Social determinants and Indigenous health: The International experience and its policy implications

Report on specially prepared documents, presentations and discussion at the International Symposium on the Social Determinants of Indigenous Health Adelaide, 29-30 April 2007 for the Commission on Social Determinants of Health (CSDH)

Commission on social determinants of health

Cooperative Research Centre for Aboriginal Health

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Summary of outcomes

Emerging from the proceedings of the International Symposium and associated material are a range of ‘key themes’ and ‘areas for action’. Through the forthcoming Report of the Commission on the Social Determinants of Health, these are meant to both inform globally oriented advocacy on Indigenous health and to prompt reflection by individual WHO Member States and, where appropriate, Member States at a regional level.

An understanding common to Symposium delegates and other contributors was that, despite very significant differences in the circumstances of Indigenous Peoples globally, numerous issues and problems are shared. So too are many policy implications.

The following is a selection from the range of other points over which there was wide agreement in the documents prepared for the Symposium and in the ensuing proceedings.

The colonization of Indigenous Peoples was seen as a fundamental underlying health determinant. This process continues to impact health and well being and must be remedied if the health disadvantages of Indigenous Peoples are to be overcome. One requirement for reversing colonization is self determination, to help restore to Indigenous Peoples control over their lives and destinies.

The failure to apply or implement various UN instruments, agreements and treaties directed at securing self determination and other rights for Indigenous Peoples was a closely related matter of concern. Symposium participants and the papers canvassed issues suggesting that more specific standards, such as those anunciated in the draft UN Declaration on the Rights of Indigenous Peoples, were required. The Symposium heard examples of where the inability of Indigenous Peoples to enjoy fundamental freedoms impacted adversely on their health and well being.

Another fundamental health determinant stressed in the Symposium is the disruption or severance of ties of Indigenous Peoples to their land, weakening or destroying closely associated cultural practices and participation in the traditional economy essential for health and well being. Rights to land necessary for sustaining Indigenous culture and livelihoods should be restored.

Linked to land rights is the resolution of Indigenous poverty and economic inequality. Poor health was seen as the corollary of poverty and inequality. Economic redistribution was considered essential for moving towards equality in health outcomes.

Along with this, the Symposium and papers highlighted the impact of widespread and devastating land degradation and climate change as a determinant of Indigenous Peoples' health and well being. This is through the limitations it imposes on Indigenous Peoples' cultural and economic opportunities and freedoms. A repeatedly mentioned means for tackling poverty and associated low socioeconomic status is through much greater investment in education, more particularly that of children and for building Indigenous leadership.

Too often Indigenous Peoples and their social conditions are invisible. Much better data and quality research on Indigenous health needs to be generated, but this must be with the specific agreement of Indigenous Peoples. In this regard, cooperation across national borders is a particular challenge.

One of the strongest messages from the Symposium concerned the lack of understanding of Indigenous culture and world views. The papers and Symposium gave examples of instrumental and constitutive value attributed by Indigenous Peoples to culture and world views as a determinant of their health and well being. The repeated implication is for increased respect for Indigenous Peoples and their cultures. This includes the need to take account of Indigenous Peoples' holistic approaches to, and understandings of, health and well-being.

Such 'difference blindness' compounded the impact of interpersonal and institutional racism that repeatedly emerged in the Symposium discourse as a determinant of health. Participants called for firm action on the part of Member States and civil society to urgently treat this danger to health and well being.

Going beyond this was the call for broader reform of institutions and service arrangements. Reforms must extend from governmental structures, including systems of political representation; through legal and judicial arrangements, including securing practical equality before the law and the recognition of customary laws; to the extension of service delivery arrangements to ensure equitable access and accountability to Indigenous People. Delegates referred frequently to the need for, and value of, properly funded primary health care services under Indigenous control.

Finally, there was a strong belief amongst Indigenous delegates that international cooperation is an important ingredient in tackling common problems. This is sustained by a conviction that 'we are all connected as Indigenous Peoples worldwide'.

Social determinants and Indigenous health: The International experience and its policy implications[1]

[1] The report was prepared by Martin Mowbray, Emeritus Professor, RMIT University, Melbourne.

'[T]he time is right for a global response to improve the health and well-being of Indigenous peoples' (Assembly of First Nations, Discussion Paper, p.40)

Background

At the fifth meeting of the Commission on the Social Determinants of Health (CSDH) in Nairobi, June 2006, the Commission undertook to take up Indigenous peoples' health as a specific part of its work. An International Review of Social Determinants of Indigenous Health was subsequently established to build on existing knowledge in the field of Indigenous health.

The Commission raised three questions in relation to this work:

- What actions on the social determinants of Indigenous health would mitigate risk conditions and improve health outcomes for Indigenous people globally?
- What examples are there of successful action on the social determinants of health that have resulted in positive outcomes for the health and well-being of Indigenous peoples?
- What policies concerning the social determinants of health are most likely to be effective in improving the health of Indigenous peoples?

To pursue these questions, a Symposium on Indigenous health was held in Adelaide on 29-30 April 2007. Initiated and endorsed by the Commission on Social Determinants of Health (established by WHO in 2005), the Adelaide Symposium was hosted and co-funded by the Cooperative Research Centre for Aboriginal Health (Australia) and convened by Flinders University. In practical terms the Symposium was also supported by the Australian Government (Department of Health and Ageing)[2]; the Canadian International Development Agency; the Canadian National Collaborating Centre for Aboriginal Health; the First Nations and Inuit Health Branch, Health Canada; and the Government of South Australia (Department of Health).

The aims of the Symposium were:

[2] The Commonwealth of Australia were one of the partners who provided funds to support the convening of the Commission on Social Determinants of Health - International Symposium on Indigenous Health - Australia 2007. The Commission on the Social Determinants of Health acknowledges the independence of the Commonwealth of Australia from the activities conducted by the Commission on Social Determinants of Health.

1. To provide a forum for international exchange between Indigenous people on the topic of the social determinants of health.
2. To allow presentation of case studies on the social determinants of Indigenous health from a variety of settings around the world and discussion about the general lessons from the case studies.
3. To derive key lessons from the case studies and background Situational Analysis concerning action needed to address the social determinants of Indigenous health globally in order to improve the health status of Indigenous peoples.
4. On the basis of the above, provide material to inform the preparation of a report making recommendations about the action required to address the social determinants of Indigenous health to be tabled and discussed at the 8th meeting of the Commission on the Social Determinants of Health to be held in Vancouver, 7-9 June 2007.

Method

Symposium organizers[3] commissioned preparation of 'a situational analysis background paper to summarise existing information on the social determinants of Indigenous health globally, including basic demography and epidemiology'. This was compiled by staff at the London School of Hygiene and Tropical Medicine. The paper's contributing authors, and reviewers, were drawn from various regions, globally.

A call was made for contributed case studies in January 2007. The purpose of this was to obtain data to help answer the Commission's questions about actions and policies 'most likely to be effective in improving the health of Indigenous peoples' set out above. The case studies were intended to be based on Indigenous individuals and communities, highlighting the ways in which social determinants frame health experiences. This was to provide a basis for considering what actions would most effectively address social determinants of poor health. They were to help focus the thinking of Symposium participants.

A call was made for contributed case studies in January 2007. The purpose of this was to obtain data to help answer the Commission's questions about actions and policies 'most likely to be effective in improving the health of Indigenous peoples' set out above. They were to help focus the thinking of Symposium participants.

The call for case studies was through WHO regions, members of the CSDH International Steering Group, and within Australia to the Cooperative Research Centre for Aboriginal Health (CRCAH). The CRCAH selected the five Australian case studies presented at the symposium.

Guidelines for preparation of the case studies, as well as an example, were circulated. To help ground the material in the lived experience of Indigenous people, it was asked that the case studies be based on either Indigenous individuals, families and / or their communities, analysing the ways in which the social determinants of health act to impede or promote the health and well-being of Indigenous peoples. It was hoped that the majority of case studies would tell success stories of action on the social determinants of health. The case studies were meant to be brief (2,000 to 4,000) words and available prior to the Symposium.

[3] Symposium organizers were based at Flinders University and the Cooperative Research Centre for Aboriginal Health. They were advised by an International Steering Committee, drawn from Australia, Canada, New Zealand, the CSDH and WHO.

As it turned out, responses to the call for case studies were not all timely, and a few were much longer than anticipated. Some material was not prepared as case studies, but more as accounts of the overall circumstances and strategic directions of particular Indigenous peoples. Much of the content of these approaches complemented the commissioned Situational Analysis, particularly its sections on the Circumpolar Region and North America.

Because of time taken for translation, and finding the necessary funds, most of the Latin American case studies became available after the Symposium. However, they are summarized, and their contents are reflected in this Report, along with the other case studies.

The commissioned Situational Analysis, the 'Overview of current knowledge of social determinants of Indigenous health', to inform participant's thinking leading into the Symposium, became available to participants as a whole immediately before the Symposium. The form this overview took was as 'a summary of existing international data on the health status of Indigenous peoples'.

Time and particularly resources placed a limit on the number people able to attend the Symposium. The 74 participants were drawn from Australia, Belize, Cambodia, Canada, Chile, China, Ecuador, Guatemala, New Zealand, The Philippines and the United Kingdom. (See Appendix 1 for list of attendees.)

The Symposium was facilitated professionally. Its structure entailed 14 formal presentations, where speakers respectively addressed the topics of the case studies or their alternative discussion papers. Along with some of the written material, these presentations, distilled by rapporteurs, provided input for the ensuing parallel focussed discussions, which made up most of the second half of the Symposium, Day 2. The contents of these discussions were fed back to participants in plenary sessions, facilitated by rapporteurs and scribes.

The process was recorded through working notes, mostly as dot points. Some records were presented using poster or PowerPoint forms. These captured the commonalities and directions identified by the rapporteurs, and pursued or elaborated in the discussion groups. In these workshops, the main themes were to be refined, and key areas for action by the CSDH pointed up.

As with most discussions dealing with complex questions, in a limited time and with limited resources, results were mixed. Naturally enough, development of points was not even, and lines of discussion were not always aligned. Understandably, a good number of points were cast in very general terms.

However, and as anticipated, a number of recurrent and quite distinct themes emerged. Predictably too, these overlapped heavily with written material produced for the Symposium. Put together, the directions for action developed considerable force – a high degree of what one contributor termed 'synchronicity'.

The original plan was that Symposium participants would have the written material in time to inform their discussion and deliberation. However, little written material was available before the Symposium. Most became available during the weeks after the Symposium. This meant that gleanings from the larger part of the written material had to be included in this Report without having been considered at the Symposium. However, the high degree of coincidence of points between the verbal and written presentations helps validate the lessons drawn.

The organizers engaged a consultant to prepare this Report following, the Symposium – by 1st June 2007. The consultant's role was to report on the Symposium proceedings and the contents of the associated working documents, rather than to undertake other inquiry and formulate independent findings and recommendations.

Because of the volume of material to be condensed into a practical working Report, of a length not to discourage reading, exercise of some judgment was necessary. Of necessity, records by rapporteurs or scribes of Symposium discussions, largely in concurrent sessions, were in point form. Distilled as they were, these notes required some interpretation.

The Report was commissioned to help transmit 'key lessons from the case studies and background Situational Analysis concerning action needed to address the social determinants of Indigenous health globally'. This is to inform discussion at the 8th meeting of the Commission on the Social Determinants of Health, Vancouver, 7-9 June 2007, and the Commission's Interim and Final Reports.

Structure of this Report

The balance of this report is made up of the following sections.

- Identification of Symposium documents
- Identification of themes in the Situational Analysis
- Summaries of the 36 case studies available
- Review of the 3 Canadian discussion papers and Overview
- Symposium proceedings
- Key issues and areas for action

Symposium documents

A list of the Symposium's working documents[4] follows. The first of these, the Situational Analysis ('Overview of current knowledge'), was specially commissioned. The others are the results of the CSDH organizer's call for case studies. Most of these documents were not available at the time of the Symposium.

- 'An overview of current knowledge of social determinants of Indigenous health' (the Situational Analysis) commissioned by the WHO Commission on Social Determinants of Health for the Symposium, and compiled by Clive Nettleton, Dora A. Napolitano and Carolyn Stephens, with contributions from authors in various countries and regions. (141 pages)
- A set of twelve case studies made available immediately before the start of the Symposium, plus notes on six case studies from Latin America. (80 pages)
- A set of twenty four[5] case studies from Latin America, prepared prior to the Symposium but not available in English until afterwards. (96 pages)
- A set of four documents from Canada, three in draft form. (209 pages)

[4] Symposium documents may be found on its website: https://som.flinders.edu.au/FUSA/SACHRU/Symposium
Login details are: Username: sachrusymp Password: symposium
You will need to type the password into the password prompt box. Copy and paste will not work.

[5] Up to four more Latin American case studies may have been written and translated, but did not arrive in Australia.

Global Overview

The Situational Analysis or 'Overview of current knowledge of social determinants of Indigenous health', commissioned by the Commission on Social Determinants of Health for the Symposium covers a wide range of the world's regions. Restrictions on time and resources left some regions uncovered, notably in South East Asia, Oceania and the Middle East. Within the regions that were covered there is a good deal of unevenness in the amount and quality of available health data.

Though the working paper is styled as an 'Overview of current knowledge of social determinants of Indigenous health', its main focus is on differential health outcomes. The degree of attention to specific causal factors or determinants varies between reports from the various regions. However, the paper's editors strive to pull explanatory observations together in their introduction and in the concluding section. Important themes picked up in these places are as follows.

- Globally, there are 'substantial limitations of existing evidence' about the state and determinants of Indigenous health. (p.1-2). 'In all sections of this report, insufficient data was reported as a major constraint. Very little is written about the social determinants of Indigenous health, largely because there is so little data available for analysis. In all but a very few places disaggregated demographic or health data are not collected or reported by governments and where they are, there are significant gaps' (p.109). (However, information from unofficial sources, such as in the way of case studies, can be telling.)
- The division of Indigenous peoples across borders constitutes a particular problem in collecting and reporting data (p.109).
- 'Where data do exist, Indigenous peoples have worse health and social indicators than others in the same society' (p.3).
- 'Indigenous peoples have rarely been actively involved in deciding how or what should be studied about them, and for what purpose. Political decisions are made on the basis of this research and often simplistic interpretations of data' (p.110). (However, positive models of Indigenous engagement and control over research do exist.)
- In many instances, '[r]esearch ends up blaming communities for their ill health through wrong behaviours, poor knowledge, non-compliance and ignorance without examining social determinants that limit individual choices' (p.110).
- Though data on various national Indigenous populations exist, there may be 'large differences in health outcomes between peoples, so that even an aggregated "Indigenous" category may mask some of the most severe effects' (p.110).
- Too little attention has been paid to explaining differences in levels of health within Indigenous peoples. (p.111) Why is it that social determinants of health can affect neighbouring Indigenous peoples in different ways?
- Amongst other things, disagreements about what constitutes indigeneity affect the quality of available data. Some nation states do not recognize Indigenous people as a population category (pp.3-4).
- Other states do not differentiate health data on Indigenous peoples, partly to avoid criticism and international embarrassment (p.109).
- Data on individual health outcomes may not reflect the holistic, and eco-social or communal, notions of health more likely to characterize Indigenous perspectives (p.4).

- ‘Prejudice, discrimination and marginalization continue to be a reality. … the differences in life expectancy, burden of disease and access to services documented in the (Situational Analysis) report are a reflection of Indigenous peoples’ lack of power within the nation state (p.111).
- Policies aimed at assimilation have been halted in some places, but the drive to “civilize” and incorporate Indigenous peoples to bring them under the control of the modern nation state and the monetarized economy continues (p.111).
- Some countries have initiated a process aimed at addressing the consequences of conquest and colonial oppression … reflected in the greater amount of information available on health. But in Asia and particularly in Africa recognition of Indigenous peoples and their collective and individual rights has hardly begun’ (p.111).
- ‘For Indigenous people, the right to self-determination is the core to addressing the problems of land, culture, and marginalization which underlie their poor health and well being’ (pp.111-112).
- ‘All contributing authors agree that land is a key component contributing to Indigenous health, however they report very few studies that really aim to examine the impacts of Indigenous peoples’ relationship with land on their health’ (p.112).
- One mechanism that appears in the various contributions to the Situational Analysis is that economic and resource management systems, and sense of community, are deeply intertwined with land. This means that threats to land, through loss or disruptive intrusion, severely damage social relations, itself leading in many places to alcohol and substance abuse, and suicide. More research on this is needed (p.112).
- Most contributors to the Situational Analysis record the lower levels of income, education and employment of Indigenous people. Some also highlight the fact that variables like these, for which there tends to be more information, cannot be uncritically understood as determinants. Other variables on which there are less data, like discrimination, may have mediating effects (p.112).
- Because Indigenous people may live to some extent outside of the monetary economy, and have different understandings of education and health, conventional social indicators may not be reliable or valid (pp.112-3).
- ‘Migration to urban areas or closer rural settlements is to a greater or lesser extent a theme everywhere … migration into unfamiliar, poor urban environments results in psychological and material stress; … Poor housing, lack of education, inability to find work and, where it is found, low wages and hazardous working environments put their lives and health at risk. ‘Everywhere there is a substantial increase in non-communicable diseases (and) especially in the consumption of alcohol and domestic violence’ (p.113).

- ‘For Indigenous people, access to health services is a substantial problem, and again, it is almost universal though for widely different reasons. For communities in rural areas access is impeded by distance from facilities and the lack of trained staff to provide the service. Resources are concentrated on services for the better off’ (p.114).
- More recent imposition of cost recovery and insurance schemes make services less accessible. So do staff who are rude and inconsiderate and who lack cultural sensitivity (p.114).

- ‘But perhaps the most crucial factor is the breakdown in traditional social structures, of culture and of language.’ In such circumstances, transmission of cultural and linguistic meaning may improve health and well being (p.114).

The case studies

Case studies complement statistical data and can provide information accessible without official support, if necessary.

The case studies cover a wide spectrum of approaches, from concentration on the adequacy of health services, to attention to the economic, social and political standing of Indigenous people.

Of course, like statistics and other research based information, case studies can give misleading impressions. This can be the result of their authors wishing to convey the most positive, or negative, view of a situation or process. Some case studies reported here were drafted by authors who appear to be relatively independent, and others by people who are closely associated with government and other organizations involved. For a few case studies, the author’s affiliation is unclear. None of this necessarily affects their validity.

Case studies on social determinants of Indigenous health presented at the Symposium

The following twelve case studies were available for the Symposium on Indigenous Health, 29-30 April 2007. Those marked with an asterisk (*) were the subject of both written and verbal presentations. The others were presented only in print.

country	Title	author / organization	story	key policy implications for Indigenous health from the case study
Australia	'The multiple determinants of Aboriginal health and their implications for policy: A case study from central Australia' *	Central Australian Aboriginal Congress	An Aboriginal child contracts rheumatic fever, a condition in Australia now only common in extremely poor communities. A series of tragic events, involving institutional racism, alcohol abuse and long term domestic violence, follow. This scenario, commonplace for Aboriginal people, culminates in the woman being fatally bashed, aged 37. Multiple, diverse but interconnected, social determinants are identified.	Multiple determinants of Indigenous health must be addressed in effective policy responses to the poor health and low life expectancy of Aboriginal people. Health and other service based interventions alone are insufficient. Some reforms, such as those addressing unequal socio-economic status, institutional racism, and Aboriginal people's lack of control over their own lives, necessitate societal level, or structural, reform.
Australia	'Social determinants and the health of Indigenous peoples in Australia: A human rights based approach' *	Tom Calma, Human Rights and Equal Opportunity Commission. Presented by Darren Dick.)	An overview of evidence about social determinants of health, including socio-economic status, perceptions of control and chronic stress, community controlled services, land ownership, and historical treatment. Human rights principles and social determinants of health are fundamentally connected.	Comprehensive comparative indicators and provisions for monitoring and performance measurement in respect of the recognition and implementation of human rights principles should be put in place. This must be in conjunction with Indigenous people.
Australia	'The social determinants of health: Poverty and water sustainability at Nepabunna' *	Eileen Willis, Meryl Pearce, Carmel McCarthy, Fiona Ryan, Ben Wadham and Kelvin Johnson, Flinders Univ and	A research based exploration of the feasibility and implications of a national policy calling for 'full cost recovery for domestic water	Sufficient readily accessible, good quality and affordable water is essential for health.

		Nepabunna	and sustainable technologies.'	
Australia	'The social determinants of Aboriginal prison health and the cycle of incarceration and their implications for policy: An Australian Capital Territory case study' *	Winnunga Nimmityjah Aboriginal Health Service	A plan for the delivery of holistic health care and other support to Aboriginal prisoners and their families. The model is based on recognition of multiple determinants of Aboriginal health, including material, cultural and personal loss following colonization. Such losses are associated with poverty, disempowerment, pain and anger, leading in part to self abusive behaviours and violence.	Interventions oriented to 'breaking the cycle of incarceration' by helping prepare and support prisoners and their families for life on the outside are indicated. These should be holistic, beginning on entry to prison and continuing after release. 'At the centre… is the need to develop a strong sense of identity.' A 'community environment that supports resilience is paramount.'
Australia	'Aboriginal community controlled health organizations address the multiple determinants of Aboriginal health through housing: A case study from an Aboriginal community controlled health organization in north eastern Victoria, Rumbalara Co-operative' *	Petah Atkinson, Michael Buckworth and Felicia Dean, with Rumbalara Aboriginal Cooperative	An Aboriginal community controlled health organization provides a range of services, including advocacy, aged care and management of rental housing stock. Health status is said to increase with physical improvements to housing and related infrastructure. Of particular importance as a health determinant is home ownership, rather than tenancy. Home ownership is linked to people's control over their lives and economic stability.	Aboriginal self-determination and community self-management is advocated. As an element in this, Aboriginal control of service delivery organizations is important for health. So too is quality housing and especially individual or family home ownership.
Belize	'The multiple determinants of Garifuna health and their implications for policy: A case study from Belize, Central America' *	National Garifuna Council	An account of the life, health and difficulties encountered by a 77 year old infirm Garifuna woman. The latter feature poverty, restricted education, deficient health services, gender based discrimination, education inappropriate for Indigenous people, and encroachment of the demands of employment on	Increased government financial support for health and social support services. Better health education is required, along with 'inter-cultural education' for health professionals. Stress too on 'psychologically based interventions to help people address their individual psycho-social development needs'. Similarly, a need to better integrate western and traditional medicine and spiritual care. Wider reforms are also necessary, including recognition of the 'right to land and a healthy environment', and reduction of cultural or institutional stresses.

			familial roles, as well as alcohol abuse by others.	
Brazil	Munduruku children with mental disability, Brazil, Amazon forest'	Helga Bruxel Carvalho, Eric Thomas Follmann, Vera Canto Bertagnoli, Fundação Nacional de Saúde Indigenous (FUNASA) and Fundação Esperança	With health service and other external intervention, a child with a mental disability who previously would have died or been killed lives for some years – in miserable conditions, neglected and sick. His parents have become dependent on food rations, passive, and distanced from traditional livelihoods. Inevitably the boy dies, of septicaemia aged 7. The case points up contradictions between non Indigenous health and welfare interventions, overall well being, and maintaining traditional culture. Solutions are not explicitly canvassed: 'The alternatives to the situation are nebulous.'	The case does not suggest that there should or can be no successful external interventions. Implicit is that the problems experienced are at least in part because the external interventions are so partial, and insufficiently developed. A clear implication is that planning must take much closer account of cultural differences, some critical, and the range of impacts of inadequately developed policies and programs.
Brazil	'The management of emergency deaths caused by malnutrition in the District of Mato Grosso do Sul Brazil at 2005'	Elaine Martins Pasquim, Fundação Nacional de Saúde Indigenous (FUNASA)	An account of a home visit based scheme (the Indigenous Nutrition Surveillance Program) targeting malnutrition in children and pregnant women. Malnutrition has multiple determinants, many centred on the devastation and loss of land, and resultant overcrowding and associated problems with sanitation and other infrastructure deficiencies. All are connected with institutionalized racial discrimination.	Health services must become more culturally sensitive. However, without concurrent attention to nutrition, medical treatment of diseases is futile in the long run. Dealing effectively with malnutrition, and associated infant mortality, necessitates access to adequate land, water, sanitation, education and employment and income.
China	'Malaria control progress in a community of Wa Ethnic minority and its implication for policy: A case study from China-Myanmar border area' *	Xu Jianwei, Yunan Institute of Parasitic Diseases	Malaria is one of the 3 most important infectious diseases is the region (with respiratory infections and diarrhoea).	The necessity for recognition of the need to achieve equity in health outcomes nationally is evident. Similarly, there is a need to balance priorities in health expenditures, between acquisition of large and expensive health assets and

			Significant improvements in malaria control followed a pilot intervention, part of a broader Asian Development Bank and WHO initiative. This entailed behavioural change through education, treatment and local control. However, the impact of these measures is limited by factors such as lack of trained personnel locally, language and other communication problems, Wa ability to purchase material for prevention and treatment, and the level of attention to the problem from nearby and interdependent Myanmar.	localized or grass roots facilities. Centralized planners need to be more in touch – aware of 'ethnic minority' or Indigenous perspectives and local circumstances. Correspondingly, increased Indigenous ownership of preventive and treatment projects is indicated. Where 'ethnic minority' or Indigenous people span political jurisdictions, effective government cooperation is essential.
New Zealand	The multiple determinants of Maori health and their implications for policy: A case study about primary health care and its ability to address social determinants of health' *	Heather Gifford, Whakauae Research Services	Review of the 'state of health, and possible determinants of health, for one family participating in a primary health organization'. For all or some family, highly interrelated health determinants included poverty, overcrowding and poor nutrition, childhood infection, social / cultural isolation, lack of health service and other support, low self esteem, incomplete schooling, limited employment opportunities, alcohol abuse, violence and some criminal influence. The family receives ongoing intensive, holistic and flexible help from a team of outreach workers, and support from a wider service network. Significant successes were evident after 3 years.	The value of intensive primary health care service intervention, underwritten through national policy, is demonstrated. In this, multi-disciplinarity, the necessity of trust, and the value of flexibility and creativeness on the part of health and other professionals appears critical. So too is their need for 'cultural competence', and practical linkages with local community networks.
New	'Commission of the Social Determinants	Clive Aspin, Nga Pae o te	A description of the situation of	The value of preserving or reconnecting with, Indigenous

Zealand	of Health-endorsed situational analysis of the social determinants of Indigenous health: The health of Maori men' *	Maramatanga (National Institute of Research Excellence for Maori Development and Advancement)	Maori men, supplemented by two short case studies. Maori men frequently suffer dislocation and loss of identity. Urban migration can accentuate this. Lack of formal education and qualifications connect with high unemployment. Dispossession and institutionalized racism are also important in marginalizing Maori. Lack of appropriate services is another determinant of poor health and low life expectancies, as are high health risk behaviours, such smoking, heavy alcohol use, poor diet and lack of exercise.	culture and associated support networks is stressed in the argument and in the case studies. Similarly important are appropriate primary health services, under Maori control. To deal with the extent of health and associated problems, such programs must be on a far larger scale than at present. The processes by which Maori continue to be marginalized, especially through dispossession of land, need to be properly understood.
Philippines	'Integrated determinants of health in the B'laan community of Landan: A case study from Polomolok, South Cotabato' *	Martiniano L. Magdolot, Mahintana Foundation Inc.	An account of how successful 'integrated development interventions', initiated when the (Mahintana) foundation 'adopted' Barangay Landan in 1993, have helped' improve the health condition and economic productivity of the B'laan Community'. Success of this community development program has been contingent on continuing external aid, including from a variety of international agencies. This integrated support, entailing financial aid, expertise and training, followed assembly of the local council's development plan, assisted by the foundation. A basic facet of the overall program has been the participation of the B'laan people, partly through formation of a cooperative. 'This case study clearly shows the	'In IP communities where public health services are insufficient due to funding limitations, economic development and community enterprises must be aggressively pursued to influence basic infrastructure support such as roads, electricity, health stations, water systems and school buildings.' The key message here is that successful efforts to improve health must go together with local level economic development activity. Another message is that success is contingent on cross sectoral partnerships, between local people through their organizations and external agencies: 'Governance of community based development programs and projects shall at all times, take into consideration the active participation of the Indigenous people and other stakeholders in the community'.

interconnection of education and economic productivity as major determinants of health.'

'Providing health services without sustainable economic source may create the culture of dependency among the IPs (Indigenous Peoples)'. A goal is economic self reliance.

Case studies on social determinants of Indigenous health available after the Symposium

country	title	author / organization /	Story	key policy implications for Indigenous health

		date		from the case study
Argentina	'Alcohol, justice and health: the case of Remigio Loncon'	Luis Wille Arrúe	Work at the individual and locality level following alcohol fuelled killing by a young Mapuche man of his friend. Existing health, educational and judicial systems are inappropriate.	The importance of culturally trained health and other professionals in rehabilitation, including language and conflict resolution.
Argentina	'Multiple social health problems in an Indigenous population and their importance for intercultural policymaking: An HIV/AIDS prevention experience shared with the Qom (Toba) community of Rosario, Argentina'	Fabiana A. Fernández, Matías A. Stival, Universidad Nacional de Rosario, March 2007	The risk of poor Indigenous migrants to an urban area contracting HIV/AIDS is compounded by the lack of appropriate health promotion, adequately trained professionals, and the failure of public institutions to enforce laws and maintain proper epidemiological data.	The importance of Indigenous participation in the development of public health policy and the design and management of community based programs is apparent. Appropriate professional cultural sensitivity is vital.
Argentina	'Social factors determining health care in Indigenous groups'.	Julio Enrique Arce, Health Care Association for Indigenous Groups	Indigenous migration to an urban locale with inadequate service infrastructure and low wages means a precarious existence, poverty and risk to health.	With appropriate support, human resilience in the face of adversity is shown. Reconnection with cultural heritage is vital, as is bilingual education in the first place. Communal ownership of land is also important for cultural recovery. 'Damage repair' should be a priority, aided by suitable professional training, integration of healthcare policy with wider measures for social justice, and use of better data for planning.
Argentina	'Health and Discrimination'	Susana Camila Torres, Julio Pietrafaccia	Wichi people, dispossessed of their land, are subject to ongoing institutional racism, some informed by neo-liberal, individualizing, policies. A child is removed from her tubercular mother by a health organization and taken a long distance. Restored after a 5 year struggle, the child did not understand her language or culture.	Racism should be targeted, partly through changing staff attitudes in public organizations by specialized training. Policies must be shaped with Indigenous people.
Argentina	'Multiple social determining factors related to the health care of Indigenous groups and their consequences in health care policies: An intervention related to a water resources problem in a Guarani community'	Mariano Althabe, Area Community Teams for Indigenous Groups	An isolated and poor Indigenous community with inadequate understanding of hygiene, and uncoordinated health services delivered episodically by external personnel without sufficient cultural awareness.	Need for health promotion, interdisciplinary on-site and adequately trained health care teams that work with the local community.
Brazil	'Survey of the Social Determinants	Dulce Lopes Barboza	Effects of loss of land, environmental degradation,	Importance of culturally appropriate diet and

	of Indigenous Health'	Ribas, Universidad Federal de Mato Grosso do Sul	changing socio-economic context and diet and declining physical activity on morbidity.	engagement in food production, linked to access to adequate land.
Brazil	'The Yanomami in Brazil and the creation of a special health care model for Indigenous groups'	Edgard Dias Magalhães, 30 March 2007	Historical oppression of Yanomami people, some in the guise of Indigenous welfare, benefited richer elements of society. Traditional health care practices broke down and with outside contacts epidemics occurred, control was lost, and new paternalist health interventions prevailed. Since 2000 the government has recognized the need for Indigenous participation in service delivery.	Importance of health care measures developed for particular groups, sensitive to cultural differences, and with systematic Indigenous involvement. To improve communication, Indigenous professionals need to be included in multidisciplinary health care teams, along with better prepared non Indigenous workers. Traditional health care is to be valued.
Brazil	'Case studies about Muscular Dystrophy, Albinism and Diabetes among Indians from the national park of Xingu and Xavante territory – Cultural, environment and political factors that influence such prevalence'	Fábio de Oliveira Freitas, Genetic and Biotechnological Resources – Embrapa; Joana Zelma Figueredo Freitas and Fátima Aparecida da Silva, Indigenous Groups' Health Department – Funasa	The first of 3 vignettes is about a young girl who, because she is albino would not normally be allowed to live. Other albino babies are killed. As her condition is seen as due to a bad spirit, and not a genetic or health issue, she does not receive appropriate care. The second case is of muscular dystrophy, a condition not locally understood as hereditary. Proper health care is also unavailable, and authorities are impassive. The third case study is of the growing incidence of diabetes mellitus, in a region where Indigenous peoples' access to traditional food has been cut through loss of their land.	Public health services need to be extended. So must the capacity of the state to intervene appropriately. The present planning practices, where uninformed non Indigenous people determine policy, as part of a move to mainstreaming services, should be changed. Indigenous people need to participate.
Chile	'Elderly Aymara: Psychological suffering and the community bond. An analysis of social determining factors in the health of an Andean community'	Nicolás Morales Sáez, Camiña, Community Iquique Health Care Services. Clemente Mamani Cusi, Indigenous Groups Association of Camiña	An illiterate 84 year old Aymara widow lives alone and in poverty. She suffers chronic heart disease, a sense of abandonment and grief over the suicide of a son 2 years ago. She had also suffered long term domestic violence from her husband. Her remaining children migrated, with many others, to distant urban areas. Alternative support services are inadequate, particularly regarding mental health needs.	Professionals trained in a different culture and on a bio medical model, require more appropriate training – including in mental health. Indigenous people need to be systematically incorporated in case management and other health service delivery. Social factors affecting health also need to be addressed, some through health promotion and more coordinated attention to issues like ageing and poverty.
Colombia	'The social determining factors related to the health of Pijao's Indigenous people in Colombia: a case study of the Bogota's Ambika municipality'	Anny Catalina Gutiérrez Cruz, Ambiká Municipality	Loss of land and environmental degradation associated with Indigenous migration to urban areas, leading to loss of identity, weakened social structure, poverty, malnutrition, bad infrastructure, unemployment, domestic violence and racism. A	Need for health care policy adapted to the 'different socio-cultural, economic reality' of specific Indigenous people.

			municipality responded with project based on intercultural dialogue.	
Colombia	‘Hypothesis for A Public Health Policy from and for Indigenous Groups in Colombia: Reflections on Suicide in Indigenous Communities’	Esperanza Cerón-Villaquirán, Universidad Itinerante	The Nukak Maku people are forced from their land. Their appointed representative fails in his efforts to communicate with a devious government and, in despair, suicides. The official cause of death, poisoning due to ‘contemporary urban stress’, says little. Loss of land is a vital factor, as is forced migration and the consequential experience of indigence, poverty and disrespect, the ‘loss of collective self-esteem’ and ‘weak political integrating mechanisms’. Forced relocation to the margins of an alien and hostile culture causes mental and social pathologies: depression, suicide, alcoholism, and domestic violence. The extinction of Indigenous communities is closely connected to loss of land.	‘Collective and individual self-esteem and feeling a part of society (physically, mentally, economically, socially, politically, territorially, and environmentally) are essential factors for the development of healthy habits, or … health self-care.’ Traditional knowledge must be respected, and engaged through open dialogue. Indigenous organizations must be involved in the design of health services. Health should be treated by the state as a fundamental human right. This entails guaranteeing equality and a hygienic and safe environment, with ‘enough high quality food, access to education and work’.
Columbia	‘The Case of a Maternal Death’	Angélica Aguilar Rugeles, Indigenous Groups’ Association of Cauca	A 41 year old Nasa woman dies from haemorrhage due to uterine atony, after delivering her 11th child at home. Her family saw a spell as responsible. Social determinants included poverty, language barriers and lack of cultural understanding on the part of the public health agency, poor education and lack of information about risks associated with age and multiple pregnancies, mistrust of the public health care agency, delayed use of traditional and western medicine, and too limited local health care infrastructure and service capacity.	‘Government must guarantee rights to health, based on the concept of universal coverage, with complete benefit plans, taking into account intercultural, individual and group cultural aspects, based on insurance or the direct provision of health services.’ Indigenous groups ‘will participate and become directly involved in the management, implementation and development of policies.’ ‘[H]igher levels of participation of women in decision-making and in the drawing up of policies for Indigenous groups.’ Land ownership is also necessary for Indigenous groups to live decently.
Mexico	‘Social determining factors and their relation to health determining factors in Indigenous emigrants and their implications’	José Luis Luna	How a relatively poor Indigenous woman who migrated to an urban area successfully reared her children, despite discrimination and multiple setbacks.	Effective education for life at the family level, especially with a responsible and authoritative father, is critical.

Costa Rica	‘Interinstitutionality and Intersectoriality: Tools for Strengthening the Development of Indigenous Peoples. The Case of Indigenous Communities in the Atlantic Huetar Region’	Grettel Rojas Vargas and Roberto Sawyers Copeland	Identification of regional Indigenous health problems and an assessment of their determining factors formed the basis for a cross-sectoral intervention, going beyond health services, and featuring cooperation between government, NGOs and Indigenous communities. The initiative is based on principles set out in the next cell. =>The long process is now under way. A major problem, one also evident amongst health determinants, is poor compliance by the state agencies with agreed policies and priorities.	‘Ensure the participation and consultation with Indigenous communities, enforce the rights consecrated in ILO Agreement No. 169 (ratified by Costa Rica); Adjust the prevailing health care model to the peculiarities of the Indigenous population;’ and finance mechanisms for coordination between agencies and with Indigenous representative organizations at national and local levels. Ways of ensuring real commitment by government leaders and state agencies to agreed goals need to be secured. Part of this rests with increasing the power of Indigenous representative bodies.
Ecuador	‘Jimbitono – Struggling for people’s health’	Klever Calle and Arturo Quizhpe Peoples Health Movement, Latin America	An account of the impact of an imposed hydroelectric project on a once tranquil Ecuadorian village. Previously a tranquil place, Jimbitono became divided. Stress associated with the development, deception and empty promises caused ill health. State agencies weakened by neo-liberal policies were not able to adequately protect people’s rights, particularly in the face of large corporate interests.	Introduced causes of poor health need to be countered through ‘education, organization and mobilizing the people’, to which ‘health organizations and movements should contribute’. Successful struggle can promote dignity, and health. Government agencies should ensure that people are treated equitably, the environment is protected, that corporations do not infringe on the public interest, and that mass media is balanced so that people are properly informed. The ILO Indigenous and Tribal Peoples Convention, No. 169 (ratified by Ecuador), should be enforced.
Guatemala	‘Maternal mortality in Totonicapan’	Ana Marina Tzul	One month after childbirth an Indigenous woman dies from ‘pulmonary oedema, with secondary high blood pressure disorders from the pregnancy.’ During her problematic pregnancy and after giving birth, the woman did not get timely medical care. This was because she needed to keep working, pressure from family, reliance on ineffective traditional medicines, her own ‘inability to identify danger signs’, and health services that were inadequately equipped, both technically and interculturally.	The death was avoidable. High levels of maternal mortality, a serious problem in countries like Guatemala, can be reduced by ‘organized, low cost, strategically planned actions from the health services.’ The latter include more culturally sensitive and flexible clinical interventions, with the participation of ‘community leaders, those who provide traditional health care and religious leaders’, and others. Indigenous people must be included in shaping government policies.
Mexico	‘Gangrene: Case Study of a Yaqui	Erica Merino González,	A 44 year old Yaqui woman worried about a rash	The death was avoidable. Health professionals must

	Indigenous Woman'	National Anthropology and History School, Chihuahua	on her legs consulted a shaman, who diagnosed witchcraft. He soothed the condition using traditional medicine, but it was accepted that only an agreement between ancestors and ancient beings (*surem*) after calls by a qualified intermediary, offered cure. The condition developed as gangrene. Persuaded to see a doctor, he advised amputation. The woman could not reconcile this with cultural practices, which the doctor said were silly. Nor could she see how to manage without legs, having no money and only her sister for support. Death eventuated.	be trained to respect, communicate with and otherwise understand Indigenous cultures. Dialogue between western and traditional medicine should be promoted. Racism also needs to be addressed, as must the poverty that limits access to appropriate treatment and other necessary care and support.
Paraguay	'Land property as a health factor'	Maria Elena Velázquez, Gente, Ambiente y Territorio (GAT)	Activism supported by an NGO (GAT) enabling the Ayoreo Totobiegosode people to regain rights to traditional land, and establish new communities with health and other essential services. With this, have come significant health improvements.	Return of land to dispossessed Indigenous people is a critical ingredient to recovering from serious health problems. Appropriate support is also vital.
Paraguay	'Health For Indigenous Peoples from an Intercultural Perspective: The Case of Boquerón, Paraguay'	Jorge Aníbal Servín, 17th Health Care Region of Boquerón	Boquerón has under-reported but high rates of morbidity and mortality – and inferior health services, matching the lower incomes, lower levels of education and lower social status of the area's 13 Indigenous groups. This is an account of a state planning response featuring open dialogue with the target communities through consultative meetings about improving health services. Other meetings, with paramedics, have resulted in more respect for other cultures, better quality information, eradication of congenital syphilis, and reduction of cases of severe dehydration.	Health services should be systematically planned in consultation with affected Indigenous groups. Professional staff must demonstrate 'respect for "other" types of understanding and ways of seeing illnesses'. Better quality information about people's health is essential.
Peru	'Integral Project for Emergency Medical Service for Hepatitis B Cases in the Towns of Kandoshi and Shapra in "Daten del Marañon" Province – Loreto Department, 2003 – 2006'	Melvy Ormaeche, General Directorate of Epidemiology, Ministry of Health	A hepatitis B epidemic threatening the future of two Indigenous minority groups, already with high levels of communicable disease, is countered by a government / NGO intervention. This features patient identification and support, vaccination and dissemination of information.	Highlights the importance of including families and communities in health promotion and project implementation and evaluation.
Peru	'The Traditional Maternity Ward as	Manuel Loayza, General	A Chopcca woman with complications gives	The interface between western and traditional

	an Intercultural Bridge: How to Attend Obstetric Complications during Childbirth, Huancavelica'	Directorate of Epidemiology, Ministry of Public Health	healthy birth in Huancavelica Hospital, where previously she would not have gone. This is partly because obstetric staff 'received several training courses on intercultural adaptation', and some staff could speak Quechua and knew the woman. The hospital had developed 'Traditional Maternity Wards', which merged 'western and traditional technologies and methods' in dealing with Indigenous childbirth. This helped resolve cultural barriers blocking access to quality health care.	methods / processes must be engaged. Clinical services can be restructured so as to be more accessible to Indigenous people. Professional staff require special training on the expectations, knowledge, traditions, and world view of Indigenous people. In addition, obstacles to quality health care through sheer 'lack of empathy and kindness at health care centres and lack of respect for [Indigenous] needs and expectations' need to be recognized and overcome.
Peru	'Social, political, and economic determinant factors regarding the health of the Achuar Indigenous group in Peru'	Miluska Carhuavilca García	A review of the impact of a poorly controlled hydrocarbon extraction industry on the livelihood and health (eg heavy metal contamination causing genetic alterations and cancer) of Achuar people. This activity is part of a pattern of exploitation of the traditional land of Peru's Indigenous people, based on and perpetuating 'discrimination, exclusion, and manifest social inequality'. A fundamental problem is the lack of systematic data collection. The 'almost non-existent presence of health care services on the part of the State leads many people to become ill and die without even a diagnosis.' Health centres that do exist are ill equipped with personnel and medicines.	Though in serious need of development, health services cannot counteract the effects of extensive environmental degradation, loss of livelihoods and cultural destruction. 'Only with political will can the problems of this and other Indigenous groups from the Peruvian Amazon and other countries be solved.' A fundamental need is to provide for ongoing monitoring and evaluation of the impact of the hydrocarbon industry. Plans for extensive environmental remediation are necessary, as well as prohibition of activity harming health. Alternative sources of income have to be found. Governments must ensure that Indigenous people have equivalent rights to the more privileged.
Venezuela	'Indigenous cultural statements on oral health and disease: culture as a dimension to consider in the design and application of oral health care programs. Case study of the Venezuelan Wayuu and Añu groups'	Mayde Pirona Gonzalez, Dental Department, University of Zulia.	Oral health problems following colonization, and land degradation, proved not amenable to 'the historically hegemonic biomedical and dental model'. Moreover, the latter may contribute to 'social, cultural and political exclusion'.	Need for an 'inter / transcultural multidisciplinary approach to oral health / diseases'. Effective interventions must be based on knowledge of how specific groups view health. They must also be part of wider primary health care and structural reforms.

Venezuela	‘Social factors affecting the health of the Indigenous groups of Venezuela: The example of the Yanomami people’	Noly Fernández, Ministry of Public Health	A woman who suffered snakebite and miscarriage in a poorly serviced and very remote area is attended by a doctor flown in two days later, and evacuated by helicopter after six days. Two years before, she would probably have died. From being historically invisible, Yanomami and other Indigenous people in Venezuela are now the subject of concerted government attention – following recognition of Indigenous rights in the constitution and ratification of ILO Convention 169. This is an account of state led progress in the provision of health services for Indigenous people. There is still a very long way to go. ‘Costs’ or ‘remoteness’ should not be accepted as explanations for lack of health care. ‘Neglect’ is a more accurate term. Health, communication and transport infrastructure should be distributed equitably. Articulation of traditional and western medicine is needed, with better communication and cross cultural practices, more consultation, logistic coordination and enhanced communication infrastructure, wider health service coverage, with Indigenous participation, and improved health promotion.

Delegates participating at the symposium

Canadian contributions

The Symposium also received considerable material from Canada, on which a number of delegates made presentations. Details are as follows.

1. Jeffrey L. Reading, Andrew Kmetic, Valerie Gideon, for Assembly of First Nations, 'First Nations Holistic Policy & Planning Model, Discussion Paper for the World Health Organization Commission on Social Determinants of Health', April 2007. (Draft) Kathleen McHugh spoke to this document at the Symposium.

2. Yvon E. Allard, for Métis National Council, 'Métis concepts of health: Placing health within a social-culture context. Social, economic and environmental (ecological) determinants of Métis health', Discussion Paper, 13 April 2007. Minister David Chartrand spoke to this document at the Symposium.

   Bryarly McEachern, for Inuit Tapirit Kanatami, 'The social determinants of Inuit health: A discussion of research, actions and recommendations', Discussion Paper, (Draft). Anna Fowler spoke to this document at the Symposium.

3. Bridgeworks Consulting Inc, 'Social determinants of health: First Nations, Inuit and Métis perspectives. Overview paper', Inc. for National Collaborating Centre for Aboriginal Health, University of Northern British Columbia, Discussion Paper, 13 April 2007. (Draft) Bernice Downey, spoke to this document at the Symposium.

The first three documents are explicitly designated as 'discussion papers' (rather than as case studies).The fourth paper is an Overview of the three other papers, and is 'intended to highlight many of the commonalities experienced by Aboriginal peoples within the context of social determinants of health' (p.4).

A prime example of these observed 'commonalities' is the nomination of critical factors 'essential to understanding how health disparities have come to exist for Aboriginal peoples' and which are 'recognized by all three Aboriginal groups'. These include 'self-determination, poverty, and colonization'. These critical factors, the authors say, 'must be at the core of solutions to addressing health inequality' (pp 4-5).

Other key observations on commonalities, most with clear relevance beyond Canada, follow.

- 'Research and dialogue at the international level has demonstrated a common element that exists for all Indigenous peoples and affects every issue confronting them as a collective: the history of colonization and the associated subjugation of Indigenous peoples' (p.7)
- Far from being seen as 'an historical process that devastated the traditional livelihood of Aboriginal peoples … the process of colonization must be recognized as a contemporary reality' (p.8).
- Though Canadian Aboriginal peoples 'all have distinct conceptions of health', there are also commonalities. One of these is that their views about health tend to be holistic, including not only physical well-being but also emotional, intellectual, spiritual and other components' (p10).
- Further, 'an individual's health, even broadly defined, cannot be understood in isolation of the collective well-being of their community and / or nation' (p.10)

- ‘The poor health of Aboriginal peoples “has to be seen in connection with the general marginalization that Indigenous peoples suffer from economically and politically”’ (p.10).
- ‘Critical factors that broadly impact the reduced health status of Aboriginal peoples in Canada include poverty, violence, poor housing and deficient physical environments’ (p.11).
- ‘Research has shown that at least three quarters of Aboriginal women have been victims of family violence, and they are three times more likely than non-Aboriginal women to die as a result of that violence.’ (p.22)
- ‘Access to, and quality of, medical care services is not the main driver of people’s health. The concept of social determinants is directed to the “factors which help people stay healthy, rather than the services that help people when they are ill.”’ (p.11)
- ‘On the international landscape, research stresses how little has been done, even in wealthy countries, to develop an adequate system of measurement for determining the impact of public health policies on marginalized groups or to test approaches for closing the gap in health outcomes.’ (p.15)
- ‘The concept of health equity, or inequity, is foundational to international reflection’ (p.17).
- ‘Indigenous peoples’ connection to the land not only distinguishes them ecologically and geographically, but a connection to the land also makes them spiritually unique. Aboriginal peoples are tied to the land and it to them. These timeless and imbricated (overlapped) relationships with the land distinguish Indigenous peoples from others around the globe. These relationships are the essence of the individual and collective identities of Indigenous peoples’ (p.27).

The final pages (29-31) of the Canadian Overview paper feature a section headed, ‘Select highlights / Issues from Aboriginal organization’s papers’. In slightly more abbreviated terms, these points are as follows:

First Nations

- A vision for improving health requires partnership between First Nations communities, investigating local and world health issues and involving governments. Colonization into the present and globalization has caused extreme poverty.
- Acceptable research must be directed at improving health, and ‘not the structural characterization of ill health’, which is ‘thought to be a significant barrier to improved health and well being’.
- The effects of poverty and social disadvantage are evident in many diseases. The path to wellness lies ‘within a holistic paradigm that includes the mental, physical, cultural and spiritual well being of both the individual and the community.’

- Effective holistic planning, as embodied in the proposed *First Nations Holistic Policy and Planning Model*, is dependent on building a better relationship with the Canadian Government – based on recognition and reconciliation.
- World pursuit of Millennium Development Goals may be leaving First Nations peoples, 'often deeply marginalized as minority populations' behind. 'The time is right for a global response to improve the health and well-being of Indigenous peoples'.

Inuit

- The 'links between socio-economic conditions and health are glaringly clear. 'Inuit suffer much lower life expectancies than other Canadians, comparatively high rates of infant mortality, the highest suicide rates', and 'disproportionate incidence of diabetes, respiratory illness, and violent crime.'
- Though unique community level action is required, there is a common need for Inuit self determination. This is 'the vital means by which Inuit can address the socio-economic inequalities debilitating their health.'
- Inuit are 'swiftly progressing toward self determination through the signing of Land Claim Agreements, a Partnership Accord, and the election of Inuit governments.'
- 'Future research activities and data collection are prerequisites for health improvements.'

Métis

- Official data on the Métis population health is deficient. To 'appropriately determine the health status, well-being and health needs of Métis', more research is necessary.
- To ensure that what is known about the health of the Métis population is shared, there is a Métis Nation portal (http://healthportal.metisnation.ca/home.html). This includes information on determinants, under these headings: social environment, physical environment, economic opportunity, health care services, lifelong learning, lifestyle habits and coping, and spirituality.
- 'Indigenous knowledge must be incorporated into the macro and micro-Aboriginal health agenda', as it is in 'direct conflict' with health care 'informed by a dominant Western worldview.
- '[S]ocial, cultural and economic conditions have played a powerful role in generating "Aboriginal" vulnerability to disease, injury and premature death.' Awareness of this 'must guide ongoing research and interventions if the disparities in health status between Aboriginal Canadians, including Métis, and the general population are ever to be eradicated.'

Symposium proceedings

Much of the Symposium connected directly to the written material, where speakers presented or spoke to their case studies, or to their other prepared material. These presentations made up the bulk of Day 1. The content of most is summarized in the review of case studies and summary of the Canadian discussion papers. As planned, along with the 'Overview (Situational Analysis) of current knowledge of social determinants of Indigenous health' and other written material, the presentations also provided material informing the Day 2. Factors such as delays in receiving written the material and its bulk meant that most participants relied on the verbal presentations and the rapporteurs' accounts.

Day 2 of the Symposium was made up of parallel small group meetings, and two plenary sessions. These followed the two rapporteurs' distilled accounts of the case study and other presentations and communication.

One rapporteur drew out the following social determinants identified in discussions: 'Poverty; Education; Housing/Land; Cultural Continuity; Economic Development; Water sustainability; Gender Balance; Mobility; Social Exclusion; and Research Capacity.'

The rapporteur identified 'Common Themes' in the following terms: 'Control over … (self-determination); Access too … (opportunity, services); Culturally appropriate …; The responsibility of the state …; Recognition of …; Inclusion in …; Capacity … .'

The rapporteur also identified common experiences of Indigenous people reflected in the Day 1 presentations. These were: Loss of land; detrimental effects of service delivery; cultural discrimination and barriers; lack of recognition or respect by the state; and the problem of 'how do we pass along our culture (continuity) to future generations.'

The second rapporteur extended the review of thematic points arising, and then moved beyond – successfully pointing Symposium discussions towards a range of possible 'Overarching statements' about the well-being of Indigenous peoples requiring, amongst other things, the following:

Ecological renewal and sustainability – **Issues and Strategies –** Including ecological damage (including global warming) and its impact on Indigenous people who are sustained by fragile ecologies; deforestation; the impact of mining and other resource based industries on Indigenous communities. The CSDH can highlight the significance of global processes to address these issues.

Political empowerment, legal and institutional reform – **Issues and Strategies –** Stop the violation of the human rights of Indigenous people; recognize the collective rights of Indigenous peoples (eg political representation; treaties, rights to self determination; participation in institutional processes, land rights); reconciliation and negotiated settlements; Ameliorate the harms caused by omission and commission by the criminal justice and legal system; Address the problems of Indigenous peoples who straddle state and jurisdictional borders; UN Declaration on the Rights of Indigenous Peoples, global governance in health. Ensure equitable, effective access to

the resources and services of a nation state or jurisdiction. The CSDH should do or recommend: Support for global fora for Indigenous health and human rights (Draft UN Declaration on the Rights of Indigenous Peoples); Draft UN General Comment on Children's Rights; Indigenous equivalent to the Kyoto Accord; Affirm fundamental significance of collective rights of Indigenous peoples' to self determination; Affirm and promote reconciliation and negotiated settlements; promote an agenda of better practice development across sectors such as housing, education, etc.; Promote an agenda of legal reform; Borders and health program.

Affirmation and respect for Indigenous cultures – Issues and Strategies – Address racism; support for Indigenous determination over the rate and direction of social change; affirm Indigenous spirituality; Promote constructive dialogues on the values and behaviours that enhance well-being; Facilitate the development of trust between Indigenous peoples and the institutions of the dominant state; Promote social inclusion but not to the detriment of Indigenous cultural development. (The rapporteur asked whether 'spiritual fulfilment' should this be a part of this set of issues) The CSDH should support the UN Draft Declaration on the Rights of Indigenous Peoples, etc; and promote anti-racism strategies.

Economic prosperity - Issues and Strategies – Support and protect subsistence economies; Minimize the misdistribution of wealth; enable Indigenous peoples to benefit from economic growth, in particular for those aspects of the economy that relate to Indigenous lands; Address poverty; Education and the development of other forms of intellectual capital. The CSDH should promote constructive dialogue on wealth distribution within states; promote ethical governance and practice in the transnational corporations responsible for the extraction of wealth.

Healing systems and services - Issues and Strategies – Invest and build the capacity of primary health care services; Promote Indigenous governance, priority setting and development in health systems; Support kin based and traditional healing practices; Primary health care; Promote access to health services on the basis of need; Link and coordinate disparate services; quality data. The CSDH should reinforce existing strategies for primary health care; Promote development of mechanisms to improve data quality; and Link into health services.

Nurturing families and Individuals - Issues and Strategies – Promote, support nurturing relations within Indigenous families with respect to gender and generations; Develop the capacity of Indigenous families and kin networks to respond to change in social roles; Support the healthy development of Indigenous children and youth; Promote resilience and 'mastery' in Individuals; Create a social climate in which Indigenous families and individuals take action to enhance their well-being; Strategies to address addictions and other harmful behaviour; Social and emotional well-being. The CSDH should reinforce significance of Indigenous self-determination in facilitating dialogue within Indigenous communities on addictions, harmful relationships, positive gender relationship, health enhancing values and behaviours; Promote programs and resources to support Indigenous families.

With this directional schema, delegates then worked in groups to 'refine key themes' from the case studies and the overview document', and guided by the rapporteurs' briefings. These themes were to assist further group discussions, directed at shaping 'final draft recommendations and / or action areas'.

Themes going into the final session emerged as:

- Self determination
- Ecology and environment
- Economic prosperity, fairness and equity
- Leadership and capacity strengthening
- Racism / dominance / imperialism
- Healing, services, systems, structures
- Cultural sustainability, protection, stewardship
- Land
- Human rights

Thematic outcomes and other major points from the various Symposium workshops are taken up in the final section.

Key issues and areas for action

The Adelaide Symposium was not structured so as to produce formal recommendations for action. Resolutions and voting were unsuited to the Symposium's discursive format and more consensual process, characterized as it was by the progressive pooling and exchange of information and ideas. However, what emerged from the proceedings of the Symposium and associated material was a range of distinct threads, variously referred to as 'key themes', 'core principles we can build on', or 'key areas for action'. These were meant to guide globally oriented advocacy on Indigenous health by the CSDH.

Diversity and concurrence

Prominent amongst the points made was that 'one size does not fit all' – that there is no single account or explanation for the relative health disadvantages of Indigenous people, or any one common strategy for change. This is partly because Indigenous people may live in very dissimilar circumstances. Some, for example, are recognized as Indigenous people with a certain corresponding status. Others are counted not as Indigenous people at all, but as minority populations. Factors such as health profiles, degrees of poverty, and geographic location within countries also differ widely.

'The relationship between interventions and health outcomes is complex, and not linear'. Nevertheless, there was also a shared belief that despite geographic and national differences, numerous issues and problems were recurrent. So were key policy implications, spelt out or implied.

The following is a list of points over which there was wide agreement in the documents prepared for the Adelaide Symposium and in the ensuing proceedings. Each point was prominent in the overall discourse. The points are illustrated by reference to various contributions to the overall Symposium.

Colonization and decolonization

A broad comment made by a participant at the end of the first day of the Symposium was: ‘Everyone agrees that there is one critical social determinant of health, the effect of colonization.’ Contributors frequently referred to the deep impact of colonization on Indigenous culture and people. Disruption or severance of connections with land meant the weakening or destruction of closely associated economic and social practices, essential for health and well being. The degradation of the land on which Indigenous livelihoods depended had a similar effect. This is a recurrent theme in the case studies.

Persistent too was the understanding that colonization is not simply an historical process. It is ongoing. As noted in the Overview of the Canadian discussion papers (p.8), far from being seen as ‘an historical process that devastated the traditional livelihood of Aboriginal peoples … the process of colonization must be recognized as a contemporary actuality’. For this reason, specific provision for healing harm caused through colonization should be put in place.

Means of countering the colonization process include self determination for Indigenous peoples; practical recognition of human rights; the restoration of rights to land; rehabilitation of degraded environments; facilitating the restoration of cultural heritage, including language; dealing with racism, and Indigenous control of research on Indigenous people. A fundamental call here is for ‘decolonization through self-determination and group empowerment for Aboriginal peoples’ (Canadian Overview paper, p.8).

A further point that was made on various occasions was that the legacy and on-going colonial impact means that Indigenous people live much of their lives in crisis. This is reflected in their much higher disease burdens and lower life expectancies. Despite this, a strong desire was expressed not to focus solely on a ‘deficit model’ or ‘framework’, and to stress positive aspects of Indigenous peoples’ experience.

Consistent with this, a point made a number of times was that in some ways the marginal existence of Indigenous peoples can be a result of efforts to resist colonization or assimilation – and even an expression of resilience. For this sort of reason, efforts to counter ‘social exclusion’ must be informed by a close understanding of Indigenous peoples’ particular circumstances and perspectives.

Another concern expressed about some measures meant to promote social inclusion was that they may not be congruent with the preservation of a distinct Indigenous culture. This again reinforces the necessity of ensuring that Indigenous people can influence or shape policy initiatives and interventions.

A quite separate and forcefully made point was that, as it is commonly used, the concept of social exclusion relates to exclusion from non Indigenous society. This is taken as a problem. In contrast, Indigenous people ‘are in fact marginalized from our capacity to practice our (own) knowledges, value our land and rivers, seas and resources’. This exclusion needs to be addressed. Indigenous people should have the right to be different and, if they wish, exempt themselves from the ‘mainstream’.

Human rights

Failure to enact or implement various legal and other instruments, agreements and treaties directed at securing rights for Indigenous people was a matter of repeated concern. Constitutional protection of the rights of Indigenous peoples, and explicitly women, was seen as important. As observed in the Canadian Overview (p.8), when properly applied 'constitutional rights impose certain positive, social, fiscal and institutional obligations on federal, provincial and territorial governments'.

Perhaps the most commonly mentioned international example was the lack of progress on the United Nations Declaration on the Rights of Indigenous Peoples, still in draft form. After two decades of development, progress of the Declaration on the Rights of Indigenous Peoples came to a halt in the UN General Assembly in November, 2006. A Namibian motion essentially for non-action was supported by a majority. Eighty two nation states voted in favour, with 67 against and 25 states abstaining. This was even though the Human Rights

Council had adopted the Declaration, in June 2006 and urged the General Assembly to follow. The Adelaide Symposium urged renewed action on this instrument, as well as on the Draft UN General Comment on Indigenous Children and Their Rights.

Another specific concern was the failure to implement the International Labour Organization (ILO) Indigenous and Tribal Peoples Convention, 1989 (No. 169), even by countries which have ratified the instrument. Its implementation would promote self determination and 'respect for Indigenous and tribal peoples' cultures, their distinct ways of life, and their traditions and customs'.

An associated concern was the lack of government agency compliance with treaties and existing policies, or stated principles and goals. The impact of deception and empty promises from politicians and state authorities was seen as another measure of disregard for Indigenous people. This has obvious ramifications for levels of stress, anger and lack of control that Indigenous people experience.

Self determination

A Symposium rapporteur labelled self determination as an 'overarching principle'. This reflected its prominence in the overall discourse. In discussions, the issue was linked with Indigenous people's status, sense of control over their destinies, as well as capacity to determine policies and shape services.

The delegate presenting the Canadian First Nations paper at the Symposium referred to research evidence connecting greater Indigenous control at the community level with both better health and 'sustainable economic prosperity'. In the same context, she used the term 'cultural continuity' as 'encompassing factors such as control over health services, recreation facilities, greater use of First Nations languages and many others.'

The question of what self determination means in practice arose in various places. The term self determination was used in differing ways, sometimes to refer to the representation of a whole Indigenous people, sometimes to refer to local or community level control, and sometimes to control of particular organizations, such as Indigenous health services.

As noted in the Canadian Overview paper (p.24), ‘Self determination does not describe any single political or social arrangement; it can take different forms in different places, contexts and cultures.’ This observation is born out in the case studies, where some point to a need for Indigenous controlled institutions as a means of elevating health levels, while others see ensuring effective Indigenous participation in policy making and service delivery as the condition for improved health. Some case studies were prepared within government, and might be expected to be more conservative.

Nevertheless, on the issue of self determination the dominant view in the Symposium discourse was that, at the least, Indigenous people have to be systematically and conscientiously included in the policy process, as well as in the delivery of services.

Symposium support for the draft Declaration on the Rights of Indigenous Peoples implies more than this. Article 3 states:

Indigenous people have the right of self determination. By virtue of that right they freely determine their political status and freely pursue their economic, social and cultural development.

Economic distribution

An overwhelming perspective is that the resolution of Indigenous poverty is fundamental to improving health. The Inuit discussion paper (p.10) reads:

Inuit view income distribution as a key determinant while Health Canada describes income as ‘the most important determinant of health’. It is difficult to distinguish the effects of income from the effects of education and employment on health, because the three factors are interdependent. However it is well recognized that socioeconomic inequalities lead to marginalization, limiting access to education, employment, good housing and nutritious food. Poverty also weighs heavily on mental well-being by lowering self esteem, increasing dependence, and vitiating one’s ability to participate fully in society. Thus, income affects health directly and indirectly, by impacting on other determinants.

Poor health was seen as the corollary of poverty. They go together. Poverty must be tackled as a matter of priority. In the Symposium itself, some delegates expressed the challenge as one of sharing economic ‘prosperity’. In this, fairness and equity are operant principles. To overcome health disparities, tackling economic inequality is viewed as fundamental. At the same time, delegates repeatedly stressed the interrelatedness of issues.

A commonly mentioned ingredient for tackling poverty and associated low socioeconomic status is through investment in education, more particularly that of children.

Investment in education was also seen as a critical ingredient in strengthening Indigenous leadership, a major concern at the Symposium, and other capacities.

Lack of data

A theme especially recurrent in the written contributions is the low ‘visibility’ of Indigenous populations in official demographic reporting, and the need for better quality epidemiological and other health related data.

One case study (from Peru) records a fundamental problem in ‘the lack of systematic data collection’ and links this in part to the ‘almost non-existent presence of health care services’, so that many people ‘become ill and die without even a diagnosis. This way, the scandalous number of deaths as a consequence of hydrocarbon contamination cannot be made visible.’

The lack of visibility in official data may accord with the reticence in some regions to even acknowledge ‘the existence of “Indigenous” peoples as a category’ (Situational Analysis, p.3).

The Métis discussion paper (p.7) notes a ‘lack of Métis population-specific health data, information and knowledge’ and ‘Minimal Métis-specific health research.’ The Canadian Overview paper (p.4) refers to the situation internationally: ‘Broad factors contributing to the poorer health status of Indigenous people globally include poor data collection and analysis, gaps in understandings about health and well-being.’

The Situational Analysis notes (p.110) that “Indigenous peoples have rarely been actively involved in deciding how or what should be studied about them and for what purpose.’ As examples of problems, it cites the appropriation of Indigenous pharmaceutical knowledge through patenting, and collection of genetic data without consultation. It also refers to the use of information about health disparities as evidence of some sort of weakness in Indigenous people themselves – as a ‘victim blaming’ exercise.

The Canadian First Nations discussion paper (pp.9-10) makes a similar point, cautioning on dangers associated with certain reporting. Its authors criticize ‘[e]pidemiological data that tend to portray First Nations peoples as generally unhealthy and implicitly unable to manage their own affairs. This has a disempowering effect … ’. The authors call for the kind of research which counters this, such as that which reveals ‘community resiliencies’. A corresponding critique appears in the Métis Discussion Paper (p.23).

A means of countering negative application of information on Indigenous people is through ‘meaningful engagement of communities in the research process’ – as well as at the policy level in influencing just how demographic data is collected, assembled and disseminated. As it is framed in the Situational Analysis (p.114)

There is certainly a lack of information and an urgent need for more data to be collected and analysed. But this has to be done within a conceptual framework agreed with Indigenous researchers and organizations.

Indigenous cultures, world views and the 'holistic paradigm'

One of the strongest messages from the case studies concerned the lack of appreciation and understanding of Indigenous culture and world views, values and aspirations, on the part of governments and those who deliver direct services. The recurrent implication is for increased respect for the Indigenous peoples' rights. The need for those who provide health and other services to Indigenous people to be trained in the relevant culture was repeatedly stressed. Intercultural skills are critical. In one case study an associated need was drawn out – for demonstration by health care personnel of more basic human empathy and kindness at health, along with respect for particular Indigenous needs, views and expectations.

Connected with such points was the recurrent call for closer dialogue and interface between western and traditional health practices. And, as is stated in the Métis Discussion Paper (p.26), 'We believe it is critical that Indigenous knowledge be incorporated into the macro and micro Aboriginal health agenda to achieve health improvement.'

The need to take account of 'Indigenous people's holistic approaches to, and understandings of, health and well-being' (Canadian Overview paper, p.7) was also repeatedly emphasized. A similar point was made in the commissioned Situational Analysis (p.3) but avoiding suggesting that Indigenous and western approaches always differed.
In elaborating on the more holistic approach, reference was made in various places to a spectrum of factors integral to Indigenous health, including those termed 'spiritual, physical, mental, emotional and cultural, economic, social (and) environmental'. In the same place, the Canadian Assembly of First Nations describes its 'Wholistic Policy and Planning Model (as) to address issues beyond the focus on health service delivery' (Discussion Paper, p.33). This approach calls for instruments to measure a range of health determinants, prioritized by their importance. Various references to concepts of a 'medicine wheel' or 'wellness wheel' indicated that the holistic approach to health and healing had distinct appeal to Symposium delegates.

A practical point relevant to the recognition of cultural factors as social determinants is highlighted in the New Zealand case studies. The health value of reconnecting Indigenous people who have been distanced from their cultural heritage and associated support networks is drawn out. 'Cultural competence' is seen as an important health determinant. A similar point is made in the Situational Analysis (p.114), referring to New Zealand work on 'how cultural and linguistic meaning can be accurately transmitted to improve health and well-being.'

Reform of institutions and services

Extending well beyond the need (noted above) for those who provide health and other services to Indigenous people to be trained in the relevant culture was the call for broader reform of institutions and service arrangements. Reforms must extend from governmental structures, including systems of political representation; through legal and judicial arrangements, including securing practical equality before the law and the recognition of customary law; to the extension of service delivery arrangements to ensure equitable access and accountability to Indigenous people. Delegates referred frequently to the need for, and value of, properly funded primary health care services under Indigenous control.

One proposal with considerable resonance in the Symposium was for standing commissions independent of governments that audit or monitor impacts on and changes in Indigenous health and well being at the national, or even international, level. Such organizations could also report on government compliance with laws, international conventions or other instruments, standards or benchmarks.

Land

The Situational Analysis reports (p.112) that '[a]ll contributing authors agree that land is a key component contributing to Indigenous health.' The displacement of Indigenous people from their land through colonization is bound up with cultural disruption, social exclusion and tension, increased stress, diminished sense of identity and status, political and social subjugation, loss of control over lives and the loss of livelihoods – including proper nutrition. All such factors are heavily implicated in Indigenous peoples' poor health.
A persistent concern in the Symposium discourse was the despoliation of the traditional territory of Indigenous peoples, devastating livelihoods, culture and health. This results from mining and other primary industry undertaken by badly regulated commercial interests, some illegal. More safeguards, and rehabilitation of degraded land and other compensatory measures, are necessary. Indigenous people should be able to say no to intrusion on their land.

Ecological sustainability was a key concern. Indigenous knowledge, stewardship and land management practices are seen as offering means by which the growing environmental crisis may be arrested. As one delegate said, 'we have something to offer'.

A corollary of loss of land is migration, particularly to urban centres. As noted in the Situational Analysis, this 'is to a greater or lesser extent a theme everywhere … migration into unfamiliar, poor urban environments results in psychological and material stress; … Poor housing, lack of education, inability to find work and, where it is found, low wages and hazardous working environments put their lives and health at risk (p.113). Apart from reuniting people with their land, there is a clear need for more effective support for Indigenous people who have migrated to urban locations.

Dealing with racism

The expression or experience of racism repeatedly emerged in the Symposium discourse as a health determinant. Racism was variously understood as operating at interpersonal and institutional or systemic levels. Its implied impact on health was through such channels as stress, associated with disrespect, personal abuse and social exclusion, or discrimination in degree of access to appropriate health and other infrastructure or services necessary to ensure equity in health outcomes.

Complementing courses in cross cultural understanding and communication, the relevance of measures to combat racism was also identified. These might take the form of specific training and public education, as well as through direct intervention by state and other authorities.

Family, community and health

The concepts of healthy or dysfunctional families and communities arose repeatedly. Family and community were seen as vital cultural entities in Indigenous health. For example, the single construct at the 'core' of the Canadian First Nations 'wholistic policy and planning model' is 'community' (First Nations Discussion Paper, p.34).

Community-based and community controlled services were considered fundamental to improving Indigenous health. Similarly, building Indigenous leadership at the community level was seen as key in tackling health and related problems, such as domestic violence.

The need to rebuild or replace weakened community networks and support was also seen as very important, especially in compensating for displacement and migration, weakened family ties and the loss of 'nurturing relationships' and identity. Along with this, efforts to preserve or rebuild trans-generational relations to deal with social inequities were thought significant.

Concern about the health and well being of Indigenous women was repeatedly expressed. The Canadian Overview (pp.21-23) records social determinants of health that impact more heavily on Indigenous women, including poverty, access to education and employment, and exposure to violence. The case study from Columbia provides an example of the importance of respect for the rights of women domestically, as well as in having a distinct voice in formulating policies and programs affecting Indigenous people.

The importance of programs directed specifically at males, who do less well in respect of various health outcomes and who perpetrate violence at the domestic level, was stressed by a number of delegates.

Global response to international experience

There was a strong belief amongst Indigenous delegates that international cooperation is an important ingredient in tackling common problems. This is sustained by a conviction that 'we are all connected as Indigenous peoples worldwide', partly at least in the light of extensive similarities in the health experiences across national boundaries. Obviously, the far from fully realized benefits of international covenants are one expression of this. Another is in the form of exchange of information and strategic directions. Indigenous peoples should be assisted in developing means for effective international cooperation, advocacy and other action. A specific task, one that received some attention in the Symposium, may be in Indigenous people themselves setting the standards or criteria by which situations are assessed and change or progress measured.

One advantage of this may be in helping deal with the special problems faced by Indigenous people who are divided by national borders or other imposed and artificial jurisdictional or administrative divisions.

Similarly, international agreements and cooperative arrangements can provide means by which the negative health and related impacts of scarcely accountable large transnational corporations might be managed.

Beginning with the Situational Analysis, Symposium documents and discussion point towards a crisis in Indigenous health internationally, and that national governments are not doing anywhere near enough to resolve the problem. A particular issue is their failure to address the social determinants of health. This takes us back to the starting quote from the Canadian First Nations paper (p.40) that 'the time is right for a global response to improve the health and well-being of Indigenous peoples'.

Symposium delegates were keenly focussed on how the CSDH will take their messages forward. They were encouraged by the chance of more forceful action in the international arena. This is partly through action to progress the United Nations Draft Declaration on the Rights of Indigenous Peoples and the Draft General Comment on Indigenous Children and Their Rights. An expressed feeling was that urgent attention to the crisis over the health and well-being of in Indigenous people can have a beneficial effect on all peoples.

Symposium delegates

Appendix 1

Attendees at the International Symposium on the Social Determinants Indigenous Health, Adelaide 29-30 April 2007

Professor Ian Anderson	Onemda VicHealth Koori Health Unit, University of Melbourne	Australia
Ms Kerry Arabena	Australian Institute of Aboriginal and Torres Strait Islander Studies	Australia
Ms Petah Atkinson	Rumbalara Aboriginal Cooperative	Australia
Professor Ross Bailie	Menzies School of Health Research	Australia
Dr Linda Banach	National Aboriginal Community Controlled Health Organisation	Australia
Professor Fran Baum	Flinders University, Department of Public Health	Australia
Ms Barbara Beacham	The Cooperative Research Centre for Aboriginal Health	Australia
Ms Stephanie Bell	Central Australian Aboriginal Congress	Australia
Mr Michael Bentley	Flinders University, Department of Public Health	Australia
Dr John Boffa	Central Australian Aboriginal Congress	Australia
Dr Alex Brown	Baker Heart Research Institute	Australia
Ms Mary Buckskin	Aboriginal Health Council of South Australia	Australia
Mr Mick Buckworth	Rumbalara Aboriginal Cooperative	Australia
Mr Harold Chatfield	Winnunga Nimmityjah Aboriginal Health Services	Australia
Mr Alwin Chong	Aboriginal Health Council of SA	Australia
Mr Henry Councillor	National Aboriginal Community Controlled Health Organisation	Australia
Dr Sophie Couzos	National Aboriginal Community Controlled Health Organisation	Australia
Mr Scott Davis	National Aboriginal Community Controlled Health Organisation	Australia
Ms Felicia Dean	Rumbalara Aboriginal Cooperative	Australia
Ms Zell Dodd	Southernn Adelaide Health Services	Australia
Ms Serene Fernando	Queensland University of Technology	Australia
Ms Felicia Fletcher	Office for Aboriginal and Torres Strait Islander Health	Australia
Professor Roy Goldie	Flinders University, Faculty of Health Sciences	Australia
Mr Mick Gooda	The Cooperative Research Centre for Aboriginal Health	Australia
Ms Vanessa Harris	The Cooperative Research Centre for Aboriginal Health	Australia
Dr Graham Henderson	Australian Institute of Aboriginal and Torres Strait Islander Studies	Australia
Ms Tanya Hosch	Consultant	Australia
Professor Shane Houston	NT Department of Health and Community Services	Australia
Associate Professor Lisa Jackson Pulver	Muru Marri Indigenous Health Unit, University of New South Wales	Australia

Mr Sam Jeffries	Indigenous Land Corporation	Australia
Mr Kelvin Johnson	Nepabunna Community	Australia
Ms Judith Johnson	Nepabunna Community	Australia
Ms Carolyn Modra	The Cooperative Research Centre for Aboriginal Health	Australia
Mr Justin Mohamed	Rumbalara Aboriginal Cooperative	Australia
Mr Romlie Mokak	Australian Indigenous Doctors' Association	Australia
Professor Martin Mowbray	RMIT University	Australia
Ms Kim O'Donnell	Flinders University, Flinders Aboriginal Health Research Unit	Australia
Dr Lowitja O'Donoghue	Aboriginal Elder	Australia
Dr Yin Paradies	Menzies School of Health Research	Australia
Dr Nerelle Poroch	Winnunga Nimmityjah Aboriginal Health Services	Australia
Ms Arwen Pratt	The Cooperative Research Centre for Aboriginal Health	Australia
Mr Ramanathan Ramanathan	Flinders University, Department of Public Health	Australia
Dr Peter Sharp	Winnunga Nimmityjah Aboriginal Health Services	Australia
Mr Andrew Stanley	South Australian Department of Health	Australia
Ms Julie Tongs	Winnunga Nimmityjah Aboriginal Health Services	Australia
Ms Laura Winslow	Flinders University, Department of Public Health	Australia
Associate Professor Eileen Willis	Flinders University, Dept of Paramedic & Social Health Sciences	Australia
Mr Darren Dick	Human Rights and Equal Opportunity Commission	Australia
Ms Dana Shen	Central Northern Adelaide Health Service	Australia
Ms Karen Glover	Children Youth & Women's Health Service	Australia
Mr David de Carvalho	Department of Health and Ageing, Policy and Analysis Branch OATSIH	Australia
Dr Ngaire Brown	Menzies School of Health Research	Australia
Dr Clive Aspin	University of Auckland, Nga Pae o te Maramatanga	New Zealand
Dr Sharon Friel	Commission on Social Determinants of Health	England
Dr Heather Gifford	Whakauae Research Services, Massey University	New Zealand
Mrs Ndioro Ndiaye	International Organisations for Migrations	Switzerland
Mr Matiniano Magdolot	Mahintana Foundation Incorporated	Philippines
Professor Jianwei Xu	Yunnan Institute of Parasitic Diseases	People's Republic of China
Ms Bou Kheng Thavrin	National Centre for Parasitology Entomology and Malaria Control	Cambodia
Ms Bernice Downey	First Nations & Inuit Health Branch, Health Canada	Canada

Ms Anna Fowler	Aboriginal Working Group: Inuit Tapiriit Kanatami	Canada
Ms Sandra Griffin	National Collaborating Centre for Aboriginal Health	Canada
Ms Gail Turner	Nunatsiavut Government, Department of Health & Social Development	Canada
Ms Dawn Walker	First Nations and Inuit Helath Branch, Health Canada	Canada
Mr David Chartrand	Metis National Council	Canada
Ms Audrey Chartrand	Metis National Council	Canada
Ms Stephanie Eyolfson	Metis National Council	Canada
Ms Kathleen McHugh	Chair of the Assembly of First Nation's Women's Council	Canada
Ms Glorian Yakiwchuk	Metis National Council	Canada
Mr Luis Fernando Sarango	Amawtay Huasi University	Ecuador
Dr Ana Marina Tzul	Maya People	Guatemala
Mr Marco Ninahuanca	Indigenous Organization of Communities Affected by Mining in Conacami, Peru	Peru
	Indigenous Organization of Displaced Communities in Reconstruction, Peru	
Ms Lucia Ellis	National Garifuna Council	Belize
Ms Edith Cumiquir Martinez	Anamuri	Chile