

Indigenous peoples: time to act now for equity and health

Last week was a landmark event for the health of 370 million Indigenous people spread across 70 countries. At the fifth session of the UN Permanent Forum on Indigenous Issues (UNPFII), a programme of action for a second decade dedicated to the world's Indigenous peoples was launched. The overarching theme of the decade is to link specific objectives for Indigenous peoples with a broader global commitment to the Millennium Development Goals. The target date for both initiatives is 2015.

When *The Lancet* announced its plans to focus on indigenous health in 2005,¹ we were warned that it would be “unwise” to devote a series of papers to the “supposedly special health problems” of groups that were impossibly hard to define.² By identifying a people based on culture, language, or social organisation, the “drift to racism”, Adam Kuper argued, “may be inevitable”. Although a serious charge, and certainly a possible risk, the overwhelming need for action on Indigenous peoples’ health easily outweighs any potential harm. Today, we launch this series,³ together with a parallel collection of six research papers⁴ drawing attention to some of the predicaments faced by Indigenous peoples.

Typically, Indigenous people, who make up about 6% of the world's population in around 5000 separate groupings, are descendents of those who lived in an area at a time when those from a different culture arrived on their land. These new arrivals subsequently came to dominate Indigenous inhabitants, who have since tried to retain their distinctive social, economic, and political characteristics amid the dominant society in which they have sometimes struggled to survive. Indigenous peoples are forced to confront many difficulties. Poor health is possibly the most intractable problem of all.

Cross-country comparisons show that life expectancy is substantially lower for Indigenous peoples. For example, Australian Aboriginal women have a life expectancy of 63 years, compared with an Australian overall average of 82.1 years.⁵ Most Indigenous populations have high mortality rates for specific diseases and injuries—eg, Māori (heart disease), Canadian First Nation peoples (intentional self-harm), and Native Americans and Alaskan Natives

Rights were not granted to include this image in electronic media. Please refer to the printed journal.

Rights were not granted to include this image in electronic media. Please refer to the printed journal.

See [Articles](#) page 1758; [Series](#) page 1775; and [Comment](#) page 1716

Still Pictures

Rights were not granted to include this image in electronic media. Please refer to the printed journal.

Lonely Planet Images

(assault). Disparities are seen across groups for cancer, respiratory disease, stroke, and diabetes. Access to health services and health education are commonly worse for Indigenous peoples. Research that *The Lancet* will be publishing in coming weeks will highlight the particular problems faced by children and those living with cancer. The quality of hospital care for Māori patients will be scrutinised. Social determinants of indigenous health will be explored. And the effects of racism on health will be investigated. Although this work can only provide a snapshot of indigenous well-being, it does demonstrate the vigour of research into this neglected area of medicine and it also points to some critical obstacles to health equity for Indigenous peoples.

There is also an important wider context to consider. Health does not exist in a vacuum. The UN's concern with Indigenous peoples is recent. UNPFII was only established in 2000. For all its good work, the situation remains acute. Indigenous peoples are consistently marginalised from the political, economic, and social mainstream. Protecting and strengthening their cultural identities seems to be getting harder for many Indigenous groups. Poverty is endemic. Political representation is weak. Access to education is highly variable. Displacement and human rights violations are common.

UNPFII therefore stresses the rights of Indigenous peoples to take part in all decisions affecting their lives; to have access to basic social services (health, education, water, sanitation); to preserve the past for

the sake of future generations; and to be assured that the best possible information is collected to enhance service delivery and policy development. These broader UN aims are summarised in five objectives for the next decade of concerted action (panel).

There have been notable successes too. UNPFII has created more awareness about Indigenous peoples than at any time in recent history. And universities have been quick to develop special programmes on indigenous issues. The Indigenous Health Unit at James Cook University in Queensland, Australia, is one example. Established in 2003 as part of the Faculty of Medicine, the unit works to recruit and retain Indigenous students, develop an indigenous health curriculum, launch advocacy programmes, strengthen links with Indigenous communities, and build research capacity to meet the concerns of Indigenous peoples.

Most importantly, globalisation offers opportunities for Indigenous peoples to connect with one another, to mobilise international support for their own unique yet often shared needs. The emergence of influential non-governmental organisations campaigning on behalf of Indigenous groups at an international level is another positive consequence of globalisation. As Stephen Kunitz has written: "Globalisation...may provide part of an answer to the destruction that states have visited upon Indigenous peoples. It has the potential, incompletely realised, to create both an audience for the airing of injustices that have threatened the very survival of Indigenous peoples and a means of redress."⁶

Carolyn Stephens and colleagues will argue in a later article⁷ that "the most appropriate call from this series is for greater respect for the views of Indigenous peoples and for their inclusion in the development of international and national policies". Respect needs to be supplemented by concrete actions: to reduce health disparities between Indigenous and non-Indigenous peoples; to raise the overall health status of Indigenous individuals; to address the broader social and environmental determinants of indigenous health; to collect better data about indigenous needs; to incorporate indigenous beliefs and practices into research that addresses Indigenous community issues; and to challenge some indigenous practices that have a negative effect on health (eg, female genital mutilation, violence against women, and child marriages).

Panel: Main objectives of the 2nd International Decade of the World's Indigenous Peoples, 2005–15

- 1 To promote non-discrimination and inclusion of Indigenous peoples at all levels of society, especially regarding laws, resources, policies, and programmes.
- 2 To promote full and effective participation of Indigenous peoples in decisions that affect their lives and lands.
- 3 To redefine development policies to include a vision of equity for Indigenous peoples, respecting their cultural and linguistic diversity.
- 4 To adopt targeted policies, programmes, and budgets for Indigenous peoples, with a particular emphasis on women, children, and youth.
- 5 To develop strong monitoring and evaluation mechanisms to meet these objectives.

Perhaps the most urgent call of all is to remove the cloak of invisibility from the shoulders of Indigenous peoples—not only to reveal their diversity and heritage, but also to reflect on their cultural fragility and to protect and strengthen their essential, foundational place in human society.

Richard Horton

The Lancet, London NW1 7BY, UK

1 Stephens C, Nettleton C, Porter J, Willis R, Clark S. Indigenous peoples' health—why are they behind everyone, everywhere? *Lancet* 2005; **366**: 10–13.

- 2 Kuper A. Indigenous people: an unhealthy category. *Lancet* 2005; **366**: 983.
- 3 Anderson I, Crengle S, Kamaka ML, Chen T-H, Palafox N, Jackson-Pulver L. Indigenous health in Australia, New Zealand, and the Pacific. *Lancet* 2006; **367**: 1775–85.
- 4 Freemantle CJ, Read AW, de Klerk NH, McAullay D, Anderson IP, Stanley FJ. Patterns, trends, and increasing disparities in mortality for Aboriginal and non-Aboriginal infants born in Western Australia, 1980–2001: population database study. *Lancet* 2006; **367**: 1758–66.
- 5 Bramley D, Hebert P, Jackson R, Chassin M. Indigenous disparities in disease-specific mortality, a cross-country comparison: New Zealand, Australia, Canada, and the United States. *NZ Med J* 2004; **117**: U1215.
- 6 Kunitz SJ. Globalisation, states, and the health of indigenous peoples. *Am J Public Health* 2000; **90**: 1531–39.
- 7 Stephens C, Porter J, Nettleton C, Willis R. Disappearing, displaced, and undervalued: a call to action for indigenous health worldwide. *Lancet* (in press).

Health of the world's Roma population

The health of the world's 10 million Roma (also known as Gypsies or Romani) has begun to receive increasing attention because several countries in the former Soviet bloc are preparing to enter the European Union (EU). To become a member, candidate nations must meet the "Copenhagen criteria" which, among other items, require respect for and protection of minorities.

Roma represent the largest ethnic minority in most of these countries, numbering about 7 million people in central and eastern Europe. To show their commitment, eight countries in the region have declared 2005–15 "The Decade of Roma Inclusion," and have developed an ambitious agenda to improve access to housing, employment, education, and health care (figure).

Yet, despite the flurry of excitement and good intentions, little is known about the health status of Roma; this shortfall will complicate efforts to assess the efficacy of planned interventions.¹ Information on even the most basic health indicators, such as infant mortality or life expectancy, is spotty at best.

The published literature on Roma health from 1985 to the present includes about 200 English language articles, half of which are about genetics or phylogenetics rather than medical issues.² Only a few addressed public health. A slightly older review noted more articles on the gypsy moth or the gypsy variant of *Drosophila* than on Roma health.³ Furthermore, 70% of the reports arose from just three countries—the Czech Republic, Slovakia, and Spain.

In addition to a lack of research, interpretation of the literature is hampered by the absence of a standard

definition of who is, and who is not, Roma. One reason for this vagueness is that Roma may want to avoid stigmatisation and so do not declare their heritage to census takers. For example, when Slovakia became an independent country in 1993, 80 627 people formally declared themselves to be Roma.⁴ However, official estimates placed the number closer to 250 000, although Roma political and cultural activists suggested as many as 350 000–400 000 Roma resided in Slovakia.⁴ Given such a malleable denominator, rates of any disease can be raised or lowered, depending on the objectives or biases of the reporting group.

The available literature for a few standard indicators is summarised below and in the table. In 2003, a United Nations Development Program (UNDP) report examined numerous aspects of Roma life, including health.¹ Much of the focus was placed on infant mortality. Among persons living in Romania, wide variation was found in infant mortality according to ethnic group. For infants of Romanian parents, the mortality rate was 27·1 per 1000; for those born in Romania of Hungarian parents, 19·8 per 1000; and for Romanian Roma, 72·8 per 1000 livebirths.

Other reports from the Czech Republic, Slovakia, and Hungary place the infant mortality rate among Roma at about double that of non-Roma residents, with a sixfold increase (40 to 240 per 100 000 births) among Roma infants born in Bulgaria in 1989.¹ Infant mortality in Italy has been described as three times higher in Roma than in other Italians⁵ and twice as high among Irish Roma than non-Roma groups in Ireland.⁶



Doctors of the World/USA

Figure: Marin Busuioac, a 74-year-old Roma man, has become the face of tuberculosis control for Roma in Romania

Diagnosed with tuberculosis in 2003, his image is now ubiquitous on posters and brochures in Roma communities, as well as from a television documentary, *TB can be cured*. The documentary emphasises that tuberculosis is a treatable illness not a death sentence, as is assumed by many Roma.