According to The Lancet Indigenous Health series of 2006, the poor health of indigenous peoples is associated with poverty, malnutrition, overcrowding, poor hygiene and environmental contamination, and prevalent infections. Some indigenous groups, as they make the transition from traditional to more modern lifestyles, are rapidly acquiring ‘lifestyle diseases’, such as obesity, cardiovascular disease, type 2 diabetes and physical, social and mental disorders linked to the misuse of alcohol and other drugs. There is also evidence that indigenous peoples are suffering from higher levels of infectious diseases, such as malaria, tuberculosis and yellow fever.

A 2007 report on the social determinants of indigenous health, prepared as part of the work of the World Health Organization’s Commission on Social Determinants of Health, found that indigenous peoples’ health is ‘intimately linked to the social and political environment in which they live’ (Netleton et al., 2007). Importantly, it recognised that, unlike many Western models of health, indigenous peoples’ notion of health is often not individual, but ‘encompasses the health of the whole community and the health of the ecosystem in which they live’.

The United Nations Declaration on the Rights of Indigenous Peoples (2007) went a long way in recognising the health rights of indigenous women and their communities. Moreover, the collective dimension of indigenous women’s rights were outlined in the declaration, which recognised that the individual rights are indivisible from the collective rights of the community and that the well-being of indigenous communities is dependent on the well-being of indigenous women, and vice versa.

How far states have met their obligations to their indigenous citizens, enshrined in the declaration, is to be the subject of the World Conference of Indigenous Peoples in September 2014, a high-level plenary meeting of the United Nations General Assembly, held to mark the end of the Second International Decade of Indigenous Peoples (2005–14).

The decade established a framework under which the rights of indigenous women were protected and promoted in several fields, including health and, in particular, gender-based violence.

Health outcomes in Commonwealth member countries

That indigenous women living in the Commonwealth require special attention was first recognised in the Commonwealth Plan of Action (PoA) for Gender Equality 2005–15, adopted by the Seventh Commonwealth Women’s Affairs Ministers Meeting (2004) and endorsed by the Heads of Government Meeting (2005). The Commonwealth PoA acknowledged that ‘indigenous women must not be left behind’.

Box 1 | Outside the framework

Indigenous peoples’ health outcomes

There are an estimated 370 million indigenous peoples living in more than 90 countries worldwide. It is projected that nearly half of these live in Commonwealth countries; in India alone, the 2001 census put the number of indigenous peoples or ‘Adivasis’ at 84 million – now likely to be nearer 100 million.

Indigenous peoples represent a rich diversity of cultures, religions, traditions, languages and histories and yet continue to be among the world’s most marginalised, discriminated against and impoverished population groups. The health status of indigenous peoples varies significantly from that of non-indigenous population groups in countries all over the world. Whether they live in an industrialised or developing nation, or in an urban or rural area, indigenous peoples experience poorer health care and are generally less healthy than the rest of the population.

According to Paul Hunt, UN Special Rapporteur on the right to health (2002–08): ‘In almost every country in the world, minorities and indigenous peoples are among the poorest and most vulnerable groups, suffering greater ill-health and receiving poorer quality of care … More often than not, this ill-health and poor health care are symptoms of poverty and discrimination.’

The discrepancies in health status between indigenous women and indigenous men was recognised as far back as 1999 by the UN Committee on the Elimination of Discrimination against Women, when it advised that ‘special attention should be given to the health needs and rights of women belonging to vulnerable and disadvantaged groups, [including] … indigenous women’.

The health challenges experienced by indigenous women were first examined in depth at the United Nations Permanent Forum on Indigenous Issues in 2004. It recognised that there are large discrepancies between the health status of indigenous women and that of non-indigenous women, with the former receiving poorer access to health care and lacking culturally appropriate services. These are seen as the two main areas of concern facing indigenous women today.

Helena Whall
women are marginalised and disadvantaged in comparison with other groups and that they face significantly greater poverty'.

The arising policy recommendations were presented to Commonwealth Women’s Ministers at their meeting in June 2007; however, the health issues were not formally acknowledged at this or subsequent meetings. With the implementation period of the Commonwealth Plan of Action for Gender Equality 2005–15 almost at an end, and the second International Decade of Indigenous Peoples nearly over, it is time to consider the health issues facing indigenous women around the Commonwealth today.

**Life expectancy**

Life expectancy at birth for indigenous peoples is ten to 20 years less than for the rest of the population. While disaggregated data for life expectancy of indigenous women is hard to obtain, particularly in developing countries, the evidence from income-rich countries suggests a pattern of lower life expectancy.

In Australia, Aboriginal women are expected to live almost ten years less than non-Aboriginal women, with a life expectancy of just 72 years, compared to 82 years. In New Zealand, a Māori woman’s life expectancy is also 72 years, eight years less than for non-Māori women (OSW, 2002). In Canada, the life expectancy for First Nations women is 76.2 years; the national average is 81.5.

**Maternal health**

Indigenous women face a number of barriers in obtaining the care they need when they are pregnant, giving birth or caring for young infants. Some of the key issues include poor health service provision, cost, discrimination and cultural barriers. Indigenous women are also often located in remote, rural areas where there are generally fewer critical care units for birthing complications, fewer traditional or trained birth attendants and large distances to travel to receive health care.

Australia’s non-indigenous and non-Torres Strait Islander women have one of the lowest maternal mortality rates in the world. But for Aboriginal and Torres Strait Islander women, the maternal mortality rate is five times the national average, and, while most Aboriginal mothers choose to give birth at home (‘in country’), there are less than 100 Aboriginal midwives registered in Australia out of a total of 330,000 registered nurses and midwives (Australian Government, 2010).

In Canada, the mortality rate for First Nations women (often as a result of violence) is three times that for other Canadian women. For First Nations women between 25 and 44, the rate is five times that of other Canadian women.4

In Malaysia, half of all Malaysian mothers who died during delivery in the 1990s were from the Orang Asli community, making an Orang Asli mother 119 times more likely to die in childbirth than a non-indigenous woman (Nicholas, 2000).

The maternal mortality rates among indigenous women ‘is very high in all countries in Africa’, with rural women in particular often having ‘only limited access to health care services, including services related to their reproductive health’ (Thornberry and Viljoen, 2009). However, the lack of formal recognition of indigenous peoples in many parts of Africa poses problems for gathering accurate evidence about indigenous women’s maternal mortality status.5

India’s Adivasis or tribal peoples have the highest maternal mortality rates in the country; rates in the tribal areas of Jharkhand and Odisha are three times the national average. Half of Adivasis women still deliver at home and less than 20 per cent have access to postnatal care.

**Health systems: Provision and access**

Remoteness is a serious factor inhibiting Amerindian women’s access to health care in Guyana, particularly for those living in rural areas in the interior of the country since these regions are far away from any health facilities and transport is poor. Without access to adequate screening, breast cancer mortality is currently on the increase in the interior of Guyana.5

The Jumma peoples living in the Chittagong Hill Tracts of Bangladesh, one of the country’s most deprived areas, suffer particularly extreme rates of ill health. The amount of unmet need for family planning services (i.e. married women who want, but who do not have access to, contraception) in Chittagong is 21 per cent, the highest in Bangladesh (for which the average is 14 per cent), and contraceptive use is 51.4 per cent, considerably lower than the national average of 61.2 per cent (Walker, 2013: p. 129).

The limited uptake of treatment among indigenous communities often reflects discriminatory practices and service structures, which promote distrust among indigenous peoples and exclude them from services that are widely available to non-indigenous populations.

Some indigenous peoples in Botswana benefit from a government development policy called the Remote Area Dwellers Programme (RADP), previously called the Bushmen Development Programme, which seeks to bring health care to people living in remote areas. However, this programme has been rendered largely ineffective due to the government’s policy of non-racialism, which results in indigenous peoples competing with, and often losing out to, other ethnic groups in such areas.7

For many indigenous communities, access to traditional medicine can supplement the services of mainstream health facilities. The Ba’Aka of Camerooon, for example, support their health needs by using their traditional medicine skills to utilise forest resources; however, with much of their traditional lands lost to agriculture, agroforestry or logging, they have lost access to such resources and their health levels are in decline (Walker, 2013: p.21).

**Violence against indigenous women**

Violence against indigenous women is widespread and takes many forms: domestic or cultural violence; state violence; and what is referred to as ecological or environmental violence. HIV/AIDS and sexually transmitted diseases (STDs) are two of the most urgent challenges faced by indigenous women today, with gender-based violence a major contributing factor.

Almost one quarter (23 per cent) of Australian Aboriginal women aged 15 or over were victims of physical or threatened violence during 2001 (ABS, 2002). Assault was found to be the most common cause of hospitalisation for injury among Aboriginal women, with such admissions 33 times higher than the average among non-Aboriginal women.
First Nations women in Canada represent ten per cent of the cases of murdered and missing women, with nearly half of the cases of missing women remaining unsolved (Teul, 2003).

The Toledo Maya women in Belize are reported to suffer high rates of domestic violence and there is little recourse a woman can take to rectify her situation. As one Maya woman writes (Jackson, D., 2003: p. 13): ‘Maya women who attempt to leave their abusers may find themselves completely isolated if they try to support a family as a single parent and are culturally discriminated against by other families.’

In Sub-Saharan Africa, indigenous women ‘are often victims of unwanted sexual attention, sexual assault and rape’, their ‘disproportionate levels of poverty’ often causing them to engage in sex work, making them vulnerable to HIV/AIDS and STDs. Perpetrators of the armed conflict in the African Great Lakes Region inflicted ‘appalling sexual violence’ on the indigenous Tw’a women of Rwanda and Uganda, contributing to a marked increase in HIV infection among Tw’a women (Jackson, 2003).

Tribal Pushhtun women in the Federally Administered Tribal Areas of Pakistan are particularly vulnerable as a result of traditional practices, such as swara (where a woman is given in compensation to bring peace between two fighting clans), so-called ‘honour’ killings, bride price and forced marriage.

In India, according to the latest National Crime Records Bureau of the Ministry of Home Affairs, a total of 654 cases of rape of tribal women were reported in 2010 as compared to 583 cases in 2009, an increase of 12.2 per cent.

Ecological or environmental violence
There is a direct link between the sexual and reproductive problems faced by indigenous women and their displacement from their traditional lands as a result of land grabbing, eviction or the rise of extractive industries in indigenous territories.

Forcibly evicted from their ancestral lands in Kenya, many Ogiek communities are now completely landless and living in extreme poverty, without proper shelter, food, safe water or sanitation.

Displacement and loss of access to ancestral territory has also had devastating effects on the Batwa communities of Uganda and particularly on the health status of Batwa women.

Looking forward: Indigenous women and the post-2015 development framework
The evidence above reveals that indigenous women continue to face serious health disparities in all Commonwealth countries examined and that, in many cases, this represents failures on the part of member states and their health systems as duty-bearers. As the Commonwealth Policy Studies Unit recognised over a decade ago, the Millennium Development Goals (MDGs) themselves are failing indigenous peoples. Advances in some MDG health indicators have masked in-country inequalities, including those between indigenous and non-indigenous peoples.

A 2009 United Nations report noted that the MDGs were ‘potentially detrimental to indigenous peoples’ since the goals were based on an approach that fails to uphold ‘indigenous peoples’ individual and collective rights’ and did not ‘consider the indigenous concept of health, which extends beyond the physical and mental well-being of an individual to the spiritual balance and well-being of the community as a whole’ (Bourne, 2003).

Paul Hunt, UN Special Rapporteur on the right to health (2002–08), has gone so far as to say that stretched resources lead governments and donors ‘to focus on easy-to-reach population groups’ and in effect allow persistent inequalities to be ignored.

At the heart of the vision for the post-2015 sustainable development agenda is the notion of equity and inclusivity, as the 2013 Report of the High Level Panel of Eminent Persons noted, the post-2015 framework must ‘leave no one behind’. It is essential that indigenous women and their communities are not left behind in the new development programme.

To ensure indigenous women and their communities achieve the right to health through the new global development framework, Commonwealth member states should adopt special measures to address their specific needs. Strategies should be put into place for building the capacity of indigenous women and their communities to claim their right to health and for member states to respect, protect and fulfil this right.

Conclusion and recommendations

Collective rights of indigenous peoples: The key to improving the health situation of indigenous women and their communities is to recognise that their health and well-being are inextricably linked to their collective rights, including their rights to land and natural resources, and their rights to conserve and practise traditional knowledge. Efforts that codify, protect and advance the individual and collective rights of indigenous peoples will have positive health impacts on indigenous women.

Rights to participate fully in institutions and decision-making: There must be ongoing integration of the perspectives and needs of indigenous women and their communities into global health programmes, plans, projects and policies, including initiatives to achieve the Millennium Development Goals.

Indigenous health institutions: This must involve the incorporation of strategies that respond to the particular needs and visions of indigenous women and their communities in policies of health care, prevention, promotion and education.

Indigenous concept of health: Indigenous health systems should be preserved and strengthened to increase access to and coverage of health care. Clear mechanisms of co-operation must be established among relevant health care personnel, communities, traditional healers, policy-makers and government officials in order to ensure that health systems respond to the specific needs of indigenous women and their communities.

Data collection and research methodology: In order to design more effective health policies, there must be concerted efforts to create improved systems of data collection and research methodology, including research into traditional medicine that incorporates the participation of indigenous women and their communities and reflects cultural and social considerations relating to the health of the same.

The 2013 Commonwealth Charter, with its opposition to ‘all forms of discrimination’ and commitment to the right to health, human
rights and sustainable development while ‘preserving and conserving natural ecosystems’, empowers the Commonwealth to take a lead in improving the health situation of its indigenous women and their communities. Now that the health of their indigenous female populations are starting to become more widely understood by the global health community, it is time for Commonwealth Health, Women’s Affairs and Law Ministers to come together and examine ways of advancing Commonwealth-wide initiatives and programmes designed to meet the health rights of indigenous women and their communities; this is the key to achieving health equity across the Commonwealth.

Acknowledgement

This article is based upon a paper presented by the author at a 2007 pan-Commonwealth workshop. For more information, see the report of the workshop: ‘Addressing the marginalisation of indigenous and tribal women’. London: Commonwealth Secretariat.

Endnotes

1 Arising from this mandate, the Commonwealth Secretariat organised the 2007 pan-Commonwealth workshop entitled Addressing the Marginalisation of Indigenous and Tribal Women. This was a key moment since it was the first time that their situation was comprehensively examined from a Commonwealth perspective.

2 Australian Bureau of Statistics.

3 Submission by the Native Women’s Association of Canada (NWAC) on Aboriginal Women and Health Care in Canada, to the Commission on the Future of Health Care in Canada, May 2002, p. 4.

4 Ibid.

5 While there is no accurate data on maternal mortality rates among the San women of Namibia, the rates are believed to be ‘extremely high’. Maternal mortality rates for non-indigenous women have doubled since the early 1990s, mainly due to HIV/AIDS, with San women being particularly vulnerable to HIV infection because of their comparatively low access to sexual and reproductive health services and information. Namibia has an adult HIV prevalence rate of 13.4 per cent, but the San do not always know about the risks since there are no public health campaigns in San languages. The remoteness of many San and Himba groups aggravates their vulnerabilities. Over 80 per cent of San live more than 80 km away from any type of health facility.


8 For example, there is a high incidence of rape among San women in Namibia; the problem is so acute that the Committee on the Elimination of Racial Discrimination highlighted the issue in its examination of Namibia’s state report of 2008. Early and forced marriage is found among the Maasai of Tanzania. In Nigeria, there is a high prevalence of vesicovaginal fistula among Fulani women, due to the fact that girls are given in marriage at a very young age. Female genital mutilation (FGM) is traditional among the pastoralist communities of Kenya and is still practised, despite being legally criminalised in 2001. According to the countries’ demographic Health Survey of 1998, more than 55 per cent of Kenyan communities still practice female (and male) circumcision. While accurate statistics are not available, recent research indicates that among the Samburu community, over 95 per cent practice FGM. Girls from indigenous pastoralist communities in northern Kenya, including the Samburu, continue to suffer very underage sexual relationships as a result of cultural practices such as ‘girl beading’. The tradition frequently leads to unsafe abortions, increases the spread of HIV/AIDS and forces girls to leave school early.

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