Global Indigenous Health: An Opportunity for Canadian Leadership

University of Victoria
Centre for Aboriginal Health Research

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With special acknowledgement to the indigenous peoples of the world and their partners on their journey towards strong, healthy communities.

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Whereas Indigenous Peoples' often are minority populations within nation states, world wide some 370 million Indigenous people[1] represent a myriad of unique cultures, speak over 4000 languages, and inhabit such geographically dispersed regions as Arctic tundra, the Kalahari Desert, and Amazonian rainforest[2]. Such astounding diversity presents conceptual and practical challenges to both global Indigenous health research and to national efforts to improve the health status of Indigenous peoples. However, it also reflects a collective abundance of knowledge and cultural resources which Indigenous peoples can apply to improving their circumstances, if only space can be made at the table for meaningful involvement of Indigenous persons and their perspectives in research and decision-making to improve health and well-being.

In recent years, much attention has been paid to the health status of Indigenous peoples, and shocking health disparities have been revealed. Indigenous people consistently suffer higher burdens of disease and lower life expectancies than the general population; it seems that no matter where one investigates health disparity, Indigenous people fare worse than their non-Indigenous compatriots[3].

In Canada, the gap in the average life expectancy between First Nation and non-Aboriginal Canadians is approximately seven years[4]. In Australia, non-Aboriginal people live on average 20 years longer than their Indigenous counterparts[5]. Similar gaps of six years and thirteen years have been reported in Mexico and Guatemala, respectively[6]. Particular health issues affecting mortality and quality of life of Indigenous peoples globally include, but are not limited to; maternal and infant mortality, malnutrition, chronic conditions including diabetes and cardiovascular disease, HIV/AIDS, malaria, tuberculosis. Though often assumed to occur predominantly

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1 *Bartlett, J., Madriaga-Vignudo, L., O'Neil, J., & Kuhnlein, H. (2007).*

2 *ECOSOC (2010); Gracey, M. & King, M. (2009)*

3 *Stephens, C., Porter, J., Nettleton, C., & Willis, R. (2006); ECOSOC (2010); WHO (2002).*

4 *Health Canada, 2007.*

5 *ECOSOC (2010).*

6 *Ibid.*

in LMICs, malnutrition is also apparent in high-income countries such as Canada, where it is associated with increased prevalence of obesity, diabetes, and other non-communicable diseases. These health concerns pose serious threats to the continuation of small, marginalized communities, and yet they do not represent the full extent of ill health, which Indigenous peoples may experience.

Indigenous understandings of health are more expansive than the definition adopted by the WHO in 1948: "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity[7]". Though Indigenous definitions of health vary across the multitude of Indigenous cultures, they share many traits: social, cultural, and spiritual connections to traditional lands; identity as a member of an Indigenous community; and, well-being is generated by balance in relationships between mind, body, spirit, and heart, between the individuals in a community, and between communities and the natural environment[8]. As described by Nettleton, Napolitano, and Stephens (2007), Indigenous perspectives on the meaning of well-being are centered on communities, rather than individuals; thus, addressing upstream social determinants of health (SDH) is critical to promoting the health and well-being of Indigenous communities.

Circumstances where Indigenous communities suffer disproportionate burdens of illness emerge from a context of material deprivation, social marginalization, colonialism, and environmental degradation[9]. In other words, the health inequities suffered by Indigenous peoples are rooted in the social and physical contexts in which Indigenous communities exist. These social determinants of Indigenous peoples' health are related to, but distinct from those which were the focus of the WHO Commission on Social Determinants of Health[10]. Social determinants of health which are missing from the Eurocentric dialogue include: relationship with and access to traditional territories; ecological integrity of traditional lands; and, identity as a member of an Indigenous community[11]. Moreover, many underlying causes of illness in the general population, such as income and education, are also relevant to indigenous health; however, conventional indicators

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7 World Health Organization (WHO) (1946). p.100.

8 Nettleton, C., Napolitano, D., & Stephens, C. (2007). p.5.

9 ECOSOC (2010) p.161; PAHO, 2003

10 King, M., Smith, A., & Gracey, M. (2009). p.76

11 Nettleton, C., Napolitano, D., & Stephens, C. (2007).

of these determinants must be interpreted differently when applied to indigenous peoples[12]. For example, many indigenous persons live outside the monetary economy and are part of a traditional community – such persons may consider themselves in better health than indigenous persons who have migrated to urban areas and are feeling isolated and out of touch with their community[13]. Careful thought needs to be given to how conventional (i.e. Eurocentric) social determinants of health 'interact' with a study population's indigeneity[14] before analyzing or interpreting data. The experience of being indigenous also leads to social determinants of indigenous health which are distinct from those of 'general' populations, specifically: relationship with traditional lands, migration to urban areas, and colonization[15].

In 1994, the UN declared the International Decade for the World's Indigenous Peoples "to foster international cooperation to help solve problems faced by indigenous peoples in such areas as human rights, culture, the environment, development, education, and health"[16] which would run from 1995 to 2004. This decade saw the formation of the UN Permanent Forum on Indigenous Issues (UNPFII) in 2002, which provides Indigenous people with a means to have their concerns aired before the general assembly. That same year, an Inter-Agency Support Group on Indigenous Peoples' Issues was formed between the UN and WHO to support the newly formed UNPFII.

The Pan-American Health Organization began its work on Indigenous health in 2003; however, as of 2007 only 3 of its 21 country members had health programs in place specifically for Indigenous people[17]. A review of indigenous health research from Australia, the US, Canada, and New

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12 Ibid. p.112-13.

13 Ibid. p.112.

14 Defining and establishing the indigeneity of any particular group is a debate which has occupied the GIHR dialogue for many years. Many Indigenous groups oppose the adoption of a single, global definition of "indigenous", as do many national governments (ECOSOC, 2010, p.5; Bartlett et al, 2007). The UN Permanent Forum on Indigenous Peoples points to the oft-cited Martinez-Cobo Study (1986/87) and the International Labour Organization convention no. 169 for working definitions of "indigenous", though ultimately the right remains with individual Indigenous communities to define themselves and self-identify, as advocated by Stephens et al (2006) and Bartlett et al (2007) and more recently the UN Declaration on the Rights of Indigenous Peoples.

15 Nettleton, C., Napolitano, D., & Stephens, C. (2007). p.113.

16 Office of the High Commissioner for Human Rights, no year

17 PAHO (2008).

Zealand – which are arguably the countries with the strongest indigenous health sectors – revealed that much of the indigenous health research taking place prior to and during the decade was descriptive in nature; it was aimed at characterizing indigenous peoples and the health challenges they are faced with rather than building indigenous capacity to address those challenges or alleviating the social conditions which exacerbate them[18].

During this time period, important seeds for global indigenous health research were planted in Canada and key partnerships developed with the support of Canadian Institutes of Health Research's Institute for Aboriginal Peoples' Health (CIHR-IAPH), a major priority of which was to "… build research capacity…in indigenous communities around the world by forming alliances and partnerships in the global health research arena"[19]. The CIHR-IAPH pursued a tri-partite agreement concerning the funding of indigenous health research with the national health research funding bodies of Australia and New Zealand and formed the International Network for Indigenous Health Knowledge and Development (INIHKD). Memoranda of understanding were also formed with the National Institutes of Health in the U.S. and Mexico.

The CIHR-IAPH participated in the Global Health Research Initiative – a multi-agency endeavour involving CIHR, the International Development Research Centre (IDRC), the Canadian International Development Agency (CIDA), and Health Canada. In Canada, the indigenous health research community has been involved with global health research from the beginning thus representing a strategic opportunity for a unique Canadian contribution to global health.

While important international bonds were formed, it was generally concluded that the Decade for the World's Indigenous People did little to improve the circumstances of Indigenous peoples worldwide[20]. As a result, a second International Decade for the World's Indigenous Peoples was declared in January 2005. In recognition of the phenomenon that social factors have significant influence over health outcomes across and within countries, the WHO formed the Commission on Social Determinants of Health (CSDH) in 2005[21]. As a part of this process, the International

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18 Sanson-Fisher, R., Campbell, E., Perkins, J., Blunden, S., & Davis, B. (2006).

19 Reading, J. (2003). p.185

20 UN General Assembly. (2005). p.7.

21 Marmot, M. (2005).

Symposium on the Social Determinants of Indigenous Health was held in Adelaide, Australia in 2007. This event brought together perspectives of the world's leading indigenous scholars, including an Assembly of First Nations discussion paper[22], and resulted in a policy paper which was presented to the CSDH emphasizing the importance of international collaboration to the improvement of indigenous peoples' health[23]. In recent years, PAHO has also been orchestrating numerous international meetings on indigenous peoples' health. In 2007, the United Nations General Assembly adopted the Declaration on the Rights of Indigenous Peoples, and this past week (Nov, 2010) the Canadian government issued a statement through Indian and Northern Affairs Canada expressing its support for the principles described in this document. In 2008, the WHO published its final report on the CSDH; however, no special attention was paid to the situations of Indigenous peoples despite the report's focus on eliminating health inequities[24].

Once again, however, Canadians are at the forefront of global indigenous health research. In 2006, the Canadian Coalition for Global Health Research (CCGHR) drafted a strategic work plan stating that "Indigenous health should become a cross cutting theme in international development efforts"[25]. The INIHKD has also continued to strengthen the bonds between indigenous health researchers in Canada and in partner countries. In the summer of 2008, CCGHR's Summer Institute for emerging global health researchers was on Indigenous health and co-hosted by the University of Victoria's Centre for Aboriginal Health Research (CAHR) and CIHR-IAPH. To build momentum based on this gathering of global health researchers, CAHR and CCGHR also co-hosted the Symposium on Global Indigenous Health Research at this time, which brought together researchers in indigenous health from across the world to share their research and perspectives on GIHR[26]. Perhaps Canada's most important contribution to indigenous health research has been CIHR-IAPH's ethics for health research involving Aboriginal people[27] which has informed revision of Canada's tri-

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22 Reading, J., Kmetic, A., & Gideon, V. (2007).

23 International Symposium on the Social Determinants of Indigenous Health, Adelaide, Australia. (2007).

24 WHO CSDH (2008).

25 CCGHR (2006) p. 1.

26 Reading, J., Marsden, N., Kurbanova, D., & Link, R. (2009).

27 CIHR (2008).

council policy of Ethics for Research expected to be released in December, 2010. The creation of research ethics in collaboration with Indigenous people for nation-wide application in research involving Indigenous people is a rarity world wide, and reinforces Canada's visionary leadership role.

As the world passes the halfway point of the Second International Decade of the World's Indigenous People, three factors have emerged as critical to global Indigenous health research: the development of global networks of Indigenous health researchers; the emphasis of Indigenous people and communities as agents of research, rather than subjects; and, the incorporation of an Indigenous lens on health and health equity with existing global health research capacity.

An important outcome of the International Symposium on the Social Determinants of Indigenous Health was the consensus that global networks of researchers contribute greatly to the advancement of GIHR. Participants argued that since the dispersion of Indigenous peoples does not always coincide with national boundaries, investigating the health of Indigenous people at the national level can mask health inequities[28]. In a world where most countries do not recognize the existence of Indigenous peoples within their borders[29] an international platform for research provides unacknowledged Indigenous peoples with recourse to research and information even when they are denied these by their own national governments[30]. Finally, in an age of decreasing communications costs and telecommunications, international networks represent a cost-effective means of information sharing, and generating 'economies of scale' in a field that is often under-resourced at the national level.

Another trend emerging from the past fifteen years of international efforts to improve the circumstances of Indigenous people is that of involving Indigenous people as agents of research. This change in attitude away from paternalism towards collaboration is reflected in the CCGHR's mission, the ethics for research involving Aboriginal people created by CIHR-IAPH, and

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28 International Symposium on the Social Determinants of Indigenous Health, Adelaide, Australia. (2007).

29 Gracey, M. & King, M. (2009). p.65

30 CCGHR (2006) explains that bi-lateral research arrangements between Indigenous communities and organizations such as theirs are, for the time-being, more desirable as many nations do not have policies or administrative processes for linking disadvantaged communities with researchers.

as a direct result of a growing Indigenous movement world wide[31]. Research methods such as participatory-action research and community-based research are consistent with these new attitudes and have been successfully implemented in many countries[32].

Finally, characterizing an Indigenous lens on health and health equity and incorporating this with existing global health research capacity is an opportunity for taking one giant step towards a more equitable society. The field of health equity already examines health justice according to PROGRESS-Plus, an acronym which encompasses many of the social characteristics (such as religion, gender, or socio-economic status) which are sources of discrimination[33]. We know that health research along these different parameters – such as women's health - often necessitates the use of different criteria for evaluating health services or public health policies. As explained above, 'indigeneity' also influences how researchers analyze social determinants of health and the criteria of adequate health services, and thus forms a pillar of global health with a strong moral prerogative. Indigenous researchers also contribute to global health through their unique perspectives which enrich the study of global health and the emphasis on fairness and collaboration, which are also important in this complex field of research. As Durie (2004) explains, the interface between Indigenous and Western knowledge – which Indigenous researchers are well-prepared to navigate – is a source of innovation. Indigenous communities' unique connections with their land yields cultures, languages, and intellectual perspectives founded upon ethics of respect, conservation, and stewardship. These values will be critical for addressing many of the world's increasingly complex challenges, such as climate change and reliance on non-renewable resources as well as health inequities.

Prioritizing the health of Indigenous peoples will redirect resources towards some of the world's most marginalized groups, and represents an important opportunity to heal our societies as a whole, and address the inequalities

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31 CCGHR (2006); CIHR (2008); Nettleton, C., Napolitano, D., & Stephens, C. (2007). p.111.

32 Nettleton, C., Napolitano, D., & Stephens, C. (2007). p.110.

33 Evans, T. & Brown, H. (2003) first employed the PROGRESS acronym: (P)lace of residence, (R)ace, (O)ccupation, (G)ender, (R)eligion, (E)ducation, (S)ocial capital & (S)ocio-economic position. Kavanagh, J., Oliver, S. & Lorenc, T. (2008) discuss expanding the scope to include age, disability, sexual orientation, and other marginalized groups, but there has been no mention of Indigenous populations in this context.

which plague other disadvantaged groups[34]. "The time is right for a global response to improve the health and well-being of Indigenous peoples[35]" and Canada is poised to take a leadership role in such an initiative.

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34 Peachey, L., McBain, K., & Armstrong, R. (2006).

35 Reading, J., Kmetic, A., & Gideon, V. (2007). p.35.

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