

# Report of the International Consultation on the Health of Indigenous Peoples



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## 1. Introduction and background

The Constitution of the World Health Organization (WHO) recognizes the right to health as a fundamental human right, and its mission is the attainment for all people of the highest possible level of health. WHO focuses on vulnerable population groups as an integral part of its activities and is currently strengthening its work in the area of indigenous peoples' health within the framework of the International Decade of the World's Indigenous People<sup>1</sup>.

Through resolutions adopted by the World Health Assembly, WHO is committed to taking an active role in the health of indigenous peoples (WHA 47.27, WHA 48.24, WHA 49.26, WHA 50.31, WHA 53.10). At the 51<sup>st</sup> World Health Assembly in May 1998 Resolution WHA 51.24, co-sponsored by 18 Member States, urged Member States "... to develop and implement national plans of action or programmes on Indigenous Peoples' health in close co-operation with Indigenous Peoples". It also emphasized the need for greater collaboration and technical support from WHO. In January 1999, a report to the Executive Board was submitted for information in accordance with the requirements of Resolution WHA 51.24.

WHO's response included the convening, in November 1999, of the International Consultation on the Health of Indigenous Peoples which is the subject of this report. This meeting was organized by the Department of Health in Sustainable Development (HSD)<sup>2</sup> within the cluster on Sustainable Development and Healthy Environments (SDE), jointly with the Committee on Indigenous Health (COIH), an informal group of indigenous peoples.<sup>3</sup> The Consultation was attended by 149 observers and participants, including indigenous representatives from the five continents and officials of the United Nations' agencies and governments. The opening address was given by the Director-General of WHO, Dr Gro Harlem Brundtland (see Annex 1).

### Purpose of the Consultation

The aim of the Consultation was to initiate, in partnership with indigenous peoples, the development of appropriate policy to address and promote the right to health of indigenous peoples for the International Decade and beyond. It was intended that the policy would be implemented through a global plan of action developed jointly by indigenous peoples and key stakeholders, such as WHO, other UN agencies, nongovernmental organizations (NGOs), and governments. As the lead UN agency in the health field, it was acknowledged that WHO would have an important role in facilitating the development and promoting the implementation of the global plan of action. The global plan of action is intended to guide the development by individual stakeholders (including WHO) of workplans for indigenous peoples' health.

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<sup>1</sup> The International Decade of the World's Indigenous People was launched in 1994, with the purpose of facilitating indigenous peoples' development globally (UN General Assembly Resolution 10/157)

<sup>2</sup> HSD is now the Department of Health and Development (HDE).

<sup>3</sup> COIH is an informal group of indigenous peoples, created in 1997 by the Indigenous Peoples' Caucus during the 15<sup>th</sup> session of the Working Group on Indigenous Populations, Sub-Commission on the Promotion and Protection of Human Rights, Commission on Human Rights.

## Objectives

The objectives of the Consultation were:

- 1) To provide key elements for the development of WHO policies, strategies, and recommendations for the protection and promotion of the right to health of indigenous peoples.
- 2) To identify and recommend specific mechanisms to ensure the partnership of indigenous peoples in the work of WHO at the global, regional, and country level.
- 3) To identify ways in which WHO might work more effectively with other partners to ensure the protection and promotion of the right to health of indigenous peoples.
- 4) In partnership with the COIH (Committee on Indigenous Health), to identify the process for developing and finalizing a comprehensive and sustainable global plan of action on the health of indigenous peoples.

The objectives were ambitious, in view of the fact that this was the first international consultation of its kind held by WHO. Although none of the objectives was fully met, substantial progress was made towards each, and the consultation represented a major step in an ongoing process to facilitate indigenous peoples' overall health development.

## **2. Process**

Parity between indigenous and non-indigenous representatives (including governments and other agencies) was a leading principle of the Consultation. Only indigenous peoples' representatives were full participants and responsible for formulating the recommendations listed on pages 16-19 of this report. Representatives of Member States and of intergovernmental and non-governmental organizations had observer status (see list of participants, Annex 2).

Preparations for the Consultation were made on a participatory basis. The active involvement of the COIH and other indigenous representatives in the planning process ensured that indigenous peoples' perspectives were reflected. The agenda (Annex 3) and criteria for the selection of participants were jointly defined. However, the agenda was modified during the meeting due to time constraints. The selection criteria required participants to have expertise in health with a comprehensive understanding of indigenous health and development issues, and to be supported by their communities and regional organizations. Two participants were invited from each geographical region to obtain equitable representation. Other relevant criteria were the balance between north and south, and gender balance.

In inviting government representatives, countries were selected according to a mix of the following criteria: significant indigenous population, existing legislation or policy on indigenous peoples (i.e. ratification of International Labour Office Convention 169 on Indigenous and Tribal Peoples), other interesting and relevant

experience relating to the health of indigenous peoples, and the need to ensure a balance between north and south, as well as large and small countries. WHO Regional Offices were requested to suggest three countries from their regions, whose governments were subsequently invited to send representatives.

The Consultation was chaired by *Professor Erica Daes*, Greece (Chairperson-Rapporteur of the United Nations Working Group on Indigenous Populations) and co-chaired by *Jose Carlos Morales* (COIH, Costa Rica) who was nominated by the Indigenous People's Health Caucus. Interpretation into English, French, Russian, and Spanish was provided.

The first day of the Consultation was dedicated to the provision of background information on relevant issues concerning indigenous peoples' health. The main topics presented were related to the importance of health and development for indigenous peoples, policy issues, research needs, existing rights mechanisms, and determinants of health. A briefing was also provided on how WHO is organized and its methods of work. An overview of WHO structure and current activities is included as Annex 5.

In parallel but independent of the Consultation, the Committee on Indigenous Health (COIH) organized a preliminary **Indigenous Peoples' Health Caucus** with the exclusive participation of indigenous peoples' representatives. The Caucus, held at the World Council of Churches, was chaired by *Dr Roy Laifungham*, co-chair of COIH. The Caucus continued to meet each evening during the week of the Consultation to discuss and prepare a Declaration. On the final day of the Consultation, the Caucus presented "The Geneva Declaration on the Health and Survival of Indigenous Peoples" (Annex 4).

### **3. Report on major issues discussed**

#### **3.1 Health of indigenous peoples**

There are an estimated 300 million indigenous and tribal people worldwide. They comprise about 5000 – 6000 distinct groups in over 70 countries, with a diverse range of culture, heritage, language, and other characteristics.

The vitality of their civilizations and their capacity to adapt to change is exemplified by their survival in the face of adversity, which has varied from systematic dislocation from their lands and pollution of their environments to cultural repression, forced separation of families, and genocide. However, these challenges to their integrity and survival have been costly. Today, most indigenous peoples are marginalized socially, economically, politically, and culturally. The extent of this marginalization is most clearly reflected in the health status of indigenous peoples around the world: typically there are wide disparities between the health status of indigenous and non-indigenous peoples within the same country.

Health, and the generally poor health conditions prevalent in communities, is one of the major concerns of indigenous peoples. Life expectancy at birth can be from 10-21 years lower than in the rest of the population, and infant mortality is often 1.5 to 3 times greater than the national average. Malnutrition, and parasitic and

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

Indigenous peoples suffer disproportionately from psychosocial problems resulting in alcoholism, high rates of suicide, depression, and violence. They are also increasingly affected by non-communicable diseases such as diabetes, obesity, and cardiovascular disease, often the result of changes in diet and lifestyle. Substance abuse (involving alcohol, tobacco, and drugs) is an additional concern.

There is increasing evidence that indigenous peoples do not have full access to health care. The reasons include lack of cultural sensitivity in health care systems, financial constraints, and geographical barriers. Meanwhile, traditional health systems remain a key component of indigenous peoples' health development. Participants sought greater recognition of traditional healing and asked WHO to review traditional health practices, in close consultation with indigenous peoples, to determine their overall acceptability in relation to traditional and international standards. There was also concern that traditional healing knowledge is being lost and that attention should be given to the retention and transmission of this knowledge.

### **3.2 Major health challenges**

#### Determinants of health

Indigenous peoples' define health in holistic terms and emphasise the interconnectedness of physical, spiritual, mental, and emotional health. Health also has cultural, political, and social dimensions for indigenous people. For example, the unique relationship between indigenous peoples and their land is fundamental to spiritual and physical health. This was emphasized by the Consultation Chairperson, *Professor Erica Daes*, who commented: "land is health, oppression is disease." Indigenous peoples have also emphasized the critical link between the health of their communities and control over their own development, lands, and natural resources. It was noted that the health of the individual is dependent on the overall health of their communities, and that this in turn requires cultural integrity and vitality. Participants underlined the value of indigenous peoples' concepts of health and healing systems and their potential contribution to all humanity.

It is now widely accepted that the major determinants of health are outside the direct influence of the health sector. Dr Cindy Kiro, a Maori participant from New Zealand, gave a presentation on the broad determinants of health from an indigenous peoples' perspective.

She stressed that social, economic, cultural, and political factors are of particular significance in considering the health of indigenous peoples, who are often socio-economically, culturally, and politically marginalized. National development and the wider process of globalization have tended to aggravate health conditions for indigenous peoples. There was concern about human rights, public health, the environment, and the impact of globalization (particular reference was made to the WTO process and the rules-based multi-lateral trading system). The interrelated factors of environmental degradation and pollution, the alienation of land, poverty,



and the aggressive expansion of industry (through logging, mining, dams and agribusiness, for example) were identified as threats to the health of indigenous peoples. It was also noted that environmental contaminants have a disproportionate impact on indigenous peoples. Other areas of concern included forced cultural and linguistic assimilation, nuclear testing (i.e. in the Pacific), forced sterilization and ethical issues relating to the human genome diversity project and to intellectual property and biotechnology.

### Human rights

The keynote speaker, Mr Wilton Littlechild from the Four Cree Nations, Canada, highlighted several international legal instruments which addressed the situation of indigenous peoples.

Some participants suggested that WHO should incorporate reference to existing international instruments on the health of indigenous peoples into its policy framework. Examples of relevant instruments are the International Labour Office Convention 169, the Convention on the Rights of the Child, the Convention on Biological Diversity, the Framework Convention on Climate Change, the Convention on Desertification, and the Berlin Agenda. In addition, the UN Working Group on Indigenous Populations has prepared a Draft Declaration on the Rights of Indigenous Peoples which is currently under discussion and is expected to be finalized in the course of the International Decade of the World's Indigenous People (1994-2003).<sup>4</sup> The rights pertaining to health in the Draft Declaration are compatible with the values of the WHO Health for All policy for the 21<sup>st</sup> Century. A declaration on the rights of indigenous peoples is also being considered in the Organization of American States. A number of participants expressed the need to ensure the protection of rights to health enshrined in agreements settling internal conflicts, such as the 1996 peace accords of Guatemala. Effective implementation of these existing instruments will be important during the remaining five years of the International Decade for the World's Indigenous People. Meanwhile, at the national level, the right of indigenous peoples to the highest attainable level of health and well-being should be reflected in constitutions, national legislation, and government policies and strategies.

Participants stressed the importance of determining the key components of indigenous peoples' right to health. Relevant human rights provisions include Article 25 of the Universal Declaration of Human Rights, Article 12 of the International Covenant on Economic, Social and Cultural Rights, International Labour Office Convention 169, and the Declaration on the Right to Development. In his presentation, Mr Julian Burger, Indigenous Team Leader of the UN Office of the High Commissioner of Human Rights (UNHCHR), identified some elements which might help in defining indigenous peoples' right to health. They include:

- 1) The right to specific measures in connection with indigenous peoples' health (the Draft Declaration of the Rights of Indigenous Peoples proposes specific treatments/measures);
- 2) The right to culturally appropriate health services;

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<sup>4</sup> Resolution 1994/45 of the Sub-Commission for the Promotion and Protection of Human Rights, Commission of Human Rights.

- 3) The right to control health delivery and services (Article 23 of the Draft Declaration contains the right to determine and develop all health programmes and priorities, recognizing that mainstream health delivery can be counterproductive);
- 4) The right to have traditional medicine recognized and respected (Article 24 of the Draft Declaration);
- 5) Recognition that the health of the individual is linked to the health of the society and has a collective aspect;
- 6) The right to determine priorities for development. This right is particularly important in view of the major negative impact of some so-called 'development' projects.

It was asked how existing human rights frameworks could be used more effectively to mobilize changes in attitudes. To this end, it was suggested that human rights instruments be used as a tool to improve accountability.

### 3.3 Strategies and approaches to promote the health of indigenous peoples

#### Policy Development

A Framework for Indigenous Peoples' Health Policy was presented by Ms Mihi Ratima, a Maori national working with HSD to prepare the Consultation. The Framework was accepted as a basis for the development of indigenous peoples' health policy. It is relevant not only to the development of WHO policy related to indigenous peoples' health, but can also be applied by a range of global, international, and national organizations (including other UN agencies and governments) in the development of indigenous peoples' health policy. It is based largely on a review of national health policies and strategies for indigenous peoples' health. The Framework is summarized in the box below, and outlined in greater detail in Ms Ratima's background paper "A Framework for Indigenous Peoples' Health Policy".

#### **Framework for Indigenous Peoples' Health Policy**

<b>Pre-requisites</b>	<b>Characteristics of the approach</b>	<b>Principles</b>
<ul style="list-style-type: none"> <li>Respect for fundamental Human rights</li> </ul>	Interconnectedness	Cultural responsiveness
		Intersectoralism
		Vertical integration
<ul style="list-style-type: none"> <li>Recognition of indigenous peoples</li> </ul>	Self-determination	Control
		Capacity-building
		Intellectual property
<ul style="list-style-type: none"> <li>Political will of the State</li> </ul>	Equity	Quality information
		Accountability
		Resourcing

The Framework identifies three prerequisites to addressing the health needs of indigenous peoples: respect for fundamental human rights; recognition of indigenous peoples; and the political will of States. It is not possible to address the health needs of indigenous peoples without first ensuring that their most basic human rights are respected. This does not mean that all human rights issues must be resolved as a prerequisite to health policy development, but that there must at least be respect for the most fundamental human right: the right to life. The second prerequisite is the recognition of indigenous peoples as a distinct group, and the third is the political will of states to ensure indigenous peoples' right to health.

The approach to indigenous peoples' health development is characterized by three inter-related themes: interconnectedness, self-determination, and equity. Each of these themes is in turn associated with three principles. The theme of interconnectedness argues that indigenous peoples' health cannot be separated from their wider development, and that indigenous peoples' concepts of health are based on an holistic perspective. The principles associated with the theme of interconnectedness are cultural responsiveness, intersectoralism, and vertical integration. Cultural responsiveness requires recognition that indigenous peoples' ways of conceptualizing the world are valid. This in turn requires policies and strategies that, among other things, respect and affirm cultural preferences. Intersectoralism recognizes that indigenous peoples' health is inextricably linked to a wide range of other sectors which influence their wider social, cultural, economic, and political development. Vertical integration involves the co-ordination of approaches at different levels to ensure, for example, that policies for the health of indigenous peoples are consistent at the global, international, regional, and country level.

Self-determination in the context of health refers to the promotion of opportunities for indigenous peoples to gain a greater degree of control over their own health. The key principles involved are: control; capacity-building; and intellectual property. Control refers to the active participation of indigenous peoples as leaders of their own health development, while capacity-building recognizes the need to focus on strengthening the capacity of indigenous communities to more effectively control their own health development. The need for capacity-building also extends to a range of agencies (including governments and United Nations agencies) to enable them to work more effectively in addressing the health needs of indigenous peoples. The principle of intellectual property refers to the recognition of indigenous peoples' intellectual property rights both to their customary knowledge and to knowledge developed through indigenous processes.

Equity for indigenous peoples means having equal opportunities to achieve their full potential, as defined in their own terms. The key principles involved are: quality information; accountability; and, resourcing. Quality information provides a basis for sound health policies, strategies, and activities that contribute to indigenous peoples' health development. Accountability requires that all stakeholders should be held accountable through formal mechanisms for their progress in addressing indigenous peoples' health issues. The principle of resourcing recognizes that since indigenous peoples are marginalized, additional resources will be required if they are to have a realistic chance of attaining equitable health outcomes. And to attain their full health potential, indigenous peoples must have access to cultural resources such as their lands, natural resources, and traditional healers.

## Research and analysis

A presentation by Dr Ethel Wara Alderete, a Calchaqui Indian from the University of Jujuy, Argentina, outlined current knowledge, research needs, and approaches to the health needs of indigenous peoples. These topics were widely discussed throughout the consultation.

Participants underlined the importance of developing a sound information base to inform health policy. They also emphasized the right of indigenous peoples to information on health issues, which would enable them to exercise a greater degree of control over their own health needs. Member States were encouraged to disseminate health information to indigenous peoples living in remote areas and to communicate this information in a way that can be understood – even by people who are illiterate. Participants also urged WHO to ensure that indigenous peoples are informed in advance about meetings and activities relating to the health of indigenous peoples in order to encourage their participation.

Many countries do not routinely collect data which is disaggregated by ethnic group. As a result, it is difficult to obtain reliable data on the health of indigenous peoples. It was proposed that governments systematically collect health statistics disaggregated by ethnicity, and that a rapid assessment of the state of indigenous peoples' health be carried out in all regions. It was also recommended that support should be provided to enable indigenous peoples to participate as health researchers – through providing training in data collection, for example, to enable them to become field workers.

A key recommendation was that indigenous peoples should formulate a research agenda which identifies research priorities. Priority areas identified included: noncommunicable and infectious diseases; mental health; substance abuse; risk factors, and protective factors. Other possible research areas included: the relationship between land loss and poor health; the measurement of the health impact of large-scale development interventions; traditional healing practices and systems; patenting and commercial use of traditional medicines and practices; and whether validation of traditional practices would promote increased understanding and articulation of indigenous healing systems.

Another recommendation was the development of a database comprising government institutions with responsibilities for indigenous peoples' health and relevant research institutions involved in indigenous peoples' health issues. It was also suggested that a series of WHO collaborating centres be established to facilitate research in the field of indigenous peoples' health. In addition, WHO was urged to develop a web-site on the health of indigenous peoples.

## Capacity-building

The capacity of indigenous peoples to lead their own health development has been restricted by their limited access to development opportunities. Therefore, there is a need to focus on capacity-building to enable indigenous communities to more effectively guide their own health development.

Proposed activities aimed at developing indigenous peoples' health research capacity included the creation of intersectoral task forces; the development of academic training programmes for indigenous peoples; community level training for monitoring, evaluation, and action; the development and adoption of new codes of ethics and procedures to replace existing models which do not always cater for the specific needs of indigenous peoples; support for committees of elders in indigenous communities; and the participation of indigenous peoples in the Global Forum for Health Research and other similar initiatives.

Another capacity-building mechanism is improved collaboration, including information sharing between and among indigenous communities, on strategies to improve indigenous peoples' health. Capacity-building is important not only for indigenous peoples, but also for other individuals and institutions (including WHO) that have a role in promoting the health of indigenous peoples. Participants were concerned that many health professionals are not well equipped to work with indigenous peoples and are often resistant to understanding and acceptance of the "world-view", lifestyle, and needs of indigenous peoples. There is a need to increase the cultural responsiveness of health professionals to ensure that they are able to provide effective health services for indigenous peoples. This will require, among other things, the development of specific training modules, policies, and guidelines for health professionals. For example, a course on indigenous health systems could be incorporated into relevant university curricula. The need for WHO to improve its capacity to address indigenous peoples health issues, in close co-operation with indigenous peoples, was also noted. WHO should take account of indigenous peoples issues in all aspects of its work. More generally, public education aimed at fostering a greater degree of tolerance and respect for distinct cultures and the rights of indigenous peoples should be promoted at the national level.

### **3.4 Partnership Mechanisms**

Partnership mechanisms were a core theme of the Consultation. A presentation on existing forms of partnerships with indigenous peoples was made by Ms Victoria Tauli-Corpuz of the Tebtebba Foundation, Philippines.

The UN Secretary General's mid-term review of the International Decade of World's Indigenous People urged all UN agencies to develop programmes on indigenous peoples' issues and incorporate them into their overall work. Within the UN system as a whole, there is increasing recognition of the need for a co-ordinating body on indigenous peoples' issues. The recent decision to establish a Permanent Forum on indigenous peoples at the UN reflects this awareness. The Forum will have a broad mandate including health, the environment, development, and human rights.

It was recognized by participants that there is a need for partnership building at all levels (global, international, regional, national, and local), and between a wide range of stakeholders. Participants emphasized that partnerships with indigenous peoples should be based upon equality, trust, and mutual respect. A variety of partnership models were discussed. These include: equal coalitions with governments and indigenous peoples at the national level; tripartite collaboration between indigenous representatives, governments, and international organizations; national

commissions; advisory bodies; expert panels; and collaborating centres. Partnerships should ensure the participation of indigenous peoples at all levels and in all matters relevant to their own health development, and should promote a greater degree of control and decision-making power for indigenous peoples. The ultimate goal should be for indigenous peoples to lead their own health development.

A key recommendation for partnership-building between indigenous peoples and WHO was to set up an informal Indigenous Peoples Health Advisory Group (IPHAG). It was recommended that WHO provide support as required to establish the group, and that the group be comprised of 13 indigenous peoples' health experts, representing all indigenous regions. It was proposed that WHO hold annual meetings with the IPHAG. Another recommendation aimed at strengthening WHO's partnership with indigenous peoples was that an International Conference on the Health of Indigenous Peoples be held in 2001. The aim of the Conference would be to focus world attention on the health situation of indigenous peoples; develop new strategies aimed at improving indigenous peoples' health; and generate global commitment. It was also recommended that WHO host, in partnership with indigenous peoples, an international consultation every two years to encourage broader debate on indigenous peoples' health.

Participants encouraged WHO to increase collaboration with key international, regional, and national organizations (including the World Trade Organization, MERCOSUR<sup>5</sup>, the Association of South-East Asian Nations, other UN agencies and programmes) to promote policies and strategies that are compatible with indigenous peoples' health development.

Participants also urged WHO to explicitly take into account the health of indigenous peoples in formulating its budget and overall programme of work. The mainstreaming of indigenous peoples' issues within WHO (headquarters, regional offices, and country offices) requires that components specifically addressing indigenous peoples' health issues be incorporated into relevant programmes. In addition, a review process to evaluate the impact of programmes on indigenous peoples, based on input from indigenous peoples' health experts, could serve to improve the responsiveness of programmes.

In order to enhance the capacity of indigenous peoples to work in partnership with WHO, some participants suggested that WHO should provide designated places for indigenous peoples on existing fellowship schemes and other professional programmes at the national, regional and headquarters levels. It was recommended that specific fellowship programmes be established to address the unique health needs of indigenous peoples, as well as mechanisms to ensure the representation of indigenous peoples in the WHO Secretariat. It was also recommended that indigenous peoples' health issues identified as priority areas for action should be presented to the World Health Assembly by an indigenous peoples' spokesperson, supported by WHO, as was the case in 1993 during the International Year of the World's Indigenous People.

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<sup>5</sup> A regional trading block, including Argentina, Brazil, Uruguay and Paraguay.

A number of participants urged WHO Regional Offices to become more closely involved in indigenous health issues, and to hold regular consultations with indigenous peoples to ensure their involvement and leadership in all relevant health issues. Participants acknowledged a major difficulty in some regions where certain countries may not recognize the existence of indigenous peoples within their boundaries.

The importance of continuing the review of existing policies and strategies specific to indigenous peoples at the regional level was also stressed. The findings of the review would inform the development of effective policies and strategies for indigenous peoples' health.

In accordance with WHA Resolution 48.24 (1995), WHO should remind Member States of their commitment to establish focal points on indigenous peoples' health at the national level. These focal points, in collaboration with indigenous peoples and other relevant stakeholders (including the United Nations Development Programme, the International Labour Office, the United Nations Population Fund, and the United Nations Environment Programme) should elaborate regional plans for indigenous peoples' health and establish, develop, and implement specific health strategies. Meanwhile, at the national level, new types of partnerships are being formed in response to the unique situations of indigenous peoples. Formal health sectors have generally not been effective in achieving equitable health outcomes for indigenous peoples, and in many cases NGOs have taken a more prominent role in facilitating the access of indigenous peoples to health care. Partnerships between indigenous peoples and both governments and NGOs will continue to be important.

#### **4. Summary of the recommendations**

Participants and observers were divided into four working groups to discuss issues related to policy formulation and partnership mechanisms. The working groups drafted recommendations addressed to WHO and Member States to promote the health of indigenous peoples. Each working group presented their recommendations at plenary. A drafting group synthesised these recommendations, which were then tabled at the final plenary.

As noted in Section 2, the recommendations from the Consultation were formally proposed and adopted by participants alone, and not by governments or organizations, which took part as observers.

These recommendations are summarized below:

**a) Recommendations relating to major health challenges**

WHO should:

- Recognize the value and validity of indigenous health systems, and support the maintenance and development of those systems.
- Explicitly take into account the health of indigenous peoples in formulating its budget and overall programme of work.
- Accept indigenous peoples' concepts of health as valid and as the basis of work to promote indigenous peoples' health development.
- Promote indigenous peoples' health within the context of their broader development. To this end, WHO should formulate, promote, and implement indigenous peoples' health strategies that are consistent with the overall positive development of indigenous peoples.
- Note that the rights pertaining to health in the Draft UN Declaration on the Rights of Indigenous Peoples are compatible with the values of its own Health for All policy for the 21<sup>st</sup> Century.

Member States should:

- Promote the preservation and respect of the cultural heritage and practices of indigenous peoples, and the integrity of their territories and natural resources. Traditional lifestyles should be seen as protective of indigenous peoples' health.
- Consider the health impact of large scale development projects (e.g. extractive industries and power schemes), and only approve those projects that are not detrimental to the health of indigenous peoples.
- Promote public education fostering a greater degree of tolerance and respect for the distinct cultures and special rights of indigenous peoples.
- Accept indigenous peoples' concepts of health as valid and as the basis of work to promote indigenous peoples' health development.
- Promote indigenous peoples' health within the context of their broader development.



**b) Recommendations relating to strategies and approaches**

WHO should:

- Act as an advocate to ensure that equity-oriented policies on indigenous peoples' health are promoted and developed, and serve as a catalyst in promoting initiatives relating to the health of indigenous peoples.
- Continue the review of existing policies and strategies specific to indigenous peoples at the regional level, and recommend to Member States policies and strategies based on the findings of the review.
- Promote the right to quality information on health, which would enable indigenous peoples to have a greater degree of control over their own health.
- Promote the systematic collection and reporting of statistics disaggregated by ethnicity by Member States. This will require the development of working criteria or definitions of ethnicity and the development of indicators that are able to measure what constitutes a positive health outcome in indigenous peoples' terms.
- Develop, in close consultation with the informal advisory group, a comprehensive research agenda which places an emphasis on the broad determinants of health.
- Conduct a review of traditional health practices in close consultation with indigenous peoples to determine the overall acceptability in terms of traditional and accepted international standards.
- Develop a database primarily of government institutions with responsibilities for indigenous peoples' health. Relevant research institutions working with indigenous peoples' health issues should also be incorporated.
- Establish a series of collaborating centres within Member States to facilitate research and development on indigenous peoples' health.
- Encourage universities to create departments or chairs to promote knowledge and research in traditional medicine and healing.
- Create a web-site on indigenous peoples' health.
- Ensure the dissemination of information on upcoming meetings, activities and events which concern the health of indigenous peoples, allowing for timely input and participation.
- Review the impact of large-scale development interventions on indigenous peoples' health. If necessary, WHO should further develop existing standards and methods, so that they are more sensitive to the situations of indigenous peoples.
- Ensure that indigenous peoples are appropriately represented on the staff of WHO at all levels.
- Ensure (through designated positions) that indigenous peoples have the opportunity to participate in existing fellowship and other professional programmes at the national, regional and HQ levels. Further, specific fellowship programmes should be established to address the unique health development needs of indigenous peoples.
- Develop other capacity-building mechanisms such as technical assistance to indigenous peoples' health programmes, training of indigenous health workers and information sharing between indigenous communities.
- Support the development of competence in indigenous peoples' health issues within Member States, particularly in relation to the capacity of health professionals to work with indigenous peoples.

**Member States should:**

- Ensure that indigenous peoples' right to the highest attainable standard of health and well-being is reflected in their constitutions, national legislation, and government policies and strategies.
- Disseminate health information to indigenous peoples living in remote areas and find ways to communicate this information to illiterate communities. Recognize the right of indigenous peoples to determine their own health development and facilitate the control of health services for indigenous peoples, by indigenous communities. This does not, however, replace government obligations in relation to indigenous peoples health.
- Formulate, in consultation with indigenous peoples, a capacity-building plan which may include:
  - a) exchange of knowledge between indigenous and non-indigenous health experts on indigenous and mainstream systems of health;
  - b) increasing the competence and skills of health professionals in working with indigenous peoples; and
  - c) incorporating a consideration of indigenous health systems in relevant university curricula.
- Adopt legislation that protects indigenous peoples' intellectual property rights in relation to health.
- Undertake the systematic collection and reporting of statistics disaggregated by ethnicity.
- Undertake rapid assessments of the state of indigenous peoples' health in all regions.
- Regularly communicate with WHO Regional Offices on the health development of indigenous peoples in countries, in terms of access to and coverage of health care.

**c) Recommendations relating to partnership mechanisms**

WHO should:

- In recognition of the need for partnership based upon equity, trust, and mutual respect, provide support as required to establish an informal Indigenous Peoples Health Advisory Group as the counterpart to work with WHO. This group would consist of at least 13 members (1 North America, 1 Central America, 1 South America, 1 East Africa, 1 Southern Africa, 1 Sahel, 1 South Asia, South-East Asia, Far Eastern Asia, 1 Pacific, 1 Australia/ New Zealand, and 1 Arctic and 1 Russian), representing indigenous peoples from the different regions of the world.
- In accordance with WHO resolution WHA 48.24 (1995), remind Member States of their commitment to establish focal points on indigenous peoples' health at the national level. The focal points, in collaboration with indigenous peoples and other relevant stakeholders (e.g. UNDP, ILO, UNFPA and UNEP), should elaborate regional health plans and establish, develop, and implement specific health strategies.
- Hold annual meetings with the advisory group. WHO should make financial provisions for these meetings.
- Ensure that indigenous peoples' health issues are presented to the World Health Assembly by an indigenous peoples' spokesperson (supported by WHO) as was the case in 1993.
- Ensure that Regional Offices hold regular consultations with indigenous peoples to ensure that they have an input to all issues relevant to the health of indigenous peoples.
- Seek to work together with WIPO, WTO, and other key agencies in ensuring the protection of indigenous peoples' intellectual property as it relates to health (e.g. traditional medicine), and identify best practises at the country level to protect indigenous peoples' intellectual property as it relates to health.
- Include in relevant programmes at all levels (headquarters, regional offices, and country offices) components specifically addressing indigenous peoples' health issues. These programmes should be reviewed and the impact on indigenous peoples evaluated. The review process should include input from indigenous health experts.
- Work with key international, regional, and national organisations (e.g. WTO, MERCOSUR, ASEAN, UN agencies and programmes) to promote policies and strategies that are compatible with indigenous peoples' health development.
- Develop, with the advisory group, a global plan of action for indigenous peoples' health following regional consultations with indigenous peoples. An International Conference on Indigenous Peoples' Health should be held by the end of 2001 to endorse this plan and to provide a forum for developing new strategies and engaging in constructive dialogue aimed at improving indigenous peoples' health globally.
- Following this meeting, hold international consultations on the health of indigenous peoples every two years to assess the health situation of indigenous peoples and then seek support from Member States and other stakeholders.

## **5. Conclusions**

The Consultation represented a major starting point in realizing the commitment of WHO to give greater attention to the health needs of indigenous peoples and to further develop its own work in this area. As stated in the Director-General's opening speech (Annex 1) the Consultation provides strong impetus towards efforts to develop a global plan of action on indigenous health. WHO wishes to be a strong partner in this endeavour, while recognizing that leadership must come from indigenous peoples themselves.

The Consultation also broke new ground in taking a participatory approach. All aspects of the planning process, including the definition of the Consultation goals and objectives, criteria for the selection of participants, and setting of the agenda, were carried out in collaboration with various members of the COIH and other indigenous representatives. Key roles were shared by both indigenous and non-indigenous peoples, and parity between indigenous and non-indigenous participants was maintained.

The proposed Framework for Indigenous Peoples' Health Policy was accepted by participants, and a wide range of recommendations were made which provide guidance, not only for the future work of WHO, but of other key stakeholders including governments, other UN agencies, and NGOs.



**Dr Gro Harlem Brundtland  
Director- General  
World Health Organization**

**International Consultation on the Health of Indigenous Peoples  
Geneva, 23 November 1999**

Ladies and Gentlemen:

It is a great privilege and pleasure for me to be here today to welcome you to this International Consultation on the Health of Indigenous Peoples. WHO is firmly committed to the rights and the aspirations of indigenous peoples for long and healthy lives. So we take pride in hosting this consultation to move the agenda forward.

Three years ago, when the United Nations Conference on Human Settlements observed the International Decade of the World's Indigenous Peoples, world leaders decried the damage to the environment and land of indigenous peoples. Wally N'Dow, Secretary-General of that conference, reminded us that the harm is not only to the peoples who have for centuries and millenniums lived on those lands. The rest of the world suffers as well. When we marginalize indigenous peoples, we cut off a vast body of knowledge that is of great value to humanity. That is clear to those of us in the health field, who depend on the wisdom passed down through the generations, of plants and herbs and flowers that have the power to heal.

But our debt to indigenous peoples is more than the knowledge they have endowed. As Mr N'Dow said, "They teach us how to live more correctly." Indigenous peoples teach us about the values that have permitted humankind to live on this planet for many thousands of years without desecrating it. They teach us about holistic approaches to health that seek to strengthen the social networks of individuals and communities, while connecting them to the environment in which they live. And they teach us about the importance of a spiritual dimension to the healing process.

We come together today to confront some daunting challenges to these values. Despite the adoption of the Universal Declaration of Human Rights 50 years ago, indigenous peoples continue to be subject to systematic denial of their fundamental human rights – to cultural identity, to land, to liberty, to health, and to life itself.

Life expectancy at birth is 10 to 20 years less for indigenous peoples than for the rest of the population. Infant mortality is 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.

The health of indigenous peoples in many regions is also threatened by damage to their habitat and resource base. Environmental assessments show 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. Radioactive contamination has made the inhabitants of the Bikini Islands dependent on food aid because the locally grown food is too radioactive to eat.

Development is taking its toll in lives as well. Large scale tourism disrupts local social, cultural and political structures. Logging, mining and the building of dams and agri-business displace thousands of people from their land, removing them from their basic food sources, their way of life, and their very livelihoods. The arrival of development ventures in Kalimantan since 1970 has resulted in the degradation of the world's oldest rainforest and the disruption of lives of three million Dayak people.

Most troublesome, indigenous peoples are over-represented among the world's poor. This does not mean only that they have low incomes. Poverty is multi-dimensional and like others in poverty, indigenous peoples are less likely to live in safe or adequate housing, more likely to be denied access to safe water and sanitation, more likely to be malnourished, and more likely to lack access to appropriate, affordable, and culturally-sensitive health services.

A commitment to preserving the dignity of human beings, and to assuring human rights tell us that we must do everything possible to maintain the culture and livelihoods of indigenous peoples. Adding more weight to this are studies which show that when this is done, the health status of indigenous peoples is higher. Maintenance of traditional lifestyles and culture has been associated with decreased rates of infant mortality, low birth weight, cancer, high blood pressure, and diabetes.

Traditional culture also confers important benefits in promoting healthy personal behaviours such as physical activity, and lower levels of cigarette smoking and drug use. Tradition and cultural grounding provide health-promoting resources on which people can draw strength. These resources are not limited to health services; they include social support networks, promotion of self-sufficiency, and access to food and other material networks.

On the other hand, preserving traditional culture can easily lead to attempts at isolating indigenous people and building "museum cultures" that are separated from the modern society that surrounds them. We must be careful not to build walls between traditional culture and modern society so that we exclude indigenous people from participation in the country's political, economic and cultural affairs. This balance between the right to participation and the right to remain different is a delicate one, but one thing is clear: no-one except the indigenous peoples themselves can determine how this balance is struck.

Clearly, indigenous peoples have the knowledge and cultural base on which to build healthier societies. But they cannot do so alone. Governments have a responsibility and an obligation to do their part as well. Many governments have not only shied away from this responsibility, but they deny formal recognition of indigenous peoples entirely. Some national governments have taken steps in the right direction, by developing comprehensive policies and strategies to address the health problems of indigenous peoples. Nonetheless, there are few examples where their actions have reduced the disparities between indigenous peoples' health and that of other people within national boundaries.

The UN International Decade for the World's Indigenous Peoples, and the Draft Declaration on the Rights of Indigenous Populations, sound the call to governments across the world that indigenous peoples have rights to survival, dignity and well-being that must be respected and promoted. Article 22 of the draft declaration make it clear that indigenous populations have the right to special measures for the immediate improvement of social conditions, including their health. Just as important are Articles 23 and 24, which emphasize the rights of indigenous peoples to determine their own priorities for health programmes and to use traditional medicines and health practices.

Partnerships between governments and the indigenous peoples movement are therefore important; indeed they are essential. Only through partnership can societal systems mutually reinforce each other. This is why the groundswell of the indigenous movement in recent years is so important. It sends a signal that collaboration must be based on the perceptions and expressed needs of indigenous peoples, rather than on assessments of those far removed from their reality.

WHO will play a role to ensure that the billion and a half people who have been excluded from economic development and the health “revolution” of the 20<sup>th</sup> century are lifted from poverty and ensured healthy lives in the 21<sup>st</sup>. Redressing the plight of indigenous peoples is an integral part of this agenda.

It has long been recognized that poverty is a major risk factor for death, disease and disability. Illness and disabilities among the poor lead to a vicious circle of marginalization, to falling into or remaining in poverty, and then to added morbidity. But the other side of that coin – that improved health status can prevent poverty and offer a route out of poverty – has been given much less attention. The evidence shows that better health translates into greater, and more equitably distributed, wealth by building physical and social capital and increasing productivity.

The significance of these findings is clear: to turn the vicious circle into a virtuous one, WHO must focus its resources more directly and effectively towards poverty reduction by improving and protecting the health of the poor, and advocating the fact that health is key to economic and human development.

How will we do it? By developing and promoting the most effective health strategies that contribute to reduction of poverty. We know that many health interventions do not adequately reach or serve the poor. We also know that universal access to health services is a necessary condition for eliminating the “health divide”. But even this is not sufficient. As indigenous peoples know well, the cultural barriers to health care are often as significant as financial barriers.

Many of the determinants of health among the poor – like those of indigenous peoples - lie outside the health sector. Thus, achieving better health among the poor requires a broad approach in which WHO and Member States engage with others responsible for economic and social development to ensure that all national policies, including those of the health sector, improve and protect the health of the poor. This means, for example, striving to make globalization more inclusive and to distribute its benefits more equitably.

This consultation will be an important boost to efforts to develop a global plan of action for improving the health of indigenous peoples. WHO wants to be a strong partner in this endeavour, while recognizing that the leadership must come from indigenous peoples themselves. What can WHO do?

WHO can build knowledge about the mechanisms by which protection of traditional lifestyles and cultural practices lead to better health among indigenous peoples. WHO can also develop better measures to monitor health inequalities between indigenous peoples and others within national boundaries, by helping national governments collect and analyze health statistics that take into account ethnic differences. WHO also can advance and widely disseminate knowledge about how policies and practices in economic development or in specific sectors affect the health of indigenous peoples.

At the international level, WHO can advocate for the plan of action developed from this meeting and others with international and regional development agencies. WHO can also urge

development leaders to recognize and support the efforts of indigenous peoples to promote their own healthy development policies. And at the national level, WHO can support national governments in making the health of indigenous peoples a higher priority, identifying effective health strategies, and promoting learning across countries about the most effective policies that improve the health of indigenous peoples.

Our success - WHO's and yours - will depend on shaping public opinion and stimulating public action through elected representatives and civil society - at local, national, regional and global levels. The fundamental message we send is that health is a fundamental human right, enshrined in the Universal Declaration of Human Rights. This means more than universal access to adequate health care. It depends on the assurance of many other rights in the Declaration: access to education and information, the right to food in sufficient quantity and of good quality, the right to decent housing, and the right to live and work in an environment where known health risks are controlled.

I believe this message is reaching and being understood by those in the development community and, to an increasing degree, by political leaders around the world. Broad political commitment can be forged to take seriously the vision of sustainable human development. But it depends on generating wider appreciation of the crucial role played by health in development, connecting health to the broader process of societal change, and gaining adherence to the principles of equity and human rights.

In 1855, Chief Seattle said "*The earth does not belong to mankind; mankind belongs to the earth. Man did not weave the web of life; he is but one strand. Whatever he does to the web, he will be doing to himself. All that happens to the earth will happen to the children of the earth.*"

He was right. We cannot separate the people from their environment. Investing wisely in health means caring for our natural environment and ensuring that we endow future generations with that precious resource. If we manage, hundreds of millions of people – now and in the future - will be better able to fulfil their potential, enjoy their legitimate human rights and be driving forces in development. People would benefit. The economy would benefit. The environment would benefit.

We have a long way to go to reach this goal. Be assured that WHO stands with you in the struggle.

Thank you.

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**INTERNATIONAL CONSULTATION  
ON THE HEALTH OF INDIGENOUS PEOPLES  
Geneva, 23-26 November 1999  
WHO Executive Board Room**

**AGENDA**

**Day 1, 23 November 1999**

*Introduction and essential background information*

- 9:00 Invocation
- 9:15 Welcome speech, by Dr Gro Harlem Brundtland,  
Director-General, World Health Organization
- 09:30 Keynote address, by Mr Wilton Littlechild, Chief of the Four Cree Treaty  
Nations at Hobbema.
- 09:45 Health as the Key Factor in the Survival of the World's Indigenous Peoples,  
by Mrs Erica Daes, Chairperson, Working Group on Indigenous Populations,  
Sub-Commission on Prevention of Discrimination and Protection of  
minorities.
- 10:05 Purpose and objectives of the Consultation, by Mrs Poonam Khetrapal Singh,  
Executive Director, Sustainable Development and Healthy Environments,  
World Health Organization.

- 10:15 Election of officers

*10:30 Coffee break*

- 11:00 Adoption of the agenda, method of work  
General announcements

*12:30 Lunch break*

- 14:00 The Geneva Declaration on the Health and Wellbeing of Indigenous Peoples,  
by the Representative of the Indigenous Caucus
- 14:30 The health of indigenous peoples, by Committee on Indigenous Health  
(COIH)
- 15:00 Discussion

*15:30 Coffee break*

- 16:00 Indigenous health: Definitions and policy implications,  
by Ms Mihi Ratima, HSD Department, WHO
- 16:15 UN Review of the Decade: Existing rights mechanisms, international norms  
and standards related to health, by Mr Julian Burger, Office of High  
Commissioner of Human Rights
- 16:45 Health of indigenous peoples: Current knowledge, research needs and  
approaches, by Dr Wara Alderete, Argentina
- 17:15 General discussion
- 18:00 Organization of Working Groups

*18:30 Reception hosted by WHO*

## **Day 2, 24 November 1999**

### *Health Policy, Objective 1, Output 1a, 1b*

- 09:00 Review of previous day's work
- 09:10 Working Groups on health policy issues
- 10:30 Coffee break*
- 10:45 Plenary Session (Working Group presentations)

*12.30 Lunch break  
Thematic panel discussion on "Mother Earth and Indigenous  
Peoples Health"*

### *Partnership Mechanisms, Objectives 2 and 3, Outputs 2 and 3*

- 14:00 Existing forms of partnership with indigenous peoples at international,  
regional and national levels: Lessons learnt, by Victoria Tauli-Corpuz,  
Philippines
- 14:15 Working Groups on partnerships mechanisms
- 15.30 Coffee break*
- 16:00 Plenary session: Working Group presentations
- 18:00 Video-film and presentation by Mrs Jackie Warledo: "Drum  
Beat for Mother Earth"*

### **Day 3, 25 November, 1999**

#### **Working towards a plan for the development of a comprehensive Programme of Action, Objective 4, output 4**

- 09:00 Review of previous day's work
- 09:10 Broad determinants of health: Synthesis with Indigenous Peoples' Perspectives, by Dr Cindy Kiro, New Zealand
- 09:30 Discussion on a comprehensive Programme of Action  
Organization of Working Groups

*10:30 Coffee break*

- 10:45 Working Groups on the comprehensive Programme of Action

*13:00 Lunch break  
Thematic Presentation (tentative)*

- 14:00 Continuation of Working Groups

*15.30 Coffee break*

- 16:00 Plenary session: Working Group presentations

### **Day 4, 26 November 1999**

#### **Finalization and adoption of a proposed policy framework for WHO and a plan for the finalization of a comprehensive Programme of Action**

- 09:00 - Drafting Group on the report.  
- For other participants, thematic presentations from various WHO departments and Regional offices.

*10:30 Coffee break*

- 10:45 - Drafting Group on the report.  
- For other participants, thematic presentations from various WHO departments and Regional offices.

*13:00 Lunch break*

- 14:00 Plenary session: Discussion and adoption of the proposed Policy Framework for WHO and a plan for the finalization of a comprehensive Programme of Action

*15:30 Coffee break*

- 16:00 Press Conference

## **THE GENEVA DECLARATION ON THE HEALTH AND SURVIVAL OF INDIGENOUS PEOPLES**

### ***PREAMBLE***

We, the representatives of indigenous communities, nations, peoples and organizations attending the International Consultation on the Health of Indigenous Peoples, held in Geneva from the 23-26 November 1999, and organized by the World Health Organization, reaffirm our right of self-determination and remind States of their responsibilities and obligations under international law concerning health, including the health of Indigenous Peoples;

Concerned that the health of Indigenous Peoples in every region of the world is acknowledged to be in a poor state due to the negation of our way of life and world vision, the destruction of our habitat, the decrease of bio-diversity, the imposition of sub-standard living and working conditions, the dispossession of traditional lands and the relocation and transfer of populations;

Welcoming the initiative of the World Health Organization for convening this International Consultation with Indigenous Peoples;

Recalling United Nations General Assembly resolution 48/163 proclaiming the International Decade of the world's Indigenous People (1995-2004), resolution 50/157 establishing the Programme of Activities for the Decade, as well as the World Health Assembly resolutions WHA47.27, WHA48.24, WHA49.26, WHA50.31 and WHA51.24, with a view "to strengthening international co-operation for the solution of problems faced by Indigenous Peoples in areas such as human rights, the environment, development, education and health";

Calling on the various institutions of the United Nations to act in partnership with Indigenous Peoples' communities, nations and organizations, to recommend to governments that they address the particular needs of Indigenous Peoples who experience disproportionate poverty, illness, social exclusion, habitat destruction and oppression and to develop policies which will enhance the health and survival of Indigenous Peoples world-wide to reverse this disparity;

Believing that a partnership between Indigenous People and the World Health Organization in co-ordination with other specialized agencies and bodies within the United Nations system plays an essential role with respect to the promotion of the health of Indigenous Peoples and our health systems;

Considering the non-recognition of the health knowledge and practices of Indigenous Peoples, and the limited access to health services, both of which we condemn as expressions of discrimination and intolerance;

Believing that the leadership of Indigenous Peoples in all aspects of development and implementation of health programmes is essential for the health needs of Indigenous Peoples;

Acknowledging that Indigenous Peoples have developed effective and viable scientific knowledge and systems of health that have contributed, and continue to contribute, to the health and survival of all humanity;

Reaffirming our commitment to our civil, political, economic, social and cultural rights, including the right to benefit from our own resources and our right to develop them;

Reminding the international agencies and other bodies of the UN system of their responsibility, and the obligation of States, towards the promotion and protection of Indigenous Peoples' status and rights, and that a human rights approach to indigenous health and survival is based on the said international responsibility and obligation to promote and protect the universality, indivisibility, interdependence and interrelation of the rights of all peoples; and finally;

Reaffirming the indivisibility of human rights with regard to the health and survival of Indigenous Peoples as essential to an effective and meaningful response to the health needs of Indigenous Peoples.

## *PART I*

### RIGHTS AND INTERESTS OF THE WORLD'S INDIGENOUS PEOPLES

Considering that the rights, philosophy and principles contained in the United Nations Draft Declaration on the Rights of Indigenous Peoples and all existing international instruments dealing with human rights and fundamental freedoms are essential for the attainment of the health and survival of Indigenous Peoples;

We hereby solemnly declare, affirm and assert that Indigenous Peoples are equal in dignity and in rights to all other peoples and, as such, have the right of self-determination;

In accordance with the status and rights of Indigenous Peoples, we:

- Affirm the right to control preventive and curative health systems and programmes in our own communities and the means to train and involve indigenous personnel in all facets of health;
- Affirm the right to the highest attainable physical, mental, social, cultural and spiritual health and survival, commensurate with Indigenous Peoples' definition of health and wellbeing;
- Call on Governments to recognize the sciences, systems of knowledge, sacred and ceremonial sites, doctors, medicine people and practices of Indigenous Peoples in health and medicine;
- Insist on free access to quality and culturally appropriate health care according to our needs, funded by the State without discrimination, that extends to support services, and to ensure accessibility of services for all Indigenous Peoples, including those in isolated, marginalized and remote regions and communities;



- Call for urgent and decisive actions to protect and preserve the integrity of indigenous territories, to stop environmental degradation and to ensure access to healthy and safe traditional food sources;
- Call for the promotion of adequate nutritional programmes and to support the campaign against substance abuse;
- Call on governments where Treaties, agreements and other constructive arrangements exist, that the original spirit and intent of these international agreements be honoured, respected and implemented;
- Call on the World Health Organization to make a substantial contribution within the context of the International Decade, in the form of a special study on the health of Indigenous Peoples, with the co-ordination, collaboration and participation of the Indigenous Peoples; and finally,
- Invite all Indigenous Peoples to support and promote this Declaration and to consider it as part of a global campaign, to obtain the largest possible participation of Indigenous Peoples in the elaboration of future documents and strategies on the health and survival of the Indigenous Peoples.

## PART II

### INDIGENOUS PEOPLES CONCEPTS OF HEALTH AND SURVIVAL, EXPRESSIONS OF CULTURE AND KNOWLEDGE ESSENTIAL TO THE HEALTH AND WELL-BEING OF INDIGENOUS PEOPLES

Indigenous Peoples' concept of health and survival is both a collective and individual inter-generational continuum encompassing a holistic perspective incorporating four distinct shared dimensions of life. These dimensions are the spiritual, the intellectual, physical and emotional. Linking these four fundamental dimensions, health and survival manifests itself on multiple levels where the past, present and future co-exist simultaneously.

For Indigenous Peoples, health and survival is a dynamic equilibrium, encompassing interaction with life processes and the natural laws that govern the planet, all life forms, and spiritual understanding.

Expressions of culture relevant to the health and survival of Indigenous Peoples includes, but is not limited to, individual and collective relationships, family and kinship systems, social institutions, traditional justice, music, dances, ceremonies, ritual performances and practices, games, sports, language, narratives, mythology, stories, names, land, sea and air and their resources, designs, writings, visual compositions, permanently documented aspects and forms of Indigenous culture including scientific and ethnographic research reports, papers and books, photographs, digital images, film and sound recordings, burial and sacred sites, human genetic material, ancestral remains, and artifacts.

PART III  
POLICIES, STRATEGIES AND MECHANISMS OF ACTION

While there are some policies and legal frameworks in the national and regional contexts, which address the health needs of Indigenous Peoples, there is still an enormous gap between policy and action. This gap is mainly caused by a lack of political will on the part of governments to implement existing policies. It also stems from the failure to recognize Indigenous Peoples' rights to self-determination, and to adhere to the principles of holism, meaningful participation, mutual respect and reciprocity, and to recognize the validity and revitalization of indigenous cultures and institutions.

Existing appropriate policies on health are also threatened by some programmes and activities of the World Bank, International Monetary Fund, and the World Trade Organization which often have negative impacts on the health of Indigenous Peoples. The WHO must take responsibility for engaging these institutions to rectify their policies and programmes and the imbalances and inequities in the World Trade Organization Treaties which have adverse health impacts. This would include overview of regional trade agreements such as the North American Free Trade Agreement and MERCOSUR.

Policies and programmes should be formulated in the following areas:

1. Capacity building through human resource development and empowerment strategies.
2. Research programmes designed for indigenous health with the leadership of Indigenous Peoples.
3. Education programmes for health professionals and others involved in health services to make their practice more culturally appropriate.
4. Proposals to rectify the inequities and imbalances in globalization.
5. Increased funding and resources for Indigenous Peoples' health.
6. Effective co-ordination between various United Nations bodies.
7. Ensuring participation of Indigenous Peoples at all stages of policy development and implementation.

As an example of a successful policy, Indigenous Peoples welcome the recent establishment of the Circumpolar Co-operative Programme, "Health and Environment of Indigenous Peoples", conducted in partnership between Indigenous Peoples, the Arctic Monitoring and Assessment Process, the United Nations Environmental Programme (UNEP) and WHO.

Indigenous Peoples urge the implementation of the following mechanisms of action:

- Constitutional and legislative mechanisms that oblige national governments to recognize Indigenous Peoples and to fulfil their health needs based on their own specific priorities and aspirations.
- Constitutional and legislative mechanisms that oblige national governments to abolish harmful practices and stop all programmes and research activities that are conducted without the free prior and informed consent and the meaningful participation of Indigenous Peoples.
- Mechanisms to monitor and evaluate the implementation of policies, in order to identify the gaps between policy and effective action.
- Mechanisms for complaints, arbitration, redress and remedial measures.

#### PART IV

### BROAD DETERMINANTS ON THE HEALTH AND WELL BEING OF INDIGENOUS PEOPLES

The health of Indigenous Peoples is overwhelmingly affected by determinants outside the realm of the health sector, namely social, economic, environmental and cultural determinants. These are the consequences of colonization, and are amenable to intervention to protect and improve the health of Indigenous Peoples. As a means of achieving this, we call on the World Health Organization and other United Nations institutions, along with their member states, to act in partnership with Indigenous Peoples to address, among others, the following;

- \* The loss of identity due to removal from family and community, displacement and dispossession of lands, resources and waters, and the destruction of Indigenous Peoples' languages and cultures, all of which have impacted the ability of Indigenous Peoples to be productive, contributing members of society;
- \* The impact of environmental degradation caused by mega-projects, extractive industries, and toxic waste disposal including trans-boundary contaminants.
- \* The need to promote sustainable forms of development rather than promote this type of industry;
- \* The need for community development as a participatory process;
- \* The limited choice and accessibility to professional care, including the lack of culturally appropriate healthcare provision, that reflects our values, beliefs and traditions;
- \* The effects of war, declared or undeclared, conflicts and vigilantism.

In order to be intellectually rigorous, scientifically sound, socially just and morally defensible, indigenous health strategies require concerted action on the part of governments and responsible agencies in relation to the social, economic and cultural determinants of the health of Indigenous Peoples. They should adopt a precautionary principle when working on development with Indigenous Peoples and act in good faith by being transparent in their dealings with Indigenous Peoples.

#### **PART V**

Nothing in this Declaration shall be construed as diminishing or extinguishing existing or future rights Indigenous Peoples may have or acquire.

## **Presentations by WHO departments**

Various WHO departments made presentations to the Consultation. These are summarised below. Restructuring since 1999 has resulted in significant changes within WHO; some of the programmes represented here have altered significantly or no longer function.

***Substance Abuse Department (HSC/SAB):*** SAB, in recognizing that alcohol and substance abuse is a major health concern of indigenous peoples worldwide, has emphasized strong involvement of indigenous peoples in its work since 1992. The Indigenous Peoples and Substance Abuse Project aims to prevent substance use, trafficking and supply and to minimize harm to the individual, family, and community. Collaborating partners include Health Canada, the Alcohol Advisory Council of New Zealand, Queensland Health of Australia, and a variety of indigenous organizations. The Project focusses on broad-based interventions and emphasizes the following principles: recognition and acceptance of cultural diversity; recognition of the special relationship of indigenous peoples with earth and land; sustainability; the right to self-determination and equality; reciprocity and partnerships; and the active participation of indigenous peoples.

***Traditional Medicine Department (TRM):*** Traditional medicine can be characterized by long-time use and a holistic approach; indigenous medicine falls within this definition. TRM is currently developing guidelines on evaluating traditional medicine.

TRM's presentation aroused great interest and debate. Indigenous peoples' representatives from Ghana and Russia noted the relationship between economic crisis and the resurgence of traditional medicine. In Russia, young people have limited knowledge of traditional medicine as Communism has eroded the knowledge-base. There is an urgent need to consider how this trend could be reversed. Transfer of knowledge on traditional medicines is a challenge because in some instances knowledge is held only by elites and there are no written records.

Indigenous participants called for a greater recognition of traditional healing processes; the view that only Western models of medicine are valid was considered racist. Indigenous representatives requested a joint review with WHO of traditional health practices, in close consultation with indigenous peoples, to determine the overall acceptability in terms of traditional and international standards. In this context, indigenous representatives proposed that best practices at the country level be identified with the aim of protecting indigenous peoples' intellectual property as it relates to health. Some meeting participants urged WHO to work more closely together with WIPO, WTO and other key agencies to ensure the protection of indigenous peoples intellectual property relating to traditional medicine. In addition, there was a call for national legislation protecting indigenous peoples' intellectual property rights. Some participants proposed that universities and other academic institutions should create departments or chairs for the research and promotion of indigenous peoples' traditional medicine and healing processes.

***Noncommunicable Diseases Cluster (NCD):*** Noncommunicable diseases, such as asthma, hypertension, cancer and diabetes, are an important health problem among many indigenous peoples. The link between noncommunicable disease and changes in lifestyle has been demonstrated in a number of studies. In North America, indigenous peoples experience a much higher rate of diabetes than white Americans. NCD has gathered information on diabetes among indigenous peoples, and evidence points towards a causal link with the rapid introduction of carbohydrate foodstuffs.

***Roll Back Malaria (RBM):*** The Programme recognises the importance of partnership in its work with indigenous peoples. In the Amazonian Region national and local governments are working in partnership with indigenous peoples, for example the Kayapo Healthy Indigenous Project in Brazil and a mobile public health programme which brings health care to indigenous communities in Venezuela. RBM also provides health care to disadvantaged communities, and particularly tribal populations, in the Western Hill Tract Regions (Bangladesh, Thailand and Myanmar) where malaria is a major health problem.

**Mental Health Department (MNH):** The department does not have a specific focus on indigenous peoples but it has recently issued a brochure on indigenous populations and mental health.<sup>6</sup> At the country-level, fifteen mental health programmes have been established and some of these are located in areas where there are indigenous peoples.

Participants raised concerns about mental health problems in indigenous communities, including violence, depression and the high rate of suicide, particularly among young people. The need to create a knowledge base to inform mental health service development was stressed by several participants. Dr Benedetto Saraceno, Director of MNH, stated that support to empower indigenous communities to gather the data themselves should be provided, through training on data-collection: "Knowledge cannot be built on somebody, it must be built from somebody." Saraceno mentioned a network of anthropologists and psychiatrists with experience in working across cultures which, with the support of WHO, could provide technical assistance to indigenous researchers. MNH is also able to provide some financial support for indigenous mental health projects. Proposals should be sent directly to Mental Health, which will reply promptly. The Department could visit communities to assess what sort of support is needed, and assist communities to access financial support from other stakeholders.

**External Relations and Governing Bodies (EGB/ECP):** The department facilitates WHO collaboration with NGOs and other agencies. Participants were very interested in the mechanisms for establishing collaboration. WHO only recognizes formal relations – known as being "in official relations with WHO" – with those NGOs which have fulfilled set criteria over a period of time. All other contacts, including working relations, are considered to be informal.

First contact with a NGO takes the form of exchanges of information and reciprocal participation in technical meetings. This type of informal contact may continue indefinitely on an ad-hoc basis and without written agreement. When a number of specific joint activities have been undertaken, collaboration may move a stage further by proceeding to a period, usually two years, of working relations. A joint assessment of the outcome of the period of working relations is undertaken at the end of the two-year period. The outcome of the assessment may result in the continuation of working relations for a further period, or an application to the Executive Board for admission into official relations with WHO. The Executive Board is responsible for approving the admission of NGOs into official relations.

Further information on these process can be found in *Principles Governing Relations Between the World Health Organization and Non-governmental Organizations*. Copies are available from ECP.

**Health and Human Rights programme in HSD:** The presentation outlined how the fundamental principles of human rights related to the concerns of indigenous peoples. The principles of respect and dignity translated into respect for indigenous cultures and different practices, including health practices.

The principle of participation was crucial to self-determination and to the right of indigenous peoples to be in charge of their own development, as is the principle of empowerment.

The WHO Constitution says that "the enjoyment of the highest attainable standard of health is a fundamental human right". This is often shortened to "the right to health". This principle is reflected in many international and regional human rights instruments.

**Child and Adolescent Health Department (CHS/CAH):** The department's Integrated Management of Childhood Illnesses (IMCI) strategy addresses many of the health problems that cause morbidity and mortality among indigenous children, whose access to basic services is often limited. The department's work on the Rights of the Child also includes a focus on indigenous children.

Adolescence was outlined as a critical period in the development of behaviours that affect health. Smoking, use of alcohol and other drugs, initiation of sexual relations, diet and eating habits, gender roles and interpersonal relations are all established during adolescence. In indigenous communities, it is the time when traditions, wisdom, language, customs are handed down, but it is also the period when threats of acculturation, discrimination, and marginalization emerge. Priority health issues during adolescence include sexual and reproductive health (including HIV/AIDS and STDs); substance

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<sup>6</sup> The Mental Health of Indigenous Peoples: An International Overview (WHO/MHH7NAM/99.1)

misuse (tobacco, drugs, alcohol); mental health (depression and suicide); nutrition; and injury. A comprehensive approach to tackling these problems is required that includes: safe and supportive environments; the provision of accurate and culturally sensitive information; the development of skills necessary for healthy development; the provision of culturally-appropriate counselling services, particularly in times of crisis; and youth-friendly and culturally-responsive health services.

The **Health Promotion Department (HPR)** The cornerstone of health promotion is the achievement of health equity through the use of community participation approaches to empower individuals and population groups to make healthy choices. This should take place along with the promotion of public policies that make such choices possible. HPR supports member states to research, design, implement and evaluate health-promotion programmes and policies.

Indigenous people's approach to health is consistent with, and complements, health promotion principles. Both espouse an integrated approach to health which links body and spirit to wellness and ill health. Moreover, health promotion approaches are grounded in the respect for culturally-acceptable strategies and actions, diversity and human rights. HPR can support indigenous communities by:

- documenting and disseminating lessons learned about promoting health that gather the wealth of knowledge of indigenous populations;
- promoting the contribution of traditional healing systems;
- ensuring the implementation of appropriate health-promotion strategies among indigenous communities;
- supporting indigenous communities to craft health education messages that are relevant to their belief systems and values, and that can increase health-improving actions.

**UNAIDS.** HIV/AIDS emerged during the Consultation as an important health concern of indigenous peoples; some studies have shown high rates of HIV and STDs among indigenous peoples. The recent guideline on *Human Rights and AIDS* identifies indigenous peoples as a priority population, because they meet all the criteria defining vulnerability to HIV infection.

As WHO recommends, UNAIDS should promote the following strategies. At country level, national strategic plans to control HIV should include prevention and care activities for indigenous peoples. Prevention strategies should provide for training, technical assistance and support to communities working actively to control HIV/AIDS. Experience has shown that failure is most likely in situations where indigenous communities have no voice in defining the threat of HIV or proposing solutions.

The framework of HIV/AIDS-related human rights protection should be promoted and used to change policy. At regional and international level, UNAIDS should encourage collaboration between indigenous organizations to share constraints and successes in HIV-related programmes. Finally, UNAIDS should advocate greater awareness and involvement of other multi- and bilateral organizations in the fight against HIV/AIDS among indigenous populations.

**Pan American Health Organization (PAHO).** In September 1993, PAHO launched the Health Initiative of the Indigenous Peoples of the Americas. The initiative centres on capacity-building; developing alliances; collaboration with Member States in order to facilitate national and local activities; formulating projects; and information dissemination. PAHO's five principles for working with indigenous communities are: the need for a comprehensive approach in health; the right of indigenous peoples to self-determination; the right to participation; respect for indigenous cultures and their revitalisation; and reciprocity in relationships.

PAHO presented progress made by the Health Initiative of Indigenous Peoples. Lessons learned included the particular importance of achieving and tracking inter-programmatic efforts; difficulties in resource mobilization; the challenge of translating discourse on equity into real action; and the necessity of achieving indigenous participation. The three main areas of future activities will be:

- 1) Strategic planning and alliances which would provide advocacy in other development sectors; consensus building among stakeholders; and developing national plans and policies on indigenous health.

2) Intercultural frameworks and models of care to promote an intercultural approach; guidelines for incorporating traditional/indigenous medicine in systems of care; and better preparing health workers to address indigenous people's health needs.

3) Information to detect and monitor inequities would include analysis of health and living conditions; systematize, monitor and evaluate national processes and experiences; identify, support and recognize progress in countries; and the production and dissemination of scientific and technical information.

The success of policies developed depend on inclusiveness and meaningful participation in their design by indigenous peoples themselves.