

Litigating the right to health for indigenous peoples

Carla Clarke

The Xakmok Kasek indigenous community lives in the Chaco region of Paraguay. Over a lengthy period they had been restricted to occupying an ever diminishing area of their traditional lands and even then it was at the whim of the private ranch owners, who forbade them to hunt, keep livestock or cultivate their own crops. Having failed to secure recognition of their land rights through the national process during the 1990s, the community started legal proceedings at the regional level in 2001 and in 2010, the Inter-American Court of Human Rights (IACtHR) found in their favour and ordered that Paraguay return their lands to them. The Xakmok Kasek thus joined with a growing number of other communities, including the Awas Tingni of Nicaragua and the Yakye Axa and Sawhoyamaxa indigenous communities, also from the Paraguayan Chaco, in invoking the right to property to secure recognition of their rights to their traditional lands (even if implementation of such favourable decisions often remains wanting).

As well as the right to property, in the case of the Xakmok Kasek community, the IACtHR was asked to examine the issue of provision of basic services, including health services, with respect to the obligation on the state to protect the right to life (interpreted as the right to a decent existence). Given that in 2009 the government of Paraguay had itself declared a local state of emergency on account of the community's precarious and vulnerable situation due in part to the absence of medical care, it is not surprising that the IACtHR found a violation of this right. Specifically, the IACtHR found that the state had not guaranteed physical or geographical access to health care establishments for the community (the nearest health care centre was 75 km away, poorly run and had no vehicle that could reach the community, while the nearest hospital was over 400 km away and the public bus fare there was out of the reach of the members of the community). Similarly, the Court found that the state had not taken any measures to ensure that the medical care and supplies would be acceptable, taking into account traditional practices. The Court therefore went on to order that until their traditional lands were returned: (1) immediate medical attention

was to be provided to the community; (2) given the difficulty of members of the community in accessing health clinics, a permanent health clinic was to be established where they were currently settled, and with the necessary medicines and supplies; and (3) a system of communication was to be established between the community's settlement and competent health care authorities for emergency cases, and, if necessary, transport was to be provided by the state for such cases. Once the community resettled on their traditional lands, both the medical centre and the communication system were to be moved there. The IACtHR also attributed a number of deaths of members of the community (predominantly children) from such preventable illnesses as pneumonia, tetanus, anaemia and dehydration to the state due to the lack of medical attention provided.

Given the fundamental relationship of indigenous peoples to their lands and resources, and that many indigenous communities either find themselves already displaced from those lands or in situations where their lands are being encroached upon without their consent by third parties (e.g. for logging, oil exploitation or the establishment of wildlife reserves), it is not surprising that where indigenous communities have been able to overcome the numerous obstacles to accessing justice it is primarily in order to claim their right to their traditional lands. Even in cases where violations of their right to health are not directly pleaded in addition to their right to property (as in *Xakmok Yasek* but also in *Yakye Axa* and *Sawhoyamaxa*), it can be argued that in securing recognition of their rights to their traditional lands they are also securing recognition of the principal underlying determinants included in their right to health. This interplay between health and secure rights over indigenous traditional lands has been recognized at the international level.¹

There have been some cases brought by indigenous peoples where health has been the primary focus, but where their submissions have emphasized the negative impact on health through spoliation of traditional lands. Such cases include *Mapuche Paynemil and Kaxipayiñ Communities v. Argentina* before the Inter-American Commission on Human Rights



(IACHR) concerning contamination of water on indigenous land with lead and mercury affecting community health, particularly that of the children; and *The Social and Economic Rights Action Centre and the Centre for Economic and Social Rights v. Nigeria* before the African Commission on Human and Peoples' Rights concerning the Ogoni and the negative health and environmental impacts of oil exploration in Ogoniland. At the national level, the case brought by the San of the Central Kalahari Game Reserve challenged a decision of the Botswana government to terminate essential services such as the provision of mobile health clinics in what was an attempt to force them off their traditional lands.

One of the few cases concerning the right to health of an indigenous people in the absence of

a property connection is that of *María Mamérita Mestanza Chávez v. Peru* before the IAHCR. Rather than being about the failure of the state to provide accessible and adequate health care, the case concerned the provision of unwanted health services, namely the forced sterilization of generally poor, rural and indigenous women as part of a government policy to change the reproductive behaviour of the population.

While the focus on litigating over indigenous peoples' property rights is understandable, the dearth of litigation on the right to health, absent a territorial connection, both at regional and national level, calls for further examination, given that report after report, study after study shows that indigenous peoples suffer from higher mortality and morbidity rates than non-indigenous populations. For example, while

Left: Bodo community villagers point to an oil spillage site in a river in the Ogoni region of the Niger Delta, Nigeria. *REUTERS/Akintunde Akinleye.*

Guatemala has already surpassed the MDG 4 target of reducing childhood mortality by two-thirds in relation to non-indigenous children, it has yet to reach it in relation to indigenous children. The gap between the mortality rates of indigenous and non-indigenous children has remained more or less constant since the base year of 1987. Even in Brazil, where a specific Indigenous Health Subsystem has existed since 1999, early improvements in indigenous health indicators have since stalled such that, despite significant expenditure, they continue to have the worst health status of any group. (See the regional chapters for other examples.)

The situation also calls for further examination given the fact that, in a region such as Latin America, activism among indigenous peoples is arguably more organized and their rights, at least in theory, are better protected (e.g. under Paraguay domestic legislation, indigenous people are entitled to free medical services) than in other regions. One key regional trend has been the exponential growth in the last two decades of the right to health litigation among the non-indigenous population, with a high rate of both success and implementation. However, not only have indigenous people not benefited from this growth, they are arguably further prejudiced by it as finite health care budgets are used on providing the medications ordered by the courts, since the litigation is, by and large, around access to (often costly) medication. An increasing number of commentators call into question the individual nature of the increase in the right to health litigation. The time appears ripe for a case to be brought which is about structural access to health care and systematic provision of essential services so that the right to health of the most vulnerable becomes a reality.

In this regard, hope can perhaps be taken from action by treaty monitoring bodies. In a relatively recent case before the UN Committee on the Elimination of Discrimination Against Women (CEDAW) concerning an Afro-Brazilian woman who died due to lack of adequate emergency

obstetric care, it was alleged that access to quality medical care during pregnancy was a systematic problem. In finding against Brazil, including finding that the woman had been discriminated against because of her ethnic status, CEDAW recommended that Brazil ensure affordable access for *all* women to adequate emergency obstetric care (*Alyne da Silva Pimentel v. Brazil*, 2011).

Litigation may not be a complete panacea but, on current trends, without judicial intervention it is difficult to see substantial progress being made in realizing the right to health for indigenous communities. ■

Endnotes

1. See the UN Committee on Economic, Social and Cultural Rights' General Comment no.14, para. 27.