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United Nations Declaration on the Rights of Indigenous Peoples

The right to health and indigenous peoples, with a focus on children and youth

Draft study of the Expert Mechanism on the Rights of Indigenous Peoples

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Contents

I. Introduction

1. In its resolution 30/4, the Human Rights Council requested the Expert Mechanism on the Rights of Indigenous Peoples to conduct a study on the right to health and indigenous peoples, with a focus on children and youth, and present it to the Council at its thirty-third session.

2. The Expert Mechanism called for submissions from States, indigenous peoples, national human rights institutions and other stakeholders to inform the study. The Expert Mechanism appreciates the submissions and is informed by them. The submissions received are, where permitted, available on the Expert Mechanism's website. The study also benefited from presentations made at the Expert Seminar on Indigenous Peoples and the Right to Health (Montreal, Canada 21 and 22 February 2016) organized by the Office of the United Nations High Commissioner for Human Rights and the Institute for the Study of International Development at McGill University ("UN Expert Seminar"). The Expert Mechanism would also like to thank the University of Auckland's Faculty of Law for providing research support.

3. Although this is the Expert Mechanism's first study focussing on the right to health, previous studies addressed links between access to justice and the health of indigenous women and indigenous persons with disabilities (A/HRC/27/65); the health implications for indigenous peoples of disaster risk reduction initiatives (A/HRC/27/66); and the importance of indigenous cultures and languages for the health of indigenous peoples (A/HRC/21/53).

4. Indigenous peoples' conceptualization of "health" and wellbeing is generally broader and more holistic than that of mainstream society, with health frequently viewed by indigenous peoples as both an individual and collective right, strongly determined by community, land, and the natural environment. The Permanent Forum on Indigenous Issues has noted that the right to health "materializes through the well-being of an individual as well as the social, emotional, spiritual and cultural well-being of the whole community" (E/C.19/2013/L.2, para 3). Indigenous concepts of health often incorporate spiritual, emotional, cultural and social dimensions in addition to physical health. These concepts are inextricably linked with realization of other rights, including rights to self-determination; development; culture; land; language; and the natural environment.

5. However, indigenous peoples' concept of health is frequently disregarded within non-indigenous health systems, creating significant barriers to access (A/HRC/30/41, para 31). In particular, a lack of understanding of social and cultural factors deriving from the health knowledge, attitudes and practices of indigenous peoples can have deleterious effects on indigenous wellbeing. Indigenous peoples worldwide experience higher rates of health risks, poorer health, and greater unmet needs in respect of healthcare than their non-indigenous counterparts. Forced assimilation; political and economic marginalization; discrimination and prejudice; poverty; and, other legacies of colonialism have also led to a lack of control over individual and collective health.

6. A comprehensive analysis of the present state of indigenous peoples' health is beyond the scope of this study; rather, this study critically analyses the content of the right to health vis-à-vis indigenous peoples, and reviews the legal obligations of States and other actors in fulfilment of this right.

II. The right to health and indigenous peoples: legal and policy framework

A. Normative framework on the right to health

7. The right to health of all peoples has been long-recognised in the Universal Declaration of Human Rights, in particular article 25, which notes that everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services.

8. The United Nations Declaration on the Rights of Indigenous Peoples (the Declaration) recognises the health rights of indigenous peoples, and expands upon their varied dimensions and interplay with rights such as self-determination. Article 21 recognises the right to improvement of economic and social conditions without discrimination, and Article 23 recognises the right to determine and to develop priorities and strategies for exercising the right to development; in particular, to be actively involved in developing and determining health programmes affecting them, and to administer such programmes through their own institutions where possible. Article 24 recognises the right of indigenous peoples to use and maintain traditional medicines and health practices, and to access social and health services without discrimination; it affirms the equal right of indigenous individuals to the enjoyment of the highest attainable standard of physical and mental health. Additionally, the Declaration recognizes the importance of collective rights of indigenous peoples. Finally, Article 29(2) requires States to take effective measures to ensure no storage or disposal of hazardous materials on Indigenous lands or territories occurs without their free, prior and informed consent.

9. Article 24 of the Declaration reflects the wording of Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), a binding normative framework enshrining the right of all people to the highest attainable standard of mental and physical health. Article 12 sets out an inclusive right, incorporating both healthcare and the social determinants of health, and containing freedoms and entitlements: notably, the freedom to control one's own health, and entitlement to a system of health protection that provides equality of opportunity in realizing the highest attainable standard of health. Non-discrimination and equal treatment are among its key components; and, although many elements are subject to "progressive realization" in view of resource constraints, obligations such as non-discrimination are of immediate effect. While States have primary responsibility for realization of the right to health, all actors in society incur responsibilities in achieving this, and individuals should have the opportunity to participate in decision-making processes affecting realization of their rights. States should respect, protect and fulfil the right, and ensure that healthcare facilities, goods and services are available, accessible, acceptable, and of good quality (E/CN.4/2003/58).

10. In General Comment No. 14, the Committee on Economic, Social and Cultural Rights (CESCR) further expands upon the right to health vis-à-vis indigenous peoples, noting that they have the right to specific measures to improve access to health services and care, which should be culturally appropriate and take into account traditional practices and medicines, and that States should provide resources for indigenous peoples to design, deliver and control services. CESCR recognises the collective dimension of health for indigenous peoples, and acknowledges the deleterious effect on health of displacement from traditional territories and environments that occurs secondary to development-related activities.

11. Article 25 of the International Labour Organization Convention No. 169 on Indigenous and Tribal Peoples (the ILO Convention) requires States to ensure that adequate

health services are made available to indigenous peoples, or to provide resources to indigenous peoples for design, delivery and control of services. It further requires preference to be given to training and employment of local community health workers. The provision recognises the importance of primary care and community-based health services, and coordination with other social, economic and cultural measures. The operation of this Article is supported by non-discrimination provisions (Article 3) and provisions requiring States to consult with and ensure effective participation of indigenous peoples, with the objective of achieving consent in relation to proposed measures (Article 6).

12. Health rights are also recognised within other binding international instruments, including the Convention on the Rights of the Child (Article 24) (CRC); the Convention on the Elimination of all Forms of Discrimination Against Women (CEDAW) (Articles 10-14); the Convention on the Rights of Persons with Disabilities (Article 25); and, the Convention on the Elimination of All Forms of Racial Discrimination (Article 5). Certain regional instruments also contain the right to health, including the African Charter on Human and Peoples' Rights (Article 16) (African Charter), the African Charter on the Rights and Welfare of the Child (Article 14), the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (Article 14), and the American Declaration on the Rights of Indigenous Peoples (Article XVII). The Pan American Health Organization (PAHO) has also passed a number of resolutions concerning indigenous health rights.[1]

13. Certain treaty bodies have also examined the right to health from an indigenous perspective, as have various Special Procedures mandate holders, including *inter alia* the Special Rapporteurs on the right to health, and the rights of indigenous peoples. Key findings of these bodies and mandate holders are referenced throughout this report.

B. Other key instruments, policy processes and documents

14. In 2014, the World Conference on Indigenous Peoples, through its Outcome Document (A/RES/69/2), committed to ensuring equal access of indigenous peoples to the highest attainable standard of physical and mental health, explicitly referencing the importance of intensifying efforts to combat HIV/AIDS, malaria, tuberculosis and non-communicable diseases, and to ensure access to sexual and reproductive health. The importance of indigenous peoples' traditional health practices, medicines and knowledge was also recognised.

15. The Sustainable Development Goals (SDGs), which were promulgated in 2015, also touch on issues concerning indigenous wellbeing. Goal 3, to ensure healthy lives and promote wellbeing at all ages, directs States to work towards achieving universal health coverage; this will require States to extend coverage of services to indigenous peoples. Other goals concerning poverty, food security, equitable and quality education, and gender equality are relevant to indigenous peoples' wellbeing. Goals 13, 14 and 15, regarding climate change, protection of ecosystems and sustainable development are also central to realizing indigenous peoples' health rights, being closely inter-related to rights to self-determination and use of traditional lands, territories and resources. Goal 16 on access to justice and accountable and inclusive institutions also has clear implications for indigenous peoples' right to health, particularly in terms of redress. Finally, Goal 17, which includes a target on data disaggregation, calls for enhanced capacity building to increase data availability, which will assist States in identifying and remedying health inequities.

[1] See e.g. Resolution CD47.R18.

16. The negotiations of the United Nations Framework Convention on Climate Change (UNFCCC) Conference of Parties are also relevant, given the disproportionate impact of climate change on indigenous peoples. These negotiations culminated in the recent Paris Agreement, which recognises the rights of indigenous peoples in its preamble, refers specifically to the right to health, and acknowledges that adaptation action should follow a country-driven, participatory and fully transparent approach, based on and guided by knowledge of indigenous peoples, where appropriate (FCCC/CP/2015/10/Add.1). The importance of the effective participation of indigenous peoples had already been noted (Decision 1/CP.16). However, the Paris Agreement goes further by explicitly referring to human rights, signalling States' commitment to recognise links between climate-related obligations, the right to health and indigenous peoples' rights.

17. Finally, the United Nations Guiding Principles on Business and Human Rights (A/HRC/17/31) are also highly relevant to indigenous peoples, who disproportionately experience health rights infringements through development-related activities perpetrated by non-state actors. Although they are not parties to international human rights conventions, non-state actors nevertheless have a responsibility to respect human rights, and adherence to the Guiding Principles is necessary for indigenous peoples' health rights to be fully realized.

III. Treaty rights, self-determination and health

18. As an indispensable element of indigenous peoples' very existence, the right to health is a central component of their right to self-determination. The right to self-determination is contained in Article 3 of the Declaration, as well as Article 1 of ICESCR. All human rights are interdependent, including the rights to health and self-determination. Indeed, full realization of health rights cannot be achieved without self-determination, which is a non-derogable right with flow-on benefits in respect of health and other social and cultural rights. These benefits can include improved diet, more frequent exercise, and reconnection of indigenous peoples with traditional economic bases.[2]

19. Some treaties between indigenous peoples and States provide mechanisms for indigenous peoples' rights to health and self-determination: these legal agreements are thus highly relevant within a right-to-health analysis. For instance, when indigenous peoples entered into Treaty No. 6 with the British Crown in Canada, its terms included a "medicine chest clause" which has subsequently been interpreted as a guarantee of provision of health care services, delivery, medicines, and supplies to indigenous peoples by the Crown.[3] Treaties in other countries provide for self-determination, which implicitly includes control over decisions concerning health and wellbeing of indigenous peoples, indirectly facilitating realization of the right to health. In Aotearoa New Zealand, the right to health of Māori people is effectively affirmed in the Treaty of Waitangi, which makes provision for protection of self-determination and cultural possessions (both tangible and intangible), shared decision-making, and equal participation in society with freedom from discrimination.

20. The Special Rapporteur on the right to health has stated that these treaties form part of international law, and Article 37 of the Declaration confirms that indigenous peoples have the right to recognition, observance and enforcement of these treaties. Article 43 of

[2] Submission: New Zealand Human Rights Commission.

[3] Submissions: Maskwacis Cree; Assembly of First Nations.

the Declaration further notes that the survival, dignity and well-being of indigenous peoples are dependent on various rights contained in the Declaration, including rights to health, self-determination, and treaty rights. Although rights to self-determination and health are not contingent upon treaty recognition, formal inclusion in treaties provides a mechanism of safeguarding these rights, and strengthens the commitment of States to work with indigenous peoples as equal partners in improving their living conditions. Accordingly, States that have not finalized such treaties should consider formal acknowledgement of these rights in agreements with indigenous peoples.

21. Free, prior and informed consent is another integral element of the right to self-determination. This principle entitles indigenous peoples to effectively determine the outcome of decision-making affecting them: it is both a procedural process and a substantive mechanism to ensure respect of indigenous peoples' rights. The principle of free, prior and informed consent should be respected in decisions regarding health legislation, policy and programs impacting upon indigenous peoples, which are frequently taken without any meaningful consultation. Healthcare policy-making should both adhere to participation rights in Article 12 of ICESCR and the Declaration, and reflect the principles outlined by the Expert Mechanism in its study on the right to participate in decision-making (A/HRC/EMRIP/2011/2).

IV. Indigenous peoples' right to health: State obligations

22. Indigenous peoples worldwide share many common challenges in realizing the highest attainable standard of health, which are examined in this report using the availability, accessibility, acceptability and quality (AAAQ) framework, with State obligations outlined using the Respect, Protect and Fulfil framework. The AAAQ framework contained in General Comment No. 14 extends beyond healthcare delivery infrastructure to encompass the facilities, goods and services comprising the underlying determinants of healthcare, such as safe and potable water, and adequate food and sanitation (E/C.12/2000/4).

A. Availability, accessibility, acceptability and quality

Availability

23. Public health and healthcare facilities, goods and services should be available in sufficient quantity within a State, depending on its level of development. However, availability is often constrained for indigenous peoples and communities. For example, infrastructure has been noted to be "non-existent" in certain areas in Africa where indigenous nomadic pastoralists and communities are located.[4] Availability also requires that facilities, goods and services are functional. Facilities located in areas inhabited by indigenous peoples are frequently non-operational due to a lack of staff, medicines, supplies and other consumables.[5]

Accessibility

24. Four primary dimensions of accessibility comprise the AAAQ framework: non-discrimination, physical accessibility, economic accessibility, and information accessibility. For indigenous peoples, these four dimensions of accessibility often intersect. Indigenous

[4] United Nations, State of the World's Indigenous Peoples, Volume II (New York, 2015).
[5] Ibid.

peoples are very likely to experience discrimination when accessing healthcare facilities, goods and services. Doctors, nurses and other healthcare professionals may refuse to treat indigenous peoples, or during treatment, indigenous peoples may encounter discriminatory beliefs, practices and experiences, fuelling fear and distrust which further discourages use of healthcare facilities. This is amplified for indigenous persons with disabilities. Racism may even lead to misdiagnosis and under-treatment for serious illnesses.[6] Physical accessibility is also frequently hampered for indigenous peoples, many of whom live in geographically isolated areas, often due to displacement or encroachment of non-indigenous peoples on their land.

25. Economic accessibility is also a concern for indigenous peoples, who are frequently among the most socio-economically marginalized groups in society. This is particularly so in countries without universal healthcare, or with high out-of-pocket payments for consumers. Information accessibility is also constrained for indigenous peoples: this can be attributed to a number of factors, including *inter alia* health information being unavailable in indigenous languages; higher rates of illiteracy amongst indigenous peoples with limited educational opportunities; lack of contact with healthcare providers due to unavailability; and, discriminatory or paternalistic attitudes amongst healthcare providers.

Acceptability

26. CESCR has acknowledged that the right to take part in cultural life encompasses cultural appropriateness, which should be taken into account in providing healthcare services (E/C.12/GC/21.). Unfortunately, healthcare facilities, goods and services available to indigenous peoples are often unacceptable in nature. Interpersonal and structural racism frequently exists, with system-wide policies and practices that can marginalize or exclude individuals, or minimise access to facilities, goods and services. One example of a basic failure to provide acceptable care—a lack of service provision in indigenous languages (CEDAW/C/FIN/CO/7)—also constitutes structural racism. This can, in turn, internalise stigma amongst indigenous peoples, creating further barriers to healthcare. Moreover, indigenous people are frequently blamed for their illnesses and medical needs, either individually or as a homogeneous population. Negative attitudes and a lack of cultural sensitivity among healthcare providers in some jurisdictions also impact upon indigenous peoples' ability to seek healthcare.

Quality

27. Healthcare facilities, goods and services should also be scientifically, medically and culturally appropriate, and of good quality: this requires skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation. Tension often exists between mainstream healthcare services, which are generally evidence-based and perceived to be of high quality, and traditional healthcare practices of indigenous peoples, for which a paucity of evidence frequently exists, often due to a lack of research attention. This should not be viewed exclusively as a source of tension between indigenous peoples and mainstream healthcare providers—indigenous communities themselves often face challenges internally in balancing traditional and modern approaches to health, and other social issues.[7]

[6] See e.g. Karen Yeates and ors, "Indigenous people in Australia, Canada, New Zealand and the United States are less likely to receive renal transplantation" *Kidney International*, vol. 76, No. 6 (September 2009).

[7] Submission: Inuit Circumpolar Council.

B. Respect, protect and fulfil framework

Respect

28. Articles 2.2 and Article 3 of ICESCR, as well as Article 24 of the Declaration, prohibit discrimination in access to healthcare and the underlying determinants of health. Thus, States must refrain from denying or limiting indigenous peoples' access to public healthcare facilities, goods and services. This immediate obligation is not subject to the principle of progressive realization. States should also refrain from prohibiting or impeding indigenous peoples' use of traditional preventive care, healing practices and medicines.

29. Laws, policies and programs concerning health should be reviewed (in conjunction with indigenous peoples) and discriminatory elements removed or replaced. This obligation extends to laws which are not *de jure* discriminatory, but disproportionately impact upon indigenous peoples. The obligation to respect extends to abstaining from enforcing broader discriminatory laws or practices which can have detrimental health effects. For example, laws and policies sanctioning practices such as forced sterilization of indigenous women and female genital mutilation, should also be removed.

30. The obligation to respect extends to the underlying determinants of health. States should refrain from unlawfully polluting air, water and soil, such as through industrial waste from State-owned facilities, or through extractive industries. These activities are too frequently carried out on land inhabited by indigenous peoples, and along with agricultural use of pesticides, can represent a violation of indigenous peoples' health rights.[8]

31. Finally, indigenous peoples must also be permitted to self-identify within States, to permit collection of disaggregated health and other data, and for provision of funding and assistance in realizing health rights. While certain jurisdictions have banned the disaggregation of data by ethnicity for compelling reasons, such laws should not be applied to prevent indigenous peoples from improving their wellbeing.[9]

Protect

32. States often turn a blind eye to racism in healthcare settings, even in the presence of pervasive, persisting evidence that indigenous peoples are treated discriminatorily. States should take measures to ensure equal access to treatment and healthcare facilities within their jurisdiction, as well as to protect indigenous peoples from discrimination perpetrated by third party healthcare providers. States should consider implementing workforce sensitization activities, and awareness campaigns challenging racist behaviour and stereotyping and promoting more culturally-sensitive approaches.

33. States should also protect indigenous communities from actions by private companies and other third parties that deny indigenous peoples their sources of nutrition, medicinal plants, and livelihoods, through increased pressure on land, environmental degradation or displacement. This necessarily includes respecting the principle of free, prior and informed consent. States should also prevent the appropriation and commodification of indigenous knowledge, traditional medicine and other practices by third parties. Article 31 of the Declaration confirms indigenous peoples have the right to maintain, control, protect

[8] See e.g. *Social and Economic Rights Action Centre (SERAC) and Another v Nigeria* (2001) AHRLR 60.

[9] Ian Anderson and ors, "Indigenous and tribal peoples' health (The Lancet–Lowitja Institute Global Collaboration): a population study" *Lancet*, April 20 2016. Available from http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(16)00345-7.pdf

and develop their cultural heritage and traditional knowledge, including manifestations of these such as human and genetic resources, medicines, knowledge of the properties of fauna and flora, and sports and traditional games; they also have the right to develop their intellectual property over the same.

34. Although indigenous peoples have the right to use traditional healthcare practices, if harmful practices are present—such as female genital mutilation—States should take steps to work with indigenous communities towards eradication of these practices (CRC/C/GC/11). More research is also needed into traditional medicines, procedures and other interventions. However, this research, and any potential commercialization, must be carried out in partnership with indigenous peoples.

35. States should also consider the wishes of indigenous communities living in voluntary isolation or initial contact, in recognition of their greater vulnerability and need of protection. States should develop preventive programs to protect the health of these groups, particularly by protecting their lands and territories from environmental damage, and avoiding the transmission of diseases to which these groups lack immunity. States must also create plans to provide access to mainstream and traditional medicine where it is sought, incorporating an emergency plan to be implemented where a threat of imminent widespread mortality eventuates.[10]

36. Finally, States should ensure that adequate mechanisms exist for redress and remedy of health rights infringements, through mainstream or indigenous juridical systems (A/HRC/27/65), which may have certain advantages in respect of resolution of complaints regarding health rights violations. In the Philippines, for example, complaints of violence against women heard through the traditional justice system have reportedly been implemented quickly, with high rates of acceptance amongst parties.[11]

Fulfil

37. States should formulate and adopt national strategies to ensure all individuals have access, without discrimination, to health facilities, goods and services necessary to achieve the highest attainable standard of health. Creation of a national strategy should be accompanied by implementation plans, and development of right to health indicators, to ensure effective monitoring, evaluation, and accountability. States that are developing national action plans for the implementation of the Declaration, as called for by the World Conference on Indigenous Peoples, should ensure that these include measures to fulfil indigenous peoples' right to health. As indigenous peoples have the right to specific measures to improve their access to health services and care, the immediate obligation to create a national health plan requires States to reference and make provision for indigenous peoples' needs in a "mainstream" plan, as in Guatemala,[12] or a separate indigenous health plan, like New Zealand's Māori Health Strategy, *He Korowai Oranga*.[13] States should also ratify and/or incorporate relevant international instruments containing health rights into their domestic law, such as the Declaration, the ILO Convention and ICESCR. Other non-immediate obligations to *facilitate, provide* and *promote* fulfilment of the right to health are elaborated below.

[10] OHCHR and AECID, Directrices de proteccion para los pueblos indigenas en aislamiento y en contacto inicial de la region Amazonica, El Gran Chaco y La Region Oriental de Paraguay (Geneva, May 2012).

[11] Submission: Asia Indigenous Women's Network (AIWN).

[12] Submission: Guatemala.

[13] New Zealand Ministry of Health, "He Korowai Oranga", 25 February 2015. Available from: http://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga.

Facilitate

38. In accordance with the right to self-determination, States should provide sufficient resources to indigenous communities to create and operate their own healthcare initiatives. Care provided by indigenous community-controlled organisations is often of a higher quality than that of mainstream services, significantly improving availability and accessibility of healthcare. These organisations can create a virtuous cycle in respect of health and employment, serving as prominent employers of indigenous peoples, and helping to combat poverty within indigenous communities. In Australia, the Aboriginal community-controlled healthcare sector employs nearly 4000 people nationally, and services over 60% of Aboriginal people outside major metropolitan centres, with superior performance to mainstream services noted on key indicators.[14] In Colombia, 80% of the professional staff of Pueblo Bello indigenous hospital in Valledupar are of indigenous origin—a significant achievement in intercultural practice.[15]

39. States should also facilitate access to healthcare services through improved birth registration processes, where appropriate. Article 7 of the CRC gives every child the right to be registered immediately after birth. Yet, many registration systems remain inadequate in relation to indigenous births. A lack of registration and identification documents directly impedes access to healthcare facilities, goods and services where identification is a prerequisite to obtaining care (CRC/C/CRI/CO/4) and prevents collection of disaggregated data, which is vital in monitoring disparities in healthcare status as between ethnic groups. Registration can be facilitated through targeted registration campaigns, as in Brazil,[16] or use of indigenous registrars or a specific minorities registration section within state institutions, as in Thailand, Peru and Panama; alternatively, traditional birth attendants can also be utilised to improve birth registration rates, as has occurred in Ghana and Malaysia.[17] However, birth registration should not be a precondition to accessing healthcare services.

Provide

40. Although certain indigenous peoples have stated that communities should take ownership over responses to emerging crises and rely less on external support,[18] this does not absolve States of their obligations in respect of provision of financial or other support where required. States incur a special obligation to provide a specific right under ICESCR (for those who do not have means) with necessary health insurance and health-care facilities (E/C.12/2000/4). Even in times of severe resource constraints, individuals/groups in situations of vulnerability should be protected by the adoption of relatively low-cost, targeted programmes (E/1991/23). Measures can be adopted by States, temporarily or permanently, to remedy structural discrimination: these can include provision of funding, programs, or other resources necessary to achieve the highest attainable standard of health.

41. States should also provide certain resources whilst indigenous peoples establish their own services and workforce cadre. For example, in the absence of sufficient medical

[14] Kathryn Panaretto and ors, "Aboriginal community controlled health services: leading the way in primary care" *Medical Journal of Australia*, vol. 200, No. 11 (16 June 2014).

[15] Anna R. Coates, Sandra del Pino Marchito and Bernadino Vitoy, "Indigenous Child Health in Brazil: The Evaluation of Impacts as a Human Rights Issue" *Health and Human Rights Journal*, May 16, 2016. Available from: https://www.hhrjournal.org/2016/05/indigenous-child-health-in-brazil-the-evaluation-of-impacts-as-a-human-rights-issue/

[16] Ibid.

[17] UNICEF, Birth Registration: Right From The Start. Innocenti Digest, No. 9 (March 2002).

[18] Submission: Inuit Circumpolar Council.

professionals that speak indigenous languages, States should provide interpretation services facilitating effective communication in healthcare settings, such as in Norway, where a 24-hour Sami interpretation service has been established in collaboration with indigenous peoples.[19] Affordable versions of such programs could be implemented by other States, given the rapidly increasing prevalence of mobile phone coverage worldwide. Up-skilling and incorporating traditional indigenous practitioners into healthcare systems can also address immediate shortages of medical staff in remote indigenous territories.

Promote

42. States should ensure that healthcare research agendas sufficiently recognise and involve indigenous peoples. Failure to collect health data disaggregated by ethnicity, self-identified indigenous status or cultural identity can conceal deep societal health inequities. Consensual disaggregated data collection should be undertaken to identify barriers to enjoyment of the right to health, and for inclusive policy-making to occur. Such data should address issues such as gender, socio-economic status, and disability, as data collection focused purely on indigenous status does not fully capture the composite rights of indigenous peoples who are marginalized due to other aspects of their identity, such as disability.[20]

43. For healthcare facilities, goods and services to be acceptable to indigenous peoples, they must be culturally appropriate. This requires respectful, inclusive communication; empowerment of patients in decision-making; and, building of relationships where patient and provider work together to ensure maximum effectiveness of care.[21] To achieve this, three steps are necessary: changes should be made to "mainstream" healthcare facilities, goods, and services; more indigenous individuals should be trained as healthcare providers; and, indigenous-specific services should be created.

44. To improve mainstream services, States should ensure that curricula of medical and healthcare training programs render graduating professionals culturally competent. This should include education on colonial history and its legacies (where relevant), indigenous culture (including traditional approaches to medicine), stereotyping and racism, and healthcare disparities and social inequities. Information on effective communication with indigenous peoples should also be included within this training. Specific programs can also be created addressing indigenous health, such as the University of Northern British Columbia Aboriginal child and youth mental health certificate (for students who want to practice in remote indigenous communities) or the Native American Child Health initiative created by the American Academy of Pediatrics (dedicated to indigenous health care).

45. States should also facilitate the entry of indigenous persons into the healthcare workforce, as indigenous peoples are currently underrepresented. Facilitation of workforce entry can take many forms: for instance, through training quotas, earmarked funding or scholarships, and/or travel allowances. Indigenous peoples can receive professional training to bridge the divide between "mainstream" facilities, goods and services, and indigenous communities. This training should be conducted sensitively, and without prejudice to indigenous medicinal and health-related knowledge and practice.

46. States should also promote health through provision of culturally-appropriate information concerning healthy lifestyles and nutrition, disease and illnesses (including

[19] Submission: Norway.

[20] Doreen Demas, Presentation to UN Expert Seminar, Montreal, 21-22 February 2016.

[21] National Aboriginal Health Organization, "Cultural Competency and Safety: A Guide for Health Care Administrators, Providers and Educators" (Ottawa, NAHO, 2008).

mental illness), harmful traditional practices, and availability of services. This includes provision of information in the patient's language as well as development of information mechanisms that incorporate non-verbal communication patterns, and cultural beliefs and practices. In some indigenous communities certain themes remain taboo, such as HIV/AIDS, and sexual and reproductive health: State cooperation with indigenous organizations is vital in implementing culturally appropriate awareness-raising campaigns among these communities.

47. Traditional healthcare practices, and use of traditional medicines, can also be utilized to promote and enhance indigenous health through its spiritual and biomedical benefits, and to bring unwell people into contact with healthcare systems, facilitating access to care. Rather than stigmatising and suppressing their use, States should consider incorporating these into their health planning and promotion activities.

48. Indigenous peoples should be supported in making informed choices about their health through provision of information, and State measures designed to facilitate healthy choices, including physical activity. States should promote healthy and traditional diets amongst indigenous people through the protection of indigenous peoples' traditional agricultural practices, education campaigns and, where necessary, direct provision of or economic subsidies for healthy foodstuffs, particularly in rural or remote areas where processed or packaged foods are frequently more available and economically accessible to indigenous peoples.

V. Indigenous children and youth and the right to health

49. Alongside ICESCR and the Declaration, Article 24 of the CRC requires States to take appropriate measures to ensure realization of the highest attainable standard of health for children. In General Comment No. 11, the Committee on the Rights of the Child notes that indigenous children frequently suffer poorer health than non-indigenous children due to inferior or inaccessible health services, and that positive measures may be required to eliminate conditions causing discrimination and ensure their equal enjoyment of Convention rights. The Committee urges States to consider implementing special measures to ensure indigenous children have access to culturally appropriate health services and are not discriminated against, and notes *inter alia* that States parties have a positive duty to ensure indigenous children have equal access to health services and to combat malnutrition as well as infant, child and maternal mortality (CRC/C/GC/11). The Committee has interpreted the right to health of all children as including the "right to grow and develop to their full potential and live in conditions that enable them to attain the highest standard of health through the implementation of programmes that address the underlying determinants of health" (CRC/C/GC/15).

50. Unfortunately, alarming gaps in child health indicators persist between indigenous and non-indigenous populations globally. Infant mortality rates remain significantly higher amongst any indigenous groups than for their mainstream counterparts.[22] Indigenous women and children can be vulnerable to violence, malnutrition and malnourishment, anaemia and malaria.[23] Some of these discrepancies are attributable to inequalities in social determinants of health. Disproportionately large numbers of indigenous children live in

[22] Alan Anderson and ors, "Indigenous and tribal peoples' health (The Lancet–Lowitja Institute Global Collaboration): a population study" *Lancet*, April 20 2016. Available from http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(16)00345-7.pdf

[23] Submission: Indigenous Women's Network, India (IWNI).

poverty (CRC/C/GC/11) and in remote areas with limited access to healthcare, quality education, justice and participation (E/C.19/2005/2, Annex III, Item 13).

51. Indigenous peoples continue to experience intergenerational trauma secondary to removal of children from families, and residential schooling. The health impacts of these practices are profound, including mental illness, physical and sexual abuse, self-harm and suicide, and drug or alcohol addiction. A correlation has been demonstrated between intergenerational effects of these events and suicide,[24] and sexual abuse during childhood.[25]

52. Indigenous children and youth are particularly vulnerable to human rights violations, due to their age and the intersectional nature of discrimination experienced by indigenous peoples. Children and youth have not historically been recognized as holders of rights; this is especially the case for indigenous children, who are frequently deprived of fundamental rights concerning their families, communities and identity. The combined effect of intergenerational trauma and lack of progress towards realization of indigenous human rights has resulted in many indigenous children experiencing a multitude of early and traumatic life experiences, placing them at risk of ill health, mental illness, suicide and contact with the criminal justice system.[26]

53. Indigenous youth frequently find themselves caught between their indigenous languages, customs and values and those of the wider community. They often migrate from their traditional communities to urban areas to seek out increased employment and educational opportunities, incurring increased health risks. Indigenous youth not only experience higher rates of unemployment than their non-indigenous counterparts: they are also vulnerable to depression, substance abuse, and other risky health outcomes that occur in the absence of strong social supports and in the presence of discrimination.

54. In addition to difficulties experienced by indigenous peoples in accessing appropriate and good-quality health services, indigenous children and youth face three key issues compounding their social and economic disadvantage: these relate to education, family and community integrity, and mental health.

Education

55. Education is a key underlying determinant of health for indigenous peoples. Illiteracy rates are frequently high (CERD/C/EDU/CO/20-22 (2012), and indigenous children are significantly less likely than non-indigenous children to attend school, which undermines health through decreased health literacy and loss of the numerous, indirect benefits of higher educational attainment. Lower educational attainment is "inextricably tied" to homelessness and over-representation of indigenous peoples in the prison system.[27] Decreased participation in formal education is frequently a combination of a lack of availability, accessibility, acceptability and quality. Even where services are accessed, differential completion rates exist: for instance, indigenous girls in Peru aged 12-16 experience school dropout rates of 89% (A/HRC/29/40/Add.2., para. 68).

56. States should do more to redress these health rights violations. Investment in indigenous children's early development through education, and provision of support to families (e.g. around parenting) are a highly effective means of reducing health inequalities. States should cooperate to ensure utilization of effective interventions: for instance, Nurse-Family Partnerships have been adapted for use in indigenous communities following

[24] Zahra Rehman, Presentation to UN Expert Seminar, Montreal, 21-22 February 2016.

[25] Gregory Corosky, Presentation to UN Expert Seminar, Montreal, 21-22 February 2016.

[26] Hannah McGlade, Our Greatest Challenge, Aboriginal children and human rights, AIATSIS, 2013, Canberra.

[27] Submission: Brenda Gunn, University of Manitoba.

evidence of effectiveness in the U.S.[28] At primary and secondary levels, educational facilities should be made available and accessible by States, including through radio broadcasts and long distance education programmes, or establishment of mobile schools for nomadic indigenous peoples (CRC/C/GC/11).

Family and community integrity

57. The importance of healthy communities and families to indigenous children also cannot be underestimated. Ensuring that indigenous children have these support networks in place has protective benefits in respect of physical, mental and social health; helps to break entrenched cycles of intergenerational disadvantage; and, builds resilience and capability. The Committee on the Rights of the Child notes that maintaining the best interests of the child and integrity of indigenous families should be primary considerations in health and other programmes. Unfortunately, indigenous children are still removed from their homes at a significantly higher rate than their non-indigenous counterparts; this can cause significant childhood trauma. Moreover, indigenous children are vulnerable to abuse whilst in care of the State. States should urgently investigate and redress this phenomenon through targeted measures developed in consultation with indigenous communities to reduce the number of indigenous children in alternative care, and prevent loss of their cultural identity (CRC/C/GC/11).

Mental Health

58. The high prevalence of mental illness and suicide among indigenous people is alarming, but this is particularly the case amongst indigenous youth. Various protective factors and preventive strategies for suicide exist: for example, strong cultural affiliations are protective against suicide risk in indigenous communities (A/HRC/EMRIP/2012/3). One systematic review found that school-based suicide prevention strategies reduced depression and feelings of hopelessness, and that "gatekeeper" training (teaching specific community groups how to identify and support individuals at high risk of suicide) increased knowledge and intention to assist those at risk of suicide; other strategies effective in non-indigenous communities, such as suicide-risk screening, could also be considered.[29]

59. Information around best practices in prevention of mental illness and suicide should be shared between communities. Research in the circumpolar region has demonstrated the value of community-based and culturally guided interventions and evaluations, which could be utilized elsewhere.[30] Regional coordinating projects, such as the Rising Sun project facilitated by the Arctic Council, assist in data sharing and comparison of interventions.[31] Finally, promising new initiatives should be explored, such as the Philippines "Health Scouts" program, where children lead resilience training.[32]

[28] Submission: Australia.

[29] Anton Clifford, Christopher Doran and Komla Tsey, "A systematic review of suicide prevention interventions targeting indigenous peoples in Australia, United States, Canada and New Zealand", *BMC Public Health*, vol. 13 (2013).

[30] Jennifer Redvers and ors, "A scoping review of Indigenous suicide prevention in circumpolar regions", *International Journal of Circumpolar Health*, vol. 74 (2015).

[31] Submission: Inuit Circumpolar Council.

[32] Penelope Domongo, Presentation to UN Expert Seminar, Montreal, 21-22 February 2016.

VI. Health rights of key indigenous groups

A. Women's health

60. Indigenous women experience a "broad, multifaceted and complex spectrum" of mutually-reinforcing human rights abuses (A/HRC/30/41); these frequently include health rights violations, which extend beyond denial of access to medical services.

61. Firstly, indigenous women face many barriers to realization of their sexual and reproductive health and rights. A lack of available, accessible and acceptable healthcare services, as well as limited access to good quality care, contributes to disproportionately high maternal mortality, teenage pregnancy, and sexually transmitted infection rates, and low utilization of contraceptives, with some indigenous women "virtually excluded" from reproductive health services.[33] High rates of teenage pregnancy can also be attributed to certain structural causes such as a lack of education for girls, and forced marriage.

62. Secondly, indigenous women persistently experience high rates of maternal ill-health. Globally, maternal mortality rates are consistently higher amongst indigenous women than non-indigenous women.[34] They are frequently at risk of undernourishment, anaemia and other nutritional deficiencies, illnesses such as gestational diabetes, and frequently have little or no access to basic antenatal, intra-partum, and postnatal care.[35]

63. Finally, indigenous women and girls continue to experience violence at higher rates than the general population. Article 22(2) of the Declaration confirms that States should take steps to ensure that indigenous women enjoy full protection against all forms of violence and discrimination. Nevertheless, indigenous women are disproportionately represented among victims of rape, assault and other forms of violence. Many forms of violence against indigenous women have a strong intergenerational element, and stem from marginalization and legacies of colonization that permit or enable abuse.[36] The health impacts of violence against women include inter alia injuries, sexually-transmitted infections, gynaecological problems, mental illness, and substance dependence. Violence against women also impacts upon children, with higher rates of morbidity and mortality seen amongst those exposed.[37]

64. These challenges can be overcome in partnership with indigenous peoples. For example, community maternity wards, maternal houses and waiting homes have reduced perinatal risk in Guatemala and Peru.[38] Involvement and further training of traditional midwives in modern healthcare delivery may also reduce maternal morbidity and mortality, whilst improving service acceptability. States should consider opportunities for South-South cooperation concerning sexual and reproductive health, particularly in relation to intercultural standards (E/2013/43).

65. In many indigenous communities, birth rates remain significantly higher than comparable country averages, partly reflecting the value indigenous communities place on motherhood and childbearing. These views can occasionally clash with prevailing beliefs

[33] United Nations, State of the World's Indigenous Peoples, Volume II (Geneva, 2015).

[34] Ibid.

[35] Michael Gracey and Malcolm King, "Indigenous health part 1: determinants and disease patterns" *Lancet*, vol. 374, No. X (July 2009).

[36] Ellen Gabriel, Presentation to UN Expert Seminar, Montreal, 21-22 February 2016.

[37] WHO, Violence against women (January 2016). Available from: http://www.who.int/mediacentre/factsheets/fs239/en/

[38] UNFPA, "Promoting Equality, Recognizing Diversity: Case stories in Intercultural Sexual and Reproductive Health among Indigenous Peoples" (Panama, August, 2010).

within "mainstream" medicine: for instance, in relation to birth practices and contraception. However, the perceived conflict between the rights of indigenous peoples, and the rights of women, is often illusory. The elimination of customary law or practices that violate women's rights, such as forced marriage and domestic violence, has long been sought by many indigenous peoples (PFII/2012/EGM). Other practices that are traditional or preferred by indigenous peoples should not be prohibited by States; instead, dialogue around pregnancy spacing, contraceptive use and parenting should be conducted in a culturally sensitive manner.

66. States must do more to address gender-based violence. Indigenous women and girls frequently have no effective legal remedies for such acts. In certain jurisdictions, violence perpetrated against women by State officials such as police, military or paramilitary forces occurs. Here, women experience a two-fold rights violation: firstly, through the experience of violence, and secondly, through prevention of redress via the very mechanism that has perpetrated the violence. States must take steps to prevent this violence, and ensure acceptable mechanisms to redress such violations are available and accessible to all women.

B. Health of indigenous persons with disabilities

67. Indigenous persons experience higher rates of disability globally, compared to the general population. Barriers such as multiple forms of discrimination, poverty, systemic and physical barriers and violence contribute to the lack of full enjoyment of their human rights. The Convention on the Rights of Persons with Disabilities recognises the right to health in its Article 25; its preamble also recognises the difficult conditions faced by persons with disabilities who are subject to multiple or aggravated forms of discrimination, including indigenous persons with disabilities.

68. Indigenous children with disabilities face physical, systemic and attitudinal barriers that impede their rights to education, accessible services and disability related rehabilitation programs. Too often, indigenous children with disabilities face discrimination, abuse and bullying from their peers, caregivers and their communities. Indigenous status, intellectual disability and imprisonment frequently co-occur.[39]

69. Indigenous persons with disabilities may also experience delays in recognition of their condition due to racism and/or discrimination, or even over-diagnosis of intellectual disability due to cultural bias in testing.[40] Moreover, "institutionalised ableism" can obscure undiagnosed illness amongst people living with disabilities, where medical abnormalities are attributed to disability rather than separate pathology.[41] The potential for this to occur in indigenous people is significant, given frequent issues with language and other communication barriers, and due to health professionals' lack of education. Training and education curriculums should also include content regarding indigenous persons with disabilities, to sensitize practitioners to their needs.

70. Finally, indigenous persons living with a disability in remote areas are often required to periodically re-confirm their disability through central medical organizations to remain eligible for disability pensions, creating hardship. States and other actors should recognise the double or multiple burdens of discrimination suffered by indigenous persons with disabilities, and take steps to address these.

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[39] M Frize, D Kenny and C Lennings, "The relationship between intellectual disability, Indigenous status and risk of reoffending in juvenile offenders on community orders" *Journal of Intellectual Disability Research*, vol. 52, [illegible] June 2008).

[40] Ibid.

[41] Submission: First Peoples Disability Network.

VII. Current challenges relating to indigenous peoples and the right to health

A. Communicable and non-communicable disease

71. Indigenous peoples experience disproportionately high levels of infectious diseases such as HIV/AIDS, malaria and tuberculosis, with HIV infection risk increased amongst indigenous peoples migrating to urban areas.[42] States should recognise the higher risk profile of indigenous peoples in relation to these diseases, and the multiple burden of discrimination they suffer upon contracting such illnesses. Additionally, indigenous peoples disproportionately suffer from "neglected" tropical diseases (NTDs), such as trachoma, helminth infections, yaws, leprosy and strongyloidiasis.[43] Widespread or mass consensual treatment for these conditions should be considered by States, where effective medications exist. It is also important that State funding for indigenous health activities is not predicated on wellness, particularly in communities already experiencing disadvantage. In the Russian Federation, an increasing incidence of tuberculosis in indigenous communities has been used as a criteria for non-approval or reduction of federal subsidies.[44]

72. There has also been an enormous rise in the incidence of non-communicable diseases (NCDs) amongst indigenous peoples; they experience disproportionately high rates of cardiovascular illness, and it has been estimated that more than 50% of indigenous adults over age 35 suffer from Type II diabetes worldwide (ST/ESA/328). This is linked to urban migration of indigenous peoples, whose lifestyles rapidly change to incorporate modern high-calorie, fat and salt diets.[45] For example, in the Philippines, development and changes in agricultural practices and dietary preferences have contributed to soaring rates of diabetes mellitus, renal disease, cardiovascular disease, hypertension and cancer.[46] Moreover, global data reveal high rates of consumption of alcohol and tobacco use amongst indigenous peoples, particularly men.[47] Pregnant indigenous women are also particularly vulnerable to diabetes (E/2006/43).

73. States should take specific steps to combat the extraordinary burden of these illnesses amongst indigenous peoples. Affordable access to key medications, such as insulin and anti-hypertensives, should be ensured, as high out-of-pocket payments for these medications can lead to rapid, preventable health deterioration. "Tele-health" or mobile health initiatives to monitor indigenous peoples with chronic illness living in remote areas should also be considered. The value of exercise and participation in sport should not be underestimated, for its direct health benefits in respect of NCD prevention, and indirect health benefits, such as increased social inclusion and self-esteem. Among Indigenous Australian youth there is a positive relationship between self-reported participation in sport and health outcomes, including mental health; involvement in sport is even demonstrated to

[42] Michael Gracey and Malcolm King, "Indigenous health part 1: determinants and disease patterns" *Lancet,* vol. 374, No. X (July 2009).

[43] Peter Hotez, "Aboriginal Populations and Their Neglected Tropical Diseases", *PlOS Neglected Tropical Diseases*, vol. 8, No. 1 (January 2014).

[44] Federal government act of 10.03.2009 №217 «On approval of the Terms of distribution of subsidies from the federal budget to the budgets of subjects of the Russian Federation to support the economic and social development of the indigenous peoples of the North, Siberia and the Far East of the Russian Federation"

[45] Michael Gracey and Malcolm King, "Indigenous health part 1: determinants and disease patterns" *Lancet,* vol. 374, No. X (July 2009).

[46] Penelope Domogo, Presentation to UN Expert Seminar, Montreal, 21-22 February 2016.

[47] See e.g. Submission: IWNI.

deter juvenile delinquency.[48] It is also very encouraging that traditional games and sports, such as the World Indigenous Games held in 2015, are being supported and promoted by States, given their role in prevention of illness and wellness promotion.

74. The importance of good occupational health for indigenous persons must also be noted. For example, some indigenous peoples suffer from silicosis as a consequence of poor occupational hygiene in stone processing factories, a traditional livelihood in some indigenous territories of the Russian Federation. States should ensure the protection of the health of indigenous peoples working in both traditional and mainstream industries.[49]

B. Environmental health, climate change and displacement

75. Poor environmental health has long been a concern of indigenous peoples. The Committee on the Rights of the Child has highlighted the importance of environmental health to children, and recognised climate change as a particularly urgent threat to indigenous children's health and lifestyles, noting that States should put children's health concerns at the centre of their climate change adaptation and mitigation strategies (CRC/C/GC/15.). Those who are already vulnerable, including indigenous peoples, experience the worst effects of climate change (A/HRC/31/52). For example, climate change is contributing significantly to food insecurity amongst the Inuit peoples of the Canadian Arctic, whose hunting and fishing practices have been threatened by changes in ice, with significant reductions in hunting grounds.[50] Replacement of traditional food sources with "mainstream" dietary elements is costly in such locations, and carries its own health risks.

76. Development-related activities of States or third parties, such as multinational corporations, may also compromise indigenous peoples' underlying determinants of health, such as food, safe drinking water and sanitation. This can occur through displacement of indigenous peoples from traditional lands, or land or water contamination, resulting in infringements of health and other rights, such as the right to life.[51] Contamination can also occur through use of pesticides banned within certain States that are nevertheless exported and used elsewhere.[52] It is an ironic outcome of development and globalization that indigenous peoples are consistently among those most vulnerable to food insecurity, malnutrition, and chronic diseases, given their wealth of traditional knowledge regarding sustainable, healthy living within rural ecosystems. This vulnerability is a living reality for many indigenous peoples; diabetes and cardiovascular diseases have been causally linked to the impact of colonization and dispossession of lands, territories and resources.[53]

77. Efforts should be made to promote cooperation between indigenous peoples and businesses, to minimise the negative impact of development, as has occurred in Russia.[54] Identifying indigenous peoples' rights to land, forests, marine and other natural resources is also vital to indigenous peoples' livelihoods and well-being. The importance of maintaining

[48] Submission: Cultural Survival.

[49] Expert Seminar "Finno-Ugric Peoples and Sustainable Development: Health of Indigenous Peoples", Petrozavodsk, Russian Federation, 25-26 May 2016.

[50] Sheila Watt-Cloutier, Presentation to UN Expert Seminar, Montreal, 21-22 February 2016.

[51] See e.g. *Xákmok Kásek Indigenous Community v. Paraguay*, Inter-American Court of Human Rights, 24 August 2010.

[52] Submission: International Indian Treaty Council.

[53] Royal Commission on Aboriginal Peoples, *Report of the Royal Commission on Aboriginal Peoples, vol. 3* (Ottawa: Canada Communication Group, 1996).

[54] The UN Global Compact in the Russian Federation: Business and indigenous peoples (Moscow, September 12, 2013).

this connection with land is also recognised in certain legal instruments.[55] Where indigenous peoples are empowered to care for and maintain their land, this creates another virtuous cycle: natural resources are used more sustainably, employment prospects are created, and the overall health of communities improves. Indigenous peoples should retain decision-making control over these resources to ensure sufficient food and nutritional security, especially where communities are dependent on marine and terrestrial resources for survival (E/C.19/2005/9).

[55] Article 4.5, African Union Convention for the Protection and Assistance of internally Displaced Persons in Africa.

Annex

Expert Mechanism Advice No. 9 (2016): The right to health and indigenous peoples

A. General

1. The right to health of indigenous peoples is enshrined in multiple international and national instruments, and forms an important part of human rights law. This right is interrelated to various key rights accrued by indigenous peoples, including rights to self-determination; development; culture; land, territories and resources; language; and, the natural environment.

2. Indigenous concepts of health are broad and holistic, incorporating spiritual, environmental, cultural and social dimensions in addition to physical health. Forced cultural assimilation; land dispossessions and use for extractive industry; political and economic marginalization; poverty; and, other legacies of colonialism have led to a lack of control over individual and collective health, and undermined realization of indigenous peoples' health rights.

3. Health statistics the world over illustrate indigenous peoples' disadvantaged position in terms of access to quality healthcare, and vulnerability to numerous health problems, including communicable and non-communicable diseases. Indigenous women, youth, children and persons with disabilities face particular challenges, including higher maternal mortality and suicide rates, and face multi-faceted forms of discrimination.

B. Advice for States

4. States should recognize, and enhance protection of, the right to health of indigenous peoples by ratifying and incorporating into their domestic law ILO Convention No. 169, the International Covenant on Economic, Social and Cultural Rights, and other key human rights treaties, and taking concrete measures to implement the United Nations Declaration on the Rights of Indigenous Peoples.

5. States should recognise the inherent right of indigenous peoples to determine their own futures, including control over their own health. States should consider entering into treaties with indigenous peoples, explicitly safeguarding rights to self-determination and health, and implement relevant treaty commitments where they already exist.

6. Health is an indispensable component of indigenous peoples' very existence, survival, and entitlement to live in dignity and determine their own futures. States should therefore seek the free, prior and informed consent of indigenous peoples before implementing laws, policies or programs impacting upon their health or health rights.

7. States should implement national plans for indigenous peoples' health in full consultation with indigenous peoples, or create or amend existing national health plans to incorporate specific programmes and policies for indigenous peoples. States should also incorporate the right to health into national action plans for the implementation of the United Nations Declaration on the Rights of Indigenous Peoples.

8. States should ensure that indigenous peoples are given full access to publicly-run healthcare facilities, goods, and services; as well as facilities, goods, and services relating to underlying determinants of health, such as safe and potable water, and adequate food and

sanitation. Introduction and implementation of comprehensive anti-discrimination laws, and collection and use of disaggregated data, is vital to achieve this.

9. Laws or policies that permit or sanction violence against indigenous peoples, even if only implicitly, should be repealed by States, and steps taken to address violence perpetrated by State representatives (such as armed forces) or by third parties. Violence in healthcare settings, such as forced sterilization and female genital mutilation, should be explicitly prohibited.

10. States should not endanger the environmental health of indigenous peoples, including through air pollution, or water and soil contamination by State-owned facilities or other activities. States should take steps to protect indigenous peoples from environmental damage caused by third parties (such as private companies), minimising the impact of extractive industries in particular on the physical and mental health of indigenous peoples through legislative and practical measures.

11. Indigenous peoples should be permitted to identify as distinct groups within States, and States should take positive measures to ensure collection of disaggregated data from indigenous peoples. States should also facilitate access to healthcare services through improved birth registration processes, and through removal of birth registration as a precondition to access to healthcare services.

12. States should take steps to support preservation of indigenous cultures, and protect indigenous peoples from appropriation and commodification of their knowledge, traditional medicine and other practices by third parties. Indigenous peoples should be allowed to practice and access traditional medicine; however, harmful practices that infringe other rights, such as female genital mutilation, should be eradicated, in partnership with indigenous peoples.

13. States should provide sufficient resources to indigenous peoples to facilitate creation and operation of their own healthcare initiatives, or in the absence of indigenous-controlled services, provide programs and interventions directly to indigenous peoples, including through the implementation of special measures necessary for indigenous peoples to fully realize their health rights.

14. States should secure access to quality healthcare services, including preventive care, for nomadic and remote indigenous peoples, including through mobile clinics, telemedicine and ITCs.

15. States should ensure interpretation services are available to indigenous patients, to ensure adequate communication in the healthcare setting.

16. States should take steps to train indigenous healthcare workers, and accredit indigenous health practitioners and integrate them into healthcare systems. States should also improve healthcare training curricula to train healthcare workers to deliver culturally appropriate services, and create programs and services to sensitize practitioners regarding treatment and management of indigenous persons.

17. Culturally appropriate health promotion tools and information should be devised and disseminated by indigenous peoples in partnership with States, to prevent both communicable and non-communicable diseases. Sufficient resources should be allocated for healthy lifestyle information programs to be devised, and States should design specific preventive strategies for communicable and non-communicable diseases in partnership with indigenous peoples.

18. States should implement legislation, policies or programs to support indigenous peoples in making informed choices about their health; these should include initiatives to

improve indigenous peoples' choices around underlying determinants of health, such as consumption of healthy food and active lifestyles.

19. Educational initiatives for indigenous peoples should be prioritized by States, given the strong direct and indirect links between health and educational attainment. States should ensure that every indigenous child has access to primary and secondary education, and that all indigenous peoples can access health-related educational resources.

20. The high rate of removal of indigenous children from families and communities worldwide, and the far-reaching health effects of intergenerational trauma attributable to removal from families and placement in residential schools and other facilities, should be further investigated by States. Steps should be taken to preserve the integrity of indigenous families in accordance with the rights of the child, and for affected indigenous persons to receive preventive and curative healthcare services they require for health sequelae, such as mental illness.

21. States, in cooperation with indigenous peoples, must take immediate steps to reduce the high rate of indigenous suicide worldwide, particularly amongst children and youth. Proven preventive measures should be implemented in high-risk communities, and sufficient resources allotted to achieve genuine improvements in mental health amongst indigenous peoples.

22. States should provide resources and materials to deliver culturally appropriate healthcare to women, especially around maternal health and sexual and reproductive health and rights.

23. States should ensure that women are protected from violence, through enforcement of criminal laws or use of indigenous juridical mechanisms. States should also offer support services and resources for women who experience violence, including monetary resources where necessary.

24. States should take steps to combat discrimination against indigenous persons living with disabilities through implementation of legislation, policies and programs, and create mechanisms to protect these people against rights abuses perpetrated by third parties. States should also implement culturally appropriate services (diagnostic and otherwise) taking into account indigenous needs in identifying and managing disability.

25. States should promote the exercise of Indigenous traditional games and sport, such as through the World Indigenous Games.

26. States need to legally recognize and protect the right of indigenous peoples to their lands, territories and resources through appropriate laws and policies, given the intrinsic connection of this recognition with the right to health.

27. States should devise concrete plans to implement the COP21 Paris Agreement provisions, to mitigate the harmful effects of climate change, and tailor their health sector planning to prepare for health-related impacts of climate change, which disproportionately affect indigenous peoples.

28. States should ensure that adequate mechanisms are in place for redress and remedy of health rights infringements, including treaty rights, either through mainstream or indigenous juridical systems. Indigenous juridical systems may have certain advantages in respect of resolution of complaints of health rights violations.

C. Advice for indigenous peoples

29. Indigenous peoples should strengthen advocacy efforts for recognition of indigenous health rights and rights to self-determination, with the aim of creating indigenous community-controlled healthcare facilities, goods and services that are available, accessible, acceptable and of good quality.

30. Indigenous peoples should continue to advocate for proportionate representation and genuine participation in policy decisions regarding healthcare, and push States to ensure that their free, prior and informed consent is obtained before implementation of laws, policies and projects affecting indigenous peoples.

31. Indigenous peoples can take measures to protect and promote traditional medicine and associated practices, including advocating for State recognition to receive full protection under the Nagoya Protocol, and for traditional healing and medical practices to be included in mainstream healthcare services.

32. Indigenous peoples should ensure that steps are taken within communities to protect children and youth from practices with negative health impacts, including alcohol and drug misuse, and work with States to address these issues.

D. Advice for international organizations

33. The World Health Organization should consider appointing a focal point on indigenous peoples' health issues, to better address the pressing concerns that are raised worldwide in respect of realization of indigenous health rights.

34. The United Nations, its agencies and other international organizations should emphasise the importance of provision of mental health services to indigenous peoples, and take steps to address indigenous suicide, particularly amongst children and youth. The World Health Organization should also coordinate further research into youth suicide. These organizations should share information and support indigenous communities in tackling this issue.

35. UNFPA should take into consideration the rights of indigenous peoples, particularly women and young people, in their planning, given the disproportionate burden of morbidity and mortality suffered by indigenous women, and the lack of realization of their sexual and reproductive health rights.

36. The World Health Organization, the World Bank, and other international organizations should conduct research into, and disseminate information regarding best practices around community-controlled healthcare, to promote its adoption.

37. Together with States, multilateral agencies and other actors should also invest more resources in research and development for novel, affordable treatments for neglected tropical diseases that are disproportionately experienced by indigenous peoples.

38. The World Health Organization and other United Nations agencies should work with indigenous peoples to develop policy guidelines for incorporation of indigenous traditional knowledge into national healthcare systems, including through recognition of best practices in this area.