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COMMISSION ON HUMAN RIGHTS
Sub-Commission on Prevention of
Discrimination and Protection of Minorities
Working Group on Indigenous Populations

Fourteenth session
29 July - 2 August 1996
Item 5 of the provisional agenda

REVIEW OF DEVELOPMENTS PERTAINING TO THE PROMOTION AND PROTECTION OF HUMAN RIGHTS AND FUNDAMENTAL FREEDOMS OF INDIGENOUS PEOPLE: HEALTH AND INDIGENOUS PEOPLES

NOTE BY THE SECRETARIAT

ADDENDUM

INFORMATION RECEIVED FROM INDIGENOUS PEOPLES AND NON-GOVERNMENTAL ORGANIZATIONS

1. In resolution 1982/34 of 7 May 1982, the Economic and Social Council authorized the Sub-Commission on Prevention of Discrimination and Protection of Minorities to establish annually a working group on indigenous populations to review developments pertaining to the promotion and protection of the human rights and fundamental freedoms of indigenous populations, together with information requested annually by the Secretary-General, and to give special attention to the evolution of standards concerning the rights of indigenous populations.

2. The Sub-Commission, in its resolution 1995/38 of 24 August 1995, requested the Secretary-General to transmit the report of the Working Group to indigenous and non-governmental organizations and to invite them to provide information, in particular on matters relating to indigenous health. The Commission on Human Rights, in its resolution 1996/40 of 19 April 1996, urged the Working Group to continue its comprehensive review of developments and welcomed its proposal to highlight the question of indigenous peoples and health. In accordance with the resolutions, appropriate communications were sent. The present document contains replies received as of 7 June 1996

from indigenous and non-governmental organizations concerned with the promotion and protection of the human rights and fundamental freedoms of indigenous populations.

FOUR DIRECTIONS COUNCIL

[Original: English]
[2 April 1996]

1. In pursuing measures to improve the health of indigenous peoples, States and international organizations should take the following three factors into account:

(a) Indigenous peoples tend to become severely malnourished when deprived of their traditional means of subsistence. Since indigenous communities are usually highly adapted to their accustomed foods, the substitution of imported staples such as cereals, milk, processed fats and oils is generally ineffective in restoring nutritional health, and may actually result in new health problems, notably heart disease and diabetes (non-insulin-dependent form). The worst nutritional deficits found in the indigenous communities that have lost their traditional foods are iron-deficiency anaemia and vitamin A deficiency, both of which are associated with childhood infections and learning disabilities;

(b) Indigenous communities tend to be exposed disproportionately to environmental degradation, in particular the contamination of water supplies by mine tailings, chemicals used by miners and pulp-and-paper mills, herbicides and pesticides used in agriculture and silviculture, and untreated sewage and trash from encroaching settlements. They are especially at risk because they not only lack the legal means to block destructive industrial activities, but lack the financial resources to install remedial environmental measures such as water purification and filtration facilities. Exposure to contaminants has direct impacts on health, causing death or, more often, chronic illness and disability. Contaminants also further weaken peoples' resistance to infection, and in this way aggravate the adverse consequences of malnutrition;

(c) Indigenous societies are rich in medical knowledge, which can be a resource for providing effective, low-cost primary health care to these peoples and their neighbours. This resource is being destroyed, very rapidly, by a combination of environmental degradation and social and cultural disruption of indigenous societies. Traditional medicine relies on pharmaceuticals prepared from hundreds of plants and animals harvested in local ecosystems; changes in the ecosystem can eliminate this pharmacopoeia, and industrial contaminants can render traditional medicinal plants and animals (if any survive) toxic. At the same time the disruption of indigenous societies by, inter alia, increased rates of adult mortality, the removal of children,

compulsory education, and imposition of official languages combine to break down the process of transmission of medical knowledge from one generation to the next. As a result, indigenous communities can lose the capacity to remedy their own basic health and nutritional problems in as little as 20 to 25 years.

2. It can plainly be seen that the protection of indigenous peoples' health can only be achieved through the protection of their lands from environmental degradation and encroachments. Nutrition and health are inseparable from land rights.

3. In view of these issues, we recommend that the United Nations and its specialized agencies consider taking the following immediate steps to protect the health and physical survival of indigenous peoples:

(a) Encourage the widest possible ratification and implementation of the ILO Convention on Indigenous and Tribal Peoples, 1989 (No. 169) as it is the strongest extant legal instrument on land rights;

(b) Direct the World Health Organization to enter into a dialogue with national health authorities, to impress on them the relationships between land rights, traditional subsistence activities and health;

(c) Direct UNICEF to prepare and publicize a major report on the impacts of land loss and environmental degradation on the survival and health of indigenous children;

(d) Request the Commission on Sustainable Development to give the highest priority to the implementation of chapter 26 of Agenda 21, and in this context to encourage all Governments to report on the measures they have taken to protect indigenous peoples' lands and subsistence;

(e) Encourage the United Nations Environment Programme to launch a project to monitor the quantity and quality of indigenous peoples' lands worldwide, in connection with articles 8 and 10 of the Convention on Biological Diversity;

(f) Request the United Nations Educational, Scientific and Cultural Organization, through its World Heritage Centre and Man and Biosphere Programme, to assist Governments and indigenous peoples with the demarcation and protection of lands that play an important role in the subsistence, health, traditional medical practices and cultures of indigenous peoples;

(g) Request UNESCO and the International Labour Organization to collaborate in facilitating the establishment of global networks of indigenous people for the exchange of information and expertise in the fields of ecology and medicine.

COORDINATING ASSOCIATION OF INDIGENOUS COMMUNITIES IN EL SALVADOR

[Original: Spanish]
[6 February 1996]

1. The health situation of our indigenous peoples in El Salvador is critical since we are living in extreme poverty as we have lived throughout history, with poor nutrition and lacking such basic services as drinkable water and electricity; we have no access to education, health and housing, our roofs are in a deplorable state; and as a final blow, we do not have access to our mother Earth since we are discriminated against, exploited and marginalized, because our rights are violated daily by the dominant society:

- No account is taken of us within the State, and we are not recognized as indigenous peoples;

- There are no articles in the Constitution of El Salvador to protect us as indigenous peoples;

- The sacred places that belonged to our ancestors have been taken over by the State, leaving us without access to them.

2. Among our peoples there is much malnutrition and sickness which we cannot cure for lack of economic resources, so that if we go to a clinic the consultation is expensive and we cannot afford to buy the medicine. We are therefore grateful for the wisdom of our ancestors, who left us a knowledge of natural medicine which helps us greatly in surviving sickness.

CHIRAPAQ

[Original: Spanish]
[28 March 1996]

HEALTH AND DEVELOPMENT AMONG THE ANDEAN AND AMAZONIAN PEOPLES OF PERU

1. According to the latest poverty map, 21.7 per cent of the population is living in abject or extreme poverty, i.e. people's incomes do not cover the minimum nutritional requirements for remaining in optimum health; we deduce that one Peruvian in five suffers from permanent hunger. To this figure must be added the 54 per cent of the population who live in poverty, whose incomes do not cover the minimum consumer basket (of goods and services): their human development is therefore deficient in many respects. Bearing in mind that the indigenous population in Peru, according to official figures, is 40 per cent of the total whereas we are in fact 60 per cent of it (including marginal cities), we

conclude that the indigenous sector for the most part constitutes the major proportion of the population lacking acceptable levels of health.

2. Even so, the statistics on the Andean and Amazonian communities are more alarming than those on the rest of the Peruvian population: 35.34 per cent of them are in the abject poverty band, 44.61 per cent in the extreme poverty band and 17.93 in the poverty band; only 2.12 per cent display an acceptable standard of living. In other words, 97.88 per cent of the indigenous population in Peru does not enjoy worthy standards of human development.

3. Clearly the infant mortality rate, already alarming at the national level (76 per thousand live births), is doubly so amid our indigenous population: 116 per thousand live births (overall), rising to 140 per thousand in the Andean region and 146 per thousand in the Amazonian region (abject poverty bands). This is due to the high incidence of disease, much of it chronic, nutritional deficiencies among expecting mothers, shortcomings in environmental health and preventive immunological care, a shortage or absence of medical infrastructure and assistance, and a lack of campaigns on reproductive health.

4. According to the Demographics and Family Health Survey (ENDES 1991-1992), 11 per cent of women between the ages of 15 and 19 are already mothers or are pregnant. By the age of 19 the proportion is one in four, and 6 per cent of them have two children or more. The high fertility among teenagers is most pronounced in the indigenous Amazonian population, where it is twice as high as in the rest of Peru.

5. In indigenous communities, 60.06 per cent of homes have no running water and 83.21 per cent, no drainage (overall). In the Andean region, the proportion of homes without running water rises to 75.01 per cent, and in the Amazonian region, to 74.63 per cent (abject poverty bands). The proportion of homes without drainage rises to 94.52 per cent in the Andean region and to 93.48 per cent in the indigenously populated part of the Amazonian region (abject poverty bands).

6. Although there are intensive immunization programmes at the national level (coverage of around 90 per cent), and the infant mortality rate has been brought down somewhat, this is not enough: health problems embrace the acute problem of infant malnutrition. Nationwide, chronic malnutrition among first-year schoolchildren is as high as 48 per cent; one of its more visible consequences is a decline in children's average height. Malnutrition, together with family instability, are the main causes of school under-performance or absenteeism. If one considers that 30 per cent of the population are children and that another 14 per cent are teenagers, what hope can there be for the future, with generations of poorly fed, academically under-performing

children? (Data from the Schoolchildren Height Survey, INEI, UNICEF.)

7. As we can see, health conditions in Peru are far from ideal, and if we look at the figures on the indigenous peoples the situation is more serious so much so that at present rates, many indigenous Amazonian peoples run the risk of extinction and their lives are turning into a daily battle for survival. By the criteria of the World Health Organization, our indigenous peoples enjoy neither physical nor mental nor yet social health.

8. The problem will not be solved by providing more medical posts, by performing mass sterilizations or by vaccinating against diseases many of which are caused quite simply by hunger and malnutrition; nor will it be solved by sporadic donations of food or by charitable campaigns. The problem is structural and the change must thus be structural. Nation-States cannot survive by turning their backs on reality and excluding such vast segments of the population from development policies, or they will be forever provoking socio-political conflicts. In the case of our country, we must begin by recognizing our diversity and, thence, honestly embracing the principle of equality in that diversity, seeing it as an advantage not a stumbling-block. Our peoples can and must secure optimum human development without renouncing their cultures and identities, for they constitute our dignity; we have much to offer the modern age - the riches of traditional medicine, to cite but one example. Andean and Amazonian cultures possess a vast fund of knowledge about the properties and handling of medicinal plants, and that knowledge may hold out much hope for the diseases that plague mankind. We seek due recognition, as there ought to be, for the rights that belong to our peoples as the bearers of that knowledge. It is not fair that researchers and pharmaceutical companies should carry it off and patent it for their own profit, as has already happened countless times.

9. It must be recognized that improving health is a social, economic and cultural issue that ought to contribute to peoples' growth and development. Health spending is, in the long run, a productive investment, since countries' greatest wealth is and should be their human capital.

LEGAL COMMITTEE ON SELF-SUFFICIENT DEVELOPMENT FOR THE AUTOCHTHONOUS PEOPLES OF THE ANDES

[Original: Spanish]
[21 March 1996]

1. The distinguishing feature of the economic tradition among the autochthonous peoples of the Andes was a high volume of food production for the population. This gave rise to a genuine preventive health-care scheme that was in effect in the Andes until the sixteenth century.

2. Public health was administered directly by each grass-roots community and entailed no expenditure by a central authority. Food was at the same time medicine, and public health was a by-product of the communal welfare.

3. Health among the autochthonous peoples of the Andes consists of two inseparable elements: the physical health of individuals, and the public health of the community. If either should fail, disease will follow.

4. The only thing that has happened in health over the past four centuries is that food production has become disorganized and the entire preventive health scheme set in train by the ancient wise men of Peru in autochthonous Inca and pre-Inca societies has been dismantled.

5. Most of the diseases afflicting the indigenous population in Peru stem from malnutrition caused by poor diet. And poor nutrition reached the Andes with colonialism.

6. Poor nutrition, combined with the arduous labour imposed on the indigenous peoples in sawmills and mines and on estates, brought about a calamitous state of health in Peru. Add to this the uprooting, the violent deaths, the Inquisition and the economic disruption that colonialism and the ensuing republican system imposed, and the result is apathy and an unhealthy society from whose effects we are still suffering.

7. No part of the indigenous tribute, imposed since colonial times and regularly paid by the autochthonous population, was allocated for restoring the health of our indigenous peoples. Each community looked after its own health at its own expense.

8. It is astonishing to see, therefore, that after five centuries of malnutrition inflicted upon our autochthonous population, the indigenous peoples of Peru and South America are still extant, thanks to the magnificent public health arrangements left to them by their ancestors which even today subsidize health expenditure in the Andes.

9. Today, the heaviest drain on the Peruvian Ministry of Health budget is the cost of treating the diseases that afflict the country's indigenous population.

10. In any hospital in the Republic one can see a host of sick Indians. Thus the public health sector requires ever greater one-way flows of resources from the Government.

11. This requirement, however, has often been used to justify a chain of debt that to this day has not solved the problems of health and poor nutrition.

12. Although there is, in some cases, a willingness to put budgetary resources to good use, excessive centralism

prevents effective monitoring of the resources allocated for the health of the indigenous peoples; poor administration by bureaucratic placemen and even health professionals has brought the health system in Peru, where nowadays no kind of service is free, into ruin.

13. There is nothing in the budget for encouraging community-specific preventive health machinery; yatiris (healers) are not officially recognized as traditional doctors in the Andes; yet the bulk of the budget goes to pay the wages of medical personnel who have no wish to understand the native psychology of their Indian patients.

14. The indigenous population of Peru has no desire to remain a burden on the public health budget or to serve as a continuing excuse for debt. What it seeks is the right to self-determination in health-care planning and provision, and that, combined with untrammelled jurisdiction over their natural resources, ought to solve their health problems.

15. The indigenous population resort to a hospital only in the event of extreme illness, for they have no confidence in official establishments they receive poor treatment, the nurses and auxiliary personnel come from originally Spanish backgrounds and are hostile to Indians, and the care they provide makes their patients worse, not better. On the other hand, the public health service disregards both the social and the spiritual health of the autochthonous population.

16. The "official" medicine in Peru is western, which is not scientifically best suited to dealing with the health problems of a country where the majority of the population is indigenous. What is needed is a health system that draws on the philosophy of the autochthonous medical tradition.

17. The Andean autochthonous medical tradition is based, as stated above, on a preventive health scheme resting on a high level of food production and appropriate distribution, far removed from notions of centralism.

18. The health resources lying in Peruvian Amazonia still await exploitation, isolated cases apart. It is distressing to find that natives of the east of the country, forcibly moved to the city, fall prey to diseases they never experienced at home.

19. Generally, natural health, so readily acquired in Peru, has no place in current public health programmes. Health investment cannot be evaluated by counting hospitals and like institutions or by looking solely at the advances that western medicine has made in the country, but only by permitting a comparison with the outcome of an alternative, natural medical scheme for the public at large.

20. Health is not just a question of bodily well-being. It embraces living conditions, the state of the environment and opportunities for attaining well-being, in the economy and

elsewhere. The predations suffered by the Indian peoples disrupted their economy, with damaging effects on the health of peoples who to this day have not managed to return to their harmonious state.

21. The poor state of health of many of Peru's indigenous peoples is due to the fact that from colonization to the present day they have never had the opportunity to manage either their economy or their environment for themselves.

22. The right to think for the Indians has been arrogated, formerly by the Crown, today by Republican Governments, depriving the Indians of their ability to decide on their fate. This weighs on the health of the Indian peoples as societies, resulting in bodily and psychological malaise among their members. Justice will have been done when they are given the right to manage their own health systems directly.

23. The social pressures to which our peoples are currently being subjected arouse anxiety, fear and the danger of marginalization. No people can live healthily if it is weighed down by evils such as these. Nor could the largest national budget bear the cost of restoring an oppressed people to health.

INDIGENOUS PARLIAMENT OF AMERICA

[Original: Spanish]
[8 May 1996]
[extracts]

1. To understand the health problems of the indigenous peoples of the Americas, one must acknowledge that those peoples constitute a multi-ethnic population displaying an extraordinary variety of groups, languages, cultures, beliefs, traditions and identities. Land ownership and use is a problem of the first magnitude for the autochthonous groups in the region, since the land is fundamental to their livelihood, their culture and history and at the same time determines their survival and levels of health and nutrition. The health of indigenous peoples varies directly with the preservation and demarcation of the land they have traditionally occupied. Malnutrition caused by the dismantling of the food-production system and the destruction of means of survival is twice as prevalent among the indigenous population as among the low-income population.

2. The disease profile among the indigenous population groups is similar to that of the least well-off socio-economic strata. Viral diseases (influenza, measles, dengue, polio, arboviral respiratory diseases, hepatitis B and so forth) often become explosive epidemics, especially among groups with low levels of immunity. The incidence of endemic disease in tropical and subtropical areas (leishmaniasis,

oncocercosis, cisticercosis, Chagas disease, etc.) remains high, the indigenous population being particularly affected. Other transmissible diseases, such as tuberculosis and malaria, have made a come-back. Cholera epidemics among the indigenous population groups are frequent and deadly, and the frequency of sexually transmitted diseases has grown. AIDS represents a serious additional risk to indigenous groups living in areas with high levels of HIV infection.

3. The incidence of mental illness and disorders due to stress, violence, depression and suicide, and of accidental and violent death, alcohol, tobacco and other substance abuse has risen in the juvenile and adult indigenous population of both sexes. Parasitosis, caloric and protein malnutrition, and diseases due to micronutrient deficiencies (in particular of iron, vitamin A and iodine) persist. Thyroid hyperplasia, kidney and gallstones, obesity and diabetes mellitus are commonplace, especially among the indigenous peoples of North America. The health profile of the average indigenous woman is alarming, largely owing to the diseases mentioned above combined with the problems associated with her reproductive functions (e.g. early pregnancy; pregnancy and birth-related complications; iron-deficiency anaemia), other mental health problems (e.g. sexual abuse and domestic violence), and problems associated with her work in agriculture, the informal or service sector, or industry.

4. In rural areas, almost half the population has no access to clean water; two thirds have no sewage or refuse disposal services. The countries with the highest proportions of indigenous inhabitants display the lowest percentages of the population provided with water and sewage services. Contamination from chemical fertilizers, pesticides and organophosphate insecticides, coupled with the disposal of toxic and radioactive waste, aggravates the health situation in rural areas to the point where significant traces of products such as DDT and toxic levels of mercury have been found in surface water, in mothers' milk, and in food. Persistent and continual over-exploitation of natural resources (timber, gold, oil, and in the past other resources such as rubber) and successive waves of settlers combined with evangelizing missions, military invasions (in border conflicts, putting down subversion, etc.) and incursions by civilians bent on pursuing illegal activities such as smuggling and drug trafficking, are the greatest challenges to human and environmental health in many of the indigenous settlements in the Amazon Pact region, especially in Brazil and on the Amazon basin side of the Andean countries. The disappearance of green space and the construction of roads, dams, hydroelectric plants and other development projects have served to stimulate the proliferation of vectors and intermediate hosts, with a consequent marked rise in the transmission of some diseases among indigenous population groups.

5. This alarming situation demands immediate and longer-term

real, comprehensive and definitive solutions yielding lasting results. Health is not merely the absence of disease but the total, qualitative, dimension of human life. The therapeutic health model is not the only answer. Eighty per cent of the world population receives primary health care via traditional medicine - remedies based on herbs and medicinal plants; and 90 per cent of births in rural areas are attended by traditional birth assistants. Ethnomedicine based on religious and secular cultural beliefs, administered by agents such as herbalists, shamans, ritualists, bonesetters, quacks, diviners, birth attendants and other indigenous specialists, forms a nucleus of primary health-care workers for many communities and peoples all round the world.

6. Suggesting a merger of ethno- with biological medicine is not to say that modern medicine should return to the practices of the past, nor to idealize ethnomedicine. It does mean the incorporation into biological medicine of many of the beneficial and adaptive practices that ethnomedicine has to offer. The combination would remedy the shortcomings of both. Intercultural research will provide the underlying theory for cooperation between these pluralist medical systems within the national health system. The trick is to make it happen while avoiding a situation in which traditional health workers perform biological medical procedures without prior training, or practitioners of western medicine adopt aspects of ethnomedicine out of context. Some countries, Ecuador, Nicaragua and Bolivia among them, already have some worthwhile experience of combining the two health systems which should be followed up and extended. An exchange of information among the countries of the region will avoid a duplication of projects and efforts.