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EFFECTIVE ENGAGEMENT WITH INDIGENOUS PEOPLES: GLOBAL HEALTH SECTOR GUIDANCE DOCUMENT

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HOW TO USE THIS GUIDANCE¹

The United States Agency for International Development (USAID) has designed this guidance document to provide a practical tool to assist USAID missions and operating units (OUs) in their efforts to more effectively engage and partner with Indigenous Peoples in global health activities. Consideration of Indigenous Peoples' own, self-determined development priorities through well-structured communication, consultation and engagement strategies helps foster local solutions to local development challenges as envisioned in the [Journey to Self-Reliance](#). By effectively engaging Indigenous Peoples in global health activity design, implementation, monitoring and evaluation, OUs can advance [USAID's global health strategic priority areas](#) while accounting for Indigenous Peoples' needs, capacities, and interests. This engagement can mitigate adverse impacts on indigenous communities, avoid conflict that could delay or derail projects, and lead to better development and health outcomes for Indigenous Peoples.

This global health sector guidance is based on desk research on international standards and implementation experiences, as well as interviews with USAID development professionals working in the sector. This guidance complements and is informed by the [USAID Policy on Promoting the Rights of Indigenous Peoples](#) (PRO-IP) and comprises one part of USAID's collection of sector-specific guidance documents on engagement with Indigenous Peoples.

The PRO-IP recognizes that development programming has not always benefitted Indigenous Peoples, who, in many contexts, remain marginalized, discriminated against, and located in isolated areas without adequate access to infrastructure and basic services. This global health sector guidance is intended to be integrated with other USAID planning and programming tools, including USAID's new [Social Impact Assessment Toolkit](#) (Social Impact Assessment Framework, Screening Tool, Sample Social Impact Assessment Statement of Work, Consultation Handbook, and Inclusive Development Analysis) and [Environmental Impact Assessment](#) process.

Multiple factors at the individual, community, national, and global levels present challenges to health and well-being. This guidance addresses a particular aspect of the problem² – the challenge of health opportunities and threats as experienced by Indigenous Peoples. This guidance identifies development challenges, lessons learned, and best practices related to health to help USAID better engage Indigenous Peoples and define activities that support global health development. Guidance documents prepared for supporting the implementation of the PRO-IP for the following other sectors are relevant and inter-related: biodiversity, energy, agriculture and food security, education, enhancing livelihoods, sustainable landscapes, and democracy, human rights, and governance.

¹ To access references, use the electronic version of the document with hyperlinks embedded.

² Challenges faced by Indigenous People (e.g., issues of discrimination based on age, sexual orientation, ability, gender, ethnicity, gender-based violence, and land rights violations) are also faced by non-Indigenous vulnerable groups. The prevalence of these issues is high among Indigenous Peoples and may unevenly affect individuals within a People. The potential for and impacts of exclusion, marginalization, and jeopardy are typically, but not always, higher for Indigenous Peoples. In this guidance, gender, conflict and land rights are cross-cutting themes while other types of vulnerability, such as age discrimination, are beyond the scope.

INTRODUCTION: USAID, HEALTH, AND INDIGENOUS PEOPLES

Globally, there are more than [370 million Indigenous Peoples who live in over 70 countries](#). They represent a wide range of experiences, cultures, languages, and traditions. Although Indigenous Peoples' experiences with healthcare vary across populations and countries, they generally have [worse health outcomes](#) than their non-indigenous counterparts. A host of factors, including socioeconomic inequality, inadequate medical care, and historical discrimination and disenfranchisement contribute to their increased health risks. Providing quality, culturally appropriate, and inclusive health services to indigenous communities starts with identifying them, understanding their individual circumstances (e.g., cultural values, environment, socioeconomic conditions, health care access and needs, etc.) and engaging them in program design and implementation.

Developing culturally appropriate health programs with Indigenous Peoples requires recognition of and sensitivity to Indigenous Peoples' traditional knowledge and cultural understanding of sickness and health. In contrast to conventional medicinal approaches that focus primarily on individual disease, physical symptoms and biomedical solutions, many Indigenous Peoples consider health to be about [overall well-being](#) — spiritual, mental, physical, community, and environmental. Within many indigenous societies, [traditional health systems, based on indigenous knowledge and traditional remedies](#), are trusted and have been passed down over generations. This knowledge has benefited society as a whole, with many pharmaceuticals derived from traditional plants and guided by indigenous knowledge that was shared freely as a public good.

[Traditional healers and traditional midwives](#) are trusted advisors who often are more [accessible and provide more culturally acceptable care](#) than conventional, allopathic medical providers. Frequently, these providers co-exist, but the two systems are [seldom integrated](#) and many Indigenous Peoples prefer traditional providers. [More understanding of the risks and benefits of traditional medicine and traditional practices](#) is needed to ensure patients are receiving safe and adequate care.

Inclusive health programming demands understanding of the unique health risks Indigenous Peoples face and the disparities of health status between indigenous and non-indigenous communities. Indigenous communities are more likely than non-indigenous communities to be geographically isolated and experience poverty and discrimination as well as social, political, and economic exclusion. This marginalization reduces indigenous access to quality health care, exposes indigenous lands to environmental contamination, deprives Indigenous Peoples of access to safe drinking water, displaces populations from their land, foments conflict, and [disrupts social cohesion and traditional cultural structures](#), all of which contribute to the serious health challenges Indigenous Peoples face.

IDENTIFYING INDIGENOUS PEOPLES

The context and circumstances of Indigenous Peoples varies in the different countries and regions where USAID works. In some countries, Indigenous Peoples constitute a small minority within the population, while in others they are the majority. In some countries, Indigenous Peoples have legal recognition and are able to maintain their distinct identities, spiritual practices, and customary relationships with their lands, yet in others their very survival is at risk. The terminology used to describe them also varies, with many countries refusing to acknowledge them as Indigenous Peoples.

Recognizing this variation, USAID has not adopted a single, standardized definition of Indigenous Peoples. Instead, USAID (like other international and inter-governmental organizations) identifies Indigenous Peoples based on a set of criteria which may be present depending on the region or country in which Indigenous Peoples are located. These criteria include: self-identification as distinct social and cultural group; recognition of this identity by others; historical continuity with pre-colonial and/or pre-settler societies; collective attachment to territories and their natural resources; distinct language or dialect; and/or resolve to maintain and reproduce their ancestral environments and systems as distinctive peoples and communities.

Available data, which are limited, indicate that Indigenous Peoples' health status is usually different, and frequently worse, than that of non-indigenous peoples, even those of the same socioeconomic status in the same country or region.³ For example, on average, Indigenous People worldwide live approximately 20 fewer years than non-indigenous people. The 2016 [Lancet-Lowitja study](#), which examined existing data on 28 indigenous populations in 23 countries, found health disparities in several key indicators including life expectancy at birth, infant mortality, maternal mortality, low birthweight, high birthweight, child undernutrition, child obesity, and adult obesity. The size of the differences in health indicators between the indigenous and non-indigenous populations varies widely across locations. And, while the disparities tend to favor non-indigenous, some indigenous populations fare better than their non-indigenous counterparts in some indicators. Other reported differences include:

- [Data from several countries](#) show that indigenous women and girls are less likely to have access to antenatal care and skilled attendance at birth (“western” definitions of care that can be done in culturally appropriate ways) and [more likely to die in pregnancy and childbirth](#) than women in the general population. Barriers to indigenous women’s and girls’ health care access vary across communities and include social (e.g., discrimination), economic (e.g., cost of transport), policy (e.g., inadequate clinic staffing), cultural (e.g., harmful practices), and geographical factors (e.g., distance to facility).
- [Health care providers often do not speak indigenous languages](#), and many Indigenous Peoples do not speak the language of the dominant population. Providers may not fully understand a patient’s symptoms and concerns, complicating diagnosis. Patients may not understand a health care provider’s guidance and instructions. Preventive health counseling is also nearly impossible when there is a language barrier.
- Data shows that the prevalence of Sexually Transmitted Infections (STIs) is [increasing among indigenous communities and that the rates of these infections are often higher than among non-indigenous populations](#).
- Indigenous communities experience many of the known [social and economic risk factors](#) that are used to identify populations [vulnerable to HIV](#): poverty, marginalization, geographical isolation, low literacy, limited health care access, lack of political or social power, fragmented relationships, and poor overall health. Data on HIV among Indigenous Peoples are scarce and do not provide a clear description of the problem, especially in low resource countries.⁴ Available data, mostly from high resource countries, indicate that HIV prevalence, patterns of transmission, knowledge of disease prevention and management, and access to testing and care among Indigenous Peoples [are often different](#) than in the general population and therefore require a tailored and culturally appropriate response. For example, [in Australia](#), indigenous women have higher rates of HIV infection and indigenous men and women are more likely to acquire HIV through injecting drug use and heterosexual sex and to be diagnosed at later stage of infection than non-indigenous men and women. Among the [Ngabe in Panama](#) there are

³ Indigenous health data are limited, and major quantitative analyses do not further disaggregate based on sex or age, so it is difficult to determine men’s and women’s specific health vulnerabilities. The Challenges/ Key Issues section, below, discusses some gender-specific concerns and issues.

⁴ There is very limited data on HIV among Indigenous Peoples in developing countries. Available data on HIV among Indigenous Peoples are primarily from the US, Canada, Australia and New Zealand. Data on key populations such as men who have sex with men, injecting drug users, sex workers, and prisoners is not readily available for Indigenous Peoples in developing or industrialized countries.

reports of recent increases in new HIV infections. Incidence among Indigenous Mayans may be [three times higher](#) than in Guatemalans overall.

- Similar to non-indigenous populations, noncommunicable diseases (NCDs), such as [obesity](#), cardiovascular disease, and Type II diabetes, are also increasing among some Indigenous Peoples, particularly in middle to higher income countries, such as Australia, Canada, and the United States, where there has been a transition in lifestyle and diet. As indigenous communities in developing countries engage in development activities that encourage a shift from traditional crop to cash crop production or as market-based diets replace traditional diets, Indigenous Peoples are [at increasing risk of a similar shift](#), which will likely occur at a different pace than among the general population. Risk factors for NCDs, have been identified among Indigenous Peoples of [India, Pakistan, and Latin America](#).

[Mental health](#)⁵ issues are also of [great concern](#) among some Indigenous Peoples. While the direct causes vary by location and culture, links have been made to poverty, disruptive and rapid social change, forced relocation, migration, the disintegration of social support and ties, [complex trauma, historical trauma](#), and the [intergenerational legacy of trauma](#) from colonization and forced assimilation that have affected some communities. In several regions, [rates of alcoholism and/or substance abuse](#) among indigenous communities are above those of the national population. [Substantially higher risk of suicide among indigenous youth](#), compared to non-indigenous youth, have been documented in several locations, including Brazil and Colombia.

CHALLENGES/KEY ISSUES

This section discusses the challenges in designing and implementing indigenous health programs, including deficient stakeholder engagement, lack of data, exploitation of indigenous knowledge, the remoteness of many Indigenous Peoples, urbanization, gender inequities, insecurity of land tenure, and the prevalence of social violence and conflict. Applying the [PRO-IP](#) will help OUs address many of these challenges and better align USAID priorities and objectives with Indigenous Peoples' self-determined development.

Deficient stakeholder engagement in program design reduces the likelihood of respectful, culturally appropriate programming and high-quality care

- When programs do not engage Indigenous Peoples in program design, there is insufficient awareness and understanding of culture and program design may not consider Indigenous Peoples' priorities and traditional practices. The limited current knowledge on Indigenous Peoples' health status is from an allopathic medicine perspective. Little is known about Indigenous Peoples' perspective on their own traditional health practices and values. Their perspectives on their communities' health status and priorities, based on traditional health practices and values, may differ from conclusions that are based on allopathic medicine and values. Lack of consultation and divergent perspectives, values, and priorities may lead to culturally inappropriate services and communication campaigns that do not meet the indigenous communities' needs. These services and campaigns may even be in direct contradiction with indigenous cultural beliefs and practices. Indigenous Peoples' trust in future services may be undermined due to these current circumstances.

⁵ Relevant sections can be found on page numbers 18, 32, 34, 40, 43, 63, 82, 83, 84, 86, 94, 97,99, 110, 112, and 113.

Lack of reliable disaggregated health data and information specific to Indigenous Peoples

Most countries do not gather or report health data specifically on Indigenous Peoples. This is especially true in Africa, Asia ([excluding India](#), which has [research data](#)), and Eastern Europe, as well as most low income countries, where disparities may be even more pronounced. Only 27 of the 90 reports published in the most recent two rounds of Demographic and Health Surveys and Multiple Indicator Cluster Surveys [include an analysis based on ethnicity](#).⁶ The lack of Indigenous Peoples-specific data leaves the needs of Indigenous Peoples outside of program and policy-making processes.

- Quality data and information are needed to understand Indigenous Peoples' health status in comparison to non-indigenous people and to understand their unique circumstances and needs. Reliable population-specific information, disaggregated by sex and age, would better inform policy development and assist in the design of culturally appropriate health programs, communication campaigns, and services.
- Indigenous communities' health situations vary by context. It is not appropriate to assume that trends from countries where data are available (mostly higher resource countries) apply across the wide variety of Indigenous Peoples around the globe. Population-specific data are needed for each group with which USAID programs are working. Because of the varying health contexts across countries and Indigenous Peoples, it may be challenging for global health programs to specifically consider Indigenous Peoples needs in program design, with a need for flexibility to consider unique situations of the various countries that participate in a given global health program.
- Collecting and reporting disaggregated data on Indigenous Peoples may be challenging, as:
 - Many indigenous communities are not formally recognized as Indigenous Peoples by governments, making it difficult and politically challenging to identify them. [Proxy measures](#) such as language or geography may be used but will not perfectly capture the situation.
 - Geographically-isolated groups, or groups who have suffered exploitation or discrimination from dominant populations, may not trust outside researchers gathering data and refuse to participate. During the baseline survey for the [Guatemala Western Highlands Integrated Program](#), negotiations with skeptical communities slowed work, and one research team was detained by an untrusting community.
 - Geographic isolation or difficult terrain makes it difficult and expensive to access certain areas. Due to difficulty accessing [northeastern Kenya](#), which is populated by indigenous pastoralists and hunter-gatherers, earlier demographic and health surveys failed to include any health data for populations in the region.
- Collecting and reporting HIV data according to ethnicity or indigenous group can contribute to further stigmatization of already marginalized groups, particularly when HIV prevalence is elevated compared to the general population. However, without data, potential needs cannot be addressed. Research activities, including gaining informed consent, handling of data samples, data collection, and data storage procedures should follow human subjects research ethics guidelines outlined in [US government guidelines](#), including the [USAID Scientific Research Policy](#).

⁶ [Ethnic groups share a common sense of identity](#) often based on shared language, ancestry, tribe, culture, race, or religion or a combination of these factors. Indigenous Peoples are ethnic groups that have distinct social, economic, and political systems and beliefs and are committed to maintaining their identity. Indigenous groups would potentially be among the ethnic groups included in DHS reports that disaggregate data based on ethnicity.

- Researchers have been disrespectful of Indigenous Peoples’ cultural expectations and values, including the need for community as well as individual consent. Researchers have misled Indigenous Peoples as to the purpose and use of their data, violated principles of informed consent, and put their research above group or individual needs. For example, researchers violated the informed consent of the [Havasupai](#) tribe by using blood samples for additional research beyond the tribe’s understanding, and there were reports of the [Human Genome Diversity Project](#) misleading individuals to believe blood draws were for clinical, rather than research, purposes. Research ethics boards may not have specific expertise in Indigenous Peoples’ issues and fail to ensure protections for the community.

Exploitation of traditional medical knowledge and plants by outside interests

The [United Nations \(UN\) Declaration on the Rights of Indigenous Peoples](#) affirms Indigenous Peoples’ rights to access traditional medicine, while the [World Health Organization \(WHO\) Traditional Medicine Strategy: 2014-2023](#) highlights the need to recognize and develop the potential of traditional medicine, while promoting its safe and effective use. Yet, as demand for traditional medicine and knowledge has grown at the global level and as indigenous medicinal plants have become [key components of pharmaceuticals](#) used in conventional medicine, Indigenous Peoples [remain vulnerable to intellectual property theft](#) by corporations who seek the knowledge and then do not compensate the providers of knowledge adequately or misappropriate or misuse traditional practices in the quest of profit-making.

- [Indigenous knowledge](#) of medicinal plants, including their sustainable management, is valuable to Western pharmaceutical companies, and nutritious traditional foods are of interest to global agricultural conglomerates. However, indigenous societies often view this knowledge as collective property and have not shared their knowledge of medicinal plants freely. At times, this knowledge has been exploited for profit that is not shared and indigenous communities are increasingly becoming more protective of their indigenous knowledge. This lack of profit-sharing could lead to further hesitations to share indigenous knowledge, resulting in delays to medicines that could potentially benefit society as a whole.
- Over [70 percent of the clinically-useful modern medicines derived from plants were developed by pharmaceutical companies based upon these plants’ use in traditional medicine](#). This includes properties of the Ayahuasca plant from the Amazon, [considered both medicinal and hallucinogenic](#) and illegal in many countries around the world, and the neem tree in India. [In 2000, a study concluded that 7,000 patents had been granted inappropriately for unauthorized use of indigenous knowledge or medicinal plants](#).

Remoteness of indigenous populations, limiting health and health care access

Indigenous Peoples frequently live in remote and difficult to access regions and face financial, social, and geographic barriers to health and health care access. Distance and cost limit access to health services for preventive or curative care. This limited access increases risk of infectious disease outbreaks (e.g., inability to achieve universal vaccination) and poor individual health outcomes (e.g., limited access to medications; antenatal, delivery, postpartum care; and other preventive and curative care). The challenges include:

- It is more expensive to provide services and oversight in hard-to-reach areas (e.g., higher cost of supply transport, travel for supervision or mentorship). Reaching more remote locations is particularly challenging in countries with weak or poorly funded health systems and transportation networks. Simultaneously, the cost of transport and the time needed to reach distant health centers can be prohibitive, even in the event of an emergency.
- Many Indigenous Peoples occupy territory that crosses political borders. Those with migratory traditions may cross internal and national borders regularly and miss opportunities for

vaccination campaigns, care given by mobile clinics, or timely diagnosis by tests that require labs to process them.

- Identifying qualified providers who are willing to work in remote areas is difficult. Health facilities are often short-staffed and/or staffed by clinicians unfamiliar with indigenous culture and language, and clinic hours do not always accommodate populations traveling long distances. These issues create barriers to receiving adequate care, even if individuals can physically reach the facility.
- Indigenous Peoples seeking health care may not understand what is available to them due to language constraints. It may be difficult for health care materials to be translated into languages that Indigenous Peoples understand or that represent a particular group.
- Voluntarily isolated and uncontacted tribes have suffered tragic loss of life [after exposure](#) to diseases to which they have no immunity, such as influenza, tuberculosis, and [measles](#). In some tribes, dietary changes brought on by contact with outside groups has caused gastrointestinal problems as well as a shift to an overall less healthy diet.

Adverse impacts of urbanization or migration of Indigenous Peoples

In recent years, millions of people from indigenous communities have [migrated](#) to other locations in search of economic opportunities or health care, or because of deteriorated living conditions in their own community due to social and/or environmental changes, such as loss of land or traditional livelihoods. An [International Organization for Migration Framework](#) identifies three main patterns of migration of indigenous peoples: urbanization, transborder (moving within ancestral territory that crosses country borders), and international. Other patterns, such as migrating from one rural area to another also exist. Migrants may stay in new areas or travel back and forth and are often employed in low wage or dangerous jobs or are unemployed. Their relative poverty forces them to live in low quality housing. Weakened social cohesion in urban areas makes it difficult for migrating individuals to maintain their tribal identity and many attempt to hide their indigenous identity, avoiding traditional language and dress in an attempt to avoid discrimination. [Studies from Chile and Peru](#) have found that adapting to a new lifestyle and culture, combined with the loss of social support structures, are associated with psychological distress, and indigenous migrants' health tends to be worse than people residing in their new locations. Sexual violence exists on the migration path that may present as a double disadvantage to indigenous women. The out migration, mostly of young men, changes the demographics and dynamics in the community with women, children, and the elderly remaining in the community. Simultaneously, the influx of non-indigenous persons to indigenous areas for commercial purposes, such as for work in mining or other extractive industries, can introduce new diseases and contribute to disease outbreaks, especially among isolated tribes, while also disrupting the socioeconomic structure of a community.

Lack of considerations for Indigenous Peoples in national health policies and systems

Indigenous Peoples' unique needs are often not addressed in national health policies and several countries, such as [Tanzania](#), [Bangladesh](#), and [Uganda](#) among others, do not recognize their indigenous populations as "Indigenous Peoples"⁷. Policies tend to focus on Western approaches to medicine and also may not address determinants of health or concerns specific to Indigenous Peoples.

⁷ Several countries, such as India, Bolivia, and the Philippines do recognize the existence of indigenous groups and have varying levels of legislation in place to provide protections. The International Work Group for Indigenous Affairs maintains country-specific information.

- When countries make efforts to develop indigenous-sensitive and inclusive health policies and systems, implementation can be compromised due to inadequate infrastructure and lack of adequately trained providers.
- Integrated health systems that combine both Western and traditional medicine face challenges of providers who may not understand, appreciate, or respect the other system. Language and cultural barriers can exacerbate the problem and make coordination of care between the two systems difficult. Uncoordinated care can put patients at risk.

Gender-specific health needs and differing women’s health situations between indigenous and non-indigenous women

The [USAID Gender Equality and Female Empowerment Policy](#) requires that gender analyses be conducted to understand the differences between men and women in a given context and identify the root causes of gender inequality to inform program design. It is important to consider gender roles, power dynamics, and cultural norms when designing health programs so programming is sensitive to gender issues and indigenous issues. [ADS 201](#) provides additional guidance on [approaches](#) to [Inclusive Development](#). The [U.S. Strategy to Prevent and Respond to Gender-based Violence Globally](#) also calls for engaging marginalized and vulnerable populations, including Indigenous People, to address gender-based violence.

- Policies and programs often do not differentiate between Indigenous and non-Indigenous women. Indigenous Peoples’ health, and women’s health programs and policies in particular, are often designed and implemented separately; there is a lack of programs dealing specifically with indigenous women’s health. Yet, their health concerns, priorities, and needs are different and indigenous women are particularly vulnerable because they are members of two typically marginalized populations.
- Indigenous men and women’s health behaviors and disease risks differ from each other and from the non-indigenous population. For example, in Latin America, [indigenous women have lower mortality than men but higher morbidity](#), often attributed to their high burden of labor.
- Reports of [mistreatment of women](#) within the health sector are quite common, especially related to reproductive health and pregnancy, influencing higher maternal mortality rates and low rates of facility-based deliveries. This affects marginalized women in general, both indigenous and non-indigenous women. However, language barriers and lack of cultural sensitivity by providers can exacerbate the problem for indigenous women. Potential for mistreatment is further heightened for indigenous women, indigenous LGBTQI, and those with a disability, particular illnesses such as HIV, if they are unmarried, and survivors of gender-based violence.
 - Indigenous women and girls are at a high risk for human trafficking, especially for sexual exploitation, and fewer culturally appropriate victim services, trafficking codes, and law enforcement exist for identifying and responding appropriately to women who experienced human trafficking.
 - Rooted in gender inequality, gender-based violence is any harm or potential harm against a person because of their gender, including physical, psychological, sexual, and socio-economic violence, and traditional harmful practices. Gender-based violence is widespread across countries and cultures and affects women and girls disproportionately. Conflict, forced displacement, and cultural breakdown have been linked to increase in some forms of gender-based violence, especially domestic violence and intimate-partner violence.
 - Gender-based violence against indigenous women and girls leads to health consequences such as physical and psychological trauma, unwanted pregnancies, sexually transmitted

diseases, and disability. Cultural norms that discourage reporting and the lack of culturally sensitive programs and services are major challenges to prevent and respond to gender-based violence and to provide adequate health services for Indigenous women and girls who experienced violence.

- Addressing violence against indigenous women and children has been highlighted as a priority by the [UN Permanent Forum](#). [United Nations estimates](#) suggest that more than [one in three indigenous women experience rape](#) during their lifetime. A study of [violence against women in Bangladesh from 2014 to June 2017](#) found 297 reported cases of violence against indigenous women and girls, but that none of the cases had been properly prosecuted and no perpetrators punished.
- Child, early and forced marriage among Indigenous Peoples are common, with early pregnancy putting young adolescent mothers at risk. This practice is not unique to Indigenous Peoples; however, it is an important risk factor to consider when designing reproductive health programs among indigenous adolescents and was highlighted as a priority by the Permanent Secretariat for Indigenous Peoples in 2005.
- Female genital cutting or female genital mutilation (FGC/M) is practiced among many Indigenous Peoples as well as non-indigenous communities. This practice offers no health benefit while placing girls and women at high risk of serious complications including infection, hemorrhage, and obstetric complications, which can lead to death. [Within a given country, the prevalence of FGC/M](#) is likely to be different among the indigenous population than the general population. [For example, in Uganda, prevalence of FGC/M is only about two percent overall, yet it is almost universally practiced by several Indigenous Peoples. Similarly, in Kenya 21 percent of the overall population of women ages 15 to 49 have been cut, whereas 78 percent of Maasai and 86 percent of Samburu women have experienced FGC/M.](#)
- Among the world's diverse indigenous populations, gender norms and related traditional practices will vary.

Obstacles for youth as Indigenous Peoples adapt to the changing environment and culture is impacted

- Poverty and marginalization, along with fraying societal structures, affect indigenous youth, particularly compromising their mental health. Substantially higher risks of suicide among indigenous youth compared to non-indigenous youth have been documented in several locations, including Brazil and Colombia. While the direct causes are not fully understood and vary by location and culture, links have been made to poverty as well as disruptive and rapid social change that may be beyond a community's ability to adapt (including forced relocation), loss of social support networks and the imposition of dominant cultures' values.
- Shifts such as the need to earn money and interact with market systems to sustain livelihoods rather than subsisting off the land changes community dynamics.
- In addition, many youth are becoming acculturated to the dominant community and intergenerational rifts are forming as young people lose the ability to speak native languages and migrate to urban areas.

Disputed land rights and loss of access to traditional lands disrupts lifestyle, livelihoods, and health

Access to traditional lands where Indigenous Peoples have sustained life over generations is essential to their health, food security, nutrition, and livelihoods. In addition to being a source of livelihoods,

Indigenous Peoples derive meaning through connection with their land. In many indigenous societies, land ownership is collective, and communities often lack formal legal titles to the land they occupy. Their [rights to traditional lands are frequently violated](#), and Indigenous Peoples have experienced loss and destruction of their lands. Continuing threats of displacement and land appropriation destabilize communities and the destruction of the natural resource base has cultural and economic effects and directly affects Indigenous Peoples' health and well-being.

- The [UN Declaration on the Rights of Indigenous Peoples](#) acknowledges that Indigenous Peoples have the right to their traditional medicines and conservation of medicinal plants. As Indigenous Peoples lose access to traditional lands and forests where medicinal plants grow, they also lose access to traditional medicine and the ability to pass down knowledge of traditional plants to the next generation.
- In some circumstances, governments and private interests have taken over traditional lands for commercial use, private ranches, cash crop farming, or public parks, affecting the health of herds, depriving people of opportunities to grow traditional crops, and disrupting traditional diets and food security. There are many examples of this disruption. [Loss of land disrupted](#) the San of Namibia's food production and was followed by subsequent decline in health status and contributed to the San's need for government food aid; the Datooga people's pastoral lands were taken for wheat farming and led to destruction of herds in Tanzania; and the Batwa of Uganda lost access to their traditional medicines through displacement.
- Industries seeking to profit from natural resources, such as oil and mining, are a threat to indigenous communities because so many untapped natural resources are on indigenous lands. [Forcible displacement](#) has occurred in places such as Colombia, Ghana, Guyana, Indonesia, Malaysia, Peru, and the Philippines. [Mining, oil, and other operations](#) have [contaminated](#) the land and water on which Indigenous Peoples rely, decreasing drinking water resources and increasing disease among Indigenous Peoples in places such as [Ecuador's Oriente](#) and [Patagonia in Argentina](#). This industrial use of resources can put Indigenous Peoples' needs in direct conflict with government and corporate economic priorities, as mining and oil create opportunities for national economic development while threatening the wellbeing of small, politically weak minority groups.
- Development programs that include land titling to smallholders can inadvertently put Indigenous Peoples, especially women, at risk because they often do not have titles to the land they have occupied for generations; they are [vulnerable to losing land or receiving unfair compensation](#). In some cultures, [women cannot be landowners](#) and, as approaches to land ownership shift from [communal access to traditional lands](#)—in which women often had equal access to land—to one of private ownership, they may struggle if a husband dies.

Adverse health outcomes due to conflicts and conflict management

Conflicts between Indigenous Peoples and non-indigenous populations arise from a host of challenges, including real or perceived inequalities, land disputes, discrimination in provision of essential services, development activities that are detrimental to Indigenous Peoples (and on which they may not have been consulted), and rights violations.

- When peaceful methods of conflict resolution fail, ensuing violent conflict may have several [consequences for indigenous health](#) in addition to deaths associated with the conflict. Violent conflict may displace individuals or communities, disrupt access to essential services, and cause fear and trauma causing accompanying psychosocial issues.

- Violent conflict changes the structure of a community, often leaving widows with increased workloads and fewer resources to provide adequate nutrition and health care to their families. In Guatemala, after the 1978–1985 period during which indigenous communities faced massacre, rape, and torture, there was a significant [increase in female-headed households in rural areas](#), over half of which were headed by widows, many of whom had experienced violence personally.

LESSONS LEARNED: USAID CASE STUDIES

The following USAID programs provide important lessons learned for working with Indigenous Peoples in the health sector.

TABLE 1. WESTERN HIGHLANDS INTEGRATED PROGRAM (WHIP) GUATEMALA (2012-2017) CASE

Program Overview: WHIP was a collaboration between USAID/Guatemala, implementing partners, and the Government of Guatemala to reduce poverty and improve nutritional status in 30 municipalities in five departments of the Western Highlands region of Guatemala. The health component worked to improve health and nutrition practices and increase Indigenous Peoples' access to quality, culturally sensitive health and nutrition services. WHIP included contributions of over 15 USAID-funded implementing instruments. An intra-mission working group, composed of staff from all technical offices, ensured that staff overseeing WHIP activities collaborated and shared information and that their activities aligned with the Feed the Future multi-year strategy.

Theory of Change	Activities	Enabling Environment	Implementation Challenges	Successes	Lessons Learned
<p>Indigenous Guatemalans have substantially higher infant mortality, maternal mortality, chronic malnutrition, and fertility rates than their non-indigenous counterparts as well as lower rates of voluntary contraceptive use and skilled attendants at birth. The rural indigenous areas of the Western Highlands are especially hard hit with inadequate personnel, infrastructure,</p>	<ul style="list-style-type: none"> • Technical support, training, and grants provided to local non-governmental organizations (NGOs) to strengthen the Programa de Extension de Cobertura (PEC). The PEC NGOs, which knew the communities, language, and culture, worked to improve access to and quality of health services in rural areas where the Ministry of Health (MOH) had limited facilities and personnel. • Improved access to and quality of voluntary family planning and reproductive health information, education, counseling, and services including increasing men's participation, expanding 	<ul style="list-style-type: none"> • Strengthened indigenous women's civil society organizations, leadership and participation in advocacy, policy dialogue, and monitoring to improve policies that affect their lives. • Supported decentralization and training of reproductive health observatories (OSARs), which design and carry out advocacy, citizen surveillance, and monitoring for 	<ul style="list-style-type: none"> • A large-scale integrated project requires substantial coordination among staff, who have limited time and may prefer the efficiency and ownership of focusing exclusively on their own sector. • The health intervention was not implemented as planned because the Guatemalan Congress halted funding to the PEC-NGO program in 2014. With no plan in place to replace the NGOs' services, access to quality health services was significantly reduced. 	<ul style="list-style-type: none"> • Empowering indigenous civil society organizations with analytical capabilities to examine budget execution reports from the Ministry of Health, Ministry of Education, and municipalities enabled these organizations to effectively advocate before the local political parties to further human capital investments in the Western Region. • The indigenous women's and men's organizations effectively advocated to change the Guatemala civil code to end loopholes that allowed judges to approve child marriages and resulted in a law that increased the 	<ul style="list-style-type: none"> • USAID efforts to strengthen indigenous civil society groups have boosted Indigenous Peoples' surveillance of the quality of public health services. For example, organized indigenous groups monitor the stocks of contraceptives, drugs, and supplies, triggering responses from health authorities to improve stocks of basic medicines at the service-delivery points. • Indigenous Peoples are gaining spaces in the national agenda and in the decision-making at the highest level of the Government of Guatemala. Representatives of the

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Theory of Change	Activities	Enabling Environment	Implementation Challenges	Successes	Lessons Learned
<p>and supplies. Through a multisectoral approach, USAID and the Government of Guatemala sought to achieve sustained rural social and economic development in the Western Highlands. WHIP invested in improving health practices and access to quality services to improve nutrition and health outcomes of vulnerable, indigenous women and children and supported indigenous civil society to advocate for</p>	<p>the range of available methods, and reducing cultural and medical barriers. This was in response to research that showed indigenous populations had a much higher unmet need for family planning than non-indigenous groups.</p> <ul style="list-style-type: none"> Increased access to skilled birth attendants, scaled up practices to reduce preventable maternal and child deaths, and trained providers on attending women in their preferred labor position; some Ministry of Health wards had rooms designed for indigenous mothers’ preferences. Increased access to micronutrient supplements, treatment of childhood illness, and education on improved nutritional practices and better hygiene, nutrition, and health behaviors, 	<p>reproductive health and indigenous women’s issues.</p> <ul style="list-style-type: none"> Supported the local indigenous men’s civil society advocacy networks for health, nutrition, and education that monitor policy implementation and health services quality. These networks promoted gender equity, responsible fatherhood, and advocated for the prevention of gender-based violence. 	<ul style="list-style-type: none"> Distrust of outsiders and the government in the more rural and isolated areas, especially in locations with a history of political violence, inhibited cooperation in participating in the baseline survey, putting some field teams at risk and delaying approval to move forward. 	<p>legal marriage age from 14 to 18 years for both boys and girls.</p> <ul style="list-style-type: none"> Because of advocacy of the women’s civil society organizations and OSARs, an intercultural healthcare unit was created as part of the Ministry of Health to increase health service accessibility for Indigenous Peoples, and improve their quality and cultural appropriateness. In 2017, these groups’ advocacy also led the Congressional Indigenous Peoples’ Commission to form a technical working group to monitor the cultural relevance of health service delivery. Maternal deaths were reduced by 40 percent in the department of Alta Verapaz between 2012 and 2013 and by 20 percent in the 30 focus 	<p>indigenous minorities have gained important positions at the National Council of Nutrition and Food Security, raising concerns before the national authorities and have also been called to occupy a position in the National Scaling-up Nutrition Movement.</p> <ul style="list-style-type: none"> USAID’s formative research in the Western Highlands showed disrespectful health care services including verbal abuse, discrimination, and lack of communication and emotional support, especially for indigenous women. Stakeholders, including health providers, traditional birth attendants, community representatives and health providers developed action plans to address gaps and barriers. Training on respectful care and cultural

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Theory of Change	Activities	Enabling Environment	Implementation Challenges	Successes	Lessons Learned
<p>public policies that addressed their unique needs and held government accountable.</p>	<p>focused on the first 1,000 days. USAID used a behavior-centered approach, incorporating intercultural and gender sensitive perspectives to integrate the roles of families, communities, and health workers in improving nutrition and health outcomes.</p> <ul style="list-style-type: none"> Developed public-private alliances to improve access to safe water to reduce diarrheal disease. 			<p>municipalities from 2013 to 2015.</p> <ul style="list-style-type: none"> USAID/Guatemala created high level political will for decentralization and universal access to health care. Previously, the Ministry of Health was reluctant to discuss these issues but now is pushing forward with those approaches. 	<p>pertinence was provided to health providers and managers; mothers and traditional birth attendants were informed on hospital rules, companion support during labor and delivery, among others. As a result, hospital staff is documenting and reporting increases in service demand.</p>

TABLE 2. THE AMAZON MALARIA INITIATIVE (AMI) SOUTH AND CENTRAL AMERICA (2001-2016) CASE

Program Overview: AMI was designed to improve prevention and control of malaria in 11 South and Central American countries. AMI provided technical assistance to help partner countries' national malaria control programs implement best practices and promote lasting, evidence-based policy change. The program focused on malaria prevention and control in the overall population, including in areas where Indigenous Peoples lived.

Theory of Change	Activities	Implementation Challenges	Successes	Lessons Learned
<p>AMI was designed to improve malaria prevention and control in malaria-endemic countries in the Americas with the goal of reducing morbidity and mortality. The strategic objective was to substantially incorporate best practices into national malaria control programs and the expected intermediate results were to improve the evidence base, communicate and use the evidence base, and promote a more inclusive and better informed policy process. The expected outcomes were: standardized and reliable surveillance information on the resistance of antimalarial drugs and</p>	<ul style="list-style-type: none"> • Rolled out rapid diagnostic tests for remote and mobile populations in Honduras and Peru, predominantly inhabited by Indigenous Peoples, improving access to timely treatment through trained community health workers. • Country and sub-regional malaria communication strategies promoted participation of special groups, including Indigenous Peoples, for a more inclusive policy process. • Designed and held a webinar on Good Practices for Collaborating with Indigenous People on Malaria Prevention and Control based on lessons learned by national malaria control programs in Guatemala, Honduras, and Panama. Topics included intercultural approaches to malaria prevention and control, active participation of indigenous community members, and formative research to incorporate 	<ul style="list-style-type: none"> • Because diagnosis through traditional microscopy involved a delay of several days, many health care workers provided presumptive malaria treatment to anyone with a fever, which was against WHO recommendations and program policy. The workers did not report such use of the medicines, leading to mismatches between the amounts of medicine on hand and amounts expected based on program records. This disrupted forecasts and budget predictions for the coming year. <ul style="list-style-type: none"> – The roll-out of rapid diagnostic tests helped curb delays in diagnosis. – Policy change was recommended to allow for reporting use of antimalarial medications for presumptive treatment. 	<ul style="list-style-type: none"> • Introduction of artemisinin combination therapy (ACT) that was selected based on the particular pattern of disease risk in a certain geographic area (e.g., Peru was using two different ACTs). • From 2001 to 2014, the number of cases of malaria in the region fell by 74 percent. • From 2001 to 2012, mortality due to malaria fell by 72 percent. 	<ul style="list-style-type: none"> • This program did not consider Indigenous Peoples as a specific group in the design or implementation of its major program activities. However, Indigenous Peoples lived in many of the remote and rural communities where AMI worked. Some activities were tailored to Indigenous Peoples' needs, or the needs of remote/scattered communities mostly inhabited by Indigenous Peoples. Some of the issues Indigenous Peoples faced regarding malaria and health care provision were directly related to their indigenous identity while others were dependent on their geographic location (i.e., remoteness) and settlement pattern (i.e., small villages composed of a few families, scattered along rivers) and were shared with non-indigenous communities settled in similar conditions. It would be helpful to understand issues related to the culture or status of Indigenous Peoples that differentiate them from the surrounding non-indigenous communities. This was not specifically done in this program. • Through AMI, USAID collaborated with a network of national malaria control programs, addressing priority

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<p>vector control used to monitor trends and direct antimalarial efforts more effectively; improved laboratory diagnosis of malaria; and tools and approaches developed, adapted, tested in local contexts, and disseminated. The design incorporated a regional approach because malaria transmission is not constrained by political borders.</p>	<p>indigenous community concepts of health in design and implementation.</p> <ul style="list-style-type: none"> Supported development of messages for educational manuals in schools for indigenous children in Panama. 			<p>issues of common interest identified based on the analysis of individual countries and regional contexts regarding malaria prevention and control. The AMI collaborative approach involved the use of complementary sources of technical assistance and of South-South exchange. Specific activities responded to each country's requests and to the results of the context analysis, and not to a preconceived agenda</p>

BEST PRACTICES

It is important that global health sector program design reflects the specific situation of the communities in which programs are being conducted, understanding health status and trends, respecting cultural traditions, and protecting the rights of Indigenous Peoples. Below are practices that can enhance partnerships with Indigenous Peoples to successfully design and implement global health activities while mitigating risks of unintended negative consequences.

Recognize and respect the contribution of Indigenous traditional medical and nutritional knowledge, plants, and systems

- Protecting Indigenous Peoples' rights to their historical lands on which medicinal plants grow and to their traditional medical knowledge is essential to prevent pharmaceutical companies from exploiting and appropriating Indigenous Peoples' lands and medicinal plant knowledge for profit and to ensure that this knowledge is continually shared to the benefit of society as a whole. For example, the [San people](#) of Namibia threatened legal action when they discovered a South African corporation was profiting from San knowledge of the Hoodia plant and were then given a share of the profits. Working and providing benefits to Indigenous Peoples for sharing their knowledge can help ensure that essential medicines reach the greater global community while benefiting and protecting the rights of Indigenous Peoples.
- Engaging Indigenous Peoples in activities that empower them to harness the expertise of their indigenous knowledge, such as traditional healing/nutrition, and to apply it to development challenges can empower them and lead to positive development outcomes.
- Employing indigenous staff to provide mainstream medicine can help address cultural sensitivities and language barriers as well as empower communities. In Indonesia, a pilot program partnering [traditional birth attendants with medically-qualified midwives](#) to provide both good clinical and culturally appropriate care increased the proportion of women delivering with a skilled birth attendant.

Collect and report health data according to ethnicity or Indigenous status; conduct research to learn information about Indigenous health situation

- Inform program and policy design, decision-making, and facilitate program monitoring with disaggregated data as well as quantitative and qualitative data that specifically focuses on Indigenous Peoples. A [Respectful Care Assessment](#) in Guatemala was conducted to identify barriers to high quality, equitable, respectful care and to understand drivers of “disrespect and abuse” experienced during facility-based delivery in three hospitals in Quiche. At regional workshops with facilities and communities, researchers shared findings to co-design future programming.
- Include Indigenous Peoples in the design of data systems and/or research and use participatory research to ensure that their values, health concepts and priorities are reflected. Apply the “do no harm” approach and assess the risks and the research impact on the indigenous population and adjust research protocols accordingly. Be sensitive to the risks of having Indigenous Peoples-specific data, including further marginalization based on the results. In consultation with affected communities, strike a balance between protection from stigma and prioritizing health needs.
- Adhere to United States and international [ethical guidelines](#) for [human subjects research](#), including provisions specific to indigenous populations, which often require [community](#) as well as individual protections. Include representation from the indigenous community on institutional review boards (IRBs) and examine and mitigate risks.

- Follow [USAID's Scientific Research Policy](#) and [Protection of Human Subjects in Research Supported by USAID](#) documents which provide guidance on research ethics, such as IRB review, identifying levels of risk and vulnerable populations, obtaining informed consent, data security and privacy protection.

Examine gender considerations specific to Indigenous Peoples when developing programs

In support of USAID's [Gender Equality and Female Empowerment Policy](#), programs should be culturally sensitive and account for gender roles and generational relationships within Indigenous Peoples, which may differ from those of other populations in the same locality, country, or region.

- Design engagement approaches that provide for the meaningful participation of women within the specific cultural context, especially in traditional indigenous cultures where norms may limit the participation of women. In addition, it is essential to engage with men and boys to increase their knowledge and understanding of health issues, gain their support, and work to transform gender-related power dynamics within the community.
- Examine the distinct roles and power relationships of indigenous males and females and how these affect their health outcomes, health access, and social determinants of health. Issues to consider include: gender-based violence, reproductive health and voluntary family planning, maternal and child health and nutrition, policy and legal frameworks and accountability, and communication about health issues between men and women.
- Balance cultural sensitivity with gender equity and health when addressing female genital mutilation, child marriage and other potentially harmful cultural practices. Efforts to curb these practices should be contextually tailored and developed with the community as national social norm influences may not represent the influences of indigenous communities. The United Nations Population Fund and the United Nations Children's Fund have highlighted [several successful efforts to reduce FGM and child marriage](#). A common theme was respectful engagement with the community – citing the wisdom of revered ancestors (Sudan), holding dialogues through existing social groups (Ethiopia), educating spiritual and traditional leaders who can develop alternatives to FGM to meet perceived community spiritual needs (Uganda), and employing traditional community decision-making and information-sharing methods (Afar, Ethiopia).
- USAID's [Gender Integration Toolkit](#) describes approaches taken by programs to address women's rights in customary courts and the efforts to support civil society organizations, "including faith-based organizations and traditional leaders, to develop dialogue, education, and advocacy programs aimed both at reducing acceptance of gender-based violence and discrimination."

Improve stakeholder engagement with Indigenous Peoples to develop health activities that fit with cultural practices and geographic limitations, and promote empowerment and self-determination

- When planning health programs with Indigenous communities, consider how their situation differs from the general population, and carefully assess and consider their values, culture, approach to health, and languages. Respect the rights of isolated or uncontacted tribes who are particularly vulnerable to diseases introduced by outsiders, and ensure procedures are in place to protect their lives and health. Successful approaches among Indigenous People are likely to be different than those used for the majority population. Engagement should be ongoing and participatory, reflecting the variety of opinions and voices in the community and creating opportunities to make adjustments and continue to meet the community's needs.

- The PRO-IP states when there are risks that a program will have adverse impacts on the rights, livelihoods, culture, lands and territories, natural resources, or sacred sites, or of relocation, USAID OUs should seek free, prior and informed consent (FPIC)⁸ from indigenous communities for project or activity implementation in accordance with international standards. FPIC should be done in a language the community members understand and in a manner that is completely transparent with regard to possible unintended consequences.
- [Social Impact Assessment, Inclusive Development Analysis](#), and consultations with Indigenous Peoples are important steps in program design. The Social Impact Assessment helps USAID OUs and implementing partners understand the potential impacts of development programming and balance adverse impacts (e.g., environmental, social, political and cultural disruptions) with program benefits. Inclusive Development Analysis can be used by OUs to understand the dynamics between indigenous populations and majority populations and within and among Indigenous Peoples. The [Indigenous People’s Consultation Handbook](#) lays out the reasons for conducting consultations, identifies essential elements of a consultation, and provides guidance on timing. These tools can mitigate risks and prevent harm.
- Developing specific strategies and approaches that address the issues pertinent to the locations in which they operate can help missions ensure indigenous consultation occurs in a systematic way. [USAID/Guatemala’s Indigenous Peoples Engagement Strategy](#) seeks to strengthen the quality of interactions with Indigenous People in program development and encourage partnerships with indigenous entities.
- Creating leadership opportunities for members of indigenous communities within USAID missions can help improve and deepen USAID’s engagement with Indigenous Peoples. For example, USAID/Guatemala has established an Indigenous Advisor who works to integrate a broader, more inclusive perspective in program design and implementation that fully embraces engagement with Indigenous Peoples. USAID/Guatemala’s Indigenous Advisor also leads the mission’s Professional Development program for Indigenous Youth, a six month internship at the mission with on-the-job training that builds their familiarity with development programming, exposes mission personnel to individuals from indigenous communities that helps break down stereotypes and promotes diversity, while facilitating opportunities for Indigenous Youth to network with their peers from other Indigenous cultures. The [Akwé: Kon voluntary guidelines](#) were established to guide cultural, environmental, and social impact assessment in communities where proposed developments will take place on, or have an impact on, indigenous communities’ sacred sites, lands, or waters.
- Effective engagement with indigenous groups specific to the health sector helps to:
 - Understand expectations as well as identify and accommodate key cultural needs, which may include families being present during clinic visits, labor/delivery, and hospitalization, and/or respecting modesty by ensuring individuals are treated by clinicians of the same sex and

⁸ FPIC is the idea that an individual or community must give approval in advance of an activity that would have a positive or negative impact on them. The PRO-IP further clarifies that this is “a process of meaningful consultation with [traditional] leaders, but not necessarily the agreement of those leaders, before the actions addressed in those consultations are taken.” Criteria for FPIC include: providing full information about the proposed activity and its potential impacts; not coercing or pressuring communities; following agreed-upon decision-making processes and institutions through recognized leaders and the community’s own decision-making systems; and including marginalized members (e.g., women, youth, persons with disabilities).

- their privacy is protected; for example, through use of screens and appropriately covering women during clinical exams;
- Learn about traditional medicine approaches to health challenges in the community and collaborate with traditional healers as appropriate;
 - Engage the community to develop solutions to their own health challenges and build trust among community members, which can, in turn, improve health care-seeking;
 - Create opportunities for indigenous community members to participate as health care providers, not just clients; and
 - Prevent discriminatory or disrespectful practices that deter Indigenous People from seeking health care, both allopathic and indigenous. Indigenous People, their cultures and way of life are often seen as primitive by those in the general population, which can fuel discrimination in the health sector. In locations such as [Guatemala](#) and other countries, indigenous women seeking to deliver at health facilities have reported disrespect, abuse, and mistreatment, which is a gender issue as well as a maternal and newborn health issue that can stem into other health areas (e.g., postpartum voluntary family planning, immunizations, and future use of facilities). Effective engagement of Indigenous Peoples when designing and implementing programs can ensure that health providers are respectful of indigenous clients (including communicating in the indigenous language or having translators available for those who do not speak the dominant language and/or need an indigenous signing interpreter), providing clear explanations of diagnosis and treatment in a way that is meaningful to the patient and possibly their family members, and having sufficient time and patience to answer questions. In countries such as [Guatemala](#) and [Ecuador](#), USAID funded programs have worked with Ministries of Health to accommodate and allow traditional practices to take place.

AKWE KON VOLUNTARY GUIDELINES

These guidelines set forth ten steps when developing an impact assessment of a project affecting indigenous and local communities:

1. Notification and public consultation of the proposed development (project) by the proponent.
2. Identification of indigenous and local communities and relevant stakeholders likely to be affected.
3. Establishment of effective mechanisms for indigenous and local community participation, including vulnerable groups (women, elderly, etc.).
4. Establishment of an agreed process for recording the views and concerns of the affected groups.
5. Establishment of a process whereby local and indigenous communities may have the option to accept or oppose the project.
6. Identification and provision of sufficient human, financial, technical and legal resources for effective indigenous and local community participation in all phases of impact assessment procedures.
7. Establishment of an environmental management or monitoring plan, including contingency plans regarding possible adverse cultural, environmental and social impacts resulting the project.
8. Identification of actors responsible for liability, redress, insurance and compensation.
9. Conclusion, as appropriate, of agreements or action plans on mutually agreed terms between the proponent of the project and the affected indigenous and local communities, for the implementation of measures to prevent or mitigate any negative impacts.
10. Establishment of a review and appeals process.