### CEDAW Committee’s General Recommendation on the Rights of Indigenous Women and Girls, General Day of Discussion, 24 June 2021

### UNFPA Submission

 16 June, 2021

**Introduction**

The United Nations Population Fund- UNFPA, works in more than 150 countries and territories that are home to the vast majority of the world’s indigenous population. UNFPA aims to strengthen comprehensive sexual and reproductive health as an essential part of health systems, including access to contraception, quality maternal and newborn health services, HIV prevention, and comprehensive sexuality education. It also works to advance gender equality and to empower women to decide freely on their fertility and sexuality free from coercion, discrimination and violence, including by preventing and addressing gender-based violence (GBV) and harmful practices such as, female genital mutilation (FGM), child, early, and forced marriage (CEFM) and gender-biased sex selection (GBSS).

As part of these efforts, supporting the rights of indigenous peoples, in particular indigenous women and girls, to enjoy their full and equal access to sexual and reproductive health and rights (SRHR) and to live a life free of violence, is a priority for UNFPA.

This UNFPA submission has been developed to inform the virtual day of general discussion as the first stage of the CEDAW Committee’s process of elaborating a draft general recommendation on the rights of Indigenous Women and Girls under the Convention on the Elimination of All Forms of Discrimination Against Women. The general recommendation provides an opportunity to amplify attention to and action on critical challenges that prevent indigenous women and girls from fully exercising their right to sexual and reproductive health and to living a life free of violence.

The UNFPA submission begins by outlining the specific challenges that indigenous women and girls face in the area of SRHR and GBV, based on recent global and country level experiences and taken forward by UNFPA. The second part of the submission focuses on recommendations and principles for CEDAW to consider in its drafting of the General Recommendation on the Rights of Indigenous Women and Girls.

1. **Challenges faced by indigenous women and girls in the context of SRHR and GBV**

While data is scarce, the data and evidence that is available shows us that across the globe indigenous women have poorer access to health care services, experience worse sexual and reproductive health outcomes and higher rates of violence than non-indigenous women.[[1]](#footnote-1) For instance, maternal and child mortality rates can be twice as high in indigenous communities as the national averages.[[2]](#footnote-2)

There are numerous challenges that indigenous women and girls face in accessing SRHR. These obstacles include geographic isolation, stigmatization, racism and discrimination, distrust of governmental health facilities and a lack of intercultural competence among health care providers, language barriers, lack of education, extreme poverty, household food insecurity, lack of access to clean water, electricity and sanitation, as well as the threats to their environment and nautural resources. These obstacles are not simply related to the presence or absence of health services and low socioeconomic status but encompass a history of disenfranchisement, land grabbing, displacements from ancestral land, dislocation and forced removal, criminalization and severe violation of human rights.

*Figure 1: Indigenous women are left behind because of a wide range of social, economic, political, cultural and geographical factors that intersect with each other [Source: UNFPA, UNICEF, UN-Women Fact Sheet on Indigenous Women's Maternal Health and Morbidity]*



The recent research that UNFPA conducted on indigenous women’s SRHR and GBV, mostly notably a 2019 Report on the Recommendations of the UN Permanent Forum on Indigenous Issues in regards to SRHR and GBV[[3]](#footnote-3) as well as the 2018 Fact Sheet on Indigenous Women’s Maternal Health and Mortality,[[4]](#footnote-4) shed valuable insights and lessons on critical challenges. These include:

* **Tensions between a universalist vision of health services and an inter-cultural perspective that incorporates the knowledge, world view and practices of indigenous peoples**.

While there has been progress in language accessibility and increasing demand for services by indigenous peoples, there are still only a few countries that also incorporate indigenous or Aboriginal knowledge and worldviews, or their health traditions into the health policy and practices. This presents a major cultural barrier to healthcare for indigenous women. And it can mean women dying in childbirth at home rather than using a system that is foreign to them and their practices.

Innovative practices and programmes to apply an intercultural approach, however, are being promoted in some countries, particularly in the area of maternal and newborn health. In Latin America, UNFPA has been supporting indigenous women’s organizations in promoting “respectful delivery” and “culturally appropriate” childbirths for several years, with positive results. For example, in Peru, indigenous women’s organizations, UNFPA Peru and the Peruvian Ministry of Health collaborated to implement the initiative “vertical birth with intercultural adjustment” as a strategy for lowering maternal mortality. This initiative adapted the infrastructure in doctors’ surgeries and hospitals to accommodate the cultural needs of women and their families regarding how they would like to give birth. This led to special rooms where indigenous women could give birth in an upright positions[[5]](#footnote-5) as per their traditional custom, placing natural resources such as plants in the room, making educational and information material available in a culturally appropriate ways, having Quechua speaking personnel in the health centres, and establishing waiting houses for expectant mothers (indigenous peoples in Peru mostly live in rural locations and lack transport).

* **The low value given to traditional indigenous medicine and traditional medical practitioners, such as traditional birthing attendants**

In Latin American countries such as Guatemala, Mexico and Peru, UNFPA, together with indigenous women’s organizations and governments have collaborated on initiatives that recognize traditional birth attendants’ (TBA) role to support the reproductive health of indigenous women. These initiatives recognize the value of TBA knowledge and their legitimacy among indigenous women, who trust them as their guides throughout this vital process.

A study carried out in the Republic of the Congo in 2012 found that in order for indigenous communities to accept medical interventions and improve their access to available medical services, the indigenous view of health and illness must be taken into account – especially the concept that a person’s health not only involves the biophysical body but also social relations.[[6]](#footnote-6) Traditional indigenous healers (nganga) are regarded as the most competent traditional healers. Indigenous communities allow women, boys, girls and older people to access traditional medical treatments, preferring to first try their own methods and then, as a last resort, visit a modern health centre. Traditional healers are also preferred because they provide culturally relevant, low-cost diagnoses. In addition, they are present in many towns and indigenous patients are treated better than in modern clinics. Despite these practices, the public health system has not opened up a dialogue with these traditional authorities to see how best they can be engaged in a way that preserves individual’s right to safe, quality, culturally appropriate and effective care.

In many countries traditional birth attendants face open discrimination and are not able to accompany and support skilled birth attendants in attending to indigenous women in health service centres. In some cases, they face criminalization.

However, there are a number of countries, including Mexico, Peru and Myanmar that have successfully implemented interventions to establish partnerships between TBAs and midwives and link TBAs to the formal health systems to better promote skilled attendance at birth. Interventions used to strengthen partnerships have included developing collaborative relationships through opportunities for sharing of traditional and professional knowledge between TBAs and professional midwives, collaboration on in-service midwifery training and including TBAs as key ‘links’ in the referral pathway for skilled care at birth.[[7]](#footnote-7)

* **Lack of policies and programmes to strengthen representation of indigenous health professionals in the health workforce**

Few countries have taken active steps to improve recruitment and training of indigenous health professionals, to address the under-representation of indigenous peoples in the health workforce. Australia and New Zealand are exceptions. They have developed specific indigenous Health Strategies, which include actions to increase the number of indigenous students studying for qualifications in health, particularly nursing, midwifery and medicine, and strengthen health workforce capacity through recruitment of indigenous peoples as health professionals to provide culturally-safe and responsive services (Australia and New Zealand).[[8]](#footnote-8)

* **Mistreatment and discrimination of indigenous women in health service centers**

While awareness about indigenous peoples’ rights is increasing, health workers continue to discriminate against indigenous women in many countries. As a result, progress made in terms of infrastructure and free and affordable services has not always translated into higher levels of quality care for indigenous women and girls.

In the Republic of the Congo, despite government measures, such as establishing integrated care centres and free treatment of malaria, HIV and AIDS, and caesarean sections, a study carried out by UNFPA in 2015 documents a low use of reproductive health services by indigenous women.[[9]](#footnote-9) These women tend not to use antenatal services and most give birth at home or in the forest, largely due to the abuse and discrimination they experience at the hands of public officials.

* **The lack of participation of community organisations and indigenous women in programmes aimed at addressing indigenous women and girls’ SRHR**

There are many barriers that indigenous women face in realizing their SRHR, including harmful social norms and stereotypes and unequal relations between men and women. Addressing these barriers requires working with and through indigenous organizations. These organizations understand their context, have access to the communities and their culture and can respectfully raise sensitive issues with women and girls, men and community leaders, using strategies adapted to the communities and their respective issues. The importance of developing interventions that allow indigenous women and girls themselves to identify cultural practices and gender relations that have negative effects on their health and well-being has been found to be critical. However, indigneous women’s organizations often lack resources and opportunities to participate in health and development processes, which in turn negatively impacts the rights of indigenous women and girls.

* **The persistence of harmful practices, such as FGM and CEFM**

While many countries have taken firm steps to eliminate harmful practices, including FGM and CEFM in their countries, there is still much work to be done. Evidence shows for instance that FGM is far from being eliminated in indigenous communities: it is still practiced in secret, despite being formally prohibited. Yet the lack of data on the practice of FGM in indigenous communities masks the extent of the practice and its gendered impact on indigenous communities.

A challenge to achieving progress in eradicating the practice among indigenous communities is the lack of an intercultural approach when working with indigenous communities. Moreover, the exclusion of indigenous girls and women from educational and economic opportunities and systems has a direct effect on the lowering of the age of marriage and first birth.[[10]](#footnote-10)

* **Violence Against Indigenous Women**

While data on violence against indigenous women and girls is lacking, the data that is available, shows that Indigenous women are disproportionately affected by violence. Underlying factors of poverty, historic marginalization, racism, and legacies of colonialism, intergenerational transmission of violence including inter parental violence, have made indigenous women frequent targets of hatred and violence. Studies in Australia have found that Aboriginal and Torres Strait Islander people are between two and five times more likely than other Australians to experience violence as victims or offenders.

A 2013 joint UN study on violence against indigenous girls, adolescents and young women titled: “Breaking the Silence on Violence against Indigenous Girls, Adolescents and young Women” [[11]](#footnote-11)revealed that indigenous women and girls are more likely to suffer gender based violence than non-indigenous women and girls, including those with disabilities. For example, Aboriginal and Torres Strait Islander women are 35 times more likely to be hospitalised due to family violence related assaults than other Australian women.[[12]](#footnote-12) This study and data concluded that generic policies and programmes to prevent and address violence against women risk overlooking indigenous women and girls if their indigenous status and specific realties are not recognised from the outset.

* **Lack of services for indigenous women and girls experiencing violence**

A critical issue for indigenous women and girls is their inability to access GBV services. Often services are not language or culturally appropriate or may be located in urban sites or by remote support which do not cater specifically for geographically isolated indigenous communities. Cases also often go unreported due to the fear and distrust of the justice systems due to social stigma, trauma, and failures in the criminal justice systems protecting the rights of indigenous women and girls.

When indigenous women and girls do report violence and manage to access services, the discrimination and stigma they face, can result in staff either not listening to them or believing that they are to blame or deserve the violence. For example, the 2015 UNFPA study in the Republic of Congo , found that in general, rapes are not reported because girls tend to be held responsible, which in turn makes them more vulnerable. When the UN Committee on the Rights of the Child asked the State about the measures taken to ensure perpetrators are prosecuted for gang rapes of indigenous girls, the State replied that there were no special measures to punish such an offence.[[13]](#footnote-13)

* **Lack of Data:**

The 2018, UNFPA, UNICEF and UN-Women Fact Sheet on Indigenous Women’s Maternal Health and Mortality highlighted that across the globe, when it comes to maternal health and maternal mortality, indigenous women and adolescents face persistent inequalities and stigma. Yet the lack of data in this area renders them invisible and presents a major barrier to efforts to address the issue.

For instance of the 90 national and sub-national surveys conducted under the last two rounds of the Multiple Indicator Cluster Surveys (MICS) and Demographic Health Surveys (DHS), only 43 included a question on ethnicity and only 27 of the published reports included an analysis based on ethnicity.[[14]](#footnote-14)

Within those 27 reports, however, it was only possible to use data from 8 of the reports because data relating to ethnicity does not always translate into data about indigeneity. So out of a total of 90 demographic and health surveys, only 8 countries had published data on indigeneity. This example underlines the dramatic absence of disaggregated data on indigenous women and girls.

1. **UNFPA Recommendations for the CEDAW General Recommendation to support indigenous women and girls’ SRHR and freedom from violence**
* **Data:** States and international, regional and national partners need to be encouraged to disaggregate data by ethnicity, in efforts to improve the lives of ethnic minorities, including indigenous peoples. As part of these efforts:
	+ Governments must consult indigenous communities about the best ways to collect, analyze and report data on indigenous peoples
	+ International institutions, donors and NGOS, must include requirements for disaggregation by ethnicity
	+ National statistics offices and line ministries should collect, analyze and disseminate data collected by ethnic categories
* **Take positive action**. Where indigenous women’s sexual and reproductive health and rights outcomes are worse than national levels, and where risks of violence are high, States must take positive actions:
	+ Allocating appropriate budgets to implement quality GBV and SRHR services which are accessible and culturally appropriate for indigenous women and girls.
	+ Fully incorporate a cultural perspective into sexual and reproductive health and gender based violence policies through co-designing these with indigenous women; and produce sensitization material in indigenous languages.
	+ Support ongoing participatory processes where indigenous peoples, with the support of international stakeholders, can participate in the design and delivery of health systems and multi sectoral GBV response services.
	+ Strengthen the recognition of TBA’s works and develop clear national guidance that describes the collaboration of the TBAs with the health system (and vice versa).
	+ Strengthen local workforce education and recruitment strategies to increase the number and capacity of professional indigenous doctors, nurses and midwives, particularly women, educated to international standards and fully integrated into the health system.
	+ Train existing healthcare workforce on cultural appropriate behaviours and responses Establish effective response services to ensure earliest possible intervention to prevent gender-based violence and enable indigenous women and girls to access immediate gender-based violence response services.
	+ Ensure engagement with children, adolescents, and youth to reduce risk of intergenerational transmission of inter partner violence.
	+ Recognize and support the role of indigenous women’s organizations in reporting and mobilizing against violence against indigenous women and girls.
	+ Support strategies for intercultural prevention and eradication of violence against women and girls that are designed and driven by indigenous women’s organizations and that consider indigenous approaches to address gender-based violence
	+ Encourage States to ensure access to justice for indigenous peoples, including indigenous women and girls, through formal and informal justice institutions, national human rights institutions and other forms of redress or recourse.
1. UNFPA Fact Sheet [↑](#footnote-ref-1)
2. UNFPA Fact Sheet [↑](#footnote-ref-2)
3. UNFPA, Chirapaq: Recommendations of the UN Permanent Forum on Indigenous Issues regarding Sexual and Reproductive Health and Rights and Gender Based Violence, 2019: [UNFPA\_PUB\_2018\_EN\_human\_rights\_report.pdf](https://unfpa.org/sites/default/files/pub-pdf/UNFPA_PUB_2018_EN_human_rights_report.pdf) [↑](#footnote-ref-3)
4. UNFPA, UNICEF, UN-Women: Fact Sheet on Indigenous Women’s Maternal Health and Mortality, 2018: [factsheet\_digital\_Mar27.pdf (unfpa.org)](https://unfpa.org/sites/default/files/resource-pdf/factsheet_digital_Mar27.pdf) [↑](#footnote-ref-4)
5. Upright birthing positions is not only a need from a cultural perspective but evidenced to progress labour, initiate fewer medical interventions and to be a preferred way of giving birth in a physiologically supportive way for all women [↑](#footnote-ref-5)
6. UNFPA, Chirapaq: Recommendations of the UN Permanent Forum on Indigenous Issues regarding Sexual and Reproductive Health and Rights and Gender Based Violence, 2019: [UNFPA\_PUB\_2018\_EN\_human\_rights\_report.pdf](https://unfpa.org/sites/default/files/pub-pdf/UNFPA_PUB_2018_EN_human_rights_report.pdf) [↑](#footnote-ref-6)
7. Miller, T., Smith, H. Establishing partnership with traditional birth attendants for improved maternal and newborn health: a review of factors influencing implementation. BMC Pregnancy Childbirth 17, 365 (2017). <https://doi.org/10.1186/s12884-017-1534-y> [↑](#footnote-ref-7)
8. Australia: National Aboriginal and Torres Strait Islander Health Plan 2013– 2023; New Zealand (2018-2022 Indigenous Health Strategy) [https://www.anzca.edu.au/resources/indigenous-health-(1)/indigenous\_health\_strategy.aspx](https://www.anzca.edu.au/resources/indigenous-health-%281%29/indigenous_health_strategy.aspx) [↑](#footnote-ref-8)
9. Benoit C, Yaba M, Laurenceau B et al. Biomédecine, savoirs et pratiques autochtones autour de la grossesse et de l'accouchement dans le département de la Sangha en République du Congo. Brazzaville : UNFPA, 2018. [↑](#footnote-ref-9)
10. [BriefingNote3\_GREY.pdf (un.org)](https://www.un.org/esa/socdev/unpfii/documents/BriefingNote3_GREY.pdf) [↑](#footnote-ref-10)
11. [Layout 1 (unfpa.org)](https://unfpa.org/sites/default/files/resource-pdf/VAIWG_FINAL.pdf) [↑](#footnote-ref-11)
12. <https://www.betterhealth.vic.gov.au/health/healthyliving/Family-violence-and-aboriginal-and-torres-strait-islander-women#family-violence-is-worse-in-aboriginal-communities> [↑](#footnote-ref-12)
13. 39 [↑](#footnote-ref-13)
14. As of 2018 when the Fact Sheet was published [↑](#footnote-ref-14)