**Input for the thematic discussion General Recommendation No. 37 on racial discrimination and the right to health under article 5 (e)(iv) of the International Convention on the Elimination of all Forms of Racial Discrimination**

**Submitted by the Indigenous Peoples and Development Branch – Secretariat of the UN Permanent Forum on Indigenous Issues/Division for Inclusive Development/UN Department of Economic Affairs**

**Introduction**

The Indigenous Peoples and Development Branch/DISD/DESA offers input to the General Recommendation on racial discrimination and the right to health. This is drawn on the recommendations of the United Nations Permanent Forum on Indigenous Issues (UNPFII),

an advisory body to the [Economic and Social Council](http://www.un.org/en/ecosoc/), with a mandate to discuss indigenous issues related to economic and social development, culture, the environment, education, **health** and human rights, and through the Council to the UN system agencies, funds and programmes.

It is noted that the *Committee on the Elimination of Racial Discrimination (CERD) decided to prepare a General Recommendation on racial discrimination and the right to health under Article 5 (e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination. The CERD aims at providing guidance on the legal obligations of States parties under Article 5 (e) (iv) of the Convention and defining the measures they should implement to ensure full compliance with this provision.*

*2. Article 5 (e)(iv) reads as follows:*

*“In compliance with the fundamental obligations laid down in article 2 of this Convention, States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, notably in the enjoyment of the following rights:*

*…(e) Economic, social and cultural rights, in particular:*

*…(iv) The right to public health, medical care, social security and social services;”*

The International Convention on the Elimination of all Forms of Racial Discrimination does not refer to indigenous peoples, but it does to ethnic origin. There is no internationally agreed definition of what constitutes indigenous peoples or ethnic groups. However, indigenous peoples might claim “ethnic” rights, but not vice versa.

As Article 5 (e)(iv) refers to ethnicity, the CERD should interpret the Convention in line with the in the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) on issues of concern to indigenous peoples and take into account the recommendations of the UN Permanent Forum on Indigenous Issues, as one of the main bodies mandated to promote respect for and full application of the provisions of the UNDRIP.[[1]](#footnote-2)

**General considerations on health and indigenous peoples**

There are over 476.6 million indigenous peoples, making up 6.2% of the world population.[[2]](#footnote-3) It has been estimated that over 80 percent of the world’s indigenous peoples live in Asia, Latin America and Africa. However, in many countries, there is still little information about their health status and levels of access to health services. In general, indigenous peoples experience higher rates of ill health, disability and reduced quality of life, with a much shorter life expectancy than other citizens in the same countries. Even in wealthy nations, most studies indicate an alarming health disadvantage for indigenous peoples.[[3]](#footnote-4)

For instance, in Australia, from 2015-2017, life expectancy at birth was 71.6 years for indigenous males and 75.6 years for indigenous females. In comparison, the non-indigenous life expectancy at birth was 80.2 years for males and 83.4 years for females. This is a gap of 8.6 years for males and 7.8 years for females.[[4]](#footnote-5)

Indigenous peoples’ health status is severely affected by their living conditions, including in many cases, geographic isolation, poverty, employment and income levels, and access to food, water, and sanitation services. The lack of cultural understanding by non-indigenous peoples to indigenous peoples, further contribute to significant structural barriers to access healthcare.[[5]](#footnote-6)

Indigenous peoples’ access to adequate healthcare remains among the most challenging and complex areas. Indigenous peoples face a myriad of obstacles when accessing public health systems. In addition, there is also an absence of adequate health insurance or a lack of economic capacity to pay for services. As a result, indigenous peoples often cannot afford health services even if they are available.

Moreover, there are also significant concerns regarding the lack of data on indigenous peoples’ health and social conditions. There is a lack of disaggregated data based on ethnicity and data related to the location of indigenous peoples’ residence, such as urban, rural, or isolated areas. As a result, there is a lack of information, analysis and evaluation of programmes and services relating to indigenous peoples’ health.

One of the crucial areas for healthcare for indigenous peoples lies in intercultural frameworks and models of care. Healthcare services need to be pluricultural to develop effective models of care and best practices so that such programmes and services are culturally and linguistically appropriate for indigenous peoples. Indigenous peoples must be able to participate in the design and implementation of comprehensive health plans, policies and programmes.[[6]](#footnote-7)

COVID-19 and other diseases have disproportionately impacted indigenous peoples around the world. Yet, indigenous peoples are seeking their solutions, using traditional and innovative knowledge, practices and preventive measures to fight the pandemic.[[7]](#footnote-8)

**The right to health under the United Nations Declaration on the Rights of Indigenous Peoples**

The United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) elaborates on the right to health of indigenous peoples in Articles 21, 23, 24 and 29, giving particular attention to the needs of indigenous elders, women, youth, children and persons with disabilities.[[8]](#footnote-9)

Indigenous peoples have the right to be actively involved in developing and determining their health programmes, and, as far as possible, to administer these programmes through their own institutions.[[9]](#footnote-10)

Furthermore, indigenous peoples have the right to their traditional medicines and to maintain their health practices, including conserving their vital medicinal plants, animals and minerals. Indigenous individuals have the right to access, without any discrimination, all social and health services. Indigenous individuals also have the right to the enjoyment of the highest attainable standard of physical and mental health.[[10]](#footnote-11)

Moreover, States shall also take adequate measures to ensure that no storage or disposal of hazardous materials shall take place in the lands or territories of indigenous peoples without their free, prior and informed consent and States shall also take effective measures to ensure as needed that programmes for monitoring and restoring the health of indigenous peoples, as developed and implemented by the peoples affected by such materials, are duly implemented.[[11]](#footnote-12)

**Questions**

The Secretariat of the Forum presents answers to the questions related to indigenous peoples' health issues.

***11. How does structural discrimination affect obligations related to the right to health? Does structural discrimination constitute a de facto limitation imposed on the right to health that States should always measure in assessing indirect discrimination? What (negative and positive) obligations are placed upon States? What sort of standards (health-related, socio-economic, risk-related, or other) should States apply to assess the effect of indirect racial discrimination?***

The Permanent Forum on Indigenous Issues has considered that the **right to health** materializes through the well-being of an individual as well as the social, emotional, spiritual and cultural well-being of the whole community. Colonization, including policies of oppression, dispossession and assimilation, has led to the health challenges many indigenous peoples face today, which will also affect future generations.

The health of indigenous peoples is weakened by a range of underlying **social and economic** determinants, including poverty, inadequate housing, lack of education, food insecurity, lower employment, loss of traditional lands and languages, barriers to political participation and **institutionalized racism**. The health gap between indigenous peoples and others is clear evidence of the **discriminatory structures** that conflict with human rights and indigenous peoples’ rights. They demonstrate the need for Governments and United Nations entities to refocus their efforts on fulfilling their obligations toward indigenous peoples.[[12]](#footnote-13)

The Forum has encouraged community organization for safe spaces and low-threshold health services, respecting **non-discrimination**, in particular where **discrimination** based on ethnicity, gender and sexual orientation is concerned.[[13]](#footnote-14)

The Permanent Forum on Indigenous Issues has recognized that the **social and economic** situation of indigenous peoples in specific countries are directly related to the mental health and **suicidal behavior**, which is also linked to the loss by indigenous peoples of their rights to their lands and territories, natural resources, traditional ways of life and traditional uses of natural resources.[[14]](#footnote-15) In this regard, the Permanent Forum urged States to fund and deliver training in suicide prevention and mental health awareness to all teaching and non-teaching staff in all schools attended by indigenous children.[[15]](#footnote-16)

Concerning mental health and the history of indigenous peoples, including reconciliation processes between indigenous peoples and colonizers, the Forum recommended Governments to support programmes led by indigenous peoples to **address intergenerational trauma** as a way of moving towards true reconciliation.[[16]](#footnote-17)

***13. Traditional medicine continues to have a very important place in certain health systems and coexists in many parts of the world with modern medicine. Certain groups exposed to racial discrimination continue to use regularly traditional medicine. How is the dialogue between modern and traditional medicine established? What status do the States give to this medicine in their health system?***

As stated, Article 24 of UNDRIP indigenous peoples have a right to their traditional medicines and to maintain their health practices.

One of the main challenges related to indigenous peoples’ traditional medicine is the role of midwives. The Permanent Forum has emphasized that despite this critical role, community-regulated indigenous midwifery is often undermined and actively criminalized, to the detriment of the health of indigenous peoples.

The Forum further considered that to close the gap between indigenous and non -indigenous health outcomes, the practice of indigenous midwifery must be supported by state health policy and integration. The right of indigenous peoples to self-determination extends to their reproductive health. States should end the criminalization of indigenous midwifery and make the necessary legislative and regulatory amendments to legitimize indigenous midwives recognized by their communities as healthcare providers. States should also support the education of new traditional indigenous midwives via multiple routes of education, including apprenticeship and the oral transmission of knowledge.[[17]](#footnote-18)

Therefore, the Forum requested governments, to fully incorporate a cultural perspective into health policies, programmes and reproductive health services aimed at providing indigenous women with quality healthcare, including emergency obstetric care, voluntary family planning and skilled attendance at birth. In the latter context, the roles of traditional midwives should be re-evaluated and expanded so that they may assist indigenous women during their reproductive health processes and act as cultural brokers between health systems and the indigenous communities’ values and world views.[[18]](#footnote-19)

The Permanent Forum has recommended Member States take measures to advance indigenous women’s right to intercultural health through its inclusion in legal frameworks and public policies, as well as programmes to guarantee culturally, geographically and financially appropriate health and social services.[[19]](#footnote-20)

Further, the Permanent Forum has noted that good practices are emerging that complement public health services with traditional health practices. These practices emphasize intercultural dialogue and discussion to ensure that healthcare is delivered in a culturally specific way, consistent with articles 23 and 24 of the United Nations Declaration on the Rights of Indigenous Peoples. These practices should be supported and promoted.[[20]](#footnote-21)

Lastly, the Forum has urged States to undertake and promote the expansion of their national health systems to provide holistic health programmes for indigenous children that incorporate preventive medical practices and family and community participation.[[21]](#footnote-22)

***14. Apart from health indicators already established by specialised organisations, which other indicators should States adopt to measure the impact of racial discrimination on groups protected under the Convention?***

The Permanent Forum has focused on production of disaggregated data on the health of indigenous peoples that would enable States to establish indicators. The Permanent Forum has invited Member States to seek the support of the United Nations Population Fund (UNFPA) and other relevant agencies, funds and programmes of the United Nations system in strengthening the disaggregation of data by ethnicity, in sexual and reproductive health and reproductive rights, (…) to enhance the implementation of the 2030 Agenda for Sustainable Development."[[22]](#footnote-23)

The Permanent Forum has considered that data collection and disaggregation remain a challenge. In particular, healthcare delivery in rural and remote areas remains a major obstacle to the right to health. In addition, there remains an urgent need for more indigenous health professionals, mental health services and programmes addressing non-communicable diseases and reproductive health. [[23]](#footnote-24)

***16. How do racial inequalities affect sexual and reproductive health and rights?***

Forced sterilization of indigenous women has been and continues to be a practice that has affected the reproductive rights of indigenous women, showing this racial inequality. Some governments have used this practice to reduce indigenous peoples’ population in those countries.

For instance, a study the US General Accounting Office found that 4 of the 12 Indian Health Service regions sterilized 3,406 American Indian women without their permission between 1973 and 1976.[[24]](#footnote-25) Alberto Fujimori, ex-President of Peru was tried for implementing a forced sterilization programme of indigenous women in the nineties, some who died from infections stemming from the tubal ligation operation.[[25]](#footnote-26) The forced sterilization of indigenous women and forced boarding constitute a practice that continues to occur in some countries, which shows a systematic pattern of discrimination against indigenous peoples.

La esterilización forzada de mujeres indígenas y el internamiento forzoso constituyen una práctica que continúa ocurriendo en algunos países, lo que muestra un patrón sistemático de discriminación contra los pueblos indígenas.

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The Permanent Forum has recommended to stop these practices, which have been considered an ethnic genocide.[[26]](#footnote-27)

Further, the Permanent Forum has expressed concern with the disparity between indigenous and national maternal mortality rates in many countries and encourages Member States to incorporate an intercultural approach to sexual and reproductive health services and promote the inclusion of indigenous health workers.[[27]](#footnote-28) Moreover, the Permanent Forum urged Member States and funds, programmes and specialized agencies of the United Nations system to implement action to reduce maternal mortality among indigenous women.[[28]](#footnote-29)

***17. How should “informed consent” be understood under the Convention?***

The principle of free, prior and informed consent is one of the fundamental rights in the UNDRIP under articles 10, 11, 19, 28, 29 and 32. This principle is directly linked to the right to self-determination and non-discrimination. This should be interpreted by the Committee according to the Declaration.

The principle refers to the right of indigenous peoples to give or withhold their consent for any action that would affect their rights.

* Free implies that there is no coercion, intimidation, or manipulation.
* Prior implies that consent is to be sought sufficiently in advance of any authorization or commencement of activities and respect is shown for time requirements of indigenous consultation/consensus processes.
* Informed implies that information is provided that covers a range of aspects, including the nature, size, pace, reversibility and scope of any proposed activity; the purpose of the activity as well as its duration; areas affected; a preliminary assessment of the likely impact, including potential risks; personnel likely to be involved in the execution of the project; and procedures the activity may entail. This process may include the option of withholding consent. Consultation and participation are crucial components of a consent process.[[29]](#footnote-30)

***19. Is there a right to consult on health with groups protected under the Convention?***

As stated, the Convention should be interpreted in light of the rights enshrined to groups protected, including indigenous peoples. The consent of indigenous peoples should be determined in accordance with their customary laws and practices. This does not necessarily mean that every member must agree, but rather that the consent process will be undertaken through procedures and institutions determined by indigenous peoples. Indigenous peoples should specify which representative institutions are entitled to express consent on behalf of the affected peoples or communities.[[30]](#footnote-31)

***21. Should States ensure the participation of groups exposed to racial discrimination in health-related processes with non-state actors and health-related corporations?***

Yes, for instance, the issues of business-related impacts on the rights of indigenous peoples have been addressed by several UN mechanisms, including treaty bodies and bodies mandated to deal specifically with indigenous peoples.[[31]](#footnote-32)

The Guiding Principles on Business and Human Rights provide a global normative framework for preventing and addressing the risks of human rights impacts of business activities, intending to enhance standards and practices about business and human rights.[[32]](#footnote-33) In the commentary on the Guiding Principles, indigenous peoples are recognized as one of the groups facing challenges to their rights, and the right to health should also be included.

***30. How should States respond to potentially harmful traditional cultural practices?***

Globally, an estimated 200 million girls have suffered female genital mutilation. Among some indigenous peoples, this practice is known to occur. For instance, according to UNFPA, Embera communities in Colombia are known to practice this, but there are no reliable statistics on how many girls are affected. But in areas where the practice is known to occur, as many as two out of three Embera women have been cut.[[33]](#footnote-34)

On this matter, the Permanent Forum emphasized the need to support work at the country level on the elimination of female genital mutilation/cutting among indigenous girls, including the elimination of other forms of harmful practices, for example early and forced marriage and early unwanted pregnancies.[[34]](#footnote-35)

***34. Have States any anti-discrimination obligation regarding the right to health outside their jurisdiction?***

According to Article 23 of the UNDRIP indigenous peoples the right to determine and develop priorities and strategies for exercising their right to development. In particular, indigenous peoples have the right to be actively involved in developing and determining health (…), to administer such programmes through their institutions.

The Permanent Forum has urged States to promote indigenous community-controlled models for the health, social, legal and other sectors of indigenous communities and service providers to follow in implementing the Declaration.[[35]](#footnote-36)

From colonial times to present days, indigenous peoples have perished due to a lack of immunity to infectious diseases transmitted by the conquerors. For example, diseases such as smallpox or measles became allies of Europeans for the conquest of America.[[36]](#footnote-37) For this reason, the right to health of indigenous peoples in isolation or recent contact is particularly worrying.

The Permanent Forum has recommended UN entities, States, non-governmental organizations and indigenous peoples’ organizations join efforts in implementing appropriate expert health-care actions to prevent disastrous disease problems affecting indigenous peoples in voluntary isolation and recent contact, and consider adopting rapid-effect emergency procedures in situations where the health situation is critical.[[37]](#footnote-38)

As mentioned, indigenous peoples also have the right to access, without any discrimination, to all social and health services. The Permanent Forum has urged States to ensure that health and education services reach remote areas and meet the needs of nomadic peoples,[[38]](#footnote-39) and has encouraged States to undertake and promote the expansion of their national health systems to provide holistic health programmes for indigenous children that incorporate preventive medical practices and family and community participation.[[39]](#footnote-40)

***41. Examples of lessons learned on racial inequality and good practices in building community-centered approaches and combatting racial discrimination during the COVID-19 pandemic***

Indigenous peoples have been seeking their own solutions to the COVID-19 pandemic. They are taking action and using traditional knowledge and practices such as voluntary isolation, and sealing off their territories, as well as preventive measures – in their own languages.[[40]](#footnote-41)

Good practices on indigenous peoples and COVID-19 taken by Member States include issuing guidelines on indigenous languages such as those issued by Colombia, Guatemala, Mexico and Peru. In Australia, the Government established a National Indigenous Taskforce to develop an emergency response plan for Aboriginal communities to combat the potential spread of COVID-19. The Governments of Canada and US earmarked specific medical support and economic stimulus funding for indigenous communities.[[41]](#footnote-42)However, the Permanent Forum noted that with few commendable exceptions, indigenous peoples had been largely neglected in the contingency measures of government authorities in response to the COVID-19 pandemic. As a result, their needs and requirements are not taken adequately into account or addressed by national programmes and policies. The Permanent Forum agreed that effective responses to the pandemic and recovery measures must be collaborative between indigenous and State institutions. Combining indigenous knowledge of what is best for indigenous communities with State services and financial support will ensure effective outcomes.[[42]](#footnote-43)

Further, the Forum recognizes the need to address the emergence of the mental health consequences of the pandemic. The results are being felt in all populations, but most acutely in peoples that have traditionally been marginalized. The Forum called for investments and preparations for mental and behavioral health interventions that are culturally adapted. Traditional medicines and practices can play a key role in the health of indigenous communities and individuals by encompassing a variety of dimensions, including the spiritual.[[43]](#footnote-44)

1. Article 42 of UNDRIP. [↑](#footnote-ref-2)
2. Implementing the ILO Indigenous and Tribal Peoples Convention No.169, p. 52. [↑](#footnote-ref-3)
3. State of the WorId’s Indigenous Peoples. Indigenous Peoples Access to Health Services. United Nations, p. 3. [↑](#footnote-ref-4)
4. Closing the Gap Report 2020. Australian Government. Available at https://ctgreport.niaa.gov.au/life-expectancy#:~:text=1-,In%202015%E2%80%932017%2C%20life%20expectancy%20at%20birth%20was%2071.6%20years,and%207.8%20years%20for%20females. [↑](#footnote-ref-5)
5. Indigenous Healthcare and Revitalization. Available at: https://www.un.org/en/academic-impact/we-are-indigenous-%E2%80%98culture-meets-care%E2%80%99-essential-indigenous-healthcare-and [↑](#footnote-ref-6)
6. United Nations. State of the World’s Indigenous Peoples. Indigenous Peoples’ Access to Health Care. pp. 3 and 4. [↑](#footnote-ref-7)
7. COVID-19 and Indigenous peoples. Statement by the Chair of the United Nations Permanent Forum on Indigenous Issues. Available at: https://www.un.org/development/desa/indigenouspeoples/covid-19.html [↑](#footnote-ref-8)
8. Article 21 of the UNDRIP. [↑](#footnote-ref-9)
9. Article 23 of the UNDRIP. [↑](#footnote-ref-10)
10. Article 24 of the UNDRIP. [↑](#footnote-ref-11)
11. Article 29 of the UNDRIP. [↑](#footnote-ref-12)
12. Report of the Twelfth session of the UN Permanent Forum on Indigenous Issues, para 4. [↑](#footnote-ref-13)
13. Report of the Twelfth session of the UN Permanent Forum on Indigenous Issues, para 8. [↑](#footnote-ref-14)
14. Report of the Fourteenth session of the UN Permanent Forum on Indigenous Issues, para 13. [↑](#footnote-ref-15)
15. Report of the Thirteenth session of the UN Permanent Forum on Indigenous Issue, para. 46. [↑](#footnote-ref-16)
16. Report of the Eighteenth session of the UN Permanent Forum on Indigenous Issues, para 124. [↑](#footnote-ref-17)
17. Report of the Seventeenth session of the UN Permanent Forum on Indigenous Issues, para 50. [↑](#footnote-ref-18)
18. Report of the Fifth session of the UN Permanent Forum on Indigenous Issues, para 48. [↑](#footnote-ref-19)
19. Report of the Tenth session of the UN Permanent Forum on Indigenous Issues, para 53. [↑](#footnote-ref-20)
20. Report of the Twelfth session of the UN Permanent Forum on Indigenous Issues, para 6. [↑](#footnote-ref-21)
21. Report of the Second session of the UN Permanent Forum on Indigenous Issues, para 80. [↑](#footnote-ref-22)
22. Report of the Seventeenth session of the UN Permanent Forum on Indigenous Issues, para 41. [↑](#footnote-ref-23)
23. Report of the Twelfth session of the UN Permanent Forum on Indigenous Issues, para 5. [↑](#footnote-ref-24)
24. National Library of Medicine. Native voices. Available at https://www.nlm.nih.gov/nativevoices/timeline/543.html [↑](#footnote-ref-25)
25. https://www.lavanguardia.com/internacional/20210302/6262229/alberto-fujimori-jucio-esterilizacion-mujeres-indigenas-peru.html [↑](#footnote-ref-26)
26. Report of the third session of the UN Permanent Forum on Indigenous Issues, paragraph 89. [↑](#footnote-ref-27)
27. Report of the Seventeenth session of the UN Permanent Forum on Indigenous Issues, para 41. [↑](#footnote-ref-28)
28. Report of the Fifteenth session of the UN Permanent Forum on Indigenous Issues, para. 38. [↑](#footnote-ref-29)
29. Office of the High-Commissioner for Human Rights. Free, prior and informed consent of indigenous peoples. Available at: https://www.ohchr.org/sites/default/files/Documents/Issues/IPeoples/FreePriorandInformedConsent.pdf [↑](#footnote-ref-30)
30. Idem. [↑](#footnote-ref-31)
31. See for example, A/68/279, A/71/291, A/HRC/18/35, A/HRC/24/41 and A/HRC/33/42. [↑](#footnote-ref-32)
32. E/C.19/2022/6. Permanent Forum on Indigenous Issues. International expert group meeting on the theme “Indigenous peoples, business autonomy and the human rights principles of due diligence, including free, prior and informed consent”. P. 3. [↑](#footnote-ref-33)
33. See https://www.unfpa.org/news/colombia-efforts-end-fgm-are-empowering-women-be-leaders [↑](#footnote-ref-34)
34. Report of the Twelfth session of the UN Permanent Forum on Indigenous Issues, para 7. [↑](#footnote-ref-35)
35. Report of the Eleventh session of the UN Permanent Forum on Indigenous Issues, para 35. [↑](#footnote-ref-36)
36. https://www.elespanol.com/cultura/historia/20200319/enfermedades-propagaron-espanoles-conquista-america-masacraron-indios/475453051\_0.html [↑](#footnote-ref-37)
37. Report of the Sixth session of the UN Permanent Forum on Indigenous Issues, para 42. [↑](#footnote-ref-38)
38. Report of the Tenth session of the UN Permanent Forum on Indigenous Issues, para 53. [↑](#footnote-ref-39)
39. Report of the Twelfth session of the UN Permanent Forum on Indigenous Issues, para, 7. [↑](#footnote-ref-40)
40. Indigenous organizations around the world have also been quick to respond, including by providing key messages through written, social media and radio broadcasts in indigenous languages. [↑](#footnote-ref-41)
41. UN DESA, Policy brief No. 70 The Impact of COVID-19 on Indigenous Peoples. https://www.un.org/development/desa/dpad/wp-content/uploads/sites/45/publication/PB\_70.pdf [↑](#footnote-ref-42)
42. Report of the Twentieth session of the UN Permanent Forum on Indigenous Issues, para 21. [↑](#footnote-ref-43)
43. Report of the Twentieth session of the UN Permanent Forum on Indigenous Issues, para 96. [↑](#footnote-ref-44)