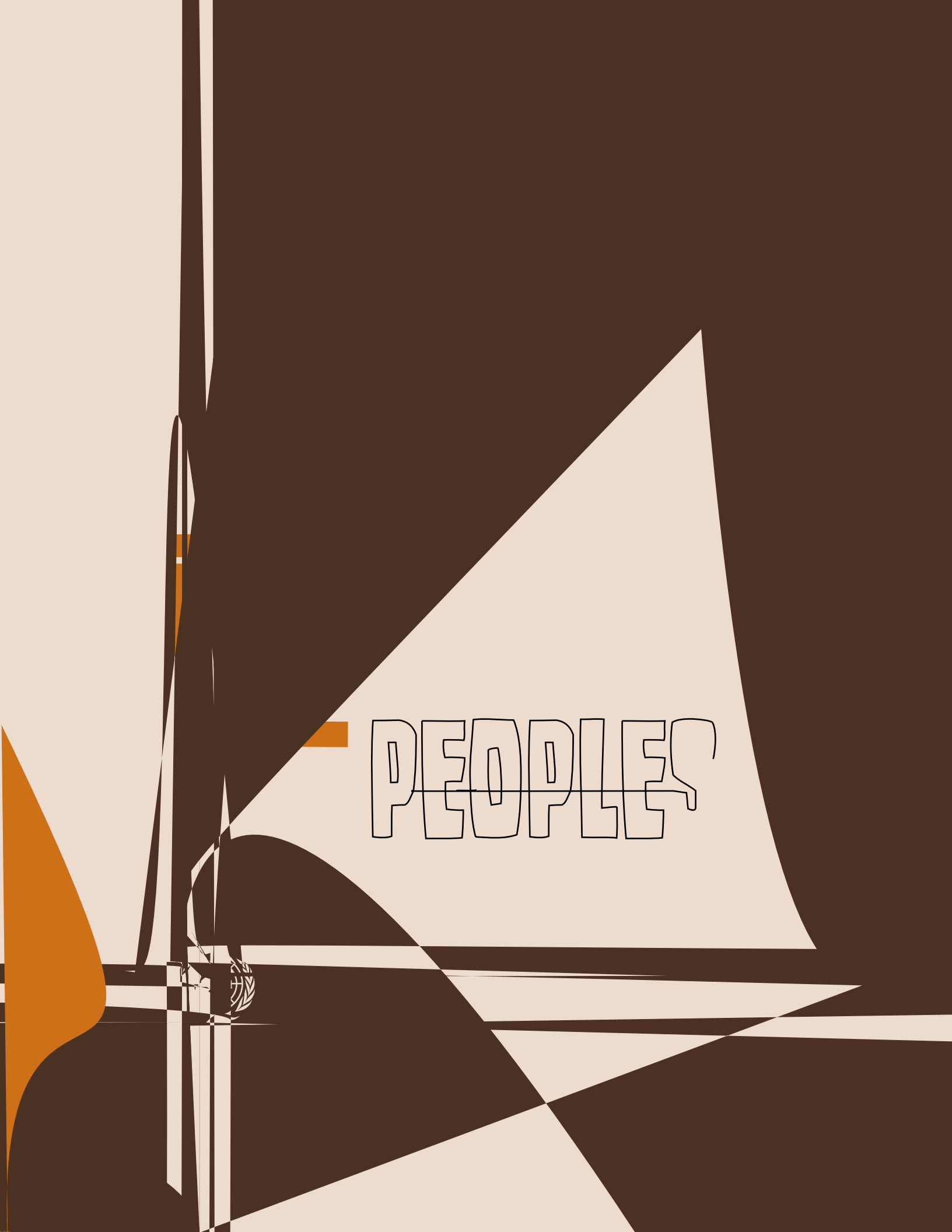
PEOPLES

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I DUC I

At its first session, the United Nations Permanent Forum on Indigenous Issues requested the United Nations System produce such a report on the state of the world's indigenous peoples.[2] It was also suggested the report be a key advocacy tool for raising awareness on indigenous peoples' issues in general and in particular to raise the profile of the Permanent Forum. In addition, the report should be of value for deliberations within the Economic and Social Council, the General Assembly and other bodies of the UN system.

The first publication of *T S a W ' I P* was published in 2009 and its major focus was on: Poverty and Well-being; Culture; Environment; Contemporary Education; Health; Human Rights and Emerging Issues. The report was well received, and, according to press reports, the publication revealed alarming statistics on indigenous peoples' poverty, health, education, employment, human rights, the environment and more. This was the first United Nations publication and provided much needed information on the status of indigenous peoples throughout the world.

The *S a W ' I P* will remain a recurrent "flagship" publication produced by the United Nations. It is intended that publications such as this will deal with a broad spectrum of indigenous peoples' issues. It is hoped that such a publication, given its function of supporting the United Nations Permanent Forum, will also promote awareness of indigenous peoples' issues within the United Nations system, with States, academia and the broader public.

The current situation of indigenous peoples remains a concern within the United Nations. It has been estimated that the world's 370 million indigenous peoples reside in approximately 90 countries of the world.[3] They are among the world's most marginalized peoples, and are often isolated politically and socially within the countries where they reside by the geographical location of their communities, their separate histories, cultures, languages and traditions. They are often among the poorest peoples and the poverty gap between indigenous and non-indigenous groups is increasing in many countries around the world. This influences indigenous peoples' quality of life and their right to health.

Indigenous peoples' access to adequate health care remains one of the most challenging and complex areas. There is an urgent need to focus on health issues as well as alternative health care frameworks. As previously stated, health is one of the six mandated areas of the United Nations Permanent Forum on Indigenous Issues and is one of the focuses of the World Health Organization, which recognizes the right to health as a fundamental human right in its constitution. The United Nations Declaration on the Rights of Indigenous Peoples includes articles (21, 23, 24 and 29) that refer specifically to the right to health, including indigenous peoples' right to improving their economic and social conditions in the area of health, with particular attention to the needs of indigenous elders, women, youth, children and persons with disabilities. Further, indigenous peoples have the right to determine their health programmes and to administer these programmes through their own institutions, as well as maintain their traditional health practices.

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2 Permanent Forum on Indigenous Issues, Report on the First session (12-24 May 2002) E/2002/43.

3 Harry Patrinos and Gillette Hall, Indigenous Peoples, Poverty and Development, 2010, p. 8.

Also, that States take effective measures to ensure that programmes for monitoring, maintaining and restoring the health of indigenous peoples, as developed and implemented by the peoples affected by such materials, are duly implemented.

Indigenous peoples face a myriad of obstacles when accessing public health systems. These include the lack of health facilities in indigenous communities and cultural differences with the health care providers such as differences in languages, illiteracy and lack of understanding of indigenous culture and traditional health care systems. There is also an absence of adequate health insurance or lack of economic capacity to pay for services. As a result, indigenous peoples often cannot afford health services even if it is available. Marginalization also means that indigenous peoples are reluctant or have difficulties in participating in non-indigenous processes or systems at the community, municipal, state and national levels.

There are also major concerns regarding the lack of data on indigenous peoples' health and social conditions. Not only is there a lack of disaggregated data based on ethnicity but also data related to the location of indigenous peoples' residence such as urban, rural or isolated areas. As a result, there is a lack of information, analysis and evaluation of programmes and services relating to indigenous peoples' health situation.

One of the important areas for health care for indigenous peoples lies in intercultural frameworks and models of care. Health care services need to be pluricultural in order to develop effective models of care and best practices so that such programmes and services are culturally and linguistically appropriate for indigenous peoples. Also, indigenous peoples must be able to participate in the design and implementation of comprehensive health plans, policies and programmes.

It has been estimated that over 80 per cent of the world's indigenous peoples live in Asia, Latin America and Africa,. However, there is still little information known about their health status and their levels of access to health services. Even in wealthy nations, most studies indicate an alarming health disadvantage for indigenous peoples. Historically, indigenous peoples have suffered the impact of colonization and assimilation policies as well as the imposition of foreign development models. Indigenous peoples continue to suffer discrimination in their own countries which has a major impact on their lives, in particular, their health. Indigenous peoples are not only a marginalized group with health problems, they are also highly aware of their situation, quite political and willing to work to towards improving their health and social status. Therefore, indigenous peoples have the right to determine their own policies, strategies and interventions in order to obtain the highest attainable standards of health and health services, as set out in the United Nations Declaration on the Rights of Indigenous Peoples.

The concept of indigenous peoples

consideration of the issues involved, Martínez Cobo o□ered a working definition of “indigenous communities, peoples and nations”. In doing so, he expressed a number of basic ideas forming the intellectual framework for this e□ort, including the right of indigenous peoples themselves to define what and who are indigenous peoples. The working definition is as follows:

> Indigenous communities, peoples and nations are those which, having a historical continuity with pre-invasion and pre-colonial societies that developed on their territories, consider themselves distinct from other sectors of the societies now prevailing on those territories, or parts of them. They form at present non-dominant sectors of society and are determined to preserve, develop and transmit to future generations their ancestral territories, and their ethnic identity, as the basis of their continued existence as peoples, in accordance with their own cultural patterns, social institutions and legal system.

This historical continuity may consist of the continuation, for an extended period reaching into the present of one or more of the following factors:

a. Occupation of ancestral lands, or at least of part of them.

b. Common ancestry with the original occupants of these lands.

c. Culture in general, or in specific manifestations (such as religion, living under a tribal system, membership of an indigenous community, dress, means of livelihood, lifestyle, etc.).

d. Language (whether used as the only language, as mother tongue, as the habitual means of communication at home or in the family, or as the main, preferred, habitual, general or normal language).

e. Residence in certain parts of the country, or in certain regions of the world.

f. Other relevant factors.

On an individual basis, an indigenous person is one who belongs to these indigenous populations through self-identification as indigenous (group consciousness) and is recognized and accepted by these populations as one of its members (acceptance by the group). This preserves for these communities the sovereign right and power to decide who belongs to them without external interference.[4]

During the many years of debate at the meetings of the Working Group on Indigenous Populations, observers from indigenous organizations developed a common position that rejected the

Declaration on the Rights of Indigenous Peoples underlines the importance of self-identification, that indigenous peoples themselves define their own identity as indigenous.

Article 33

1. Indigenous peoples have the right to determine their own identity or membership in accordance with their customs and traditions. This does not impair the right of indigenous individuals to obtain citizenship of the States in which they live.
2. Indigenous peoples have the right to determine the structures and to select the membership of their institutions in accordance with their own procedures.

ILO Convention No. 169 also enshrines the importance of self-identification. Article 1 indicates that self-identification as indigenous or tribal shall be regarded as a fundamental criterion for determining the groups to which the provisions of this Convention apply. Furthermore, this same Article 1 contains a statement of coverage rather than a definition, indicating that the Convention applies to:

a. tribal peoples in independent countries whose social, cultural and economic conditions distinguish them from other sections of the national community and whose status is regulated wholly or partially by their own customs or traditions or by special laws or regulations;
b. peoples in independent countries who are regarded as indigenous oEMC /Span ≤MCn accordancvention

The Report of the Working Group of Experts on Indigenous Populations/Communities of the African Commission on Human and Peoples' Rights therefore emphasizes that the concept of indigenous must be understood in a wider context than only the colonial experience:

> The focus should be on more recent approaches focusing on self-definition as indigenous and distinctly di□erent from other groups within a state; on a special attachment to and use of their traditional land whereby ancestral land and territory has a fundamental importance for their collective physical and cultural survival as peoples; on an experience of subjugation, marginalization, dispossession, exclusion or discrimination because these peoples have di□erent cultures, ways of life or modes of production than the national hegemonic and dominant model.[6]

In the 60-year historical development of international law within the United Nations system, it is not uncommon that various terms have not been formally defined, the most vivid examples being the notions of "peoples" and "minorities". Yet the United Nations has recognized the right of peoples to self-determination and has adopted the Declaration on the Rights of Persons Belonging to National or Ethnic, Religious and Linguistic Minorities. The lack of formal definition of "peoples" or "minorities" has not been crucial to the Organization's successes or failures in those domains nor to the promotion, protection or monitoring of the rights accorded to these groups. Nor have other terms, such as "the family" or "terrorism" been defined, and yet the United Nations and Member States devote considerable action and e□orts to these areas.

In conclusion, in the case of the concept of "indigenous peoples", the prevailing view today is that no formal universal definition of the term is necessary, given that a single definition will inevitably be either over- or underinclusive, making sense in some societies but not in others.

About this publication

The publication includes seven chapters that examine indigenous peoples' access to and utilization of quality health care services within the seven sociocultural regions of the Permanent Forum: Africa; Asia; Central and South America and the Caribbean; the Arctic; Central and Eastern Europe, Russian Federation, Central Asia and Transcaucasia; North America; and the Pacific.

Each of the authors provides an overview of health issues in their sociocultural regions as well the challenges that indigenous peoples face in trying to access and utilize health services.

The first chapter by Dr. Priscilla S. Migiro emphasizes the di□culties that indigenous peoples in Africa face in being recognized, firstly, as indigenous peoples and, secondly, accessing health ser

In the second chapter, Dr. Mukta S. Lama provides an overview and analysis of the situation of indigenous peoples in the Asian region. The Asian subregions include a multitude of indigenous groups who comprise 70 per cent of the estimated 350 million indigenous peoples worldwide. Indigenous peoples in Asia die younger, have higher rates of malnutrition and child mortality, and carry high burden of “diseases of the poor”, namely undernutrition and infectious diseases. Dr. Lama points out that the health of indigenous peoples is often not considered a priority by national governments and as a result, health care needs remain unheard in health care planning with weak representation of indigenous peoples in the government system. Dr. Lama concludes that

2002 – A Voluntary Fund for Indigenous and Local Communities is established by the Convention on Biological Diversity (http://www.cbd.int).

2003 – A Voluntary Fund is established by the United Nations to support the Permanent Forum.

2005 – The Second International Decade for Indigenous People is launched (2005-2015), including a fund to support small-scale projects.

2005 – A Voluntary Fund for Indigenous and Local Communities is created by World Intellectual Property Rights.

2007 – The UN Declaration on the Rights of Indigenous Peoples is adopted by the UN General Assembly (http://www.un.org/esa/socdev/unpfii/en/declaration.html).

2007 – The new Expert Mechanism on the Rights of Indigenous Peoples is established by the Human Rights Council.

2014 – High Level Plenary Meeting of the United Nations General Assembly also known as the World Conference on Indigenous Peoples.

UN Photo/Broddi Sigurdarson

Cha e O e

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Akie number about 5,200, while the Hadzabe population number between 1,000 and 3,000. The concept of indigenous peoples is not acknowledged in Tanzania, but the government “recognizes the vulnerability of some of the marginalized communities”.[28] The delivery of health services in

tions.[32] The government of Botswana has expressed concern over the difficulties faced by providing a health care system that incorporates and respects both Western and traditional medicines. In recognition of these challenges the Special Rapporteur on the Rights of Indigenous Peoples highlighted the need to enhance the understanding of and respect for traditional medicine, which continues to be practiced among indigenous communities but remains largely excluded from the government health system.

Namibia

The San, the Himba (Ovatue, Ovatjimba and Ovazemba) satisfy the criteria for indigenous peoples. The loss of their lands, destitution, cultural breakdown and high poverty levels have made the San the only ethnic group in Namibia whose health status has declined since independence. Having lost their original source of food, they now depend entirely on government food aid. The health problems are due mainly to poverty and marginalization. Most of the population has poor access to health facilities. More than 80 per cent of them live more than 80 kilometres from any sort of health facilities. These facilities are expensive, and mobile outreach services are irregular and often ill-equipped to deal with complicated problems. In some cases the staff of the mobile units cannot speak any of the San languages, giving rise to the likely risk of miscommunication and wrong diagnoses.[33]

Namibia has a high prevalence of HIV/AIDS, and the San are particularly vulnerable due to lack of information, low standard of living and the unavailability of adequate treatment. The Special Rapporteur on the Rights of Indigenous Peoples recommended measures to mitigate these negative effects. These included educating indigenous communities on health issues, which should be done in all languages in the communities concerned, allocating adequate resources to indigenous peoples' health services, including them in medical insurance programmes, capacity-building, collaboration and coordination, as well as funding organizations that are working towards the eradication of diseases.[34]

South Africa

The Khoi/San peoples of South Africa are among the poorest and most marginalized populations. There is lack of access to safe water and also high levels of domestic violence. The Special Rapporteur on the Rights of Indigenous Peoples also noted that although HIV prevalence was high in the country, there were no figures for indigenous peoples, and therefore HIV/AIDS should be considered a serious threat. The Special Rapporteur also made the following recommendations:

> The possibility of establishing a fully equipped clinic in Platfontein to serve the area;
>
> Health services should target the specifically marginalized indigenous communities;
>
> Introduction of drinking water to indigenous communities should be considered a priority in the development plans in the areas where services either do not exist or is insufficient.[35]

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32 A/HRC/15/37/Add.2.

33 Country Report of Research Project by ILO and ACHPR on the Constitution of and legislative protection of rights of indigenous peoples.

34 Country Report of Research Project by ILO and ACHPR on the Constitution of and legislative protection of rights of indigenous peoples.

35 E/.CN.4/2006/78/Add.2.

mistrust of government. Therefore, the provision of essential drugs and supplies was considered more helpful;

Having nomadic pastoralist community health workers who can be trained to provide a mix of essential services, obtain regular medical supplies and refer complicated cases is likely to be more affordable and sustainable in the long run.

HIV/AIDS and indigenous peoples in the African region

As of December 2012, there were 22 million people living with HIV in sub-Saharan Africa.[40] As most indigenous peoples live in remote regions, they may be protected by their isolation from HIV/AIDS and have lower prevalence rates than their neighbours. For example, in Botswana in 2002 it was

Indigenous peoples face a higher vulnerability to HIV due to a range of factors including stigmatization, structural racism and discrimination and individual/community disempowerment. Health Canada in collaboration with UNAIDS and Public Health Agency Canada hosted an International policy dialogue on HIV/AIDS and indigenous peoples. This dialogue provided a platform to discuss the impact of HIV/AIDS on indigenous peoples and to explore a way forward in terms of research, policy and program development.

Report findings of the dialogue included:

Relationship between HIV/AIDS and indigenous peoples has not received due international attention despite them being vulnerable;

It clearly identified patterns of transmission for indigenous men and women including a higher proportion of new HIV diagnoses among indigenous peoples;

It noted high rates of HIV transmission among indigenous women, particularly in developing countries;

In the present day, indigenous Africans rely on traditional medicine and practitioners as they have done for generations. Compared to western medicine practitioners, traditional medicine practitioners are more readily available, less expensive and more acceptable. It is estimated that in Malawi 80 per cent of the 12 million people make use of traditional medicine for their needs.[47] In 2000, there were approximately 4500 traditional healers in Zimbabwe and only 1400 doctors.[48] Generally, in sub-Saharan Africa the ratio of traditional healers to the population is 1:500, while doctors trained in western medicine it is 1:40,000.[49] As indigenous peoples have always lived in harmony with their environment and learned the important plants which can be used as medicines, they resort to this method of healing before seeking treatment in orthodox medicine. For a long time there has been little e□ort to understand traditional medicine as it was considered to be shrouded in mystery. Some governments tried to suppress indigenous medicine, which then went underground and continued to thrive.[50] Most African countries have the tolerant model of health system where western medicine is practiced but other forms are tolerated.[51] The World Health Organization estimates that up to 80 per cent of people in the African region use traditional medicine and that the widespread use is due to its a□ordability.[52] Moreover, it is popular because it is firmly embedded in the wider belief system. Traditional medicine is also said to be more e□ective in the treatment of psychic and psychosomatic conditions. This is because the healers have knowledge of the patient's background while conserving African culture.[53]

Some African countries have made e□orts to integrate traditional medicine into the health system. There are countries where traditional medicine practitioners have been registered and have associations. In South Africa, for instance, traditional healers are recognized and regulated by law.[54] However, caution is required in advocating for blanket use of traditional medicine because further research is needed to ascertain the e□cacy of certain medicinal plants and treatments used.

E□ects of sedentarization on indigenous peoples

The world is changing rapidly, and the lifestyles of indigenous peoples are also changing and will continue to change. This means that their previously active lifestyle and dietary habits will change. While indigenous peoples have a higher burden of infectious diseases, non-communicable diseases are also emerging. Living in settled areas with higher population densities predisposes them to infectious diseases. Increased population density in settled areas facilitates the transmission of density-dependent diseases such as malaria. At the same time, pathogenic organisms may be

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47 Peltzer 1988, "The role of faith healers in primary mental health care: A South African perspective", Curare:11.207-210).

48 UNAIDS (2000). Report of the Inter-regional Workshop on Intellectual Property Rights in the Context of Traditional Medicine, Bangkok, Thailand.

49 Richter, 2004, PEP for rape survivors in South Africa: Reflecting on the process to get to government policy: International Conference on AIDS.

50 Green, E.C., Engaging indigenous African healers in the prevention of AIDS and STDs in Anthropology in Public Health: Bridging di□erences in culture and society, Edited by Robert A Hahn, Oxford University Press Inc. New York 1999.

51 WHO 2002, Traditional Medicine Strategy 2002-2005; Anfom ,E.E 1986: Traditional Medicine in Ghana; J.B. Danquoh memorial lectures.

52 WHO 2002, Traditional Medicine Strategy 2002-2005.

53 Steinglass M., "It Takes a Village Healer - Anthropologists Believe Traditional Medicines Can Remedy Africa's AIDS Crisis. Are They Right?" Lingua Franca April 2002, p. 32.

54 E/CN.4/2006/78/Add.2 of 15/12/05.

According to Ngomane et al., indigenous women made the following comments about their treatment in the hospital:

> “The kneeling position is not allowed in hospital and nurses give you instructions and won’t listen to you”.
>
> “If you air your views or your opinion, they laugh at you and ridicule you”.
>
> “They make you feel small and useless“.
>
> “The nurses give you instructions and will not listen to you”.

The women also indicated that their rationale for going to clinics and hospitals is often motivated by fear of complications or maternal death and complications that could cause them to lose their infants:

nous peoples, denying them access to basic health services and devaluing their traditional health

has made indigenous peoples vulnerable as they cannot access the healing medicines and traditional food as they did in the past. Improving indigenous peoples' situation needs their active participation in the design and implementation of health services. Legal recognition by states will help to pave the way for documenting and tackling the current challenges in health care. Adopting targeted intervention and conducting research will also go towards meeting the health care challenges, including the need to increase the level of accessible and responsive health services, document and preserve traditional medicine practices which are e□ective, improve education status and train indigenous health workers. Indigenous peoples' resource and knowledge must not be discarded, otherwise Africa will be poorer.

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Chapter

Access to Health Services by Indigenous Peoples in Asia

Introduction

Indigenous peoples living in Asia have limited access to appropriate health care services. As a consequence of this and other health determinants, they suffer the worst health of identifiable groups in the Asian region. Indigenous peoples in Asia die younger, have higher rates of malnutrition, child mortality, and carry high burden of "diseases of the poor" namely undernutrition and infectious diseases. A number of explanations account for the disparities in access to health services experienced by the indigenous peoples. The health of indigenous peoples is often not a priority of the national governments, thus health care needs remain unheard in health care planning with no or weak representation of the indigenous peoples in the government system. The general health care services in most cases do not arrive in the remote regions of the country where most indigenous peoples live, and even when they do arrive, they are often not appropriate to address the needs of indigenous peoples and often do not accommodate the belief systems and processes for improving health and well-being. There is an urgent need to address disparity and deficits in indigenous health in Asia, which is a challenge for democratic governance in the region.

The UN Special Rapporteur on the right to health noted that the right to health and right to survive are two of the most basic human rights. This is aligned with the provision of International Covenant on Economic, Social and Cultural Rights (ICESCR), in which Article 12 recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". Further, the General Comment No. 14 of the UN Committee on Economic, Social and Cultural Rights, elaborates that the right to health, "is the right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.... [The right includes both] timely and appropriate health care ... [and] the underlying determinants of health, including access to safe and potable water, and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health". In this context, morbidity and mortality of children and poor health of indigenous peoples is a matter of pressing social justice inequality for which governments and other actors must be held accountable. Despite the impressive improvements in poverty reduction and social development in a number of Asian countries over the past decades, the persistence problems of poor indigenous health remain a major issue in the Asian region.

One of the major challenges in addressing the issue of indigenous health deficit is the invisibility or obscured visibility of the issue from the national discourse in many states. Little is known in the rest of the world about their struggle for equality and their profound disparities in health status and/or access to health services. The majority of countries in the Asian region do not have any

structural capacity for collecting health information disaggregated for indigenous peoples from within the larger non-indigenous populations. Some governments intentionally avoid collecting the disaggregated data by indigenous ethnicity in their e□ort to portray national unity or discourage di□erentiation within their citizenry. Many Asian countries lack capacity to acknowledge the relevancy of indigenous-specific data in part due to competition for resources and lack of incentives for institutions to support the creation of an evidence base for an indigenous peoples' health information system. The United Nations has repeatedly called for nation states to gather baseline disaggregated information specific to indigenous peoples, and in some situations this is gradually beginning to occur. Nevertheless, in Asia, unlike other parts of the world like the Americas and Australia, an additional complexity, coined the "Asian controversy", relates to the definition of precisely who is indigenous. Deprived of clear client identification of membership in indigenous population groups and/or tribes, the task of collecting data and the subsequent use in planning, implementing and monitoring health initiatives are not simply possible.

In practice, di□erent countries with specific historic and contextual relationships to the state and the dominant population, indigenous peoples in Asia have been identified and referred to by different names such as "minority nationalities", "schedule tribes", "ethnic minorities", "hill tribes", "cultural communities", "adivasi", "janajati", and others. Some of the Asian states o□cially recognize the term "indigenous peoples" to identify those people who have distinct cultural tradition and history. Countries such as Philippines, Taiwan, Malaysia, Nepal and, more recently, Japan have embraced the term following the United Nations Declaration on Rights of the Indigenous Peoples (UNDRIP) and ILO Convention No. 169 on Indigenous and Tribal Peoples. While countries such as China, India and Bangladesh, for example, resist the recognition due to contentions in the definition, they have adopted various a□rmative action and special measures for the peoples by adopting specific labels in their specific country context.[75]

Notwithstanding the diverse country-specific stance in formally recognizing the category "indigenous peoples", the majority of the Asian countries engage with the distinct group of populations in their legal, administrative and political uses ranging from the purpose of a□rmative action to assimilation and discrimination. China for example, in its 2000 census enumerates 55 o□cially recognized terms for minority nationalities or [illegible] who reside in five autonomous geographic regions. For instance, the identification of China's [illegible] emphasizes the social, cultural, economic conditions, customs, traditions, language and geographic concentrations that distinguish indigenous peoples from other sections of national community.[76] Despite not o□cially adopting the term "indigenous", identification of China's minority nationalities largely corresponds to the definition developed by ILO Convention No. 169 and the World Bank.[77] China's case echoes that in other countries in Asia, including, for example, India, Malaysia and other countries. Scholars have debated both for and against the adoption of the term but they appear to agree that the definition in the Asian setting should be broad enough to encompass the plurality of indigenous groups in question with respect to their historic and country-specific contexts. The category "indigenous peoples", supplemented by the assertion of the peoples who wish to self-identify themselves by

75 Kingsbury 1998; Erni 2008.

76 Minority A□airs Editorial Department. Working Handbook of Minority Nationalities [CHN: Minzu Gongzuo Shouce]. Kunming (CHN): Yunnan People's Publishing House; 1985.

77 Chee-Beng 2008; Li 2008.

the term has increasingly become a social reality in Asia,[78] thus is the term “indigenous” is being used interchangeably with the other more specific terminology contained in this chapter.

Who are indigenous peoples in Asia?

Asia includes a vast geographically diverse area of about 12 million square kilometres that is culturally and ecologically divided into five subregions. The distribution of indigenous peoples into very different geographic subregions and the degree of engagement in indigenous issues by the various nations’ actors and the differences within the concerned indigenous peoples themselves differs substantially. For example, the knowledge about indigenous peoples in different countries within subregions varies greatly. Five subregions are conventionally categorized as western, south-eastern, southern eastern and central Asian subregion.

The following table shows the distribution of countries with the subregions:

Table 1: Subregions and countries in Asia

Central Asia
Kazakhstan, Kyrgyzstan, Tajikistan, Turkmenistan, Uzbekistan
Eastern Asia
China, Taiwan, Democratic People’s Republic of Korea, Japan, Mongolia, Republic of Korea
Southern Asia
Afghanistan, Bangladesh, Bhutan, India, Iran (Islamic Republic of), Maldives, Nepal, Pakistan, Sri Lanka
South-Eastern Asia
Brunei Darussalam, Cambodia, Indonesia, Lao People’s Democratic Republic, Malaysia, Myanmar, Philippines, Singapore, Thailand, Timor-Leste, Viet Nam
Western Asia
Armenia, Azerbaijan, Bahrain, Cyprus, Georgia, Iraq, Israel, Jordan, Kuwait, Lebanon, Oman, Qatar, Saudi Arabia, State of Palestine, Syrian Arab Republic, Turkey, United Arab Emirates, Yemen

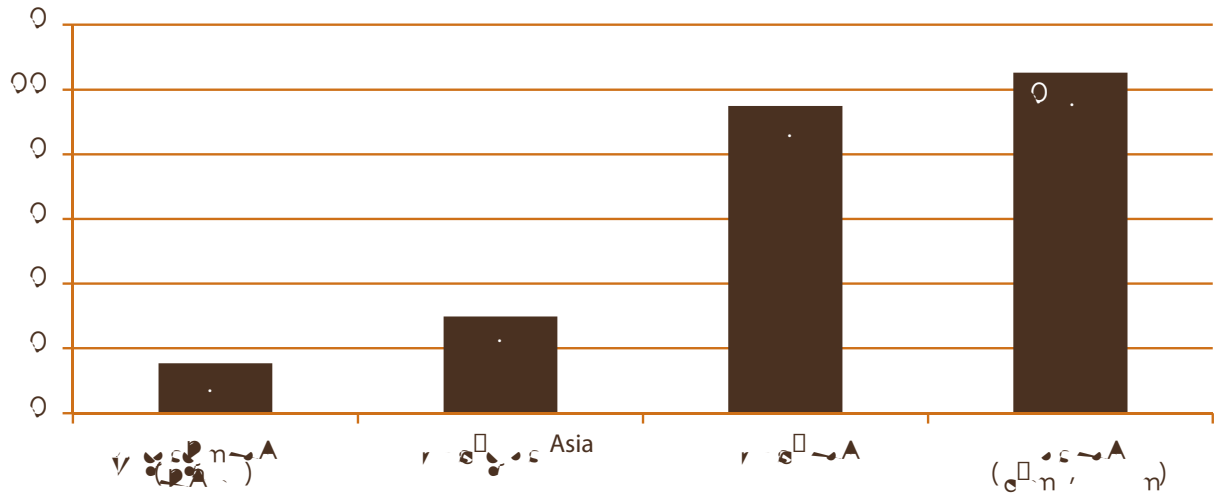
Source: DESA.

The Asian subregions are culturally diverse in their ecology, geography and physical features. The regions include a multitude of indigenous groups who comprise 70 per cent of the estimated 350 million indigenous peoples worldwide. As mentioned earlier in the report, comprehensive data on the demographic status of the indigenous peoples in the Asian region are incomplete or not available. Information on indigenous peoples in Central and Western Asia, in particular, is so scarce it is very difficult to draw even a rough profile of the population. The data available within subregions

[78] Baviskar 2007; Hathaway 2010.

on the population of indigenous peoples are also limited for various reasons. An estimate o□ered by the International Working Group on Indigenous A□airs (IWGIA) in 2008 with a subsequent edition by Hall and Patrinos (2012) is an often cited source for understanding the distribution of the indigenous peoples is in the subregions of Asian continent. The following figure shows the approximate distribution of the population in the four subregions:

Figure 1: Indigenous Population in Asia (million)



list to include other self-defined indigenous groups. A similar scenario is also true for other South Asian counties. Although the names of each specific group are di□cult to list with the current state of the information collected and access to it, the following table gives an idea of the major groups until relatively better data can be collected on the subcontinent:

Table 2: Names of indigenous groups in South Asia Country

Table 3: Indigenous peoples in East and South-East Asia

Country	Commonly referred names	Major indigenous groups	Approximate population
Myanmar	Ethnic nationalities, national races	Shan, Karen, Rakhine, Karenni, Chin, Kachin, Kayah, Mon	32 per cent of the total population
Thailand	Chao-Khao or hill tribes	Chao-Khao or hill tribes include Hmong, Karen, Lisu, Mien, Akha, Lahu, Lua, Thin and Khamu; indigenous fisher communities chao-ley, and hunter gatherers group Mani people	923,257 (not including people in south and north)
Viet Nam	Ethnic minorities (dan toc thieu so, dan toc it nguoi)	53 groups identified including Tay, Thai, Nung, Hmong, Dao and Khmer	14 per cent of the total population

Source: IWGIA 2008.

Colonialism, especially of European origin is regarded as less applicable to Asia in defining the context of indigenous peoples' history. The past and present dispossession of the land and re-

> Indigenous peoples' concept of health and survival is both a collective and an individual intergenerational continuum encompassing a holistic perspective incorporating four distinct shared dimensions of life. These dimensions are the spiritual, the intellectual, physical, and emotional. Linking these four fundamental dimensions, health and survival manifests itself on multiple levels where the past, present, and future coexist simultaneously.

The above description clearly shows the need for broader approach to collecting information to document the present health status of indigenous peoples to contribute to the development of appropriate strategies and programmes. Baseline data on a broad range of health indicators are urgently needed to compare health indicators, and improve health standards by developing health goals between di□erent groups of indigenous and non-indigenous peoples, as well as to study what interventions can improve the health of indigenous peoples over time.

Current health information, even when available, does not generate a comprehensive picture for the Asian region as a whole nor does it permit comparisons among indigenous peoples and between them and their non-indigenous mainstream counterparts. This section presents some basic indicators available from government and academic sources to highlight the health status of indigenous peoples in Asia.

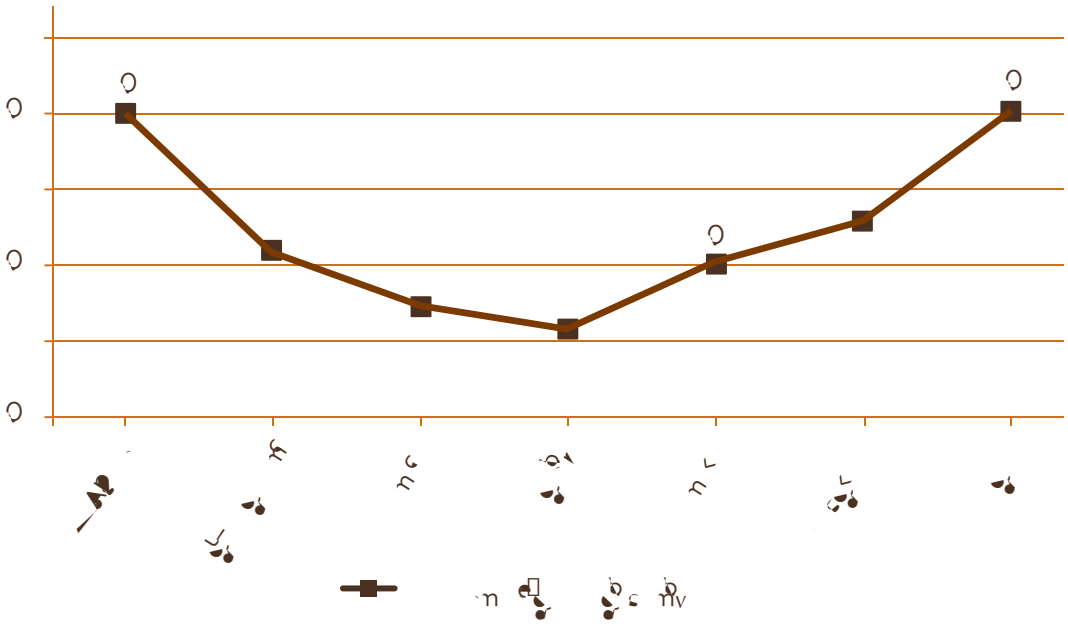
The most commonly used health indicators in the National Census and Demographic and Health Surveys carried by the governments are infant mortality, mortality of children aged 0-5 years, child nutrition, incidence or prevalence of diseases and their risk factors, and life expectancy at birth. As has been indicated earlier, the scope for comparison across the country is limited as variations in the approach taken by the specific countries exist.

Health-related Millennium Development Goals include: 1) eradicate extreme hunger and poverty;

nous health based on a review of the literature clearly shows that there is a systematic gap across the Asian states. The clear message coming from these data is that if the indigenous health gap is left unattended, then the disparities gap will expand. Hence, in the coming decades, the Asian indigenous peoples will experience even poorer health due to lower education and employment in a vicious cycle created by extreme poverty.

The case of China can be illustrative of the health situation of the indigenous peoples. An analysis of the trends in infant/child mortality and life expectancy in indigenous populations in Yunnan using the population census of the China from 1953 through 2000 and data obtained from Yunnan Provincial Health Department shows that the minority nationalities have lower rates in key health indicators. For example, the weighted average life expectancy at birth in 2000 for minority nationalities was 64.5 whereas the total Chinese population was 71.4. The variance between the majority Han population and minority nationalities within autonomous provinces where minority population are concentrated, however, is slightly less. For example, life expectancy of the Han population in Yunnan was 68.8, which shows a difference between Han and minority nationalities of only about 4.4 years.[80] Although a considerable heterogeneity between the different minority populations is to be noted, the pattern of data on the life expectancy can give an important indication of the poor situation of the population concerned.

Figure 2: Gap in life expectancy: comparing indigenous and non-indigenous populations, with states in order of 2009 HDI rating



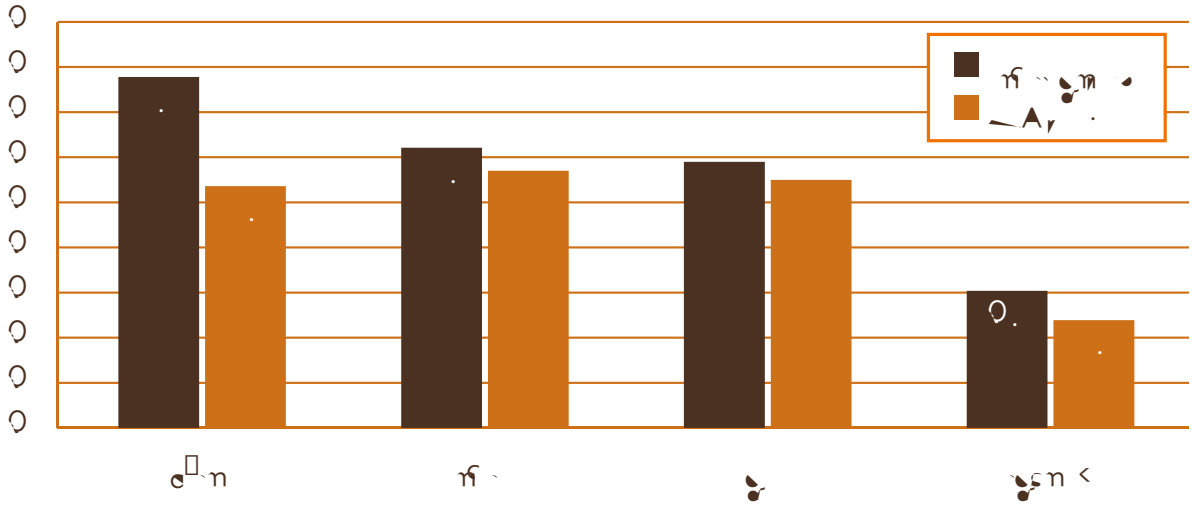
Source: MacIntosh, 2012:76.

Life expectancy is one of the key indicators of Human Development Index (HDI). Available data show a remarkable gap in life expectancy between indigenous and non-indigenous populations

est recorded gap in life expectancy--20 years--between indigenous and non-indigenous, it was comparable to that of low-income Nepal, as shown in Figure 3.[81] Nepal falls at 157th in HDI ranking.

Comparison between indigenous and non-indigenous groups in di□erent countries depicts similar picture on infant and child mortality rate. Analysis of the health data made above by Jianghong Li (2008) for China, for example, shows that the weighted average mortality rate under age 1 for the sample minority nationalities was 77.8 deaths per 1,000 live births versus 53.6 for the Han Chinese in 2000. India shows a similar picture according to the 2005-2006 National Family Health Survey (NFHS-3) which provides estimates of important indicators on family welfare, maternal and child health, and nutrition according to social groups. Infant mortality rate for the Scheduled Tribe (ST) was recorded to be 62.1 against the rate of 57.0 per 1,000 live births for the total population in India.[82] The data also show that the highest morality rates are concentrated in the regions with indigenous populations, especially in rural areas. Similar to Yunnan in China, where a higher rate of the infant mortality exists, in India infant mortality is concentrated in the regions of Madhya Pradesh and Arunachal Pradesh, where significant indigenous population live. The pattern is clear; for provinces where indigenous peoples are in higher concentration, the mortality rates are correspondingly higher.

Figure 3: Infant mortality rate: indigenous versus mainstream by country (per 1,000 births)



Sources: Li 2008, Mohindra and Labonté 2010, Bennett and Dahal 2008, Dang 2012.

Nepal and Viet Nam display a similar picture. For example, according to NDHS , in 2006 the infant mortality average in Nepal for indigenous peoples was 55 deaths per 1,000 live births while the national average was 59.[83] Viet Nam appears to be doing better in terms of reducing the infant mortality rate, but it has not been successful in reducing the disparity between its vulnerable ethnic minorities and the majority population. Viet Nam for example, has 30.4 infant deaths per 1,000 live births for ethnic minorities while national average is only 23.9.[84] The table above shows a comparative scenario on the infant mortality of the four di□erent Asian countries.

81 Cunningham, 2009; MacIntosh, 2013.

82 Ministry of Tribal A□airs 2010.

83 Bennett, Dahal, et al. 2008.

84 Dang, 2012.

The case for child mortality and under-five mortality is also very similar in terms of the disparity between indigenous and non-indigenous populations in the Asian countries. Given the highly variable information availability we have information on the indicators for only few countries. In South Asia, for example, Nepal provides a glimpse of the situation in all three aspects of child mortality based on the further analysis of the national data. For India, Mohindra and Labonté (2010) have analysed the time trend information from the National Family and Health Survey (NFHS-1), 1992-1993; NFHS-2, 1998-1999; NFHS-3, 2005-2006. Bennett and Dahal (2008) did same for Nepal using the data set generated from National Demographic and Health Survey 2006. We draw from analysis of VHLSS by Dang (2012) for Viet Nam on the mortality rates. The following table shows the comparative picture of three countries in Asia disaggregated for indigenous population compared to the total population of the country.

Table 4: Infant, child and under-five mortality in selected Asian countries

the most dangerous places in the world to be a pregnant woman".[86] It is estimated that "one third of these deaths occur due to postpartum haemorrhage, a condition that can be prevented with the provision of basic health care services".[87]

Child nutrition is another major indicator used to assess the health status of the population. The available data reveal that a number of Asian countries have shown improvement in child nutrition over the last two decades. Astonishingly, despite such improvements, changes in the nutritional status of the children in indigenous communities are much slower in pace than their non-indigenous counterparts. A study by Ouyang and Pinstrup-Andersen (2012:1456) on health inequality between ethnic minorities and the Han populations in China states, "Health and nutrition status in terms of height-for-age and weight-for-age actually improved for both the Han group and the minority group, but the improvement is much smaller for the minorities, and hence the growing health gap". Another study conducted in China has made similar conclusions and suggested that stunting, wasting and being underweight were distinct indicators of the nutritional status of children and chronic growth retardation is the major type of child protein-energy malnutrition in poor rural minority areas of Yunnan Province, China.[88]

In Cambodia, more than 20 per cent of indigenous children under five children su□er from malnutrition and 52 per cent are classified as underweight and stunted in growth (Health Unlimited 2002). The country has a small population of indigenous peoples, approximately 100,000 with most concentrated in two provinces in one of the world's poorest countries with low human development index (UNDP 2004). The prevalence of malnutrition in Indonesia is similarly high at 24.6 per cent of children under five years old as of 2000. Indigenous Adat populations su□er greater risk of child mortality. Human development levels among the Philippines indigenous groups in region of Cordillera and specifically Manabo households vary, showing that the Manabo households had a much higher rate of under-five mortality at 96 deaths per 1,000 live births, which is higher than national average of 42 per 1,000.[89]

In Bangladesh indigenous peoples are largely concentrated in Chittagong Hill Tract (CHT) where approximately 600,000 indigenous Jumma peoples live. CHT, being one of the country's most deprived areas, su□ers particularly extreme rates of ill health. Immunization coverage in CHT is recorded to be considerably low, with full immunization coverage by age 12 months at 51 per cent compared to 71 per cent overall in Bangladesh.[90]

The case of India corroborates the findings in China and other Asian countries and shows that nutritional status of the Scheduled Tribes (ST) children falls behind the national average compared with the mainstream or dominant communities. The mortality rate of ST children is worse and improvement is slower than for other communities in the country. Adequate nutrition and access to vaccination are key determinants in child growth and mortality, thus both are depicted in Figure 4 and Figure 5, which show time trends in the child nutrition status and access to vaccination over the period from 1992-1993 to 2005-2006 in India:

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86 Walker 2013:145.

87 http://www.unpo.org/article/11087#sthash.Zc7ut7Jr.dpuf.

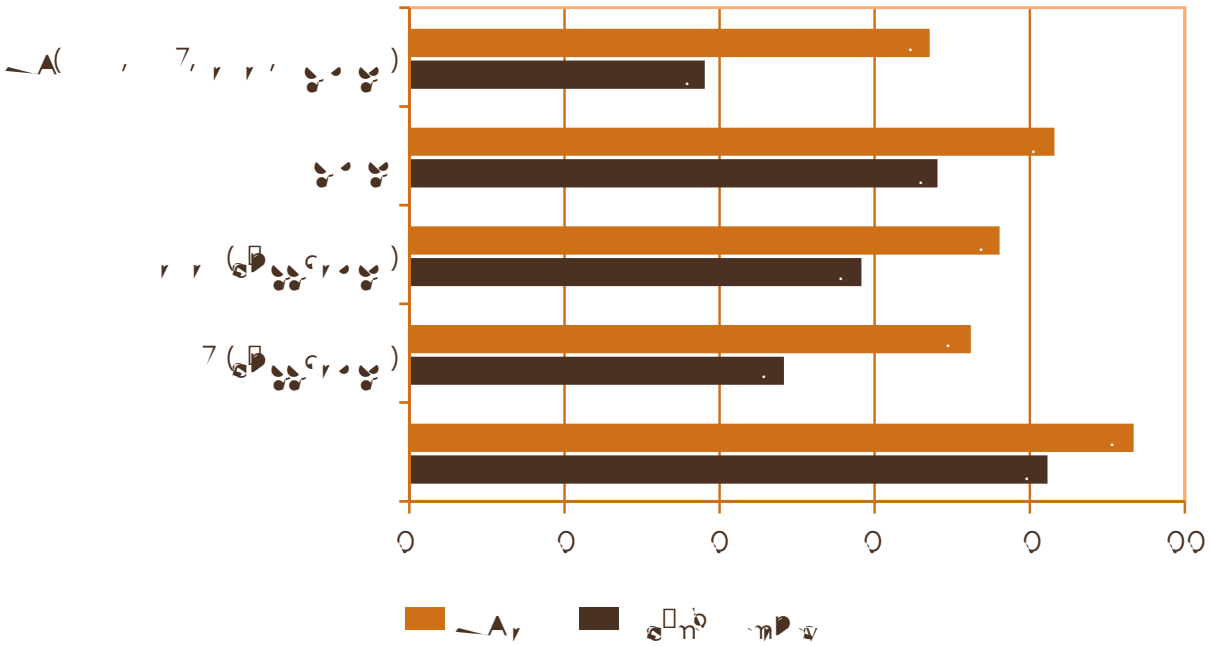
88 Li, Guo et al., 1999.

89 Macdonald, 2012.

90 Minsitry of Health and Family Welfare, 2011.

Figure 4: Scheduled Tribe, malnutrition and vaccination, India

Figure 5: Children with full vaccination, Viet Nam 2002 (per cent)



Source: Dang, 2012.

Access to vaccination in other Asian countries also shows that there have been improvements in the coverage, but the available data show that the ethnic minorities remain below the national

hypothyroidism, shortness of iodine a□ects hundreds of millions of people; poor vitamin intake (e.g., vitamins A and D, folic acid); and heavy metals, such as zinc. These deficiencies and any underlying causes, including poverty and inadequate food, should be corrected to reach satisfactory outcomes for those a□ected.[92]

Table 5: Major health problems of indigenous peoples

High infant and young child mortality
High maternal morbidity and mortality
Heavy infectious disease burdens
Malnutrition and retarded growth
Shortened life expectancy at birth
Diseases and deaths associated with cigarette smoking
Social problems, illnesses and deaths linked to misuse of alcohol and other drugs
Accidents, poisonings, interpersonal violence, homicide and suicide
Obesity, diabetes, hypertension, cardiovascular disease and chronic renal disease (life-style diseases)
Diseases caused by environmental contamination (e.g., heavy metals, industrial gases, and e□uent wastes) and infectious diseases caused by faecal contamination

Source: Gracey and King 2009:66.

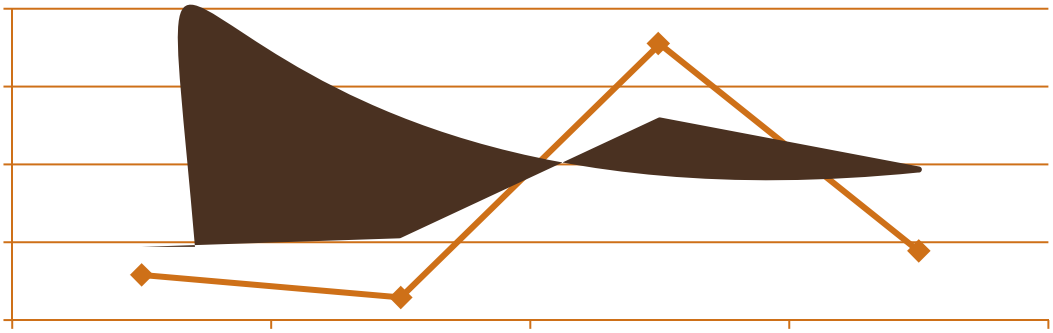
Contemporary indigenous health issues in Asia are strikingly similar in many aspects to problems of indigenous peoples worldwide. Although the gap is gradually being narrowed in health status of indigenous and non-indigenous populations substantially over the last few decades in the region, there is a significant burden of disease for the indigenous population as compared to general population. The studies show that indigenous peoples in Asia "bear a triple burden of persisting infectious diseases, increasing chronic conditions, and a growing recognition of injuries and violence".[93] It further states that incomplete demographic transitions, greater risks of communicable diseases including HIV and AIDS, massive unplanned urbanization and a host of social determinants of health compound these problems. Thus poor health is caused by a number of

There are several other factors that impede indigenous access to health services besides the state capacity and willingness to provide necessary support for improving indigenous health. Unfortunately, only limited disaggregated information is available on utilization of existing health care services for indigenous peoples. One exception and a key indicator for assessing the utilization of the health care services by the population has been the visit of pregnant women to a health facility prior, during and after delivery. The data generated from national surveys in selected Asian countries show that a considerable disparity exist between the indigenous and non-indigenous population on access and utilization of such maternal-child services. For example, in China 73 per cent of the pregnant women in non-autonomous prefectures had antenatal examination but only 51 per cent of the mothers from autonomous prefectures with larger population of minority nationality made such visits.[97]

Other countries depict similar picture on health care service to mothers. Viet Nam shows that ethnic minority people are 16 per cent less likely to visit hospital when they are ill.[98] In Bangladesh, districts in Chittagong Hill Tracts (CHT), where the majority of Bangladeshi indigenous peoples live, antenatal care visits, assistance during delivery by medically trained personnel and post-natal care for mothers were lower than that of national figures. For example, the Khagrachhari district in CHT has recorded rate of 30 per cent antenatal, and 6.6 per cent post natal care visits which is lower than national average of 47.6 and 16.1 per cent, respectively.[99] Further analysis of demographic and health information for a 2005-2006 survey in Nepal shows that 34 per cent of mothers from indigenous nationalities receive antenatal care from a skilled birth attendants as compared to 44 per cent for average population. The disparity appears wider still when comparing access to antenatal care with hill Brahman community, where 76 per cent of mothers receive such assistance. The Indian situation is not very di□erent as the only one third of women belonging to Scheduled Tribes receive antenatal care as compared to the population average of about one half (49 per cent) for the mainstream. It even indicates the worst case scenario as the proportion of Scheduled Tribe women to have received such care actually declined from 35 per cent in 1998 to 32 per cent in 2006 (Das and Hall 2012).

Another measure to assess the access of health institutions and facilities by the population has also been through identifying the place of birth or delivery. Asian countries have varying records of delivery, but on the whole, the majority of indigenous mothers tend to give birth in their homes. In India for example, only about 29 per cent of mothers from the indigenous population had delivery in the health facilities indirectly, which means that some 71 per cent give birth in their own homes without any assistance from skilled birth attendants. The situation of the non-ST communities was better than of the STs, with 49 per cent of the mothers having access to health facilities for delivery. The following table shows the place of delivery in India for indigenous and non-indigenous population:

Figure 6: Place of delivery (access to health institutions and facilities), India



work force is substantially behind in almost all countries. Indigenous representation and participation in decision-making with regards to health policies, planning and evaluation at the national level and their right to participate in decision-making in local health facility management are critical to improving indigenous access to health services.

Indigenous health and post-2015 development framework

the progress on MDGs with visibility of the specific ethnic groups. The second critique of the MDGs has been its lack of reference to the principles of human rights for attaining these goals.

Another major weakness of the conventional approach, including that of the MDGs, has been to target general health application population health initiatives where the exclusive focus has been on non-indigenous notions of health primarily consisting of biomedical perspectives on disease and treatment. The mainstream health strategies have not yet taken into consideration the relational and holistic concept of indigenous health that defines health and well-being in broader terms than the absence of disease and physical health. Indigenous health embraces spiritual, emotional and mental aspects together with physical health in their understanding of well-being and health. The indigenous concept of health also goes beyond the individual and considers the collectivity and harmonious relationship with other members of the community and nature as intricate part of the well-being.

The United Nations is currently engaged in the process of devising a new global development plan for the post-2015 period, when the MDG program will conclude. There is a wide range of agreement that the new global development framework that will replace the MDG should situate inequality and human rights central to it strategy. Such an approach is crucial not only because inequality has negative impact on growth and creates tension between communities but also undermines democracy. Indigenous peoples have called for post-2015 framework to be based on a foundation of human rights. This is highly relevant as the right to life is broadly interpreted as not just protection from arbitrary killing, but also as creating material conditions where food, clean water, and medicine are available to all. With regard to indigenous peoples, ILO Convention No. 169 on Indigenous and Tribal Peoples, which has been key reference for indigenous peoples worldwide, recognizes the health related rights specifically in Article 25.[104] This provision complements with the similar health rights a□rmed in UNDRIP 2007, Article 21 (1) which recognizes the rights of indigenous peoples to the improvement of their economic and social conditions "in the areas of education… housing, sanitation, health and social security".

The report of the High Level Panel on the Post-2015 Development Agenda recommended five big transformative shifts; one of them is stated as "Leave no one behind". This recommendation recognizes the issue of inequality and discrimination as central ones and calls for further work on the MDG achievements. It states that; "We must keep faith with the original promise of the MDGs, and now finish the job. … We should ensure that no person—regardless of ethnicity, gender, geography, disability, race or other status—is denied universal human rights and basic economic opportunities". This indicates the necessity to emphasize the task of removing both direct and indirect discrimination faced by the a□ected communities for achieving equity in health. As elsewhere, indigenous peoples in Asia face direct discrimination as manifested in a range of spheres, from

[104] ILO C 169, Article 25 1) governments shall ensure that adequate health services are made available to the peoples concerned, or shall provide them with resources to allow them to design and deliver such services under their own responsibility and control, so that they may enjoy the highest attainable standard of physical and mental health; 2) health services shall, to the extent possible, be community-based. These services shall be planned and administrated in co-operation with the peoples concerned and take into account their economic, geographic, social and cultural conditions as well as their traditional preventive care, healing practices and medicines; 3) the health care system shall give preference to the training and employment of local community health workers, and focus on primary health care while maintaining strong links with other levels of health care services; and 4) the provision of such health services shall be coordinated with other social, economic and cultural measures in the country.

access to health facilities and the delivery of health services. They are also adversely a□ected by the underlying determinants of health, such as access to safe drinking water, sanitation, adequate housing and nutrition. Additionally, health practitioners may give lower-quality diagnoses, medication and care and may even show neglect towards those discriminated against. Indirect discrimination that indigenous peoples experience may on the surface appear neutral, but it has the e□ect of discrimination. One prime example of indirect discrimination includes providing health information and services only in the dominant language or in accordance with dominant cultural practices, which results in the de facto exclusion of indigenous peoples.

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Hathaway, M. (2010). “The emergence of Indigeneity: Public intellectuals and an indigenous space in Southwest China”. Cultural Anthropology 25(2): 301-333.

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King, M., A. Smith, et al. (2009). “Indigenous Health Part 2: The Underlying Causes of the Health Gap”. The Lancet 374: 76-85.

Kingsbury, B. (1998). “”Indigenous Peoples” in International Law: A Constructivist Approach to the Asian Controversy”. The American Journal of International Law 92(3): 414-457.

CAUCUS

and Russia's Kola Peninsula, as depicted on Map 1.[119] They belong to the Finno-Ugric language group. The Sami language consists of several dialects and distinct written languages.

The Kildin (Kola) Sami population was 1,991 persons in the 2002 Russian Census, 89 per cent of whom resided in Murmansk Oblast. According to the 2002 Census, about 38 per cent of Sami live

The Beginnings of political transformation for Sami peoples

During the last three decades, Sami society has undergone an ethnic and cultural revival.[121] Their political situation has also improved. In Norway, Sweden and Finland the Sami have been recognized as the original inhabitants of northern Scandinavia.[122]

has increasingly become dependent upon commercial fishing, which represents 90 per cent of the region's export income. The economy is however dependent upon subsidies from Denmark which amounts to approximately 50 per cent of public spending in Greenland.[130]

The influence of colonialism

The Sami people in Sápmi and the Inuit in Greenland have a common history with colonization. Greenlandic social anthropologist Aviâja Egede Lynge has stated: "We have always been taught that we were one of the best colonies in the world. No slavery, no killing … so why, then should we have had a reason to de-colonize? And why should we have a reason to ask questions about 250 years of colonial presence?"[131] Today, Greenland has achieved greater self-determination with the home rule, however, Greenlanders still feel ruled by Denmark. Despite the fact that the members of the home rule government are native Greenlanders, most leading positions are still in the hands of the Danish population who have strong influences on decision-making processes.

In Norway, the process of assimilation, frequently referred to as "Norwegianization", lasted from 1850 to approximately 1980. According to the Land Act of 1902, property could be transferred only to Norwegian citizens (i.e., persons able to speak, read and write Norwegian), and proficiency in the Norwegian language continued to be a criterion for buying or leasing state land until the 1940s. For almost a century, the Sami language was prohibited in Norwegian schools, from 1860 to 1959. Residential schools were important arenas for the assimilation of Sami children into the dominant cultures assisted by individual experiences of stigmatization and discrimination.[132]

Although the overt policies of assimilation may be a thing of the past in terms of Nordic society and politics, the negative consequences have been projected into the present and, indeed, will inform relations in the future. It takes time to fundamentally change general frameworks in politics, legislation and ordinances, as well as myths and attitudes, to appropriately redress and reclaim Sami culture, language, traditions and social needs; including equitable access to health care, education and employment and other determinants of health. Many people remain influenced by past assimilation policies despite the o□cial legislation and policies having been reversed. Simply put, "being di□erent" is often the source of discrimination and harassment, and, as a minority population, the Samis and Inuit are particularly vulnerable. Studies conducted abroad reveal discrimination against indigenous peoples tends to be closely associated with health issues. Discrimination has been found to be associated with negative mental and physical health outcomes, negative health behaviours and increased mortality.[133] Centuries of colonial contact haociaCenturiMC /Span <M

The right to health care for indigenous peoples

Everyone has the right to access health facilities, goods and services without discrimination.[134] This means non-discrimination both in access to health care and in enjoyment of the underlying determinates of health. One key contextual barrier for indigenous peoples to access health care is the continuing impact of colonization. Even though the health status of indigenous peoples has improved in the last decades, significant health disparities continue to exist, for example, increasing rates of diabetes, cardiovascular diseases and cancers among the Inuit in Greenland.[135]

In countries where indigenous peoples were significantly impacted by colonization, it is important to understand the cultural and biological consequences of colonization and how these have a□ected the health status of indigenous peoples historically and currently.[136] One possible way to approach this issue is to investigate present di□erences in health care access and utilization between the indigenous peoples and the majority populations. This may assist in the e□ort to understand how ethnic, cultural and racial factors influence access and utilization. Specifically, this could be a way to study barriers to health care such as communication, cultural sensitivity, socioeconomic status, trust in the health care system and the level of satisfaction by the indigenous peoples who use the services.

Health status of Sami peoples

Past research on Sami peoples' health has revealed a uniquely positive situation compared to other indigenous peoples of the circumpolar regions of Greenland and Arctic Russia.[137] Life expectancy and mortality rates of the Norwegian and Swedish Sami and their non-Sami neighbours were quite similar.[138] Many of the health problems that indigenous peoples in the circumpolar region and elsewhere face are not as prevalent among the Sami, such as dramatic elevated risk for diabetes, cardiovascular disease, lung cancer and various infectious diseases. There are generally small di□erences in risk for the major diseases and causes of death.[139] At the same time, the knowledge of the health conditions of the Sami is not available, particularly regarding the condition of Russian Sami. However, the situation has improved over the last few years. An increasing number of articles on Sami health have been published in the Scandinavian countries, particularly in Norway and Sweden where a number of specific health problems have been identified. For example, among the Swedish reindeer-herding men a significantly higher risk of fatal accidents, work-related stress and suicide have been identified.[140] The increased risk of suicide among Sami men is also found in Norway and Finland.[141] The health problems of the Sami peoples are thought to be associated with discrimination and marginalization and lack of knowledge of the Sami identity and culture.[142] Several studies consider discrimination as an

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134 ICESCR and International Convention on the Elimination of all forms of Racial Discrimination, ICERD, Article 5.e. iv.

135 P. M. D. Bjerregaard and Young, 2008, pp. 31-34.

136 Marrone, 2007, p. 189.

137 Ketil Lenert Hansen, 2011, p. 54.

138 Brustad, Pettersen, Melhus and Lund, 2009; S. Hassler, Johansson, Sjolander, Gronberg and Damber, 2005.

139 Hassler in P. M. D. Bjerregaard and Young, 2008, pp. 158-161.

140 S. Hassler, et al., 2005; Kaiser, Sjolander, Liljegren, Jacobsson and Renberg, 2010.

141 Silviken, Haldorsen and Kvernmo, 2006; Soininen and Pukkola, 2008.

142 Sjolander, 2011, p. 9.

studies have found that long distances to medical care or Sami ethnicity have no influence on the cancer patient survival in Northern Finland.[156]

The Greenland government has a separate and independent health care system from that of Denmark, although much of the bureaucracy is staffed by Danish people. The Ministry of Health (Departementet for Sundhed/Peqqissutsimut Naalakkersuisoqarfik) has overall responsibility for all health services, from the operation of the tertiary care Queen Ingrid Hospital in Nuuk to health centres and rural hospitals in towns and villages. Greenland is organized into 16 health districts. Danish is the dominant language spoken because a large proportion of the medical staff is recruited from Denmark.

Since the 1990s, health reforms in Russia have focused on financing and decentralization. The regions are key players in health care provision and the impact of reform varies widely across the country. The remoteness and small size of indigenous settlements affects access to, and the expense of medical care. All indigenous peoples of Russia are entitled to free medical care coverage, which includes a compulsory annual check-up at state and municipal health care facilities. Yet federal and regional health care programs do not always provide medical brigades to visit remote areas. Medical personnel often lack modern, mobile equipment that allows them to go out and examine indigenous peoples in remote settlements, such as reindeer herding camps. Nomadic reindeer herding is the traditional livelihood of many indigenous peoples in the Russian north. Working with indigenous peoples out in the tundra is complicated due to the practical difficulties of carrying out examinations in the constantly moving reindeer herding camps, as well as difficulties with controlling the prescribed treatment. Poorly equipped health care facilities and lack of investment means that it is extremely difficult to retain medical staff and attract specialists to come and work in rural hospitals.[157]

A major challenge in international comparison of health care systems is that different countries have different health care systems with different financial management practices. However, a basic measure in the international comparison of health care systems is health care expenditures. It provides a glimpse of the health care resources available to, and used by the various health care agencies. Conversely, there is international agreement on the inclusion criteria and classification of types of expenditures in the form of the System of Health Accounts (SHA) developed by the organization for Economic Cooperation and Development (OECD).[158,159] The Nordic countries, all have similar levels of per capita health expenditures, with health care accounting for 8-10 per cent of GDP.

strengthen the Sami peoples.[166] Since 1980, problems of underutilization of health services and communication between health workers and Sami patients were brought into focus, and the result was that the first outpatient psychiatric clinic was funded in the Sami core area of Karasjok with Sami-speaking therapists. Several years later, an outpatient clinic with Sami clinicians provided

of Sami adolescents (15-16 years old) and their non-indigenous peers it was found that Sami and non-Sami youth use health services with equal frequency. In another study of mental health care,[174] Sami patients showed less satisfaction with all investigated treatment parameters than

culturally safe social and health care services.[179] Traditional Sami cultural aspects, such as Sami language, traditional Sami foods, spirituality and way of life, are important aspects that are being emphasized in the care of elderly Sami, especially those suering from dementia.

There has been very little attention paid to the needs of elderly Sami peoples in the health care system and this area requires strengthening in the future, especially when it comes to cultural-specific features in health care services. The development of cultural competent standards of care for health providers is a necessary pre-condition to achieve this goal.

Use of traditional medicine

Integrating traditional healing within health services for indigenous peoples has currently taken on a much stronger focus. Traditional healing is a part of traditional knowledge among indigenous peoples. Knowledge traditions and world views constitute the context for the health care system of a society. In recent studies in the Arctic region it was found that the therapist showed little awareness of their client's use of traditional healers. While over a third of the Sami clients had used traditional healers in relation to their current health problems, less than half reported that this was given any consideration during the hospital stays.[180]

Other studies found that some Sami users were giving greater importance to religion and spirituality and were less satisfied with the public psychiatric services than those Sami patients who had not used traditional or complementary treatments. Studies suggest that dierent aspects of traditional healing within the health services to the Sami community should be given greater consideration.[181]

It is likely that the issues regarding the use of traditional medicine is similar and relevant to circumstances among the indigenous peoples in the other Nordic countries and among the Inuit in Greenland, but this is an area that needs to be a higher priority area for health services research.

Health status and health care delivery in Greenland

Greenland is a Danish colony, and in the last few decades, the home rule government has been given extensive powers to govern. The future goal is to attain full independence. The conditions for health care in Greenland dier in a number of ways from the Sami in the Nordic countries, because of geographic and climatic conditions. The health care system is obligated to deliver equal care to all citizens regardless of their place of residence. This requires a large number of small, cost-ective health centres capable of providing acute care because the expenses for transport of patients and sta are very high.[182] Due to their small size and isolation, towns and villages in Greenland often need to be self-sucient and are very vulnerable to external factors.[183] No private providers of health care services exist in Greenland, but private dental care, physiotherapy, psychotherapy and treatment for alcohol and drug abuse are available in Nuuk.

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179 Tervo, Muller-Wille and Nikkonen, 2003, p. 120.

180 Sorlie and Nergard, 2005.

181 Sexton and Sorlie, 2008, pp. 135-146.

182 Bjerregaard and Stensgaard 2008 Greenland in W ≠M. 135-146.

In the last 50 years, Greenland as well as other indigenous societies in the circumpolar regions has undergone rapid social, environmental and economic changes, which have influenced all aspects of their life, impacting on living conditions and health care. In the past, perinatal complications, acute and chronic infectious diseases and injuries dominated as the leading causes of morbidity.[184] Recently, chronic and lifestyle diseases and disabilities dominate morbidity concerns despite the fact that the "old" diseases have not decreased to the same low levels found in Western countries. Furthermore, the burden of poor health related to social conditions does not appear to be decreasing.[185]

Specific health care access study shows that 83 per cent of the population in Greenland had been

the health challenges among the Inuit in Greenland. Inuuneritta focuses on diet, physical activity, alcohol and drug abuse, smoking, violence and sexual health. It also includes programs on suicide prevention, early interventions for the health and development of children and dental health.[192]

In 2008, a new plan for reorganization of the health care system was proposed. Researchers Niclasen and Mulvvad (2010) describe the important issues of the plan as follows:

> "A fundamental component of the structural reorganization is tying all parts of the health care system together through telemedicine and in the future with a joint electronic patient file. The rapid epidemiological changes make surveillance and monitoring of health particularly important, and data on core indicators of health and health care are urgently needed. Furthermore, better steering instruments on resource allocation and quality, and securing best clinical practice are areas where focus in the future is needed".

In order to attract students, the nursing education has been extended to include a university-based bachelor's degree, and to meet the needs for high-quality health care in the small villages, a specialized training program to qualify nurses to work without direct supervision by a medical

ethnic groups.[201] A study carried out in 1980 concluded that linguistic and cultural barriers prevented Sami patients from going to the doctor, leading to an inferior health service for Sami people.[202] In Norway (as well in Sweden and Finland) all municipalities and counties with Sami peoples are responsible for solving language barriers associated with services, so that the basic user rights can be met. Research indicates that Sami patients experience linguistic and cultural barriers in the meeting with the health services.[203] For many Sami, it is important to be able to use their mother tongue in conversations with their doctor, nurse, social worker and other health care personnel. Language barriers can lead to inadequate health care and treatment for Sami patient. Sami patients often do not receive health services in their own language, because only a few health workers can speak Sami. Further, interpreter services are poorly developed in the rural Sami areas. Many Samis are also reluctant to admit that they do not understand the majority language or are in need of interpretation. Some Sami therefore fail to seek health care services, even when they have significant care needs.[204] Surveys have indicated that there is severely limited use of interpreters in health and child welfare services.

Today, children under school age and elderly Sami are completely monolingual in the Sami language. At the same time, bilingual Sami have difficulty communicating in Norwegian, especially when they are seeking health care.

In the report titled "Discrimination of the Sami—the rights of the Sami from a discrimination perspective" (2008), by the Ombudsman against Ethnic Discrimination (DO) in Sweden, reported that many Sami are met with discrimination and prejudice when they seek medical care for their Sami-speaking children:

> "In their contact with the DO, parents of Sami-speaking children describe that when they seek medical care, they feel insulted by medical staff. Several parents have experienced situations where doctors, nurses and speech therapists have commented on the fact that the child and his/her parent speak Sami with each other. Examples of such comments include "Speak Swedish. We live in Sweden". "Can the child only speak Sami?" and "When is this child going to learn Swedish?" The perceived insinuation is that the child is not fully functional because he or she speaks his/her mother's tongue better than Swedish".[205]

Cultural barriers in health care settings

Indigenous peoples often hold different priorities and perception of health than their mainstream majority peers. This can stem from traditional cultural or religious beliefs about health and well-being, different customary practices around health care, or living in distinct locations with unique health challenges. In order to achieve better equity in health outcomes, these different viewpoints must be taken into consideration in policy development and service delivery.[206]

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[201] Marrone, 2007, pp. 192-193.

[202] Fugelli, 1991.

[203] Nystad, et al., 2008, pp. 119-120.

[204] NorwegianHealthAuthorities, 2009.

[205] Pikkarainen and Brodin, 2008, p. 30.

[206] MRG, 2013, p. 18.

impact from the nuclear accident that may a□ect their health and future prospects for reindeer husbandry.[215]

The Sami and Inuit peoples in the Arctic are primarily exposed to pollutants through traditional food and water, but also through the air. Pollutants are particularly a problem for indigenous peoples, who mainly live on traditional diets. Although the largest emissions of pollutants do not happen in the Nordic countries and in Greenland, the air currents which transport airborne contaminants to the Arctic are particularly worrisome. Therefore, this is an issue for the Sami and Inuit peoples. Long-range pollution seems to have shown a downward trend in recent years, but local pollution from industries could be a problem for indigenous health and the environment.[216] Recently, in northern Sweden there has been a mining dispute where hundreds of Sami and other

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Chapter Four

Access to Health Services for Children with Disabilities and Special Health Care Needs in the Caribbean Region

Introduction

Despite State subjugation policies aimed at their destruction, indigenous peoples are still managing to uphold and rebuild their identity, language and culture, as well as their traditional social, legal and political systems, or a large part thereof. Central America, South America and the Caribbean's history and very essence are rooted in the cultural and social foundations of indigenous

The Inter-American instruments ensuring the right to health and other human rights of indigenous peoples include:

American Declaration on the Rights and Duties of Man

American Convention on Human Rights

Additional Protocol to the American Convention on Human Rights

Inter-American Convention on Prevention of Violence Against Women (“Belem Do Para”)

Inter-American Convention to Prevent Torture

Inter-American Convention on the Elimination of All Forms of Discrimination Against Persons with Disabilities

These are, inter alia, some international mechanisms that have the mandate to address the health rights of indigenous peoples in the Central, South America and the Caribbean region such as:

linked to basic access to foods, water and shelter and, in many contexts, risks from predators.[229] Health and well-being prior to colonization was closely related to sophisticated knowledge and use of the local ecosystems. The early period of colonialism brought new diseases that were especially lethal for communities in the coastal areas.[230] Current-day problems still have a major impact on indigenous peoples' lives in the region. The security of indigenous peoples' lands, territories and resources has become a competition between the governments of the region in the areas of agricultural, mining and energy generation initiatives particularly in Argentina, Bolivia, Brazil, Chile, Guatemala, Honduras, Mexico, Panama and Peru. This has had negative impacts on indigenous peoples, particularly for indigenous peoples living in remote areas and forest zones, including those living in voluntary isolation in the Amazon rain forest.

Indigenous peoples and their communities in most Central and some South American States continue to face limited economic opportunities, poor access to social services, high levels of public insecurity and the strong influence of organized criminal enterprises. All of these challenges are exaggerated by the generally weak state presence in remote geographical zones, as well as by fragile institutions, uneven justice administration, politicized judicial systems, and continuing high levels of corruption and impunity particularly in Central and South America.[231] This situation has resulted in major inequalities between indigenous peoples and their non-indigenous counterparts. Indigenous peoples experience the worst social conditions and thus health profiles include the highest rates of morbidity and mortality and the least access to health services compared to the rest of the population. According to unpublished data, in 2003 the average rate for infant mortality in Colombia was 19 per 1,000 infants, but for the Wayuu indigenous group the infant mortality rate was 111 per 1,000.[232] In terms of morbidity rates in Bolivia, the Guaraní, with a population of 153,483 have a prevalence of tuberculosis five to eight times that of the national average.[233] Indigenous peoples are more likely to su□er from substance abuse, depression and other mental disorders that are obstacles to the enjoyment of the right to the highest attainable standard of physical and mental health. HIV/AIDS and other sexually transmitted diseases are also spreading in indigenous communities. At the same time, indigenous communities are faced with economic exploitation of indigenous women and lack of information about physical and mental health.[234]

The right to life for indigenous peoples in the region is frequently at risk due to higher mortality and morbidity rates compared to the general population. The health and personal integrity of indigenous peoples is at risk throughout their lives—from infancy where there are high mortality rates, and throughout life where there is a great prevalence of disease and death at early age. Among the Maya in Guatemala, life expectancy for indigenous peoples is 17 years shorter than for

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229 Raul Montenegro and Carolyn Stephens, "Indigenous health in Latin America and the Caribbean" www.thelancet.com, Vol 367, June 3, 2006.

230 Raul Montenegro and Carolyn Stephens, "Indigenous health in Latin America and the Caribbean" www.thelancet.com, Vol 367, June 3, 2006.

231 Minorities Rights Group International State of the World's Minorities and Indigenous Peoples 2012, p. 90.

232 Raul Montenegro and Carolyn Stephens, "Indigenous health in Latin America and the Caribbean" www.thelancet.com, Vol 367, June 3, 2006.

233 Raul Montenegro and Carolyn Stephens, "Indigenous health in Latin America and the Caribbean" www.thelancet.com, Vol 367, June 3, 2006.

234 Pan American Health Organization (PAHO), "Human Rights and Health: Indigenous Peoples" 2008, p. 2.

In Chile the indigenous population is estimated to be 10.3 per cent[245] of the total population, and 16 per cent of the indigenous population lives in poverty. The infant mortality rate in general is 11 per 1,000 live births, while the rate for the indigenous peoples is 12.8 per 1,000 live births.[246] In Bolivia the indigenous population is 52 per cent[247] of the total population. Poverty among indigenous peoples has reached 64.3 per cent.[248] The maternal mortality rate in Potosí, the province with the largest indigenous population, is 496 per 100,000.[249]

In Peru the indigenous population is 40.25 per cent of the total population and 79 per cent of the indigenous population is poor. The Peruvian Institute for Statistics has no consolidated number for the infant mortality rate for indigenous children but has indicated that in indigenous communities the infant mortality rate goes from 99 to 153 per 1,000 live births. In Puno, one of the provinces with a large indigenous population, the maternal mortality rate reaches 36 per 100,000.[250]

In Ecuador, according to the 2011 census, the indigenous population is 7.1 per cent of the total population, and 49.9 per cent

Interculturality and health

It must be recognized that advancements in establishing norms for compliance with health rights of indigenous peoples are the result of the hard struggles by indigenous peoples themselves. They have promoted actions to the States demanding recognition of their rights, the elaboration of public policy and plans to revert situations of inequality in which they live, their social and economic marginalization, and their exclusion through racial discrimination, as well as addressing their deplorable health situation in comparison to other social and cultural groups.

The elaboration of policies, plans and projects and other initiatives for indigenous peoples have taken place in the Central, South America and the Caribbean region since the beginning of the 1990s. Several countries in the region have included an intercultural approach for health in their development plans. At the same time, sociocultural and linguistic barriers continue to exist, as well as barriers in terms of geographic access to health services and the 0.e same timee 563.3021m9i

Interculturality must be considered as an initiative for changing the health conditions, as long as change serves to improve epidemiology indicators, that is, to get people to live longer and better. If, on the other hand, change is understood as only having the objective of giving new value to traditional medicine, it will be di□cult for health services to improve, and therefore to produce improvements in the health of the population.[255]

In this sense, countries in Latin America with indigenous peoples have incorporated the intercultural approach in their laws, policies, management and health care models, and technical norms, in order to contribute to health equity according to the sociocultural contexts of indigenous peoples. The big challenge is to make those instruments function.

In Guatemala, the Inclusive Health Model (MIS, Modelo Incluyente de Salud) has been implemented since 2003 by the Consorcio Médicos del Mundo Navarra-CORDAID in coordination with the Ministry of Public Health and Social Assistance (MSPAS, Ministerio de Salud Pública y Asistencia Social) and with the financial support of the European Commission and the Government of Navarra. It is a model for individual, family and community care at the primary level, based on three pillars: the right to health, interculturality, and gender perspective.[256] The intercultural approach of MIS recognizes the existence of health concepts and practices that originate from cultural diversity and promotes interactive processes (it includes referral and cross-referral) between di□erent knowledge and practices of care and treatment.[257]

In Mexico, the National Program for Action "Salud y Nutrición para los pueblos indígenas"[258] (Health and Nutrition for indigenous peoples) has the responsibility for promoting the strategy for good quality health services with cultural sensitivity and has been able to implement "Unidades de Salud Competentes"[259] (competent health units), which make health services culturally adequate (cultural infrastructure and equipment), incorporating medical sta□ with intercultural capacities, intercultural care of births and intercultural services including indigenous traditional medicine. The implementation of the National Health Program 2007-2012 has made it possible to promote integrated intercultural policies, increase the knowledge and use of traditional/ancestral medicines according to requirements of the population, as well as the application of mixed models for care that combine traditional/ancestral medicine with conventional medicine.

In Bolivia, successful experiences have been identified. These have been supported by the Ministry of Health and Sports (Ministerio de Salud y Deportes) and carried out by agencies for international cooperation together with public health institutions.[260] One case is from the Department of Potosí,[261] and its main components are the articulation of diverse health systems. Integrating

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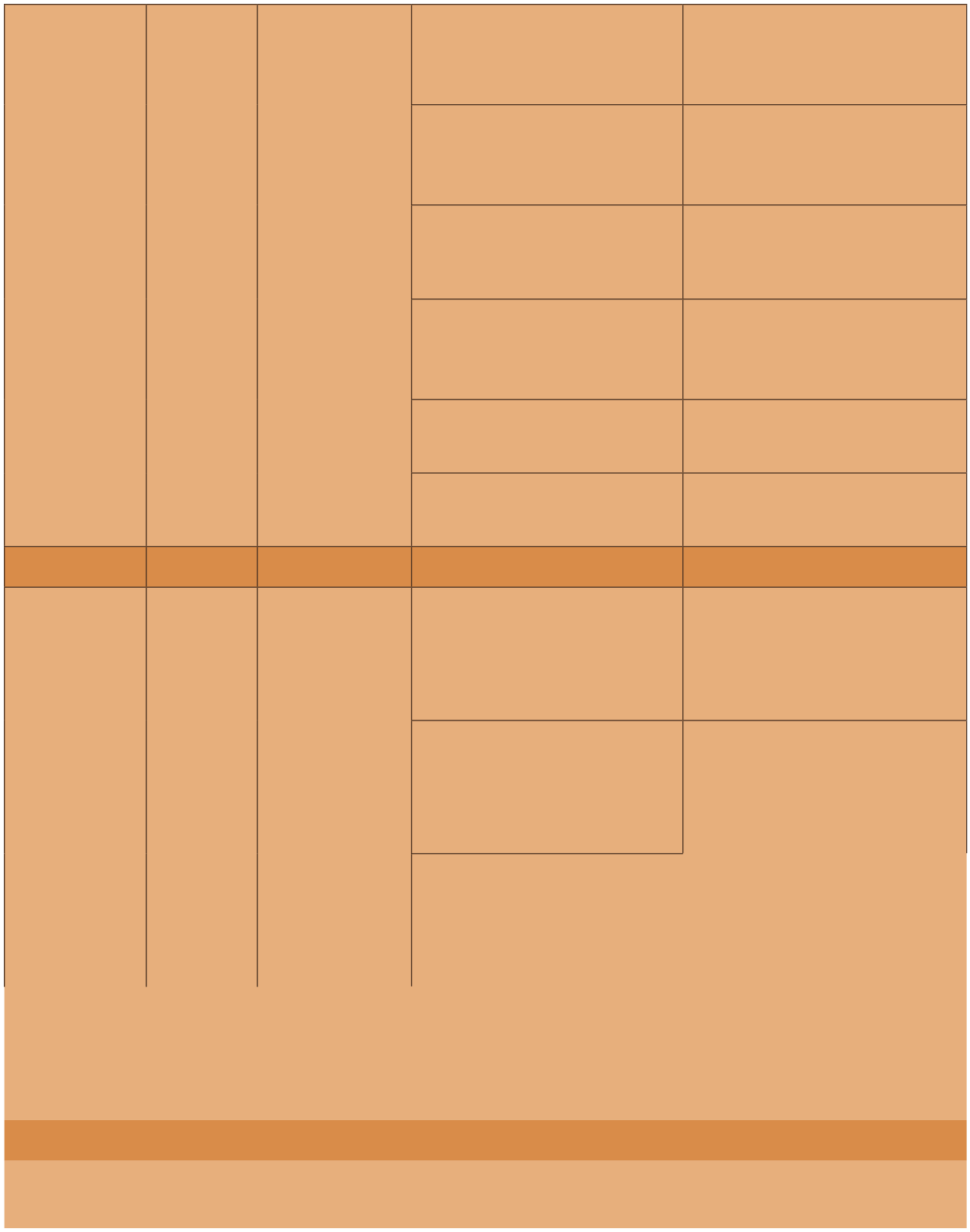
[255] Salud Intercultural: Crítica y problematización a partir del contexto boliviano, Susana Ramírez Hita, La Paz, ISEAT, 2011, pp. 31-38.

[256] Del Dicho al Hecho: Los avances un primer nivel de atención en salud incluyente, Medicus Mundi Navarra—Guatemala, Sacatepéquez, Guatemala, 2008, p.7: http://www.saludintegralincluyente.com/ftp/saludintegralincluyente/DOCU-

Table 1: Latin America: Overview of the process of incorporation of variables for the ethnic identification in continuous data registration regarding health

Country	Policy/ Program	Ethnic Identification (need to footnote short forms)	Registers/registries	Variables
Argentina	Yes	Yes (Pi)	Case history Perinatal case history	Self-identification
Bolivia	Yes	Yes (Pi)	Case history model SNIi Perinatal case history Snis Certificate for the recently born	Self-a□liation Spoken language Mother tongue
Brazil	Yes	Yes (Pi Y A)	Unified public health system	Ethnic and racial self-identification
		Si (Pi)	Family registry Forms for those seeking medical treatment Personal records Registration log book Monthly consolidated report of activities Forms for referral and cross-referral Vaccination registers	Territorial
Colombia	Yes	Yes (Pi Y A)	Case history	



Nicaragua	Yes	Yes		
Panama	Yes	N/A		
Paraguay	Yes	Yes	Basic case history	Ethnic group
			Registry of discharges from hospital	Ethnic group
			Daily register of people seeking medical treatment	Ethnic group
Peru	No	Yes	HIS system Daily register of people seeking medical treatment	Ethnic group
Bolivarian Republic of Venezuela	Yes	Yes	Primary care Immunization Epidemiologic records Register of people seeking medical treatment	Ethnic self-identification Race Ethnic group Indigenous peoples

Source: Ana María Oyarce, 2012.

In the case of surveys, an ◄8peop fthnlf-identificat havt

Conclusion

International and national frameworks exist for the protection of the rights of indigenous peoples, which authorize signatory states to ensure the application of the right to health by policy actions that promote health with an intercultural approach, providing health services with intercultural management and care, and fostering citizen participation of indigenous peoples in the analysis and decision-making on health.

However, despite the existence of international and national legal norms for the protection of indigenous peoples, health inequalities persist, which are characterized by 1) the prevalence of preventable diseases and illnesses easily solvable when addressed in a timely way; 2) barriers to both geographic and sociocultural access to high-quality and culturally relevant health services; 3) scant recognition of the wisdom and practices of the traditional medicines of indigenous peo-

Organize conferences, seminars and forums to allow for the understanding of the situation of health among indigenous peoples and the holistic process of connecting health, disease, care and healing from the perspective of di□erent world views to strengthen wisdom about traditional medicine and to define mechanisms for the interaction and complementary nature of traditional medicine and conventional medicine.

Support processes of community legitimization for traditional/ancestral physicians and to develop registers for indigenous therapists at the Ministry of Health, in coordination with indigenous organizations and indigenous peoples in each country.

Establish an intercultural epidemiological profile incorporating traditional diseases and health determinants for indigenous peoples.

Diasggregate data from databases to include analysis using the indigenous identifiers and ethnic variables in health registers for national information systems, to produce regular reports of the health situation according to the epidemiological profile of indigenous peoples and indicators for intercultural health management and care, information on the services provided by traditional/ancestral physicians and traditional midwives as part of the process of integral health information and the interaction of traditional/ancestral medicine, conventional medicine and other types of medicine existent in the territory.

Strengthen by specific and targeted capacity building measures the participation of indigenous peoples in the ongoing analyses of their health status, intercultural health management and care, articulation and harmonization of traditional/ancestral medicine with alternative medicine, conventional medicine and health promotion.

CEPAL/CELADE", Mortalidad infantil y en la niñez de pueblos indígenas y afro descendientes de

PAHO/WHO honors e□orts to improve gender equity in health in Latin America, 7 June 2013: http://www.paho.org/hq./index.php?option=com_content&view=article&id=8769%3Apahowho-honors-e□orts-to-improve-gender-equity-in-health-in-latin-america&catid=740%3Anews-press-releases&Itemid=1926&lang=en.

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Chapter Five

Access to Health Services: Bridging the Gap in North America

Introduction

This chapter on North America applies to the United States of America and Canada as per the Permanent Forum's seven sociocultural regions which gives broad representation to the world's indigenous peoples. In the United States, indigenous peoples are collectively known as Native Americans, which include American Indians and Alaska Natives as well as the people indigenous to Hawaii, or Native Hawaiians.[274] In Canada, the collective term aboriginal peoples refers to three groups namely, First Nations, Métis and Inuit defined by section 35 (2) of the Canadian Constitution Act 1982.

their own membership. Federally recognized tribes have reservations or other lands that have been left or set aside for them, over which they exercise their own powers of self-government.[278]

Many other groups in the United States that identify as indigenous peoples have not been federally recognized, although some of these have achieved recognition at the state level.[279] Today, according to the United States census, people who identify as Native American represent approximately 1.7 per cent of the overall population of the United States, with 5.2 million persons identifying as American Indian or Alaska Native.[280] It should be noted that this number significantly exceeds the number of those who are enrolled or registered members of federally recognized indigenous groups.

Canada

Membership and identification as an indigenous person in Canada is complex. Given limited space here, this chapter will briefly describe an overview of the membership categories. In the context of health services these categories determine access by government jurisdiction to a range of health services and program eligibility in areas including health and beyond health.

According to Statistic Canada's National Household Survey (NHS) in 2011, the total number of people who self-identified as indigenous peoples in Canada was 1.4 million, representing 4.3 per cent of the total Canadian population of 30 million inhabitants.[281] First Nations represent 60.8 per cent of the total aboriginal population and 2.6 per cent of the total Canadian population. Of the aboriginal population, 33 per cent are Métis and 4 per cent are Inuit. The greatest numbers of First Nations peoples live in Ontario and the western provinces including British Columbia, Alberta, Sasketchewan and Manitoba. The regions with the largest proportion of indigenous peoples in the total population are the Nunavut, the Northwest Territories, the Yukon Territory and the Provinces of Manitoba and Saskatchewan.

First Nations

Today, there are more than 600 federally recognized First Nations, 2,787 First Nation reserves (land set apart and designated as a reserve for the use and occupancy of an Indian group or band) across the country.[282] A significant number of indigenous peoples are not registered Indians under the Federal Government's 1876 Indian Act, which defines who is considered a "status Indian" or not, and the law stipulates specific criteria which must be met to determine whether an individual is eligible to receive a range of services and benefit from a range of programmes o□ered by federal and provincial government agencies.[283]

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278 James Anaya Report of the Special Rapporteur on the rights of indigenous peoples, The situation of indigenous peoples in the United States of America A/HRC/21/47/Add.1 30 August 2012 p. 5.

279 James Anaya Report of the Special Rapporteur on the rights of indigenous peoples, The situation of indigenous peoples in the United States of America A/HRC/21/47/Add.1 30 August 2012 p. 5.

280 U.S. Census Bureau, the American Indian and Alaska Native Population: 2012, pp. 1-3.

281 "An Overview of Aboriginal Health in Canada", National Collaborating Centre for Aboriginal Health p. 1.

282 Aboriginal Peoples in Canada in 2006: Inuit, Métis and First Nations, p. 9.

283 "An Overview of Aboriginal Health in Canada", National Collaborating Centre for Aboriginal Health p. 1.

In 2011, some 637,660 First Nations people were reported as Registered Indians, representing 74.9 per cent of all First Nations peoples, the remainder were non-status First Nations peoples who identify with a specific First Nations but do not meet the Indian Act membership criteria and

Historically, distinct Métis communities developed along the routes of the fur trade and across the Canadian Northwest within the Métis Nation Homeland. As stated above, this Homeland includes the three Prairie Provinces (Manitoba, Saskatchewan, Alberta), as well as, parts of Ontario, British Columbia, the Northwest Territories and the Northern United States. Today, manes of the fur trade and across the

First Nations, Inuit and Métis living in urban centres often find themselves excluded from many of the benefits and services that arise from the FNIHB. Indigenous peoples moving into or living in urban areas are faced with having to negotiate a range of health care provisions as they exit their community health networks and enter the provincially funded public health care system. While there are various successful, culturally appropriate urban initiatives across Canada, there remains a problem of inadequate assessment of health care needs and often there are very few resources to o□er appropriate services to the urban, and particularly the poor, women, men and children. Aboriginal women continue to search for services that are gender-sensitive, culturally appropriate and at the same time inclusive of their children.[300] For the northern territories of Nunavut, the Northwest Territories and the Yukon health services funding are allocated by the territorial governments.

Analysis of the Health Situation for Indigenous Peoples in USA and Canada

Overview

The appropriation and displacement of indigenous peoples from their lands and their subsequent marginalization from the rest of society is a historical reality with continuing repercussions today in the United States and Canada.[301] Indigenous peoples current social inequalities results from a combination of socioeconomic deficits that are ongoing such as colonization, globalization, and migration, loss of language and culture and disconnection from land. The severance of ties to their lands, can a□ect indigenous peoples' associated cultural practices and participation in traditional economies, all of which are essential for health and well-being.[302]

One of the most devastating consequences of colonialism in both the United States and Canada which are still felt today, was the forced assimilation policy involving the systematic removal of indigenous children from their families to place them in government or church-run residential or boarding schools, with the objective of expunging their indigenous identities. The Indian boarding or residential school policy which began in the 1880s continued well into the mid-1900s. That emotional, physical and sexual abuse occurred in boarding schools, as well as punishment for speaking their languages and practicing their cultures has been well documented, has been acknowledged and has tarnished the human rights record of Canada and the United States. The e□ects of boarding schools on generations of indigenous peoples, including generations still living and future generations, cuts deep in indigenous communities throughout the United States and Canada, where many believe are the root cause of pervasive social problems such as alcoholism and sexual abuse and the widespread loss of indigenous languages.[303] Negative memories of this institutionalization are thought to have created a social climate of distrust of other government-funded institutions such as hospitals and clinics, resulting in avoidance until an illness is advanced.

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300 Cecilia Benoit, Dena Carroll, Munaza Chaudhry "In search of a Healing Place: Aboriginal women in Vancouver's Downtown Eastside" Social Science & Medicine 56 (2003) 821-833, p. 831.

301 Carolyn Stephens, John Porter, Clive Nettleton, Ruth Willis " Disappearing, displaced and undervalued: a call to action for indigenous health worldwide", www.thelancet.com, Vol 367, June 17, 2006, p. 2023.

302 Malcolm King, Alexandra Smith, Michael Gracey " Indigenous Health part 2: the underlying causes of the health gap", www.thelancet.com, Vol 374, July 4, 2009, p. 76.

303 James Anaya Report of the Special Rapporteur on the rights of indigenous peoples, The situation of indigenous peoples in the United States of America A/HRC/21/47/Add.1 30 August 2012 p. 5.

diseases have been dramatically reduced through increased clinical care and public health e□orts such as vaccinations for infectious diseases and the construction of sanitation facilities, newer threats such as diabetes and other chronic conditions mean that indigenous peoples continue to experience health disparities and higher death rates than the rest of the population.[307]

The data on health disparities provided by the Indian Health Service's own fact sheets presents enormous health issues for Native Americans and Alaska Natives. Indigenous peoples born today have a life expectancy that is 5.2 years less than the US population of all races (72.6 years to 77.8 years, respectively). They also die at higher rates than other Americans from tuberculosis (500 per cent higher), alcoholism (514 per cent higher), diabetes (177 per cent higher), unintentional injuries (140 per cent higher), homicide (92 per cent higher) and suicide (82 per cent higher).[308]

Mortality disparity rates for American Indians and Alaska Natives (AI/AN) in the IHS Service Area 2005-2007 and U.S. All Races 2006 (age-adjusted mortality rates per 100,000 population)

	AI/AN rate 2005-2007	U.S. All races rate 2006	Ratio AI/AN to U.S. all races
All causes	953.7	776.5	1.2
Alcohol induced	45	6.9	6.5
Breast cancer	19.6	23.5	0.8
Cerebrovascular	43.8	43.6	1
Cervical cancer	2.8	2.4	1.2
Diabetes			

/Alcohol induced ET23 /56.9 0 jET EMC1911/MCID 6266 BDC BT10 0 0 10 239BT10 0 0 10 408

likely to occur during periods of socioeconomic, family and individual crisis (e.g. loss of a loved one, unemployment, sexual orientation, difficulties with developing one's identity, disassociation from one's community or other social/belief group and honour). Other factors include alcohol and drug abuse, access to firearms, exposure to domestic/family violence, physical health problems and less access to suicide prevention and intervention programs.[317]

The prevalence of diabetes is higher among the American Indian and Alaska Native population (16.5 per cent) than any other major racial or ethnic group in the United States, and the prevalence of diabetes has been increasing.[318] Diabetes kills roughly four times as many American Indians and Alaska Natives as it does members of the mainstream United States population.[319] In general, people are more likely to develop type 2 diabetes and die from its complications as they grow older, a pattern that is even more pronounced among American Indians and Alaska Natives.[320] Many people do not know they have type 2 diabetes until the symptoms of complications appear.[321] Indigenous peoples with diabetes are six times more likely than the general population to have kidney disease and between three to four times more likely to require lower-limb amputations. In this way, diabetes not only contributes to early mortality but it is among one of the leading causes of disability, contributing to unemployment and poverty. Gestational diabetes is also of great concern and is noted to occur more frequently among American Indian and Alaska Native women than women in other minority groups. Women who experience gestational diabetes have a 20 to 50 per cent chance of developing type 2 diabetes in 5 to 10 years after pregnancy.[322] Children whose mothers had diabetes during pregnancy are at increased risk of developing type 2 diabetes themselves.

In April 2007, Amnesty International issued a report entitled Maze of Injustice: The failure to protect Indigenous women from sexual violence in the United States. The report confirmed what Native American and Alaska Native advocates have long known: that sexual violence against indigenous women is at epidemic proportions and that survivors are frequently denied justice. The United States Department of Justice's own statistics indicate that Native American and Alaska Native women are more than two and a half times more likely to be raped or sexually assaulted than women in the United States in general and that 86 per cent of the reported crimes are committed by non-Native men. Health Service providers have a key role to play in providing survivors with medical attention

examinations. IHS also lack clear protocols for treating victims of sexual violence, are severely underfunded and lack personnel trainers to provide services in the event of sexual violence.[323]

Age-adjusted percentages of persons 18 years of age and over with diabetes, 2004-2008

	American Indian/ Alaska Native	White	American Indian/ Alaska Native/white ratio
Men and women	17.5	6.6	2.7
Men	18.2	7.2	2.5
Women	16.2	6.2	2.6

Source: CDC 2010. Health Characteristics of the American Indian and Alaska Native Adult Population: United States, 2004-2008.

Radioactive tailings are one of the major concerns for many indigenous peoples living near abandoned uranium mines on tribal lands. The first major uranium mine in the United States was started in 1953 near Laguna Pueblo, New Mexico.[324] Since that time there have been over 15,000 uranium mines with a majority of those being on indigenous peoples' lands. Most of the other mines lay abandoned with radioactive tailings and dust present at almost all of them. Most of the mining has been on the Colorado Plateau, but other areas in Washington State and the Dakotas have also been impacted. Indigenous peoples have had their water sources impacted by the radioactive tailings from the mine operations. A large part of the workforce for these mines included a large

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was still 13.0 per cent which was more than 2.5 times higher compared to non-indigenous people (5.2 per cent).[332]

Indigenous peoples in Canada face many urgent health issues. For example, indigenous Canadians are overrepresented in HIV infection rates. Indigenous peoples are especially vulnerable to HIV infection when compared the general Canadian population due to poor access to health services, high rates of poverty, substance abuse, intravenous drug use and also tattooing. While indigenous peoples account for 4.3 per cent of the total Canadian population, they account for 8 per cent of people living with HIV and 12.5 per cent of new infections in 2008. Indigenous peoples also experience disproportionately high rates of tuberculosis at 2

diverse, youthful and growing population.[339] Despite their growing numbers, urban aboriginal people in Canada continue to earn far below the median average income for non-urban counterparts. Urban aboriginal people also tend to have comparatively higher rates of homelessness, greater housing needs and higher rates of suicide and are particularly at risk of substance abuse, contracting tuberculosis and/or HIV or developing diabetes. This indicates that many aboriginal people, especially those residing in urban areas, are in danger of falling through the cracks of the Canadian health care system and social security safety net.[340]

Other examples where the underlying causes or determinants of health are most felt is the experience of the Indian residential school system survivors. In Canada and the United States, as well in other colonized nations, many generations of indigenous children were sent away from parents and their communities to residential schools. The e□ect of this experience is collective trauma, consisting of, the structural e□ects of disrupting families and communities; the loss of parenting skills as a result of institutionalization; patterns of emotional response resulting from the absence of warmth and intimacy in childhood; the carryover of physical and sexual abuse; the loss of indigenous knowledge, languages and traditions; and the systemic devaluing of indigenous peoples' identity. The legacies of these and other policies of forced assimilation are also seen in the present relationships of indigenous peoples with the larger society.

The situation of indigenous women in Canada remains a serious social issue and a major concern. According to Canadian government statistics, indigenous women are five times to seven times more likely than other women to die as the result of violence. The Native Women's Association of Canada, through its own hard work, documented more than 582 cases of missing and murdered indigenous women in Canada, most within the last three decades. Due to the gaps in police and government reporting, the actual numbers may be much higher.[341]

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populations resides, food insecurity in 2007-2008 was 11.6 per cent, 12.4 per cent and 32.6 per cent respectively. Health Canada,[346] The Special Rapporteur also stated that First Nations Regional Longitudinal Health Survey (RHS 2008-2010) indicates that 17.8 per cent of First Nations adults (ages 25-39) and 16.1 per cent of First Nations adults (ages 40-54) reported being hungry, but did not eat due to lack of money for food in 2007-2008.[347]

Access to health services in the United States and Canada

Indigenous peoples in the United States and Canada do not have easy access to basic western health care when needed. Access is constrained by financial, geographical and cultural barriers. Indigenous peoples tend to be low on Government priority lists, especially when they live in remote areas where services are di□cult and costly to provide. When services are available, indigenous peoples are often reluctant or afraid to use them because sta□ can be insensitive, discriminatory and unfriendly.

In Canada, within the fly-in or isolated communities, some indigenous women are required to fly over a thousand kilometres to reach a hospital in order to give birth, have a tooth extracted or treat and illness. Many have never left their community before and there is a reluctance to do so in many cases. Even when a□ordable health services do exist within indigenous communities, they are often of lower quality than services available for non-indigenous peoples. While health care priorities may be set by the Government may do not match the priorities of indigenous communities, there has been some progress made in terms of indigenous peoples and their communities' managing and administering their own health care systems.[355]

In Canada, there c5

souls of their community members. Sweat lodge ceremonies have been used to treat alcoholism, post-traumatic stress disorder in both white and Native veterans. Prisons in several states have allowed indigenous inmates to practice sweat lodge and other tribal religious ceremonies as part of their rehabilitation.

Traditional medicine is a very important part of First Nations health that is almost always overlooked by the health care system. Traditional medicine uses a holistic model of well-being through the integration of emotional, physical, mental and spiritual aspects of being. Even though specific practices vary between di□erent tribes, all traditional medicine is based on the understanding that humans are part of nature and health is a matter of balance. Therefore, there is respect for the land and all of her o□erings. Traditionally, elders understood the importance of respecting and using their environment for foods, medicines, and ceremonies for overall health.

In September 2009, the First Nations Health Society, on behalf of the First Nations Health Council conducted an environmental scan to gather information from the 123 First Nations Health Centres in British Columbia Canada, on traditional models of wellness (or traditional practices and medicines). This project is aimed at providing background information for the FN Health Society to undertake further work, if needed, on promoting traditional models of wellness within British Columbia for First Nations.

During the environmental scan on traditional models of wellness, such models of wellness were defined as having a healthy mind, body and spirit and that wellness from a traditional perspective encompassed a person feeling well emotionally, physically and spiritually and leading a healthy lifestyle, which involved connection to the land and one's culture and beliefs. Maintaining wellness involved carrying out traditional practices of the community such as fishing, hunting, berry gathering and participating in healing circles, sweats, drumming and learning the language. Identity and connection to culture were seen as integral to maintaining wellness from a traditional perspective.

Conclusion

Indigenous peoples in North America have long experienced lower health status when compared with the rest of the population. Lower life expectancy and the disproportionate disease burden exist because of inadequate education, disproportionate poverty, discrimination in the delivery of health services, and cultural di□erences. These are broad quality of life issues rooted in economic adversity and poor social conditions.

Indigenous health is at a crisis and there is an urgent need for a more holistic vision of health and health intervention driven by indigenous peoples' own vision of health and well-being. Further research and action, driven by indigenous peoples themselves is required at the international and national levels but most importantly at the local levels as well.

Commentators and Scholars across all sectors of the health studies of indigenous peoples concur

torical indigenous societies needs to be restored as an intervention to begin to addictions and the epidemics of preventable conditions facing indigenous peoples.

In spite of the considerable health issues and challenges outlined above, indigenous peoples continue to demonstrate resilience and strive for wellness based in indigenous ways of knowing and being. Indigenous peoples' approaches to health are often rooted in a healthy balance of four elements or aspects of wellness: physical, emotional, mental and spiritual. These four elements are sometimes represented in the image of the medicine wheel.[366]

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Chapter Six

Access to Health Services by Indigenous Peoples in the Pacific Region

Introduction

This chapter addresses indigenous peoples' access to health services in the Pacific region. It provides a background of the historic, political and cultural factors which have shaped events in the various countries, and influenced the health status of indigenous peoples in the Pacific region. It describes the current health situation, social determinants of health, health service funding and delivery, major challenges as well as the initiatives that have been shown to be effective in improving indigenous peoples' access to all levels of health care.

The Working Group on Indigenous Populations Working paper on the concept of "indigenous people" lists the following factors that have been considered relevant to the understanding of the concept of "indigenous" by international organizations and legal experts:[367]

> Priority in time, with respect to the occupation and use of a specific territory;
>
> The voluntary perpetuation of cultural distinctiveness, which may include the aspects of language, social organization, religion and spiritual values, modes of production, laws and institutions;
>
> Self-identification, as well as recognition by other groups, or by state authorities, as a distinct collectivity;
>
> An experience of subjugation, marginalization, dispossession, exclusion or discrimination, whether or not these conditions persist.

Self-identification as indigenous or tribal is considered as a fundamental criterion and this is the practice followed by the United Nations. Article 33 of the United Nations Declaration on the Rights of Indigenous Peoples refers to the right of indigenous peoples to decide their own identities and procedures of belonging.

The Pacific region includes indigenous peoples of the Pacific Ocean which stretches between the Southern Ocean, Asia, Australia, and North and South America. Thousands of islands are spread across this expanse, which adds to the region's considerable geographical, cultural, and linguistic diversity. For example, the region accounts for only a tiny fraction of the global population, but it

[367] http://www.ohchr.org/EN/Issues/IPeoples/Pages/WGIP.aspx.

contains close to a quarter of the world's languages.[368] Some of the indigenous peoples of the Pacific are well known e.g. Maori in Aotearoa/New Zealand, but the needs of others are less well recognized e.g. Kanaks of New Caledonia. According to the sociocultural regions of the United Nations Permanent Forum on Indigenous Issues, the Pacific is seen to include Australia, New Zealand, Papua New Guinea, the province of West Papua, the small island states of the Pacific region, including the Federated States of Micronesia, the Northern Mariana Islands and Marshall Islands, the indigenous peoples of Hawaii as well as indigenous peoples of Rapa Nui (Easter Island). For the purposes of this chapter the regions of Asia and North America are covered elsewhere in this publication.

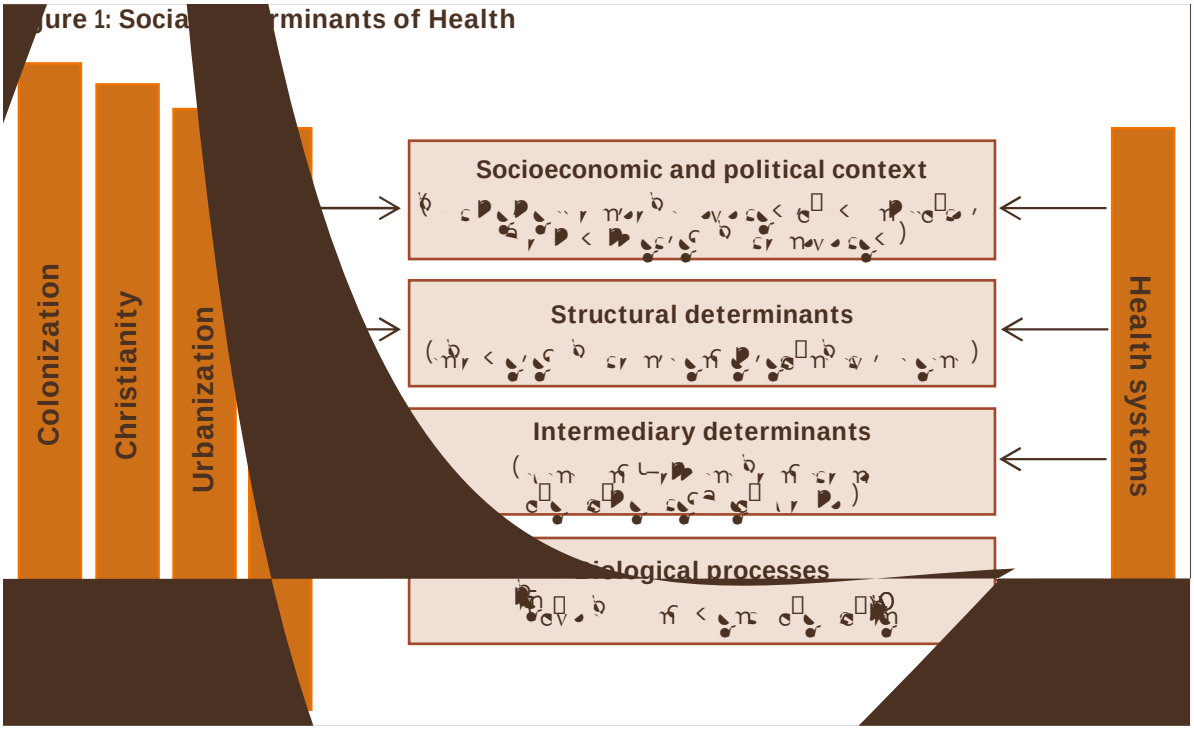
Colonized by European powers relatively late in global terms, the Pacific indigenous peoples were also among the last to be decolonized. Since the early 1960s the process of decolonization has created independent small island States (Fiji, Kiribati, Nauru, Papua New Guinea, Samoa, Solomon Islands, Tonga, Tuvalu, Vanuatu). It should be noted that Tonga is the only Pacific island country not formally colonized by a foreign power. Other countries remain as territories or self-governing states in "free association" with a former colonial power (American Samoa, Cook Islands, Federated States of Micronesia, French Polynesia, Guam, Marshall Islands, New Caledonia, Niue, Northern Mariana Islands, Palau and Tokelau).[369]

The Pacific islands are a culturally diverse region and indigenous peoples have distinct cultures that have existed for thousands of years and have unique systems of knowledge and understanding, such as those related to ocean navigation, vessel construction and traditional medicines. Pacific peoples, especially those who still live in the islands are more likely to speak their mother tongue and view their culture as something that is lived and continuously demonstrated. In contrast, political and economic transformations have displaced large numbers of Pacific people who have moved away from their home islands to inhabit a diaspora spanning the globe, from Australia and New Zealand to Europe and North America. There are also communities of Pacific peoples living on other islands, creating further cultural diversity in an already complex region. Pacific peoples today as in the past have adopted a number of creative survival strategies in the face of rapid cultural, social, political, and economic transitions. Among these are abilities to navigate multiple worlds that might include both Christian and indigenous spiritual practices, western and indigenous lifestyles, and western and "traditional" political and economic structures, while still maintaining a commitment to family and community relations.

Indigenous peoples in the Pacific region have unique characteristics that reflect their local situations but they also share a number of characteristics with other indigenous peoples globally, such as:

> The diversity of languages and cultural practices, although some similarities are seen where indigenous peoples share common origins e.g., the Maori of New Zealand, Native Hawaiians in Hawaii and Maori in the Cook Islands.

part of increased incidence of non-communicable diseases (NCDs). Cardiovascular diseases are


ure 1: Socia rminants of Health
Colonization
Christianity
Urbanization
Socioeconomic and political context
Structural determinants
Intermediary determinants
iological processes
Health systems

judiciary. Indigenous peoples are underrepresented in most professions although there are several a□rmative action training programmes with encouraging results in New Zealand.[382,383] In the ma-

Urbanization

Rapid industrialization of New Zealand and Australia following the Second World War saw increased migration from rural areas to cities and urban areas for work. Maori peoples in New Zealand best exemplify the urban migration by indigenous peoples in the Pacific. Before the Second World War (pre 1939), over 80 per cent of Maori were living in rural areas, primarily within their own tribal districts. For most Maori it was a deliberate migration in search of what has been described as "the Big Three": work, money and pleasure. In the beginning, the majority of migrants were unmarried young Maori looking for a more "modern" life. By the 1960s families had begun to migrate in significant numbers. The government had also realized that the economic future of most Maori lay in the larger towns and cities. The Hunn Report of 1961, made recommendations for social reforms of the Maori as "relocation" of Maori became o□cial policy and rural Maori families were encouraged to move to the cities with the provision of accommodation, employment and general assistance in adjusting to a new life. The urban migration of Maori has been described as the most rapid movement of any population in the world. In 1945, 26 per cent of the Maori population lived in the towns and cities. By 1956 this had increased to 35 per cent. The urban population grew to 62 per cent in 1966, and reached nearly 80 per cent by 1986. Today, 84 per cent of Maori live in urban areas.[390]

Urbanization is a two-edged sword with risks and benefits. Migration to urban areas is usually associated with increased isolation from family, land, language, traditions and cultures but urbanization also improves education, employment prospects and socioeconomic circumstances of many indigenous families. While urbanization can improve the socioeconomic circumstances of many people, it can often be di□cult to find employment with an adequate level of income needed for city living. When indigenous peoples migrate to urban areas, links with the "home area" remain but may weaken over time as families develop new lifestyles in urban areas. In recent times, some indigenous people have returned "home" to their tribal lands, partly in response to increased unemployment in the cities as a result of the global financial crisis.

Globalization

Globalization is an important influence on the health status of indigenous peoples especially since the mid-1990s. New Zealand, Australia and the United States are among the world leaders in promoting free trade. In simple terms, globalization is the free flow of goods, ideas and services across national borders. Globalization is a process by which national and regional economies, societies, and cultures have become integrated through the global network of trade, communication, immigration and transportation.[391] Globalization was often primarily focused on the economic side, such as trade, foreign direct investment and international capital flows but more recently the term has been expanded to include a broader range of areas and activities such as culture, media, technology, sociocultural and political factors.[392]

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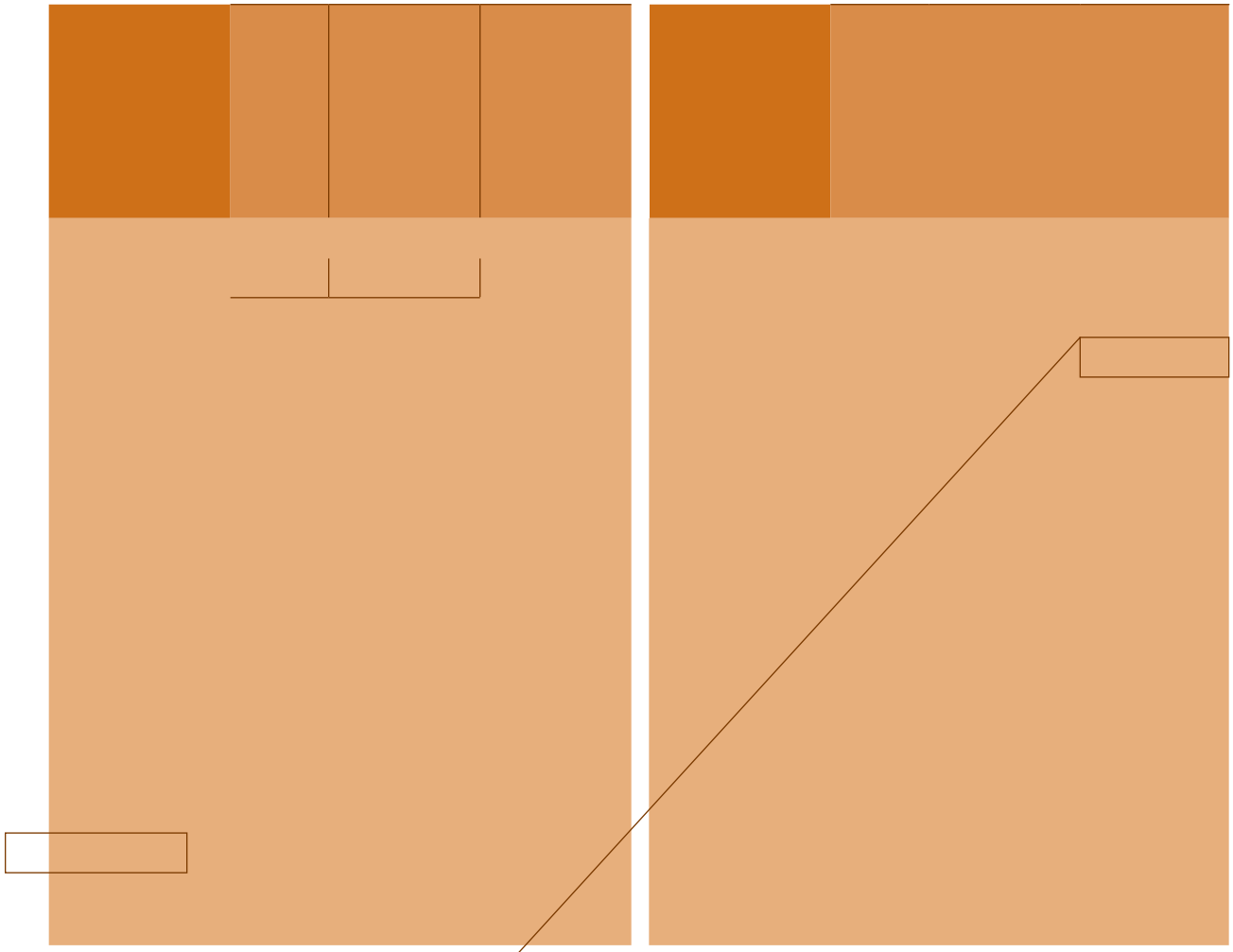
390 "Urbanisation—Urban Mā ori –". Te Ara Encyclopedia of New Zealand. http://www.teara.govt.nz/en/urban-maori/page-1 (accessed 04/10/2013).

391 Globalisation and Trade, retrieved 04/10/2013 from http://www.wto.org/english/res_e/booksp_e/anrep_e/wtr08-2b.

392 "Definition of globalisation". Financial Times Lexicon. http://lexicon.ft.com/Term?term=globalisation (accessed 4/10/2013).

Table 1 and 2: Pacific-born doctors and nurses in Australia and New Zealand by country to the domestic workforce



Pacific region are in worse health than the general population in both the developed and developing countries alike.

Malnutrition and undernutrition are common within the region with more than one fifth of children and pregnant women being anemic. Iron deficiency anemia a□ects more than 25 per cent of the general population. This has a direct impact on the productivity of the workforce as well as an immediate e□ect on one's sense of well-being and stamina and yet can easily be rectified. In Fiji, Papua New Guinea and Vanuatu, iodine deficiency and related goitre are endemic although, in Fiji and Papua New Guinea, great progress has been made recently through salt iodization. About 40 per cent of the Pacific island region's population has been diagnosed with a non-communicable disease, notably cardiovascular disease and hypertension and cancers, which are on the increase and are being diagnosed in younger people.[398] These diseases account for three-quarters of all deaths across the Pacific archipelago and 40-60 per cent of total health care expenditure. Infectious diseases such as malaria, leprosy, filariasis, tuberculosis, hepatitis and sexually transmitted infections including HIV/AIDS in some islands are major health issues. These can be controlled through environmental and public health measures.[399]

In many areas of the Pacific region, the inadequacy of communication and infrastructure and lack of access to health care also result in indigenous women dying from the complications of pregnancy and childbirth at rates which approach those in sub-Saharan Africa. However, despite this, birth rates in the region are high. Coupled with greater infant and childhood survival, population growth rates are high. Furthermore between 40 per cent and 50 per cent of the population of some countries are less than 15 years old. Young people in some societies are sexually active early, but this occurs in the absence of informed choices about behaviour and responsibility. Consequently, there are high rates of sexually transmitted infections and teenage pregnancy with its consequential physical and social risks including HIV.

Maori peoples have the poorest health of any population group in New Zealand. In 2012, life expectancy at birth for Maori men was 72.8 years, while life expectancy at birth for non-Maori men was 80.2 years. Life expectancy at birth for Maori women was 76.5 years, while life expectancy at birth for non-Maori women was 83.7 years. Avoidable death rates are almost double for Maori than for other New Zealanders, and Maori die, on average, eight-ten years earlier. Maori have a higher mortality rate than non-Maori as well as higher rates of illness. For example, excess cancer deaths among Maori account for two-thirds of the excess male cancer deaths and one-quarter of the excess female cancer deaths in New Zealand, compared to Australia.[400]

Inequalities in overall Maori health persist even when confounding factors such as poverty, education and location are eliminated, demonstrating that cultural or biological factors or something about the lived social experiences, seemingly specific to Maori theoretically exert an independent influence as an indigenous determinant of health. It is also likely that part of the cause if unequal access to health services and medical treatment and care.

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398 "Pacific Islanders Pay Heavy Price for Abandoning Traditional Diet". Bulletin of the World Health Organization 88 (7 July 2010): 484-485.

399 http://www.who.int/bulletin/volumes/88/7/10-010710/en/

400 Jansen P, Jansen D 2013. Māori and Health. Chapter 5 in St George IM (ed.). Cole's medical practice in New Zealand, 12th edition. Medical Council of New Zealand, Wellington.

Maori women have rates of breast, cervical and lung cancer that are several times those of non-Maori women. There is high incidence of obesity in the Maori community, which contributes to the higher incidence of diabetes, and the younger age of diagnosis. Maori have lower access to medical care and rehabilitation services when compared with non-Maori. Even though Maori turn up for general practitioner appointments at the same rate as non-Maori, they obtain fewer diagnostic tests, less e□ective treatment plans and are referred for secondary or tertiary procedures at significantly lower rates than non-Maori patients.[401]

ment of land, law and economic activities. In addition to the impacts of introduced diseases and conflict, colonization of indigenous peoples' lands undermined the ability of indigenous peoples to lead healthy lives by devaluing their culture, destroying their traditional food base, separating families and dispossessing whole communities. This loss of autonomy undermined social vitality, which, in turn, a□ected the capacity to meet life's challenges, including maintaining health as a vicious cycle of dispossession, demoralization and poor health was established.

These impacts on indigenous peoples eventually forced colonial authorities to try to "protect" remaining indigenous people. This pressure led to the establishment of Aboriginal "protection" boards, the first established in Victoria by the Aboriginal Protection Act of 1869. A similar Act established the NSW Aborigines Protection Board in 1883, with the other colonies also enacting legislation to "protect" indigenous populations within their boundaries. The "protection" provided under the provisions of the various Acts imposed enormous restrictions on the lives of many indigenous peoples. These restrictions meant that, as late as 1961, in eastern Australia "nearly one-third of all Australians recorded as being of Aboriginal descent lived in settlements". The provisions of the Acts were also used to justify the forced separation of indigenous children from their families "by compulsion, duress or undue influence". The National Inquiry into the separation of the children concluded that "between one in 3 and one in 10 Indigenous children were forcibly removed from their families and communities in the period from approximately 1910 until 1970". It was the 1960s, at the earliest, when the various "protection" Acts were repealed.[405]

The health status of Australia's indigenous peoples is poor in comparison to the remainder of the Australian population.[406] There remains a large inequality gap in Australia across all health and social statistics. For example, for all age groups below 65 years, the age-specific death rates for indigenous Australians are at least twice those experienced by the non-indigenous population. The causes of death with the largest contribution to excess mortality among indigenous males are circulatory diseases, cancers, injuries, respiratory diseases and endocrine, metabolic and nutritional disorders. The indigenous male death rates due to external causes (injuries) were more than three times those for non-indigenous males aged 25 to 44 years.[407]

Between 2004 and 2008, two-thirds (66 per cent) of indigenous deaths occurred before the age of 65 years compared with 20 per cent of non-indigenous deaths. [illegible] (indigenous) 65 y) 13 (ears c

health services relative to need.[408] The 2012-2013 National Australian Aboriginal and Torres Strait Islander Health Survey (NATSIHS) is the largest survey of indigenous Australians health status, and results are being released progressively during 2013-2014.

While there have been improvements on some measures of indigenous health status, they have not matched the rapid health gains made in the general population in Australia. For example, death rates from cardiovascular disease in the general population have fallen 30 per cent since

siderably over the past several decades, prevalence rates among Native Hawaiians have remained elevated by comparison with other groups.

Figure 2. Current smoking among adults by demographic characteristics in Hawaii[418]

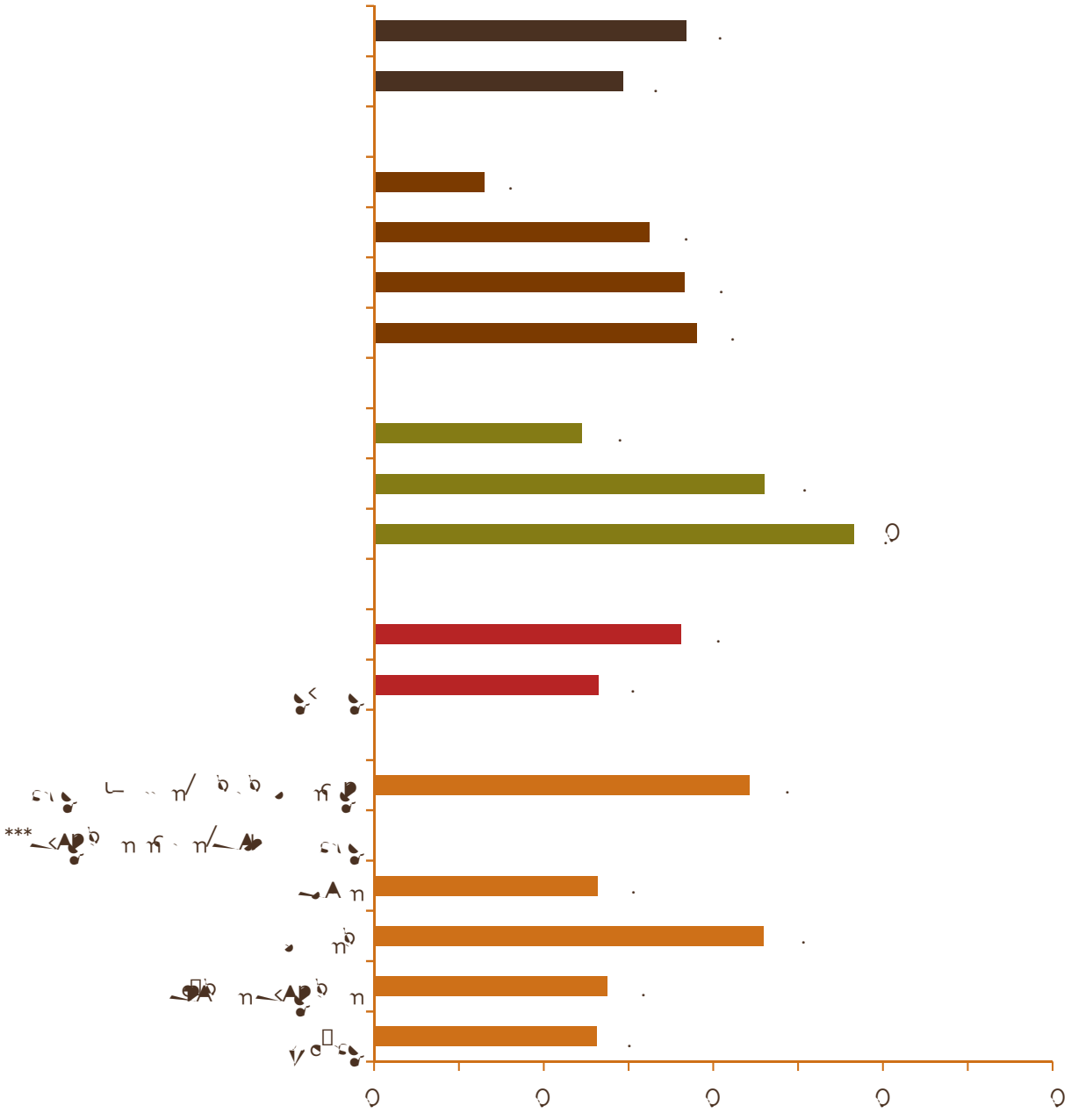
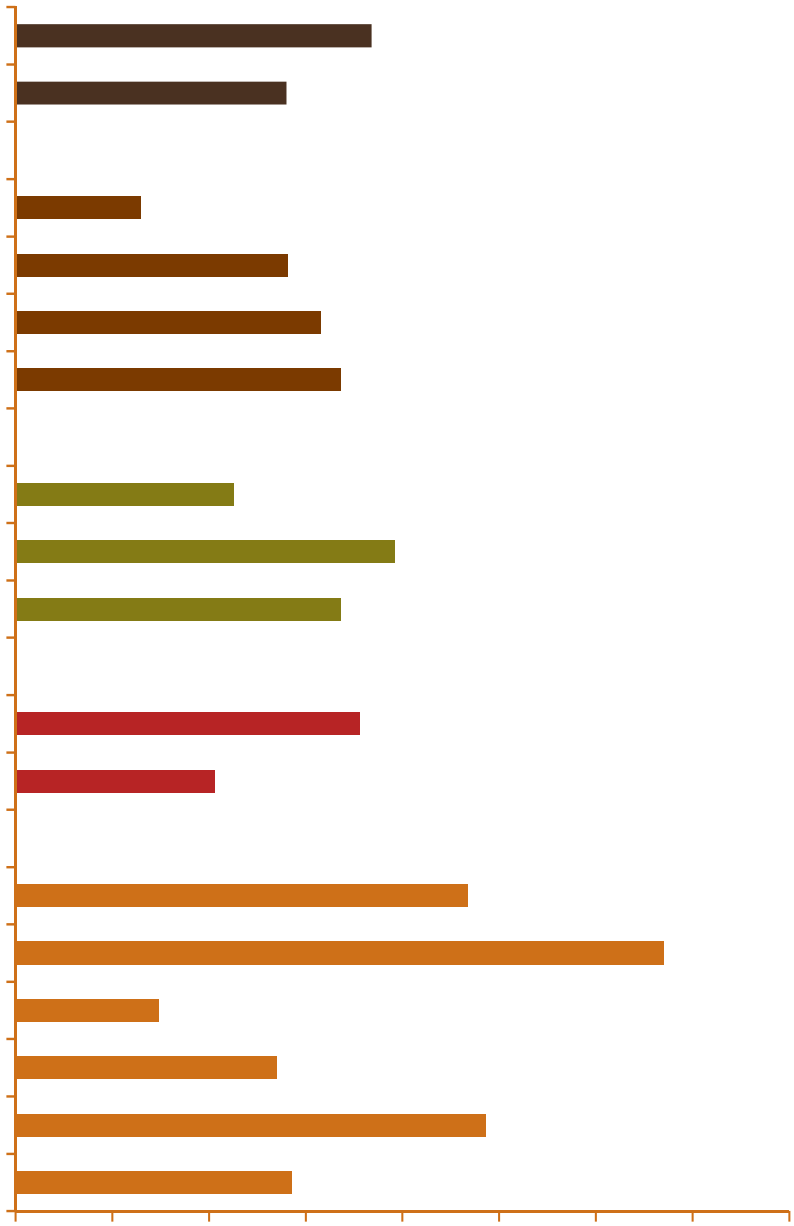


Figure 3. Current smoking among adults by demographic characteristics in California[419]



programmes, and to administer funding to Aboriginal and Torres Strait Islander community controlled clinics. IHSDD funds a comprehensive range of services for indigenous Australians with the aim to close the gap in health outcomes within the 2013-2023 decade. The aim is to provide coordinated clinical care, population health and health promotion programs for disease prevention, early intervention and e□ective disease management. The IHSDD pursues a three way approach, namely;

to improve access to, and responsiveness of the mainstream health system;

to ensure complementary actions through Aboriginal and Torres Strait Islander specific health initiatives;

to increase collaboration across governments and the health sector to improve service delivery and health outcomes.

The National Aboriginal Community Controlled Health Organization (NACCHO)

NACCHO was established in 1992 and is a peak body on Aboriginal health representing the interests of Aboriginal Community Controlled Health Services (ACCHSs). ACCHSs deliver a range of services to meet the complex health needs of indigenous Australians. ACCHSs plays a central role due to the religious, cultural, spiritual and social needs including provision of culturally appropriate primary health care services specific to the needs of local communities. ACCHSs aims to respond to the unique needs of indigenous Australians through a network of centres throughout Australia. Examples of ACCHSs initiatives include the Aboriginal Health Worker Forum, the Kimberley Aboriginal Medical Services Council Inc., Nunkuwarrin Yunti of SA Inc., Wu Chopperen Social Health Programme in Cairns and others. In 2013, NACCHO launched the HEALTHY FUTURES 10-point plan 2013-2030, which outlines priorities and strategies for ACCHSs, government and other stakeholders for improving the health of indigenous Australians.[431] The plan includes a range of measures including research, funding and support for the workforce to deliver innovative and comprehensive primary health care.[432]

Like most indigenous societies, indigenous Australians have a rich and sophisticated system of traditional medicine and healing practices. Traditional medicine practice (TMP) by indigenous Australians encompasses a holistic world view, which recognizes good health as a complex system involving interconnectedness with the land, spirit and ancestry and the connectedness of social, mental, emotional and physical well-being of the individual and community. A recent review of the role of TMP in primary care within Aboriginal Australia showed that the practices were used concurrently or sequentially with conventional health care services.[433]

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[431] Investing in Healthy Futures for Generational Change, retrieved from 10/10/2013 from http://www.naccho.org.au/download/naccho_health_futures/NACCHO%20Healthy%20Futures%2010%20point%20plan%202013-2030.pdf.

[432] "Aboriginal Male Healthy Futures for Generational Change". National Aboriginal Community Controlled Health Organisation. N.p., 1 Aug. 2013. Web. 28 Feb. 2014. http://www.naccho.org.au/download/naccho_health_futures/A%20Blueprint%20for%20Aboriginal%20Male%20Healthy%20Futures%20.pdf.

[433] Oliver S. The role of traditional medicine practice in primary health care within Aboriginal Australia: a review of the literature. Journal of Ethnobiology and Ethnomedicine 2013, 9:46 doi:10.1186/1746-4269-9-46.

risk factors and cultural barriers a□ecting the health conditions of Native Hawaiians.[438] The Molokai Diet study has served as a model for current traditional Hawaiian Diet Programs such as the Waianae Diet Program and the Waimea Diet Program.[439]

The aggregation of Native Hawaiian smoking data with that of Asians has drawn attention away from the serious smoking problems that Native Hawaiians experience, thus, limiting funding, programs, and policies to reduce tobacco-related health disparities in their respective communities. In California, community-based organizations (CBOs) have played a major role in supporting the state's comprehensive tobacco control program, which is arguably one of the most successful in the nation. One study described the tobacco control activities of five Native Hawaiian serving CBOs in Southern California and how they have provided anti-tobacco education for thousands of Native Hawaiians, Chamorros, Marshallese, Samoans, Tongans, and other Pacific Islander subgroups, and used advocacy and coalition building to promote smoke-free environment policies in their communities. The concerted e□orts of the CBOs and their community members have made vital contributions to the reduction of tobacco-related disparities for indigenous populations in California.[440]

Small islands of the Pacific

In most of the small islands of the Pacific, governments are the main funders and providers of health services.[441] Several small island states spend less than 5 per cent of GDP on health care services. It is generally accepted that health expenditure above this threshold is required in order to ensure the availability of basic health care services.[442] Rural areas and outer islands tend to have lower availability of health care services and residents need to travel to cities and urban areas for health care.[443] Most small island states are struggling to fund and provide health care services as a result of a growing and ageing population as well as the demands caused by people with NCDs, including costly complications such as kidney failure needing dialysis. NCDs have become the major causes of costly o□-island referrals.[444]

Discussion

Indigenous peoples in the Pacific region have similar health status, due in large part to their shared colonial history and health determinants. Socioeconomic determinants of health are part of the environmental causes of ill health that a□ect population health. They point to evidence that highlights higher susceptibility to illness and disease as a product of particular socioeco-

nomic and physical environments. The social determinants of health are the conditions in which people are born, grow, live, work and age. These circumstances are shaped by the distribution of wealth, power and resources at global, national and local levels.[445,446] "The inequity is systematic, produced by social norms, policies and practices that tolerate or actually promote unfair distribution of and access to power, wealth and other necessary social resource(s)".[447] This statement by Michael Marmot acknowledges that there are larger "causes of causes", or distal determinants, of unhealthy life conditions. At an International Symposium on the Social Determinants of Indigenous Health,[448] it was demonstrated that the determinants of indigenous health di□er from those of the mainstream population. This is in part due to how health is conceptualized amongst indigenous peoples compared to Western, biomedical definitions

Indigenous populations were relatively large prior to contact with European settlers but conflict and diseases led to sharp declines in the numbers of indigenous peoples, especially those living in New Zealand, Australia and Hawaii, threatening the very existence of indigenous peoples. The increase in population numbers has led to the revival of interest in their languages and cultures and interest from the wider society within all three countries. Loss of languages and cultures were a result of intentional and unintentional actions by the colonizers, often with oppressive regulations and legislations aimed at assimilation into the body politic of the developing nation states. While some aspects of indigenous cultures are being celebrated, they continue to experience the poorest health status with higher rates of preventable disease and disability and premature death in the Pacific region.

Universal access to health care services in New Zealand is an integral part of the welfare and health policies but the Maori peoples have had generally low access to health care at all levels. Successive New Zealand Health Surveys have shown that Maori generally have lower access to health care despite having higher health needs. The establishment of Maori health care providers has improved the availability of primary and community health care services, but the impact on health outcomes remains unclear and needs to be carefully evaluated. Most Maori peoples continue to receive health care from mainstream health care providers. Early indications are encouraging in that 65 per cent of the caseload for Maori health providers is regarded as high need compared with mainstream providers where their "high needs" population base is 26 per cent. There is evidence of improved access to primary and community health care services primarily as a result of the changes to the criteria for universal access and availability of low-cost clinics, for example; Maori health providers also have a strong presence in rural communities where the majority of the resident population tends to be Maori.[449]

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445 Commission on Social Determinants of Health retrieved 10/10/2013 from http://www.who.int/social_determinants/the commission/en/index.html.

446 Social determinants of health, retrieved 10/10/2013 from http://www.who.int/social_determinants/B_132_14-en.pdf.

447 Commission on Social Determinants of Health retrieved 10/10/2013 from http://www.who.int/social_determinants/the commission/en/index.html.

448 Social determinants and Indigenous health, retrieved 10/10/2013 from http://www.who.int/social_determinants/resources/indigenous_health_adelaide_report_07.pdf.

449 Ellison-Loschmann L, Pearce N. Improving access to health care among New Zealand's Maori population. American Journal of Public Health. 2006;96:612-617.

The relatively profound socioeconomic disadvantage experienced by indigenous peoples in Australia compared to non-indigenous people places them at greater risk of exposure to behavioural and environmental health risk factors. Indigenous peoples also do not enjoy equal access to primary health care services and health promotion and disease prevention public health community level infrastructure including safe drinking water, e□ective sewerage systems, rubbish collection services and healthy housing. The Royal Australasian College of Physicians describes these health inequities as "both avoidable and systematic".[450]

The Native Hawaiian Health Care Improvement Act (NHHCIA), as amended is a Congressional Special Initiative with the purpose of improving provision of comprehensive disease prevention, health promotion, and primary care services to Native Hawaiians in Hawaii. The NHHCIA authorizes funding opportunities for the following activities:

> Service grant to Papa Ola Lokahi (POL) for the activities described in the NHHCIA, including the coordination of the health care program and services provided to Native Hawaiians;
>
> Service grants to the five recognized community-based Native Hawaiian Health Care Systems (NHHCS) to provide a full range of services identified by the legislation and tailored to fit the needs of their respective island communities.

The Hawaii Health Authority (HHA), which was established by the Hawaii Legislature as part of the state's Department of Budget and Finance and tasked with being "responsible for overall health planning for the state", in 2011.[451] The HHA is expected to demonstrate how to get from the present health care situation in Hawaii to an e□cient, cost-e□ective universal health care system, and is intended to provide health policy guidance to both the administration and legislature over the next several years.

In addition to the health status and health services for indigenous peoples in the developed countries in Pacific region, there are targeted programmes for advanced health research in Australia, New Zealand and USA (Hawaii). There are clear national, state and local policies and programmes designed to improve access to health services by and for indigenous peoples in these countries. Indigenous peoples are also actively involved in research, policy development and service delivery incorporating traditional health concepts into ways of explaining health phenomenon and service delivery. In some programs, a□rmative action policies operate, particularly at training institutions[452] and research funds are available for research by indigenous and non-indigenous people into the health issues of indigenous peoples. At the same time, while the data and information are available and policies are o□ered, indigenous people continue to have the poorest health indicators and social conditions.

In all settings, including small island nations of the Pacific, colonialism seems to be universally identified as having a profound and long-lasting influence on the health status of indigenous peoples. In the past and continuing to the present day, colonialism impacts negative72 .5

aspects of the health and well-being of indigenous peoples, including a dramatic decline in population numbers at first contact with settlers, due to the introduction of unfamiliar diseases, loss of languages and cultures, marginalization and discrimination often supported by legislation. It seems the forces of missionary-style religion, pursuit of trade and commerce and fueled by the European expansionist doctrine of Manifest Destiny converged in the Pacific region, as it did across the globe, to marginalize indigenous peoples in their homelands. The Pacific region experienced myriad loss of cultures and traditions that were aggravated by the introduction of Christianity which led to the systematic destruction of Pacific cultural practices and symbols. The Pacific was also a region of intense military strategic importance thus laid claim to by a variety of European nations. It is di□cult to quantify the impact of colonization and Christianity and other forces on the health status of indigenous peoples in the Pacific. Nonetheless, it is clear that the process of colonization destroyed and undermined not only the external expression of indigenous cultures, but their inner sense of self-belief and confidence as distinct cultural groups. Increased prevalence of stress and mental disorders and social problMani9 (ed sal e)5 DC BTayout ☒DC Ba7.1 (t)9 1 encounto

many developed countries does not cater well for the needs of indigenous children. Improvements in educational achievement are essential for improvements in indigenous health.

Policies and programmes to improve indigenous peoples' health have been in place in developed countries (Australia, New Zealand and USA (Hawaii) in the Pacific for some years. These initiatives involve both adjustments to mainstream funding and delivery of health services as well as support for indigenous health programmes. Adjustments to mainstream provision include funding

Greenhill, S, and Russell D. Gray. “Testing Population Dispersal Hypotheses Pacific Settlement”. In. The Evolution of Cultural Diversity: Phylogenetic Approaches. Ed. Ruth Mace et al. London: UCL Press, 2005. 31-52.

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Kritharides L, Brown A, Brieger D et al. Overview and Determinants of Cardiovascular Disease in Indigenous Populations. Heart, Lung and Circulation 2010; 19:337-343.

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Whiteford, Peter Australia: Inequality and Prospersity and their impacts in a radical welfare State, March 2013 p. 76, https://crawford.anu.edu.au/public_policy_community/content/doc/Australia_Inequality-and-Prosperity_final-15-March-13.pdf.

Wilkinson R, Marmot M (2003) Social determinants of health: the solid facts. Denmark: World Health Organization.

Yap M, Biddle N (2012) Indigenous fertility and family formation: CAEPR Indigenous population project: 2011 census papers. Canberra: Centre for Aboriginal Economic Policy Research.

Appendix

Pacific Island Countries and Territories (excluding Australia, New Zealand, and Hawaii):[455]

American Samoa

Cook Islands

Federated States of Micronesia

Fiji

French Polynesia Guam

Kiribati

Marshall Islands

Nauru

Chapter Seven

Access to Health Services for Children and Pregnant Women in the Federal District

Introduction

fil (take positive steps to realize the right to health, such as ensuring that proper legislation and finance mechanisms are in place). The General Comment obliges states to have a national public health strategy that addresses the health concerns of the whole population, giving particular attention to all vulnerable and marginalized groups.[466]

The United Nations Declaration on the Rights of Indigenous Peoples, which incorporates the concept of collective rights, includes government obligations to provide indigenous peoples' access to health services and to respect indigenous health systems. Article 24 states that "indigenous individuals have the right to the enjoyment of the highest attainable standard of physical and mental health" and that "states shall take the necessary steps with a view to achieving progressively the full realization of this right".[467] "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".[468] In accordance with Article 29, "States shall also take e□ective measures to ensure, as needed, that programmes for monitoring, maintaining and restoring the health of indigenous peoples, as developed and implemented by the peoples affected by such materials, are duly implemented".[469] Furthermore, Article 23 states that indigenous peoples have the right to be actively involved in developing and determining health programmes a□ecting them and to administer such programmes through their own institutions.[470]

The right to health care and medical assistance is guaranteed in Article 41 of the Constitution of the Russian Federation.[471] The Article also guarantees that medical assistance shall be made available by state and municipal health care institutions to citizens free of charge, with the money from the relevant budget, insurance payments and other revenues.[472] The Article states that "The Russian Federation shall finance federal health care and health-building programmes, take measures to develop state, municipal and private health care systems, encourage activities contributing to the strengthening of human health, to the development of physical culture and sport, and to ecological, sanitary and epidemiologic welfare".[473] Article 42 guarantees everyone's right to a favourable environment, reliable information about its condition and to compensation for damage inflicted to his or her health or property by ecological violations.[474] While the Constitution does not specifically mention the right to health guarantees for people with disabilities, children and youth, it states that fundamental rights and freedoms shall be inalienable and shall belong to everyone from birth (Article 1),[475] and it contains a special clause stating that men and women shall have equal rights and freedoms as well as equal opportunities for their pursuit (Article 19).[476]

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466 WHO (2012).

467 United Nations Declaration on the Rights of Indigenous Peoples, Article 24.2.

468 United Nations Declaration on the Rights of Indigenous Peoples, Article 24.1.

469 United Nations Declaration on the Rights of Indigenous Peoples, Article 29.3.

470 United Nations Declaration on the Rights of Indigenous Peoples, Article 23.

471 Russian Constitution, Article 41.

472 Russian Constitution, Article 41.

473 Russian Constitution, Article 41.

474 Russian Constitution, Article 42.

475 Russian Constitution, Article 1.

476 Russian Constitution, Article 19.

Article 19 additionally guarantees the equality of human and citizen rights and freedoms, regardless of gender, race, nationality, language, origin, property and official status, place of residence, attitude to religion, convictions and membership of public associations or other circumstances. The Article forbids any restrictions of citizen rights on social, racial, national, linguistic or religious grounds.[477] With health care coverage in the Russian Federation being guaranteed as a constitutional right, universal and free (under mandatory medical insurance), the responsibility for enforcing this right is shared between central, regional and local authorities.[478]

With Russian as the state language throughout the territory of the Russian Federation (Article 68),[479] Article 26 of the Constitution guarantees the right to use one's native language as well as to choose freely the language of communication, upbringing, education and creative work.[480]

The Russian federal law On Fundamental Principles of Health Care in the Russian Federation (21 November 2011) states that territorial state guarantee programmes providing free medical care shall take into account the climate and geography of a particular region and the transport availability of medical organizations (Article 81).[481] This is particularly relevant for indigenous people in remote locations.

In 1999 the Russian Federation issued the federal law On Guarantees of Rights for Indigenous Numerically Small Peoples of the Russian Federation. Article 8 of this law entitles indigenous people to free medical care in state and municipal health care facilities within the framework of the Programme of state guarantees for mandatory health insurance.[482] As described above, the legal framework is comprehensive and includes specific provisions for indigenous peoples' access to health services.

Analytical frameworks

To examine indigenous peoples' access to health services in the Russian Federation, it is useful to review three existing analytical frameworks, which inform the following sections. The first framework focus is on the core elements of the right to health; the second on the core elements of health care access; and the third on the determinants of indigenous health.

Analytical framework 1: The four components of the right to health

According to the aforementioned General Comment on the Right to Health, the right to health contains four core elements, namely, availability, accessibility, acceptability and quality. Availability refers to the provision of a sufficient quantity of functioning public health and health care facilities, goods, services and programmes. Accessibility implies that health facilities, goods, services and

Health status and access to health services in the Russian Federation

Overall population health in the Russian Federation

Despite the stabilization trends in recent years, the health of the general population of the Russian Federation remains poor relative to other WHO European Region[493] and other G8 countries.[494] Certain indicators, such as mortality rates for men, are very high compared to countries at similar development and income levels.[495]

In the 1990s, the whole of the Russian Federation experienced a dramatic decline in life expectancy due to social and political transformation and to soaring poverty rates resulting from the economic collapse following the dissolution of the Soviet Union. Such a striking rise in Russian mortality was beyond the experience of industrialized countries, with a five-year decline in life expectancy.[496] In Moscow life expectancy decreased by 7.7 years over a period of four years from 1990 to1994; and in the whole of Russia by 6.4 years.[497] Changes in life expectancy were due to many factors including economic and social instability, high rates of tobacco and alcohol consumption, poor nutrition, depression and deterioration of the health care system.[498] For example, cigarette consumption increased by 81 per cent between 1990 and 2000.[499]

The decline was particularly sharp in the life expectancy of men of working age, especially those in lower socioeconomic groups within regions experiencing a particularly rapid economic transition.[500] Traditionally responsible for family income, men found themselves under extreme pressure, leading to soaring rates of depression, alcohol and drug use, accidents and suicide.[501]

The top three killers in Russia today are cardiovascular disease, cancer and external causes. In addition to the abovementioned problems, Russia has one of the highest vehicular fatality rates in Europe.[502] Whereas chronic conditions and external causes are leading causes of premature death and disability, communicable diseases, particularly multidrug resistant tuberculosis and the tuberculosis epidemic intersected with HIV/AIDS also pose a considerable threat to health and well being.[503] Female mortality is significantly lower than male mortality, with female rates 117 in 1990 and 144 per 1,000 in 2009, while male mortality was 318 in 1990 and 391 in 2009,[504] but disability-adjusted life expectancy data point to the fact that even though women live considerably longer, their overall quality of life and health status is poor.[505]

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493 Popovich et al. (2011), p. 12.

494 Popovich et al. (2011), p. 175.

495 Popovich et al. (2011), p. 11.

496 Notzon et al. (1998).

497 Leon and Shkolnikov (1998), p. 790.

498 Notzon et al. (1998)

499 Danishevski et al. (2007), pp. 276-83.

500 Leon and Shkolnikov (1998) p. 790.

501 Abryutina (2012), p. 215.

502 Popovich et al. (2011), p. 12.

503 Popovich et al. (2011), p. 12.

504 WHO (2012) World Health Statistics.

505 Popovich et al. (2011), p. 12.

Having reached 148.3 million in 1992,[506] Russian's population declined to 142.9 million in 2010[507] and increased to 143.6 million in October 2013, due to immigration.[508] The context of mainstream Russian health challenges is important for framing the health of indigenous peoples' because as will be shown indigenous peoples are among the poorest of the poor with the greatest health challenges in the country.

Overall access to health services in the Russian Federation

Universal access to primary health care, the principle guiding health care in the Soviet Union, is still central to the discourse and practices in the health care system of the Russian Federation. With independence, Russia inherited a centralized health care system boasting an extensive network of medical facilities and a high number of physicians per capita.[509] The system had substantial overcapacity and patients were largely guaranteed free treatment.

cations including lack of telephone connections contributes to undermine the development and maintenance of information systems.[519] According to the OECD, enhancing access, restoring the capacity of the health care system to provide quality care, and reducing mortality through preventative interventions are among the top five policy priorities at the national level.[520]

Indigenous peoples' health status and access to health services in the Russian Federation

Data availability

According to the Federal law On Guarantees of Rights for Indigenous Numerically Small Peoples of the Russian Federation, the indigenous are the numerically small peoples living on the territories of traditional residence of their ancestors, adhering to their original way of life, trades and crafts, and believing themselves to be independent ethnic entities; their total number in Russia is less than 50,000 people.[521] Nearly all the peoples currently recognized as indigenous live in the North.[522]

Between 1926 and 1993 the official list of indigenous peoples included 26 peoples occupying the vast territory of over 9 million square kilometres stretching from the Kola Peninsula to Chukotka. The government has been expanding the list since 1993. Forty groups were recognized by 2000,[523] many of the newly recognized indigenous groups were residing in the southern parts of Siberia. At the same time, some of the groups that had been previously recognized as distinct indigenous groups were merged.[524] The current official list of indigenous peoples living in the Russian Federation consists of 47 groups;[525] almost all of them live in the northern regions of the country. They are highly diverse in their origins, cultures and languages.[526] According to the census conducted in 2010, there are 316,000 indigenous people living in 23 subjects of the Russian Federation.[527]

Forced migration to cities and towns caused indigenous peoples, who lacked the skills necessary for survival in urban settings and could not rely on their usual family and social networks, to be pushed to the bottom of the social ladder.[536]

The introduction of mandatory boarding schools had the most pronounced consequences. In the 1950s, the children of nomadic hunters and reindeer herders received education for several months a year in large settlements; a decade later, this was replaced by a system of boarding schools, which became mandatory for both nomadic and settled populations in the North and were financed by the state. Education was delivered in Russian by non-indigenous teachers. Indigenous languages were taught only as a separate subject in elementary grades. Boarding schools did not take into consideration indigenous cultures, indigenous physiology or psychology. Education in Russian and extended stays far away from family resulted in the gradual replacement of the mother tongue with Russian, created a generation gap, had a negative effect on family cohesion and led to psychological deprivation.[537] Boarding school diets did not take into account indigenous physiology: for example, indigenous children were regularly given milk, though it has been proven that 50-90 per cent of northern indigenous children are unable to digest milk sugar and should, therefore, exercise caution with the consumption of whole milk.[538]

The policies that the Soviet Union adopted vis-à-vis indigenous peoples had both negative and positive consequences. Withdrawal from family and social networks and the disruption of cultural transmission mechanisms resulted in the loss of the mother tongue, traditional skills and indigenous healing practices. The reduction in traditional nomadic migration resulted in some consanguineous marriages, a practice leading to genetic disorders. Stress and psychological deprivation contributed to alcohol abuse. On the positive side, indigenous peoples received equal rights with non-indigenous peoples, secure employment and income, literacy, access to medical care and preservation of indigenous traditional diet, as well as access to non-indigenous food.[539]

Indigenous peoples' health status

The health of indigenous peoples in northern Russia is extremely poor, and there are clear differences with Russia as a whole.[540] Rapid social transformation and transition from traditional to new occupations, as well as dietary changes, led to a high incidence of diseases that were rare in indigenous peoples in the past.[541] New health problems include myopia, myocardial infarction, ischaemic heart diseases and hypertension, the latter two problems being particularly explosive.[542] Indigenous peoples of the North have unusually high rates of oesophageal cancer: in 1976-1990, incidence in the Chukchi, Koryak[543] and Taimyr[544] autonomous districts was 4-12 times higher than

[536] Nettleton et al. (2007), p. 63.

[537] Kozlov and Lisitsyn (2008), p. 86.

[538] Abryutina (2012), p. 213.

[539] Abryutina (2012), p. 213.

[540] Snodgrass (2013) p. 79.

[541] Medvestnik (2008).

[542] Medvestnik (2008).

[543] Note that the Koryak autonomous district ceased to exist as a distinct federal subject as of 1 January 2007.

[544] Note that the Taimyr autonomous district ceased to exist as a distinct federal subject as of 1 January 2007.

the average in Siberia and the Far East.[545] Parasite infections in the North are twice as common as in the general Russian population.[546] Among the indigenous peoples of the Yamal-Nenets autonomous district, the incidence of parasitic infections was 3.5 times the average district rate.[547] Tuberculosis incidence among indigenous northerners is several times the Russian average.[548] For example, in the Koryak autonomous district, tuberculosis incidence was almost 7 times higher at a rate of 444.6 per 100,000 of population compared to 67 per 100,000 in the Russian Federation.[549] The incidence of death from infectious diseases, mainly from tuberculosis, is more than twice higher in indigenous northerners as in the general Russian population. Generally, the data available from 1998-2007 reveal the deterioration of indigenous peoples' health over this period.[550]

Table 2: Summary of the health information and key risk factors for selected indigenous peoples in northern Russia[551]

Indigenous people	Overall health and key health challenges	Main lifestyle, innate?
Evenki, Khanty, Mansi, Yakut[552]	Overall poor health; pronounced disparities compared with non-native population Life expectancy lower by approximately 10 years (but Russia is low in general)[553] High infant mortality rate High cardiovascular disease burden (especially stroke) but relatively low type 2 diabetes Moderate obesity levels and very high hypertension rates Modestly elevated infectious disease burden Very high rates of alcoholism, suicide and violence	Dietary change Low activity levels High smoking levels Very high rates of alcoholism Psychosocial stress Pollution Poor living conditions Climate change Adaptive pattern that may predispose to high blood pressure

The life expectancy of the indigenous people living in the North of Russia is considerably lower than the overall life expectancy in the Russian Federation. Indigenous northerners can expect to live 10-11 years less and non-indigenous northerners 3-4 years less than the overall average Russian population. Indigenous men live 14 years less than women,[554] which generally correspond to

[545] Choynzonov et al. (2004), p. 51.

overall Russian di□erences between male and female life expectancy. For example, in the Berezovo region of the Khanty-Mansi autonomous district, in the late 1990s the average age at death was 48 for men and 60 for women.[555]

Table 3: Life expectancy at birth in 2000[556]

	Numerically small peoples of the North	All-Russian average
Male	45	61
Female	55	74

Another important indicator for access to health services is infant mortality rates, which have been consistently high. In 2003-2004 the infant mortality rate was 20 per live births among indigenous peoples in the North, compared with the Russian average of 13.3 per 1,000 live births.[557]

Table 4: Selected demographic indicators of the northern indigenous population (crude birth rate, crude death rate, and natural increase per 1,000: infant mortality rate per 1,000 live births.[558]

Period	Crude Birth Rate	Crude Death Rate	Natural increase	Infant mortality rate

of indigenous peoples in the Russian Federation increased by 9,567 between the 2002 and 2010 censuses. However, population increase occurred only in 16 out of 47 indigenous groups.[571]

Organization of health care provision in the North of the Russian Federation

Russia's North has the same formal structure of health care services as the rest of the country and, in addition, it practises the use of mobile health teams. Small rural villages are serviced by medical aid stations equipped with a few beds. These stations are sta□ed by medical assistants and midwives and report to local hospitals. The latter are equipped with clinical laboratory and radiology units and have one or more physicians, a surgeon and a gynaecologist. The closer to

undermines indigenous peoples' health. Indigenous northerners in the Russian Federation live in regions with rich natural resources, among them oil, gas and gold, and extractive industries contribute to ecological destruction. The environment is contaminated with petroleum products, radioactive fallout from nuclear testing and fallen rocket debris. About 40 per cent of reindeer pastures are no longer usable.[578] Lack of sewage facilities in the North adds to water pollution.

Toxic chemicals are a major source of environmental pollution and causal factor in poor health. Among the most dangerous of these toxins are persistent organic pollutants (POPs)—pesticides, industrial chemicals and by-products—that have a particular combination of physical and chemical properties that, when released into the environment, remain intact for years. They become widely distributed as a result of natural processes involving soil, water and air. POPs accumulate in the fatty tissue of living organisms are more concentrated higher in the food chain and are toxic to both humans and wildlife. POPs end up in the Arctic through the "grasshopper e□ect", a process by which pollutants released in one area are transported to far-removed regions by way of continuous evaporation and condensation in the atmosphere. POPs also concentrate in living organisms through bioaccumulation process through which pollutants are absorbed and stored in fatty tissue. Fish, predatory birds, mammals and humans, all of which are high in the food chain, absorb the greatest concentrations of pollutants. As a result, POPs are found in people and animals living in the Arctic, thousands of kilometres from any major POPs source.[579]

Today, then, indigenous northerners' diet consists of either expensive commercial processed foods high in sugar and salt or cheaper traditional foods containing dangerous contaminants. The effects of POPs on human health can include allergies, immune system disruption, damage to the nervous system, reproductive disorders and cancer.[580] POPs are transferred from mother to foetus in utero, which can lead to the development of new pathologies.[581] One of the most dangerous POPs is DDT, widely used in the past for pest and disease control. DDT remains in the soil 10-15 years after application and long-term exposure is associated with chronic illnesses.[582] Indigenous northerners also used DDT for cleaning, treating their homes and even washing.[583] Empty DDT containers were used for storing water, making dough and brewing alcohol. In addition, indigenous peoples used DDT for processing reindeer hides and meat, and often did so on the banks of rivers and lakes from which they took drinking water.[584]

Among other toxic substances present in Russia's North are heavy metals such as mercury, lead and cadmium. The quantity of mercury released into the environment in the Yamal-Nenets and Taimyr autonomous districts[585] reaches 15 tons a year; polychlorinated biphenyls, 3.2 tons. In a number of coastal regions of the Russian Arctic, the blood of the indigenous residents has con-

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578 Novikova (2008), p. 283.

579 Stockholm Convention on Persistent Organic Pollutants.

580 WHO Glossary: Persistent Organic Pollutants (POPs).

581 Abryutina (2012), p. 217.

582 The 12 initial POPs under the Stockholm Convention. Stockholm Convention on Persistent Organic Pollutants (POPs).

583 Abryutina (2012), p. 217.

584 Abryutina (2012), p. 217.

585 Note that the Taimyr autonomous district ceased to exist as a distinct federal subject as of 1 January 2007.

Table 6:

Awareness Raising: Persistent toxic substances (PTS), food security and indigenous peoples of the Russian North.[608]

The project Persistent Toxic Substances, Food Security and Indigenous Peoples of the Russian North was a joint project established by the Association of Indigenous Peoples of the North, Siberia and Far East of the Russian Federation (RAIPON), the Arctic Monitoring and Assessment Programme (AMAP) and the Global Environmental Facility (GEF). The project was implemented in 2001-2005 in four Arctic regions: Murmansk oblast and the Nenets, Taimyr and Chukchi autonomous districts. AMAP Assessments had documented how PTS have a tendency to be transported to, and accumulate in, the Arctic region. Arctic indigenous communities have some of the highest exposures to PTS of any populations on Earth due to cold Arctic climate, lipid-rich food chains, and lifestyles of indigenous people and their reliance on traditional food. The economic changes of the 1990s resulted in increased consumption by indigenous people of traditional food rich in PTS. The project aimed at assisting indigenous peoples of the Russian north in developing appropriate remedial actions to reduce the health risks associated with contamination of their environment and traditional food sources. The project distributed accessible information materials about PTS and ways to reduce health

sures need to be accompanied by urgent local, national and international action to address the root economic, social and environmental causes impacting on indigenous peoples' health.

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