Asia indigenous Caucus

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**9th Session of the Expert Mechanism on the Rights of Indigenous Peoples**
11 – 15 July 2016

**Agenda item no. 5: Study and advice on the right to health and indigenous peoples, with a focus on children and youth.**
Presented by: **Phnom Thano**

Thank you, Mr. Chairperson,

On behalf of the Asia Indigenous Peoples Caucus, I wish to advance our genuine concerns with regards to the right to health and indigenous peoples, focusing on children and youth.

As we discuss our problems here, there are many who are falling victims due to serious health issues that are basic and necessary in the views of the world. Needless to elaborate much on the legal provisions of the international core conventions—such as Conventions on the Rights of Child's Article 24, United Nations Declaration on the Rights of Indigenous Peoples, Article 17 paragraph 2, Article 21 paragraph 1, and Articles 23 and 24, and Article 29 paragraph 3, and Convention on the Elimination of all Forms of Discrimination Against Women Article 12— that deal with the health issues and obligations, we believe that most of the states around the world today are aware with their duties in fulfilling them.

Mr. Chairperson, when it comes to the health issues, the major problem cutting across the gender and age is the problem of lack of respect, to facilitate, provide, protect and fulfil integrated and multi-sectoral approaches which had already been emphasised by Special Rapporteur on the Right of Everyone to the Highest Attainable Standard of Mental and Physical Health, in December last year and if addressed could reduce some of the health problems. There are examples to substantiate such issues. Just as Myanmar's Kachin state faces heroin addiction there is an open opium cultivation and addiction issues among the Khamptis and Mishmis tribes in State of Arunachal Pradesh in India. Authorities have failed to understand that, more than the addiction issues, these problems need the underlying holistic approach to solve the issues such as time-bound accessibility and availability of non-discriminatory economic, physical and culturally-sensitive meaning-based restorative actions on the ground to engage the locals in starting a new life.

Medicines that were once available in the public hospitals free of cost are no longer available because private companies have monopolized most of them. As the major players in the discourse of health, they should contribute more by eliminating any harmful chemicals in medicines, which, unfortunately, are what is widely accessible to the poor masses. While the state government must be in support to facilitate good health, there are reports where health insurance cards available to patients in India as a part of free health packages are refused by hospitals despite having fully complied the terms and conditions by patients merely because state government had allegedly failed to reimburse the required amount to hospitals. It is also learnt that in the same state despite receiving 71 calls by Emergency Call Center between September 2015 to March 2016 as per their own data, only 12 could be assisted due to the alleged claim of absence of ambulance in contrary to 94 ambulances which the state has received according to governments' own official record.

Further, reports of frequent suicide of farmers are heard but what is not heard is frequent suicide rate among teenagers in the endangered indigenous Mishmi tribes from northeast India. We believe that their right to be heard in this case would be much more helpful if states offer assistance that goes beyond consultation.

In the South-East Asian Region, such as Vietnam, Indonesia, and Burma the main focus is required for mother and new born, nutrition, (preventable) communicable diseases (like diarrhoea, malaria, measles and HIV infection), and quality of hospital and child development. The challenges remain with regard to improving access to effective child health interventions, improving quality care of mothers and children, and resource mobilization. The life expectancy of the low-income countries are 15 years lower for boys and 18.9 years for girls than the high-income countries according to the World Health Statistics 2014 of WHO.

Mr. Chairperson, we believe that the article 12 of the International Covenant on Economic, Social and Cultural Rights refers to the highest attainable standard of physical and mental health, which, according to the Committee on Economic, Social and Cultural Rights, is not confined to the right to health care. It should embrace a wide range of socioeconomic factors that promote conditions in which all peoples have the right to the highest attainable standard of health. Considering all the above-mentioned problems, we urge the EMRIP to strongly encourage states to review the underlying determinants of these health problems encountered by indigenous peoples.

Thank you for this opportunity, Mr. Chairperson.