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**Nutritional vulnerability in indigenous children of the Americas
– a human rights issue**

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Mr Chairman, distinguished members of the Permanent Forum, honourable
delegates,

I am truly grateful for this opportunity to share the findings of my study on
infant mortality and chronic malnutrition in indigenous children of the Americas
with the Permanent Forum.

During previous sessions, the Permanent Forum has called for comprehensive
information on the health and wellbeing of indigenous children.

In UN documents and declarations from international conferences, indigenous
peoples tend to be listed among vulnerable groups worthy of particular
attention, also in regard to health and malnutrition. Furthermore, indigenous
representatives have repeatedly expressed their concern for their health and
nutrition situation in international fora. On the national level, however, there
tend to be little information available on indigenous health and malnutrition.

As part of my research on the right to adequate food of indigenous peoples, I
decided to take some time looking systematically into indigenous children's
nutritional health; choosing two indicators; infant mortality and chronic
malnutrition. These two indicators were chosen because information is
relatively available, being collected by health centers in all countries, and
because they tell the story about food insecurity, insufficient health services
and income poverty in the children's communities. I limited the study to the
American continent.

Beside web-based scientific databases on health, my main sources of
information were the Pan American Health Organization (PAHO) publication
"Health in the Americas" which provides information and references to national
and scientific studies on indigneous peoples' health, and the WHO Global
Database on Child Growth and Malnutrition. I found three types of data;

- National health and nutrition data on the indigenous population from national health reports;
- health and nutrition data from predominantly indigenous areas within a country, using national health surveys as source
- Data from smaller scientific studies.

To judge whether the indigenous children were worse off than their peers, I created a ratio by dividing the levels of infant mortality and malnutrition identified in indigenous children, with the national average in the same country. If the two values were similar, the ratio would be close to one, and if the indigenous value was higher, the ratio would be greater than one. The weakness in this method is that if the indigenous population is large, differences are underestimated. On the positive side, if the findings tend to underestimate the problem, but still show differences, the conclusions are built on safe ground.

In twenty-two countries on the continent there are indigenous populations. I found relevant information from 20 countries.

Countries and regions of the Americas with large indigenous populations show the highest rates of infant mortality and chronic malnutrition. The problems seem most serious in the Andean region, in the tropical rainforests of South America, and in Central America.

Some countries, including Canada, the United States, and Guatemala, regularly produce official health data on indigenous children.

In rather wealthy countries like Argentina, Chile, USA, Canada and Brazil, one notes with interest that, in spite of their relatively strong economy and small indigenous populations, the ratios remain approximately the same as in other parts of the Americas. In Canada, the infant mortality rate is relatively low, but still an Inuit child or a First Nation or Métis child have about double chance of dying before one year of age compared to a non-indigenous child.

These studies revealed that there may be substantial variations between areas and ethnic groups. In a small shipibo community in Ucayali in the tropical rainforest in Peru, the infant mortality was 153/1000, while the country average was 43/1000. In Paraguay, Chile, Mexico and Peru, the indigenous children may be from 2 to 4 times more likely to die before their first birthday than the average child. The rates of chronic malnutrition followed the same pattern.

The gravity of the problem varied between indigenous communities and areas.

It turned out that in many countries the urban areas were better off than the rural ones. In 1988-90, forty-four percent of the children in the predominantly indigenous area of Potosí in Bolivia were chronically undernourished. The country average was 35%, making the ratio between indigenous and country average 1.25. In 1998 the ratio was up to 1.8. The indigenous rate of chronic malnutrition had actually risen to 47%, while the national average was down to

27%. The urban centers have gone through rapid improvements, while the rural and indigenous areas lagged behind.

To conclude my findings, each and every study confirmed what had already been claimed; that the indigenous children in the Americas were more disadvantaged than their peers.

Even if the actual rates of infant mortality and chronic malnutrition are very high in the poorer countries on the continent, like Guatemala, Bolivia, and Ecuador, and are approaching zero in richer countries like the US, Canada, Chile and Argentina, it is intriguing to see that the relative difference between indigenous and the average child, expressed through the ratio, is relatively similar in all countries.

Seen in its wider context, the findings suggests that a socioeconomic divide exists between indigenous and non indigenous peoples all over the Americas, and that IP, more than the population at large, are subject to risk factors compromising their nutritional health and their probability of surviving childhood.

Health is a human right, but it seems that this right is systematically being denied indigenous peoples of the Americas.

So, what is the content of the right to health? An authoritative interpretation of the right to health, General Comment no 14, was submitted in year 2000, by the UN Committee on Economic, Social and Cultural Rights. For obvious reasons, good health cannot be provided and ensured by a state, nor can states provide protection against every possible cause of human ill health. Consequently, the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.

In regard to indigenous peoples and the right to health one may talk about various *layers* of rights. One does not exclude the other, and they may all be applied at the same time.

Firstly,

- the right to *non-discrimination* implies an obligation on the part of the State to ensure equal distribution of all health facilities to all;
- secondly, the state has an obligation to provide time-restricted compensatory measures, aimed at bringing the health of a group that lag behind up to the level enjoyed by the general population; and
- thirdly, indigenous peoples have a right to *special measures*, to conform with the principles of equity. According to the ILO Convention 169, state parties are obliged to assist the members of the peoples concerned to eliminate socio-economic gaps that may exist between indigenous and other members of the national community, in a manner compatible with their aspirations and ways of life. Such measures should eliminate unjust differences while allowing, respecting and even facilitating "the

differences that make the difference". What these measures should consist of would have to be determined in consultation and collaboration with the peoples in question.

According to the General Comment No 14, States parties to the Covenant should adopt and implement national strategies and plans of action to ensure equitable distribution, and, based on epidemiological evidence, establish indicators and benchmarks for action, giving particular attention to all vulnerable and marginalized groups.

To identify who within a country are vulnerable and why, one first step is to differentiate or *disaggregate* the health statistics, to show, in the case of indigenous peoples, the difference by ethnic group.

So, should it be recommended that ethnicity is included as a category in national health surveys?

The answer should be yes - if it is ensured that such information is collected in a way that does not add to the stigmatization of these peoples, and that the ultimate goal is to improve the health of indigenous peoples, not merely to collect information for the sake of increased insight.

Data collection should lead to targeted interventions based on the principles of non-discrimination and equity, and based in culturally appropriate measures adapted to particular indigenous needs in collaboration with indigenous peoples themselves. Furthermore, the states should adhere to human rights principles, and accept to be held accountable by their own populations and the international community for progress or regression in regard to the right to health.

It would also seem appropriate that a UN body, in collaboration with the Permanent Forum, would take on the effort to coordinate the collection and dissimulation of data on indigenous health, and also other indicators linked to the human wellbeing of indigenous peoples worldwide. It will require collaborative efforts between UN organizations, countries and indigenous peoples to overcome the challenges of improving the data material. Regular updates on the situation of indigenous peoples will also prove very useful in the process of implementing the Millennium Development Goals, and lead to an improved attention to the situation of indigenous peoples.

Thank you for your attention.