

The Convention on the Rights of Persons with Disabilities and its implications for the health and wellbeing of indigenous peoples with disabilities: A comparison across Australia, Mexico and New Zealand

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This paper explores how the expressed health needs of Indigenous peoples with disabilities resonate with the mandate of Article 25 'Health' of the United Nations Convention on the Rights of Persons with Disabilities (CRPD). The perceptions of indigenous peoples with disabilities are investigated, regarding their access to, and expectations of, health care. Their views are compared to those of health workers, senior bureaucrats and United Nations delegates. An exploratory case study approach was taken to compare three jurisdictions: Australia, Mexico and New Zealand. The data collection techniques used involved semi-structured interviews, focus groups and field notes. The findings suggest that the health needs of indigenous peoples with disabilities are largely underserved and misunderstood by health departments. Specialised and preventive health care for those with disabilities was found to be particularly problematic. Poverty, discrimination and disenfranchisement emerged as being the possible major determinants of the ill health experienced by indigenous peoples with disabilities. The findings and conclusions outlined in this paper advocate the need to build capacity and rights literacy for indigenous peoples with disabilities, particularly with respect to the CRPD, in order to enhance its impact on the health of indigenous people. A legitimate redistribution of resources and decision-making in response to the expressed health needs of indigenous peoples with disabilities is needed if the vision of the CPRD is to be realised in relation to Article 25.

Keywords: Indigenous persons with disabilities; Right to health; CRPD; Barriers to health care; Disability

Introduction

Disability is known to be a cause and consequence of poverty (WHO and World Bank, 2011). It took 30 years, from 1976 (when the UN adopted the Declaration on the Rights of Disabled Persons) to 2006 to the adoption of the Convention on the Rights of Persons with Disabilities.

For over 30 years, persons with disabilities have been advocating to achieve this binding international convention. In 2001, Mexico, a middle-income country, empowered by a new wave of political will, took the lead in representing the biggest global minority and advocating for the CRPD.

The CRPD reflects a shift in global politics, advocacy and disability scholarship. In 2016 the world celebrated the 10th year anniversary of the adoption of the CRPD. This landmark has been an opportunity to reflect on the progress achieved as well as the challenges ahead and the need to further policy responses that address and remove social and contextual barriers that persons with disabilities continue to face. This challenge is particularly relevant to those people encountering double layers of discrimination, such as indigenous people with disabilities.

The Convention does mention indigenous peoples in its preamble as subject to multiple or aggravated forms of discrimination; however indigenous peoples are not included as a protected group within the binding text of the Convention, even though indigenous peoples are disproportionately represented among persons with disabilities worldwide (Braithwaite et al., 2009; Mégret, 2008; Wiley, 2009; Rivas Velarde, 2015). This exclusion within the binding text could be seen as a legal barrier, as it is through international legal frameworks that greater protection has been achieved for indigenous people's rights (Pasqualucci, 2006). Despite this omission, the CRPD has shown some positive impact in counteracting past invisibility and rights infringements faced by indigenous peoples with disabilities. This paper seeks to explore the Right to Health, as enshrined in Article 25 of the CRPD for Indigenous peoples across three country sites: Australia, Mexico and New Zealand. Drawing upon rich original case study material, the paper illustrates barriers to the realisation of the Right to Health across all three country sites for Indigenous persons with disability. The core findings are discussed, along with an extensive discussion in relation to ways forward. The following section addresses how the paradigm shift embedded in the CRPD could serve as a catalyst for change for indigenous peoples with disabilities.

Transformative vision of the CRPD

The 50 Articles of the CRPD provide legal protection for people with disabilities, establishing accountability systems to monitor the signatory countries on their actions towards the progressive realisation of the mandate of the Convention. Thus, the transformative vision of the CRPD relies on its legislative power to promote change in disability law and policy at the domestic level (Lord and Stein, 2008). Disability scholars had emphasised the paradigm shift embedded in its principles and Articles (Quinn, 2010). Kayess and French (2008) stated that the CRPD gave opportunities for a higher degree of public participation by people with disabilities than any other human rights treaties. However, their statement has been challenged from the indigenous viewpoint. Hickey (2008) argued that indigenous people with

disabilities were excluded from the development of the CRPD. Reasons given included a possible lack of support from their governments, a lack of financial resources, and fears of losing focus due to the political complexities behind the acceptance and representation of indigenous people. Nonetheless, the CRPD does reflect a particular historical moment. To date, Hickey's early views are complemented by those of Meekosha (2011:670) who elaborated on the implementation of the CRPD and the potential benefits that it may have for indigenous peoples upon its development and implementation:

Disabled people in the South mobilised for the introduction of the United Nations Convention on the Rights of Persons with Disabilities (CRPD), which was initiated by Mexico. The countries of Latin America are now playing a leading role in motivating other countries to ratify and implement the CRPD

Human rights treaties such as the CRPD need concrete responses within domestic systems to allow them to function (Beco, 2009). The CRPD mechanisms need a clear understanding of indigenous needs and priorities to be documented from an indigenous perspective. Member states are mandated to submit reports under Article 35 'Reports by States Parties'. In April 2013, the Committee on the Rights of Persons with Disabilities (2013) responded to the initial mandatory progress report presented by Australia. This was the first country to be reviewed out of the three included in the sample countries for the research that this paper is based upon. In the final recommendation, the CRPD Committee urged Australia to present disaggregated data regarding the rates of disability among Aboriginal and Torres Strait Islander peoples, as well as taking action on non-discrimination and the health of indigenous people with disability. The report submitted by the Australian government (2010) with respect to Article 25 did not include any data or mention indigenous people with disabilities. This omission was also observed with other Articles within the Australian (CRPD/C/AUS/1), Mexican (CRPD/C/MEX/1) and New Zealand (CRPD/C/NZL/1) initial country reports mandated by Article 35. The official responses to all three reports also highlighted the need to further each country's actions in relation to their indigenous peoples with disabilities.

The CRPD Committee made it evident through its recommendations that the implementation of the CRPD can contribute to alleviating the inequity, segregation and lack of access to health services experienced by indigenous peoples with disabilities. Therefore, in keeping with the expressed need of indigenous people for self-determination (Andersen, 2010; Awatere, 1984; Calma, 2004), it is timely that the voice of indigenous people with disabilities should be heard in relation to their health needs and what they see as the implications of the implementation of the CRPD.

Article 25 'Health'

Health care is often not accessible or available to persons with disabilities on an equal basis with others. Such restriction is strongly linked to inaccessibility and denial of treatment based on a disability (Lord et al., 2010). Persons with disability have many unmet health and

rehabilitation needs (Tomlinson et al., 2009). For indigenous people with disabilities, this becomes exacerbated due to social exclusion and racism, factors further restricting access to health services and rehabilitation. Increases in cardiovascular diseases, mental illness, cancers, and respiratory illnesses observed in all parts of the world are expected to have a profound effect on the prevalence of disability among indigenous peoples (Albala and Corvalan, 2011; Gracey & King, 2009; Kritharides et al., 2010; Ohenjo et al., 2006; Vos et al., 2009). Indigenous peoples from Australia, Mexico and New Zealand have systematically reported poorer health outcomes, such as lower life expectancies, higher infant mortality and a higher prevalence of disability.

Systematic negative outcomes can be linked to a history of inadequate health policies (Dickert et al., 2002; Krahn and Campbell, 2011). It is, therefore, important to explore what has been responsible for the patterns of health and well-being in populations, and how these patterns have resulted in the health patterns of indigenous peoples.

Article 25 provides a framework to respond to the health needs of persons with disability. It urges member states to address and take action to promote the highest attainable standards of health for people with disability. It covers issues related to non-discrimination, the provision of free and informed consent, physical accessibility, as well as proximity of health services. It also spells out some key issues such as sexual and reproductive health and early identification and prevention of further disabilities. More importantly, the CRPD as an International human rights framework, puts into effect the right to the highest attainable standards of physical and mental health as an inclusive right, not only extending to timely and appropriate medical care, but integrating it with the social determinants of health (Schofield, 2015).

Methodology

A qualitative approach was chosen to aid revealing the personal insights and views held by Indigenous peoples with disabilities. The views of Denzin and Lincoln (2008) and Smith (2007) regarding indigenous enquiry, framed the research methodology for this study. As the aim of this research was to enhance the voice of indigenous participants, a case study approach (Yin, 2008) utilising grounded theory strategies (Charmaz, 2003, Corbin and Strauss, 2007) was selected, coupled with participatory indigenous methodologies (Barker and Murray, 2010; Pennycook, 2002).

The exploratory approach followed Yin's (2008) case study design utilising a set of qualitative techniques including semi-structured interviews, focus groups and observation strategies. An informal, conversational style of data collection was chosen to eliminate power relationships between participants and researcher, interviewee and interviewer (Denzin and Lincoln, 2008).

In this study, the following criteria were used to select the countries and indigenous

communities:

- a. Signatory countries to the CRPD
- b. Countries that have been colonised
 - i. Variation in type of colonial settlement
 - ii. Variation in the way in which sovereignty of their indigenous peoples has been/or not been recognised
- c. Countries that currently recognised the existence of their indigenous peoples
- d. Variation in geographical settings
- e. Indigenous communities with an interest in the study

Australia, Mexico and New Zealand were selected for this study. The variation and parallels within these countries allowed for the identification of facilitators and barriers in meeting the health needs of indigenous peoples with disabilities. These three countries, all signatories to the CRPD, have a shared history of colonisation, all recognising the existence of indigenous peoples. However, the recognition of indigenous sovereignty varies between them. New Zealand signed a Treaty with the British Queen in 1840, protecting Māori sovereignty. Mexico has just recently recognised the pluricultural nature of its country in its constitution. Today, Article 2 of the Mexican Constitution protects the sovereignty and self-determination of indigenous peoples. In comparison, Australia does not recognise the legal sovereignty of Aboriginal and Torres Strait Islander people.

Data collection

The data collection techniques used involved semi-structured interviews, focus groups and field notes. The views of 50 participants were collected including 18 indigenous peoples with disabilities users of health services, 19 health workers, 16 senior policy makers with some specifically working on health and the development or implementation of the CRPD. Data gathered were verbatim-transcribed and analysed using N-vivo10, following case study analysis guidelines and the incorporation of grounded theory tools.

Identification codes have been assigned to participants outlining first their country of precedence, followed by their gender and identification number, for example, Australia, Male/Female, Participants number (A, M.1), Mexico, Male/Female, Participants number (Mx, F.2) and New Zealand, Male/Female, Participants number (NZ, M.3)

Findings

Each case study was analysed separately. Then a cross-case analysis was conducted. Three core themes emerged related to how the expressed health needs of indigenous peoples

resonated with Article 25 of the CRPD. A pathway emerged which portrays the interrelationship between the oppression, resilience and emancipation of indigenous people with disability in relation to obtaining their rights- an ‘Indigenous health trajectory’ (see Figure 1).



Figure 1: Indigenous health trajectory

The uni-directional movement of the trajectory does not deny that the relationship between the pillars may not always be forward looking. The pillar of resilience is needed to balance any disappointments arising from the struggle to be emancipated from poor health, whilst safeguarding against swinging back to feelings of oppression and hopelessness.

These three themes of on-going colonial oppression, building resilience and emancipation will now be further explored.

Ongoing colonial oppression

The outcomes of this research have indicated that, for indigenous peoples with disabilities, oppression is more than a denial of access, with findings reflecting that oppression ‘is about being powerless and viewed as essentially worthless in an alien society’ (Fulcher, 1996: 12), leading to ill health, which metaphorically was the operationalization of social and political oppression. The multiple layers of this theme are now presented.

Rights in the context of poverty

Poverty is a constant through the narratives of users of health care across the three countries. Poverty was seen to resonate with experiences of social and health deprivation regardless of

whether the country concerned had a high or low Gross National Income (GNI). Although Australia and New Zealand have a considerably higher GNI than Mexico, the quality of life experienced by indigenous peoples with disability in these two countries did not reflect this difference. The manifestations of poverty that were observed and narrated by Aboriginal and Torres Strait Islander people were significantly more severe than those reported by Purepecha Mexicans and Māori. Lack of economic resources determined the ways in which indigenous peoples live; for example, the sharing of unsafe accommodation without a proper infrastructure, which increases the risk of communicable diseases. Health workers in Australia stated that:

Four or five families were living in the one house...they have to understand that they want to live in that house with 15 people (HW.A.FG1).

In general, across the three countries, indigenous peoples were not able to afford specialised health care or medication, which often resulted in the development of secondary disability or a rapid deterioration in health.

More indirectly, narratives indicated the impact that poverty had on health and related this to the effects of colonialism, lack of education, and the denial of human rights. In effect, being treated as less than human, and impacting on a sense of well-being:

Aboriginal peoples, we only got our rights as Aboriginal peoples in 1967. And the policy has been, we'll try and breed Aboriginal peoples out; that was forced...they work for wages, [Aboriginal] people work for rations, which was a scoop of tea, a scoop of sugar, white bread (SPM.A.I F1)

The narratives from each of the three case studies also highlight how poverty and social deprivation will not be reversed unless indigenous self-determination is honoured and fully implemented as mandated by the Treaty of Waitangi and the Mexican Constitution. The following quote synthesised the discourse of senior policy makers and health workers who all defended the view that health cannot be thought of distinctly from having a dignified well-remunerated job:

There is also no future or space for democracy if there is not promotion of the economic development of every member of the society (SPM.MX.I M2)

Lack of effective universal health coverage for indigenous people with disabilities

Indigenous users indicated that limited health coverage imposed a significant barrier to them of getting involved with health care. Policy makers across the three countries stated that there was a need for comprehensive and universal health coverage. In Australia, health workers

claimed that the universal health coverage scheme (Medicare) was inadequate for covering specialised health services and resources for persons with disabilities:

People are still out of pocket ... for example, they get the patient assistance travel scheme, (which) has huge problems in our part of the country. People travel and (all) they get (is) \$35 accommodation (SPM.A.IF2)

Similarly, in New Zealand and Mexico, limited health-related coverage was perpetuating financial hardship. For example, in Mexico, indigenous peoples with disabilities were reported to spend more than 30% of their household income on health related issues. Even in Australia and New Zealand, where universal access to comprehensive range of services was available, treatment and medical services covered for those with disabilities, did not always cover specialised services. Indigenous peoples with disabilities participating in the study faced the challenge of the gap between what the insurance paid out and the costs they actually needed to cover, which often stopped them from enjoying services or treatments. Participants considered that overheads were:

...too expensive. Nothing is free. This government wants to privatise health. They're out there but you've got to be prepared to pay for it and I don't have the money'. (IPWD.NZ.IF1).

Discrimination and health of indigenous people with disabilities

Race-based attitudes were perceived to be a barrier to health as they affect quality of life, social mobility and social inclusion. Discrimination affected the mental health of indigenous people with disabilities and their feelings of self-worth. Feeling discriminated against was often linked to anxiety and uncertainty about health entitlements. This feeling was reinforced with race-based attitudes that hindered participant users of health care from gaining access to health services, as well as to a lack of acceptance within their local and wider communities. The race-based attitudes described across the three countries involved indigenous people being seen as different, as reluctant to both learn and/or change their practices, as well as being seen as stubborn and over-demanding of services. In Mexico, users of health care expressed concerns about negative social attitudes towards Purepecha people, reporting a sense of 'othering', which often judged their cultural protocols as 'ignorant'. This was corroborated by the narratives of other participating groups across the Mexican case study. Some manifestations of race-based attitudes also emerged in Australia: here there was a very strong sense of worthlessness and a loss of hope on behalf of indigenous peoples with disabilities. Senior policy makers stated that race-based attitudes could be traced back to the effects of colonisation, which had led to:

...a white Australia policy... that added to the difficulties of indigenous Australians (SPM.A.I.M1).

All participating groups across all three countries claimed that discrimination was a barrier to improving the quality of life and health of indigenous people with disabilities. Even where success had occurred, as in the case of Māori indigenous participants gaining employment, their sense of wellbeing was disturbed by their having to take jobs that undermined their qualifications. Māori argued that they were hindered from finding a well-paid job by discrimination; additionally, they stated that claiming social benefits was more complex for Māori than for non- Māori.

The findings of this study that have illustrated systemic, historical and political barriers to health care faced by indigenous peoples with disabilities in Australia, Mexico and New Zealand, would suggest that it could be linked back to the social class formation arising from colonial regimes (Good, 1976; Horvath, 1972; Marx, 1853; Moyn, 2010).

To live up to the standards outlined on Article 25 of the CRPD, member states need to demonstrate political will to honouring indigenous self-determination. The following elements of the pathway to emancipation will be now explored.

Building resilience

The second theme refers to the embracing of a dialogue that builds resilience by creating a discussion on indigenous cultural understanding of health and disabilities, acknowledging land bonds, the respect of indigenous leadership, and the recognition of culturally responsive health. It also outlines areas where challenges to effective communication were identified. This theme incorporates what indigenous people with disabilities across the three case studies called inner-strength, or the inherent capacity to overcome historical challenges and those faced today. This capacity to cope will be discussed as the driving force behind recovery from colonisation.

Need to open up to the discourse about health and disability from an indigenous perspective

The findings reported a significant mismatch between the perceptions of health and disability of indigenous peoples with disabilities and health personnel. The users of health care tended to relate their perceptions of health to their feelings and their environment, including being at home surrounded by their family and sharing food; this was a part of their culture, as opposed to consumption of fast, processed foods. They did acknowledge diagnoses, such as diabetes, gastritis and hearing diseases. However, health workers often struggled to engage effectively

with indigenous people with disabilities, particularly culturally, as they did not speak the same language. Opening up to discussing differences was seen as a way of overcoming harm and the social distance imposed by past inadequate health practices. Co-developing interventions utilizing indigenous terms, ancestral knowledge and making references to the immediate environment helped to overcome this communication barrier promoting respect and effective engagement. This was expressed very positively by a senior bureaucrat in Mexico when describing the reaction from indigenous communities to the re-interpretation of dietary guidelines to accommodate indigenous traditional food and languages. She stated:

When we arrived with the new guidelines and training material they often say ‘Oh, they know our things!’...so they were open to communicate with us (SPM.MX. I F3)

Disability was seen by indigenous users of health care as an imposed concept and often referred to as ‘western’ or ‘doctor’s language’, suggesting an urgent need to create a dialogue between all stakeholders of indigenous health care and service users. Across the three case studies, the majority of indigenous people with disabilities did not identify as people with disabilities. Their narrative associated with health care, was as they saw it, for all indigenous people as opposed to seeing it as different for indigenous people with disabilities. As a result, their contribution to the findings did not distinguish one group from the other in keeping with their own rejection of the term disabled. Although there was a reluctance to be associated with the concept of disability, however, they did acknowledge their impairments (Rivas Velarde, 2015). This distancing was often made by drawing comparisons with indigenous people’s views on disability, which were described as less implosive and more welcoming to diversity:

In my community I’m not disabled. They see me as [profession] that’s how I work with my clients the best. But they [non-indigenous people] have got to start acknowledging indigenous ideology and the framework around that with disability (IPWD.NZ. I F1).

Users of health care recalled indigenous values as a way of coping and battling against what they perceived as the oppressive labels of ‘sick’ or ‘disabled’. Their discourses addressed the impact that western medical culture has had on indigenous people, but it also pointed out that indigenous people who were seen as disabled by others had found values in their past that have enabled them to gain the strength to reject such labels and embrace their acceptance by their communities.

Bonds to ancestral lands

Data from the three countries suggested that a connection to ancestral land, self-identification

and culture all have a very positive effect on the health of indigenous people with disabilities. In relation to land, indigenous users of health care, related inhabiting their land and owning the land provided a positive political discourse also with feelings of relief and protection:

This is my house; my family is here; I am better here! (IPWD.MX. IF3)

Being and identifying as an indigenous person was seen from different standpoints within each of the respective case studies; common understandings included self-determination, land ownership, culture, resilience and pride in heritage. For some, the link between indigenous identity and a positive attitude was very strong, such as in this case of this indigenous man in Australia:

What does it mean to be Aboriginal?' Response: 'Oh black power' (IPWD. A. I M6)

However, some indigenous health user participants also associated 'indigenous' with negative adjectives such as 'poor', 'uneducated' and 'stubborn', which had arisen from a long history of social segregation and stereotypes created by social positions within an oppressed cultural group. Within all three countries, being proud of being indigenous as an identity has evolved over time, supported by the creation of social and political movements such as the Zapatista movement in Mexico, Māori Renaissance in New Zealand, and the 1967 Referendum in Australia. Such groups and events have given indigenous people voice, and created opportunities for dialogue and emancipation. These political, ideological and social movements were seen as a response to indigenous peoples' status as an underclass due to colonial practices. Such movements saw people claiming their heritages and making statements indicating pride such as:

I am Purepecha, indigenous Purepecha, a race of indigenous people, with long-standing tradition (IPWD.MX.IM5).

Indigenous peoples' leadership

Leadership and involvement in advocacy were strongly linked with gaining an awareness of disability rights, including rights to health. Indigenous peoples' leadership was also linked with positive health policy responses. For example, in Australia, indigenous leaders such as Professor Mick Dodson were perceived as giving indigenous people hope, bringing back empowerment and embracing the resilience needed to recover from colonisation. Professor Dodson was credited with 'getting our constitution to recognise indigenous peoples' (SPM.A.IF2).

Leadership at a community level was also very important, as those health care users within

the study who were involved in local advocacy groups, were more likely to have a connection with health services and were more aware of their health and disability entitlements. Those involved in advocacy groups tended to be more active in the community and generally were employed either formally or informally, regardless of their level of disability, their level of education or geographical location.

Indigenous senior policy makers believed that there was a lack of advocacy and local engagement arising from a history of having programmes and policies imposed. They believed that community leadership must emerge from within the community if it is to be sustainable and legitimate. They also believed that small communities may be affected by complex and delicate politics that would be difficult for outsiders to interpret.

Leadership was linked with being listened to, and was stressed as being important to indigenous users of health care. They were often deprived of the opportunity to give an opinion, as summed up in comments such as:

I am Purepecha, that must be recognised, and people should trust us (Purepecha). It should be the same everywhere in the doctors as well (IPWD.MX.I M1).

Indigenous users of health care often made claims that they had never been asked about their beliefs or perceptions of their disability and health needs. They found being able to speak about such things as both liberating and empowering.

Culturally responsive health care

Participants from groups across the three countries including users agreed that the fulfilment of Article 25 and any other mandates from the CRPD had not yet occurred with respect to indigenous people with disabilities. Their right to the highest attainable standards of health without discrimination and the underlying determinants of good health have continued to be infringed upon, with current structures failing to alleviate the high rates of ill health across indigenous people with disabilities.

Senior policy makers stated that health systems in general are reluctant to fully incorporate indigenous approaches to health within their mainstream provision. New Zealand and Mexico have integrated some traditional medicine into their health systems, but the availability remains limited. Whilst New Zealand provides the Rongoā Māori (traditional medicine), its availability was perceived as being highly restricted. The Mexican government has produced a series of training publications for all clinical personnel for the dissemination of traditional medicine which is respected across the medical profession, and historically their presence has been very important within indigenous communities across the world (Durie, 1985; Fanon,

1978; Wilson and Richmond, 2009). For some indigenous people in Mexico, traditional healing was the only option available. This was delivered within communities, accessible, at no cost and the traditional healer tended to be well known within the community.

Health workers in Mexico reflected on their training in traditional medicine and stated that having traditional healers trained in western medicine has been a great success. They claimed that this practice had resulted in the creation of reliable communication networks with indigenous communities, which allowed them to build upon the knowledge that traditional practitioners have about their own communities:

We now have communication with midwives, the process started not long ago, so the traditional midwife will come and receive training with the doctor, they receive information ... and now they come regularly to the medical services (HW.MX.I M1).

On the other hand, in the Australian case study, there was a weak discourse about traditional healing across users of health care, although it was more robust across senior policy makers. It is important to clarify that this discourse may differ significantly throughout the Australian states and territories, as the use of traditional medicine appears to be more prevalent in central and Northern Australia (O'Connell et al., 1983; Saethre, 2007).

Although traditional views on health and traditional healing were generally very positively perceived, some participants had concerns about the risks of practices within traditional healing. Health workers stated that this fear has been overcome by showing the positive results derived from engaging with traditional practitioners. In general, health services did not appear to be communicating effectively with indigenous people with disabilities, and hence health workers believed that they were often judged to be not doing their jobs properly. They urged their health system to develop a better understanding of the issues within indigenous communities by creating more culturally responsive protocols and providing health care workers with adequate cultural training. Such support is summed up in the following quotation:

You shouldn't force white medicine on them or whatever without understanding that, you know their culture (HW.A.FG1).

The cross-case findings indicated that a much stronger partnership between health services and indigenous people was needed, if the CRPD mandate to the right to health was to be fulfilled.

Emancipation

The CRPD was perceived as an emancipatory instrument that could facilitate advocacy for indigenous health and combat social and political invisibility. The CRPD through its reporting mechanism was perceived to have a political and legitimate mandate to address the alarming rates of ill health and exclusion among indigenous people with disabilities. Reporting mechanisms were perceived as strong tools for advocacy. The CRPD is laying the ground for moving towards equity on health and social justice. Senior policy makers in Australia believed that:

[indigenous people with disability] have got greater potential now to get results from the CRPD than say five years ago (SPM.A.IF1).

Visibility in human rights mechanisms

Senior policy makers from New Zealand and Mexico claimed that although their countries recognised indigenous peoples' sovereignty, they were sorely aware that indigenous rights remained a highly controversial issue within the United Nations. Reasons for this, include overburdening within the UN reporting systems and unresolved conflicts within occupied territories such as Palestine (OHCHR, 2013). The UN delegates reported that although significant changes have been brought about with international treaties, such as the Declaration of the Rights of Indigenous Peoples, its adoption and effects of such documents remains limited. However, they did not place all the responsibility on the UN system. They referred to the responsibilities that domestic governments have, not only as signatories of international treaties but under their own domestic laws. They hence urged for the full implementation of such laws as a priority as stated by this Mexican participant:

We have changed our constitution that must be the primary force to end with inequities (SPM.MX.IM2).

Senior policy makers reported that governments and domestic advocacy groups must be strengthened to maximise the opportunities provided by instruments including the CRPD, which is particularly relevant to addressing the right to health, culture, non-discrimination and social and economic development faced by people with disabilities.

Discussion

Article 25 mandates the principles of non-discrimination regarding access to health on the

basis of disability. However, the everyday lives of the indigenous peoples interviewed, reflected discrimination and inequity across all public health institutions. Discussions about on-going colonisation and oppression have started in the voice of indigenous scholars from various part of the world and need to be strengthened worldwide (Gilroy and Donnelly, 2016; Grech and Soldatic, 2016; Rivas Velarde, 2018). It is necessary to challenge the concept of rights itself, and face the fact that their legal protection has not been universal. The findings presented in this paper link with those of Moyn (2010) and Pasqualucci (2006) who defended the idea that historically indigenous people have been left behind with respect to the protection of human rights, and they are ‘painfully aware that western humanism had not been kind to them’ (Moyn, 2010: 87). The non-discriminatory principles of the CRPD (respect for differences, equity and self-determination) cannot be achieved if the CRPD fails to address current colonisation practices, as exemplified in the case studies of all three countries. The findings of this study add to the work of Meekosha (2011) in proposing a pathway for indigenous peoples with disabilities to overcome colonialism, taking the CRPD and its principles as a framework for addressing the grassroots problems of the global south.

Overcoming oppression

To overcome oppression, there is a need to develop positive relationships with indigenous people, based upon mutual responsibility and respect. Legitimate and effective policy responses need to be based on legitimate governance, which enhances and empowers previously oppressed minorities, such as indigenous communities and their advocates. Exclusion of indigenous people with disabilities from their right to health, as described in Article 25, has been fuelled by a lack of respect of rights and the negative attitudes towards them, and will continue unless member states become sensitive and knowledgeable about indigenous peoples’ health and social issues (Harris et al., 2012; Harris et al., 2006; Yoshioka, 2010). Ways must be found to include indigenous peoples with disabilities fully in communities, building upon their capacity and literacy about human rights, particularly about the CRPD. Equity of access to health services requires health service infrastructure to be transformed, but as important is the transformation of ways in which indigenous peoples are accepted, considered and perceived as needing to be in control of all decision-making that affects their lives.

How will emancipation work as a way forward?

Systematic change and political sustainability of such change requires a re-distribution of power, honouring indigenous sovereignty. It requires abolishing unilateral decision-making, limited participation and inefficient communication. The CRPD needs to be reconstructed with a language and discourse that makes sense of the needs and struggles of indigenous people with disabilities. As Arnardóttir and Quinn (2009:5) advocated, ‘we need a new

vocabulary to reframe the debate that has just begun’, because language is more than a channel of communication, it is a form of social action (Holtgraves, 2013). It is therefore necessary to have a re-interpretation of the CRPD for indigenous issues, posing new questions and raising new issues, whilst creating a new vocabulary that could successfully engage with every aspect of the lives of indigenous people with disabilities. If human rights are to live up to the expectations of indigenous people, it will be necessary to challenge the language of the CRPD and ask what the CRPD means to the lives and health of indigenous people. The findings of this research suggest that it does not mean much, due to a lack of development and ongoing engagement with indigenous people with disabilities and the limited or lack of representation of the social and legal constraints they have faced, such as ongoing colonisation.

The CRPD, with its related optional protocol, is a relatively new UN Convention adopted in 2006, and coming into force in May 2008. Its monitoring mechanism has faced numerous delays due to the overburdening of the UN systems (Committee Convention on the Rights of Persons with Disabilities, 2013), although delays and its current limited dissemination could be seen as part of its natural evolving developmental pathway. Nevertheless, the CRPD represents a major philosophical and legal paradigm shift (Lord and Stein, 2009; Quinn, 2010; Stein, 2007). However, its mandate relies on a state’s available economic resources and its political will to implement it. Fyson and Cromby (2013:1166) added to this argument, claiming that, ‘while international conceptions of rights such as the CRPD are undoubtedly important in setting a moral tone, the legal rights enforceable for individual citizens depend entirely upon the laws of the country in which they reside’. Whilst time could be a constraint, it is important to hold governments to account and not to allow the time factor to be a justification for avoiding compliance with their human rights obligations, which require immediate intervention. It is imperative that indigenous people with disabilities gain equal access to health care.

Conclusion

The CRPD has created a forum for the discussion of disability and specifically health in relation to Article 25. However, from this study, it appears that if indigenous people with disability are to be emancipated from their loss of rights, there is a need for a cultural framework to be embedded within the CRPD to protect culturally adequate health delivery and the native rights of indigenous peoples (Balcazar et al., 2010; Hickey, 2008; Meekosha, 2011; Rivas Velarde, 2015). The implementation of Article 25, Health of CRPD must be linked with other human rights instruments that protect indigenous rights such as the United Nations Declaration on the Rights of Indigenous Peoples, The Indigenous and Tribal Peoples Convention 169 (ILO, 1989). To come into line with these mandates, which are focused on indigenous people as opposed to indigenous people with disabilities, the CRPD needs to

address the gap associated with the health of indigenous people with disabilities by building into its Articles an indigenous pathway making rights infringements experienced by indigenous people with disabilities across the international boundaries visible as well as safeguarding them.

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