The Health of Indigenous Peoples

World Health Organization
THE HEALTH OF INDIGENOUS PEOPLES

SUSTAINABLE DEVELOPMENT AND HEALTHY ENVIRONMENTS (SDE)

HEALTH IN SUSTAINABLE DEVELOPMENT (HSD)

Ethel (Wara) Alderete

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EXECUTIVE SUMMARY
EXECUTIVE SUMMARY

There over 300 million indigenous people in the world today. They live on every continent and represent thousands of different cultures. Indigenous people are over represented among the poor, and their living conditions and health status are invariably below those of the general population of each country. Their health status is severely affected by low income levels, and by low availability of safe water, food, sanitation and access to health services. One of the main threats, not only to their health, but to their very survival, is the destruction of their habitat, which provides spiritual and material sustenance. Acculturation and the loss of cultural cohesion also have a deleterious impact on their health.

Health Indicators

In the majority of countries, there is no systematic collection of epidemiological data disaggregated by ethnicity. Available mortality and morbidity data, however provide sound scientific evidence of significant inequities in health status. These include the following:

- Life expectancy at birth is 10 to 20 years less for indigenous people than for the overall population in a country.

- Infant mortality rates are 1.5 to 3 times greater than the national average.

- Malnutrition and communicable diseases, such as malaria, yellow fever, dengue, cholera and tuberculosis, continue to affect a large proportion of indigenous peoples around the world.

- In some instances, higher suicide rates are indicative of the deterioration in conditions that affect mental health.

- Smoking, alcohol and substance abuse are significant health and social problems.

- Cardiovascular diseases, diabetes, cancer, unintentional injuries and domestic violence are significant health problems among some indigenous peoples, and many of these illnesses are associated with lifestyle changes resulting from acculturation.

- Land displacement and contamination affects the food supply of indigenous people, increasing the likelihood malnutrition and starvation. The same holds true for indigenous communities who find themselves in the vicinity of extractive industries that are prone to damage the environment.

There are nevertheless some agreeable surprises. The infant mortality rate among some indigenous peoples is lower than that of the national average (e.g. Native Americans in the USA or the Metei in India). Also, where traditional ways of life and diet have not been significantly disrupted, a lower prevalence of non-communicable diseases is observable. Studies among immigrants (e.g. Tokelauans in New Zealand) suggest that culture maintenance may be associated with lower prevalence of risk factors such as smoking.
Just as inequalities in health and living conditions among indigenous peoples can be documented throughout the world, marked differences in disease patterns occur among different indigenous communities even within countries. Cancer rates, for example, vary widely among Native Peoples (e.g. differences in age-adjusted cancer rates among US Native Americans across Indian Health Service areas). Disease distribution and the effect of risk factors vary across genders as well. For example, lifestyle changes and acculturation may be associated with a greater risk of developing disease among indigenous women than among men (e.g. there is a greater increase over time of age-standardized rates of diabetes among Tokelauan migrant women in New Zealand, than among Tokelauan migrant men).

Access to health care

Access to health services, and health promotion and prevention programmes for indigenous people is limited and inadequate. In general, services and programmes are culturally inappropriate.

Barriers to health care include:

- **Structural and economic factors**: distance and location of health care facilities, isolation of indigenous communities; lack of health insurance or economic capacity to pay for services; the relative value of losing a day of productive activity.

- **Lack of cultural sensitivity and appropriateness of health care systems**: unacceptability of traditional healing practices and vice versa; language barriers; uncomfortable and impersonal environment of hospitals and clinics; problems of attitude.

A review experiences indicates that programmes are more effective when they ensure indigenous ownership and leadership, as well as incorporating culturally specific approaches. The training of indigenous people in the health professions, and providing cultural sensitivity training to all health professionals, are urgent tasks that hold out promise for the future. The principles of WHO’s health for all strategy and primary health care approach are compatible with the development of appropriate health systems for indigenous people, and can form the basis for such systems.

Articulation of traditional and medical health systems

The interaction of the Western medical establishment with traditional practitioners has been characterized by ethnocentric preconceptions and poor performance in terms of cultural sensitivity. The emphasis on top-down training rather than mutual learning approaches has been ineffective. It is possible to achieve collaboration between traditional practitioners and medical professionals within the physical space of the community, without the need to institutionalize joint practices in a medical setting.

Indigenous healing systems

Indigenous healing systems are based on a holistic approach to health. Well-being is perceived as the harmony of individuals, families, and communities with the universe that surrounds them. These practices respond to the internal logic of each community of indigenous
people and are a product of their unique relationship with the elements and the spiritual world in which they live.

**Medicinal Use of Plants**

Community-based projects led by indigenous people, focus on the systematization of knowledge of medicinal plants and their use in community health care, have generally yielded positive results. This knowledge can then be articulated as part of the provision of community health care. Overt interest in the curative properties of plants has, however, troubled indigenous peoples and their organizations. The focus of pharmaceutical research on developing potentially profitable products rather than an interest in improving the health condition of indigenous peoples is perceived as an instance of the blatant disregard that dominant society displays toward their cultural heritage.

**International organizations and health initiatives for indigenous peoples**

The prevailing international climate, at the mid-point of the UN International Decade of the World’s Indigenous People, is seen as an opportunity to capitalize, in favour of health, on such initiatives as the establishment of a permanent forum in the UN for indigenous peoples and the adoption of a draft universal declaration.

The WHO Constitution recognizes the right to health as a fundamental human right, and its approach is therefore to pursue the universal enjoyment of the highest achievable standard of health. WHO targets vulnerable groups and countries as an integral part of its activities, including those characterized by acute instability and apparently stalled development.

The goal of WHO’s programme on sustainable development and healthy environments is to protect health as a cornerstone of sustainable development. Emphasis is placed on breaking the vicious circle of poverty, food insecurity, malnutrition, environmental degradation and contamination, factors of vulnerability, disasters, and loss of lives and assets.

Clearly, by adjusting the role of the health sector and partners from other areas, such as education and agriculture, to meeting the needs of indigenous people in a given national context, it will be possible to move head. By including indigenous people as social actors in dialogue between governmental and nongovernmental sectors, public policy is given a chance to reflect their interests and concerns. At the international level, dialogue is required to focus the goals of the UN and specialized agencies, such as WHO, on the health of indigenous people. Factors that facilitate the implementation of international initiatives on indigenous peoples include the existence of favourable local sociopolitical environments, the establishment of reciprocal relations with indigenous peoples, and the availability of specifically targeted funds.
INTRODUCTION

This document was drafted at the request of WHO’s programme on intensified cooperation with countries and peoples in greatest need to serve as a basis for discussion during the Third Healing our Spirits Conference, New Zealand, 1-6 February 1998. The conference provided an opportunity for networking among indigenous peoples in the health professions. One of the items on the agenda of the conference was the mandate recently established WHO’s governing bodies to develop a global programme of action on the health of indigenous peoples.

The information presented was designed to promote an understanding of indigenous perspectives on health and healing, what it means to be indigenous, the indigenous ways of understanding the world, and how these are related to health and well-being (Chapter I). In sum, the aim was to develop a common language and understanding for working together in a world where diversity of cultures is one of the most precious assets. To a large extent, the information and recommendations are based on the ideas produced in meetings, conferences and workshops where indigenous people have expressed themselves on issues that affect their lives.

Chapter II presents information on the socioeconomic and health conditions of indigenous peoples around the world. The data comprise evidence of ethnic-based disparities and inequities in morbidity and mortality patterns. Information is presented in relation to issues such as environmental degradation, rapid cultural change, conflicts and global economic systems. This is expected to clarify the association between sociopolitical and economic policies, and the ill-health of indigenous peoples. Data are also presented on the health promoting elements of traditional ways of life and on the importance of indigenous cultures in the maintenance of the physical, mental and spiritual well-being of individuals and communities.

Chapter III discusses traditional and Western healing systems and the ways in which they interact. It includes examples of indigenous initiatives in health care, and current trends such as managerial transfer and indigenous ownership. Concise information on international initiatives that affect indigenous peoples, such as bioprospecting, is also included.

Chapter IV presents information on health-related international initiatives. It includes selected illustrations of current WHO activities, including WHO/PAHO’s initiative on the health of indigenous peoples. The lessons learned from this initiative, as well as its accomplishments and limitations, are discussed.
CHAPTER I
CHAPTER I

INDIGENOUS PEOPLES OF THE WORLD: TODAY’S CONTEXT

In recent decades, issues concerning indigenous peoples have been incorporated into the agendas of multilateral agencies, and definitions of the term “indigenous” have been drafted. The World Bank, in its operational directive on indigenous populations,\(^1\) refers to “indigenous peoples, tribal groups, and scheduled tribes” as those "social groups with a social and cultural identity distinct from the dominant society where they live, who have close attachment to their ancestral lands, and who are susceptible to being disadvantaged in the development process.” Similarly, ILO Convention 169 on Indigenous and Tribal Peoples in Independent Countries (1989), recognizes as indigenous, that distinct section of the national community which is understood to consist of ”...peoples in independent countries who are regarded as indigenous on account of their descent from the populations which inhabited the country, or geographical region to which the country belongs, at the time of conquest or colonization or the establishment of present state boundaries and who, irrespective of their legal status, retain some or all of their own social, economic, cultural and political institutions."

Conceptual and historical framework

Indigenous societies represent cohesive systems of life, imbued with a shared world view. Every aspect of indigenous life is governed by sets of rules and values, and sustained by a sound knowledge base. Indigenous peoples have achieved harmonious integration with the environment and have sustained this relationship over the centuries.

Historically, indigenous peoples have suffered the impact of colonization and assimilationist policies as well as of Western development models. These communities now show varying degree of disarticulation. Few, if any, indigenous communities lack contact with the Western world and for the majority daily life takes place in two worlds, the modern and the traditional. Many have close contact with urban environments or reside permanently in cities. Internal and international migrants, the urban Indians, the indigenous diaspora have not received sufficient attention because the image of the "savage living without contact with Western civilization" still prevails in non-indigenous societies. Cultural contact in some cases results in identity conflicts and acculturative stress, with a variety of detrimental consequences for the individual and communities. On the other hand, when indigenous people acquire intercultural skills while maintaining their own cultural identity, social and cultural negotiations with dominant societies become possible. Colonialism establishes a set of social relations based on ethnic status that do not disappear when formal colonial relations have ceased to exist. Discrimination is therefore part of the daily life of society in most countries. But discrimination is seldom recognized as a problem by the dominant society. WHO/PAHO has shown that

"Discrimination in many countries is part of the life of the society. The scale of artificial social prestige relegates the indigenous population to the lowest position...thus giving rise to negative stereotypes, and a derogatory attitude to everything associated with the Indigenous culture” (WHO/PAHO, 1995).

Western development, cultural and economic globalization, environmental degradation, and armed conflicts and violence have a serious impact on Indigenous communities around the world. In recent decades, indigenous peoples have received increasing attention within the global agenda. This is reflected in a series of resolutions, operational directives, covenants and initiatives adopted by the ILO, the UN. However, there is often a considerable gap between the statement of good intentions and action. Indigenous peoples experience serious problems but even after fifteen years of deliberations no consensus has been reached on the UN Declaration on the Rights of Indigenous Populations. The dynamics of large scale capital movements and multinational corporations also complicate conflict resolution, particularly where the problems of indigenous peoples are concerned. The traditional territories of indigenous peoples have commonly had high economic value. Activities such as mining, oil exploitation, logging, dam building, and the establishment of national parks represent an enormous threat to the well-being of indigenous peoples (International Working Group for Indigenous Affairs, 1996). Furthermore, indigenous peoples are highly dependent on the land and the natural environment for their survival. They are also over-represented among the world’s poor (Psacharopoulos & Patrinos, 1994), and seldom have the opportunity of participating in the decision-making processes within countries. These circumstances make indigenous peoples highly vulnerable to macro-economic and Western development policies.

The increased vulnerability of indigenous peoples, compared with other poor or marginalized populations, stems from several factors:

- **Attachment to the land**, which is the basis for both spiritual and material sustenance. Indigenous people have developed complex and diverse systems of adaptation, and their subsistence is based on elements offered by the **natural environment**. Thus, environmental degradation has devastating consequences.

- Profound differences exist between the world view and cultural norms of indigenous peoples and those of Western societies (see Figure 1, page 9). A holistic conception of the world entails, among other factors, unity between the material and spiritual realm, and a collective orientation. This differs from the more materialistic and individualistic orientation of Western societies. Cultural interactions, although necessary, impose **enormous psychological stress**. These stressful processes may lead to individual and community disintegration.

- Many policies, programmes, and actions designed by non-indigenous individuals or institutions have been inappropriate. Differences in world views, and even in the notion of “development,” often result in inefficient and possibly harmful approaches. Furthermore, the colonial experience, assimilatory policies and discriminatory attitudes place indigenous peoples in a condition of greater social and political marginality than other poor populations. Thus, there is a need for indigenous decision-making and self-determination.

Relatively little information is available on the health of indigenous peoples. It is apparent that more is known about their habitat, than about indigenous peoples themselves. Studies and assessments conducted by environmental organizations and institutions have, however, produced data that point to the relationship between environmental degradation and the health of indigenous peoples. Nevertheless, little is known about the physical, mental, social and spiritual impact of Western development on indigenous communities. For example, after decades of nuclear testing
WHAT DO YOU MEAN "INDIGENOUS?"

"Indigenous" has been defined by the World Council of Indigenous Peoples as: 1. The original inhabitants of an area. 2. The descendants of the original inhabitants of an area who are colonized; and 3. Those who live in an indigenous way and who are accepted by the indigenous community. The Sami include those whose grandparents spoke the Sami language in this definition. When asked what it means to be "Sami", they often answer, "It's just a way of life we have".

**The Indigenous Way of Life:**

**HARMONY WITH NATURE**

- Everything has spiritual value.
- The spiritual and the physical are united.
- The laws of Nature are emphasized.
- Nature reflects the Creator.
- Feelings are important.
- Society is based on cultural pluralism and the extended family.
- Roots are remembered.
- Cosmology is spatial, timeless.
- Education is experiential.
- Teachings are from Nature and traditional elders.
- Community spiritual life is based on cultural renewal.
- Technology serves the Peoples and Nature.
- Material wealth is shared and given away.
- Behavior is cooperative.
- Justice and equality are achieved by cultural forms.
- Society is egalitarian.
- Women and men have equal freedom and power.
- Leaders put the People above themselves.
- The balance of Nature is maintained.

**Western “progress”:**

**DOMINATION OF NATURE**

- Everything has monetary value.
- The spiritual and the physical are divided.
- The laws of Man are emphasized.
- The Creator is in Man's image.
- Feelings must be rationalized.
- Society is based on the melting pot and the nuclear family.
- Roots are forgotten.
- Cosmology is linear, time-oriented.
- Education is from the mass media and salaried professionals.
- Community spiritual life is based on personal alienation.
- The people and Nature serve technology.
- Material wealth is hoarded and consumed.
- Behavior is competitive.
- Justice and equality are achieved by legislation.
- Society is patriarchal.
- Women are subservient to men.
- Leaders put themselves above the people.
- The balance of Nature is destroyed.

Footnote:

> Faith Feld (Sami), from 'The Mother Earth vs Western Man: the American Confrontation Between Two Opposing Value Systems,' San Francisco State University. Drawing: Núu-Azán Yáxásaal (Sami), from 'Trainways of the Wind,' CAT. The above is revised for use by The Saami Båte Foundation, 1714 Franklin St #311, Oakland, CA 94612. (510) 456-0930.
in the Pacific, an international cooperative effort to address its health consequences for the local population was launched only recently. Even though it is tempting to blame others, the poor response to the health needs of indigenous peoples reflects the weakness of the health sector, and of indigenous health professionals, in presenting a sound and convincing argument for promoting a more sensible, sensitive, sustainable, healthy and caring human way of life on this planet.

Legal Framework

The provisions of the ILO Convention 169 on Indigenous and Tribal Peoples, adopted in 1989, which is legally binding once ratified by governments, is the most comprehensive and up-to-date international instrument on the conditions of life of indigenous and tribal peoples. Provisions for social security and health in this convention include the following:

- The coverage of social security schemes, which are applicable to all citizens, shall be gradually expanded so as to encompass indigenous and tribal peoples.

- Governments are required to provide indigenous and tribal peoples with adequate community based health services, drawing upon their traditional preventive and healing practices and medicines. This constitutes a recognition of the value of traditional medicine and of the need to preserve and further develop it.

- Indigenous and tribal peoples shall participate in the planning and execution of these services, or undertake overall responsibility and control over health services. In both cases, it is the State’s responsibility to supply the needed resources. Local community health workers should be given training and employment on a preferential basis.

Within the United Nations, indigenous peoples have been the subject of active concern since the formation of the UN Working Group on Indigenous Populations in 1982. The Working Group is composed of independent human rights experts. In 1996, theWGIP focused on health, and at that time the Committee on Indigenous Health was established. Health has been identified as a priority by the Draft Declaration on the Rights of Indigenous Populations. It is expected that the UN General Assembly will adopt the declaration during the International Decade of the World’s Indigenous Peoples (1995-2004). The draft declaration aims to set the minimum standards for the survival, dignity and well-being of the indigenous peoples of the world. Health considerations of the Declaration include: Article 22: “the right to special measures for the immediate …improvement of social conditions… including health;” Article 23 "the right to determine and develop priorities and strategies...for health programmes affecting them"; and "the right to their traditional medicines and health practices" Article 24.

The Committee on Indigenous Health was established to ensure that health remains a priority on the agenda of the Working Group on Indigenous Populations. The establishment of the Committee stemmed from the need for indigenous peoples to be represented and to participate in the development of health policies, plans and initiatives. The Committee was also set up to examine the impact of problematic global practices (e.g dumping of toxic waste, mining, bioprospecting) and other health issues such as reproductive and psychosocial health and their impact on the well-being of indigenous peoples. The Committee is comprised of individuals representing a diversity of regions and nations, and will strive to bring the injustices suffered by indigenous peoples to the attention of the international community.
The World Bank operational directive on indigenous peoples originally focused on the protection of land rights and the provision of health services, particularly for forest-dwelling peoples in lowland South America. A revised policy (OD 4.2) extended the definition of indigenous peoples to include a much wider array of peoples who maintain social and cultural identities distinct from their national societies. Particular reference has been made to the right of indigenous to choose the manner and level of participation in development projects. More recently, the World Bank has begun a process of building an indigenous factor into all its programmes.

The WHO/PAHO initiative on the health of indigenous peoples of the Americas was adopted in 1993 (see Appendix III). It was developed within the framework of achieving health for all by the 21st century, and deals with inequalities in health status and access to appropriate health care for indigenous peoples. It is based on the principles of self-determination of indigenous peoples, a holistic approach to health, and reciprocity in relations. The WHO/PAHO initiative is discussed in more detail in Chapter IV.
CHAPTER II
CHAPTER II

DEMOGRAPHIC, SOCIOECONOMIC, AND HEALTH CONDITIONS

There are over 300 million indigenous people in the world today. They live on every continent and represent thousands of different cultures. (see Map 1). There are more than 6,000 languages in the world (Mackey, 1991; Dwyer & Darkakis-Smith, 1996) and native languages make up the bulk of this linguistic diversity. Unfortunately, only about 60 of these languages have more than half a million speakers, and hundreds of languages lack adolescent speakers (Mackey, 1991; Williams, 1995).

The ratio of indigenous people to total population varies among regions. The largest number of indigenous people is found in Asia with over 150 million, followed by Central and South America with over 40 million. Despite cultural diversity and differences in local conditions of life, indigenous peoples share common factors. These factors include philosophical principles, as well as practical aspects of everyday life. Living in harmony with nature and the universe, and sharing a collective orientation, are among these principles.

Indigenous people are over-represented among the world’s poor (Pscharopoulos & Patinos, 1994). Their health status is severely affected by their living conditions, income levels, employment, access to safe water, sanitation and health services, and food availability. One of the main threats, not only to their health, but to their very survival, is the destruction of their habitat, which provides both spiritual and material sustenance. Acculturation, with the subsequent undermining of traditional practices that are protective of their health, also has a detrimental effect. Data on the socioeconomic and health conditions of indigenous peoples are presented below by region. The information demonstrates that there are inequalities in the living conditions, as well as in morbidity and mortality patterns, between indigenous peoples and non-indigenous populations. Where possible, an assessment is made of the association between sociocultural and environmental factors and health.

The Arctic1

The lives of the indigenous peoples of the Arctic are closely linked to local resources, particularly wildlife harvesting. This dependence forms a basis for indigenous societies, cultures, economies and spirituality. Their diet is based on traditional foods with high nutritional benefits. Environmental assessments show, however, that certain Arctic populations are among the most exposed in the world to environmental contaminants. Some of these contaminants are carried to the Arctic and accumulate in animals used as traditional foods. Some significant contaminants also arise within the Arctic itself. The Arctic Monitoring and Assessment Program was established in 1991 under the Arctic Environmental Protection Strategy to monitor levels and assess the effects of pollutants.

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1 Source: Arctic Monitoring and Assessment Program (1997).
# WHERE INDIGENOUS PEOPLES LIVE

The following listing of Indigenous Peoples is not comprehensive, nor exclusive, but instead representative of peoples living worldwide.

## MAP KEY

<table>
<thead>
<tr>
<th>1. Arctic</th>
<th>8. Great Basin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aleut</td>
<td>Shoshone, Ute</td>
</tr>
<tr>
<td>Chipewyan</td>
<td>Navajo, Zuni</td>
</tr>
<tr>
<td>Inuit</td>
<td>Diffra, Otome</td>
</tr>
<tr>
<td>Saami</td>
<td>Ayara, Papoo</td>
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</table>

<table>
<thead>
<tr>
<th>2. Sub-Arctic</th>
<th>9. Southwest</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cree</td>
<td>Apache</td>
</tr>
<tr>
<td>Dene</td>
<td>Apache</td>
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<tr>
<td>Naskapi</td>
<td>Apache</td>
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<tr>
<td>Ojibwa</td>
<td>Apache</td>
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<tbody>
<tr>
<td>Micmac</td>
<td>Bella Coola</td>
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<tr>
<td>Potawatomi</td>
<td>Chinook</td>
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<tr>
<td>Shawnee</td>
<td>South America</td>
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<table>
<thead>
<tr>
<th>4. Southeast</th>
<th>11. Central America</th>
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<tbody>
<tr>
<td>Cherokee</td>
<td>Brirri, Chol</td>
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<tr>
<td>Chickasaw</td>
<td>Chupinque, Chol</td>
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<tr>
<td>Creek</td>
<td>Chupinque, Chol</td>
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<tr>
<td>Seminole</td>
<td>Chupinque, Chol</td>
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<thead>
<tr>
<th>5. Great Plains</th>
<th>12. Circum-Caribbean</th>
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<tbody>
<tr>
<td>Arapaho</td>
<td>Arawak</td>
</tr>
<tr>
<td>Cheyenne</td>
<td>Bari (Mudimbe)</td>
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<tr>
<td>Pawnee</td>
<td>Bora</td>
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<td>Sioux</td>
<td>Chippewa</td>
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<tr>
<td>Nez Perce</td>
<td>Auarana</td>
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<td>Watsco</td>
<td>Auarana</td>
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<tr>
<td>Yakima</td>
<td>Auarana</td>
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<tr>
<td>California</td>
<td>Auarana</td>
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<tbody>
<tr>
<td>Cahuilla</td>
<td>Akawalo</td>
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<td>Pomo</td>
<td>Baru</td>
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## Asia

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<th>19. North and Central Asia</th>
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<td>Aina</td>
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<td>Bui</td>
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<td>Manch</td>
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<td>Miao</td>
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<th>20. South Asia</th>
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<tr>
<td>Bhils</td>
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<td>Daiji</td>
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## Africa

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<tr>
<th>23. Sahara, Sahel</th>
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<tbody>
<tr>
<td>Fulani</td>
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<td>Tuareg</td>
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## Australia and the Pacific

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<th>28. Australia and the Pacific</th>
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<tbody>
<tr>
<td>Aboriginals</td>
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<td>Arapesh</td>
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<td>Amat</td>
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<td>Bangsa</td>
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<td>Bontoc</td>
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<td>Chamorro</td>
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<td>Dani</td>
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<td>Dayak</td>
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<td>Hanunoo</td>
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<td>Hawaiian</td>
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<td>Iban</td>
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<td>Ilugao</td>
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<td>Kalima</td>
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<td>Kamber</td>
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<td>Kurang</td>
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<td>Mundaguny</td>
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<td>Penan</td>
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<td>Rapa Nui</td>
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<td>Tahitian</td>
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## East Africa

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<th>25. The Horn and East Africa</th>
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<td>Barabisc</td>
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<td>Ertiee</td>
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<td>Maasai</td>
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<td>Oromo</td>
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<td>Somali</td>
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<td>Tigray</td>
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Some of the conclusions stated in its first report are as follows:

- Radioactive contamination arises from three primary sources: atmospheric nuclear weapons testing (1950-1980); releases from European nuclear reprocessing plants (e.g. Sellafield in the 1970s); and fallout from the Chernobyl accident in 1980.

- Of the heavy metal contamination in the Arctic, industrial sources in Europe and North America account for up to one third of the deposits.

- Sulphur and nitrogen compounds from sources associated with industries, energy production and transport in areas remote from the Arctic result in low but widespread levels of these contaminants throughout the Arctic.

- Two thirds of airborne heavy metals in the High Arctic originate from industrial activities on the Kola Peninsula, the Norilsk industrial complex, the Urals, and the Pechora Basin.

**Russia**

Common occupations of indigenous peoples in Russia are reindeer herding, hunting, fishing, and producing reindeer fur for handicrafts. The primary indigenous people in the Murmansk Oblast region are the Sami. Others are the Nenets, who live in the tundra, and the Khanty, Selkup, Dolgan, Nganasan, Evenk, Yakut, Yukagir, Chukchi, Yupik, Even, Chuvan, and Koryak.

Statistics on mortality and the incidence of various diseases bear witness to a dismal health situation. The incidence of disease as well as traumas has increased several hundred per cent since 1970. The risk of disease among indigenous peoples of the Arctic reflects lifestyle patterns. A study in the Nenets Autonomous Okrug showed that the rates of disease were 50% higher in the settled population compared with those living on the tundra. Psychological disorders were 2.5 times higher among the settled population. In the north, the mortality rate in 1989 for indigenous peoples was 10.4 per thousand, compared to 6.6 per thousand for other residents of the area. At the end of the 1980s, life expectancy was 54 years for men and 65 years for women, which is 10 to 20 years lower than the respective Russian averages. Trauma, infectious diseases (especially tuberculosis), cardiovascular diseases, parasites and respiratory diseases are common causes of death. Many health problems are related to alcoholism. The infant mortality rate is as high as 53 per thousand among the Koryak, and 48 per thousand among the Eskimos. Certain diseases are particularly common. One is the "northern lung," a form of respiratory disease widespread among indigenous peoples. Chronic ear infections are also common. The incidence of tuberculosis is 2.5 to 3 times higher than among newcomers to the region. Dietary changes, including more carbohydrate intake compared with traditional foods, may be in part responsible for the high incidence of gastrointestinal disorders. Up to 95% of the population suffers from vitamin deficiencies. The future of the indigenous peoples of the Russian Arctic is uncertain and although the Russian Federation has passed some laws to protect minority interests, implementing the new legislation will take time, energy and resources.
Alaska

The Native Peoples of Alaska are the Aleut, Alutiiq, Athabaskan, Central Yupik, Eyak, and Inupiat. Several problems contribute to high rates of disease and early death among these native communities. Many of the problems result from the loss of traditional ways of life, such as poor housing, poor sewage disposal, and lack of safe drinking water. Alaska natives smoke more than the population at large, and alcohol abuse is also prevalent. Moreover, health care facilities are not adequate to meet people's needs. In 1993, the legislature of Alaska concluded that "by all measures, the health status of Alaska Natives is significantly lower than other Alaskans. The health needs of Alaska Natives outstrips the resources available. Many villages do not have basic water and sanitation services." Among some groups of native peoples in Alaska, pneumonia is up to 60 times more prevalent than in the United States population as a whole. In certain areas, botulism reaches its highest incidence worldwide. The age-adjusted mortality from some types of cancer is higher than for the United States population, even though the incidence of cancer is comparable. Many cancer deaths are tobacco-related. The overall leading cause of death in Alaska is cancer, followed by heart disease, unintentional injury, and suicide. Diabetes, breast cancer, suicide, chronic obstructive pulmonary disease, lung cancer and neoplasms are increasing among Alaska native peoples.

Despite this worrying picture, there are some positive developments. The overall death rate has been declining in recent decades, and life expectancy for indigenous newborns increased from 46.8 years in 1950 to 66.6 years in 1980-84. Deaths from injuries, accidents, drowning and homicide declined significantly between 1980 and 1990.

Canada

Peoples of the Arctic region of Canada include the Inuit, Dene and Metis. They total about 93,000 people. Hunting, fishing and gathering are important activities in the economy of indigenous societies, but native peoples also participate in the wage economy. Health conditions for Canadian natives have improved dramatically in the past half century, but mortality rates are still higher in the north than for Canada as a whole.

Much of the improvement in health has come about through better health care, such as the nursing stations that have now been established in many communities. Hospitals are centralized in major cities, but mobile clinics provide some speciality care that would otherwise not be locally available. Life expectancy at birth among Inuit doubled between the early 1940s and the 1980s, when it reached 66 years. Life expectancy has continued to improve but it is still four to five years lower than the Canadian average. In the Northwest Territories, infant mortality was 28 per thousand in 1981-85, compared to 144 per thousand two decades earlier. Infant mortality is, however, still three times higher than for the Canadian population as a whole. Major problems include poor water and sewage disposal systems. A threat to the health of native peoples in Canada is the extremely high percentage of smokers. By the age of 19 years, 63% of Indians and Inuit smoke, compared with 43% for non-natives. Smoking is the most likely explanation for the recent increase in lung cancer among Inuit in the Northwest Territories.

The heavy reliance on natural food seems to reduce the risk for certain health problems. indigenous peoples in the Canadian Arctic have among the lowest age-standardized prevalence of diabetes in the country. The most common foods are caribou, other wild mammals, fish, and
berries. Diabetes is one of the most prominent health risks associated with change to a more Western diet.

**Greenland**

Kalaallit is the collective name for the indigenous peoples of Greenland: the Kitaamiut in the west, Tunumiut in the east, and Inughuit in the north. In 1994, the population of Greenland was 55,419, of which 87% was indigenous. The introduction of home rule in 1979 and the improvement in Greenland's educational system have reduced the number of non-indigenous people working and living in Greenland. Almost 80% live in towns and the remainder reside in smaller villages. Commercial fishing and the fishing industry are the most important activities, and 10% of the population depends on hunting. Among hunters and fishermen, 44% eat their own products daily. In the villages, 31% of residents eat Inuit food, compared with 26% in towns. Disease patterns include high mortality from natural causes and relatively low mortality from heart disease. The incidence of unintentional injuries and suicides is, however, high. The average life expectancy at birth is 68.4 years for women and 60.7 years for men. Smoking is very common among all age groups; 84% of Inuit men and 78% of Inuit women are current smokers.

**Samiland**

The Sami homeland expands through four different countries: Russia, Sweden, Finland, and Norway. There are no reliable estimates of the number of Sami because ethnicity is not included in the national census data. Adjusted older data put the figure at about 85,000 people. Of these, approximately 50,000 live in the Arctic, where they make up about 2.5% of the population. In 1951, the civil rights of the Sami were recognized in the Sami Codicil.

**The Pacific**

The region of the Pacific covers about one third of the area of the globe. The 1.1 million Kanaka Maoli, indigenous Hawaiians constitute 20% of the total population in Hawai‘i; the 3.2 million Maori represent 15% of the total population in Aotearoa (New Zealand); and the 15 million Aborigines make up 2% of the total population in Australia.

Some of the indigenous peoples of the Pacific have been recognized as such by the international community. These are the Chamoru, the American Samoans, the Kanaka Maoli of Hawaii, the Maori of Aotearoa, the Aborigines and Torres Strait Islanders of Australia, the Kanaks of Kanaky (New Caledonia), the East Timorese, and the Tokelauans. These peoples are included in the UN list of non-self governing territories with a right to decolonization through a process actively supported by the UN Decolonization Committee.

Other indigenous peoples of the Pacific include those of the new Melanesian States, such as the peoples of Santo and Tanna in Vanuatu, and the Bouganvileans of the North Solomon Province of Papua New Guinea. In Micronesia and Polynesia, some of the small independent island States encompass several indigenous peoples. These States, however, are still highly

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dependent on the former colonial forces, international corporations, multinational banks or
development agencies. The first peoples, although nominally in control of their own lives,
continue to suffer social and cultural disintegration, including large scale emigration, resource
exploitation and environmental destruction.

The environmental challenges to the Pacific are enormous. They include hazardous
dumping of waste, chemical burn-off (Kalama, Johnston Atoll), nuclear shipments, nuclear
testing, deforestation, mining, agroforestry and logging, building of dams and establishment of
grazing areas. Another significant threat is pressure on the environment from tourism, shopping
malls, golf-courses, and over-exploitation of the ocean from fisheries and sea bed mining.

Some development schemes are so big that they will completely alter the local social and
political structure. This is happening in Belau, where six hundred not-yet-built houses have been
sold to buyers from one Asian country. This will change the population composition of the
16,000 Belauans. Leasing of prime public lands for the planned construction of a mall in the
Northern Marianas has been halted by civil action. The Northern Marianas receives 600,000
visitors per year, or 30 tourists per indigenous person, almost the same ratio as for the Kanaka
Maoli of Hawaii.

Since the 1950s, more than 180 nuclear tests have been carried out on Fangataufa and
Moruroa in the overseas French territories of Polynesia. The testing has now stopped, but the
contamination and the dumping of nuclear waste continues. The island of Bikini depends on
food aid because the locally grown food is too radioactive to eat. At the same time, seven new
types of cancer have been added to the list of conditions eligible for compensation (Pacific News
Bulletin, Spring 1997:215). A cooperative study is under way, involving a Tahitian non-
governmental organization, Hiti Tau, the World Council of Churches in Geneva, and the
University of Wageningen in the Netherlands, among others. The project seeks to obtain data
on the environmental and health situation of the Polynesians who worked at the test-sites and on
the inhabitants of the islands around the sites.

Cheap labour is available in some Pacific nations, often because of immigration from
other countries. Filipinos comprise the largest ethnic group today in Saipan in the Northern
Marianas, where many are currently located many garment factories. They produce famous and
expensive brands such as GAP, LA Gear and Levi Strauss. Immigration has shaped the Pacific
nations, but emigration is an important factor as well. More than two-thirds of the population
of American Samoa now live in Hawaii and on the West Coast of the United States. About one
third of the Kanaka Maoli of Hawaii live outside Hawaii; more than one-third of the Tongans
have left their country, and more than half of the population of the former and present New
Zealand Territories of Tokelau, Niue and Cook Islands live abroad.

Table 1 shows gradients of association between high blood pressure and levels of
acculturation among indigenous peoples in the Solomon Islands (Melanesia) and in Polynesia
(Page, Damon & Moellering, 1974; Harburg, Glieberman, Harburg, 1982; Podlendank, 1989).
In Puka-Puka, an isolated island with a more traditional culture, there was no association between
age and blood pressure. Maupiti, near Tahiti, where blood pressure levels are lower, has
undergone rapid cultural and economic change since the 1970s, but the population is still less
Westernized and urbanized than Samoans, Rarotongans or the Maori, who have higher blood
pressure levels. In the Solomon Islands (Melanesia), data from the 1966-72 survey of blood
pressure also showed that the less acculturated groups tended to exhibit little or no increase in blood pressure with age and had a lower proportion of males with higher blood pressures. In the 1978-80 follow-up survey of the same persons, the least acculturated, including the Aita and the Kwaio, showed little increase in average pressures (especially diastolic pressure) with age. The Nagovisi are becoming more acculturated, especially in their diet, and increases in blood pressure were noted longitudinally between 1966-72 and 1978-80. The pattern of change in blood pressure over time was, however, complex. For example, in Hawaii, Samoans in urban areas had significantly lower blood pressures than those in rural areas, suggesting either selective migration or sociocultural differences (Hanna & Baker, 1979).

### TABLE 1:
Relationship between degree of acculturation and blood pressure in various studies

<table>
<thead>
<tr>
<th>Solomon Islands groups</th>
<th>Nasioi</th>
<th>Nagovisi</th>
<th>Lau</th>
<th>Baegu</th>
<th>Aita</th>
<th>Kwaio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Degree of acculturation</td>
<td>+++</td>
<td>+++</td>
<td>++</td>
<td>+</td>
<td>+</td>
<td>0</td>
</tr>
<tr>
<td>Correlation: Age by systolic blood pressure (females)</td>
<td>0.36</td>
<td>0.30</td>
<td>0.36</td>
<td>NS</td>
<td>NS</td>
<td>NS</td>
</tr>
<tr>
<td>Percentage of males with pressure 140/90 or higher</td>
<td>3.4</td>
<td>2.7</td>
<td>7.8</td>
<td>0.8</td>
<td>0</td>
<td>0.8</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Polynesian groups (males)</th>
<th>Rarotonga</th>
<th>Samoa</th>
<th>Maori</th>
<th>Maupiti</th>
<th>Puka-Puka</th>
</tr>
</thead>
<tbody>
<tr>
<td>Degree of acculturation (approx.)</td>
<td>Highest</td>
<td>Intermed.</td>
<td>Lower</td>
<td>Lowest</td>
<td></td>
</tr>
<tr>
<td>Association between age and blood pressure</td>
<td>Strong</td>
<td>Intermed.</td>
<td>Lower</td>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

Redrawn from data in Page et al. (1974) and Harburg et al. (1982). Approximate relative degree of acculturation is rated from 0 (lowest) to +++ (highest) on the basis of eight criteria including diet (Western versus traditional), economy (cash versus other), education, and medical care.

Solomon Islanders are Melanesians (see Chapter 3)

See references in Harburg et al. (1982) and Baker et al. (1986) for details on studies in Polynesians. The Solomon Islands data have been updated by Freidlander et al. (1987) and the Kwaio remain the least acculturated or most traditional group.
Aotearoa (New Zealand)

In 1840, the Maori outnumbered the European settlers by 1,000 to 1. Maoris owned 66 million acres of land and were engaged in a flourishing export trade across the Tasman Sea. Within the space of 50 years, the Maori were outnumbered by the new settlers by 10 to 1 and their land holdings had shrunk to 11 million acres. In 1894, the Maori population reached such a low level that they were thought soon to become extinct. They had been devastated by a series of epidemics, such as influenza, measles, whooping cough and typhoid fever. With public health interventions after the 1940s, the population grew, reaching a total of 511,278 by 1991. After the Second World War, rapid urbanization of the Maori took place and, by 1968, over 80% lived in cities. Maori unemployment rates reached about 25%. The Maori nation is now in the process of promoting its cultural, economic and political revitalization.

By almost every indicator, Maori health compares unfavourably to the total New Zealand population (Hunn, 1961; Rose, 1961, Pomare & De Boer, 1988). Life expectancy of indigenous people in New Zealand (male 63.8, female 68.5) is lower than that of non-indigenous people (male 70.8, female 77.0) (Kunitz, 1994). The infant mortality rate for Maoris was 15.1 per thousand for the period between 1989 and 1993, while the non-Maori rate was 7.4 per thousand.

Maori male mortality from road accidents is almost twice the non-Maori male accident rate. Young Maoris between 15 and 24 years of age have the highest psychiatric first admission rate, and this rate is two to three times higher than for non-Maoris. Alcohol and drug-related illnesses are the most common causes of first admission (Te Puni Kokiri, 1993a). In 1992, 85% of all Maori hospitalizations were to public hospitals. Unintentional injury is the main cause of hospitalization for men between 35 and 44 years of age. For Maori women in this age group, childbirth and its associated risks are the main causes of morbidity (Te Puni Kokiri, 1993b). Maori hospitalization rates for kidney and urinary tract disorders are high, 68 per ten thousand compared with 38 per ten thousand for the non-Maori population. Diabetes results in hospitalization rates over four times higher, and mortality rates four to six times higher among Maoris than among the general population. Maoris have high age-standardized rates of cancer of the lung, with the rate for females being three times higher than for non-Maori females. Maoris also have higher death rates for cancers of the stomach, uterus and cervix. The Maori death rate for cancer of the stomach is at least two times higher, and that for cancer of the cervix is three times higher than for non-Maoris. Non-Maoris, in turn, have higher rates for cancers of the large bowel, breast and brain.

Mental health is the area of greatest concern for Maoris in the 15-24 year age group. This age group has the highest psychiatric admission rate from all causes, the Maori rate being two to three times higher than that for non-Maoris. A community sample of 3,000 women in Otago found that approximately 40% of women under 65 years had suffered sexual abuse either as children or adults, and a further 2% had suffered physical abuse. Those women with a history of abuse were more likely to advocate preventive measures than punitive measures to reduce the impact of violence in the community (Martin, O'Shea & Romans, 1993).

The Pacific Islands population living in New Zealand was about 167,000 in 1991. It comprises Samoans, Tongans, Cook Islanders, Tokelauans, Niueans, Fijian Tuvaluans, and people from the Melanesian countries of Papua New Guinea, Vanuatu and the Solomon Islands (Public Health Commission, 1994). Like the Maoris, they have high rates of unemployment,
reaching 21.5% for males and 20.0% for females in 1991. The Quality of Life survey showed that nearly 53% of the Pacific Islands people described their situation as being bad, compared with 16% of non-native respondents (Manukau City, 1993).

A survey of the Tokelau atolls in 1963 showed the persistence of the traditional diet based on taro, breadfruit, coconuts and fish. Pork, chicken and fruit are eaten at feasts (Davidson, 1975). There were few cases of hypertension, and blood pressure did not increase significantly with age (Prior et al. 1977). The longitudinal follow-up (1972-1982) of the Tokelau Migrant Study showed the occurrence of major dietary changes among migrants to New Zealand and in the Atolls, following increased shipping contacts. The study also showed that the incidence of diabetes was higher among Tokelauans who had immigrated to New Zealand (male 4.4, female 10.8), than among non-migrants (male 2.3, female 6.1), with a larger increase occurring among women (figure 2). The prevalence of gout and hypertension also increased among immigrants. Ostbye, Welby and Prior. (1989) listed the factors most likely to contribute to the increasing rate of diabetes upon migration. These are a high energy, protein and alcohol diet causing a greater weight gain, plus a decreased level of physical activity. It is likely that a genetic predisposition for diabetes occurs in Pacific Islands populations, responding to factors existing in an urbanized environment and lifestyle.

Figure 2:

Age-standardized prevalence rates per thousand of definite and known diabetes in Tokelau migrants to New Zealand over time.

Source: Stanhope and Prior, 1980
Scragg et al. (1993) have shown that, compared with non-natives, Pacific Islands people living in New Zealand had higher mean blood pressure levels when controlled for age, blood pressure treatment, and body mass index. Of the hypertensive subjects, Pacific Islands people were least likely to be receiving treatment, and were therefore considered to be at higher risk. In some Islands, there were marked differences in blood pressure levels between the rural populations living in a traditional lifestyle and the urban modernized populations. Blood pressure levels tend to rise with age more readily in the latter environment (Prior *Rom.*, 1968; Baker, Hanna & Baker, 1968). This was attributed to a number of factors including increased sodium intake (Prior *Rom.*, 1968), body fat (McGravey & Baker, 1979), blood lipid levels (Tuomiletho *Rom.*, 1989), stress levels (Beaglehole, 1992), decreased glucose tolerance (Tuomiletho *Rom.*, 1989), and decreased physical activity (Prior & Stanhope, 1980). All these factors are associated with moving from a traditional to a modern lifestyle. The rise in blood pressure appears to express itself earlier and is most noticeable in women (Beaglehole, 1992).

Pacific Islands males in 1981 had higher rates of smoking than all males, but among females, Pacific Islanders had lower smoking rates. Among Pacific Islands males, smoking was most common in the 45-64 years age group (45%). Among Pacific Islands women, the highest smoking rates were among those aged 15-24 (26%). The rates of cigarette smoking among immigrant Tokelaunans increased significantly between 1972 and 1982. In young people aged 15-19 years, the rates increased from 30% to 56% in males, and from 17% to 46% in females (Wessen, 1992). Among alcohol drinkers, 50% were "moderate" drinkers (New Zealand Ministry of Health, 1993). Pacific Islands women and children represented 10.6% of all those admitted to a collective refuge for victims of domestic violence in New Zealand. Domestic violence is attributed to lack of employment, insufficient money, overcrowding, alcohol abuse, and the lack of understanding between parents and children.

Differences in health status and risk factors are also found across native populations. A 1992-93 Household Health Survey revealed that 53% of Pacific Islanders over 15 years of age and living in New Zealand never used alcohol, compared with 27% of Maori. The Plunket National Child Health Survey 1990-1991 showed that 12% of Pacific Islands mothers interviewed consumed alcohol during pregnancy, compared with 44% of Maori mothers. The relatively high level of abstention among Pacific Islands mothers was attributed to cultural factors, since it was culturally inappropriate in Pacific Islands society for women to drink alcohol (Counsell, Smale & Geddis, 1994).

**Hawaii**

In 1986, Kanaka Maoli (indigenous Hawaiians) in the Islands were estimated to number 294,000. Approximately two-thirds were living in Hawaii with the remainder living in the continental United States (Barringer, 1989). In Hawaii, two-thirds are concentrated in the metropolitan island of O'ahu, with one-third on the less populated and more rural islands. Skeletal remains show that before contact with the Europeans, the Kanaka Maoli had metabolic diseases such as gout and arthritis, and non-infectious inflammatory illnesses such as rheumatoid arthritis, as well as a low frequency of dental caries and bone abscesses. They did not, however, have to contend with the epidemics that plagued other continents. They consumed a healthy traditional diet and did not consume substances such as alcohol, tobacco and drugs in a harmful manner. By 1980, the Kanaka Maoli had the highest poverty rates in Hawaii, (14.3%) compared to 7% for whites. In 1980, their life expectancy at birth (74.0 years), was lower than the state
average (78.0). Infant mortality rates were 14.1 per thousand in 1980-86, compared to 9.3 for all races (Bell, Nordyke & O'Hagan, 1989). Their overall age-adjusted mortality rate was 34% higher than for all races in the United States (779 per hundred thousand, as against 541 per hundred thousand (Miike, 1987). Adjusted mortality from heart disease was 44% greater among the Kanaka Maoli, (344.5 for men and 244.1 for women) than for the general United States population (212.2 for men and 109.3 for women) (Johnson, 1989). Kanaka Maoli had the highest overall cancer mortality rate (319.6 per hundred thousand compared to 132 for all races). The highest death rates were for tumours of the respiratory, digestive and breast tissues. Mortality from diabetes was 32.5 per hundred thousand for the Kanaka Maoli, compared to 12.7 for all races. With a differential of over 200%, this is the largest gap in any disease category (Miike, 1987). Prevalence of high blood pressure was 85 per thousand for Kanaka Maoli, and 62 per thousand for all races. In 1985, the Moloka'i island cardiovascular risk study showed that 42% of Kanaka Maoli men and 34% of the women were current cigarette smokers. Since 1958, the Kanaka Maoli suicide rate has been increasing, reaching 29.2 per hundred thousand in 1978-82, compared to 18.5 for Whites (Blisdel, 1993).

Australia

Aboriginal people are the original inhabitants of the continent of Australia. They constitute 1.5% of the population of Australia as a whole, and 22% of the population in the Northern Territory. According to the 1986 Australian Census of Population and Housing, the Aboriginal population was 227,645. Of these, 206,104 were Australian Aboriginals and 21,541 Torres Strait Islanders. Before colonization, Aboriginals were nomadic, lived off the land, and used their own traditional healing systems. They were free from many of the health problems that beset them today. Diseases unknown in traditional communities are now common. During the last 20 years the Australian government has tried various policies and programmes but failed to improve the poor health of Aboriginals.

In Australia, Aboriginal life expectancy (male 54.0, female 61.6) is around 20 years less than for non-Aboriginal Australians (male 72.8, female 79.1). The life expectancy of Aboriginal people is considerably lower than that of indigenous peoples in the United States (male 67.1, female 75.1), and Canada (male 64.0, female 72.8). Age standardized death rates for Aboriginal males are 2.8 time those for non-Aboriginal males, while age standardized death rates for Aboriginal females are 3.3 times those for non-Aboriginal females. Over the past 40 years, the Aboriginal infant mortality rate has declined, but it is still over three times the national average. Over the same period, adult mortality in the Aboriginal population has increased. Aboriginal women in the Northern Territory have cervical cancer rates more than five times that of other women. Currently, the main causes of death among Aboriginal people are the so-called lifestyle diseases, such as diabetes, kidney disease, heart disease, and the diseases of anger and despair: alcohol-related ill health and violence (Khan, 1986). Among Aboriginal men in the Northern Territory, the most important causes of premature death, measured in excess deaths in years of potential life lost before age 65 (YPLL65), were motor vehicle accidents (11% of excess deaths and 17%YPLL65), ischaemic heart disease (10% of excess deaths and 10% of YPLL65), and pneumonia and influenza (8% of excess deaths and 6% of YPLL65). For Aboriginal women, the most important causes of death included homicide (7% of excess deaths and 11% of YPLL65), chronic obstructive pulmonary disease (10% of excess deaths and 5% of YPLL65), and rheumatic heart disease (7% of excess deaths and 8% of YPLL65) (Cunningham & Condon, 1996). Between 1979 and 1991, compared to the total Australian population, remote Aboriginal
areas in North Australia had higher rates for a range of diseases, such as infectious and parasitic diseases (up to 22 times higher), cancer of the cervix (almost 12 times higher), diabetes (17 times higher for females), respiratory diseases (12 times higher for females), diseases of the genitourinary system (up to 17 times higher), and homicide (15 times higher for males) (Mathers, 1995). The incidence of hepatitis B in the top end of the Northern Territory was estimated from notification data and hospital data to be 42 per hundred thousand among Aborigines, and 4 per thousand among non-Aborigines, with an odds ratio of 9.7 : 1 (95% CI=3 to 33). Among Aboriginals, 60% of cases of acute hepatitis B occurred in children under 10 years of age, whereas non-Aboriginal cases occurred in adults aged 20 to 29, most with behavioural risk factors (Wan, et al., 1993).

Asia³

Information about indigenous peoples in Asia is scarce, so only a few individual cases are discussed. Examples of other indigenous peoples not covered in the report include the Kazakh, Ulghur and Kyrgyz in eastern China.

To respond to the needs of aborigines in Taiwan, China, in 1996 the government created several aboriginal committees on various administrative levels. The first, established in March 1996, was the Taipei Municipal Government Aboriginal Committee. This was the first time that the term “Aboriginal Committee” was used since the beginning of the aboriginal movement. Negotiations are ongoing for the recognition of the Ainu as indigenous peoples by the Japanese government. Many of the health problems of the Ainu stem from identity conflicts, "not knowing who we are, where we come from and not wanting to be Ainu, even though the Ainu identity is kept deep inside." Alcoholism, domestic violence and abuse are some of the ailments of the Ainu people. Caring for the old who often live alone is also a preoccupation. The Ainu are seeking to recover and revitalize their culture as a way to heal their ailments.

Some of the indigenous peoples in South East Asia are the Kachin, Wa, Palaung, Lahu, Pao, and Karen in Myanmar. The Asakan coastal region, in western Myanmar, is the homeland of the Rakhaing people. This was once a flourishing land and a core area of the world's rice bowl. Today its population lives in abject poverty. Thousands of young people emigrate in search of a livelihood in foreign countries, often to be exploited in mining areas.

The tribal peoples of Thailand have traditionally lived in the highlands of the north and west, along the waterways where they practice rotational agriculture. They have different farming systems for each season, and ceremonies for asking forgiveness for disturbing the land and for giving thanks. They consciously manage natural resources and wildlife, while local leaders maintain peace and good relations within the communities. They have lived together peacefully with the land, water, forests and animals under the principle of use and maintain. Decades of uncontrolled logging and extensive deforestation have, however, reduced the country's forest cover to 26%. The massive flooding and landslides of 1988 also had disastrous consequences. The government subsequently declared a logging ban, but the situation of indigenous peoples has not improved since then and they are now facing new problems, such as relocation from their lands.

Recently demographic data show that indigenous peoples in Viet Nam have increased from 13.1% to 13.5% of the population between 1989 and 1995. The densest concentration of indigenous peoples is in the northern mountain zone that includes the central highlands. Indigenous peoples in Viet Nam are mostly subsistence farmers. A World Bank study showed that 59% and 50% of the population lived below the poverty line in the northern mountain and central highland zones, respectively. Health problems remain severe. Studies undertaken in the northern mountain zone report a high prevalence of malaria, dysentery, malnutrition and acute respiratory infections, as the most common ailments. Other problems include iodine deficiency, bubonic plague and leprosy. The health services infrastructure differs greatly across provincial boundaries, with better capacity in the central highlands. Conflict over land tenure remains the main threat to the survival of indigenous peoples in Viet Nam. The form of cultivation practised requires that patches of land remain uncultivated for prolonged periods of time. Such land is often classified as barren or idle, and its use by indigenous peoples is restricted by the government.

In Sabah (northern Borneo Island), there are 39 different ethnic groups (among others, the Rungus, Dusun, Murut, and Lun Dayeh) which make up 50% of the total population of two million. In Sarawak, 10,000 Penans are threatened by logging. Because their traditional nomadic hunter-gatherer way of life is intricately connected to the forests, only 400 still live in this way, while most are semi-settled. The projected Baku Dam will flood 700 square kilometres and affect 9,500 people from 16 indigenous communities (Kenyah, Kayan, Penan, and Ukit). In peninsular Malaysia, the Orang Asli remain the most poor and marginalized sector of Malaysian society. According to official statistics from the Department of Orang Asli Affairs, 80% of this population lives below poverty level. Their death rate from tuberculosis is twice as high as the national average, while the infant mortality rate is more than three times the national average. Malnutrition is common in many Orang Asli localities. According to a 1995 study, Orang Asli women are the most malnourished adult group in west Malaysia, with 35% of them having protein-energy malnutrition. Between 23% and 68% of Orang Asli children are underweight, while 41% to 80% are stunted in their growth. Distressingly, 60% of all mothers who die in childbirth are Orang Asli.

Amungume means the first people; they are one of the hundreds of indigenous peoples in Irian Jaya (West Papua). There are 14,000 mountain people, and the land for them has a unifying and deep meaning. However, 2.6 million hectares of their habitat have been lost to a mining area that yields 100,000 dry metric tons of mineral per day.

Dayak is a collective name for the 3 million indigenous peoples of Kalimantan, with their 450 different languages and cultures. Development ventures in Kalimantan since 1970 have resulted in degradation of the world’s oldest rainforest. Some positive developments in the country have been an increase in public awareness, especially by nongovernmental organizations and local scientists, of the problems faced by indigenous peoples. In addition, on the part of the international public, there is a growing respect for, and recognition of the outstanding contribution of indigenous peoples in Indonesia in conservation and sustainable natural resource management. This was evidenced by the 1997 Goldman Award to the leader of the Nentian Dayak of East Kalimantan, L.B. Dingit. The award was presented for his struggle to preserve the rattan stands in their customary forest from invasion by an industrial timber company. Local institutions and organizations, based in indigenous communities in various localities in Indonesia, are gaining strength with their growing capacity to accommodate and channel the
aspirations and interests of the people. These institutions and organizations conduct many critical educational activities, which form the basis for sustaining their culture.

Indigenous peoples comprise about 14% of the population in the Philippines, with more than 140 different languages. General assumptions about indigenous peoples are that "they are primitive, continue to observe traditional beliefs and practices, wear colourful clothing with matching beads and adornments, and are either fierce head hunters, or timid and afraid of strangers (International Working Group for Indigenous Affairs, 1996 and 1997). Colonization and proselytization created a cultural divide between the diverse Philippine population: the Christianized lowlanders, the Islamicized Bangsamoro, and the "pagan hill people." The former became the cultural majority, of which some became the native political masters and economic elites. The latter two resisted or retreated into the interior, opposing various schemes to integrate them into the mainstream culture. They were able to preserve their ways of life, while the lowlanders assimilated the colonial culture and lifestyle. Recent political developments have brought some of these indigenous peoples together, transcending cultural barriers and differences. In the forefront are the various Cordillera Peoples, who are now referred to as Igorot. In Mindanao, the non-Islamic and non-Christian groups are known by the term Lumad (native), while in Mindoro, the groups on the island are the Mangyan. There are also indigenous peoples that are grouped together on the basis of their areas of concentration, such as the Negros-Panay or Bisayans (Panay, Bukindon, Negros, Bukindon, and Ati), the Sierra Madre Region (Bugkalot, Kalinga, Alta, Agta, and Remontado), and Palawan (Taganuna, Palawan, Batak, and Molbo). The Ayta people, who are distributed over Luzon, Palawan, Visayas, and Mindanao, have organized locally. Others have formed regional groups, such as the Mamanua. A large number of their settlements are located in marginal areas, where they practice diversified subsistence strategies or a mixed economy of agriculture, hunting and gathering, trading forest products, salaried labour and, in many areas very recently, permanent agriculture. The issues affecting the indigenous peoples in the Philippines can be summed up in terms of recognition of their ancestral domain, aggressive development schemes, and environmental destruction.

India, in South Asia, is a multicultural State so vast and diverse that it is often referred to as a sub-continent. Each state is a mosaic of indigenous populations recognized as Scheduled Tribes by the government. About 200 distinct cultures total over 33 million people (Debabrata Roy, 1997). In order to support their buffalo milk production, the Van Gujjar pastoralists inhabit the forests or the plains during the winter months and the highland Himalayan pastures during the summer. A kinship exists between them and the animals of the wild because they perceive both to be derived from the same forest womb. They thus consider the killing of wild animals to be a sin leading to public condemnation and social ostracism. To them the forest is a benign and nurturing place. Their understanding is that prosperity comes to those who honour nature's way, just as poverty will automatically strike those who scorn her laws. With international support, they have developed an alternative to a government-proposed state park that would have evicted them from their land. Thus, the creation of the Community Forest Management Protected Areas Plan granted the Van Gujjar the management of the first People's Park in India.

The Kolta are the original inhabitants of the hill region of Jaunsar Bhabar in India. The landlords from the plains subjugated the 19,000 Kolta people and forced them into bondage. The bondage included wives and children. The Abolition of Bonded Labour Act was passed in 1976; however, to this day, the Kolta remain destitute. Furthermore, instead of being granted the status of a Scheduled Tribe, they were deemed to be a Scheduled Caste. In India, under the 73rd
Constitutional Amendment pertaining to local government, a number of Janusari women and men have taken their place in governance. The government of India has recently passed the Provisions of the Panchayats (Extension to the Scheduled Areas) Act, 1996. The population of the scheduled areas is almost entirely tribal and indigenous, and all the seats as chairperson in these territories are reserved for tribal and indigenous people.

In the Indian region of Maharashtra, the tribal people number over 7 million, according to the 1991 census. There are 47 tribes, among them the Bhils, Gamits, Mahadeo, Kolis, Warlis, and Koknas. Maharashtra has the distinction of being a state where extremes coexist. While it boasts of being the most advanced industrialized state in the country, the poverty of tribal Peoples is abysmal, with thousands of deaths from starvation and malnutrition. Tribal people have lost their habitat and survival resources. According to government statistics, a total of 3,821 Korku children below the age of six died in the past four years from malnutrition and starvation. The Korku inhabit the forests of the Melghat region in central India. Most of the reported deaths have occurred in a cluster of 22 villages located within the Melghat Tiger River Reserve in the state of Maharashtra where approximately 21,000 Korku families live. The root of the problem is the restrictions and denial of access to traditional sources of subsistence in the forests. In 1857, the British forced settlement of the Korku people and used them as captive labour for timber logging. In 1973, the area was declared a tiger reserve and the inhabitants of the 22 villages were asked to vacate their homes without receiving adequate compensation from the government. The Adivasi people of the Kalahandi-Bolangir region in Orissa and Palamu have also reported food shortages and deaths from starvation in the past three years. According to the Central Planning Committee of the Government of India, the populations of the 41 districts with significant Adivasi populations at risk of death by starvation..

In Manipur in northern India, the Meiteis represent half of the total population of 1.8 million (Debabrata Roy, 1997). Other indigenous peoples in this state are the Nagas and the Kuki Chin. There has been armed insurgency over the past four decades. In addition, the region has received a large influx of refugees and displaced people from neighbouring countries with a history of political instability. Manipur has remained isolated from the overall social and economic development of India, but continues to be the major source of raw materials for industries in other parts of the country. Agriculture and forestry are still the major means of livelihood. Most of the inhabitants of the region have access to their own, or to community-owned, land and resources. They are aware that their standard of living may not be satisfactory, compared to other regions of the country, but they do not perceive themselves as poor. Rather, they perceive their situation in terms of relative deprivation.

In 1977-78, 29% of the rural and 27% of the urban population in Manipur were living below the poverty line. By 1991, the number of rural families living in poverty (67%), had more than doubled. Infant mortality rates derived from the 1991 Census of India and the 1993 National Family Health Survey, are around 21 per thousand for urban, and 23 per thousand for rural areas, compared with 94 per thousand for the country for 1988 (UNICEF, 1990). This is indicative that, even within economic constraints, a relatively low infant mortality rate can be attained. However, only 29% of young children were fully vaccinated, and 32% had received no vaccination at all (National Family Health Survey, 1993). During the two weeks preceding the National Family Health Survey in 1993, 15% of children under 4 years of age had symptoms of acute respiratory infection, 25% were sick with fever and 12% had diarrhoea. For each of these medical conditions, only about one-third of the children had been able to reach a health facility.
or health care provider. Malaria has the highest prevalence throughout the state, ranging from 16 to 47 per thousand among stable residents in households. In 1995, 63% of the villages in the state were declared malaria-affected. Over 35% of all pregnant women suffer from nutritional anaemia, and 12% of children suffer from severe malnutrition. Alcohol and heroin addiction are very common. According to the Health Department of Manipur, there were an estimated 20,000 to 30,000 heroin users in 1994-95. The illicit traffic routes to Myanmar and the "Golden Triangle" pass through this state. In 1991, about 2% of women attending prenatal clinics were infected with HIV, and in 1995, 3.3% of tuberculosis clinic patients had HIV co-infection (Debabrata Roy, 1997). The effects of conflict-related stress are still largely unassessed, even though people's livelihood is seriously disrupted by a social atmosphere of aggression and fear.

Africa

The nomadic Kwe originate from the Kalahari Desert. They have lived in balance and harmony with the desert environment for over 40,000 years. This demonstrates their skills in conservation, and knowledge of natural resource management. The ovaHimas are semi-nomadic pastoralists who have lived in the northern part of the Kunene region, northwest Namibia, since the 16th century. This region is often called Africa's last wilderness, because of the remoteness of the region and the traditional way of life of the ovaHima nomads. Similarly, the Konkombas live a hidden life, scattered in the bush in northern Ghana.

The Wodaabe are indigenous people who live off extensive pastoralism, migrating great distances every year in search of pasture and water for their animals. They inhabit the open semi-desert landscape in the Saharan zone in West Africa and the northern savanna. There are around 125,000 Wodaabe, of whom 65,000 live in the Niger. Others live in northern Nigeria, the southwestern part of Chad, northern Cameroon and the Central African Republic. A few Wodaabe extended families migrate into Burkina Faso and even northern Ghana. The situation of the Wodaabe in West Africa is similar to that of the Maasai of East Africa. Both Maasai and Wodaabe are pastoralists and have a culture very distinct from the settled farmers of the same countries. The Wodaabe continue their north-south migration every year. In the rainy season they migrate north within the Niger, and in parts of the dry season they are forced to cross the national boundaries into northern Nigeria or Cameroon, or other countries south of the Sahara to search for pasture, simply to survive. In years of drought they are forced to migrate even farther, to save their animals (Bovin, 1984). They have recurrently suffered severely from drought, hunger and death, especially between 1969 and 1984. Nowadays, the Wodaabe face the threat of desertification as well as and pressure from agricultural colonization by Hausa and Kanuri farmers in southern Niger and northern Nigeria. The situation of the Wodaabe is complicated by the fact that uranium, gold, diamonds and oil are found in the sub-Saharan zone. This means that pastoral nomads will not be allowed to migrate freely as they do now, in the areas near Lake Chad. The Wodaabe refuse to attend schools, since these are for settled children. The Wodaabe believe that it is better to keep their children in the bush: "Our children will be thrown out of school, and thereby just end up as unemployed youngsters smoking cigarettes on street corners in towns." The Wodaabe are stigmatized, and are called "primitive bush people wearing pagan clothing" by settled farmers in villages and by urban West Africans.

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The *Equatorial African* region contains the largest contiguous area of moist tropical forest in Africa, representing 12% of the world's remaining moist tropical forest (Sayer, Harcourt & Collins, 1992). It is home to several hundred related cultures numbering 12 million people, as well as about 300,000 hunter gatherers (Colchester, 1994). Forest dwelling peoples in Central Africa have suffered severe social disruption and exploitation over the past few centuries (Colchester, 1994). They have, however, retained much of their customary systems of land rights and have clear concepts of land ownership and control.

The issue of indigenous peoples is very important at present in *South Africa*. This springs from the new Constitution that provides for the right of all to participate in their own culture. The Department of Foreign Affairs is in the process of establishing a working group on indigenous affairs. A section on traditional affairs has been established within the Department of Constitutional Development. Some of the indigenous peoples in South Africa are the Girau, Outeniqua, Khome, !Xu, and Khwe. The !Xu and Khwe Trust is continuing its efforts in community empowerment and development. A cultural mediation programme was introduced with the aid of international funding to provide training to teachers, pupils, community leaders and governmental authorities.

**North America**

In *Canada* there are an estimated 750,000 registered native people comprising about 3.6% of the total population. The native population is heterogeneous with ten major languages. The three main categories by which indigenous people in Canada identify themselves are First Nations (Indians), Metis, and Inuit. Approximately 60% of Indians and Inuit live in the 642 reservations. The overall health condition of the indigenous communities is poor and indicators suggest that they are at a greater risk of tuberculosis, diabetes, suicide, violent death, and alcohol-related illness and injury than the general population. Infant mortality rates are also higher among natives. Even with an improved health outlook over the past five years, the situation is far from optimal. Other social and economic problems facing indigenous peoples in Canada include high unemployment, incarceration, poorer educational attainment, decreased life expectancy and poor housing conditions. Substance abuse is one of the major social and health issues. Even though the First Nations have the political autonomy of a separate government in Canada, native peoples continue to occupy a very marginal position relative to the overall political, economic, social and cultural institutions of the country (WHO, 1996). In 1968, life expectancy at birth among native men and women in Canada was 63.7 years and 71.0 years, respectively. For the general population, life expectancy was 73.0 for men and 79.7 for women in 1987 (WHO/PAHO, 1994c). The infant mortality rate among native people decreased from 80 per thousand in 1960 to 10.1 per thousand, in 1990, but it is still higher than the rate for the general population (6.8 per thousand).

The Medical Services Branch collects data on native peoples living in reserves throughout Canada, highlighting the main problems in these communities. Data from 1991 (Indian Health Information Library, 1996) showed that 45% of native people in Canada smoked tobacco, 60% of whom smoked 11 to 25 cigarettes per day. A total of 41% of adults said that violence is a problem in their communities. Among the youth, 22% were chronic solvent users. With regard to immunization, 31% of native children living in non-isolated areas and 49.7% of those living in isolated communities were up to date for all immunizations by 2 years of age. Among native Americans, the age-adjusted mortality rate resulting from accidents and violence was 81 per
hundred thousand in 1990, compared with 46 hundred thousand among the general population. A high mortality rate in the 15 to 44 year age group was associated with motor vehicle accidents resulting from alcohol consumption. Suicide rates are higher among native people between 10 and 24 years of age, who had a rate twice the national average (22 per hundred thousand as against 11 per hundred thousand (WHO/PAHO, 1994c).

In Canada as well as in the United States, alcohol and drug abuse are a common problem among native Americans. A number of studies on alcohol and drug use conducted among native peoples (Wingert & Marvin, 1985; Oetting & Beauvais, 1990; Young, 1992) show higher rates of use than among their non-native peers. Another consistent finding is the high suicide rate among North American natives. In contrast with overall population suicide patterns, Indian suicide rates are higher among the youth (McIntosh, 1984; Berlin, 1987; Young, 1990). Suicide has been linked to failure to adhere to traditional ways of living, weak family structure, and conditions of severe disadvantage (Young & French, 1996; Travis, 1983).

The socioeconomic and health status of native Americans in the United States is considerably lower than for the total population (Indian Health Service, 1996). In 1990, 16.2% of Indian males living in reservation states were unemployed, compared with 6.4% for the US male population, and 31.6% lived under the poverty line, as against 13.1% for the US all races male population (Figure 3, page 34). Life expectancy at birth for native Americans was eight years less than the US all races life expectancy in 1972-74. By 1991-93, the gap had narrowed to 2.6 years, with life expectancies of 73.2 years for native Americans and 75.8 years for US all races. The infant mortality rate for American Indians and Alaska natives during 1991-93 (8.8 per thousand) was similar to the US all races rate for 1992 (8.5 per thousand), and somewhat higher than the rate for Caucasians (6.9 per thousand). It was also considerably lower than the native American infant mortality rate for 1972-74 (22.2 per thousand).

Although there have been significant gains, inequities in health status between native Americans and the total US population persist. The American Indian and Alaska native age-adjusted mortality rate for 1991-93 (all causes 549.1) was above that of the 1992 US all races (all causes 504.5). Higher rates were found among native Americans for tuberculosis, chronic liver diseases and cirrhosis, accidents, diabetes mellitus, pneumonia and influenza, suicide, and homicide. The age-adjusted death rate for tuberculosis was 2.1 per hundred thousand for Indians, versus 0.4 per hundred thousand for US all races; and the death rate for diabetes was 31.5 per hundred thousand for Indians, compared to the overall US rate of 13.2 per hundred thousand. Indian rates were below those of the US all races for HIV infection, chronic obstruction, malignant neoplasm, and diseases of the heart.

For suicide, the highest rates for Indians were found among the 15-24 year age group. Rates for native Americans in this age group were 51.7 hundred thousand for males and 10.9 per hundred thousand for females, compared with US all races rates of 21.9 per hundred thousand for males, and 3.7 per hundred thousand for females. The age-specific accident death rate for Indian males (83.4 per hundred thousand 1991-93), was nearly three times that of the US all races population (29.4 per hundred thousand in 1992); and the age-adjusted Indian death rate resulting from alcoholism was 38.4 per hundred thousand, compared with 6.8 hundred thousand for US all races.
Figure 3

Employment and income status, American Indians and US all races, 1990 census.

Examination of cancer mortality rates (1984-88) among native Americans is of interest, since it shows dramatic differences among tribes (Indian Health Service, 1997). Overall, cancer mortality rates for the southwest Indian Health Service areas (Albuquerque, Navajo, Phoenix, and Tucson), are well below the US all races rates, for both males and females. On the other hand,
rates in the northern part of the country (Aberdeen, Alaska, and Billings), are much higher than rates in the southwest Indian Health areas, and are equal or greater than the US all races rates (Figure 4). In the general US population, females have a lung cancer mortality rate approximately one-third that of males. The Indian Health Service (IHS) data do not show the same male-female rates relationship. In the Alaska area, females have a lung cancer mortality rate 2.6 times the US female rate, and the Alaska IHS female rate is almost as high as that for Alaska IHS Area males. In the Billings IHS area, females have a lung cancer mortality rate 2.5 times the US female rate, and equal to that for the Billing IHS area males. For cervical cancer, where there is an easy and inexpensive preventive intervention (PAP smear screening), data showed that all IHS areas had cervical cancer mortality rates higher than the US rate. In the Billings IHS area, cervical cancer mortality was over 5 times the US rate.

**Figure 4:**

Age-adjusted lung cancer mortality rates, by Indian Health Service (IHS) area, both sexes, United States, 1984-1988

![Chart showing lung cancer mortality rates by IHS area](chart.png)

*Alaska*  
*Billings*  
*Aberdeen*  
*Bemidji*  
*Nashville*  
*Portland*  
*Oklahoma*  
*California*  
*Tucson*  
*Phoenix*  
*Albuquerque*  
*Navajo*

Rate per 100,000 per year  
Adjusted to the 1970 US population

*Excluding California, Oklahoma and Portland areas

The leading causes of hospitalization for US Indian males in 1994 were respiratory system diseases (16.6%), followed by injury and poisoning (15.1%), and diseases of the digestive system (13.6%). About 30% of US Indian female hospitalizations pertained to obstetric deliveries and complications in the puerperium and pregnancy. These were followed by respiratory system diseases (10.9%) and digestive system diseases (10.8%).
Indigenous people constitute a significant proportion of internal and international migrants in the United States. Since 1975, for example, over 50,000 Hmong refugees have settled in the United States. In the city of Minneapolis alone, there were 21,000 Hmong in the early 1900s (Osborn, 1992). In recent decades, a growing number of indigenous people from Mexico, Central, and South America have joined this migratory path into the United States. Over 30,000 Mixtecos, Zapotecos, Triquis, and other Indians, mostly from the southern, more impoverished regions of Mexico, have joined the pool of farm workers in the west coast of the United States (Zabin, 1992). About 40,000 Zapotecos live in the city of Los Angeles in California. In the agricultural fields of the state of Miami, Mayas from Guatemala, displaced by armed conflicts, are also prominent among farm workers. The living conditions of indigenous migrants in the United States are precarious. Access to health services is minimal. Language is a constant barrier, since many migrants speak only their native language.

South and Central America and Mexico

Threats to the health and well-being of indigenous peoples in South and Central America, and Mexico (Table 2, page 37), as in other regions, include environmental degradation and exploitation of natural resources (oil drilling, logging, the construction of dams, and water management mega-projects). Land encroachment and displacement, narcotics trafficking, and violence also affect indigenous peoples. Access to health services is inadequate, and particularly so in remote communities. In Peru, while there were 2.77 physicians per 10,000 people in the capital city of Lima, the proportion of physicians in the Amazon department was 0.9 per 10,000 people (WHO/PAHO, 1997b).

In Honduras, the areas with a majority of Indigenous populations have limited access to health services, and the basic social services infrastructure is weak (WHO/PAHO, 1997a). According to a 1993 census 74% of the indigenous population of the Amazon rainforest lived in poverty, compared to the national average of 49.6% (WHO/PAHO, 1997b). In Ecuador, in 1996, 80% of the rural children and adolescents in the Andes and the Amazon --where most indigenous people live-- were living in poverty (WHO/PAHO 1997c). In Nicaragua, in 1995, unemployment reached 40% among indigenous communities of the Atlantic Coast, 70% in the Autonomous Region of the South Atlantic, and 90% in the Autonomous Region of the North Atlantic (Indera, 1995). In Argentina, in the four provinces with the largest concentration of indigenous people (Chaco, Formosa, Jujuy and Salta), the percentage of the population with unmet basic needs (35.2% to 38.3%) was about twice the national average (19.3%) (Ministerio de Salud y Acción Social de la Nación, 1996). The Indigenous Census of 1994 showed that, in Bolivia, only 9% of the Guarani people had access to safe drinking water (WHO/PAHO 1997d). Life expectancy among indigenous people in the region is lower than for the general population. In Honduras, life expectancy among the Pech is 39 years for men and 42 years for women. Among the Lencas, life expectancy is 47 for men and 57 for women. These figures are considerably lower than those for the total population (male 65.4, female 70.1) (WHO/PAHO, 1997a). Similarly in Brazil, life expectancy among the Marubos del Valle de Jaravi in the Amazon, was 42.6 years, versus 66.3 years for the general population (Cipola, 1996). In 1993, life expectancy for the Aymara and Mapuche in Chile was 63.3 and 67.5 years, respectively, compared with the national figure of 72 years (WHO/PAHO, 1997g).

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<table>
<thead>
<tr>
<th>Percentage</th>
<th>Country</th>
<th>Indigenous Population (millions)</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 40%</td>
<td>Bolivia</td>
<td>4.9</td>
<td>71</td>
</tr>
<tr>
<td></td>
<td>Guatemala</td>
<td>5.3</td>
<td>66</td>
</tr>
<tr>
<td></td>
<td>Peru</td>
<td>9.3</td>
<td>47</td>
</tr>
<tr>
<td></td>
<td>Ecuador</td>
<td>4.1</td>
<td>43</td>
</tr>
<tr>
<td>5% - 20%</td>
<td>Belize</td>
<td>0.029</td>
<td>19</td>
</tr>
<tr>
<td></td>
<td>Honduras</td>
<td>0.70</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Mexico</td>
<td>12.0</td>
<td>14</td>
</tr>
<tr>
<td></td>
<td>Chile</td>
<td>1.0</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td>El Salvador</td>
<td>0.4</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>Guyana</td>
<td>0.045</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Panama</td>
<td>0.14</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Surinam</td>
<td>0.03</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Nicaragua</td>
<td>0.16</td>
<td>5</td>
</tr>
<tr>
<td>1% - 4%</td>
<td>French Guiana</td>
<td>0.004</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Paraguay</td>
<td>0.10</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Colombia</td>
<td>0.60</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Venezuela</td>
<td>0.40</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Jamaica</td>
<td>0.048</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Puerto Rico</td>
<td>0.072</td>
<td>2</td>
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<tr>
<td></td>
<td>Canada</td>
<td>0.35</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Costa Rica</td>
<td>0.03</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Argentina</td>
<td>0.35</td>
<td>1</td>
</tr>
<tr>
<td>0.01% - 0.9%</td>
<td>United States</td>
<td>1.6</td>
<td>0.65</td>
</tr>
<tr>
<td></td>
<td>Brazil</td>
<td>0.3</td>
<td>0.20</td>
</tr>
</tbody>
</table>

The 210 different indigenous cultures living in Brazil have increased in population, currently reaching 280,000 individuals distributed in over 400 villages and settlements. Among the indigenous peoples of Brazil are the Yanomami, Macuxi, Guajajara, Krikati, Guaja, Kaiapo, Xucuru, Aikewar, and Ava-Guarani. Within the context of the disarticulation of their traditional ways of life, they do not have adequate access to public social services, and decentralized federal resources rarely reach the villages. The Sistema Unico de Salud (Unified Health System) is the system on which all health policy is based. There is a Coordinator for Indigenous Health in the National Health Foundation, an organization that could disappear as part of State reform. This entity works with some indigenous communities but does not have the scope to carry out a consistent nation-wide policy. Although there is no systematic collection of data, there is strong evidence that the health situation of the majority of indigenous communities is worsening. There are frequent localized epidemics of malaria, tuberculosis, lung disease and sexually transmitted diseases. Among the Tiriyo, in the northern part of the state of Para, on the border with Surinam, four cases of AIDS were detected when half of the population of 800 was examined. Health is one of the main causes for concern about the Yanomami. According to the Roraima Indigenous
Council, statistics from the Yanomami District Health Officer of the National Health Foundation showed that the prevalence of onchocerciasis was alarming. Among 14 communities that participated in an intervention, 66.2% of the people were found to be carriers of river blindness. In 1991, a study conducted among the Yanomamis revealed that the most common diseases were malaria (357.9 per thousand), intestinal parasitosis (117.5 per thousand), and acute respiratory infections (104 per thousand).

The state of health of the Ayoreo, Enxet, Ava-Guarani, Tomarabos, and other indigenous peoples in Paraguay is desperate. During 1996, hundreds of children died from diarrhoea, lung infections, and other illnesses that affected 80% of the indigenous population. The incidence of tuberculosis among indigenous people is ten times greater than the national incidence rate (WHO/PAHO, 1997e). Undernourishment, destruction of their habitat, and lack of health care aggravate the poor health of indigenous people in Paraguay. Faced with this, the Paraguayan Institute of Indigenous Affairs, has budgeted a meager one US dollar per person to provide care for indigenous people throughout one year.

Contamination of the Colorado River Basin and the water tables in the Paynemil with petroleum spillage has endangered the health of the Mapuche people of Argentina. Blood and urine sample analysis on indigenous people living in the area revealed high concentrations of lead and mercury. The oil company blames the mining companies upstream but neither is assuming responsibility for the ill-health of the Mapuches. Other indigenous peoples in Argentina are the Wichí, Chorote, Kollas, Diaguita-Calchaquis, Guarani, and Tobas. In Argentina as a whole, the experience of local programmes for the prevention and control of Chagas disease and cholera, and the maternal and child health programme indicates that the health condition of the indigenous population has seriously deteriorated (WHO/PAHO, 1997h). For example, of the 188 cases of cholera reported in 1994-95, all but three (98%) occurred in the provinces of Salta and Jujuy, where there is the highest concentration of indigenous population (Ministerio de Salud y de la Acción Social de la Nación, 1996). Starvation is a continuous threat among the Tobas in the Chaco region and the Wichí in the province of Salta.

In Panama, in the provinces with a majority of indigenous people, such as Boca del Toro where the Ngobe Bugle, Bokotas, and Teribe people live, the mortality rate resulting from diarrhoea in 1995 (34.3 per hundred thousand) was five times the national rate (6.4 per hundred thousand). This district also reported the highest incidence of leishmaniasis in the country (776 per hundred thousand). The incidence of pneumonia in San Blas, the Kuna territory (1,203 per hundred thousand), was six times greater than the national incidence (200 per hundred thousand) (WHO/PAHO, 1997h). Furthermore, in Honduras, infectious diseases account for a very high infant mortality rate (IMR) (WHO/PAHO, 1997a).

Infant mortality rates among indigenous children in the region are alarming. Of the indigenous children born alive in Bolivia, 20% die before they are one year of age. Of the surviving children, 14% die before reaching school age (Cenda, 1993). The average infant mortality rate in Ecuador was 22 per thousand in 1994, while in the indigenous communities of Colimbuela and Cumbas it reached 83 and 67 per thousand, respectively. Among indigenous children of the Amazon in Peru, the Campa-Asháninka had an infant mortality rate of 99 per thousand and the Machiguenga an infant mortality rate of 100 per thousand. In Mexico, 12% of indigenous children die before reaching school age, compared to 4.8% of children in the general population (WHO/PAHO, 1997i). The maternal mortality rate for indigenous women in Guatemala in 1994 was 83% higher than the country's average (Velasquez, 1994). In Panama,
in 1994, the highest maternal mortality rate (44 per thousand) was reported in the Kuna community of San Blas (WHO/PAHO, 1997h).

Malnutrition is a common condition among indigenous peoples in the region. In Honduras, in 1993, 95% of children under 14 years of age were undernourished (WHO/PAHO, 1997a). In Venezuela, the percentage of undernourished children in states with a majority of indigenous population (Delta Amacuro, 21.3%; Apure, 17.5%; Amazona, 16.9%) was higher than the national average (13.8%) (WHO/PAHO 1997j). In Bolivia, undernourishment is higher than the national average in the Aymara provinces of Inquisivi, Tamayo, and Omasuyos (WHO/PAHO 1997d). In Belize, a greater proportion of Maya children of school age have developmental retardation compared to children of other ethnic groups (Government of Belize, 1996).

The Centre for Social Development and Human Affairs of the United Nations has estimated the migrant worker population in Latin America at three million, and their family members at 1.5 million. A large proportion of these are indigenous people. The principal host countries are Argentina, with 1.4 million workers, and Venezuela, with 755,000. Most migrant workers work in plantations (sugar cane, banana, tobacco, and others) or in other high risk and low pay jobs such as construction work. They suffer abuse because most lack legal documents. It is estimated that 40% of the economically active population of Bolivia, a country with a majority Indigenous population, migrates in search of jobs. The displacement of indigenous families has serious implications for health. Lack of protection against abuse, labour exploitation of minors, unsanitary living conditions, and lack of health care or health insurance put entire families at risk (WHO/PAHO 1994). A study showed that in Guatemala, 7% of indigenous migrant workers were sick as they left their home, and 34% had one to five episodes of illness in the plantations. Of those who fell sick 34% did not receive medical care (WHO/PAHO, 1997k).


Main Findings

As shown above, the, mortality and morbidity patterns among indigenous peoples around the world reflect tremendous inequalities and obstacles to achieving the right to health. It is also apparent that indigenous communities face constraints in their capacity to generate and manage health information. Health status data generated through participatory processes can strengthen the capacity of indigenous communities to assess their assets and problems, and design their own solutions. It is important to develop indicators that can capture not only indigenous people’s liabilities, but also their strengths. Poverty or unemployment categories, for example, are inadequate for quantifying the material assets and resources of rural or pastoral life, or barter-based economies. In these societies, a person’s employment status, or monetary affluence may be quite meaningless (WHO, 1997a). Whereas the use of variables and indicators that allow comparisons across ethnic groups is necessary, it is also important to develop culture-specific health indicators.
Environmental degradation and land displacement

Data show that environmental degradation and contamination constitute serious threats to the health of indigenous peoples. Environmental assessment indicates that Arctic populations are among the most exposed to certain environmental contaminants (radioactive contamination, heavy metals). Contamination also affects the food supply, thus deteriorating one of the determinants of good health among indigenous peoples. Heavy reliance on natural foods decreases the risk of health problems (e.g. diabetes and hypertension). For example, the Inuit -- who eat natural foods -- have lower mortality from heart disease. Radioactive contamination has made the inhabitants of the Bikini Islands dependent on food aid because the locally grown food is too radioactive to eat.

Large scale tourism disrupts local social, cultural and political structures. The Northern Marianas, for example, receive 600,000 tourists per year or 30 tourists per indigenous person. In Belau, with 16,000 indigenous inhabitants, Taiwanese buyers have purchased 600 real estate properties.

Logging, mining, and the building of dams and agribusiness displace thousands of indigenous people from their land. Logging threatens the Penan people in Indonesia, because the Penan’s nomadic hunter gatherer way of life is intricately connected to the forest. A total of 3,821 Korku children in India died in the last four years from malnutrition and starvation after their families were denied entry to the Melghat Tiger River Reserve. The projected Baku Dam in Malaysia will flood 700 square kilometres and affect 9,500 people from 16 indigenous communities (Kenyah, Kayan, Penan, and Ukit). In Africa, agricultural colonization, national boundaries, and the exploitation of natural resources restrict the migration paths of nomadic people. The arrival of development ventures in Kalimantan since 1970 has resulted in degradation of the world’s oldest rainforest and the disruption of the lives of three million Dayak people.

Health and maintenance of culture

Low socioeconomic status to a large extent determines the health conditions of native peoples. Poverty and marginalization are associated with diseases of the poor. Malnutrition and infectious diseases take their heaviest toll among infants and the elderly. In addition, changes in traditional lifestyles increase the susceptibility of native peoples to a variety of chronic diseases and addictions related to modern dietary and behavioural patterns. Amidst this double burden of disease, scientific evidence nevertheless indicates the existence of a variety of protective factors associated with traditional culture and lifestyles.

Studies have shown an association between maintenance of culture and decreased rates of infant mortality (Becerra et al, 1991), low birth weight (Guendelman et al., 1990), cancer (Elder et al., 1991), high blood pressure (Scrugg, 1993; Prior Rom., 1968), diabetes (Ostbye et al., 1989), body fat (McGravey & Baker, 1979), and blood lipid levels (Tuomilehto Rom., 1989). Traditional lifestyle and maintenance of culture have also been shown to be associated with protective behavioural factors such as increased physical activity (Prior & Stanhope, 1980) and lower stress levels (Beagelhole, 1992), as well as with lower prevalence of cigarette smoking (Wessen, 1992) and drug use (Oetting & Goldstein, 1979; Bryde, 1970; Vega Rom. 1993).
Tradition and culture provide a variety of health-promoting resources, such as networks of social support, self-sufficiency, and access to food and other material resources. By contrast, a variety of sociocultural factors associated with a Western lifestyle are conducive to deterioration of health among indigenous peoples, including severed social networks, perceived socioeconomic inequalities, stress resulting from discrimination, and disjunction between the material and spiritual world (Alderete, 1996).

The present day conditions of ill-health and poverty among indigenous communities are not the result of indigenous culture or ways of life. On the contrary, these situations are the result of hundreds of years of colonialism, enslavement, land dispossession, and the systematic destruction of indigenous people’s complex social, cultural, political, spiritual, economic, and environmental order. Indigenous people define and understand the circumstances surrounding their life in terms of multifactorial processes, rather than taking a problem specific approach. This integral approach also applies to health issues. Thus the territory, family relations, social issues, environmental problems, food security, spiritual strength, and intercultural relations all form part of strategies to achieve health and well-being. Indigenous peoples do not claim the right to return to a primitive past, but instead, to be allowed to maintain or as far as possible materially and spiritually prosperous communities. This is the thrust of indigenous paths to development and the renaissance of the universal cycle of life.

Conclusions

a. Indigenous people are over-represented among the poor.

b. In the majority of countries, epidemiological data are not collected and disaggregated by ethnicity.

c. Information is particularly scarce for indigenous people living in urban areas or away from reservations or territories, who may be at a greater risk for diseases related to lifestyle and cultural change.

d. Culture-specific indicators of health need to be developed.

e. Malnutrition and communicable diseases in particular continue to affect indigenous peoples.

f. Life expectancies at birth are 10 to 20 years less than for the general population of countries.

g. Infant mortality rates among indigenous people are from 1.5 to 3 times higher than those of the general population.

h. Higher suicide rates indicate the need to assess the origins of mental health status of indigenous peoples.

i. Smoking, alcohol and drug use are prevalent among many indigenous populations.

j. Cardiovascular diseases, diabetes, cancer, unintentional injuries and domestic violence
are a significant health problem among some indigenous peoples.

k. Land displacement and contamination affect food supply, increasing the likelihood of malnutrition and starvation.

Indigenous Peoples perform well with respect to:

l. Despite economic limitations, the infant mortality rates among some indigenous peoples are comparable or lower than those of the general population (e.g. native Americans in the United States, 8.8 per thousand in 1991-93 as against 8.5 per thousand in the overall population in 1992; Meitei in Manipur, 21 per thousand in 1991 as against 94 per thousand in the overall population in 1988). The Rapa Nui in Chile have a greater life expectancy at birth (72.7 years) than the general population (72 years).

m. Indigenous peoples whose traditional ways of life and diet have not been significantly disrupted have low prevalence of diabetes, cardiovascular diseases, and hypertension.

n. Studies among immigrants (e.g. Tokelauans in New Zealand) show a lower prevalence of health risk factors such as smoking among less acculturated individuals.

There are differences in disease patterns across native populations:

o. Cancer rates vary widely among native peoples (e.g. differences in age-adjusted cancer rates among US native Americans across Indian Health Service areas). Some differences in rates, such as those for lung cancer, may be explained by the higher prevalence of risk factors (e.g. smoking and air contaminants); others, such as those for breast cancer, have no identified cause.

There are also differences in disease patterns across genders:

p. In the United States, in the Alaska Indian Health Service (IHS) area, females have a lung cancer mortality rate 2.6 times the US female rate, and the Alaska IHS female rate is almost as high as that for Alaska IHS area males. In the Billings (IHS) area females have a lung cancer mortality rate 2.5 times the US female rate, and equal to that for the Billing IHS area males.

q. In 1981, among Pacific Islanders, males had higher rates of smoking than all males, but among females, Pacific Islanders had lower smoking rates. Among Pacific Islands males, smoking was most common in the 45-64 years age group (45%). Among Pacific Islands women, the highest smoking rates were among those aged 15-24 (26%).

r. Lifestyle changes and acculturation may be associated with a greater risk of developing disease among indigenous women, than among indigenous men (e.g. there is a greater increase over time in age-standardized rates of diabetes among Tokelauan migrant women in New Zealand, than among Tokelauan migrant men).
CHAPTER III
CHAPTER III

HEALTH SYSTEMS

Indigenous health and well-being

There are as many interpretations or definitions of health as there are different cultures in the world, for each people develops a concept of well-being derived from its own internal logic and intimate theory of knowledge. There are, however, some common and unifying elements across indigenous cultures (see Figure 4). The Western biomedical paradigm treats body, mind and society as separate entities that can be comprehended in isolation from each other. Indigenous healing systems are based on a holistic approach to health, where well-being is perceived as the harmony that exists between individuals and communities and the universe that surrounds them. Human beings, nature, and the collective history of the ancestors are indivisible from each other. Since matter and spirit never exist independently, illness is a phenomenon of the soul as well as of the body. Furthermore, all elements of the universe possess spiritual qualities, which is why every natural element can either cause illness or cure. Bad air can bring illness, and a plant can restore health, because they have special spiritual powers. Since earth is the mother, the well-being of indigenous peoples is closely related to the well-being of the land. Health is also contingent on adherence to social norms and compliance with moral obligations. When these are transgressed, illness may occur. To restore harmony and heal, a retribution must be offered to compensate for the offence.

Figure 4- Indigenous Health

![Diagram of Indigenous Health](#)
As a Maori woman said, "Health is the strength of the body, the pride of the youth...the dignity of age... Health is the true knowledge of Maori, the spirit of Maori. Health is our mana and our right...To know and to understand where I come from, where I am going, our history" (In Maori Health Decade, 1994).

Differences between the Western and indigenous concepts of health go beyond what words can convey. The indigenous concepts are based on different knowledge systems that can be only partially understood by those who have not had this conception of the world handed down through the centuries.

"In order to interpret a symbol we have to try to understand the universe that surrounds it...If we cannot understand Andean symbols...we will never be able to read the messages and knowledge...that are still left...in our ayllus (communities). We would have found merely the text of a myth that only an identification with the Andean spirit will allow us to interpret" (Milla Villena, 1983).

Traditional healing systems

Healing systems are the knowledge-based practices used by indigenous peoples to maintain harmony of individuals with their communities and with the universe that surrounds them. These practices respond to the internal logic of each of the indigenous peoples and are a product of their unique vision of the universe (cosmo vision). The knowledge of curative properties of plants that is dispersed throughout the communities (e.g. home remedies) is different from the more complex healing practices of traditional healers. Healing practices involve a variety of elements other than the use of medicinal plants, such as communication with spiritual beings, dreams and the use of the healing power of water and minerals. These practices also carry a strong spiritual component, require special strength and powers, and are conducted only by selected members of the community, the healers.

Indigenous healers possess a broad knowledge base, the product of thousands of years of learning experiences. Furthermore, they possess special strength and wisdom, and have the responsibility for maintaining and transmitting the teachings of the ancestors. They are also political and social leaders of the communities.

"Our wisdom we have not learned in the school, for us there is no university. Our knowledge is not a recipe, but it is a constant walk in a historical process of our ancestors. With life experience one learns many things. On the path, there are so many stones, thrown there because our ancestors have taught us to look on the path, look ahead, look back....we continue to learn...life teaches us and that is why I say each thing has roots, each thing is sacred, each thing has its wisdom" (Adair [healer] in the Andes).

Traditional healing systems are still vital parts of the healing strategies of most indigenous communities. In all regions of the world, Western medical care and traditional healing systems coexist. For most people, health-seeking strategies involve complex pathways that include choosing from and using a range of methods and providers that may be at their disposal, including both traditional and modern health systems. According to WHO estimates, at least 80% of the population of developing countries rely on traditional healing systems for their primary source of health care (Baedeker, 1997). There are as many indigenous healing systems
as there are cultures in the world, for systems of healing are unique products of indigenous peoples' history, cosmovision, and interaction with their natural environment. They constitute complex, centuries-old systems of knowledge. As such, traditional healing systems are appropriate and sustainable ways for the maintenance of a community's well-being. From the medical perspective, however, traditional healing systems are often viewed as backward cultural beliefs that impair acceptance of modern health care, or as a last and inadequate resource for populations that have no access to medical services. In some instances they are regarded as harmful. The denial of indigenous peoples' cultural values, science and traditional medicine constitutes a barrier to the attainment of health (World Council of Churches, 1996). In practice, given availability and access, the complementarily of traditional and Western medical healing systems occurs without the need for specific interventions. Besides lack of availability or access, negative social sanctions may preclude the use of traditional systems. On the other hand, lack of cultural sensitivity and appropriateness may preclude the use of medical care.

Institutionally, organizational relations between medical health services and traditional healing systems have been categorized as:

- Monopolistic: only certified medical doctors have the right to practice.
- Tolerant: traditional practitioners are not recognized but are free to practice.
- Parallel: medical doctors and traditional practitioners are officially recognized in equal but separate systems as, for example, in India.
- Integrated: medical doctors and traditional practitioners merge in medical education and practice jointly within a unique health service, as for example in Bhutan, China and Viet Nam (Bodeker, 1993).

Most countries with indigenous populations, particularly outside of Asia -- where parallel or integrated systems are common -- have either a monopolistic or tolerant organization of health services that permit the coexistence of traditional and Western healing systems. This is conditional upon the recognition by a country of the existence of indigenous peoples as such.

Access to health care

The information on the health situation of the indigenous peoples around the world, presented in Chapter II, is indicative of inadequate access to health services and health prevention and promotion programmes, and/or of the cultural inappropriateness of these services and programmes:

- Compared to the total Canadian population, native peoples were less likely to use physician services, even though Natives ranked their health similarly to the total Canadian population. Location was an important factor in physician use. Natives residing on reserves had lower levels of self-assessed health, but were less likely to have seen a physician (Newbold, 1997).

- In the United States, about 1 million native Americans, one-third of the total, are not eligible for access to health care provided by the Indian Health Services (IHS). Given the over-representation within the poor and unemployed, these native Americans are likely to have no health insurance or economic means to pay for private providers. Budget constraints raise issues of quality and comprehensiveness of care provided by IHS.
Although the population served by IHS has increased during the past five years, its per capita budget (US$ 1,100) is about a third of that for the US population (US$3,100).

- In Peru, while there were 2.77 physicians per 10,000 people in the capital city of Lima, the proportion of physicians in the Amazon department was 0.9 per 10,000 people (WHO/PAHO, 1997b). In Guatemala, in 1995, 16.4% of the indigenous mothers received prenatal care, compared with 47.5% of mothers in the general population. Furthermore, 11.7% of indigenous mothers were assisted by personnel trained in Western medical care, compared to 51.8% of non-indigenous mothers (Gomez, 1997). In Bolivia, a country with a large indigenous population, the Ministry of Public Health had 6.9 physicians per 1,000 people in urban areas, while in rural areas there were only 8.0 physicians per 10,000 people, in 1986.

- In Alaska, the age-adjusted mortality for some types of cancer is higher than for the United States population as a whole, even though the incidence of cancer is comparable.

- Poor access to screening and prevention programmes among indigenous peoples is indicated by higher cervical cancer death rates among native American women. Many indigenous peoples also have higher rates of a wide range of avoidable risk factors and preventable health conditions (e.g. childhood illnesses, diabetes and other "lifestyle change" diseases, and smoking) than the general population in the countries.

- Compared with non-natives, Pacific Islands people living in New Zealand had higher mean blood pressure levels when controlled for age, blood pressure treatment, and body mass index. Of the hypertensive subjects, Pacific Islands people were least likely to receive treatment, and were therefore considered to be at higher risk (Scrugg et al., 1993).

Barriers to health care access include:

- **Structural and economic factors**: distance and location of health care facilities; isolation of indigenous communities; lack of health insurance or economic capacity to pay for services; time factor - losing a day of pastoral, agricultural, or insecure wage production has a higher value for indigenous people than for individuals protected by social benefits packages.

- **Lack of cultural sensitivity and appropriateness of health care systems**: disregard and disdain of health personnel towards indigenous peoples or their culture; disrespect for traditional healing practices; language barriers; uncomfortable and impersonal environment of hospitals and clinics.

**Primary health care, health development and local health systems**

The strict medical approach to health services delivery, in addition to failing to meet demand, is inadequate to deal with an epidemiological profile as complex and difficult as that found among indigenous peoples. Moreover, traditional healing practices, while efficient for the management of a variety of illnesses, fall short when it comes to articulating an effective response to some of the new profiles of diseases and health problems arising from current social contexts (e.g. HIV/AIDS). Many of the principles of health for all and primary health care are
compatible with indigenous peoples’ health needs. Community ownership and participation, building partnerships, equity, an integral approach that goes beyond the provision of medical care, and emphasis on disease prevention, are elements conducive to the well-being of indigenous communities. Health promotion and the development of local health systems (SILOS) are tools for "enabling people to increase control over, and improve their health" (WHO/PAHO, 1993b). The ethnic and cultural heterogeneity of indigenous peoples makes it difficult to adopt single programmes or universal health care models. Diversity means that each indigenous people must be considered individually and that the emphasis must shift towards strategies for sustainable health development, primary health care and local health systems. Within this context, the traditional wisdom of indigenous peoples can be strengthened and revitalized.

WHO has defined health systems as a complex of interrelated elements that contribute to health in homes, educational institutions, workplaces, public places and communities, as well as in the physical and psychosocial environment in the health and related sectors. The aim of a health system is health development - the process of continuous, progressive improvement of the health status of a population (WHO, 1997c; WHO, 1997d). Similarly, local health systems are a set of processes that comprise all social activities in health at the local level, including but not restricted to health services delivery (WHO/PAHO, 1993a). The strategy of development of local health systems is a valid response to this health situation, particularly in areas with a diverse ethnic population or a significant proportion of indigenous inhabitants. Health development, primary health care, and local health systems, together with social advances, have contributed significantly to the declines in infant and child mortality and morbidity worldwide, and to the increases in life expectancy at birth seen over the past 20 years. The pace of improvement and the achievement of targets has not, however, been uniform. Inequities between and within countries in health status and health care access are greater now than two decades ago. Disparities in health status have increased among certain population groups within countries, with an impact on indigenous peoples in particular.

The Declaration of Alma-Ata, adopted in 1978 by the International Conference on Primary Health Care, which was jointly sponsored and organized by WHO and UNICEF, clearly stated that primary health care was the key to attaining health for all as part of overall development.

Four basic principles underlie the primary health care approach (Tarimo & Webster, 1996):

- Universal accessibility and coverage on the basis of need.
- Community and individual involvement and self-reliance.
- Intersectoral action for health.
- Appropriate technology and cost-effectiveness in relation to the available resources.

Improvement of a population’s health involves much more than simply delivering health services. The people themselves must become key actors in the process. Primary health care therefore promotes community self-reliance and a more active, responsible involvement in improving the community’s own health.

This concept of community ownership and involvement has two important aspects. The first is a political issue: the more socially accountable governments are, the greater the potential
for real community involvement, in health as in other matters. In addition, decentralization of decision-making allows for greater social control and better implementation of action for health at various levels of the health system. The second aspect of community involvement recognizes that if individuals are to realize their potential for self-reliance, they must take greater personal responsibility for their own and their families' health.

The call for health for all was — and remains fundamentally — a call for social justice. Health for all is a process leading to progressive improvement in the health of people, and is not a single finite target. It can be interpreted differently according to the social, economic and health characteristics of each country. There is, however, a health baseline below which no individuals in any country should find themselves; all people in all countries should have a level of health that will permit them to work productively and to participate actively in the social life of the community in which they live. Health for all acknowledges the uniqueness of each person and the need to respond to their spiritual quest for meaning, purpose and belonging. At the same time, health for all is a societal response that acknowledges unity in diversity.

Health development and socioeconomic development are inseparably linked. Health development implies coordination at all levels between activities in the health sector and activities in other social and economic sectors such as education, agriculture, industry, housing, public works, water supply and communications. Hence the need for intersectoral action, that is, action in which the health sector and other relevant sectors interact for the achievement of a common goal. The determinants of health disparities make it clear that access to health care for all population groups is only one area among others to be developed. Others are related to public health services (such as preventive medicine, health education and information); to social policies (legislation, codes of practice) and infrastructure which promotes health, especially the health of the most vulnerable; and, finally, to economic policies, maximizing health impact and minimizing health risks.

Health for all involves making health goals a high priority in the overall development process. This requires the fullest consideration of health matters whenever general economic developments are being planned. Evidence must be gathered to sharpen people's awareness of the health benefits of alternative economic development policies and to determine the costs of these alternatives. The health impact of a rise in food prices, a new factory, an irrigation project, or a social security scheme should be fully evaluated. Who benefits and who loses as part of these endeavours should also be assessed (Tarimo & Webster, 1996).

WHO's mandate in the area of sustainable development and health environments springs from the policy declarations of intergovernmental bodies. Three of its most pertinent components are as follows:

Health for all. The overall objective of the health for all policy for equity, solidarity and health is to assist countries and to ensure that health has its rightful place in development. This was endorsed by the Social Summit in Copenhagen in 1995. To reduce poverty and its health consequences is one of the strategic priorities.

Environment and development. In its Principle 1, the Rio Declaration states that "Human beings are at the centre of concerns for sustainable development. They are entitled to a healthy and productive life in harmony with nature". Principle 3 stipulates that: "The right to
development must be fulfilled so as to equitably meet developmental and environmental needs of present and future generations”.

**Health and Human rights.** The WHO Constitution recognizes that the enjoyment of the highest attainable standard of health is a fundamental human right, and WHO will therefore pursue the universal enjoyment of this right by all.

Principles inherent in translating this mandate into action include:

- **Sustainability:** WHO is concerned with the health component of sustainable development, taking account of emphasizing the dynamics and impact of globalization, trade and aid, and rapid socioeconomic transitions, and will develop policies for ensuring sound nutrition, healthy environments and the right to health.

- **Equity:** Access to socioeconomic development opportunities, a safe environment and adequate food and nutrition is considered a fundamental right. Equity means that people’s needs, rather than their social privileges, guide the distribution of opportunities for physical, mental and social well-being.

- **Responsibility:** Through their acceptance of the WHO Constitution, WHO Member States have taken on a shared responsibility for the advancement of human health. This embodies a moral imperative to support vulnerable groups, least developed countries and those affected by disasters, as well as the rights and responsibilities of individuals to promote and protect human health.

WHO’s focus on health in sustainable development, encompasses a response to the health needs of indigenous peoples. It has set out to provide this response by:

- Integrating health objectives in development policy:
  - technical cooperation with most needy countries to develop and implement health components of poverty reduction and sustainable development with a strong focus on equity;
  - strengthening national capacities in the analysis of the linkages between poverty, environmental degradation and ill-health and in the assessment of macroeconomic and sectoral policies;
  - identifying and advocating the most effective health contributions to development policies of both countries and their development partners through collaborating with national and international development research institutions;
  - promoting health in development through personal advocacy by political leaders and eminent representatives of civil society and business.

- Incorporating an anti-poverty and equity focus in health policies and interventions:
  - promoting methodologies for identifying the poorest populations and regions as the basis for focused national policies and intervention programmes;
  - technical cooperation and action research, particularly with the most needy countries, to identify effective intervention strategies for combating health inequities and meeting the health needs of very poor populations;
promoting the health and well-being of minorities and marginalized populations such as indigenous peoples through international initiatives;
- developing and exchanging experience of policies in favour of the poor through instigating a network of agencies.

- Coping with the health consequences of globalization, international conventions and other international trends:
  - assessing the health risks and impacts of globalization, including international trade and travel, private capital and aid, migration and transboundary pollution;
  - developing risk assessment tools, instruments and methodologies to assess impact, and supporting their application by countries and regional economic cooperation associations;
  - making trade and aid work better in improving health outcomes of the poor; supporting countries in trade and aid negotiations in order to protect health;
  - managing WHO collaboration with WTO, UNCTAD, FAO and other international forums concerned with globalization and health;
  - contributing to the monitoring and follow-up of major international agreements and conferences related to health, poverty and sustainable development.

Health care reform and indigenous peoples

The transformation of national health systems and the development of local initiatives are valuable tactical resources to overcome limitations of health systems among the indigenous population (Paganini & Capote Mir, 1990). This strategy aims to increase equity through decentralization and intersectoral action. However, given the poor social status or geographical marginality of the majority of indigenous peoples, it is necessary to assess and monitor closely the potentially negative effects of health reforms.

The aim of health sector reform is to achieve one, some or all of the following goals (Kutzin, 1994):

- To improved health status and consumer satisfaction by increasing the effectiveness and quality of services
- To obtain greater equity by improving the access of disadvantaged groups to high quality care.
- To obtain greater value for money (cost-effectiveness) from health spending, considering improvements in both the distribution of resources to priority activities (allocational efficiency) and the management and use of the resources that have been allocated (technical efficiency).

Health sector reforms have been implemented under strong pressures to prioritize budget reductions and cost-efficiency. Economic pressures have determined that reform efforts should focus on financing through user charges and health insurance. In addition, it is unlikely that additional support will become available from governments for health services. Health sector reform is based on the principles of economic efficiency and budgetary constraint. In practice, the goals of reaching equity in access to health care and the need to provide basic health care services to all sectors of the population are often assigned a low priority in the implementation process (Kunitz, 1994). This is so despite the economic theory assessment that, contrary to the
case in many other parts of the national economy, governments should intervene in the health sector because of the presence of market failures, for example, reasons why the actions of producers and consumers alone will not yield a socially optimal or economically efficient result (Barnum & Kutsin, 1993; World Bank, 1993a).

Health care reforms in general have fostered privatization of health care, fees for services and reliance on health insurance. For poor populations, this has resulted in the disintegration of safety nets provided by States to their citizens. Thus, the sectors in society with low purchasing power, indigenous peoples in particular, have suffered the greatest impact (WHO, 1995a; WHO, 1995b). The social contract between citizens and the State has been unilaterally and drastically modified to the detriment of the most vulnerable social sectors, as States relinquish their duty to secure their citizens' right to health. One of the immediate consequences of health sector reforms has been the collapse of district hospitals and community-level health centres and clinics, and the introduction of user fees, cost recovery, and free market sales of drugs. Even local medical supplies and pharmaceutical industries have been affected, as market liberalization brings in imported medicines, paradoxically at exceedingly high prices. In Viet Nam, for example, by 1989, the domestic production of pharmaceuticals had declined by 98.5% in relation to its 1980 level, with many national drug companies closing down (Chossudovsky, 1997). The average annual consumption of pharmaceuticals per capita is of the order of US$ 1 (1993), which even the World Bank considers to be too low. In addition, the real salaries of health care workers have declined significantly, with many of them abandoning the public health sector (World Bank, 1993a). Because of the contraction in public expenditure, communicable disease control and prevention activities have been dramatically curtailed. In sub-Saharan Africa and in Latin America, there has been a resurgence of communicable diseases, including cholera, yellow fever, dengue and malaria. In Viet Nam, the number of malaria deaths increased threefold in the first four years of the economic reforms. This is attributed largely to the deterioration of health services and the increase in price of antimalarial drugs (UNDP, UNESCO, 1992).

According to a WHO analysis (Kutzin, 1995), the potential beneficial effects of health sector reform from the standpoint of equity are usually not realized because:

- Fees tend to dissuade the poor more than the rich from using services.
- Income-based pricing and exemptions have proved very difficult to implement in a consistent and accurate manner.

Studies in many countries, including Bangladesh, Ghana, Peru, Swaziland, and Zaire, have shown that poor people are more likely to be put off by fees than the rich. Travelling distances, which reflect cost both in time and money, and which are more likely to affect indigenous peoples, have been shown to have a similar deterrent effect (Creese, 1991; Gertler & van der Gaag, 1990). Although the imposition of user fees has decreased utilization of services, there is no evidence that those deterred did not need them (Creese, 1991). Furthermore, no study has conclusively demonstrated the effect of user fees on health status. In addition, user charges have mobilized little economic support to improve the quality of government health services.

Another issue of concern regarding health sector reform is the increase in interregional inequities under decentralization schemes, particularly when they include local generation of resources such as user fees. The regions where indigenous peoples live are usually the poorest. Wealthier districts in a country would be able to spend more on health care and offer better
service, thus exacerbating inequities between regions (Thomason, Kolehmainen-Aitken & Newbrander, 1991). Distortions created by health sector reforms should be compensated for by securing additional resources or reallocating existing resources to those in greatest need.

**Health systems among indigenous peoples**

The following are some examples of existing health systems among indigenous populations. A discussion on management transfer from government-operated Indian health services to Indian tribes and communities in the United States and Canada is also included.

*Coexistence of traditional and Western health systems*

- **Meitei**

  The health system in Manipur (India) is essentially pluralistic in character. It falls into two distinct categories: the indigenous community system and traditional institutions, on one hand, and the state-run Western health system on the other. Formal health services are still in a developmental stage and are mainly concentrated in the few urbanized areas. Traditional health systems and practitioners are numerous and are also widely accepted. The main disciplines within the traditional systems are pulse and palpatory diagnostics and manipulative healing, bone-setting and related treatments, herbal cures, and various prayers and ritualistic cures for the individual, family and clan. The preventive and health promotion traditions are also linked to Meitei astrology. The British introduced a Western medical care system to Manipur at the turn of the 20th century. Since the early 1970s, it has been a regionally administered State Health Service organized into district and sub-district level hospitals and primary health care centres and dispensaries. The health service is beset by a general lack of resources (1.3% of the total state budget in 1995-6), inadequate training, lack of equipment, and no supervision. A recent trend has been that nongovernmental organizations are beginning to take on State responsibilities in health care. This is particularly true in the field of alcohol and drug addiction, and rehabilitation, the training of nurses and community health care workers, care and support of the mentally ill and handicapped, and home and community care and psychosocial support for HIV/AIDS (Debabrata Roy., 1997).

*Indigenous Ownership*

A serious barrier to health care access is the lack of cultural sensitivity within the health care system. Indigenous cultures and ways of life, including healing systems, are viewed with disdain. Health professionals often hold arrogant attitudes that interfere with patient-provider relations. Furthermore, the infrastructure and rules of functioning of health care facilities are utterly unfamiliar and uncomfortable for indigenous peoples. Therefore, increasing access necessitates accommodating indigenous peoples requests and suggestions on how to feel more at home. Indigenous peoples have also engaged in establishing ownership of the process of health development for indigenous peoples. This includes the incorporation of indigenous cultural practices and a holistic approach to healing. There is growing emphasis on the recognition and acknowledgment by native and non-native peoples that indigenous peoples are leaders in community development and in the uniqueness of their healing approaches. Issues of relevance for indigenous peoples are the relationships between land, cultural dispossession, poor health status, and the revitalization of traditional healing practices (Stout & Coloma, 1993).
A WHO/PAHO workshop on human resources and intercultural exchange, held in Managua, Nicaragua in September 1998, brought together participants from government, indigenous organizations and training institutions from seven countries to address the cultural dimensions of health care. It concluded that the cultural dimension was a key factor in developing national health plans and in health sector reform, and was a fundamental strategy in developing health systems.

- Maori

Recent years have seen the growth of a wide range of Maori health provider initiatives motivated by the need to improve the poor health status of Maoris and fill gaps in services. Many initiatives have focused on primary medical care services as part of a broader primary health care service. It is now widely accepted that culturally appropriate services are needed to help improve Maori health status. Some examples of Maori health care organizations are the following (Te Puni Kokiri & Alcohol Advisory Council of New Zealand, 1995): Waipareira Trust provides a wide range of health services, such as cervical screening, substance and alcohol abuse treatment, monthly diabetic clinics, and free wellness checks; Waiwhariki branch of the Maori Women’s Welfare League provides cervical screening services; Hiri Hauora provides a culturally appropriate and integrated maternity health service for Maori women; Nga Wairere o Te Ora Clinic conducts spiritual and herbal healing combined with primary health care delivery; and the Maori Mental Health Team has been working on the integration of Maori development through the Mental Health Services.

- Aborigines

Crucial to the improvement of Aboriginal health is the development of Aboriginal community-controlled health services. For Aboriginal peoples, community control is the most practical and effective approach to solving their health problems. These services, however, are under-resourced and have not received enough support from government agencies. Furthermore, Aboriginal participation in health planning is still at an early stage (Aboriginal Medical Services Alliance - Northern Territories, 1996). An example of Aboriginal-managed health care initiatives is the Alukura, an Aboriginal women’s community-controlled health and birthing centre. The Alukura model of primary health care incorporates law, language and culture into a women’s birthing service, and provides an alternative for Aboriginal women who feel coerced by the medical system. The feeling among Aboriginal women is exemplified by a quote from a participant in the Alukura programme “White people have never asked us where we want to have our babies. They’ve always said, ‘You’ve got to go to the hospital’.”

- Central and South America, and Mexico

The current process of decentralization of health services, within the framework of civil participation and local governance, and with a greater understanding of the pluricultural make-up of Latin American society, may open up possibilities for increased ownership by indigenous peoples (Consejo Mundial de Iglesias, 1996). They are, however, few experiences of indigenous management.

Two of these experiences are the indigenous health programme developed and managed by AIDESEP (Indigenous Association of the Peruvian Rainforest) and Hambi Huasi, a project...
of FICI, the Indigenous and Peasant Federation of Imbabura, Ecuador. International funds provided support to set up Hambi Huasi, a community-based clinic staffed by Western-trained medical doctors who are indigenous, form part of the community, and have preserved a strong cultural identity and commitment to the community. The clinic's staff also includes a traditional healer. The relationship between the indigenous Western-trained professionals and the healer is one of mutual respect, and is non-hierarchical; patients choose providers freely.

The Interethnic Association of the Peruvian Rainforest (AIDESP) has maintained health as a priority issue since its establishment in 1980. At present, the indigenous health programme of AIDESP is a decentralized entity. The health programme is based on a system of clinics and health promoters, following a primary health model. Medical care to isolated communities has been extended and improved. A team of physicians, nurses and health promoters work as part of travelling teams. The health situation of 25 communities is systematically monitored through community-based medical outposts. Recovery, systematization, and dissemination of knowledge on medicinal plants are components of the skills building strategy promoted by the programme. In the present phase, the programme is strengthening partnerships with the state health sector and universities in joint but indigenous-owned initiatives. At the same time, one of the main objectives of the programme is to strengthen and revitalize shamanic knowledge and the leadership role in communities. Shamans are mediators and have the political skills to intervene in all aspects of community life. The programme also supports indigenous students and professionals, and facilitates their organizational activities (AIDESP, 1997).

- Canada

In Canada, there are 382 prevention programmes and 50 treatment programmes, as well as inhalant abuse programmes and research initiatives funded by Health Canada and staffed and governed by Aboriginal Boards of Directors or by Chiefs and Councils. In addition, there are approximately fifteen provincially funded treatment centres. These treatment initiatives translate into more than 895 treatment beds. A national health promotion programme (Celebrating Success) promotes national alcohol-free and drug-free role models for youth. Over 1,400 communities are involved, initially with government funding, but now many are initiating their own programmes.

The approach in Canada has focused on abstinence; but, in recent years, increasing emphasis has been placed on health promotion and research strategies (WHO, 1996). The community is the heart of indigenous substance abuse prevention and treatment in Canada. Traditional healing practices and philosophy are seen by many Aboriginal people as the foundation for community wellness and empowerment, and such practices need to be part of both training and treatment. The National Native Alcohol Abuse Program has been the primary national organization involved in treatment efforts. Two major prevention and awareness efforts initiated by the Neechi Institute are the National Native Addictions Awareness Week and the Keep the Circle Strong Campaign which now involves 1,400 native communities across Canada. Spirituality and traditional healing practices are an important part of substance abuse prevention and rehabilitation programmes among native Americans in Canada and the United States. A study conducted in 1982 in an urban center for alcoholism treatment among native Americans showed that 74% of clients preferred a treatment approach that includes traditional medicine (Locust, 1985). In Canada and the United States, healing circles, sweat ceremonies, and teachings of the elders are the building blocks in substance treatment programmes (York, 1990).
One example of these treatment centres is the Okonagegayin programme for solvent sniffers in Canada. The programme takes place at a rough bush camp about 50 kilometres from the district hospital. It operates in the Ojibwa language and in English, and it is built around four phases of ceremonies. These ceremonies include and symbolize detoxification, purification, healing, and unification. Intensive use of sweat lodges is used to detoxify sniffers. Local native people help in preparing food and participate in talking circles. There is drumming, singing and dancing, walks and other ritual practices (WHO, 1996)

- United States

A variety of health care programmes in the United States are based on traditional healing practices. Such programmes include the Recovery and Spirit Camps. They are based on the belief that the land, living on it, having intimate contact with it, has intrinsic healing effects. In Alaska, the Spirit Camp idea came from a meeting of elders who were concerned about the effects of modernization and alcoholism on young people. They based the idea on recreating traditional fish camps in which people caught, fried and smoked their winters’ supply of fish, living in a peaceful and friendly natural environment. Each village decides on a theme to be addressed in its Spirit Camp, so that the goals, activities and operations are determined by the villages. The project has support from the Alaska Native Human Resource Development Project at the University of Alaska. The Alaska Recovery Camp was started by an ex-drinker. It developed from a belief in the health influences of engaging in traditional activities in the bush, and from the poor results of sending people away to urban treatment centres (WHO, 1996).

Population Control and Native Women

The promotion of birth control methods as a means of population control among native American women is a source of concern. This concern does not imply that the right of indigenous women to informed choice and access to birth control methods should be jeopardized. On the contrary, the preoccupation is shared by indigenous women throughout the world. This preoccupation stems from the history and experiences of imposition of surreptitious population control practices among poor and marginalized populations around the world (Hartman, 1995). For indigenous women, this is not a thing of the past, but an issue and a practice that can resurface at any time. A report by the Native Women’s Health Education Resource Center in the United States addressed the use of norplant - a relatively new form of contraception -, among native women who use the Public Health Service system. Concerns stem from the lack of appropriate guidelines for counselling, the lack of follow-up of norplant users, and the lack of concern for the frequency of side effects experienced (Asetoyer, 1992).

In Peru, a broad range of social actors, including health professionals and women’s organizations, have severely criticized the current national family planning programme. This programme is plagued by problems, including the use of quotas, coercion and material incentives to promote sterilization among poor women, the majority of whom are indigenous. Independent research has confirmed that information to patients has been misleading, and the conditions under which surgery is performed have been poor, leading to several deaths (New York Times, 1998).

A fundamental issue is that indigenous perspectives on reproductive health do not find any resonance within the health care system. No channels exist to facilitate the systematization of an indigenous framework for the health of women, the family and the community, that can
inform the making of health policy (WHO/PAHO, 1995). Indigenous women lacked adequate representation and participation, even in highly publicized international events such as the International Conference on Population and Development (Cairo, 1994) and the Fourth World Conference on Women (Beijing, 1995).

**Managerial transfer of health systems: indigenous ownership and State responsibility**

- **Canada**

The Medical Services Branch of Health Canada was created in 1962. This is a Federal Government organization responsible for providing health care services to Indian people. An evaluation of Indian health services strongly suggested that efficiency was often compromised by cultural differences between native people and the health professionals providing services (Gibbons, 1992). The recommendations stressed the need for more Native involvement in staffing, and more appropriate training and orientation for care givers. In 1968, following increasing pressure from First Nations for constitutional endorsement of Indian self-governance, the Canadian government initiated a new approach to health development. The Health Transfer initiative offered an option to communities in reserves to negotiate the transfer of funds for individual tribe control of certain public health programmes. The types of services that could be transferred included community health work, nursing, environmental health, health education, and management. The sustainability of community health programmes has, however, been compromised by a chronic lack of funds (Walters & Ankomah, 1996).

In Saskatchewan, there are 72 First Nations communities, five different tribes (Assiniboin, Cree, Dene, Sioux, and Saulteaux), nine Tribal Councils, and various non-affiliated bands. The geographic region is vast, with four types of communities: those classified as remote isolated communities, which are those northern communities accessible only by plane; the isolated communities, which are those that have a road but are very distant from a medical facility; the semi-isolated communities which are accessible by road and are at least 60 miles from a medical facility; and the non-isolated communities, which are accessible by road and close to medical facilities. Given this situation, it is not easy to make decisions that take into account the needs of all. The 72 First Nations of Saskatchewan found it beneficial and cost-effective to work collectively on common issues. One such response was the collective effort and agreement to bring the issue of funding to the attention of the Medical Services Bureau. For this purpose an advisory group was established in 1995. It reviewed government funding received by tribes and made recommendations. As a result, some projects were coordinated regionally. Examples of these projects are the organization of the Women and Wellness Conference, and the Men and Wellness Conference, the establishment of a Community Wellness Center, and the Community Action Plan on Inhalant Abuse (Saskatchewan First Nations Youth Inhalant Treatment and Outreach Program, 1997).

- **United States**

In the United States, members of the 550 Indian tribes recognized by the government are eligible for services provided by the Indian Health Service (IHS). Federally recognized tribes enjoy a government to government relationship with the United States of America, based on treaties, Supreme Court decisions, legislation, and Executive orders. The IHS is an agency of the US Public Health Service that operates hospitals, ambulatory centres, village clinics, and
urban clinics. It provides health care to approximately 1.4 million American Indians and Alaska natives. Native Hawaiians are not included within the system, nor are native Americans who are members of non-government recognized tribes, members of recognized tribes who reside away from their tribal territory, or those who have less than 25% blood quantum. Thus, close to one million native Americans, not including native Hawaiians, lack access to the IHS system. The Indian Self-Determination and Education Assistance Act, passed in 1993, provides tribes with the option of taking over from the IHS the administration and operation of health services and programmes in their communities, or remaining within the IHS direct health system. In 1966, 76 (53%) of the 144 administrative units of IHS were operated by the tribes. Since the allocation of budget for tribes that assume control of their health care programmes and infrastructure is based on a quasi population-based quota, those tribes with a smaller population are at a disadvantage. The health plan for native peoples and the transfer of services management to the indigenous communities have received some criticism on the part of native peoples, both in the United States and in Canada, because of its Western medical bias. Critics believe that the transfer is aimed at complying with other national policies, such as reducing the fiscal budget, and that this aim takes priority over the improvement of native Americans' health status (Culhane Speck, 1989; Bobet, 1988). Nevertheless, many native Americans consider that the managerial transfer of health services is a recognition of the right of self-determination of native peoples and that the transfer of health services to the tribes will maximize the possibilities for improving the health of indigenous peoples (Gibbons, 1992).

**Training of indigenous people**

**Training of Native Health Professionals**

The training of native health professionals is a preoccupation of Indian communities and tribes. In Canada there are only about 45 native physicians. Of the 234,000 graduated nurses and nursing students, only 2,755 are native peoples (Johnson, 1992). In Canada, the training of addiction counsellors and treatment staff has a history of more than twenty years. Aboriginal training and education programmes now exist in almost all of the provinces and territories, but only a limited number are owned and staffed by natives. One of the native-owned and native-staffed programmes is the Nechi Training, Research and Health Promotion Institute, established in 1974. This Institute has trained over 3,000 native aboriginals in alcohol and drug abuse treatment and prevention skills. Culture and spirituality, with emphasis on the re-introduction and practice of traditional ceremonies, are at the core of the Nechi Institute's training.

In the United States, the American Indian Health Care Association and the Indian Health Board are involved in health issues relating to native Americans. Activities include research on health risk factors among urban Indians. The Association and the Board conduct research training for indigenous peoples. They conducted studies on barriers and facilitating factors for cervical cancer screening among Native women, and an educational programme on HIV/AIDS prevention. Recognizing that diabetes is a critical health problem for many native American communities, not only in the United States but in other countries as well, the University of Arizona, Native American Research and Training Center, periodically organizes an International Conference of Diabetes and Indigenous Peoples. The purpose of the Conference is to exchange information about successful cross-cultural prevention and intervention strategies and programmes. The presence of native Peoples in the health professions facilitates provision of culturally appropriate health care for native Americans. Tribes in the United States concerned
at the lack of native health professionals have set up scholarships for their members. Other scholarships and training programmes receive government funding. The National Cancer Institute, for example, has funded the Native Americans Cancer Research Training Programme, targeting more specifically native women. This programme aims at increasing the number of native professionals involved in the assessment, development and implementation of cancer prevention and treatment programmes.

**Training of Traditional Healers and Midwives as Health Care Workers**

Significant efforts have been invested around the world in the training of traditional midwives and healers both to adapt their practice to Western medical standards and to function as promoters of the Western medical paradigm. An informal assessment by WHO/PAHO in the Region of the Americas reached the following conclusions:

- The training programmes usually did not appreciate or incorporate the knowledge and experience of the traditional practitioners. In general, the training used a top-down approach to impart information, and focused on and emphasized only negative aspects of traditional healing systems.

- According to WHO/PAHO's evaluation, trainees did not substantially change their practice. Midwives, for example, did not use the basic surgical instruments provided. The bag with the instruments provided during training was commonly seen displayed in homes as a souvenir next to the course diploma, while the surgical scissors were used for trimming bushes.

- The need for the regulation of professional practice of traditional practitioners has also been a matter of discussion. It is important to acknowledge that malpractice can occur in both traditional and medical systems. Unscrupulous physicians exist for whom economic gain prevails over the patient's well-being. The practice of biomedicine by individuals who are not appropriately trained or certified is also known to occur. Similar anomalies may occur in the realm of traditional healing practices. Indigenous communities possess customary regulatory and monitoring systems that provide legitimacy for traditional healing practices. These forms of regulation are not systematized according to Western logic and may not be self-evident to outsiders. Within each culture, however, they are as valid as Western regulatory laws.

An evaluation of training programmes for traditional practitioners conducted by WHO (1991a) included a review of the literature and field evaluations of specific projects in Bangladesh, Ghana and Mexico (dealing with traditional practitioners and primary health care). The evaluation documented a few cases with positive outcomes. These included increased referrals to clinics for patients with dangerous symptoms, and improvement of working relations between nursing staff and traditional practitioners. Overall, however, the conclusions point to a series of limitations in this strategy. There was little if any evaluation or follow-up after completion of the training programmes for traditional practitioners. Not enough data were available to assess effectiveness and community satisfaction (WHO, 1991a). Similarly, a review by Prior (1997) states that the evaluation of training programmes for midwives has not produced any clear-cut answers. Rather, the studies have shown that the success of programmes depends on the resources available and on how the training is carried out. There has to be an
understanding of traditional beliefs and practices, and a willingness to build on them. The review also states that there have been unwanted side-effects, such as increased infection resulting from regular vaginal examination, discouraging the squatting position, and promotion of bottle-feeding.

Differences in perceptions and lack of mutual knowledge impair the development of collaborative relations between traditional and medical health systems. In a village clinic in Bolivia, for example, the health worker in the clinic, actually a local himself, thought that healers were ineffective in treating illness, and that villagers were ignorant and lacking in hygiene. Villagers, on the other hand, thought that clinic personnel had a judgemental attitude towards their culture and towards the traditional systems of healing. They also thought that the care received at the clinic was ineffective. Through the intervention of a local nongovernmental organization, which aimed at strengthening local systems of knowledge and at improving mutual understanding and cultural sensitivity among health professionals, relations between villagers and clinic personnel have improved (Centro de Comunicación y Desarrollo Andino, 1993). These experiences point to the need to create spaces and opportunities for healers and medical personnel to come together at a common meeting point. Such a common meeting point could be mutual learning about what each can contribute to community well-being.

The Medicinal Use of Plants

Medicinal plants are a useful resource for healing ailments of both indigenous and non-indigenous populations, but the use of medicinal plants should not be confused with indigenous healing systems. As previously stated, the latter constitute complex healing systems, and plants are only one of many intervening elements. Besides, medicinal plants often play a variety of roles within community life, other than their therapeutic function. Some plants are used in religious ceremonies, possess sacred qualities, and are used as social facilitators and as a medium to communicate with the spiritual world. When ethnobotanists studied the gardens of the shamans of the Sibundoy Valley in Ecuador, it became apparent that these were much more than community pharmacies. In the first place, it was learned that the ethnobotanical categories used in the gardens had a greater degree of discrimination and wider variety of information than the categories used by Western botanists. It was also learned that, through the cultivation of plants, the shamans stored information about the community’s history, symbols, and strategies to utilize the environment. The gardens were, in fact, a reservoir of collective knowledge (Pinzon & Garay, 1990).

Economic factors and crises such as wars and epidemics serve to increase the official acceptance, research, and promotion of the use of medicinal plants (Bodeker, 1993). Following this trend of using low cost resources, Thailand’s Ministry of Health, promotes the use of medicinal plants in primary health care. Other examples are the research and systematization of plants useful in the treatment of burns in Viet NAM, the research on plants active against AIDS in Africa (Baedeker, 1993), and the search for antimalarial drugs to replace chloroquine-resistant synthetic drugs in South America (Milliken, 1997).

Information on the classification and use of medicinal plants is extensive (Duke & Vazquez, 1994, Morton, 1981). A variety of teaching modules for medical students as well as community resource educational materials also exist. Recovery and revitalization of traditional knowledge, particularly of medicinal plants, for community use, have been the focus of many
grassroots experiences led by nongovernmental organizations around the world. Community-based experiences have been successful in the systematization and dissemination of information on medicinal plants, as well as in promoting local cultivation. These initiatives commonly involve indigenous women, thus gender issues and women’s health are also addressed. The following are examples of current initiatives related to the use of medicinal plants.

**Medicos Descalzos (Barefoot Doctors)**

In Guatemala, the nongovernmental organization Medicos Descalzos has conducted a successful project to strengthen, socialize, and apply traditional knowledge on the healing properties of herbs at the community level. The project’s goal is to recover and systematize, through a participatory methodology, the knowledge of traditional healers and communities. It involved information gathering, plant classification, studies of therapeutic effects, and the preparation of didactic material for the communities. Furthermore, it achieved the revalorization and incorporation of this knowledge within the existing governmental and nongovernmental primary health care system. Medicinal plants are now grown and processed in local gardens, thus providing communities with basic therapeutic products. This programme was initiated in 1990 in a small municipality in Quiche (Guatemala). By 1995, seven geographical areas in the country were participating in the programme.

**Global Initiative for Traditional Systems (GIFTS) of Health**

The Global Initiative For Traditional Systems (GIFTS) of Health was established in 1993. Its aim is to ensure safe, effective and sustainable health care to those who use traditional medicine in the developing world, and to bring policy and funding attention to this area. Part of the work of GIFTS has been to hold a series of international meetings on the theme of traditional health systems and policy. Meetings were held in Canada, Uganda, the United Kingdom (Oxford), Venezuela and Viet NAM, in conjunction with indigenous organizations and traditional medicine research and health care centers. The initiative published a series of documents and studies showing that it is possible to articulate biomedical and traditional health practices and services so that a genuinely sustainable pattern of health care can develop (Bodeker & Parry, 1997).

**WHO’s traditional medicine programme**

A traditional medicine programme was established by WHO in 1977 by a resolution which stressed "the need of the governments of the countries interested in the use of traditional medical practice to give adequate support to engaging traditional medical practitioners in primary health care teams as and when appropriate, to the utilization of appropriate technology in these traditional medical practices, and to undertake adequate measures for effective regulation and control of traditional medical practices." The programme is conducted under the rationale that traditional medicine is an important part of health care. From 35,000 to 70,000 plant species have at one time or other been used for medical purposes. Most populations in the developing countries still rely mainly on indigenous traditional medicine for their primary health care needs. However, traditional medicine is not incorporated in most national health systems, thereby losing the potential of the traditional understanding of herbal medicines and their importance to the health of individuals and communities.
In recent decades, in many developed countries there has been a growing interest in herbal medicine, acupuncture and alternative systems of medicine. As a result, the cost of herbal medicines and their international trade has increased. In 1993, the total sales of herbal medicines in China amounted to more than 14 billion yuan, not including US $400 million worth of exports. The Malaysian government estimates that sales of traditional medicine currently amount to US $60 million, which, for a country with a population of only 15 million people, is quite significant. In the United States of America and Canada, according to a report in the journal *Market of Herbal Medicines*, sales of herbal medicines reached US $860 million with a growth rate of 15% in 1990. In Germany, market sales of herbal medicines reached US $1,500 million. The national growth rates in other Western European countries were from 5% to 22%, as reported by the European Scientific Cooperative on Phytotherapy in 1992. In Japan, from 1997 to 1989, there was a 15-fold increase in herbal sales according to the Regulation on Herbal Medicine.

In most countries, the same scientific methodology is expected to be used for the evaluation of pharmaceutical drugs and medicinal plants. This involves isolation of an active component, as well as animal testing of toxicity and efficacy. The adequacy of this methodology as it applies to medicinal plants is, however, being questioned and reassessed. Medicinal plants do not act through an active component principle, but derive their properties from the synergy of the totality of component elements. Furthermore, often a variety of plants is used in treatment. Similarly, medicinal plants act by restoring systemic equilibrium rather than curing a single disease. WHO’s guidelines for the assessment of herbal medicines state that "as a general rule, in this assessment, traditional experience means that long-term use as well as the medical, historical and ethnological background of those products shall be taken into account," and that "prolonged and apparently uneventful use of a substance usually offers testimony of its safety" (WHO, 1991b).

**United States National Institutes of Health and Office of Alternative Medicine**

In 1991, the United States Congress mandated the establishment of the Office of Alternative Medicine (OAM) within the National Institutes of Health. The mission of the OAM is to encourage and support research on complementary and alternative medicine practices, with the ultimate goal of integrating validated medical practices into health and medical care. The OAM is also charged with training investigators who can help fulfill this mission. This programme encompasses a variety of alternative medical practices, not only the use of medicinal plants. Its main focus is to validate and institutionalize the use of alternative medical practices among the non-indigenous population. It also seeks to obtain knowledge on indigenous healing practices that may benefit the non-indigenous population, and to conduct validation tests. So far, the programme has not conveyed the practical significance of its activities to indigenous peoples.

**Bioprospecting**

Bioprospecting is the search for plant, animal or human genetic materials of potential commercial interest. The launching of new international bioprospecting ventures has produced uneasiness among indigenous communities and organizations, since the implications in terms of environmental and cultural disruption have not been clearly addressed (Coordinadora de las Organizaciones Indigenas de la Cuenca Amazonica, 1997; Grifo & Rosenthal, 1995; Shiva, 1997; Shiva et al., 1997; International Development Research Center, 1994; Simpson, 1997).
United States National Institutes of Health Biodiversity Programme

The International Cooperative Biodiversity Groups Project is designated to stimulate the field of bioprospecting, to provide models for the development of sustainable use of biodiversity, and to gather evidence on the feasibility of bioprospecting, as a means to:

- Improve human health through the discovery of natural products with medicinal properties.
- Conserve biodiversity through the evaluation of natural resources, training and infrastructure building to aid in management.
- Promote sustainable economic activity of communities, primarily in less developed countries in which much of the world’s biodiversity is found.

The project includes analysis of natural products as potential therapeutic agents for diseases of concern both to developed and developing countries. Among its goals, the project also lists efforts to examine and preserve traditional medicine practices, to ensure sustainable harvesting, to carry out biodiversity inventories and surveys, and to promote training and infrastructure support for host-country institutions, and long term funding for biodiversity conservation in the host countries.

The project falls under the auspices of three United States governmental agencies: the National Institutes of Health, the National Science Foundation, and the US Agency for International Development. A team is established to conduct each international cooperative diversity group. Each team includes an academic principal investigator, academic research institutions, local and international nongovernmental organizations working in the host country, and pharmaceutical partners. The awards are in the form of cooperative agreements rather than grants. This means that the United States Government has continued involvement in the projects through scientific advisory committees that comprise representatives from each agency, as well as providing general facilitation and policy advice.

The cooperative relationship is established on the basis of innovative agreements, rather than contractual terms. The project requires that benefits flow back to the collaborating communities. Local individuals who collaborate with the project, frequently traditional healers, usually receive payment for their services. Royalty terms of contracts are negotiated depending upon the relative contribution of the partners to the invention and other aspects of the drug discovery process. The project prospectus, however, acknowledges that a "seemingly simple idea like returning benefits to communities can be extraordinarily complicated in practice." Bias towards the value of Western science, for example, would probably bear upon the determination of the relative contribution towards the invention. Thus Western scientists and researchers are likely to receive greater recompense than shamans and other knowledgeable individuals in the collaborating communities. Other problems include competing claims and representation. In addition, local communities or their representatives do not have sufficient commercial and legal experience to negotiate agreements. Furthermore, legal counsellors may lack cultural awareness and ignore potentially disruptive aspects of such contractual agreements. The unforeseen consequences of this new form of natural and cultural resource exploitation are yet to become fully apparent. Implementation of this programmes does not take into account the detrimental and disruptive effects of the introduction or enhancement of dependence on a monetary economy, or of the promotion of individual competitiveness or animosity between communities.
Five cooperative biodiversity partnerships have already been established between academic institutions in the United States, pharmaceutical companies, and local partners, in Argentina, Cameroon, Chile, Costa Rica, Mexico, Nigeria, Peru and Surinam. Local partners include academic institutions and, in most cases, indigenous communities or organizations.

The Human Genome Diversity Project

The Human Genome Diversity Project is an effort of scholars around the world to document the genetic variation of the human species worldwide. This scientific endeavour is designed to collect information on human genome variation to help understand the genetic makeup of all humanity. The information will also be used to learn about human biological history and the biological relationships between different groups, and may be useful in understanding the cause and determining the treatment of particular human diseases.

The project has produced widespread concern and uneasiness among indigenous peoples. Indigenous organizations have manifested disapproval of this initiative through their declarations (PAHO/WHO, 1993b). The project, with a budget of US $ 5 million per year, intends to collect blood samples, hair roots, cells scraped from the inside of the cheek, sputum, and other biological material from a range of 4,000 to 8,000 distinct human populations around the world. A reason for urgency in collecting these samples, according to the project prospectus, is that many human groups may soon disappear. Although informed consent is a prerequisite for sample collection, it is unclear how the information will be made culturally appropriate in each case. An alleged benefit for indigenous peoples is the possibility of "learning what science believes to be the history and origins of sampled populations." Should any commercial products develop, the project is committed to return part of the financial gains to the sampled population. However, it is stated that "the best ways to implement those commitments are not yet entirely clear. Implementation depends on some complex issues of patent and contract law that have not been entirely resolved."

Indigenous peoples, governance and nongovernmental organizations

The following are selected examples of mechanisms that facilitated participation of indigenous peoples in country and local level governance (e.g. alliances with other social sectors, skill building and training, strengthening of indigenous organizations):

- In 1751, the civil rights of the Sami were recognized in the Sami Codicil.

- In India, under the 73rd constitutional amendment pertaining to local government, a number of Janusari women and men have taken their place in governance. The government of India has recently passed the Provisions of the Panchayats (Extension to the Scheduled Areas) Act, 1996. The population of the scheduled areas is almost totally composed of tribal and indigenous peoples. All seats for chairpersons in these territories have been reserved for the Scheduled Tribes.

- The relevance of indigenous peoples issues in South Africa stems from the Constitutional reform that ensures the right to participate in one's own culture. The Department of Foreign Affairs is in the process of establishing a working group on indigenous affairs, within the Department of Constitutional Development and a section on traditional affairs...
has been established. International funding has facilitated the introduction of a cultural mediation programme. Training has targeted teachers, pupils, community leaders and other authorities.

- The Russian Federation has passed some laws to protect minority interests, but implementing the new legislation is expected to take time and effort.

- The leader of the Nentian Dayak of East Kalimantan, L.B. Dingit, received the 1997 environmental Goodman Award. International recognition fostered an increase in public awareness of the problems faced by indigenous peoples within Indonesia, especially by nongovernmental organizations and local scientists.

- In Latin America, governments such as those of Colombia and Argentina passed constitutional reforms recognizing the social, cultural and land rights of indigenous peoples. These accomplishments are the result of the mobilization of the Indigenous organizations and communities. The indigenous movement in these countries made effective use of communication media, and developed education campaigns and alliances with diverse sectors of society.

- In some countries, the indigenous movement strives to have indigenous representatives in parliament. This process implies the use of the structures of traditional political parties, or building and leading new political movements that amalgamate different sectors of society (e.g. as in Bolivia, Colombia, Ecuador and Guatemala).

- Alliances and coordination with international and local environmental nongovernmental organizations has facilitated resistance to development projects deemed to be harmful. Nevertheless, evaluation of the role of non-indigenous nongovernmental organizations with regard to indigenous peoples calls for a case by case approach. The impact of each initiative must be carefully assessed on its own merits.

- In India (Manipur) as in most countries, nongovernmental organizations are taking over the State's responsibilities in health care. This is particularly true in the fields of alcohol and drug addiction, HIV/AIDS, rehabilitation, the training of nurses and community health care workers, and the care and support of the mentally ill and handicapped.

- Indigenous organizations in Latin America have been wary of non-indigenous nongovernmental organizations acting as intermediaries, and receiving funding in the "name of the Indians." As Indigenous organizations get stronger or dialogue is established, relations may improve. In many cases, however, there is good mutual collaboration.

- With support from nongovernmental organizations and academic institutions, the Van Gujjar (India) have developed an alternative to a government proposed state park that would had evicted them from their land. The Community Forest Management Protected Areas Plan is the first People's Park in India and it is managed by the Van Gujjar.
Conclusions

Health Systems

- Access to health services and health promotion and prevention programmes for indigenous peoples is limited and inadequate. In general, services and programmes are culturally inappropriate.

- Barriers to health care include:
  - **Structural and economic factors:** distance and location of health care facilities, isolation of indigenous communities; lack of health insurance or economic capacity to pay for services; time factor - the relative value of losing a day of productive activity.
  - **Lack of cultural sensitivity and appropriateness** of health care systems: disregard and disdain shown by health personnel towards indigenous peoples or their culture; disrespect for traditional healing practices; language barriers; uncomfortable and impersonal environment of hospitals and clinics.

- Indigenous ownership and leadership should drive the development of culturally appropriate health care programmes.

- Training of indigenous peoples in the health professions and providing cultural sensitivity training to all health professionals are urgent tasks if culturally appropriate health care systems are to be developed.

- The principles of health for all and primary health care are compatible and could form a basis for developing appropriate health systems for indigenous peoples.

Health sector reform

- Economic pressures determine a focus on cost-effectiveness rather than on equity of access and quality of care for disadvantaged groups.

- The impact of health sector reform on health status is not properly assessed.

- There is no evidence that those deterred from seeking health services do not need them.

- Health sector reform tends to exacerbate interregional inequities.

- Indigenous peoples and communities suffer the greatest impact from the privatization of health care and the imposition of fees for services because of their low purchasing power and their location at a greater distance from services. This distortion should be compensated for by devoting additional resources to health and by the reallocation of existing resources to those in greatest need. Urgent measures must be taken to counter the negative impact of health sector reform on indigenous populations.
Articulation of traditional and medical health systems

- In general, the interaction of the Western medical establishment with traditional practitioners is characterized by ethnocentric preconceptions and poor performance in terms of cultural sensitivity. The emphasis on training rather than on mutual learning approaches shows a disregard for traditional knowledge. Top-down and hierarchical relations have precluded bidirectional learning and articulation.

- Proclamatory language and practical guidelines often include recommendations for conducting participatory and culturally sensitive interventions. In practice, paternalistic attitudes have been difficult to overcome.

- Collaboration between traditional practitioners and medical professionals can be promoted within the physical space of the community, without the need to institutionalize joint practices within a medical setting.

Medicinal use of plants

- Community-based and indigenous-led projects focusing on the systematization of knowledge about medicinal plants, and their use in community health care have yielded positive results.

- Innovative, promising approaches seek partnership with indigenous organizations, and focus on ailments affecting indigenous peoples rather than populations in industrialized countries. Initiatives should channel academic and scientific contributions towards practical applications for indigenous communities and avoid commercialism.

- Current interest in the curative properties of plants has provoked a sense of uneasiness among indigenous peoples and organizations. This uneasiness stems from the following considerations:
  - The focus of pharmaceutical research is on potentially profitable products. Thus, major efforts are directed at finding products that are active against diseases that affect or concern affluent populations in developed countries, rather than those affecting indigenous peoples.
  - Indigenous healing systems use a variety of methods of restoring harmony, other than plants (e.g. ceremonies and manipulations of the body), and traditional communities constitute reservoirs of knowledge on many issues other than therapeutic science.
  - Plants used out of the cultural and physical context of a community, or provided without the power that emanates from the healer, may not have the expected effect.
  - Contractual agreements between pharmaceutical industries or their intermediaries and indigenous communities or individuals must be closely monitored.
  - The long term effect of these new joint enterprises on the overall social and cultural cohesiveness of indigenous communities is of concern. Monitoring and evaluation mechanisms must be set up to avoid unethical exploitation and potentially harmful cultural disruption.
CHAPTER IV
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SOME WHO INITIATIVES ON THE HEALTH OF INDIGENOUS PEOPLES

Within the framework of the UN Decade of the World’s Indigenous Peoples, WHO’s Executive Board has issued a mandate for developing a global programme of action (WHO, 1997b; Appendices I and II).

Indigenous peoples and substance abuse project

WHO’s indigenous peoples and substance abuse project was proposed as a result of the initial findings from a number of activities of the WHO programme on substance abuse in 1992 and requests from indigenous peoples throughout the world. The first phase of the project involved commissioning case study reports from 11 different indigenous communities, and a summary document bringing together the important issues raised in the reports. The second phase was initiated in late 1995. A project planning meeting took place on 25-29 March 1996 in San Jose, Costa Rica.

The project principles are:

- Recognition and acceptance of cultural diversity among indigenous peoples.
- Recognition of the special relationship of indigenous peoples to the earth/land.
- The need for sustainability, self-determination, equality and reciprocity.
- The need for partnership and active participation.

The project is based on the understanding that, over centuries, indigenous peoples have come to learn about the mind-altering properties of many of the naturally occurring substances around them. These substances are often highly valued for their medicinal and nutritional properties, and used in religious and sacred practices. Within indigenous cultures, strict taboos and restrictions have helped to regulate the use of traditional psychoactive substances. Whereas many indigenous communities have managed to maintain their traditional practices, many more have seen the erosion of their cultures in the face of assimilation and integration policies of dominant groups. The situation is extremely dynamic; as global economic development occurs, more communities are exposed to non-indigenous psychoactive substances. With no tradition of use and social controls, the introduction of new substances can be devastating. In some communities, the use of substances poses the greatest threat to their healthy development. Thus, it is not possible to promote health for all among indigenous peoples without addressing the problems associated with substance use.

Nations for Mental Health initiative

Nations for Mental Health is a global initiative of the WHO developed in collaboration with the Department of Social Medicine of the Harvard Medical School. Its aims are:

- To raise awareness of people, communities and governments of the world about the effects of mental, neurological and behavioural problems on psychosocial well-being and physical health.
- To promote and support the implementation of mental health policies around the world.
To create country level demonstration projects to serve as models for larger scale implementation.

Dementia, mental retardation, depression, schizophrenia and epilepsy are five examples of disabling mental and neurological problems which Nations for Mental Health will address. Each disorder adversely affects the ability of persons to function in society, and each has dramatic consequences for families and communities. Nations for Mental Health is primarily an initiative for undeserved populations. There exist a number of groups of people who, because of extremely difficult circumstances or conditions, are at special risk of being affected by the burden of mental problems. These groups include persons in extreme poverty, children and adolescents experiencing disrupted nurturing, abused women, abandoned elderly people, persons traumatized by violence in various forms, migrants, and many indigenous populations. Nations for Mental Health is currently in the process of issuing “An international overview of the mental health of indigenous peoples”.

**Special programmes in the Western Pacific Region**

In the Western Pacific Region, two countries have particularly active programmes. In Australia, programmes include increasing the availability of general medical practitioners and improving health services for sexually transmitted diseases, including HIV/AIDS. A national training and employment strategy, in partnership with Aboriginal communities, supports the development of a workforce for health service delivery to indigenous communities, especially those in rural and remote areas. The New Zealand government plans to increase the responsiveness of the health sector, with resource allocation priorities which take into account specific Maori health needs. A critical requirement to support improvements in Maori health status is an accelerated development of professional Maori health care.

**WHO/PAHO Initiative on the health of indigenous peoples**

In 1993, PAHO's indigenous health initiative was established in the context of the heightened attention on indigenous peoples that surrounded the 500th anniversary of the arrival of Europeans on the American continent. During this period, indigenous peoples and their organizations were able to capture the interest of the media, forge alliances with a range of social sectors, obtain government recognition, and lobby for supportive legislation. An ongoing dialogue was also established with international organizations that conduct programmes affecting the lives of indigenous peoples. Within this framework, the Canadian Government drew attention to the need to address the health of indigenous people. Recognizing the technical complexity and political implications of the issue, it was recommended that a regional consultative workshop be held. This workshop was held in Winnipeg, Canada, in 1993, under the sponsorship of the Canadian Society for International Health and other agencies, including the International Development Research Centre. Eighteen countries were represented in the consultation. The meeting brought together government officials, health professionals, indigenous organizations, international agencies and nongovernmental organizations. As a result, the initiative on the Health of Indigenous Peoples of the Americas was born.

Indigenous recommendations were incorporated into a report, adopted by PAHO's Directing Council and confirmed by the countries' Ministers of Health. PAHO's resolution, approved in September 1993, entails a commitment, at least at the policy level, of the member
Governments to give priority to the improvement of the health of indigenous peoples, and to respect their culture and ancestral knowledge. The resolution is based on the following principles that incorporate the fundamental concerns of indigenous peoples (PAHO, 1993b):

- The need for a holistic approach to health.
- The right to self-determination of indigenous peoples.
- The right to systematic participation.
- Respect for and revitalization of indigenous cultures.
- Reciprocity in relations.

Subregional meetings replicated the consultative process and served to sensitize not only PAHO's representatives but government officials as well. Indigenous leadership and participation has continued to be part of the planning and analytical aspects of the initiative. At the institutional level, there has been a predisposition to believe in the capacity and potential of indigenous peoples, to recognize the contributions of indigenous knowledge and culture, and to appreciate cultural diversity as an asset. At the country level, however, greater involvement of indigenous peoples and organizations needs to be achieved. Country level implementation of institutional directives is generally more problematic and difficult to monitor.

PAHO's initiative is in concert with the goal of achieving health for all and with the equity principles of health sector reform that accords priority to the provision of health care to the most vulnerable groups of the population. The initiative currently comprises four areas of work:

- Building capacity and alliances.
- Supporting the countries to implement the resolution.
- Mobilizing resources for projects that address priority health problems in vulnerable populations.
- Developing and strengthening health systems in multicultural communities.

Initial efforts focused on the promotion of intercultural training of human resources, and the elaboration of basic health indicators for indigenous peoples in the Americas.

The following are some of the tangible process-oriented products of the initiative:

- Adoption of Resolution V (Health of Indigenous People) by PAHO's Directing Council.
- Intersectoral regional workshops (Andean, 1994; Meso American, 1994).
- Collaborative agreement with the indigenous Parliament of the Americas (1996).
- Traineeship for indigenous health professionals.
- Regional meeting on traditional medicine (Guatemala, 1994).
- Working meeting on health policy and indigenous people (Quito, Ecuador, 1996).
- Working meeting on research and indigenous peoples (Washington DC, 1995).
- Sponsorship of country workshops on indigenous peoples and health, and facilitation of the establishment of task forces in countries.
Lessons learned

Six years after the launching of the PAHO initiative on the Health of Indigenous Peoples, it is important to reflect on its accomplishments and limitations. As an innovative approach to interethnic and intersectoral relations in the continent, the initiative has contributed significantly to the development of public policy. The implications of this approach and the lessons learned can provide insights for the sectors involved, and for those interested in the development of social policies in a world that has a precious yet undervalued asset: its cultural diversity.

In terms of public policy, the initiative's accomplishments have been as follows:

Promotion of intersectoral dialogue.

The PAHO initiative is innovative in several ways. First, it represents an institutional response to expressed needs of indigenous peoples. Second, indigenous participation and ownership is essential. Third, it requires multi-sectorial participation at the country level. Thus, governments and indigenous organizations must come together in a process of negotiation and consensus building. This type of initiative provides an opportunity for a horizontal, bidirectional joining of parties that often regard each other with mutual distrust.

Recognition of indigenous peoples as social actors.

Direct contact and involvement with international organizations accords recognition to indigenous peoples as social actors and strengthens their negotiating leverage with governments. Issues of common interest to indigenous peoples and international institutions include: the contribution of indigenous peoples' knowledge to achieving sustainable lifestyles, the protection of the environment, and the benefits of a holistic approach to health and development. The ability of indigenous peoples to mobilize funds and social support at the international level has a positive influence on the way in which local multisectoral relations are conducted. Indigenous peoples and organizations often have to deal with local governments from the standpoint of disenfranchised citizens with little lobbying capacity. International recognition of their cause increases their validity as social actors capable of participating in local governance.

Education of the Public.

Contributing factors to mistrust, prejudice and paternalism towards indigenous peoples are misinformation and lack of knowledge. A common pattern throughout the countries of the Region of the Americas is that the mainstream society in general, and professionals and public officials in particular, lack information and understanding of indigenous peoples. Even in those countries where indigenous peoples constitute a broad and evident sector of the population, explicit and covert social segregation and boundaries keep indigenous peoples invisible to the eyes and minds of the non-indigenous. Although often living in close contact, few venture into the indigenous social sphere. Even fewer do so without preconceptions of the superiority of Western culture. Socially constructed perceptions about the "invisible others" are blurred and arise from fear of the unknown. They are based on the distorted and prejudiced descriptions inherited from a history of colonial relations. Lack of mutual knowledge and misinformation hampers the possibility of dialogue and understanding. Recognizing this state of affairs, public information and education have been a main focus of activity of the indigenous movement.
Paucity of information has also been recognized by international institutions as one of the main barriers in the implementation of programmes related to indigenous peoples in the region. On one hand, there is disbelief in the capacity and potential of indigenous peoples to assume positions of leadership and management, and in the premise that traditional knowledge and ways of life constitute a sound basis for sustainable and prosperous communities. On the other hand, the aspirations of indigenous peoples to assume control over their collective and individual destiny have raised fears of segregation and separatism. Whether in one-to-one personal contacts or workshops and public forums, initiatives of international agencies contribute to bidirectional education and information, and to influencing public perceptions about indigenous peoples. They create opportunity for dialogue, where potentially conflictual issues can be explained and negotiated.

**Factors facilitating the initiative include the following:**

**Favourable socio-political conditions.**

At the time PAHO's initiative was launched, the indigenous social movement in the Region of the Americas had achieved a significant level of organization. Furthermore, the sociopolitical environment was conducive to public debate and civic participation. This is not to imply that similar initiatives cannot be launched under less favourable political conditions, but rather that, under such circumstances, opening channels of social participation and intersectoral dialogue may be a necessary component of the initiative.

**Tagged project funds.**

As with any other resource, the distribution and allocation of government funds is to a large extent a function of the lobbying capacity and political clout of each interest group within a country. Indigenous peoples are at a disadvantage, compared to other sectors of society, in lobbying for State funds. The drastic programs of economic reform programmes launched by governments in the region, coupled with the increase in the population living in poverty in the last decade, have reduced the capacity of the state to divert specific economic resources to meet the needs of indigenous peoples. The availability of international funds specifically tagged for indigenous peoples provide a response to the plight of those in greatest need. Alternative channels that allow direct allocation of funds to indigenous organizations and communities must be sought. However, when resources are managed through State agencies, indigenous leadership, ownership and participation must be ensured.

**Speaking a common language.**

Speaking a common language means a meeting of minds aimed at sharing value systems. Understanding the differences between concepts such as a "vision of the universe" and "human development" is bound to bear fruit in terms of common understanding of what is needed and how to formulate it. Indigenous perspectives on health, well-being, spirituality and traditional healing systems - in sum, the indigenous cosmvision - have been incorporated as part of the philosophy of the PAHO initiative. This process has entailed a revision and reassessment of the medical paradigm and its relevance to non-Western populations. The common language of the initiative and of indigenous peoples is conducive to developing mutual understanding and learning.
Reciprocal relations.

Reciprocal relations refer to dialogue and a will to learn and understand. These are factors that contribute to consolidating trust and more solid collaborative relations. PAHO has strived to establish a dialogue with indigenous peoples. It has promoted among professionals, within and outside of the institution, a predisposition to learning and a belief in the capacity of indigenous peoples. The social dynamics derived from this approach have facilitated the interrelationship of indigenous peoples with the institution and its representatives. The emphasis on this approach has been reaffirmed in a recent resolution of PAHO’s Directing Council (WHO/PAHO, 1997). This resolution states that, in recognition of the multicultural character and heterogeneity of the people in the region, the initiative’s plan of action will be based on a multicultural, multidirectional, intersectoral and interdisciplinary process of mutual learning and skill building.

PAHO’s evaluation of the initiative on the Health of Indigenous Peoples has highlighted the following setbacks and limitations that need to be addressed to improve the initiative’s effectiveness:

Lack of epidemiological data.

Few countries routinely collect and analyze vital, epidemiological or health service data by ethnicity. Therefore, it has been difficult to develop baseline data by country, and to have an adequate assessment of the health and living conditions of indigenous peoples in the Region. Future efforts will be directed at promoting the classification of core data by ethnicity, with the goal of monitoring inequalities in health status and access to services. In the short term, substitute indicators will be used, such as data by municipalities with 50% or more indigenous population as compared to national data. This database will permit a more efficient allocation of scarce resources. It will also permit further analysis of risk and protective factors by ethnicity.

Lack of recognition of ethnic diversity.

The majority of the countries in the Region have demonstrated interest or are actively participating in the initiative. However, a few have taken the position that they do not have an indigenous population or that all citizens have access to health services. They argue that there is no need to focus on a particular ethnic group. This may result from a lack of understanding of the attributes of distinct societies and cultures.

Equity and health care reform.

The countries in the Region have advanced in health sector reform. Equity and provision of essential health services for all is a stated guiding principle of this reform. However, the process is driven by an emphasis on privatization and economic efficiency. In order to comply with the equity principle of health care reform, governments should assume responsibility for providing quality and appropriate health services for indigenous peoples.

Limited indigenous participation.

Although the initiative has sought indigenous guidance, only a few of the large number
of organizations and communities throughout the continent are involved. Therefore, not enough progress has been made in systematic indigenous participation. Very few countries have established technical government commissions with indigenous representatives, although a number have developed inter-programmatic task forces or commissions in ministries of health. Governmental indigenous institutes do not always have visible indigenous involvement and do not consider health as a high priority.

*Slow indigenous mobilization to participate in intersectoral initiatives.*

At times, indigenous organizations are suspicious of the efforts of international or governmental institutions to establish a dialogue, without thoroughly assessing the potential benefits of the situation. When an undesirable outcome is feared, and the benefits of the situation are not clear, indigenous organizations may choose to withdraw from participating. This strategy is often a result of negative experiences in the past.

*Institutional deficiencies in tracking inter-programmatic efforts.*

Tracking inter-programmatic initiatives within PAHO that relate to indigenous peoples has been problematic, especially when a more general project includes a component or activities related to indigenous health. In the case of the initiative, this issue acquires special significance, since it entails the adoption of ethical and practical principles that may not be evenly understood or shared across programmatic areas within the institution. Monitoring compliance with guiding policies at the institutional level is problematic. This is even more difficult at the country level.

*Uneven commitment across PAHO’s programmatic areas.*

Another problem, common to large institutions, is the uneven level of interest and commitment to the initiative across different programmatic areas within PAHO. Given the high workload and demands of existing programmes, it is common to encounter the perception that most of the responsibility for carrying out the initiative falls on the initiative's own staff. The aims of the initiative and its development tend to be isolated from overall programmatic interests.

*Limited capacity to disseminate information about the initiative.*

PAHO's initiative and the adopted declaration constitute important tools for indigenous peoples and concerned health professionals since they express a governmental commitment to promote the participation and the health and well-being of indigenous peoples. Dissemination of this information in the countries, however, has been limited. This in part results from the limited capacity of PAHO to reach a variety of social sectors and to elicit the interest of some indigenous organizations, which may mistrust PAHO as a foreign institution. In response to these concerns, PAHO has produced and distributed a video and a brochure. It is nevertheless also important for indigenous peoples and their organizations to assume responsibility for inquiring, examining, assessing and socializing relevant information, especially when it has been delivered to them. Similarly, indigenous participants in regional consultative workshops must also assume responsibilities for information dissemination.
Deficiencies in resources mobilization.

Mobilization of economic resources in support of the initiative has been slow. Funding sources are fewer than initially expected. Barriers to accessing funds have not yet been clearly identified. PAHO will focus on efforts that can be carried out with limited additional resources, encourage programmes and countries to allocate small amounts of regular funds, and look for assistance from less traditional donors.

The barriers to effective implementation of the initiative include the following:

Human attitudes.

Human attitudes and behaviours are inherently difficult to modify. Human beings construct their perceptions and their view of the world as they process and internalize information from the physical and social environment that surrounds them. As a human being reaches maturity, behaviours and attitudes are normally ingrained in the individual personality. Behavioural change is by then a difficult process, and sometimes it is an impossibility. However, it is always worth attempting. As in every other aspect of human socialization, interethnic relations bear the burden of preconceptions and stereotypes that the social actors bring into the interaction. In developing a programme of action such as the Indigenous Peoples Health initiative, the individual ability to overcome potentially prejudiced preconceptions are of utmost significance. On the other hand, the inability to effectively overcome ethnic stereotyping and prejudget is a significant barrier to the development of constructive interethnic relations. The latest programme of action designed by PAHO (1997) takes into account a felt need expressed in almost every intersectoral workshop and consultation: the need to develop effective strategies for intercultural sensitivity training and skills development for health professionals and health sciences students.

Complexity of working through governments.

On one hand, working through government agencies provides opportunities for institutionalization and continuity of specific actions. On the other hand, it imposes on projects a slow pace and reduced effectiveness that may be avoided by direct involvement of indigenous organizations or communities. Effective indigenous participation and ownership require special efforts. Governments may be prone to seek participation only from indigenous organizations or communities that are political affiliates. Alternatives to working through governments should also be sought as a means of diversifying activities and approaches.

Coordination among indigenous organizations.

A barrier to the more systematic and widespread participation of indigenous peoples is their deficiency in developing effective mechanisms of coordination at the country level. Often, indigenous organizations appear fragmented, and to outsiders the internal politics of the indigenous movement may seem like a maze. Even though the existence of centralized indigenous organizations may facilitate the work of outside institutions, this may not be the choice of the local organizations or communities. In fact, in some cases, this will not be in their best interests. Nevertheless, the new opportunities for social participation require the development of some forms of indigenous coordination that will allow for effective interactions,
flow of communications, and participatory and expeditious decision-making.

**Implementation of international initiatives for indigenous peoples**

*In summary, the contributions of international initiatives are as follows:*

- Development of intersectoral dialogue and concordant public policy.
- Recognition of indigenous peoples as social actors.
- Education of the public.

*Factors that facilitate the implementation of international initiatives include:*

- Favourable sociopolitical conditions.
- Tagged project funds.
- Speaking a common language.
- Reciprocal relations.

*Limitations and setbacks likely to be faced by international initiatives for indigenous peoples include the following:*

- Cases in which there is a lack of recognition of ethnic diversity.
- Limited indigenous participation.
- Deficiencies in tracking inter-programmatic efforts.
- Uneven commitment across programmatic areas.
- Limited capacity to disseminate information about the initiative.
- Deficiencies in resource mobilization.
- Poor country-level coordination among indigenous organizations.
- Slow indigenous mobilization to participate in intersectoral initiatives.
- Unfavourable human attitudes.
- Complexity of working through government.
CONCLUSIONS
CONCLUSIONS

The conclusions listed below include those drawn from the main findings of this review as well as general conclusions drawn principally from the proceedings of meetings of indigenous peoples in the Region of the Americas.¹

Public action for supportive environments for health must recognize the interdependence of all living beings and must manage all natural resources taking into account the needs of coming generations. Indigenous peoples have a unique spiritual and cultural relationship with the physical environment that can provide valuable lessons for the rest of the world. It is essential therefore for indigenous peoples to be involved in sustainable development activities and negotiations that are conducted concerning their rights to land and cultural heritage.

Initiatives that involve indigenous peoples should be based on sound philosophical principles that ensure mutual understanding and respect. These principles include:

- The need for incorporation of a holistic world view.
- The decision-making rights of IPs over issues that affect their life.
- The right for systematic participation.
- Respect for and revitalization of Indigenous cultures and ways of life.
- Reciprocity in relations.

In terms of health conditions, the following conclusions may be drawn:

- Mortality and morbidity patterns among indigenous peoples reflect inequities and curtailment of their right to health.
- Tradition and culture provide health-promoting resources, such as social support network, self-sufficiency, and access to food and other material resources such as healthy diets.
- Environmental contaminants such as radioactivity, heavy metals, oil spills, and land displacement, pose significant risks for indigenous peoples, who are highly dependent on the environment for survival.

• Sociocultural factors associated with Western lifestyles are conducive to deterioration of health among indigenous peoples (e.g. severed social networks, perceived socioeconomic inequalities, stress as a result of discrimination, and disjunction between the material and spiritual world).

• The health situation of indigenous peoples is the end result of a historical process that has fostered dependency, loss of identity and marginalization.

• Indigenous peoples define and understand the circumstances surrounding their life in terms of multifactorial processes, rather than by taking a problem-specific approach.

With regard to health systems, the following conclusions may be drawn:

• Data on the health conditions of indigenous peoples around the world are indicative of inadequate access to health services and prevention programmes or of the cultural inappropriateness of the health care system.

• Barriers to health care include structural and economic factors, and lack of cultural sensitivity and appropriateness.

• Current evidence indicates that access to health services among social groups with low purchasing power, such as indigenous peoples, has been further limited by health sector reforms.

• The interaction between the Western medical establishment and traditional practitioners has been characterized by poor performance in terms of cultural sensitivity.

• The principles of the health for all strategy are compatible with, and serve as a basis for developing appropriate health systems for indigenous peoples.

• The development of appropriate health services requires the training of indigenous peoples in the health professions, and providing cultural sensitivity training to all health professionals. These are urgent tasks if culturally appropriate health care systems are to be developed.

• Health care planning requires capacity building within indigenous communities for monitoring and evaluating physical, mental, spiritual and cultural conditions, and for defining and implementing solutions.

With regard to the medicinal use of plants, it can be concluded that:

• Community-based and indigenous-led projects focusing on the systematization of knowledge about medicinal plants and their use in community health care reflect generally positive experiences.

• Current interest in the curative properties of plants is a source of concern among indigenous peoples and organizations. This uneasiness stems from a focus on potentially profitable products and from a disregard for the potential long-term detrimental effects
on health, culture and the environment of these commercial ventures

With regard to policy, the principles of equity demand immediate concerted actions on the part of governments and international agencies to ensure access to comprehensive and culturally appropriate health services, and to promote health development among indigenous peoples. Policy guidelines include:

- Promotion of indigenous ownership, and management of culturally appropriate health services for indigenous peoples.
- Strengthening and revitalizing traditional healing systems; promoting the articulation of Western and traditional healing systems, with mutual learning approaches.
- Promotion of respect for ethnic and cultural heterogeneity of indigenous peoples and understanding of the inadequacy of universal health care models.
- Promotion of joint efforts between indigenous peoples, governments and national and international governmental and nongovernmental agencies to address the complexity of the health situation of the indigenous peoples.
- Promotion of joint international action to set boundaries to development and ensure support for alternative indigenous self-development models.

Proposals for action

International agencies should take the following steps:

- Require the participation of indigenous peoples in the leadership and management of initiatives from the earliest stages.
- Establish a programme of international and national cooperation activities.
- Establish intra-institutional, inter-programme coordination.
- Provide support for workshops in countries, to promote dialogue, networking and the establishment of links between official institutions, nongovernmental organizations, and indigenous organizations.
- Provide technical assistance and cooperation through collaborative action programmes to countries, and to indigenous communities and organizations.
- Seek direct relations with communities and nongovernmental organizations in addition to working through governments.

Suggested activities include:

- Facilitating local programmes of action (technical assistance, fund-raising).
• Traineeships for indigenous health professionals.

• Programmes for cultural sensitivity training among health professionals.

• Elaboration of basic health indicators and health monitoring systems for indigenous peoples.

• Promoting intersectoral regional and national action plans.

Countries should ensure that the following measures are implemented:

• Establishment of multisectoral task forces (government, indigenous organizations, and nongovernmental organizations).

• Formulation of country policies and strategies at the local level, with indigenous leadership.

• All health projects and programmes for indigenous peoples should require indigenous leadership and ensure respect for the culture, values and traditions of indigenous peoples.

• Provide cultural sensitivity training to nonindigenous health workers who work with indigenous peoples.

• Universities and other training centres should provide scholarships to ensure that indigenous peoples have access to training in the health professions.

• Develop health monitoring systems for indigenous people, and build local capacity among indigenous communities for monitoring health status, risk and protective factors.
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APPENDICES

1. WHO COLLABORATION WITH UN. INTERNATIONAL DECADE OF THE WORLD'S INDIGENOUS PEOPLES REPORT TO THE DIRECTOR-GENERAL.

2. PAHO'S IP' INITIATIVE - RESOLUTION V.
International Decade of the World’s Indigenous People

Report by the Secretariat

Submitted to the Executive Board for information

BACKGROUND

1. This report is submitted in accordance with resolution WHA51.24. This resolution, cosponsored by 18 Member States, built on those of previous years; the principal difference being that it was based on recommendations presented by indigenous peoples at the third Healing Our Spirit Worldwide Conference (New Zealand, February 1998), and cosponsored by WHO. The resolution emphasized greater collaboration and technical support from WHO for indigenous peoples’ initiatives, the participation of indigenous people in WHO and the issue of traditional healing and medicines.

2. Poor socioeconomic conditions together with the loss of cultural cohesion have adversely impacted on the health of indigenous people. A considerable gap remains between good intentions and action, and indigenous people still experience serious problems and represent a high proportion of the poor. Access to health services and to health promotion and prevention programmes for indigenous people are limited, inadequate and frequently culturally inappropriate. Experience also indicates that programmes that ensure indigenous ownership and leadership and incorporate culturally specific approaches, including training, prove to be the most effective.

3. The principles of WHO’s current policy and strategy on the International Decade of the World’s Indigenous People are compatible with the health concerns of indigenous peoples, and could form the basis for developing appropriate health systems for them. To secure positive outcomes at national level, international initiatives need to be implemented in such areas as the development of intersectoral dialogue and concordant public policy, recognition of indigenous peoples as social actors, and education of the public.

4. During the sixteenth session of the working group on indigenous people (Sub-Commission on Prevention of Discrimination and Protection of Minorities, United Nations Commission on Human Rights, July 1998), WHO organized a forum on indigenous peoples and health, moderated by the co-chairman of the Committee on Indigenous Health, aiming to reach a better understanding of the respective roles of the Committee, indigenous nongovernmental organizations and WHO during the Decade. The forum set out
to clarify the health concerns of indigenous peoples so as to enable the Committee to recapitulate their health needs; to reach a better understanding of WHO's commitment and position; to understand the relationship between traditional medicine and health institutions and public policy; and to make recommendations to WHO and other organizations of the United Nations system.

5. The forum concluded that:

- indigenous peoples and their perspective on health should penetrate the policy-making process;

- the existing expertise and experience of voluntary organizations should be built upon and their role enhanced by involving them in monitoring programmes and initiatives;

- new communication technology, although held in suspicion, can be used in positive ways, e.g., to exchange ideas and views and to develop political energy to make the changes in health systems, programmes and policies identified by indigenous people.

6. During the working group session, the Committee acknowledged WHO's commitment to indigenous health. It did, however, express concern that as the mid-decade review approached, a comprehensive programme of action, with sufficient and appropriate resources and priority, had not yet emerged from the focal point for indigenous health during the International Decade. Moreover, interagency and intersectoral cooperation had so far failed to set clear goals and strategies to reduce health and related social disparities for the world's indigenous peoples.

7. Lastly, the Committee recommended, *inter alia*, that:

- the working group should re-examine and consider the recommendations of the Committee, as reflected in the report of the working group on indigenous people on its fifteenth session, in order to ensure the establishment of a comprehensive programme of action on indigenous health in consultation with representatives of indigenous peoples;

- the organizations and bodies of the United Nations system concerned with activities relating to health must share information on relevant programmes on a regular basis with the Committee and with organizations of indigenous peoples;

- health issues should remain a permanent item on the agenda of the working group to ensure that it continues to monitor closely progress regarding indigenous health issues.

**ISSUES**

8. Many of the activities outlined in the report of the Director-General on the International Decade to the Fifty-first World Health Assembly are being carried out according to plan.¹ Some examples for the Board's information are provided below.

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¹ Document A51/22.
9. WHO’s activities in traditional medicine in cooperation with WIPO have been developing a new focus on holders of indigenous and traditional knowledge of medicine. A feasibility study has started on the establishment of databases of traditional knowledge of medicine.

10. At the biennial meeting of the International Union for Health Promotion and Education (Puerto Rico, June 1998), WHO associated itself with the two main thrusts that emerged, namely, that in promoting the health of indigenous people it was important that governments should integrate such areas as education, social support and the physical environment; and that indigenous people should be included when engaging societies in action aimed at health promotion. Such intersectoral approaches will be taken forward in the intervening period and up to the next meeting of the Union in Paris in 2000.

11. The world’s indigenous people continue to be affected disproportionately by diabetes mellitus. The disease is particularly prevalent in indigenous Americans and Pacific Island populations, in which more than one-third of all adults may be affected. Diabetes may be accompanied by severe complications, but the risks can be substantially reduced by appropriate measures. Therefore, establishment of comprehensive diabetes programmes remains a priority for many indigenous communities.

12. Phase III of WHO’s project on indigenous peoples and substance use is currently being implemented with the assistance of an indigenous advisory group. Indigenous experts have visited communities in Argentina, Australia, Canada, New Zealand, Nicaragua, Philippines, Thailand and Tonga to provide technical assistance for the development of community-based programmes and policies for substance abuse prevention and treatment.

13. PAHO/WHO has focused on the development of processes and technical capacity to identify, monitor and eliminate inequities in health status and in access to basic health services by indigenous peoples. The 1998 edition of Health in the Americas includes an expanded section on the health of indigenous peoples, and information on health conditions of indigenous peoples in 17 countries. The subject of the mental health of indigenous peoples was addressed during a working group on mental health programmes and services in indigenous communities, organized by PAHO and WHO’s Nations for Mental Health initiative (Bolivia, July 1997).¹

14. In order to consolidate and strengthen these efforts, a consultative process is under way between WHO and institutions concerned with indigenous health, and indigenous representatives with a view to deciding upon the broad focus of a comprehensive programme of action for the remainder of the International Decade and beyond. A consultation foreseen in the first half of 1999 will bring together these and other partners from the international community, including ILO and the Centre for Human Rights to address the social, economic and political determinants of the health of indigenous peoples, and ways of circumventing obstacles that perpetuate their exclusion from the benefits of development and health.

³ See document OPS/HSP/HSO/98.12.
International Decade of the World’s Indigenous People

The Fifty-first World Health Assembly,

Recalling the role of WHO in planning for and implementing the objectives of the International Decade of the World’s Indigenous People as recognized in resolutions WHA47.27, WHA48.24, WHA49.26 and WHA50.31;

Noting the report by the Director-General to the Executive Board;¹

Further recalling United Nations General Assembly resolution 50/157, which adopted the programme of activities for the International Decade, in which it is recommended that “specialized agencies of the United Nations system and other international and national agencies, as well as communities and private enterprises, should devote special attention to development activities of benefit to indigenous communities”, that the United Nations system should establish focal points for matters concerning indigenous people in all appropriate organizations, and that the governing bodies of the specialized agencies of the United Nations system should adopt programmes of action for the Decade in their own fields of competence, “in close cooperation with indigenous people”;

Recognizing with satisfaction the progress made in the Initiative on the Health of Indigenous People of the Americas;

Noting the importance of the traditional medical knowledge of indigenous people;

Noting with appreciation the activities of the focal point for the International Decade,

1. URGES Member States:

To develop and implement national plans of action or programmes on indigenous people’s health, in close cooperation with indigenous people, which focus on: ensuring access of indigenous people to health care; supporting the participation of indigenous representatives in WHO meetings; ensuring health services are culturally sensitive to indigenous people; respecting, preserving and maintaining the knowledge of traditional healing and medicine in close cooperation with indigenous people; ensuring the active participation of indigenous people in identifying their health needs and appropriate research for developing strategies to improve their health status and the future direction of their health;

¹ Document EB99/23.
2. REQUESTS the Director-General:

(1) to promote the inclusion of indigenous health in the work programme at the country, regional and global level;

(2) to report annually to the World Health Assembly on progress on indigenous health initiatives globally, incorporating regional updates, and highlighting significant activities at the country level;

(3) to improve and increase, in close cooperation with indigenous people, institutional and technical cooperation between WHO and Member States in the area of indigenous people’s health, so that models of good practice in indigenous people’s health are shared, globally, regionally and between countries to inspire, compare and highlight the rich diversity of projects, experiences and approaches;

(4) to encourage the representation of health workers of indigenous origin in WHO work, including meetings;

(5) to promote in close cooperation with indigenous people, the respect, preservation, and maintenance of the knowledge of traditional healing and medicine, and to promote the equitable sharing of the benefits arising from the use of such knowledge, in conformity with trade and intellectual property conventions.¹

Tenth plenary meeting, 16 May 1998
A51/VR/10

¹ Conventions and agreements administered by the World Intellectual Property Organization and the World Trade Organization.
PAN AMERICAN HEALTH ORGANIZATION

APPENDIX III

The Health of the Indigenous Peoples Initiative

In 1992, given the evidence of the growing inequity in the health situation of indigenous populations and in their access to basic services, the Subcommittee on Planning and Programming of the Pan American Health Organization proposed to more thoroughly consider the health and well-being of indigenous peoples in the Americas. It initiated a process of consultation to determine what the Pan American Health Organization (PAHO) and its Member States should do in that regard.

In 1993, after a consultation workshop held in Winnipeg, Canada, in which delegates of indigenous organizations, peoples, and nations in the Hemisphere participated, as well as official delegations from the governments of eighteen countries, international agencies and nongovernmental organizations, the recommendations made were grouped together in a proposal entitled *The Health of the Indigenous Peoples Initiative*. That initiative was subsequently presented to the Governing Bodies of the Organization and adopted by the XXXVII Directing Council through Resolution CD37.R5.

The recommendations from the Winnipeg meeting and Resolution CD37.R5 establish five principles for work with indigenous communities, which guide the work, facilitate monitoring, and lay the groundwork for the evaluation of the processes at the end of the Decade, in the year 2004. Those principles are:

- The need for a holistic approach to health;
- The right to self-determination of indigenous peoples;
- The right to systematic participation;
- Respect for and revitalization of indigenous cultures; and
- Reciprocity in relations.

In addition, Resolution CD37.R5 (Annex C) provides the frame of reference for the activities of PAHO and its Member States, in collaboration with indigenous peoples themselves, for finding realistic and sustainable solutions to the serious problems in health and living conditions of many of these peoples throughout the Region.

The work during the first years of the Initiative, through the Regional Office and the Representative Offices in the countries, and the need to systematically implement the recommendations of the Winnipeg Workshop and the mandates in Resolution V contributed to the identification of strategies, areas of work, and clear goals in organizing the *PAHO/WHO Plan of Action for Promoting the Initiative in the Region of the Americas 1995-1998*.

To date, the work has focused on the following areas: strengthening the capacity and development of alliances; collaboration with the Member States to implement national and local processes and projects; projects in priority program areas; strengthening traditional systems and scientific, technical, and public information.

The following are some of the important lessons that have been learned in implementing Resolution CD37.R5 and the Health of the Indigenous Peoples Initiative. It is
from these lessons that the criteria for reorienting future work will be derived:

- The mobilization of resources has required more time than predicted when the Plan of Action was formulated in 1995.

- Closely following the interprogrammatic activities continues to be a problem, particularly when a general project includes a component or activities related to the health of indigenous peoples.

- Obtaining reliable data as a benchmark for the countries and adequately evaluating the health and living conditions of indigenous peoples in the Region have been difficult, because few countries systematically compile and analyze vital or service statistics that are broken down by ethnic group.

- Sufficient progress has not been made on the participation of indigenous representatives and organizations.

In 1997, the Directing Council reviewed the Progress Report and expressly reiterated its concern over the inequities in the health situation of indigenous peoples in the Region of the Americas and reaffirmed the commitment to the Health of the Indigenous Peoples Initiative. Taking into account the economic, geographic, and cultural obstacles in the effective and efficient provision of health services, the Directing Council adopted Resolution CD40.R6, at the eighth plenary session of the XL Meeting of the Directing Council on 25 September 1997. Resolution VI addresses the inequities, as well as obstacles in providing care, and reaffirms the Organization’s commitment to the International Decade of the World’s Indigenous Peoples.

The Health of the Indigenous Peoples Initiative is an opportunity to demonstrate our effort to recognize the rights of different peoples, in order to adapt public policies to their specific conditions, in search of equity. It is also a test of our commitment to the International Decade of the World’s Indigenous Peoples. In addition, it encourages the countries to detect and monitor the inequities resulting from belonging to an ethnic group, as well as to institute programs and launch processes to improve the health situation of the above-mentioned peoples and their access to health services.

In this context, PAHO convened the consultative meeting known as Strategic Orientations for the Implementation of the Health of the Indigenous Peoples Initiative, which is summarized in this document.¹

¹ The information submitted by the presenters is part of the Initiative archives.
RESOLUTION V

HEALTH OF INDIGENOUS PEOPLES

THE XXXVII MEETING OF THE DIRECTING COUNCIL,

Having seen Document CD37/20 on the initiative "Health of the Indigenous Peoples of the Americas";

Taking into account the recommendations formulated by the participants at the Working Meeting on Indigenous Peoples and Health, held in Winnipeg, Manitoba, Canada, from 13 to 17 April 1993;

Recognizing that the living and health conditions of the estimated 43 million indigenous persons in the Region of the Americas are deficient, as reflected in excess mortality due to avoidable causes and in reduced life expectancy at birth, which demonstrates the persistence and even the aggravation of inequalities among indigenous populations in comparison with other homologous social groups;

Considering the aspiration of indigenous peoples to take charge of their own institutions and ways of life, the need for them to assert their own identity, and the need to respect their rights with regard to health and the environment;

Recognizing the unique contribution that indigenous peoples make to the preservation of ethnic and cultural diversity in the Americas, to biodiversity and a balanced ecology, and, most especially, to the health and nutrition of society;

Emphasizing the need to take a new look at, and respect the integrity of, the social, cultural, religious, and spiritual values and practices of indigenous peoples, including those related to health promotion and maintenance and the management of diseases and illnesses; and

Reiterating the importance of the strategy for the transformation of national health systems and the proposal for the development of alternative models of care at the level of local health systems as a valuable tactical resource and a fundamental requisite for dealing with current problems relating to insufficient coverage, inadequate access, and the lack of acceptability of health services on the part of indigenous populations,
RESOLVES:

1. To adopt Document CD37/20, which describes the initiative "Health of the Indigenous Peoples of the Americas," and the report of the Winnipeg Working Meeting containing the conclusions and recommendations on which the initiative is based.

2. To urge the Member Governments:

   (a) To facilitate the establishment or strengthening of a high-level technical commission or other mechanism of consensus, as appropriate, with the participation of leaders and representatives of indigenous peoples, for the formulation of policies and strategies and the development of activities in the areas of health and the environment for the benefit of specific indigenous populations;

   (b) To strengthen the technical, administrative, and managerial capacity of national and local institutions that are responsible for the health of indigenous populations with a view to progressively overcoming the lack of information in this area and ensuring greater access to health services and quality care, thus contributing to a higher degree of equity;

   (c) To implement intersectoral actions, as appropriate in each case, in the areas of health and the environment both in the official sector and through nongovernmental organizations (NGOs), universities, and research centers that work in collaboration with indigenous organizations;

   (d) To promote the transformation of health systems and support the development of alternative models of care, including traditional medicine and research into quality and safety, for indigenous populations within the local health system strategy;

   (e) To promote the development of disease prevention and health promotion programs in order to address these problems and the most important areas relating to indigenous health in their countries.

3. To request the Director, within the limits of available resources:

   (a) To promote the participation of indigenous persons and their communities in all aspects of PAHO's work on the health of indigenous persons;

   (b) To identify technical cooperation resources within existing cooperation programs and provide support for the mobilization of additional resources at the international and national level for implementation and evaluation of the initiative "Health of the Indigenous Peoples of the Americas";
(c) To coordinate the regional effort by promoting the establishment of information and mutual cooperation networks between organizations, centers, and institutions whose activities are concerned with the health of indigenous peoples, organizations, and communities, enlisting the Organization's existing mechanisms, initiatives, and programs at the regional level and in the countries and also seeking the cooperation of other agencies and organizations;

(d) To expand the evaluation of living conditions and the health situation to include the indigenous peoples of the Region, with a view to gradually overcoming the current lack of information in this area at both the regional and the country level;

(e) To promote collaborative research at the regional level and in selected countries on high-priority health issues and health care for indigenous peoples.

(Adopted at the fourth plenary session, 28 September 1993)
HEALTH OF INDIGENOUS PEOPLES - RESOLUTION VI

THE XL DIRECTING COUNCIL,

- Having examined the report on the health of indigenous peoples (Document CD40/14);

- Recognizing the growing evidence of inequities in health status and access to basic health services for the estimated 43 million indigenous persons in the Region of the Americas; and

- Considering the economic, geographic, and cultural barriers to the efficient and effective delivery of public health and personal health care services in isolated rural and marginal urban areas in most countries,

RESOLVES:

- To take note of the report on progress in the implementation of Resolution CD37.R5, to reaffirm the commitment to the goals of the Decade of the World’s Indigenous Peoples, and to approve the activities proposed in Document CD40/14.

- To urge the Member States, in the process of the implementation of health sector reform, to be persistent in efforts to detect, monitor and reverse inequities in health status and access to basic health services for vulnerable groups, including indigenous peoples.

- To call to the attention of Member States that renewal of the goal of health for all requires that sustainable solutions are found to address the economic, geographic, and cultural barriers to adequate care for vulnerable groups.

- To request the Director to continue his efforts to implement the Health of Indigenous Peoples Initiative.

(Adopted at the eighth plenary session, 25 September 1997.)
# CONTACTS FOR THE HEALTH OF INDIGENOUS PEOPLES

<table>
<thead>
<tr>
<th>NAME/ADDRESS</th>
<th>TEL/FAX/E-MAIL</th>
</tr>
</thead>
</table>
| Esther van der VELDE | Tel: (022) 917 91 90  
OHCHR, unog  
1211 Geneva  
(Office of the High Commissioner for Human Rights)  
Fax:  
E-mail: evandervelde.hchr@unog.ch |
| Roberto De VOGLI | Tel:  
WHO Internship Programme  
Department of Substance Abuse  
1211 Geneva 27  
Fax:  
E-mail:devogli@interplanet.it |
| Julian BURGER | Tel: (022) 917 92 72  
OHCR, UNOG  
1211 Geneva 10  
Fax: (022) 917 90 10  
E-mail:jburger.hchr@unog.ch |
| Annick THEBIA-MELSAN | Tel: (022) 917 93 43  
OHCR, UNOG  
Fax:  
E-mail: athebiamelans.hchr@unog.ch |
| Jacqueline SIMS | Tel: (022) 791 37 55  
World Health Organization  
SDE/HSD  
1211 Geneva 27  
Fax: (022) 791 41 53  
E-mail:simsj@who.ch |
| Paolo HARTMANN | Tel: (022) 791 27 35  
World Health Organization  
SDE/HSD  
1211 Geneva 27  
Fax: (022) 791 41 53  
E-mail:hartmanp@who.ch |
| Eugenio POMA | Tel: (022) 791 62 09  
WCC/IVP  
Fax:  
E-mail: EPA@WCC-coe.org |
| Jaime QUISPE | Tel: 059 450 49 40 80  
Fax:  
E-mail: Quispe.jaime@wandeo.fr |
| Claude AUROI | Tel: (022) 740 34 33  
DOcip  
14, avenue de Trembley  
1209 Genève  
In charge: Pierrette Birraux-Ziegler  
Fax: (022)  
E-mail:docip@iprolink.ch  
Http://www.docip.org |
| Wend WENDLAND | Tel: (022) 338 99 24  
WIPO  
34, Chemin des Colombettes  
1211 Geneva 20  
Fax: (022) 338 81 20  
E-mail:wend.wendland@ipo.int |
<table>
<thead>
<tr>
<th>NAME/ADDRESS</th>
<th>TEL/FAX/E-MAIL</th>
</tr>
</thead>
</table>
| Chandra ROY                             | Tel: (022) 799 65 43  
ILO                                                   
4, Route des Morillons  
Geneva                                                |
|                                         | Fax: (022) 799 64 89  
E-mail: roy@ilo.org                               |
|Henriette RASMUSSEN                      | Tel: (022) 799 64 17  
ILO, Box 500                                        
1211 Geneva                                        |
|                                         | Fax: (022) 799 64 89  
E-mail:rasmussen@ilo.org                          |
|John HENRIKSEN                           | Tel: (022) 917 91 42  
OHCHR, UNOG                                        
1211 Geneva                                        |
|                                         | Fax:  
E-mail:Henriksen.hchr@unog.ch                    |
|Atencio LOPEZ                            | Tel: 507-227-5886  
Casa3-8 Bella Vista  
Ciudad de Panama  
Panama                                               |
|                                         | Fax: 507-225-4105  
E-mail:napguana@pty.com  
E-mail:atencio@inkarri.net                        |
|Ken COURCHENE                            | Tel:  
Chief Executive Officer  
Sagkeeng Treatment Centre  
PO Box 5                                              
Fort alexander, MB ROE OPO  
Canana                                               |
|                                         | Fax:  
E-mail:  
E-mail:  |
|Maggie HODGSON, LL.D (Hons)              | Tel & Fax: (502)755-1420  
Training & Research Division  
Nechi                                               
PO Box 34007                                        
Kingsway Mall Edmonton, AB T5G 3G4  
Canada                                              |
|                                         | E-mail:otdqui@ios.org-gt  
E-mail:otdqui@ops.org.gt                           |
|Juan Jose ESCALANTE                      | Tel: 403-235-0731  
Oficina Sanitaria Panamericana  
OTD Quiche                                          
Local Comercial La Terminal, Local No.14 Zona 5  
Santa Cruz del Quiche, El Quiche  
Guatemala                                           |
|                                         | Fax: 403-291-1490  
E-mail:meldrjo@nucleus.com                        |
<table>
<thead>
<tr>
<th>NAME/ADDRESS</th>
<th>TEL/FAX/E-MAIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rhonda GRIFFITHS</td>
<td>Tel &amp; Fax:011-6723-22465</td>
</tr>
<tr>
<td>P. O. Box 612</td>
<td></td>
</tr>
<tr>
<td>Norfolk Island 2899</td>
<td></td>
</tr>
<tr>
<td>Norma MONTEYA</td>
<td>Tel &amp; Fax:011-91-735-6-07-32</td>
</tr>
<tr>
<td>Alepete Nahauas de la Montana de Guerrero</td>
<td></td>
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<tr>
<td>Alvarez No.3</td>
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<td>GRO</td>
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<tr>
<td>Mexico</td>
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<tr>
<td>Jose MORALES</td>
<td></td>
</tr>
<tr>
<td>Association Tohil MORALES (OTM)</td>
<td></td>
</tr>
<tr>
<td>des enfants Mayas du Guatemala</td>
<td></td>
</tr>
<tr>
<td>35 rue pres des audigers</td>
<td></td>
</tr>
<tr>
<td>91820 BOUTIGNY</td>
<td></td>
</tr>
<tr>
<td>France</td>
<td></td>
</tr>
<tr>
<td>Lyle MORRISEAU</td>
<td>Tel: 204-367-2287</td>
</tr>
<tr>
<td>Box 78</td>
<td>204-367-9629 (home)</td>
</tr>
<tr>
<td>Sagkeeng, Ojibway Nation</td>
<td>Fax: 204-367-4315</td>
</tr>
<tr>
<td>Ancinabce Territory</td>
<td></td>
</tr>
<tr>
<td>Manitoba, Canada ROE OPO</td>
<td></td>
</tr>
<tr>
<td>Charon ASETOYER (Comanche)</td>
<td>Tel: 605-487-7072</td>
</tr>
<tr>
<td>P. Box 572</td>
<td>Fax: 605-487-7964</td>
</tr>
<tr>
<td>Lake andes, SD 57356</td>
<td>E-mail:<a href="mailto:comanche@charles-mix.com">comanche@charles-mix.com</a></td>
</tr>
<tr>
<td>Terrance NELSON</td>
<td></td>
</tr>
<tr>
<td>Box 346</td>
<td>Tel: 204-427-2312</td>
</tr>
<tr>
<td>Letellier, Manitoba</td>
<td>Fax: 204-427-2584</td>
</tr>
<tr>
<td>Canada ROG 1C0</td>
<td></td>
</tr>
<tr>
<td>Vincent M. Ole NTKERET</td>
<td>Tel &amp; Fax: 011-254-305-2083</td>
</tr>
<tr>
<td>MAA Development Association</td>
<td></td>
</tr>
<tr>
<td>P.O. Box 231</td>
<td>E-mail:<a href="mailto:maa@inconnect.co.ke">maa@inconnect.co.ke</a></td>
</tr>
<tr>
<td>Warok, Kenya</td>
<td></td>
</tr>
<tr>
<td>Rosemary ROE (Australian Aborigine)</td>
<td>Tel:011-08-99-411614 (home)</td>
</tr>
<tr>
<td>31 Fane Crescent</td>
<td>Fax:011-08-99-413780 (CDEP)</td>
</tr>
<tr>
<td>Carnavon 6701</td>
<td></td>
</tr>
<tr>
<td>Western Australia</td>
<td></td>
</tr>
<tr>
<td>Laifungbam ROY (Meitei people)</td>
<td>Tel: 011-91-385-228169</td>
</tr>
<tr>
<td>CORE (Ctr. For Org., Research and Education)</td>
<td>Fax: 011-91-385-228169</td>
</tr>
<tr>
<td>Yaiskul, Imphal</td>
<td>011-91-385-222936</td>
</tr>
<tr>
<td>795001 Manipur, India</td>
<td></td>
</tr>
<tr>
<td>NAME/ADDRESS</td>
<td>TEL/FAX/E-MAIL</td>
</tr>
<tr>
<td>--------------</td>
<td>----------------</td>
</tr>
</tbody>
</table>
| Germaine TREMMEL (Lakota)  
P. O. Box 8882  
Lake Street Station  
Minneapolis, NM 55408 |  |
| Elaine WRIGHT (Lakota)  
P. O. Box 459  
Lower Brule, SD 57548 |  |
| Steten LARKIN  
Chief Executive Diector  
National Secretariat  
National Aboriginal Community Controlled Health Organizatin Inc.  
P. O. Box 168  
Deakin West  
ACT 2600 | Tel: 06-282 7513  
Fax: 06-282-7516  
E-mail:steve@naccho.org.au |
| Jorunn EIKJOK  
Senior Officer  
Sami Centre  
University Hospital  
9037 Tromsoe  
Norway | Tel: 47-77676984  
Fax: 47-77626680 |
| Sandra LAND  
World Health Organization  
Regional Office for the Americas/  
Pan American Sanitary Bureau  
525, 23rd Street N.W.  
Washington, D.C. 20037  
USA | Tel: 1 202 974 3000  
Fax: 1 202 974 3663 |
| Ted WEBSTER (formerly WHO Focal Point)  
196 rue Reculet  
F-01710 Thoiry  
France | Tel: (059) 450 41 21 31  
Fax: |