

**RESEARCH AND EXPERT
SEMINAR MATERIAL
ON THE THEME "INDIGENOUS PEOPLES
AND THE RIGHT TO HEALTH"**

**Expert seminar
“The FinnoUgric peoples
and sustainable development.
Health of indigenous peoples”**

**May 26 – 27, 2016
Petrozavodsk, Republic of Karelia,
Russian Federation**



DAY 1

GREETINGS

Andrey Aleksandrovich Manin delivered a welcoming speech on behalf of The Ministry of the Republic of Karelia for National Politics, Relations with Public and Religious Associations and Mass Media.

Ombudsman for Human Rights in the Republic of Karelia Aleksandr Sergeyevich Sharapov greeted the seminar participants. He announced that, on the request by the Ombudsman for Human Rights in the Russian Federation, his administration has produced a report, which inter alia covers information on the state of public health services, including statistical data on the accessibility of health care facilities, preventive medical examination among indigenous peoples, the morbidity rate, protection of the disabled from among indigenous peoples. The ombudsman asserted that they all have a stake in the results of the expert seminar.

THEME “International law and national standards regarding the right to health of indigenous peoples”

Moderator Vasily Nikolayevich Nemetchkin gave a review of the Russian legislation and International law regarding a guaranteed right to health of indigenous peoples. He specifically dwelled upon the Constitution of the Russian Federation and the UN Declaration on the Rights of Indigenous Peoples. The moderator summarized this section of the speech by saying that the key principle is to make it possible for indigenous peoples to avail of the highest attainable standards in the area of physical and mental health.

Chair of the UN Expert Mechanism on the Rights of Indigenous Peoples Alexey Vasilyevich Tsykarev presented the preliminary results of the study “Of indigenous peoples and the right to health, with a focus on children and youth”. He dwelled more specifically upon the major challenges and trends revealed by the international experts: an increase in the suicide rate among youth, alcohol abuse, population outflow from places of traditional residence to cities, the loss of language and culture and its impact on people’s mental health, violations of women’s reproductive and sexual rights, a low awareness level about diseases, limited or inhibited access to health care in remote places of residence of indigenous peoples.

The speaker presented to the participants a project of recommendations of the Expert Mechanism for nation states, indigenous peoples and international organizations (Appendix №1). These recommendations call on states in cooperation with indigenous peoples to modernize their legislation and elaborate national plans in the field of public health services for indigenous peoples, and also ensure their access to health care facilities and medications. Nation states are also recommended to provide for obtaining statistical information regarding the health of indigenous peoples. Indigenous peoples and nation states are also advised to draw up culturally acceptable educational programs in the field of health promotion for indigenous peoples. The World Health Organization is recommended to prioritize the health matters of indigenous peoples and to appoint a designated representative that would be in charge of this subject. Summing it up, the speaker emphasized that without ensuring the right to health there is no point in talk-

ing about the observance of other rights of indigenous peoples including the right to development.

Answering the participants' questions A. V. Tsykarev emphasized the importance of ensuring access to public health services for nomad tribes and peoples living in remote and inaccessible areas. He also explained that there is no universal term "indigenous people", but the existing range of terms and international instruments makes it possible to effectively protect the collective rights and interests of various groups of indigenous peoples. In relation to the question of the impact of business and large industrial projects on the health of indigenous peoples, the speaker referred to the United Nations Guiding Principles on Business and Human Rights.

In the course of the discussion the participants also brought up the question of access to health care facilities of indigenous peoples in an urban setting and the negative impact of hostel-schools on their mental health. The participants agreed that the primary focus in the sphere of the health of indigenous peoples of Russia should be on native minorities and other peoples with similar characteristics. The participants came to a conclusion that in the context of the discussion it is possible to talk about the majority of the Finno-Ugric peoples of Russia.

Vice-Chair of The United Nations Permanent Forum on Indigenous Issues Aisa Bokkayevna Mukabenova presented the work of this subsidiary body established at UNECOSOC regarding the right to health of indigenous peoples. The Permanent Forum pays special attention to issues related to the health of indigenous peoples, always adverts to this subject both in during the sessions and in the course of special studies. Recently, a range of questions

connected with the health of youth from among indigenous peoples have been considered, especially the problem of suicides and the subject of sexual health and reproductive rights. It is characteristic of indigenous peoples in different countries to have a low life expectancy, a high level of maternal and infant mortality and social diseases, such as tuberculosis. The access to public health services is often limited or restricted due to the cultural divides, language differences, a vast geographical distance, poverty and other factors. A high level of mental diseases, depression, drug addiction and alcohol abuse, as well as an increase in the suicide rate are all connected, among other things, with the history of colonization, the loss of traditional land, as well as the difficulties of adaptation to the demands of modern life, imposed by industrialization, commercialization and urbanization.

In regard to the Russian reality, the speaker also highlighted the social and economic (the destruction of the tradition lifestyle pattern and living environment, the shutting down of unprofitable production based on traditional crafts, unemployment, etc.) and biomedical (the genetic functional peculiarities of an organism, low adaptive resources, the change in the daily diet and its quality) reasons for the deterioration of health among indigenous minorities of the Russian Federation. In view of this, nation states must create innovative models that would make it possible to increase access to public health services, first of all for those who lead a nomadic life or live in remote and inaccessible areas. Statistical data collection is still a priority because it would allow an adequate evaluation of the health of indigenous minorities in order to take appropriate measures in the sphere of health care.

THEME “Access to health care facilities and morbidity rate of indigenous peoples of Russia”

10. Head of Department of Health Service Provision of the Ministry of Public Health of the Republic of Karelia Andrey Grigoryevich Mikhailov described the morbidity rate by main disease classes across the board in the Republic of Karelia, placing special emphasis on the data relating to three national districts (Kalevalsky, Olonetsky and Pryazhinsky) and Prionezhsky district (where three Vepsian rural settlements are located). The speaker emphasized that there are no diseases associated with the national identity, but it is possible to elicit a certain disposition. By way of example, he mentioned hypolactosia – milk protein intolerance observed in the Finno-Ugric peoples.

Among the main trends A.G. Mikhailov mentioned the higher mortality rate, the growth of the morbidity level. According to the speaker, the mortality rate due to circulatory system diseases and oncological diseases in Karelia is higher than in North-western Federal District. Due to the ecological issues and dietary problems there is an increase in the number of oncologic patients. Cases of pneumonia have also been reported. The speaker noted a positive trend regarding tuberculosis, but also a high mortality rate from diseases associated with alcoholism. At the same time, the tendency of tuberculosis incidence in the areas of compact settlement of indigenous peoples is one of the criteria for the allocation of federal aids to regions for the purpose of supporting indigenous minorities.

The speaker pointed out the rise in the number of ambulance calls. The preventive medical examination of population reveals the following risk factors: an improper diet,

excessive body weight, genetic background. The speaker also mentioned the possibility of the influence of traditional crafts on the health of indigenous peoples. For instance, people keen on fishing should take into consideration that fish has a tendency to accumulate harmful substances.

The representative of health care industry observed that suicides and alcoholism among youth are determined by social vulnerability, low income and unemployment. A. G. Mikhailov considers lung diseases in Vepsian rural settlements to be occupational illnesses, attributing their increase to the non-observance of health and safety rules. He also emphasized the necessity of cooperation between health care facilities and local government bodies.

The expert from Murmansk region Valentina Vyacheslavovna Sovkina explored the theme of the seminar from the point of view of the realization of the right to health by the Saami people. The speaker mentioned the high level of alcohol abuse and the lack of relevant statistical data. She also provided a few examples of positive discrimination, when the patient files of representatives of indigenous peoples in local clinics were marked with special notes. She also mentioned the “Health Train” project as an example of positive practice.

V. V. Sovkina believes that representatives of indigenous peoples refuse to undergo a preventive medical examination due to its complicated procedure. Also, according to the speaker, a lot of people are not informed about the medical checkup being carried out. Indigenous peoples are often uninvolved in the preparation of awareness campaigns in the sphere of health care, and the level of interdepartmental interaction still remains low.

The speaker expressed great concerns about the constant growth and the high

levels of the so called social diseases (tuberculosis, substance dependence disorders). The major factor of the propagation of these diseases is associated with asocial way of life and the influence of alcoholism on these processes. The speaker noted the lack of official statistics on diseases among indigenous peoples and emphasized the necessity to ensure access to health care facilities for representatives of indigenous peoples.

Member of Presidential Council of the Russian Federation for Interethnic Relations Gulvaira Kudenovna Kutsenko emphasized the necessity to strike a balance between the development of tourism and the preservation of the traditional lifestyle. According to the speaker, tourists and rotational employees in the places of traditional residence of indigenous peoples allow for promiscuity, which influences the incidence rate of HIV/AIDS and venereal diseases in indigenous communities.

G. K. Kutsenko shared her observations about the fact that the topic of sexual health is a taboo subject among indigenous populations, which in its turn hinders preventive actions. Along with that, the speaker also reported that non-profit institutions organize workshops and seminars devoted to the prevention of HIV/AIDS for youth from among indigenous peoples, local authorities and government bodies. The speaker is confirmed that the authorities should support such activities of non-profit institutions and among other things provide funding for them.

19. In the course of the discussion, the participants suggested supporting the WHO Strategy to fight the global tuberculosis epidemic (for the period 2016-2035). It was also mentioned that it is necessary to use joint effort of the state and indigenous peoples in order to eliminate traditions and

practices that have a negative effect on people's health.

THEME "Spiritual health, traditional medicine, demography, ecology"

The leading research associate of the Institute of Ethnology and Anthropology RAS Natalia Ivanovna Novikova presented a report on the topic "Life among oil derricks: the emotional well-being of aboriginal population and oil-industry workers". According to the speaker, due to the hopelessness and frustration in the fight with the industrial exploitation, the indigenous peoples of the North can suffer from insuperable stress leading to a feeling of pre-determinacy of everything that is going on around them. In this respect, indigenous peoples are more prone to alcohol abuse and suicides. In order to prevent alcoholism the speaker suggests introducing tougher regulations concerning alcohol sales, following the example of Norway and Canada. The speaker is firmly convinced that it is essential to release to the public the objective findings on the health of indigenous peoples, and in particular the data on alcoholism in indigenous communities.

According to the speaker, indigenous peoples care for their future – not their personal future as individuals, but their future as bearers of certain knowledge. Indigenous peoples fear that this knowledge which preserves their land can be lost. The speaker strongly believes that oil destroys the connection between man and his land, as well as the connections with their cultural foundations, which gives rise to such phenomena as alcohol abuse and suicides. The state of psychological stress leads to their escape into their own culture, which in its turn results in the encystment of the self.

According to N. I. Novikova, traditional crafts and industries of indigenous peoples is their freedom, whereas oil and oil derricks curtail this freedom. This is the reason why indigenous population seeks escape in their culture, and the next step would be death, escape from life. Oil and money lead to ostentatious wealth and bring in a lot of alien and negative elements to indigenous communities.

Another problem is the lack of special knowledge about the customs and traditions of indigenous peoples among the managerial staff of oil companies, despite the fact that it is recorded in their own internal regulations that they are supposed to know and respect the traditions of the indigenous population. The speaker emphasized that for aboriginal peoples the issue of industrial exploitation is a matter of life and death.

A possible way out from the current situation, according to the speaker, could be the observance of the right of indigenous peoples to free, prior and informed consent that the state must guarantee.

DAY 2

THEME "Public health services in the areas of compact settlement of indigenous peoples. Focus: the Republic of Karelia".

Chief Medical Officer of the Prionezhsky District Central Hospital Izabella Vitalyevna Kraskova made a report on the accessibility of public health services in the areas of compact settlement of the Veps people. The speaker specifically dwelled upon the problems of the wear-out and depreciation of the equipment and facilities. By way

of example I. V. Kraskova mentioned the building of the local medical and obstetrical station that was erected in the 1920-s.

Another challenge that the health care institutions of Prionezhsky district face is the prevention of tuberculosis and silicosis, as well as the prevention of infectious diseases. In this realm, a number of international projects have been implemented. There is a problem of underfunding and use of outdated diagnostic methods. For instance, it is known that X-ray fluorography does not reveal tuberculosis at an early stage, however it is exactly this diagnostic method that is currently used everywhere.

The speaker pointed out that stone working and carving – a type of activity that many Vepsians are engaged in – has been proposed for being included into the list of traditional business activities of indigenous peoples. At the same time, due to the non-observance of safety rules, poor workplace hygiene and a lack of preventive actions, silicosis has become an occupational disease in the places of traditional residence of the Veps people. This is a rare instance of a traditional craft having a negative impact on the health of the indigenous population.

According to the speaker, the business in places of residence of indigenous peoples is supposed to provide financial support to the development of health care, especially in the cases when the business has a negative effect on the health of the population in these territories.

Among other challenges that the local health care faces the speaker also noted the problem of personnel reduction, the so called optimization. A high percentage of children's and familial morbidity is reported. Poor nutrition and the declining living standards negatively affect the immune resistance of the residents in the

places of traditional settlement of indigenous peoples.

Chief Medical Officer of the Kalevalsky District Central Hospital Svetlana Vasilyevna Krupenkina outlined the situation regarding the morbidity rate and the state of health care in the places of traditional residence of the Karelians – Kalevalsky national district. According to the speaker, the current situation in the district is characterized by a population decline due to the negative migration and the high mortality rate. Every other resident of the district has one or another disability status. The hospital provides services not only to residents of Kalevalsky district, but also to people from the neighboring settlements of Loukhsky district.

There are also other challenges that hinder the accessibility of public health services in Kalevalsky district, among them – a shortage of personnel and a lack of funding. The poor quality of the road network leads to the quicker wear-out of ambulances. The statistics on suicides and diseases associated with alcoholism also raise concerns. The hospital has experience in developing tele-health (health care at a distance), possesses advanced equipment. Many doctors speak Karelian and know some folk medicine practices, in particular, the medicinal properties of some herbs. Herbal medicine is considered to be one of the elements of the Karelian culture.

Elaboration of recommendations for the World Congress of the Finno-Ugric Peoples.

DEVELOPMENT OF SUGGESTIONS FOR THE STUDY OF THE UN EXPERT MECHANISM ON THE RIGHTS OF INDIGENOUS PEOPLES.

The seminar participants suggested

dividing all the recommendations of the seminar into two groups: a) more general recommendations for the World Congress of the Finno-Ugric Peoples and the study of the UN Expert Mechanism on the Rights of Indigenous Peoples, б) more specific recommendations for the federal and regional government bodies of Russia.

The participants' suggestions covered the following aspects:

- *occupational diseases and workplace hygiene*
- *preventive measures and use of modern technology in preventive actions the need for equipment and facilities improvement*
- *transport accessibility improvement*
- *ensuring accessibility of public health services*
- *development of paramedicine*
- *spread of best practices*
- *obtaining objective statistical data*
- *training programs and maintaining workforce capacity*
- *use of native languages in health care*
- *violence against women*
- *a balance between business and ecology*
- *mental health and the activities of industrial companies*
- *the right to free, prior and informed consent*
- *the problem of social orphanhood*
- *promotion of healthy eating habits and a healthy lifestyle*
- *the social responsibility of business in the places of traditional residence of indigenous peoples*
- *sanitation and hygiene promotion*
- *revision of the law on medical and social assessment*
- *revision of the periodicity for confirming one's disability status in remote and inaccessible areas*

- *the need for urgent measures to fight the high incidence rate of tuberculosis*
- *revision of the factors and indicators in the sphere of health care for the allocation of federal aids to regions for the purpose of supporting indigenous peoples.*

THEME “The goals and indicators of Sustainable Development and the rights of indigenous peoples. Adaptation of the Sustainable Development Goals in the Finno-Ugric agenda. Elaboration of recommendations for the World Congress of the Finno-Ugric Peoples”.

34. Associate Professor of the Department of Legal Disciplines of N. P. Ogarev’s Mordovian State University Vasily Nikolayevich Nemechkin presented the Sustainable Development Goals adopted by the member states of the UN in 2015. He also reported on how the rights of indigenous peoples have been reflected in the sustainable development agenda for the period till 2030. The speaker pointed out the differences in terminology and suggested that along with the rights of indigenous minorities we should also take into consideration the rights of other native peoples with similar characteristics.

Executive Director of the Association of Finnish Culture and Identity Sakari Linden in his capacity as a moderator of the topical field “Economics and the environment” of the VII World Congress of the Finno-Ugric peoples presented his vision of the main discussion trends in this section. The speaker believes that the main viability indicators of the Finno-Ugric peoples are: the population size, the number of native speakers and the social status of their language and culture.

The discussion in the topical field “Economics and the environment” is going to consist of two parts: “Sustainable economic development, indigenous peoples and business” and “Sustainable tourism (ecotourism and ethnotourism)”. The speaker believes that the Finno-Ugric movement does not take full advantage of the potential of the participation in the global movement of indigenous peoples, especially when it comes to adopting best practices. He is confirmed that the key focus in the sustainable development should be on the language preservation and its greater representation in the economic life. Sakari Linden also provided a number of examples of the commercial importance of the use of native languages in tourism.

Aisa Bokkayevna Mukabenova emphasized the importance of improving the qualification of representatives of indigenous peoples for their more effective involvement in the process of outlining and realization of the sustainable development agenda for the period till 2030. She also mentioned a number of other UN documents aimed at the enhancement of the role of indigenous peoples in the process of exercising their right to development, such as the resulting document of the World Conference on Indigenous Peoples (2014), launched in May of this year. The system-wide plan on indigenous peoples has been designed to ensure the coordination of all UN agencies in the sphere of the protection of indigenous peoples’ rights and interests, especially in the realization of the sustainable development goals. The report on the implementation of the Agenda will be carried out with the use of a set of global indicators, which are expected to be supplemented by indicators developed by the state on the regional and national levels. The Permanent Forum is also elaborating specific indicators, which will be used for

statistical measurements of the progress in the development of indigenous peoples of the world. She also emphasized the necessity of elaboration of such indicators on the regional and federal levels in Russia, which would allow the assessment of the progress in the implementation of such documents as the Concept of Sustainable Development of Indigenous Minorities of the Russian Federation.

THE MAIN CONCLUSIONS:

- Due to the social and economic ill-being, stress, poor nutrition, lack of awareness and insufficient prevention, indigenous peoples have a weak immunity and are subject to various infectious, non-infectious and social diseases.
- The access of indigenous peoples to high-quality public health services is hindered by the current state of the equipment and facilities, shortage of personnel, limited use of information and communication technology, insufficient funding, closing down of the “unprofitable” health care institutions.
- There is no clear strategy regarding the elimination of the negative impact of industrial companies on the health of indigenous peoples.
- The potential of the cooperation between organizations of indigenous peoples, public authorities and health care institutions, that together could carry on awareness-raising and preventive campaigns, is nowhere near exhausted.

RECOMMENDATIONS TO THE BODIES OF EXECUTIVE POWER OF THE RUSSIAN FEDERATION:

- To ensure exchange of good practices in the area of health care and to provide

support to initiatives aimed at the improvement of the periodic medical examination system and health promotion of indigenous peoples, such as the “Health Train” in Murmansk region.

- To ensure collection and publication of objective statistical data on the morbidity rate among indigenous peoples. To introduce statistical recording of medical, demographical and social indicators of indigenous minorities through the use of different forms of federal state statistical monitoring.
- In cooperation with organizations of indigenous peoples, to elaborate educational and training programs for the staff of industrial companies on the traditions and culture of indigenous peoples for the purpose of raising awareness of the companies’ managerial staff about the importance of the traditional lifestyle for the preservation of the culture of indigenous peoples and their emotional health.
- To elaborate programs for the development of paramedicine and for the training of paramedics, involving specialists from among the indigenous population. To make provision for the funding for the development of paramedicine.
- To revise the system of periodic confirmation of one’s disability status for representatives of indigenous peoples residing in remote and inaccessible areas.
- To revise the indicators for allocating grants-in-aid to regions for the purpose of supporting indigenous peoples connected with the incidence rate of tuberculosis.

TO THE LEGISLATIVE BODIES OF THE RUSSIAN FEDERATION:

1. To formalize in legislation the responsibility of industrial companies to perform timely repairs of the infrastruc-

ture and to ensure workplace hygiene and safety, and also to implement policies that would secure the right to health, in particular the mental health of indigenous peoples, in compliance with the UN Guiding principles on Business and Human Rights.

2. To prohibit alcohol advertizing and considerably restrict the retail sales of alcoholic products in the places of traditional residence of indigenous peoples.

TO LEGAL INSTITUTES AND HUMAN RIGHTS BODIES:

The human-rights ombudsman in the Russian Federation and the regional representatives are to prepare topical reports on the enforcement of the right to health of indigenous peoples.

TO ORGANIZATIONS OF INDIGENOUS PEOPLES:

In cooperation with the public authorities and health care institutions, to elaborate awareness-raising campaigns, seminars and workshops for indigenous peoples on a healthy lifestyle, healthy nutrition, sexual health, prevention of venereal diseases and HIV/AIDS.



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Right to health and indigenous peoples with a focus on children and youth

Study by the Expert Mechanism on the Rights of Indigenous Peoples

SUMMARY

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

The present study consists of a critical analysis of the content of the right to health vis-à-vis indigenous peoples and a review of the legal obligations of States and others in terms of fulfilling that right.

Expert Mechanism advice No. 9 on the right to health and indigenous peoples is contained in the annex.

CONTENTS

I. Introduction	15
II. Right to health and indigenous peoples: legal and policy framework	16
A. NORMATIVE FRAMEWORK ON THE RIGHT TO HEALTH	16
B. OTHER KEY INSTRUMENTS, POLICY PROCESSES AND DOCUMENTS	18
III. Treaty rights, self-determination and health	19
IV. Indigenous peoples' right to health: State obligations	20
A. AVAILABILITY, ACCESSIBILITY, ACCEPTABILITY AND QUALITY FRAMEWORK	20
B. RESPECT, PROTECT AND FULFIL FRAMEWORK	22
V. Indigenous children and youth and the right to health	27
VI. Health rights of key indigenous groups	30
A. WOMEN'S HEALTH	30
B. HEALTH OF INDIGENOUS PERSONS WITH DISABILITIES	31
VII. Current challenges relating to indigenous peoples and the right to health	32
A. COMMUNICABLE AND NON-COMMUNICABLE DISEASES	32
B. ENVIRONMENTAL HEALTH, CLIMATE CHANGE AND DISPLACEMENT	34

ANNEX

EXPERT MECHANISM ADVICE NO. 9 ON THE RIGHT TO HEALTH AND INDIGENOUS PEOPLES

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 States, indigenous peoples, national human rights institutions and other stakeholders to provide information for the study. The submissions received have been made available on the Expert Mechanism website whenever permission to do so has been granted. The study also benefited from presentations made at the Expert Seminar on Indigenous Peoples and the Right to Health (Montreal, Canada, 21-22 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. The Expert Mechanism would like to thank the University of Auckland Faculty of Law for providing research support. The Pan American Health Organization reviewed the study, provided comments and contributed to the text.

3. Although this is the first study of the Expert Mechanism focusing on the right to health, previous studies have addressed the 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 well-being is generally broader and more holistic than that of mainstream society, with health frequently viewed as both an individual and a 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" (see E/2013/43-E/C.19/2013/25, para. 4). Indigenous concepts of health often incorporate spiritual, emotional, cultural and social dimensions in addition to physical ones. Those concepts are inextricably linked with the realization of other rights, including the rights to self-determination, development, culture, land, language and the natural environment.

5. Indigenous peoples' concept of health is frequently disregarded within non-indigenous health systems, however, creating significant barriers to access (see A/HRC/30/41, para. 31). In particular, a lack of understanding of social and cultural factors deriving from the health-related knowledge, attitudes and practices of indigenous peoples can have deleterious effects on indigenous well-being. Indigenous peoples worldwide experience higher rates of health risks, poorer health and greater unmet needs in respect of health care than their non-indigenous counterparts. Forced assimilation, political and economic mar-

ginalization, 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 state of indigenous peoples' health is beyond the scope of the present study, which contains, instead, a critical analysis of the content of the right to health vis-à-vis indigenous peoples and a review of the legal obligations of States and others in terms of fulfilling that right.

II. 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 long been recognized, for example in the Universal Declaration of Human Rights, in particular its article 25, according to which everyone has the right to a standard of living adequate for the health and well-being of himself or herself and of his or her family, including food, clothing, housing and medical care and necessary social services.

8. The United Nations Declaration on the Rights of Indigenous Peoples recognizes the health rights of indigenous peoples and expands upon their varied dimensions and the interplay with rights such as the right to self-determination. Article 21 recognizes the right of indigenous peoples to the improvement of their economic and social conditions without discrimination. Article 23 recognizes their right to determine and to develop priorities and strategies for exercising the right to development

and, 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 recognizes the right of indigenous peoples to their traditional medicines, to maintain their 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. In addition, the Declaration recognizes the importance of upholding the collective rights of indigenous peoples. Finally, article 29 (2) requires States to take effective measures to ensure that no storage or disposal of hazardous materials shall take place in the lands or territories of indigenous peoples 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, a binding treaty 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 health care and the social determinants of health, and containing freedoms and entitlements: notably, the freedom to control one's own health and the 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 realizing the right to health, that

responsibility is shared by all in society and individuals should have the opportunity to participate in decision-making processes affecting the realization of their rights. States should respect, protect and fulfil the right to health and ensure that health-care facilities, goods and services are available, accessible, acceptable and of good quality (see E/CN.4/2003/58, para. 34).

10. In its general comment No. 14 (2000) on the right to the highest attainable standard of health, the Committee on Economic, Social and Cultural Rights 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. The Committee recognizes the collective dimension of health for indigenous peoples and acknowledges the deleterious effect on health of the displacement from traditional territories and environments that occurs as a consequence of development-related activities.

11. Article 25 of the International Labour Organization (ILO) Indigenous and Tribal Peoples Convention, 1989 (No. 169), requires States to ensure that adequate health services are made available to indigenous peoples and to provide resources to indigenous peoples to allow them to design and deliver such services under their own control. It also requires preference to be given to the training and employment of local community health workers. The provision recognizes the importance of primary care and community-based health services and of coordination with other

social, economic and cultural measures. Implementation of article 25 is supported by non-discrimination provisions (art. 3) and provisions requiring States to consult with and ensure the effective participation of indigenous peoples with the objective of achieving consent in relation to proposed measures (art. 6).

12. Health-related rights are also recognized in other binding international instruments, including the Convention on the Rights of the Child (art. 24), the Convention on the Elimination of All Forms of Discrimination against Women (arts. 10-14), the Convention on the Rights of Persons with Disabilities (art. 25) and the International Convention on the Elimination of All Forms of Racial Discrimination (art. 5). Certain regional instruments also uphold the right to health, including the African Charter on Human and Peoples' Rights (art. 16), the African Charter on the Rights and Welfare of the Child (art. 14), the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (art. 14) and the American Declaration on the Rights of Indigenous Peoples (art. XVII). The Pan American Health Organization too has passed a number of resolutions concerning the right to health of indigenous peoples.¹

13. Treaty bodies and special procedures, including the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and the Special Rapporteur on the rights of indigenous peoples, have examined the right to health from an indigenous perspective. Key findings of

¹ For example, see resolution CD47.R18.

these mechanisms are referred to throughout the present report.

B. OTHER KEY INSTRUMENTS, POLICY PROCESSES AND DOCUMENTS

14. In 2014, the States participating in the high-level plenary meeting of the General Assembly known as the World Conference on Indigenous Peoples committed themselves to ensuring that indigenous individuals have equal access to the highest attainable standard of physical and mental health and to intensifying efforts to reduce rates of HIV and AIDS, malaria, tuberculosis and non-communicable diseases and to ensure access to sexual and reproductive health. The importance of indigenous peoples' health practices and their traditional medicine and knowledge was also recognized.²

15. The Sustainable Development Goals, adopted in 2015, also touch on issues concerning indigenous well-being.³ Goal 3 (to ensure healthy lives and promote well-being for all at all ages) directs States to work towards achieving universal health coverage, which will require States to extend services to indigenous peoples. The Goals on poverty, food security, equitable and quality education, and gender equality are also relevant to indigenous peoples' well-being. Goals 13 (on climate change), 14 (on the protection of ecosystems) and 15 (on sustainable development) are central to the realization of indigenous peoples' health rights, as they are closely interrelated with the rights to self-determination and to the use of traditional lands, territories and re-

sources. Goal 16 (on access to justice and accountable and inclusive institutions) has clear implications for indigenous peoples' right to health, particularly in terms of redress. Finally, Goal 17 (which includes a target on the availability of disaggregated data) calls for enhanced capacity-building to increase data availability, which will assist States in identifying and remedying health inequities.

16. The negotiations held at the twenty-first session of the Conference of the Parties to the United Nations Framework Convention on Climate Change are also relevant, given the disproportionate impact that climate change has on indigenous peoples. Those negotiations culminated in the adoption of the Paris Agreement, in the preamble to which the parties to the Convention recognized the rights of indigenous peoples, referring specifically to the right to health. The parties also acknowledged that adaptation action should follow a country-driven, participatory and fully transparent approach, based on and guided by the knowledge of indigenous peoples, where appropriate (see decision 1/CP.21, annex). While the importance of the effective participation of indigenous peoples had already been noted (see decision 1/CP.16), the Paris Agreement went further by explicitly referring to human rights, signalling that States recognized the links between climate-related obligations, the right to health and indigenous peoples' rights.

17. Finally, the Guiding Principles on Business and Human Rights are also highly relevant to indigenous peoples, who disproportionately experience health rights infringements through development-related activities carried out by non-State actors. Although they are not parties to international human rights conventions,

² General Assembly resolution 69/2.

³ General Assembly resolution 70/1.

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. The right to health is an indispensable element of indigenous peoples' very existence and a central component of their right to self-determination. The right to self-determination is contained both in article 3 of the United Nations Declaration on the Rights of Indigenous Peoples and article 1 of the International Covenant on Economic, Social and Cultural Rights. All human rights are interdependent, including the rights to health and self-determination. Indeed, full realization of health-related rights cannot be achieved without self-determination, which is a non-derogable right the realization of which has associated benefits in respect of health and other social and cultural rights. These can include an improved diet, more frequent exercise and a renewed connection with traditional economic bases.⁴

19. Some treaties between indigenous peoples and States provide mechanisms for the realization of indigenous peoples' rights to health and self-determination. These legal agreements are thus highly relevant to a right-to-health analysis. Treaty No. 6, for example, to which the British Crown and indigenous peoples in Canada became parties starting in the 1870s, included a "medicine chest clause" and a

"famine and pestilence clause" that have subsequently been interpreted as guarantees for the provision and delivery of health-care services, medicines and supplies to indigenous peoples by the Crown.⁵ Treaties in other countries provide for self-determination, which implicitly includes control over decisions concerning the health and well-being of indigenous peoples, indirectly facilitating the realization of the right to health. In New Zealand, the right to health of the Maori people is effectively affirmed in the Treaty of Waitangi, which provides for the protection of self-determination and cultural possessions (tangible and intangible), shared decision-making and equal participation in society without discrimination.

20. The Special Rapporteur on the right to health has stated that the right to health raises important issues of law, such as treaty rights to health.⁶ Article 37 of the United Nations Declaration on the Rights of Indigenous Peoples confirms that indigenous peoples have the right to the recognition, observance and enforcement of treaties. In line with article 43, the survival, dignity and well-being of indigenous peoples are dependent on the rights recognized in the Declaration, including the right to health, the right to self-determination and treaty rights. Although the rights to self-determination and health are not contingent upon the recognition of treaties, their formal inclusion in treaties provides a mechanism for safeguarding those rights and strengthens the commitment of States to working with indigenous peoples

⁴ Submission by the New Zealand Human Rights Commission.

⁵ Submissions by the Maskwacis Cree and the Assembly of First Nations.

⁶ Statement to the Third Committee of the General Assembly, 29 October 2004.

as equal partners in improving their living conditions. Accordingly, States that have not yet adhered to such treaties should consider formally acknowledging those rights in agreements with indigenous peoples.

21. The principle of free, prior and informed consent is another integral element of the right to self-determination. It entitles indigenous peoples to effectively determine the outcome of decision-making affecting them. It is both a process and a substantive mechanism to ensure respect of indigenous peoples' rights. Free, prior and informed consent should be respected in decisions regarding health legislation, policy and programmes affecting indigenous peoples, which are frequently taken without any meaningful consultation. Health-care policymaking should adhere to both article 12 of the International Covenant on Economic, Social and Cultural Rights (on the right to participate in decision-making) and the United Nations Declaration on the Rights of Indigenous Peoples, and reflect the principles outlined by the Expert Mechanism in its study on the right to participate in decision-making (A/HRC/18/42).

IV. Indigenous peoples' right to health: State obligations

22. Indigenous peoples worldwide share many challenges in realizing the highest attainable standard of health. The challenges are examined in the present report using the availability, accessibility, acceptability and quality framework, with State obligations outlined using the respect, protect and fulfil framework. The availability, accessibility, acceptability and quality framework extends beyond the infrastructure for delivering health care to

encompass the facilities, goods and services comprising the underlying determinants of health care, such as safe drinking water and adequate food and sanitation.⁷

A. AVAILABILITY, ACCESSIBILITY, ACCEPTABILITY AND QUALITY FRAMEWORK

AVAILABILITY

23. Public health and health-care 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, in certain areas in Africa where indigenous nomadic pastoralists and communities are located, health infrastructure is non-existent.⁸ For facilities, goods and services to be available, they must also be functional. Facilities located in areas inhabited by indigenous peoples are frequently not operational owing to a lack of staff, medicines, supplies and other consumables.

ACCESSIBILITY

24. The four primary dimensions of accessibility are non-discrimination, physical accessibility, economic accessibility and information accessibility. For indigenous peoples, these four dimensions often intersect. Indigenous peoples are very likely to experience discrimination when accessing

⁷ Committee on Economic, Social and Cultural Rights, general comment No. 14.

⁸ United Nations, Department of Economic and Social Affairs, State of the World's Indigenous Peoples: Indigenous Peoples' Access to Health Services, second volume (New York, 2015).

health-care facilities, goods and services. Doctors, nurses and other health-care professionals may refuse to treat indigenous peoples or indigenous peoples undergoing treatment may encounter discriminatory beliefs, practices and experiences, fuelling fear and distrust that further discourages use of health-care facilities. That situation is amplified for indigenous persons with disabilities. Racism may even lead to misdiagnosis and mistreatment for serious illnesses. Physical accessibility is an issue for indigenous peoples, many of whom live in geographically isolated areas, often because of displacement or the encroachment of non-indigenous peoples on their land.

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

ACCEPTABILITY

26. The Committee on Economic, Social and Cultural Rights has acknowledged that the right to take part in cultural life encompasses cultural appropriateness, which should be taken into account

in providing health-care services.⁹ Unfortunately, the health-care facilities, goods and services available to indigenous peoples are often unacceptable in nature. Interpersonal and structural racism frequently lead to system-wide policies and practices that marginalize or exclude individuals and minimize access to facilities, goods and services. One example of a basic failure to provide acceptable care is the non-provision of services in indigenous languages (see CEDAW/C/FIN/CO/7), which constitutes structural racism. Such failures can result in indigenous peoples internalizing stigma, creating additional barriers to health care. Moreover, indigenous people are frequently blamed for their illnesses and medical needs, either individually or as a group. Negative attitudes and a lack of cultural sensitivity among health-care providers in some jurisdictions also have an impact on indigenous peoples' ability to seek health care.

QUALITY

27. Health-care facilities, goods and services should be scientifically, medically and culturally appropriate, and of good quality. That requires skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe drinking water and adequate sanitation. Tension often exists between mainstream health-care services, which are generally evidence-based and perceived to be of high quality, and the traditional health-care practices of indigenous peoples, on which there is a paucity of evidence, often owing to a lack of research. That should not

⁹ See the Committee's general comment No. 21 (2009) on the right of everyone to take part in cultural life.

be viewed exclusively as a source of tension between indigenous peoples and mainstream health-care providers. Indigenous communities themselves often face challenges internally in seeking to balance traditional and modern approaches to health and in addressing other social issues.¹⁰

B. RESPECT, PROTECT AND FULFIL FRAMEWORK

RESPECT

28. Articles 2 (2) and 3 of the International Covenant on Economic, Social and Cultural Rights and article 24 of the United Nations Declaration on the Rights of Indigenous Peoples prohibit discrimination in access to health care and the underlying determinants of health. States must refrain from denying or limiting indigenous peoples' access to public health-care facilities, goods and services. That 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 programmes concerning health should be reviewed (together with indigenous peoples) and discriminatory elements removed or replaced. That obligation extends to laws that are not de jure discriminatory but that have a disproportionate impact on indigenous peoples. The obligation to respect extends to abstaining from enforcing broader discriminatory laws or practices that can have detrimental health effects. For example,

¹⁰ Submission by the Inuit Circumpolar Council.

laws and policies sanctioning practices such as the forced sterilization of indigenous women and female genital mutilation should be removed.

30. The obligation to respect extends to the underlying determinants of health. States should refrain from unlawfully polluting the air, the water and the soil, for example through industrial waste from State-owned facilities or extractive industries. Such activities are too frequently carried out on land inhabited by indigenous peoples and, along with the agricultural use of pesticides, can represent a violation of indigenous peoples' health-related rights.¹¹

31. Indigenous peoples must also be permitted to self-identify within States, which would facilitate the collection of data disaggregated by health and other criteria, for the provision of funding and assistance in realizing health-related rights. While certain jurisdictions have banned the collection of data disaggregated by ethnicity for compelling reasons, such laws should not be applied to prevent indigenous peoples from improving their well-being.¹²

PROTECT

32. States often turn a blind eye to racism in health-care settings, even in the presence of pervasive, persistent evidence that indigenous peoples are treated discriminatorily. States should take measures to ensure equal access to treatment and

¹¹ See, e.g., Social and Economic Rights Action Centre and Center for Economic and Social Rights v. Nigeria (2001).

¹² Ian Anderson and others, "Indigenous and tribal peoples' health (The Lancet-Lowitja Institute Global Collaboration): a population study", *The Lancet*, vol. 388, No. 10040 (20 April 2016).

health-care facilities within their jurisdiction, as well as to protect indigenous peoples from discrimination perpetrated by third-party health-care providers. States should consider implementing workforce awareness-raising activities and campaigns challenging racist behaviour and stereotyping and promoting more culturally sensitive approaches.

33. States should 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. Doing so necessarily includes respecting the principle of free, prior and informed consent. States should prevent the appropriation and commodification of indigenous knowledge, traditional medicines and practices by third parties. Article 31 of the United Nations Declaration on the Rights of Indigenous Peoples confirms that indigenous peoples have the right to maintain, control, protect and develop their cultural heritage, traditional knowledge and traditional cultural expressions, as well as the manifestations of their sciences, technologies and cultures, including 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 such cultural heritage, traditional knowledge and traditional cultural expressions.

34. Although indigenous peoples have the right to engage in traditional health-care practices, States should take steps to work with indigenous communities towards the eradication of harmful practices

such as female genital mutilation.¹³ More research needs to be carried out into traditional medicines, procedures and other interventions. However, such research, and any potential commercialization, must take place in partnership with indigenous peoples.

35. States should 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 programmes to protect the health of those groups, in particular by protecting their lands and territories from environmental damage and by avoiding the transmission of diseases to which those groups lack immunity. States must also create plans to provide access to mainstream and traditional medicine where it is sought and develop an emergency plan to be implemented in the event of a threat of imminent widespread mortality.¹⁴

36. Finally, States should ensure that adequate mechanisms exist for the provision of redress and remedy in cases of infringements of the right to health, through mainstream or indigenous juridical systems (A/HRC/27/65), which may have certain advantages in respect of the resolution of complaints. In the Philippines, for example, complaints of violence against

¹³ Committee on the Rights of the Child, general comment No. 11.

¹⁴ OHCHR and the Spanish Agency for International Development Cooperation, "Directrices de protección para los pueblos indígenas en aislamiento y en contacto inicial de la región amazónica, el Gran Chaco y la Región Oriental de Paraguay" (Geneva, May 2012). Available from http://www.amazonia-andina.org/sites/default/files/directrices-de-proteccion-para-los-pueblos-indigenas-en-aislamiento-y-en-contacto-inicial_o.pdf.

women heard through the traditional justice system have reportedly been resolved quickly, with high rates of acceptance by the parties.¹⁵

FULFIL

37. States should formulate and adopt national strategies to ensure that all individuals have access, without discrimination, to the health facilities, goods and services necessary to achieve the highest attainable standard of health. The creation of a national strategy should be accompanied by implementation plans and right-to-health indicators for effective monitoring, evaluation and accountability. States that are developing national action plans for the implementation of the United Nations Declaration on the Rights of Indigenous Peoples, as called for by the World Conference on Indigenous Peoples, should ensure that such plans 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 make provision for indigenous peoples' needs in a "mainstream" plan, as in Guatemala,¹⁶ or a separate indigenous health plan, like the Maori Health Strategy, *He Korowai Oranga*, in New Zealand.¹⁷ In addition, States should ratify and incorporate into national law relevant international instruments containing health rights, such as the Declaration, the ILO Indigenous and Tribal Peoples Convention,

¹⁵ Submission by the Asia Indigenous Women's Network.

¹⁶ Submission by Guatemala.

¹⁷ See www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga.

1989 (No. 169), and the International Covenant on Economic, Social and Cultural Rights.

FACILITATE

38. In accordance with the right to self-determination, States should provide sufficient resources to indigenous communities to create and operate their own health-care initiatives. Care provided by indigenous community-controlled organizations is often of a higher quality than that provided by mainstream services, significantly improving the availability and accessibility of health care. Indigenous organizations 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 health-care sector employs nearly 4,000 people and services over 60 per cent of Aboriginal people outside major metropolitan centres, with superior performance to mainstream services noted on key indicators.¹⁸ In Colombia, 80 per cent of the professional staff of Pueblo Bello indigenous hospital in Valledupar are of indigenous origin — a significant achievement in intercultural practice.¹⁹

39. States should also facilitate access to health-care services through improved birth registration processes, where appro-

¹⁸ Kathryn Panaretto and others, "Aboriginal community controlled health services: leading the way in primary care", *Medical Journal of Australia*, vol. 200, No. 11 (16 June 2014).

¹⁹ Anna R. Coates and others, "Indigenous child health in Brazil: the evaluation of impacts as a human rights issue", *Health and Human Rights Journal*, vol. 18, No. 1 (16 May 2016).

appropriate. Article 7 of the Convention on the Rights of the Child 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 health-care facilities, goods and services where identification is a prerequisite for obtaining care (CRC/C/CRI/CO/4) and prevents the collection of disaggregated data, which is vital in monitoring disparities in health-care status between different ethnic groups. Registration can be facilitated through targeted registration campaigns, as in Brazil,²⁰ or use of indigenous registrars or a specific minorities registration section within State institutions, as in Panama, Peru and Thailand; alternatively, traditional birth attendants can improve birth registration rates, as has occurred in Ghana and Malaysia.²¹ Birth registration should not, however, be a precondition for accessing health-care 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,²² this does not absolve States of their obligations to provide financial and other support. States incur a special obligation to provide (for those who do not have means) the necessary health insurance and health-care facilities, a specific right under the International Covenant on Economic,

Social and Cultural Rights.²³ Even in times of severe resource constraints, individuals and groups in situations of vulnerability should be protected by the adoption of relatively low-cost, targeted programmes (E/1991/23-E/C.12/1990/8). States can adopt measures, temporarily or permanently, to remedy structural discrimination: these can include programmes or the provision of funding or other resources to achieve the highest attainable standard of health.

41. States should also provide certain resources while indigenous peoples establish their own services and workforce cadre. For example, in the absence of sufficient medical professionals able to speak indigenous languages, States should provide interpretation services facilitating effective communication in health-care settings, as is done in Norway, where a 24-hour-a-day Sami interpretation service has been established in collaboration with indigenous peoples.²⁴ Affordable versions of such programmes could be implemented by other States, given the rapidly increasing prevalence of mobile telephone coverage worldwide. Training and incorporating traditional indigenous practitioners into health-care systems could also address immediate shortages of medical staff in remote indigenous territories.

PROMOTE

42. States should ensure that health-care research agendas sufficiently recognize and involve indigenous peoples. Failure to collect health data disaggregated by eth-

²⁰ Ibid.

²¹ United Nations Children's Fund, "Birth registration: right from the start", Innocenti Digest series No. 9 (March 2002).

²² Submission by the Inuit Circumpolar Council.

²³ Committee on Economic, Social and Cultural Rights, general comment No. 14.

²⁴ Submission by Norway.

nicity, self-identified indigenous status or cultural identity can conceal deep inequities. Disaggregated data should be collected, in a consensual manner, to identify barriers to the enjoyment of the right to health and for inclusive policymaking. Such data should address issues such as gender, socioeconomic status and disability, as data focused purely on indigenous status does not fully capture the composite rights of indigenous peoples who are marginalized owing to other aspects of their identity.²⁵

43. For health-care facilities, goods and services to be acceptable to indigenous peoples, they must be culturally appropriate. This requires communicating in a respectful and inclusive way, empowering patients in decision-making and building relationships so that patients and providers work together to ensure maximum effectiveness of care.²⁶ To achieve this, three steps are necessary: changes should be made to mainstream health-care facilities, goods and services; more indigenous individuals should be trained as health-care providers; and indigenous-specific services should be created.

44. To improve mainstream services, States should ensure that curricula of medical and health-care training programmes render graduating professionals culturally competent. Programmes should include education on colonial history and its legacies (where relevant), indigenous culture (including traditional approaches

to medicine), stereotyping and racism, and health-care disparities and social inequities. Information on effective communication with indigenous peoples should also be included. Specific programmes 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) and the Native American Child Health initiative created by the American Academy of Pediatrics (dedicated to indigenous health care).

45. States should facilitate the entry of indigenous professionals in health care, 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. Such training should be conducted sensitively and without prejudice to indigenous medicinal and health-related knowledge and practice.

46. States should also promote health through the provision of culturally appropriate information concerning healthy lifestyles and nutrition, disease and illnesses (including mental illness), harmful traditional practices, and the availability of services. Information should be provided in the patient's language and information mechanisms that incorporate non-verbal communication patterns, as well as cultural beliefs and practices, should be developed. In some indigenous communities, certain issues, such as HIV/AIDS and sexual and

²⁵ Doreen Demas, presentation to the Expert Seminar on Indigenous Peoples and the Right to Health.

²⁶ National Aboriginal Health Organization, *Cultural Competency and Safety: A Guide for Health Care Administrators, Providers and Educators* (Ottawa, 2008).

reproductive health, remain taboo: State cooperation with indigenous organizations is vital in implementing culturally appropriate awareness-raising campaigns among these communities.

47. The spiritual and biomedical benefits of traditional health-care practices and traditional medicines can promote and enhance indigenous health and bring unwell people into contact with health-care systems, facilitating access to care. Rather than stigmatizing and suppressing such practices and medicines, States should consider incorporating them into their health planning and promotion activities.

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

V. Indigenous children and youth and the right to health

49. Alongside the International Covenant on Economic, Social and Cultural Rights and the United Nations Declaration on the Rights of Indigenous Peoples, article 24 of the Convention on the Rights of the Child requires States to take ap-

propriate measures to ensure the realization of the highest attainable standard of health for children. In its general comment No. 11 (2009) on indigenous children and their rights under the Convention, the Committee on the Rights of the Child noted that indigenous children frequently suffer poorer health than non-indigenous children owing to inferior or inaccessible health services, and that positive measures may be required to eliminate conditions causing discrimination and ensure the equal enjoyment of Convention rights. The Committee urged States to consider implementing special measures to ensure that indigenous children are not discriminated against and can maintain their cultural identity, and noted that States parties have a positive duty to ensure that indigenous children have equal access to health services and to combat malnutrition as well as infant, child and maternal mortality. In its general comment No. 15 (2013) on the right of the child to the highest attainable standard of health, the Committee 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.

50. Unfortunately, alarming gaps in child health indicators persist between indigenous and non-indigenous populations globally. Infant mortality rates remain significantly higher among indigenous groups than among their mainstream counterparts.²⁷ Indigenous

²⁷ Ian Anderson and others (see footnote 12).

women and children can be vulnerable to violence, malnutrition, malnourishment, anaemia and malaria.²⁸ Some of these discrepancies are attributable to inequalities in social determinants of health. Disproportionately large numbers of indigenous children live in poverty (general comment No. 11) and in remote areas with limited access to health care, quality education, justice and participation opportunities (see E/C.19/2005/2, annex III).

51. Indigenous peoples continue to experience intergenerational trauma owing to the removal of children from families and residential schooling. The health impacts of such practices are profound and include mental illness, physical and sexual abuse, self-harm and suicide, and drug or alcohol addiction. A correlation has been demonstrated between the intergenerational effects of those events and suicide²⁹ and sexual abuse during childhood.³⁰

52. Indigenous children and youth are particularly vulnerable to human rights violations, because of their age and the intersectional nature of the discrimination experienced by indigenous peoples. Children and youth have not historically been recognized as holders of rights; that 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 the 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.³¹

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 support 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, relating 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) and indigenous children are significantly less likely than non-indigenous children to

²⁸ Submission by the Indigenous Women's Network, India.

²⁹ Zahra Rehman, presentation to the Expert Seminar on Indigenous Peoples and the Right to Health.

³⁰ Gregory Corosky, presentation to the Expert Seminar on Indigenous Peoples and the Right to Health.

³¹ Hannah McGlade, *Our Greatest Challenge: Aboriginal Children and Human Rights* (Canberra, Aboriginal Studies Press, 2013).

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 the overrepresentation of indigenous peoples in the prison system.³² Decreased participation in formal education is frequently the result of a combination of a lack of availability, accessibility, acceptability and quality. Even where services are accessed, boys and girls record different completion rates: for instance, 89 per cent of indigenous girls in Peru aged 12-16 drop out of school (see A/HRC/29/40/Add.2, para. 68).

56. States should do more to provide redress for these health rights violations. Investing in indigenous children’s early development through education and providing support to families (e.g. around parenting) are highly effective means of reducing health inequalities. States should cooperate to ensure the adoption of effective interventions: for instance, nurse-family partnerships have been adapted for use in indigenous communities following evidence of effectiveness in the United States of America.³³ At the primary and secondary levels, educational facilities should be made available and accessible by States, including through radio broadcasts and long-distance education programmes or through the establishment of mobile schools for nomadic indigenous peoples (general comment No. 11).

FAMILY AND COMMUNITY INTEGRITY

57. The importance of healthy communities and families to indigenous children cannot be underestimated. Such support networks provide physical, mental and social health benefits, help to break entrenched cycles of intergenerational disadvantage and build resilience and capability. The Committee on the Rights of the Child has noted, in its general comment No. 11, that maintaining the best interests of the child and the integrity of indigenous families should be primary considerations in the development of health and other programmes. Unfortunately, indigenous children are still removed from their homes at a significantly higher rate than their non-indigenous counterparts, which can cause significant childhood trauma. Moreover, indigenous children are vulnerable to abuse while in the care of the State. States should prevent and provide redress for any action that deprives indigenous peoples, including children, of their ethnic identities, such as placement of indigenous children in alternative care.

MENTAL HEALTH

58. The high prevalence of mental illness and suicide among indigenous peoples is alarming, particularly among indigenous youth. There are various protective factors and preventive strategies for suicide, including strong cultural affiliations (A/HRC/21/53). 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 the knowledge and ability to as-

³² Submission by Brenda Gunn, University of Manitoba, Canada.

³³ Submission by Australia.

sist those at risk of suicide. Other strategies effective in non-indigenous communities, such as suicide-risk screening, could also be considered.³⁴

59. Information on best practices for the 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.³⁵ Regional coordinating projects, such as the Rising Sun project facilitated by the Arctic Council, assist in sharing data and comparing interventions.³⁶ Finally, promising new initiatives such as the “health scouts” programme in the Philippines, where children lead resilience training, should be explored.³⁷

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 that extend beyond denial of access to medical services.

61. Firstly, indigenous women face many barriers to the realization of their sexual and reproductive health and rights. A lack of available, accessible and acceptable health-care services, as well as limited access to good-quality care, contributes to disproportionately high rates of maternal mortality, teenage pregnancy and sexually transmitted infections and to low rates of utilization of contraceptives, as indigenous women are often excluded from reproductive health services. 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 among indigenous women than among non-indigenous women.³⁸ Indigenous women 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.³⁹

63. Finally, indigenous women and girls continue to experience violence at higher rates than the general population. In accordance with article 22 (2) of the United Nations Declaration on the Rights of Indigenous Peoples, States should take measures to ensure that indigenous women enjoy full protection against all forms of violence and discrimination. Nevertheless, indigenous women are disproportionately

³⁴ 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).

³⁵ Jennifer Redvers and others, “A scoping review of indigenous suicide prevention in circumpolar regions”, *International Journal of Circumpolar Health*, vol. 74 (2015).

³⁶ Submission by the Inuit Circumpolar Council.

³⁷ Penelope Domogo, presentation to the Expert Seminar on Indigenous Peoples and the Right to Health.

³⁸ *Ibid.*

³⁹ Michael Gracey and Malcolm King, “Indigenous health part 1: determinants and disease patterns”, *The Lancet*, vol. 374, No. 9683 (July 2009).

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.⁴⁰ The health-related impacts of violence against women include injuries, sexually transmitted infections, gynaecological problems, mental illness and substance dependence. Violence against women also affects children exposed to such violence, who experience higher rates of morbidity and mortality.⁴¹

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.⁴² Involvement and further training of traditional midwives in modern health-care delivery approaches may reduce maternal morbidity and mortality, while also improving service acceptability. States should consider opportunities for South-South cooperation concerning sexual and reproductive health, in particular in relation to intercultural standards (E/2013/43-E/C.19/2013/25).

65. In many indigenous communities, birth rates remain significantly higher compared with the national aver-

⁴⁰ Ellen Gabriel, presentation to the Expert Seminar on Indigenous Peoples and the Right to Health.

⁴¹ World Health Organization, "Violence against women: intimate partner and sexual violence against women", factsheet No. 239 (January 2016). Available from: www.who.int/mediacentre/factsheets/fs239/en/.

⁴² United Nations Population Fund and the Spanish Agency for International Development Cooperation, "Promoting equality, recognizing diversity: case stories in intercultural sexual and reproductive health among indigenous peoples" (Panama, August, 2010).

age, partly reflecting the value indigenous communities place on motherhood and childbearing. These views can occasionally clash with prevailing beliefs in mainstream medicine regarding, for instance, birth practices and contraception. The perceived conflict between the rights of indigenous peoples and the rights of women, however, 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. Other practices that are traditional or preferred by indigenous peoples should not be prohibited by States; instead, dialogue on 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 officers and military or paramilitary forces occurs. In such cases, women experience a two-fold rights violation: firstly, through the experience of violence and, secondly, through the lack of redress from the very mechanism that has perpetrated the violence. States must take steps to prevent such violence and ensure that acceptable mechanisms to provide redress for 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 recognizes the right to health (art. 25) and the difficult conditions faced by persons with disabilities who are subject to multiple or aggravated forms of discrimination, including indigenous persons with disabilities (preamble).

68. Indigenous children with disabilities face physical, systemic and attitudinal barriers that impede the realization of their rights to education, accessible services and disability-related rehabilitation programmes. Too often, indigenous children with disabilities face discrimination, abuse and bullying from their peers, caregivers and members of their communities. Indigenous status, intellectual disability and imprisonment frequently co-occur.⁴³

69. Indigenous persons with disabilities may also experience delays in recognition of their condition owing to racism or discrimination, or even an over-diagnosis of their intellectual disability owing to cultural bias in testing.⁴⁴ Moreover, “institutionalized ableism” can obscure undiagnosed illnesses among people living with disabilities, where medical abnormalities are attributed to disability rather than to a separate pathology.⁴⁵ The potential for this

to occur in indigenous people is significant given frequent issues with language and other communication barriers and given health professionals’ lack of education. Training and education curricula should include content regarding the needs of indigenous persons with disabilities, so as to raise the awareness of practitioners.

70. Indigenous persons living with a disability in remote areas are often required to periodically reconfirm their disability through central medical organizations to remain eligible for disability pensions, creating hardship. States and other actors should recognize and address the multiple burdens of discrimination suffered by indigenous persons with disabilities.

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

A. COMMUNICABLE AND NON-COMMUNICABLE DISEASES

71. Indigenous peoples experience disproportionately high levels of infectious diseases such as HIV/AIDS, malaria and tuberculosis, with the risk of becoming infected with HIV increasing among those migrating to urban areas. States should recognize the higher risk profile of indigenous peoples in relation to these diseases and the multiple burden of discrimination indigenous peoples suffer upon contracting such illnesses. In addition, indigenous peoples disproportionately suffer from “neglected” tropical diseases such as trachoma, helminth infections, yaws, leprosy and strongyloidi-

⁴³ Matthew Frize, Dianna Kenny and C.J. 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, No. 6 (June 2008).

⁴⁴ *Ibid.*

⁴⁵ Submission by the First Peoples Disability Network.

asis.⁴⁶ 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 criterion for the non-approval of or reduction in federal subsidies.⁴⁷

72. There has also been an enormous rise in the incidence of non-communicable diseases among indigenous peoples, who experience disproportionately high rates of cardiovascular illness and diabetes. Such high rates are linked to the migration of indigenous peoples from rural to urban areas, whose lifestyles rapidly change to incorporate modern diets high in calories, fat and salt.⁴⁸ For example, in the Philippines, development and changes in agricultural practices and dietary preferences have contributed to soaring rates of diabetes, renal disease, cardiovascular disease, hypertension and cancer.⁴⁹ Moreover, global data reveal high rates of alcohol and tobacco use among indigenous peoples, in particular men.

⁴⁶ Peter Hotez, "Aboriginal populations and their neglected tropical diseases", *PLoS Neglected Tropical Diseases*, vol. 8, No. 1 (January 2014).

⁴⁷ Russian Federation, federal government act No. 217 of 10 March 2009 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.

⁴⁸ Michael Gracey and Malcolm King (see footnote 39).

⁴⁹ Penelope Domogo, presentation to the Expert Seminar on Indigenous Peoples and the Right to Health.

73. States should take specific steps to combat the extraordinary burden of these illnesses among indigenous peoples. Affordable access to key medications, such as insulin and anti-hypertensives, should be ensured, as their high out-of-pocket costs can lead to a rapid, yet preventable, deterioration in health. Telemedicine or mobile health initiatives to monitor indigenous peoples with chronic illness living in remote areas should also be considered. The value of exercise and sport should not be underestimated, both in terms of non-communicable disease 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 has even been shown to deter juvenile delinquency.⁵⁰ It is very encouraging that traditional games and sports events 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. Good occupational health for indigenous persons is also crucial. 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 protect the health of indigenous peoples working in both traditional and mainstream industries.⁵¹

⁵⁰ Submission by Cultural Survival.

⁵¹ Outcome document of the expert seminar entitled "Finno-Ugric peoples and sustainable development: health of indigenous peoples", held in Petrozavodsk, Russian Federation, on 25 and 26 May 2016.

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 recognized 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 (general comment No. 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 among the Inuit peoples of the Canadian Arctic, whose hunting and fishing practices have been threatened by significant reductions in their icy hunting grounds.⁵² Replacement of traditional food sources with mainstream dietary elements is costly in such locations, and carries its own health risks.

76. The 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 the displacement of indigenous peoples from traditional lands or from land or water contamination, which in turn results in infringements of the right to health and other rights, including the

right to life.⁵³ Contamination can also occur through the use of pesticides that are banned in certain States but that are nevertheless exported and used elsewhere.⁵⁴ 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 in 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.⁵⁵

77. Efforts should be made to promote cooperation between indigenous peoples and businesses and to minimize the negative impact of development, as examples from the Russian Federation illustrate.⁵⁶ Identifying indigenous peoples' rights to land, forests and marine and other natural resources is also vital to indigenous peoples' livelihoods and well-being. The importance of maintaining a connection with the land is also recognized in regional legal instruments.⁵⁷ Where indigenous peoples are

⁵² Sheila Watt-Cloutier, presentation to the Expert Seminar on Indigenous Peoples and the Right to Health.

⁵³ See e.g. *Xákmok Kásek Indigenous Community v. Paraguay*, Inter-American Court of Human Rights, 24 August 2010.

⁵⁴ Submission of the International Indian Treaty Council.

⁵⁵ Royal Commission on Aboriginal Peoples, Report of the Royal Commission on Aboriginal Peoples: Volume 3 — Gathering Strength (Ottawa, Canada Communication Group, 1996).

⁵⁶ United Nations Development Programme, Russian Union of Industrialists and Entrepreneurs and Global Compact Network Russia "United Nations Global Compact Network Russia: corporate social responsibility practices".

⁵⁷ See the African Union Convention for the Protection and Assistance of Internally Displaced Persons in Africa, art. 4 (5).

empowered to care for and maintain their land, another virtuous cycle is created: 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/2005/43-E/C.19/2005/9).

ANNEX

**EXPERT MECHANISM ADVICE NO. 9
ON THE RIGHT TO HEALTH
AND INDIGENOUS PEOPLES**

A. GENERAL ADVICE

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. That right is interrelated with various key rights accrued by indigenous peoples, including the 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 the use of indigenous land for the 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 the realization of indigenous peoples' health rights.

3. Health statistics the world over illustrate indigenous peoples' disadvantaged position in terms of access to quality health care and their 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 multifaceted forms of discrimination.

B. ADVICE FOR STATES

4. States should recognize and enhance the protection of the right to health of indigenous peoples by ratifying and incorporating into their domestic law the Indigenous and Tribal Peoples Convention, 1989 (No. 169), of the International Labour Organization, the International Covenant on Economic, Social and Cultural Rights and other key human rights treaties, and by taking concrete measures to implement the United Nations Declaration on the Rights of Indigenous Peoples.

5. States should recognize the inherent right of indigenous peoples to determine their own futures, including in terms of exercising 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 programmes affecting their health or health rights.

7. States should implement national plans for indigenous peoples' health with the full participation of indigenous peoples and with their free, prior and informed consent, 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 health-care facilities, goods and services, as well as to facilities, goods and services relating to underlying determinants of health, such as safe and potable water and adequate food and sanitation. The introduction and implementation of comprehensive anti-discrimination laws and the collection and use of disaggregated data are vital for achieving this objective.

9. Laws and policies that permit or sanction violence against indigenous peoples, even if only implicitly, should be repealed by States, and steps should be taken to address violence perpetrated by State representatives (such as armed forces) and third parties. Violence in health-care settings, such as forced sterilization and female genital mutilation, as well as discrimination against lesbian, gay, bisexual and transgender indigenous persons, 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) by minimizing, through legislative and practical measures, the impact that extractive industries in particular have on the physical and mental health of indigenous peoples.

11. Indigenous peoples should be permitted to identify as distinct groups within States and States should take positive measures to ensure the collection of disaggregated data on indigenous peoples. States should facilitate access to health-care services through improved birth registration processes and by removing birth registration as a precondition for accessing health-care services.

12. States should take steps to support the preservation of indigenous cultures and protect indigenous peoples from the appropriation and commodification of their knowledge, their traditional medicines and other traditional practices by third parties. Indigenous peoples should be allowed to practice traditional medicine and enjoy its benefits but harmful practices that infringe on 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 the creation and operation of their own health-care initiatives or, in the absence of indigenous-controlled services, provide programmes 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 health-care services, including preventive care, for nomadic and remote indigenous peoples, indigenous peoples in conflict-affected areas and indigenous persons in detention, including through mobile clinics, telemedicine and information and communications technologies.

15. States should ensure that interpretation services are available to indigenous patients, to ensure adequate communication in health-care settings. Recognizing the role of languages in the healing process, States should also promote the use of indigenous languages in health-care settings.

16. States should take steps to train indigenous health-care workers and accredit indigenous health practitioners and integrate them into health-care systems. States should also improve health-care training curricula to train health-care workers to deliver culturally appropriate services, and create programmes and services to raise the awareness of practitioners regarding the 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 programmes to be devised and States should design specific strategies for the prevention of communicable and non-communicable diseases in partnership with indigenous peoples and with their free, prior and informed consent.

18. States should implement legislation, policies and programmes that support indigenous peoples in making informed choices about their health and that include initiatives to improve indigenous peoples' choices regarding the underlying determinants of health, such as healthful food and physical activity.

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 their families and communities worldwide and the far-reaching health effects of intergenerational trauma attributable to such removal 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 to ensure that affected indigenous persons receive the preventive and curative health-care services they require for addressing 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, in particular among children and youth. Proven preventive measures should be implemented in high-risk communities and sufficient resources should be allotted to achieve genuine improvements in mental health among indigenous peoples.

22. States should provide resources and materials to deliver culturally appropriate health care to women, especially in respect of maternal health and sexual and reproductive health and rights.

23. States should ensure that women are protected from violence by enforcing

criminal laws and making 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 with disabilities by implementing legislation, policies and programmes and creating mechanisms to protect these people from having their rights abused 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, for example 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 their intrinsic connection with the rights to health and to food.

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

28. States should ensure that adequate mechanisms are in place to provide redress and remedy for health rights infringements, including treaty rights, either

through mainstream or indigenous juridical systems. Indigenous juridical systems may have certain advantages in terms of the resolution of complaints linked to health rights violations.

C. ADVICE FOR INDIGENOUS PEOPLES

29. Indigenous peoples should strengthen advocacy efforts for the recognition of indigenous health rights and rights to self-determination, with the aim of creating equitably funded indigenous community-controlled health-care 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 health care and push States to ensure that their free, prior and informed consent is obtained before implementing 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 on Access to Genetic Resources and the Fair and Equitable Sharing of Benefits Arising from Their Utilization to the Convention on Biological Diversity, and for traditional healing and medical practices to be included in mainstream health-care 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. While acknowledging the work done in this area by the Pan American Health Organization, the Expert Mechanism suggests that the World Health Organization consider appointing a global focal point on indigenous peoples' health issues to better address the pressing concerns that are raised worldwide in respect of the realization of indigenous health rights.

34. The United Nations, its agencies and other international organizations should emphasize the importance of providing mental health services to indigenous peoples and take steps to address suicide among indigenous people, in particular indigenous children and youth. The World Health Organization should also coordinate further research into youth suicide. The above-mentioned organizations should share information and support indigenous communities in tackling this issue.

35. The United Nations Population Fund should take into consideration the rights of indigenous peoples, in particular women and young people, in their planning, given the disproportionate burden of morbidity and mortality suffered by indigenous women and the gaps in the 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 on best practices regarding community-controlled health care, to promote its adoption.

37. Together with States, multilateral agencies and other entities 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 health-care systems, including through the recognition of best practices.