Briefing paper

Non-communicable diseases in Indigenous populations – Raising the voices of Indigenous Peoples and Communities within the global NCD discourse

Focus:

● Indigenous populations  ● Youth  ● Community & shared voice

Introduction:
Hello and good morning. My name is Kaitlyn Hunsberger, I am a member of the Fort McDowell Yavapai Nation in Arizona, USA. I am attending as a participant with CLAN (Caring & Living As Neighbours) CLAN is committed to rights-based, community development approaches to optimising quality of life for children, young people, families and their communities living with NCDs in resource poor settings.

There are approximately 370 million Indigenous Peoples worldwide, in over 90 countries. Although they make up 5 percent of the global population, they account for about 15 percent of the extreme poor. Indigenous populations are socially disadvantaged, experiencing high rates of abject poverty, high unemployment, low education, poor diet (due to unavailability of fruits/vegetables), higher rates of infectious disease burden - especially amongst children and higher burden of life-style related NCDs amongst adults. They are experiencing a transition from traditional to transitional and modern lifestyles and with this, an increased prevalence of NCDs.

It is a noted irony that Indigenous peoples living in the richest countries of the world, such as the United States and Canada are among their poorest citizens. In terms of addressing the healthcare disparities that many


3 https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5121965/
Indigenous people face, there are structural issues that require consideration because of the unwillingness to address issues of difference.

The data on health disparities provided by the Indian Health Service’s own fact sheets presents enormous health issues for Native Americans and Alaska Natives. Indigenous peoples born today have a life expectancy that is 5.2 years less than the US population of all races.

The prevalence of diabetes is higher among the American Indian and Alaska Native population (16.5 per cent) than any other major racial or ethnic group in the United States, and the prevalence of diabetes has been increasing. Diabetes kills roughly four times as many American Indians and Alaska Natives as it does members of the mainstream United States population.

There are very similar disparities in various parts of the world. For instance, in Australia:

Aboriginal and Torres Strait Islander peoples (or, Aboriginal people) make up 3% of the Australian population, and also experience significantly worse health, social and economic outcomes compared with non-Aboriginal Australians. Life expectancy for Aboriginal peoples is approximately 10 years less for males, and 9 years less for females born in 2010-12, than it is for the non-Aboriginal population. NCDs explain 70% of this gap, and highlights the fact that NCDs have a disproportionate impact on the mortality and morbidity of Aboriginal Australians.

The main risk factors which contributed to the health gap between Aboriginal and non-Aboriginals are all risk factors for chronic disease development, namely: tobacco (17%), obesity or high body mass index (16%), physical inactivity (12%), high blood cholesterol (7%) and alcohol (4%). Furthermore, Aboriginal people are three times more likely to be living with diabetes or elevated blood sugar levels than non-Aboriginal Australians.

Although the Australian Government recognises inequities exist for Aboriginal Australians, there is urgent need for sustained investment in community controlled solutions to drive change. The Aboriginal Community Controlled Health Service (ACCHS) sector is a proven best practice model for redressing Aboriginal health inequities in Australia. An international UN campaign recognising the poor NCD-related health outcomes of Indigenous peoples would provide a source of global pressure to help support the work of local Aboriginal groups.

Closing:

The Zero draft does not include Indigenous youth in planning or accountability with regard to NCD policies and

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their implementation by Member States. This is a serious oversight, given the enormous and inequitable burden NCDs place on Indigenous communities around the world. Without inclusive language, the needs and priorities of Indigenous peoples and cultures risk being ignored altogether. To this end, CLAN would respectfully request meaningful inclusion and acknowledgement of Indigenous Peoples and Cultures within the Political Declaration on NCDs coming out of the Third High Level Meeting (HLM) of the UN on NCDs in September 2018 and acknowledgement of the important role Indigenous Community Controlled Health Organisations play in driving equity for Indigenous peoples living with and at risk of NCDs.

Beyond the 3rd UN HLM on NCDs, the #IndigenousNCDs movement seeks ongoing and active involvement of First Nations Peoples within the global NCD discourse. This is with a view to First Nations communities engaging with governments to inform and lead culturally safe and appropriate approaches to sustainably meet the SDGs and reduce the inequitable impact of NCDs on First Nations peoples and communities.
First Nation Health and non-communicable chronic diseases

First Nation health and healing challenges in the context of non-communicable chronic diseases require an analysis of non-classic risks associated with the higher prevalence and incidence rates found among these communities. These include colonisation, racism, oppression and the ongoing violence aimed to eliminate indigenous communities across the globe. A recent publication addressed the relationship between the high rates of type 2 diabetes and obesity in offspring of First Nation peoples imprisoned within the residential schools in Canada. These schools aimed to eliminate the Indian within the Indian child. The high rates of sexualized violence, chronic hunger, death and practices of cultural erasure carry to the children and grandchildren in the form of non-communicable chronic diseases.

Additionally, the burden of secondary complications and poor primary care services result in late presentations such as advanced chronic kidney disease and severely diseased limbs. First Nation communities have the highest rates of hospitalisation for primary care sensitive conditions across the province of Manitoba. As well, First Nation patients experience racism at the local nursing stations in remote Manitoba to the same degree as in the secondary health care systems outside the isolated communities. (unpublished data Nanaandawewigamig)

Within these systems First Nation peoples living with non-communicable chronic diseases can experience lower rates of screening, limited access to medications
and treatment modalities, late diagnosis and chronic racial micro-aggressions among non-Indigenous health care providers limiting the possibility of a productive and therapeutic engagement.

Federal departments responsible for health and social services in First Nation communities limit access to resources for health prevention, promotion and basic treatment options and including no availability of physician services for most communities underpin challenges for community based innovation to prevent non-communicable chronic diseases.

Such structural racism appears as normal in Canada. The resulting culmination of chronic and intergenerational poverty and racism impact the health and healing opportunities of First Nation women. And it is the conception within a hostile environment research considers a risk factor for chronic diseases such as type 2 diabetes and chronic kidney disease.

We respectfully request the United Nations change the discourse about the prevention and treatment of non-communicable chronic diseases within indigenous communities. We request the United Nations facilitate this by:

1. Making space for dialogue within civil society discourse through placement of the word *indigenous* in all documents on a go forward basis

2. Acknowledging the need to prioritize indigenous communities and the challenges they face addressing NCDs across the globe

3. Articulating the need to eliminate *indigenous specific racism* across the globe.
Hello and good afternoon. My name is Kaitlyn Hunsberger, I am a member of the Fort McDowell Yavapai Nation in Arizona, USA. I am attending this hearing as a participant with CLAN and am speaking on behalf of Indigenous peoples.

Indigenous peoples 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, 7 years.

It is a noted irony that Indigenous peoples living in the richest countries of the world, such as the United States Canada, and Australia are among their poorest citizens.

The combined death rate from all causes among American Indians and Alaska Natives was nearly 50% higher than death rates among whites between 1999 and 2009, according to a recent CDC report. A lot of this number is correlated to NCDs.

There are currently over 2.1 million Native Americans under the age of 24 living in the United States. Suicide is the 2nd leading cause of death next to Diabetes. In the US, between 1 in 5 Native youth report attempting suicide each year. Recent research shows that while the US child mortality rate for children ages 1 to 14 has decreased by 9% since 2000, it has increased by 15% among Native American children.

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.

Worldwide, many indigenous peoples with NCDs remain undiagnosed, untreated and at risk from life threatening complications that can be effectively prevented. I am tired of seeing my people die from these NCDs, especially at this growing rate. It has continued to go on for too many years, and I hope to give a voice to Indigenous peoples to promote better outcomes.

The Zero draft does not include Indigenous youth in planning or accountability with regard to NCD policies and their implementation by Member States. This is a serious oversight, given the enormous and inequitable burden NCDs place on Indigenous communities around the world. Without inclusive language, the needs and priorities of Indigenous peoples and cultures risk being ignored altogether. I am pushing for advocacy support for #IndigenousNCDs and more language that support this cause and to turn these stark statistics around.
STATEMENT AT CIVIL SOCIETY HEARING FOR NCD CHILD:
Nadine Clopton, UN Youth Representative
CLAN (Caring & Living As Neighbours — Founding Secretariat for NCD Child)

Good morning, my name is Nadine Clopton and I am a student at Lehigh University and a youth representative with NCD Child and Caring and Living As Neighbours as well as the daughter of a mom with Type 1 Diabetes. Thank you for convening us here today.

Millions of children and adolescents live with or are at risk for NCDs and investment in youth health is investment in the future.

Children in low and middle-income countries often die due to late diagnosis or lack of access to medicines or treatment, or suffer long-term disabilities from chronic conditions not adequately managed, causing extreme fiscal disparity for many families. Especially indigenous populations, who are completely frozen out of this discourse.

Excluding children and youth is neither just nor sustainable and impedes understanding of the full burden of disease. Additionally, indigenous youth bear an incredibly large burden of disease compared to their non-indigenous counterparts and face large barriers to accessing prevention and treatment resources.

Addressing NCDs and maximizing healthy life requires a rights-based approach to both prevention AND treatment of NCDs for all. Half of adult NCDs begin in childhood, with most behavioral risks for NCDs beginning in adolescence.

The upcoming High-Level Meeting is an opportunity for commitment to life-course strategies that effectively address this worldwide public health crisis, inclusive of marginalized and vulnerable populations. An age restriction abolishes the opportunity to align with and leverage global and national investments for NCD interventions, including existing population-based maternal and child health programs. We urge member states to recommit to NCD goals that will address a true life-course approach to prevention and treatment for all children, adolescents and families, First Nations people, and that recognizes the inclusion and importance of young people’s voices in these plans.
My name is Nadine Clopton and I am the youth representative for Caring and Living as Neighbours, an NGO in consultative status with ECOSOC, a university student, as well as a 20 year old woman living with anxiety and depression and the daughter of a mother living with Type 1 diabetes.

So how do we ensure support for children, parents, and family members of those living with NCDs so that they know how to navigate the health system alongside their loved ones? How do we empower children and families to take charge of their own healthcare and advocate for their own rights to health in context of their own country? With NCDA’s prioritization of “put people first”, how do we ensure that communities are at the forefront as changemakers in their own right?

Additionally, I would like to highlight that when a child is affected by an NCD, it is a life-course health issue. How do we ensure that vulnerable populations not only have access to treatment and medicines at the time of entry into the health system, but for the duration of the life course? I urge the panel here today to support stronger data tracking mechanisms for marginalized communities to ensure that they are being meaningfully engaged by their health system and getting access to equitable treatment and essential medicines. Thank you.