Furthermore, this recognition entails the structural reforms necessary to exercise self-determination, which in the case of health, corresponds to supporting the development of indigenous health systems while also ensuring full and effective participation in the health services offered by the state. Third, there must be political will, since the mere existence of policies aimed at improving the health of indigenous peoples is insufficient if they are not successfully implemented. Finally, there must be a conscious decision on the part of the national society to engage in an exchange and sharing of knowledge, values and customs, which, if practised on a daily basis, would overcome monoculturalist structures. Each of these prerequisites can be described in terms of the fundamental elements of interculturalism.

For a health system to be truly intercultural, these principles must be reflected in national laws and policies that incorporate the reforms necessary for cultures to thrive together in a multiethnic society. These principles will thus establish the basis for multiethnic alliances, cooperation among actors, and shared responsibility among local communities, governments, international agencies, non-governmental organizations, the private sector and research and training institutions.

At the same time, there are approaches to health systems that may masquerade as attempts to incorporate the needs of indigenous peoples but do not fully meet the criteria for being intercultural. In these situations, an inequitable distribution of resources persists, while the state promotes an illusion of cultural sensitivity. Some of these policies are paternalistic or integrationist and are based on policies of assimilation or integration that seek to "resolve" the problem of indigenous peoples.[78] In integrationist models, the concept of health is defined from the top down, privileging a biomedical paradigm over indigenous health models, and indigenous cultures are treated as interesting folkloric elements without true value for health promotion. Similarly, culturalistic approaches recognize cultural pluralism as intrinsically valuable but prioritize the didactic, linguistic or folkloric aspects without delving into questions of participation or power. In this approach, there are minimal consultations conducted with indigenous peoples, and projects, programmes and policies are designed by actors external to indigenous communities who treat indigenous peoples as a "target population". There may be translation of educational materials into several languages, for example, but without a critical examination of the pedagogical or cultural implications. Finally, the harmonious living approach has been promoted in response to increases in

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[78] The International Convention of Pátzcuaro, approved by the countries of the Americas in 1940, has served as a legal framework for the definition and application of public policies relative to indigenous peoples for the last 60 years. It is framed within the "indigenist" perspective, which was put forth to encourage the "integral development" of indigenous peoples. While it promoted the recognition of cultures and strategies to overcome the situation of colonization, it did so from an outside paternalistic perspective that posited the indigenous situation as a "problem" to be resolved by the countries. This was expressed as integrationist measures of acculturation (Del Val, 1996). Since the VIII Inter-American Indigenous Congress, celebrated in 1980 in Mérida, México, there has been a period of critical revision of "indigenism" with approaches that abandon this paternalism. There has been increased recognition of the management capacity of indigenous organizations, the right to participate in public management, the pluricultural and multilingual character of national societies, and the need to respect and support the human rights of indigenous peoples. It was recommended that they continue to evaluate "indigenism" more profoundly and propose modifications in cases where it is referred to in principles, actions or institutional frameworks.

internal and external migration that have generated increased contact among different cultures. This approach recognizes that knowledge of other cultures is indispensable to the success of a multicultural society, and that cultures must learn to understand and value each other beyond mere tolerance. It therefore promotes dialogue with the goal of reaching a harmonious coexistence. However, if this approach is taken without the full participation of indigenous peoples, there is a risk of merely advancing integration without more equitable decision-making or clearer power relations. Harmonious living approaches, for example, may encourage ethnographic studies that are conducted only with the objective of learning about other cultures so that the dominant group can feel that those who are different are indeed "normal" and, based on this, can create health programmes for them.

Challenges

There are a variety of challenges to building intercultural health systems. First, states continue to assert monoculturalism as a way of promoting national unity. Second, health care sector reform is leading to increased privatization, making it more difficult to hold health providers accountable even to international human rights standards, much less to any of the collective rights of indigenous peoples. In addition, as traditional medicine is explored by non-indigenous actors, there is an increased risk of piracy of the intellectual property of indigenous peoples, as well as a risk that indigenous practices will be popularized and performed in ways that do not adhere to the histories, values and visions of indigenous peoples. Finally, the ongoing challenges of a lack of human and financial resources, as well as a lack of adequate data and research methodologies, limit the capacity of governments to design policies that could serve to build an intercultural health system.

> [the full and effective participation of indigenous communities in various decision-making institutions related to their health is imperative]

Concluding Remarks

In summary, to improve the health situation of indigenous peoples around the world, it is critical to recognize that their health and well-being are inextricably linked to their collective rights, such as rights to land and natural resources and to conserve and practise traditional knowledge. Efforts that codify, protect and advance the individual and collective rights of indigenous peoples, particularly indigenous women, will therefore also have positive health impacts. Furthermore, there must be ongoing integration of the perspectives and needs of indigenous peoples into global health programmes, plans, projects and policies, including initiatives to achieve the Millennium Development Goals.

In addition, the full and effective participation of indigenous communities in various decision-making institutions related to their health is imperative. At the same time, states must recognize and respect indigenous health institutions and incorporate strategies that respond to the particular needs and visions of indigenous peoples in policies of health care, prevention, promotion and education. In order to design more effective health policies, there must also be concerted efforts to create improved systems of data collection and research methodology, including research into traditional medicine that incorporate the participation of indigenous communities and reflect cultural and social considerations relating to the health of those communities.

Furthermore, models of health care must take into account the indigenous concept of health, and preserve and strengthen indigenous health systems as a strategy to increase access and coverage of health care. This will demand the establishment of clear mechanisms of cooperation among relevant health care personnel, communities, traditional healers, policy makers and government officials in order to ensure that the human resources respond to the epidemiological profile and socio-cultural context of indigenous communities. In other words, state health systems must develop to become truly intercultural, and this will involve exchanges of experience and knowledge among various actors, with the goal of improving the health of indigenous peoples, as well as the health of other poor and marginalized groups.

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