

Health Inequalities and Indigenous People The NCD Alliance – December 2012

The NCD Alliance (NCDA) was founded by four international NGO federations representing the four major non-communicable diseases (NCDs) – cancer, cardiovascular disease, chronic respiratory diseases and diabetes – uniting a network of 1,000 member associations and a further 1,000 civil society organisations in more than 170 countries. NCDA is focused on ensuring the integration of NCDs and broader global health priorities into all dimensions of development, as related to the contours and content of the post-2015 development agenda.

NCDs are the leading cause of morbidity and mortality, accounting for two out of three deaths and half of all disability worldwide. Indigenous people face disproportionately high rates of NCDs, exacting a heavy and growing toll on both physical health and economic security and increasing inequalities within and across these diverse populations.

Member States and the UN system have a political mandate to ensure that NCDs are adequately addressed in indigenous populations. The UN convened a High-level Meeting on the Prevention and Control of Non-Communicable Diseases in September 2011, with Member States unanimously adopting a Political Declaration on the same topic. The Political Declaration on NCD Prevention and Control recognised that indigenous people suffer major health disparities in the incidence of NCDs and committed to implement culturally relevant policies and programmes for NCDs that involve indigenous people.

Health inequalities among indigenous people

The term “indigenous peoples” refers to some 300–370 million people in at least 5,000 diverse and separate groups living in 70 countries on five continents. They are among the world’s most marginalised people, isolated politically and socially within the countries where they reside by the geographic location of their communities and by their separate histories, cultures, languages and traditions. While statistical data on these groups is very incomplete, according to the UN Permanent Forum on Indigenous Issues, they represent 5% of the global population, but about 15% of the poor. Of the 900 million poorest rural people in the world, they represent one-third.

Indigenous peoples have their own traditional health systems, but can face a myriad of obstacles to accessing systems such as public health care, including economic, geographic, linguistic, educational and social/cultural/religious barriers. In Guatemala, for example, health services only reach 54% of the total indigenous population, and in rural areas, access drops to 25%. As a result, they suffer higher rates of ill health and have dramatically shorter lifespans than other groups living in the same countries. For example, the life expectancy gap between indigenous and non-indigenous people in two countries as different as Australia and Nepal is 20 years; in Guatemala, it is 13 years; and, in Canada, seven years. The health inequity that results in indigenous peoples suffering poorer health, being more likely to experience disability and ultimately dying at younger ages than non-indigenous counterparts is a violation of the human right to health.

The burden of non-communicable diseases among indigenous populations

Numerous studies report that indigenous peoples have higher rates of non-communicable diseases (NCDs) than the general population.

The NCD Alliance was founded by:



According to the UN, worldwide more than 50% of indigenous adults over 35 have type two diabetes and the incidence is rising among this population. A study comparing homeless aboriginal people in Canada with the non-aboriginal population found that 43% suffered from arthritis or rheumatism (versus 14% of the non-aboriginals), 35% had heart disease (versus 4%), 24% had chronic obstructive pulmonary disease (versus 1%); 22% had asthma (versus 6%) and 22% had diabetes (versus 4%). Since these were homeless aboriginal people, clearly extreme poverty was a contributing factor to the results.

Asthma is the second most common cause of hospitalisation among indigenous peoples from Australia – an indication not only of the high incidence, but also of poor asthma management. Although mortality rates for asthma are not high – approximately 250,000 deaths each year out of a global population of 235 million affected by asthma, deaths from asthma are higher among indigenous peoples than other groups. A study in Australia found the death rate was 3.2 times higher; while among the American Indians and Alaskan Natives living in Washington State in the USA, the rate was two times higher. In Washington, close to 25% of low-income indigenous people suffer from asthma.

Acute rheumatic fever (ARF) and rheumatic heart disease (RHD) are other NCDs that disproportionately affect indigenous peoples. These diseases, which seem to go hand-in-hand with the crowded living conditions and lack of access to medical care that are common among the poor, have declined in industrialised countries except among these groups. While data is not available for all indigenous peoples, studies of Alaskan Natives in Alaska found their mortality rate due to RHD was twice that of other Alaskans, while indigenous Fijians were 2.2 times as likely to have ARF as the non-indigenous population.

NCDs are also linked to and interact with communicable diseases. For example, people with diabetes are two to three times more likely to develop active tuberculosis, and they tolerate TB treatment less well. The rising incidence of diabetes may therefore also lead to an increase in TB among indigenous peoples.

Worldwide, many indigenous peoples with NCDs remain undiagnosed, untreated and at risk from life-threatening complications that can be effectively prevented with medicines, technologies and self-management of the disease. Further, failures in health data collection and surveillance means that the actual burden imposed by NCDs is underestimated.

As with other vulnerable and low-income populations, indigenous peoples suffer disproportionately from the economic impact of NCDs on individuals, families and communities.

Risk factors for NCDs

Underlying social, economic, environmental, historical and genetic factors are the structural drivers of health inequality for indigenous peoples. Forced displacement, the degradation of customary lands and waters, extreme poverty, the lack of access to education, employment and social services, the decline of socio-political structures and dramatic changes in traditional food sources and diets increase exposure to NCDs and worsen health outcomes. Health solutions for indigenous peoples will require addressing the major risk factors for NCDs, including tobacco use, physical inactivity, indoor air pollution, poor diet and inadequate nutrition, and the harmful use of alcohol.

Studies have shown that tobacco use is significantly higher among indigenous peoples. For example, a study published in 2011 found that among USA/Alaskan Native Americans, 32% smoke – a rate 10%

higher than for non-indigenous residents. Among indigenous people from Australia, the difference between the two rates was even greater, 45% versus 20%. Among Inuits not living on reservations, the smoking rate was 59.8%, while the rate for non-indigenous Canadians was only 18%.

Nearly three billion people, most from in low-income populations including indigenous people, rely on solid fuel for cooking, lighting and heating. Studies have found that, in Mexico alone, 27 million people use wood as their energy source and that, among Alaskan Native infants, bronchiectasis, a severe form of chronic pneumonia, remains common although it is now rare in industrialised countries. The WHO estimates that nearly two million people die each year from pneumonia and other respiratory diseases, as well as cancer, caused by indoor air pollution from unhealthy cook stoves.

Poor nutrition is a major health issue among the indigenous peoples. Challenges range from the loss of traditional food sources due to environmental changes and loss of land or territory to shifts in diet, such as eating more processed foods. Malnutrition is widespread in many regions; for example, among indigenous populations in Latin America, 95% of children under 14 in Honduras are malnourished. A literature review published in 2007 found that the rate of overweight and obesity among American Indians and Alaskan Natives of all ages – pre-school through adult – was higher than US rates for all other races combined. In addition to cardiovascular diseases, studies show that obesity is associated with a greater risk of asthma, as well as worse asthma symptoms.

Alcohol use patterns vary among indigenous peoples. A 2008 study in Australia found that almost twice as many indigenous people had *not* had a drink for 12 months as non-indigenous people, but an earlier study (2004–2005) found they were twice as likely to binge drink (17% versus 8%). In the United States, a CDC report found that American Indians and Alaskan Natives were approximately twice as likely to die from alcohol-related causes than the general population. Of these deaths, ischemic heart disease almost matched acute causes, such as traffic accidents; and, in total, chronic causes, including hemorrhagic stroke, hypertension, liver cancer, alcoholic liver disease and cirrhosis (unspecified), outnumbered acute causes by close to two to one.

Indigenous people also experience major structural barriers to accessing health care. Geographical isolation and poverty from out-of-pocket payments for transport, treatment and care are compounded by discrimination, racism and a lack of cultural understanding and sensitivity. Many state health systems do not reflect the social and cultural practices and beliefs of indigenous peoples; communication between different communities is often challenging; and indigenous people's concept of health – which encompasses physical, social, mental, environmental and spiritual wellbeing – is often ignored. This makes the treatment and management of lifelong health conditions a significant challenge.

Strategies and/or interventions to address inequalities

Over the past two decades, overarching international efforts have been made to improve broad awareness of the needs and rights of indigenous peoples, as well as indigenous peoples' engagement in developing policy and programmes to improve their human rights. In the first Decade of the World's Indigenous Peoples (1995–2004), the UN created the UN Permanent Forum on Indigenous Issues (UNPFII). A Second Decade has followed (2005–2015) and the UN Declaration on the Rights of Indigenous Peoples passed in 2007 after having been debated for more than 20 years. This non-legally-binding declaration addresses both individual and collective rights and covers issues related to health strategies in requiring protection and promotion of traditional cultures, the right of self-determination and participation of indigenous people in decisions that affect their lives.

An approach to health based on human rights will be critical for reducing health inequalities, because this approach would address the underlying social determinants of poor health and tackles structural barriers to health care with culturally appropriate programmes and policies that fully involve indigenous people. Any policies, strategies and interventions must respect the individual and collective rights to the highest attainable standards of health and health services, as set in the United Nations Declaration on the Rights of Indigenous Peoples.

To this end, the NCD Alliance calls for:

- The active participation of indigenous peoples in the design, implementation and evaluation of the response to NCDs, with full recognition of indigenous concepts of health and wellbeing.
- Early detection and treatment of NCDs in indigenous communities that are identified as being at high risk through validated risk scores, screening, immediate treatment for those with NCDs, and counseling and future screening for those at high risk. This will avoid life-threatening complications and is essential for addressing the deadly NCD burden in these populations.
- Urgent action to reduce the exposure to NCD risk factors – primarily tobacco use, physical inactivity, unhealthy diet and harmful use of alcohol – through education, health promotion campaigns and a Health in All Policies approach.
- Specific focus on the education, screening and detection of NCDs in indigenous women – especially those who are pregnant or of reproductive age.
- Strengthening of health systems to address the prevention, treatment and management of NCDs in indigenous communities, with specific focus on expanding the presence of indigenous peoples within the health workforce and integrating traditional knowledge, medicines and practices into broader health systems.

Lack of data is a major factor creating inequality for indigenous peoples. One of the key issues emerging from the “decade” campaigns has been that the Millennium Development Goals (MDGs) were too broadly defined, and that data would need to be disaggregated to determine what gains the indigenous peoples made during this period.

The WHO’s Health of indigenous peoples Fact Sheet No 326 (October 2007) also points to the critical need for more and better data on indigenous peoples as a starting point for culturally appropriate health care that is provided in an equitable and accountable way.

Some examples of success in addressing NCDs:

- The Washington State Department of Health (USA) produced a report in 2012 on “Asthma Among Native Americans and Alaska Natives in Washington State”, which is described as the first to describe the burden of asthma specific to this population. (Washington is home to 29 federally recognised American Indian tribes that account for 1.5% of the state’s population.)
- Several agencies within the US Department of Health & Human Services collaborated on a “CultureCard: A Guide to Build Cultural Awareness” to provide basic information for disaster

responders and other service providers working with American Indian/Alaskan Native groups. It briefly covers myths and facts, cultural customs and religious beliefs, do's and don'ts and more.

- A literature review of smoking cessation efforts in Australia, New Zealand, Canada and the US found that community-based, flexible interventions could be successful, but that, for indigenous peoples, more tailored approaches were needed.

Based on experience, what are the most important recommendations that could be proposed in the Post-2015 Development Agenda for making a lasting and transformative impact on the different forms of inequalities faced by indigenous peoples?

Since its inception in 2009, the NCD Alliance has been working to ensure that non-communicable diseases, which were not included in the Millennium Development Goals (MDGs), are well placed on the post-2015 health agenda. This will be essential for addressing the major health inequalities faced by indigenous people. Combatting the rising incidence of NCDs among these groups will require the same intensive efforts as for low-income countries. These targeted efforts will need to range from health education regarding risk factors to access to health care that includes resources for both preventive and chronic care, as well as acute care, and endeavours to reach these groups in ways that acknowledge and respect their traditional knowledge and beliefs.

The NCD Alliance aims to ensure that future goals drive progress on prevention, treatment and care for all people. We support an overarching focus on reduced morbidity and mortality – or healthy life expectancy – that will drive progress on health for all. We stress that this must be underpinned by specific targets for priority health issues, such as NCDs, and for vulnerable groups, such as indigenous populations.

Further, we are calling for the post-2015 framework to include specific enablers – health in all policies, universal health coverage, food and nutrition security, the life course approach and patient empowerment – that will be crucial for addressing health inequalities in indigenous people. It will also be important to ensure health indicators are integrated throughout the post-2015 framework – in issues ranging from economic development to environmental sustainability – to ensure that development promotes rather than harms health. This is a priority for indigenous health and wellbeing threatened by current patterns of economic development, trade and globalisation.

What actions and initiatives could be taken by different stakeholders, including civil society and indigenous peoples organizations, to bring about lasting improvements in these inequalities? And how should those who face inequalities themselves be enabled to participate in the implementation phase of the new Development Framework?

Following their political mandate in the UN Political Declaration on NCD Prevention and Control, UN Member States agreed a set of nine global targets and twenty-five indicators for NCDs in November 2012. These political commitments, if fully and equitably implemented across the whole of society, will drive major progress in the health inequalities faced by indigenous peoples. Monitoring data collected will be disaggregated by gender, age group, socio-economic position and “other relevant social determinants”, which must include indigenous groups, where relevant.

As we go forward into the post-2015 era, governments at all levels need to build an enabling environment for civil society that includes clear roles, consultation and engagement. This will help to ensure that indigenous people with NCDs – or at risk of them – can participate in the implementation of the UN Political Declaration, including the development of national NCD plans, voluntary global NCD targets, the Global Action Plan for NCDs 2013–2020 (under development) and the post-2015 development agenda. Capacity building at the country level and support for civil society monitoring and evaluation are also essential. Finally collaborative and multisectoral partnerships will be needed to drive action at all levels – including intersectoral collaboration between different UN agencies and the UN Permanent Forum on Indigenous Issues.

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