World Health Organization

Global Plan of Action on the Health of Indigenous Peoples (2027-2040)

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Guidance for reviewers: The maximum permitted wordcount is 5,000 for any WHO global plan of action to be considered by WHO Governing Bodies. To reflect as much as possible the extensive feedback received on draft 1, this second draft of the Plan is now more than that length, when not considering references and the table of contents. The next draft will need to be within the word count, so we welcome suggestions on where text could be cut and that all requested additions be accompanied by suggestions of where text could be cut. Please refer to the paragraph number and section and/or priority and action area when making comments, and please provide full references with links for supporting documents.

Background

1. In 2023, the 76th World Health Assembly (WHA) adopted Resolution 76.16[1] on the Health of Indigenous Peoples, which acknowledges that Indigenous Peoples have an equal right to the enjoyment of the highest attainable standard of physical and mental health.

2. WHA Resolution 76.16 requests WHO to develop a Global Plan of Action for the Health of Indigenous Peoples (henceforth referred to as "the draft Plan"), in consultation with Member States, Indigenous Peoples, relevant United Nations (UN) and multilateral system agencies, as well as civil society, academia and others. Details of the process undertaken are included in Annex 1.

3. WHO has undertaken these steps during 2023-2026 for development of the draft Plan: a review of existing evidence conducted with Indigenous and non-Indigenous researchers in 2024; an input session in Mexico City organized by PAHO in coordination with the Government of Mexico, with Indigenous leaders and representatives working on Indigenous health in Ministries of Health of six countries (Plurinational State of Bolivia, Brazil, Ecuador, Mexico, Peru and Bolivarian Republic of Venezuela); a side event at the UN Permanent Forum on Indigenous Issues (UNPFII) in 2025 to raise awareness of the development of the Plan; development of the first draft, with inputs from Indigenous experts and launch of a global online call for feedback in 2025; support to the 158th Executive Board[2], which agreed to defer consideration of the draft Plan to 2027 in order to allow more time for consultations; and gathering of inputs from WHO/HQ programmes, WHO Regional Offices and the Interagency Support Group on Indigenous Issues. The draft Plan is also informed by learnings from PAHO's Strategy and Plan of Action on Ethnicity and Health 2019-2025[3].

4. The draft Plan recognizes the need for health policies, programmes and initiatives to incorporate Indigenous Peoples' vision and priorities, with their free, prior and informed consent (see the section "Guiding Principles"). The draft Plan supports delivery on commitments in the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP)[4], adopted by the United Nations General Assembly through resolution A/RES/61/295, including but not limited to:

   - Article 23 on the rights of Indigenous Peoples to be actively involved in developing and determining health (and other) programmes affecting them, and
   - Article 24 on Indigenous Peoples' right to their traditional medicines, to maintain their health practices and to access, without any discrimination, to all social and health services.

5. The draft Plan is informed by a review of existing evidence[5] that highlighted key issues in Indigenous health, while showing variations across country contexts. Globally, and acknowledging data gaps, evidence suggests that Indigenous Peoples can face disproportionately high rates of maternal, newborn and child mortality; elevated prevalence of chronic and infectious diseases; and, in many contexts, significantly lower life expectancy compared to non-Indigenous populations.[6,7,8] The review highlighted that data on Indigenous health disaggregated by sex, age, disability and socio-spatial characteristics such as geography and income is limited. The review also underlined the important impacts of social and environmental determinants on Indigenous

health, alongside the intergenerational health impacts of colonization, multidimensional deprivation and structural discrimination.

6. Non-communicable diseases, including cancer, cardiovascular disease, chronic respiratory diseases and diabetes, can disproportionately affect Indigenous Peoples,[9] alongside poorer oral and eye health.[10],[11]. Access to treatment by Indigenous Peoples for these conditions can also be less[12]. Commercial tobacco use, often initiated during adolescence, is a leading cause of disease and premature mortality among some Indigenous communities.[13],[14],[15] Mental health among Indigenous Peoples is a growing concern, with common issues including depression, suicide and substance use, particularly among Indigenous youth.[16]

7. Existing evidence suggests that communicable diseases, such as HIV infection and AIDS[17], tuberculosis[18], Hepatitis C[19], and malaria[20] can disproportionately affect Indigenous Peoples.

8. Some Indigenous populations, such as Indigenous migrants, refugees, those living in conflict-affected areas, and Indigenous persons with disabilities often fare worse. While there is a lack of disaggregated global data, it is estimated that Indigenous persons are disproportionately impacted by disabilities.[21]

9. Indigenous Peoples disproportionately experience a range of health risks linked to environmental degradation, including biodiversity loss, climate change, and pollution, which can disrupt traditional food systems, reduce access to medicinal plants and undermine cultural relationships with land and ecosystems.[22],[23] They are also more likely to not have access to safely managed drinking water and sanitation[24], [25].

Scope

10. The draft Plan refers to "Indigenous Peoples" in line with UNDRIP. The Plan acknowledges the diversity within regions and countries, and that differences in historical contexts, cultures and other factors mean that there is no single, authoritative definition for all Indigenous Peoples.

11. The draft Plan aims to reflect the country and subnational contexts in which Indigenous Peoples live, whereby in some contexts they represent a smaller percentage of the total population and in some contexts they represent the majority. The draft Plan also recognizes the diversity of Indigenous knowledge systems, cultural practices and relationships with ecosystems, land, water, and territory that shape Indigenous Peoples' health and wellbeing.

12. The draft Plan acknowledges the heterogeneity *within* specific groups of Indigenous Peoples, including differences by age, sex, residence (e.g., rural/urban), income, education level, livelihood and employment, situations of voluntary isolation or initial contact, language, disability, migrant and refugee status, IDP status, sexual orientation and gender identity, lack of legal identity, and other factors including discrimination on different grounds[26]. It also pays specific heed to the intersectionality of these factors, and it considers gender equality as being critical for the Indigenous Peoples' health and wellbeing.

13. The draft Plan acknowledges Indigenous Peoples living in humanitarian contexts and/or experiencing health emergencies (either of natural or human origin).

14. The priorities of the draft Plan are transversal in nature, in that they are relevant to any health topic (e.g., diabetes, hypertension, mental health, maternal and child health, malaria, Tuberculosis, among others). The priorities aim to contribute to stronger health systems that advance equity, human rights and gender equality in relation to health, and whole-of-government approaches to public health.

15. The draft Plan spans the 2027-2040 period. Hence, the priorities aim to be relevant to health in the Sustainable Development Goals (SDGs) and the future post-SDG agenda. In addition, the priorities synergize with priorities in WHO's current (14th) General Programme of Work (GPW), while also incorporating flexibility to align with future GPWs through 2040.

16. The Plan's five Priorities and 18 Action Areas are directed predominantly towards Member States as the main duty bearers, alongside other actors including academia and research institutes, civil society, the private sector, professional associations, and entities in the multilateral system, amongst others. Advancing on any of the Action Areas must entail coordination with Indigenous Peoples, with their Free, Prior and Informed Consent. Member States are encouraged to consider dedicated budget lines and human resources to support implementation of this Plan in their national contexts.

Guiding principles

16. ***Free, Prior and Informed Consent*** is a human rights principle recognized in UNDRIP. WHA Resolution 76.16 urges Member States and other relevant actors to take actions for the health of Indigenous Peoples in consultation with Indigenous Peoples, with their free, prior and informed consent. Every action proposed in this draft Plan should be considered with this principle in mind.

17. ***A Human Rights-Based Approach*** (HRBA) means that health policies and programmes are designed and implemented in line with a country's human rights obligations and commitments under international human rights mechanisms (including UNDRIP). More specifically, for Indigenous Peoples' rights, the approach focuses on the recognition, respect, and fulfilment of the individual and collective rights of Indigenous Peoples, as distinct rights holders, and identifying and addressing the specific inequalities and inequities faced by Indigenous Peoples.

18. ***The right to self-determination.*** The Charter of the United Nations, the International Covenant on Economic, Social and Cultural Rights and the International Covenant on Civil and Political Rights, as well as the Vienna Declaration and Programme of Action, affirm the fundamental importance of the right to self-determination of all peoples. UNDRIP Article 3 emphasizes Indigenous Peoples right to self-determination, and UNDRIP Article 23 highlights their right to be actively involved in *developing and determining* health, housing and other economic and social programmes affecting them and, as far as possible, to administer such programmes through their own institutions. ***Indigenous data sovereignty,*** focused on the ownership, control, access, and possession by Indigenous Peoples of data on their own health, is linked to the right to self-determination.

19. ***Culturally safe, holistic and strengths-based approaches*** recognize the importance of Indigenous leadership in aligning health initiatives with the worldviews of Indigenous Peoples. As elaborated in work on Indigenous determinants of health, this means acknowledging Indigenous perceptions

of physical and mental health as inextricably linked and shaped by the interactions between the body, mind, emotions, spirit, land and the environment that sustain Indigenous Peoples' health, livelihoods and cultural continuity, and their rights as defined in UNDRIP[27],[28]. These approaches also entail focusing on the strengths of Indigenous Peoples, and restoring, maintaining and promoting Indigenous cultures, languages, practices, and knowledge systems that enhance health and well-being. The emphasis on language is in line with the Global Action Plan for the UN International Decade of Indigenous Languages, including its output 4 calling for *appropriate Indigenous language frameworks designed to offer better health provision, recognizing traditional systems of medicine, as well as promoting social cohesion and delivering humanitarian responses, especially during health crises, times of conflicts and natural disaster[29]*. A holistic approach to health is linked with a lifecourse and transgenerational approach, including incorporation of a specific focus on child, adolescent, and youth, as well as older person, mental health and psychosocial wellbeing.

20. ***Applying approaches that advance health equity, gender equality and disability inclusivity*** means that health policies and programmes:
    - aim to reduce gaps in health service coverage and financial protection, and address intersecting social (including commercial) and environmental determinants of health;
    - address harmful gender norms that are the root causes and consequences of unequal power relations and that affect the health of Indigenous Peoples in different ways; and
    - promote the meaningful participation of people with disabilities, promote their rights and consider disability-related perspectives.

21. ***A Primary Health Care (PHC) approach*** aims to strengthen health systems and to bring comprehensive and integrated health services closer to communities. It encompasses multisectoral action to address the determinants of health; to empower individuals, families and communities; and to meet people's essential health needs throughout their lives. For Indigenous Peoples, this includes traditional medicines and practices, and intercultural approaches that recognize the coexistence of Indigenous and biomedical health practices.

22. ***A life course approach*** aims to promote and protect people's health at all ages by addressing needs, providing effective coverage with health services and financial protection, and safeguarding the right to health throughout their lifetime. This approach considers individuals and generations over time, and how life trajectories are shaped by social, cultural, environmental intermediate and structural factors. For Indigenous Peoples, central to this approach is intergenerational connection, cultural continuity, knowledge transmission, and collective well-being.

23. ***A One Health approach***, acknowledging the inter-relatedness between people and with the environment, is an integrated, unifying approach that aims to sustainably balance and optimize the health of people, animals and ecosystem. The draft Plan recognizes inter-relatedness with land and the natural elements as key determinants of Indigenous health. These relationships resonate with the One Health approach, while reflecting Indigenous holistic understandings of the interconnected wellbeing of people, land, animals, plants and ecosystems.

Operational framework: Global Plan of Action on the Health of Indigenous Peoples (2027-2024)

Goal	To promote, provide and protect the health and well-being of Indigenous Peoples

Principals and approaches	• Free, Prior and Informed Consent • Human Rights Based Approach • Right to Self-Determination • Culturally safe, holistic and strengths-based approaches	• Applying equity-oriented, gender equality and disability-inclusive approaches • Primary Health Care approach • Life course approach • One Health approach

Priority areas / Action areas

Priority 1: Indigenous Peoples' leadership and engagement	Priority 2: Health service coverage and financial protection for Indigenous Peoples	Priority 3: Intercultural, strengths-based and holistic approaches including traditional medicines	Priority 4: Environmental and social determinants of Indigenous Peoples' health, & gender inequalities	Priority 5: Evidence generation, Indigenous data sovereignty, and joint accountability
1.1: Leadership and engagement in health policies and programmes 1.2: Indigenous health and care workforce 1.3: Indigenous Peoples role in the global health architecture	2.1: Equitable coverage with quality health services 2.2: Health-related financial protection 2.3: Indigenous Peoples' health needs in emergencies	3.1: Intercultural services including models of integrated health services 3.2: Intellectual property rights to traditional medicines 3.3: Capacity-building for intercultural, non-discriminatory and holistic service delivery	4.1: Environmental determinants 4.2: Indigenous Peoples' food systems and health 4.3: Social determinants including commercial determinants 4.4: Indigenous women and girls 4.5: Indigenous Peoples in "Isolation and Initial Contact"	5.1: Leadership and co-development of health research 5.2: Indigenous Peoples data sovereignty 5.3: Monitoring health inequalities 5.4: Platforms for joint accountability

WHO Contribution

Country support. Tailored support to Member States, upon request, to deliver on the priorities and action areas in the Global Plan of Action

Leadership and coordination. Strengthened collaboration with Indigenous Peoples and cross-cutting coordination and engagement with relevant UN and multilateral system agencies, human rights mechanisms, civil society, academia and other stakeholders to promote Indigenous Peoples' health

Governance and accountability. Secretariat support reporting to the World Health Assembly on implementation progress, and establishment of an internal WHO cross-cutting coordination mechanism.

Development of normative products and capacity-building. Mainstreaming a focus on the health of Indigenous Peoples scaled up across all WHO programmes and levels, and co-development with Indigenous Peoples, as appropriate, guidance, tools, and training materials

Assumptions and enablers

• Strong coordination and collaboration with Indigenous Peoples, in line with the principle of Free, Prior and Informed Consent
• Sustained political commitment by Member States, and of other actors with important roles in the plan
• Sufficient financing
• An optimized WHO secretariat, at all levels
• Strong UN and multilateral system coordination, at all levels

Priority 1: Indigenous Peoples' leadership and engagement in developing, determining, administering, and implementing health policies and programmes

Action domain 1.1: *Member States and other actors promote Indigenous Peoples' leadership and engagement in developing, determining, administering, implementing and monitoring and evaluating health policies, programmes, and initiatives affecting them*

24. As appropriate in their national contexts, Member States are urged to strengthen Indigenous Peoples' leadership and engagement in developing, determining, administering, implementing, monitoring and evaluating health policies and programmes affecting them (for more on monitoring and evaluation, see Priority 5). This entails supporting administration of health programmes through their own institutions, as far as possible, and sustainable funding for Indigenous-operated health services to be able to effectively deliver self-determined, culturally safe services and advance intersectoral work for a health-in-all-policies approach. The domain supports the principle of Free, Prior, and Informed Consent and supports intercultural dialogue, including at community level, for health programming. It involves creating, maintaining or reinforcing participation mechanisms that are culturally and linguistically appropriate, reflective of gender parity, socio-spatially inclusive (e.g., overcoming gender-, disability-, geographic-, timing-, and income-related barriers), livelihood appropriate (e.g., responsive to seasonal farming or pastoralist realities) and intergenerationally accessible. Adequate, predictable, and ring-fenced resources for Indigenous Peoples' participation and respect for Indigenous People's own procedures for electing representatives are critical components of this domain.

Action domain 1.2: *Member States and other actors (including academic institutions and professional associations) create policies, programmes, and initiatives to empower, reinforce and expand the Indigenous health and care workforce*

25. Central to all other Action domains, this domain recognizes the role of Indigenous Peoples as health and care workers, defined as occupations[30] with the primary intent of enhancing health. This encompasses all health occupations, including traditional medicine practitioners. Health and care workers who are Indigenous Peoples are key to help meet the health needs of their communities through people-centred and culturally safe health services. Indigenous health workers bring not only technical expertise, but also linguistic skills, cultural knowledge, and trusted relationships within their communities. This advances disease prevention, health promotion, case detection, and continuity of care, while improving the health system's responsiveness to determinants of health. Indigenous Peoples who are health researchers, public health experts, and One Health experts, alongside Indigenous Peoples who are experts in Indigenous knowledge systems related to health, land stewardship, biodiversity and environmental governance, constitute important parts of this workforce.

26. Targeted policies and interventions, co-developed with Indigenous Peoples, and sustainable resourcing can reinforce the Indigenous health workforce. Consistent with the *WHO guideline on health workforce development, attraction, recruitment and retention in rural and remote areas[31]* (2021), and as appropriate in their national contexts, Member States should consider adopting

culturally appropriate bundled, context-specific strategies to develop, attract, recruit and retain Indigenous health workers, including those from rural communities (as almost 3 out of every 4 Indigenous Peoples globally live in rural areas[32]) and underserved communities. Reinforcing the Indigenous health workforce includes expanding education pathways for Indigenous students, with due attention to cultural safety training for academics, clinicians and other students and connecting students to their professional bodies[33]. These policies are more effective when bundled together with appropriate regulatory measures, financial and non-financial incentives, and strong personal and professional support systems. Consistent with the aforementioned WHO guideline, Indigenous communities should be meaningfully involved in the planning, implementation, and evaluation of these interventions. Policy focus is needed to recognize and support the essential contributions of Indigenous health and care workers working in the informal economy or providing unpaid care, as such work tends to be undervalued despite its critical importance to health outcomes. Attention is also required for Indigenous women's roles as traditional medicine practitioners and gender equality in workforce policies.

Action domain 1.3*: Actors in the multilateral system scale-up measures to strengthen Indigenous Peoples' role in the global health architecture*

27. This domain supports the leadership and engagement of Indigenous Peoples in the global health architecture, defined as the *system of principles, agreements and actors of global health[34]*. This involves strengthening (through intentional and sustained mechanisms and funding) Indigenous Peoples engagement with other global health actors including the UN system, multilateral organizations, bilateral donors, global public-private partnerships, philanthropic organizations, professional associations, and civil society organizations, amongst others[35], in the SDG and post-SDG eras.

Priority 2: Health service coverage and financial protection for Indigenous Peoples, including in health emergencies

Action domain 2.1: *Member States ensure Indigenous Peoples' equitable coverage with comprehensive quality health services across the continuum of care*

28. Member States are urged to advance the realization of the right to health of Indigenous Peoples by ensuring their health needs are met in reforms towards UHC (in relation to service coverage and financial protection), with due attention to both the provision and experience of care. To be backed by relevant legal and policy frameworks, this domain addresses barriers to comprehensive, non-discriminatory, and linguistically and culturally safe health services, whether these be promotive, preventive, curative, rehabilitative and palliative services. It also accounts for the specific needs of children, adolescent, youth, and older persons. The domain comprises efforts for enhancing the availability, accessibility (including geographic, administrative, informational and financial accessibility), acceptability and quality of health services by Indigenous Peoples. Linked with priorities 1 and 3, the domain entails intercultural service delivery models and practices, that reflect cultural, linguistic, socio-economic, livelihood and geographic realities experienced by Indigenous Peoples, with due attention to the intersections of age, sex and disability with other factors, and prevention of discrimination by health providers.

29. Extending beyond health services provided in health facilities, the domain extends to include services provided in the community and settings such as schools, homes, workplaces, prisons, amongst others. Acknowledging that many Indigenous Peoples globally live in rural areas, it entails specific efforts to strengthen service provider networks in these areas, including through addressing health workforce gaps (see action domain 1.2), strengthening multidisciplinary primary care teams and outreach work, and enhanced use of culturally and linguistically appropriate telemedicine and digital health technologies. It also pays particular attention to service delivery design for meeting the health needs of Indigenous women and urban and migrant, internally displaced and refugee Indigenous Peoples.

Action domain 2.2: *Member States guarantee health-related financial protection for Indigenous Peoples*

27. Acknowledging the role of out-of-pocket health care expenditure in contributing to financial hardship and/or unmet health care need amongst Indigenous Peoples, this domain focuses on ensuring adequate coverage with financial protection arrangements. Indigenous Peoples can disproportionately experience poverty and a range of barriers (e.g., administrative, residency-related, linguistic and other) to financial protection for health care services and products. This domain entails strengthening financial protection in health to limit out-of-pocket health payments to cover the cost of care.

Action domain 2.3: *Member States, the multilateral system and other actors meet the needs of Indigenous Peoples' impacted by health emergencies, including in humanitarian and natural disaster contexts*

28. This domain underlines the importance of co-designing, co-leading, and co-implementing health emergency preparedness, mitigation and response strategies with Indigenous Peoples, optimizing their potential impact in Indigenous communities. It also highlights the need for specific and targeted attention to Indigenous Peoples in humanitarian and natural disaster contexts, as they may experience disproportionate impacts (due to higher levels of socioeconomic vulnerability and/or livelihoods particularly susceptible to climate-change-related hazards), and barriers to accessing health-related services, food aid and other protections. Attention to Indigenous Peoples' health across the lifecourse, and for conditions including mental health[36], is relevant in health emergencies.

Priority 3: Intercultural, strengths-based and holistic approaches that ensure the right to traditional medicines and maintaining health practices

Action domain 3.1: *Member States and other actors support intercultural services including models of integrated health services[37], acknowledging Indigenous Peoples' right to maintain, control, protect and develop their traditional medicines and practices*

29. This domain aims to support and strengthen safe and effective Indigenous Peoples' traditional medicines and practices according to the WHO Traditional Medicine Strategy[38]. Traditional medicine refers to codified or non-codified systems for healthcare and well-being, comprising practices, skills, knowledge and philosophies originating in different historical and cultural contexts, which are distinct from and pre-date biomedicine, evolving with science for current use

from an experience-based origin. Traditional medicine emphasizes nature-based remedies (including herbal medicines) and holistic, personalized approaches to restore balance of mind, body and environment. This domain entails policies, strategies, legal frameworks, protocols, quality assurance models, and funding streams recognizing Indigenous traditional medicine and enabling its integration into national and subnational health systems.

30. The domain promotes respect for and compliance with both national health systems and Indigenous Peoples' protocols at primary care and other levels, while enabling intercultural health models that value Indigenous traditional medicine and strengthen responsiveness to Indigenous People's holistic health needs. This domain acknowledges the rights of Indigenous Peoples to maintain, control, protect and develop their traditional medicines and practices, across the continuum of care, and for a range of health issues (e.g., maternal health and mental health services), and co-develop models of integrated health services -- using a combination of biomedical and Indigenous traditional medical knowledge, skills and practices -- with national health systems as they deem appropriate. This includes involving Indigenous Peoples as equal partners in developing effectiveness and safety protocols for traditional medicine, ensuring that validation studies respect and incorporate their knowledge and worldviews. Such approaches align existing WHO work on quality of care[39], and person-centred care, characterized by respect, dignity, effective communication, informed choice and emotional support, which is closely linked to continuity of care and trusted care relationships.

Action domain 3.2: *Member States and all relevant actors respect and protect the intellectual property rights of Indigenous Peoples to their traditional medicines and practices*

31. This domain entails actions, in line with international instruments[40], to protect the intellectual property rights of Indigenous Peoples over their traditional medicines and practices, safeguarding their knowledge against misuse, misappropriation or exploitation. Integrated health services require respectful collaboration among practitioners and knowledge holders in recognition of all rights and privileges granted in UNDRIP and all other related international instruments, including the Indigenous and Tribal Peoples Convention (No. 169 of 1989), the Convention on Biological Diversity (1992) and the Treaty on Intellectual Property, Genetic Resources and Associated Traditional Knowledge (2024)[41]. This domain applies to the Indigenous Peoples' herbal medicines, including herbs, herbal materials, psychoactive plants, herbal preparations and finished herbal products, that contain as active ingredients parts of plants, other plant materials, or combinations thereof, as well as other traditional medical knowledge, skills and practices. This domain also involves promoting the appropriate and equitable sharing of benefits derived from the use of Indigenous traditional medicine, in line with existing international instruments as well as relevant country and local level treaties.

Action domain 3.3: *Member States and other actors including academia and civil society co-create with Indigenous Peoples capacity-building initiatives for intercultural, non-discriminatory and holistic health service delivery*

32. Building on Action domain 1.2 on the Indigenous workforce, this domain supports co-development and implementation of competency-based education and in-service training curricula for the health workforce, in partnership with Indigenous Peoples, to enable culturally safe, respectful, and rights-based practice, that advances gender equality across the lifecourse. This includes building understanding to address discrimination and strengthen the capacity of all

health workers to work collaboratively with Indigenous Peoples as partners in managing their own health and as members of multidisciplinary health teams. It also can involve – with Indigenous Peoples' Free, Prior, and Informed Consent and their co-leadership, co-design and co-delivery– integration in medical education of Indigenous methodologies, ethics, culture, and values, emphasizing cultural awareness, and respect of Indigenous Peoples traditional medicine knowledge systems and practices.

Priority 4: Interlinked environmental and social determinants of Indigenous Peoples' health, and gender inequalities

Action domain 4.1: *Member States and other actors address the impacts of climate change, biodiversity loss, and environmental degradation on Indigenous Peoples' health, and support Indigenous-led ecosystem stewardship and nature-based approaches that safeguard health*

33. This domain urges Member States and other actors to ensure Indigenous Peoples' full engagement in the co-design, co-production, implementation, monitoring and evaluation of the health-related dimensions of climate change mitigation, adaptation and response strategies; biodiversity- and land-conservation and management strategies; and environmental impact and risk assessments. This domain calls for increased action on the health impacts of climate change, biodiversity loss, pollution and environmental degradation on the health of Indigenous Peoples. These environmental changes can disrupt traditional food systems, lessen agrobiodiversity[42], reduce access to medicinal plants and other components of traditional medicine systems, and undermine cultural and spiritual relationships with land and ecosystems that are foundational to Indigenous Peoples' health and wellbeing. Actions in this domain should be guided by principles of respectful knowledge exchange with Indigenous Peoples, including those reflected in WHO's emerging framework on biodiversity, health and traditional knowledge systems.

34. This domain also calls for Member States to support Indigenous Peoples' engagement and leadership in policy and planning platforms on environmental determinants. It aims to ensure that their perspectives inform decisions on preventive approaches (as environmental stewardship, biodiversity conservation and climate mitigation function as primary prevention measures for many health risks), highlighting the health and wellbeing benefits of Indigenous governance, stewardship and knowledge systems.

35. The domain requires adequate resourcing and supporting of Indigenous Peoples' roles in conducting holistic health, environmental, and climate-related monitoring and knowledge generation in their territories (linked to Priority 5). It also requires culturally appropriate emergency response measures when climate hazards strike, and the role of Indigenous Peoples in their design, determination and administration. These measures should be inclusive and equitable, acknowledging the heterogeneity within Indigenous Peoples (see paragraphs 12 and 13) and differing contextual factors.

Action domain 4.2: *Member States and other actors support the role of Indigenous Peoples' food systems in enhancing health and wellbeing*

36. This domain comprises support to and leadership by Indigenous Peoples for healthy, safe and sustainable diets, with these being rooted in traditional food systems, food preferences, agroecology and territorial management practices, and Indigenous food sovereignty. The domain recognizes that disruptions in traditional Indigenous Peoples' food systems (combined with global changes in food production and food systems, rapid urbanization and changing lifestyles) have led to a shift in dietary patterns for some Indigenous Peoples, with Indigenous women particularly negatively impacted[43],[44]. This includes increased consumption of more highly processed foods high in unhealthy fats, free sugars and salt/sodium, alongside lower levels of fruit and vegetables, whole grains, legumes and nuts. Unsustainable food systems have also contributed to environmental degradation that impacts health, including loss of biodiversity and deterioration of critical ecosystem services like pollination. This domain entails scaling up WHO best buys for healthy diets[45] such as front-of-pack labelling and restricting marketing of unhealthy food. It also entails co-designing cross-sectoral action for leveraging the contribution of traditional food systems towards Indigenous Peoples healthy diets and the health of ecosystems. It involves innovations in the role of the health sector in promoting this, including through Indigenous-led engagement in public food procurement, subsidies or social prescribing of healthy foods for Indigenous Peoples, and nature-based solutions for enhancing biodiversity and nutrition.

Action domain 4.3: *Member States work cross-sectorally and with other actors to address the social determinants, including commercial determinants, of Indigenous Peoples' health*

36. The WHO 2025 World Report on Social Determinants of Health acknowledged *Indigeneity as a determinant of health and health equity (shaped by discrimination and historical injustices, as well as protective factors)*[46]. The health sector can provide evidence on, advocate, and partner for whole-of-government action on social determinants impacting the health of Indigenous Peoples, as part of a holistic and cross-sectoral approach. For enhancing protective factors for Indigenous wellbeing, measures can include but are not limited to safeguarding of Indigenous land rights, promotion of Indigenous languages, and support for intergenerational cultural and community programmes that benefit health[47],[48]. While varying across contexts, adverse social determinants that impact Indigenous Peoples health may include disproportionately higher rates of multidimensional poverty and deprivation, linked to historical legacies of colonialism, violence, discrimination and racism, cultural damage and forced assimilation, land dispossession/forced relocation from traditional lands, and intergenerational trauma[49],[50]. To address adverse determinants, actions by authorities can include anti-discrimination policy and programming; enhancing access to integrated social protection floors, poverty reduction and income-generation activities; and culturally appropriate/Indigenous-led early childhood development in Indigenous communities. The latter comprises support to culturally safe and Indigenous-led caregiving, early learning, and community-based services as foundations for lifelong health. Specific attention is required to ensure equitable access to adequate social protection benefits including sick leave, maternity and disability coverage, by Indigenous Peoples working in both informal and formal settings.

37. Commercial determinants of health are defined as private sector activities (and outputs) that affect people's health, directly or indirectly, positively or negatively. Some commercial determinants have environmental health implications (e.g., like extractive industries, with nearly

half of the world's mineral reserves located on or near Indigenous traditional lands[51]). Others like ultra-processed food, alcohol and consumer tobacco are prominent contributors to NCDs among Indigenous Peoples. Outside of direct government control, other commercial determinants such as illicit drug trafficking, wildlife poaching, and illegal deforestation expose Indigenous Peoples to violence, mental distress and physical harm. This domain underlines the needs for adequate health impact assessments; health-related regulations and regulatory enforcement across production, supply, service delivery, costing and marketing; adequate culturally appropriate health-related information; strengthened government control of illegal activities impacting the health and safety of Indigenous Peoples; and respect for Indigenous Peoples health-related rights by local, national and transnational private sector actors.

Action domain 4.4: *Member States and other actors increase culturally appropriate approaches for improving the health of Indigenous women and girls*

38. Linked to this Plan's underlying principle of gender responsiveness, this domain calls for Member States and other actors to advance explicit action on the health-related needs, and circumstances of Indigenous women and girls. While Indigenous women can have important roles as traditional and other health providers, there is a need for culturally safe health system strengthening to recognize these roles and ensure gender equality in national health systems. Due to the compounding effect of gender inequality on other barriers to health, Indigenous women and girls may also face disproportionate exposure and vulnerability to risk factors to ill-health, and lesser access to quality health services and products. This domain relates to health programming for Indigenous Peoples across all health conditions.

39. The Plan gives specific attention to sexual and reproductive health and rights and the prevention of gender-based violence. Historically, Indigenous girls and women have been disproportionately subjected to coercive sterilization[52]. This domain calls for frameworks that guarantee Indigenous women's reproductive rights, culturally appropriate information, guidelines and capacity strengthening on the requirement of full, free and informed consent for health providers should be ensured. This domain also calls for promoting strategies that support women's decision-making around culturally safe birth[53]. Promoting Indigenous girls' equitable access to higher education, culturally appropriate comprehensive sexuality education, and existence and enforcement of laws against child marriage are important tools to prevent child marriage and adolescent pregnancy amongst Indigenous girls. In some countries, the adolescent birth rate amongst Indigenous girls is nearly five times as high as the general population[54]. In some contexts, Indigenous women and girls can face pervasive, systemic violence driven by gender inequalities, colonial legacies, and racism. This is manifested in violence by intimate partners, trafficking, disappearances, harmful practices, and intergenerational trauma[55]. Culturally appropriate health sector responses are vital, as are improved data systems, strengthened legal protections and culturally safe access to justice.

Action domain 4.5: *Member States and other actors recognize and safeguard the health-related rights of Indigenous Peoples in "Isolation and Initial Contact", including the right to isolation*

40. Indigenous Peoples in isolation and initial contact do not maintain regular contact with majority populations and tend to avoid all forms of contact with individuals outside their group[56]. Linked to UNDRIP Article 3 on self-determination, they have a right to not be contacted[57],[58]. They often lack legal identity and are invisible in national statistics. Isolation can be voluntary or forced, with the latter due to risks of exploitation, violence, and/or contagious diseases (noting health risks due to

their low immunity to common illnesses like influenza). Authorities have key roles in creating, promoting and enforcing policies and laws for protecting the health of these Indigenous Peoples. This domain supports the critical and cross-sectoral public health action of their recognition, safeguarding their territories (through engagement with protection organizations and neighbouring communities) and minimizing environmental contamination, biodiversity loss and ecosystem degradation, given that Indigenous Peoples in isolation and initial contact rely on these for food security, traditional medicines and health practices, and availability of drinking water. The domain also promotes health contingency planning for these Indigenous Peoples and investment in appropriately trained rapid response teams.

Priority 5: Evidence generation, Indigenous data sovereignty, and joint accountability for the health of Indigenous Peoples

Action domain 5.1: *Member States and other actors including academia promote Indigenous Peoples leadership and co-development of health research*

41. This domain supports Indigenous-led health research, alongside Indigenous Peoples' co-production of/participation in health research led by others that is underpinned by the principles of Prior, Free and Informed Consent, "nothing about us without us" and "do no harm". It entails national health authorities and partners, including academia and research institutes, supporting and adequately resourcing Indigenous-led or co-produced research that recognizes the scholarly contributions of Indigenous knowledge systems, including their diverse ontologies, epistemologies and methodologies[59] and worldviews. This will allow evidence production to better support culturally appropriate health services and action on health determinants, enabling the protection, strengthening, and promotion of Indigenous health. This domain also recognizes the importance of research by Indigenous Peoples, including Indigenous women, in relation to the Plan's priorities 1-4.

Action domain 5.2: *Member States and other actors strengthen efforts towards Indigenous Peoples data sovereignty and coordination with Indigenous Peoples for inclusion, in relevant national data sources, of indicators reflecting their conceptualization of health and wellbeing*

42. This domain addresses the importance of data about Indigenous Peoples being in the control of Indigenous Peoples, through appropriate ethical data governance frameworks and research approaches[60],[61],[62]. It calls for Member States to support the application of Indigenous data sovereignty principles to ensure Indigenous ownership, control, access, and possession of health data and to prevent harmful research practices. While acknowledging that the Indigenous data governance approaches may vary by context, in accordance with national legal and constitutional frameworks, key issues include ethical review from Indigenous perspectives, enabling accessibility of the data by and its collective benefit for Indigenous Peoples, ensuring research is in line with Indigenous Peoples' priorities, having appropriate consent processes on data use and reuse, and conducting risk assessments from Indigenous perspectives. With Free, Prior and Informed Consent and Indigenous co-production, the domain also entails incorporation of Indigenous-defined wellness indicators.

Action domain 5.3: *Member States and other actors expand the generation of disaggregated data and the monitoring of health inequalities to improve understanding of and action for Indigenous Peoples' health*

43. In many contexts, action for improving the health of Indigenous Peoples is impeded by weak health information systems. Routine health facility data may be weaker in rural and remote areas and other locations where Indigenous Peoples reside. This relates to its collection, reporting and analysis, including by sex, age and different socio-spatial characteristics. Population surveys may not enable disaggregation of health and health determinant-related indicators by Indigeneity and/or by geographical areas/units of a country with higher densities of Indigenous Peoples. Vital registration, such as birth registration, can also be lower amongst indigenous Peoples, with implications for health and social service accessibility across the lifecourse.

44. As appropriate in the national context, this domain calls for Member States and other actors to strengthen health information systems, across sources, for generation of data on Indigenous health with a gender and intersectional lens, while ensuring the necessary legal and operational standards and measures to ensure data protection (including removal of all personal identifying information) and prevention of misuse, alongside respect for Indigenous Peoples' data sovereignty (see action domain 5.2). This domain also promotes capacity building tools and training on health inequality monitoring, alongside resources supporting multivariate, intersectionality and gender analysis to understand the situation of Indigenous women and girls.

Action domain 5.4: *Member States, the multilateral system and other actors create and/or strengthen platforms for joint accountability for the health of Indigenous Peoples*

45. This domain addresses joint accountability for the health of Indigenous Peoples, at local, subnational, national, regional and global levels. For example:

- At *local levels*, it comprises establishment of culturally safe, Indigenous-informed platforms/modalities for joint accountability by duty bearers and rights holders, as well as grievance mechanisms and redress processes. Enforceable accountability mechanisms are required rather than depending solely on training or awareness initiatives.

- At *national and subnational levels*, this domain entails relevant laws and policies protecting Indigenous Peoples' health-related rights (specifically or as specific objectives within wider laws and policies), backed by monitoring, evaluation and learning frameworks and implemented in accordance with planning cycles. Linking with Priority 1, it also involves Indigenous Peoples' leadership/engagement and prioritization of Indigenous Peoples' health by mechanisms that can have legal frameworks behind them, such as Indigenous Peoples' bodies/parliaments and health sector councils, health committees, district committees, advisory boards, steering groups (for example, health sector coordination committees), and review boards.

- At *regional and global levels*, this domain entails mainstreaming of a focus on the health of Indigenous Peoples in the agreements and safeguards underpinning overseas development aid and development assistance for health, as part of a wider cross-cutting focus on human rights, equity and gender equality. It entails reflecting health of Indigenous Peoples in compacts, strategies, plans, partnerships and other initiatives advanced by the multilateral

system, as appropriate, done in tandem with action domain 1.3, on strengthening Indigenous Peoples' role in the global health architecture.

Support by the WHO Secretariat

46. The Plan will be supported through its strategic integration in the relevant General Programme of Work at the time, with a focus on support to countries, leadership and coordination, governance and accountability, and development of normative products and capacity-building opportunities.

    - **Technical support to countries.** Dependent on available resources, WHO technical support will be provided, upon request of the Member States and as called for by WHA Resolution 76.16, in line with the Priorities and Action domains of the draft Plan. WHO will work with Member States and Indigenous Peoples to identify a core set of indicator domains, for adaptation and application at country level to support monitoring of progress under this Plan.

    - **Leadership and coordination.** Leveraging its existing convening and coordination role, this entails WHO's facilitation of cross-country learning across Member State entities charged with the health of Indigenous Peoples. It also entails strengthening the Secretariat's collaboration with Indigenous Peoples, including through optimizing the use of WHO civil society engagement platforms, as appropriate and in line with their respective mandates, to promote inclusive dialogue on the health of Indigenous Peoples. Across its programmes and levels, WHO will also deepen cross-cutting coordination and engagement with relevant UN and multilateral system agencies, human rights mechanisms, civil society, academia (including through WHO Collaborating Centres) and other stakeholders to promote Indigenous Peoples' health.

    - **Governance and accountability.** During the 2027-2040 period, WHO will support reporting to the World Health Assembly on implementation progress, in line with timeframes to be set by the World Health Assembly. Establishment of an internal WHO cross-cutting coordination mechanism with designated focal points at Country Office, Regional Office and HQ levels will be done to support implementation and reporting.

    - **Development of normative products and capacity-building.** Dependent on availability of resources, this entails support for mainstreaming a focus on the health of Indigenous Peoples into the work of WHO at all three levels, leveraging implementation of the United Nations System-Wide Action Plan on the Rights of Indigenous Peoples[63] in line with the priorities and action areas in this Plan, and as part of a wider approach to integrating a human rights, health equity and gender equality focus in WHO's work. If resourced, this could also entail guidance, tools, and training materials to enhance culturally safe practices within health systems and for cross-sectoral action on health determinants, co-developed with Indigenous Peoples and taking appropriate steps to bring Indigenous perspectives into health-related policymaking, practice and research.

Linkages to the wider UN system

47. In the spirit of One United Nations and for maximizing coherence, optimizing resources and avoiding duplication, WHO – as lead and coordinating agency on health in the UN system – will scale up its coordination with other UN agencies for the health of Indigenous peoples. This is also in keeping with Indigenous Peoples' calls to move beyond fragmented efforts towards cohesive action on Indigenous determinants of health that cross sectoral divides[64].

48. WHO will also continue and/or expand coordination for the health of Indigenous Peoples with other multilateral system actors, including the H6 agencies, regional development banks, intergovernmental organizations, bilateral donors and philanthropic foundations, amongst others, for cohesive action for the health of Indigenous Peoples.

References

[1] WHO (2023). The Health of Indigenous Peoples. World Health Assembly Resolution WHA 76.16, Geneva. https://apps.who.int/gb/ebwha/pdf_files/WHA76/A76_R16-en.pdf

[2] WHO (2026). Draft global plan of action for the health of Indigenous Peoples. Report by the Director-General. 158th Executive Board Document EB 158/29, Geneva. https://apps.who.int/gb/ebwha/pdf_files/EB158/B158_29-en.pdf

[3] PAHO (2023). Strategy and Plan of Action on Ethnicity and Health 20189-2025: progress report. 60th Directing Council 75th session of the Regional Committee of WHO for the Americas. Washington, DC. https://www.paho.org/sites/default/files/2023-08/cd60-inf-10-e-e-ethnicity.pdf

[4] UN (2007). United Nations Declaration on the Rights of Indigenous Peoples. 61/295. Resolution adopted by the UN General Assembly on 13 September 2007, New York. https://www.un.org/development/desa/indigenouspeoples/wp-content/uploads/sites/19/2018/11/UNDRIP_E_web.pdf

[5] Extracts of this are featured in the background paper accompanying GPA draft 1: https://cdn.who.int/media/docs/default-source/documents/gender/gpa---background-document.pdf?sfvrsn=c0f22e35_1

[6] Anderson I et al. (2016). Indigenous and tribal peoples' health (The Lancet-Lowitja Institute Global Collaboration): a population study. Lancet, 388(10040):131–157. https://pubmed.ncbi.nlm.nih.gov/27108232/

[7] Barreto CTG et al (2019). Factors Associated with Low Birth Weight in Indigenous Populations: a systematic review of the world literature. Rev Bras Saúde Mater Infant (Online), 19(1):7– 23 https://www.scielo.br/j/rbsmi/a/CVQdT3XyBSHMCR76PBNP6RS/?lang=en

[8] Bowker, S.L., Williams, K., Volk, A. *et al.* Incidence and outcomes of critical illness in Indigenous peoples: a systematic review and meta-analysis. *Crit Care* 27, 285 (2023). https://doi.org/10.1186/s13054-023-04570-y

[9] NCD Alliance (2012). Health inequalities and Indigenous Peoples. Geneva https://ncdalliance.org/sites/default/files/rfiles/Health%20inequalities_indigenous_11Dec12_NCDA.pdf

[10] Furtado JM et al (2023). Indigenous Eye Health in the Americas: The Burden of Vision Impairment and Ocular Diseases. *International journal of environmental research and public health*, *20*(5), 3820. https://doi.org/10.3390/ijerph20053820

[11] Poirier B et al. (2023). Facilitators and Challenges to Maintaining Oral Health for Indigenous Communities Globally: A Qualitative Systematic Review. Journal of Health Care for the Poor and Underserved. 34. 377-398. 10.1353/hpu.2023.0025. https://pubmed.ncbi.nlm.nih.gov/37464501/

[12] UN (2025). Political declaration of the fourth high-level meeting of the General Assembly on the prevention and control of noncommunicable diseases and the promotion of mental health and well-being. Document A/80/L.34. New York https://docs.un.org/en/A/80/L.34

[13] Minichiello A et al (2016). Effective strategies to reduce commercial tobacco use in Indigenous communities globally: A systematic review. BMC Public Health. 2016 Jan 11;16:21. doi: 10.1186/s12889-015-2645-x. https://pmc.ncbi.nlm.nih.gov/articles/PMC4710008/

[14] Chamberlain, C. *et al* (2017). Evidence for a comprehensive approach to Aboriginal tobacco control to maintain the decline in smoking: an overview of reviews among Indigenous peoples. *Syst Rev* **6**, 135. https://doi.org/10.1186/s13643-017-05209

[15] Maddox R et al (2019). Commercial tobacco and indigenous peoples: a stock take on Framework Convention on Tobacco Control progress. Tob Control. 2019 Sep;28(5):574-581. doi: 10.1136/tobaccocontrol-2018-054508. https://pmc.ncbi.nlm.nih.gov/articles/PMC6824741/

[16] PAHO (2016). Promoting Mental Health in Indigenous Populations. Experiences from Countries. Washington, DC. https://iris.paho.org/bitstreams/e118f21d-5d78-4120-820c-408e06c09540/download

[17] Graeff SV et al (2019). Epidemiological aspects of HIV infection and AIDS among indigenous populations. Rev Saude Publica. 2019 Sep 9;53:71. https://pubmed.ncbi.nlm.nih.gov/31508778/

[18] Tollefson, D et al (2013). Burden of tuberculosis in indigenous peoples globally: a systematic review. *The international journal of tuberculosis and lung disease*. *17*(9), 1139–1150. https://doi.org/10.5588/ijtld.12.0385

[19] Elliott E (2024). Prevalence of hepatitis C virus exposure and infection among Indigenous and tribal populations: a global systematic review and meta-analysis, Public Health, Volume 233, 2024, Pages 65-73, ISSN 0033-3506, https://doi.org/10.1016/j.puhe.2024.04.035

[20] WHO (2024). World Malaria Report 2024. Geneva, pg 108 https://www.who.int/teams/global-malaria-programme/reports/world-malaria-report-2024

[21] United Nations (2024). Indigenous persons with disabilities Report of the Special Rapporteur on the rights of Indigenous Peoples, JF Calí Tzay, Document A/HRC/57/47. New York, https://www.ohchr.org/en/documents/thematic-reports/ahrc5747-indigenous-persons-disabilities-report-special-rapporteur

[22] UNDESA (2025). State of the World's Indigenous Peoples 2025: Volume VI, Climate Crisis. New York, https://desapublications.un.org/publications/state-worlds-indigenous-peoples-volume-vi-climate-crisis

[23] Fernández-Llamazares A, et al (2020), A State-of-the-Art Review of Indigenous Peoples and Environmental Pollution, Integrated Environmental Assessment and Management, Volume 16, Issue 3, 1 May 2020, Pages 324–341, https://doi.org/10.1002/ieam.4239

[24] United Nations (2022). Human rights to safe drinking water and sanitation of Indigenous Peoples: state of affairs and lessons from ancestral cultures. Report of the Special Rapporteur on the human rights to safe drinking water and sanitation, Pedro Arrojo Agudo. Human Rights council, 51st session, document A/HRC/51/24. New York https://www.ohchr.org/en/documents/thematic-reports/ahrc5124-human-rights-safe-drinking-water-and-sanitation-indigenous

[25] WHO and UNICEF (2025). Progress on household drinking-water, sanitation and hygiene 2000-2024: Special focus on inequalities. Geneva, https://www.who.int/publications/i/item/9789240115149

[26] UN CESCR (Committee on Economic, Social and Cultural Rights) (2009). General Comment No. 20: Non-Discrimination in Economic, Social and Cultural Rights, 02 July 2009, E/C.12/ GC/20. http://www.refworld.org/docid/4a60961f2.html

[27] UN (2026). Restoring Indigenous health by connecting systems through the Indigenous determinants of health: local to global evidence. Document E/C.19/2026/5 Permanent Forum on Indigenous Issues Twenty-fifth session, New York, 20 April–1 May 2026, https://docs.un.org/en/E/C.19/2026/5

[28] UNICEF, & FILAC (2025). Voces de las niñas, niños y adolescentes indígenas de América Latina y el Caribe. Una aproximación para conocer su situación. New York, https://www.unicef.org/lac/media/52351/file/Voces%20de%20las%20niñas%20niños%20y%20adolescentes%20-%20ultima%20version%2027%20de%20julio%202025.pdf.pdf

[29] UNESCO (2023). Global Action Plan of the International Decade of Indigenous Languages, (IDIL2022-2032); abridged version , Paris https://unesdoc.unesco.org/ark:/48223/pf0000383844

[30] This refers to all occupations, as described in WHO (2023). National health workforce accounts: a handbook, second edition. Geneva. https://iris.who.int/server/api/core/bitstreams/747ab58d-0c29-44bf-844d-b684a8f2cecd/content

[31] WHO (2021). WHO guideline on health workforce development, attraction, recruitment and retention in rural and remote areas. Geneva. https://www.who.int/publications/i/item/9789240024229

[32] ILO (2019). Implementing the ILO Indigenous and Tribal Peoples Convention No. 169: Towards an inclusive, sustainable and just future. Geneva: International Labour Organization https://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/---publ/documents/publication/wcms_735607.pdf

[33] Milne T, Creedy DK, West R (2016). Integrated systematic review on educational strategies that promote academic success and resilience in undergraduate indigenous students, Nurse Education Today, Volume 36, 2016, https://pubmed.ncbi.nlm.nih.gov/26521033/

[34] eClinicalMedicine (2025). Reimagining global health architecture for a sustainable future. EClinicalMedicine, 87, 103532. https://doi.org/10.1016/j.eclinm.2025.103532

35 See: Gostin, L. O., Friedman, E. A., & Finch, A. (2023). The Global Health Architecture: Governance and International Institutions to Advance Population Health Worldwide. The Milbank quarterly, 101(S1), 734–769. https://doi.org/10.1111/1468-0009.12627

36 IASC (2022). Minimum Service Package Mental Health and Psychosocial Support. New York and Geneva https://interagencystandingcommittee.org/iasc-reference-group-mental-health-and-psychosocial-support-emergency-settings/iasc-minimum-service-package-mental-health-and-psychosocial-support

37 To achieve optimal outcomes, health services should be coordinated seamlessly across different medical disciplines and should prioritize individual well-being. Integrating safe, effective and sustainable Traditional, Complementary and Integrative Medicine (TCIM) can contribute to an approach that supports health and well-being.

38 WHO (2025). Global traditional medicine strategy 2025-2034. Geneva https://www.who.int/publications/i/item/9789240113176

39 WHO (2016). Standards for improving quality of maternal and newborn care in health facilities. Geneva https://iris.who.int/server/api/core/bitstreams/c81bbde3-7c3a-4ca5-8787-e5e4bb43d074/content

40 These include the Nagoya Protocol on Access to Genetic Resources and the Fair and Equitable Sharing of Benefits Arising from their Utilization to the Convention on Biological Diversity (2010) and the WIPO Treaty on Intellectual Property, Genetic Resources and Associated Traditional Knowledge (GRATK, 2024).

41 WHO (2025). Integration of traditional, complementary and integrative medicine into health systems: conceptual framework. Geneva. https://iris.who.int/server/api/core/bitstreams/0c74b1b8-f0bb-4553-8bec-1bdeb2739c87/content

42 IFAD (2019). Supporting nutrition-sensitive agriculture through neglected and underutilized species: Operational framework. Rome https://www.ifad.org/en/w/publications/supporting-nutrition-sensitive-agriculture-through-neglected-and-underutilized-species

43 IFAD (2022). Sustainable and resilient Indigenous Peoples' Food Systems for improved nutrition. Rome https://www.ifad.org/en/w/publications/sustainable-and-resilient-indigenous-peoples-food-systems-for-improved-nutrition

44 FAO (2026). The Global-Hub on Indigenous Peoples' Food Systems [web site]. Rome https://www.fao.org/indigenous-peoples/secretariats/global-hub/en, in particular the publication: FAO (2021). The White/Wiphala Paper on Indigenous Peoples' food systems. Rome https://openknowledge.fao.org/items/f2db136c-b20f-4691-b337-04666c54df33

45 WHO (2024). Tackling NCDs: best buys and other recommended interventions for the prevention and control of noncommunicable diseases, 2nd ed. Geneva https://www.who.int/publications/i/item/9789240091078

46 WHO (2025). World report on social déterminants of health equity. Geneva https://www.who.int/publications/i/item/9789240107588

47 Carroll SR, Suina M, Jäger MB, Black J, Cornell S, Gonzales AA, Jorgensen M, Palmanteer-Holder NL, De La Rosa JS, Teufel-Shone NI. Reclaiming Indigenous Health in the US: Moving beyond the Social Determinants of Health. Int J Environ Res Public Health. 2022 https://pubmed.ncbi.nlm.nih.gov/35742745/

48 UNICEF (2025). UNICEF and the Ministry of Health launch "EN MI MENTE," an initiative to strengthen adolescent mental health in Guatemala. Guatemala City, https://www.unicef.org/guatemala/en/press-releases/unicef-and-ministry-health-launch-en-mi-mente-initiative-strengthen-adolescent

49 PAHO (2019). Just Societies: Health Equity and Dignified Lives. Report of the Commission of the Pan American Health Organization on Equity and Health Inequalities in the Americas. Washington, D.C. https://iris.paho.org/items/e824e2fa-9f29-4080-9f31-cf10ecb28dec

50 UNPFII (2023). Indigenous determinants of health in the 2030 Agenda for Sustainable Development – Note by the Secretariat. Permanent Forum on Indigenous issues. 31 January 2023. https://digitallibrary.un.org/record/4004608

51 OECD (forthcoming), Strengthening Indigenous peoples' wellbeing and engagement in mining regions, OECD Publishing, Paris

52 WHO (2014). Eliminating forced, coercive and otherwise involuntary sterilization: an interagency statement, OHCHR, UN Women, UNAIDS, UNDP, UNFPA, UNICEF and WHO. Geneva (https://iris.who.int/server/api/core/bitstreams/f32e6f52-8cd4-45a5-8b19-6aecd9c71575/content

[53] Interagency Support Group on Indigenous Issues (2014). Thematic Paper on Sexual and Reproductive Health and Rights of Indigenous Peoples for towards the preparation of the 2014 World Conference on Indigenous Peoples, 2014, New York. https://www.un.org/en/ga/69/meetings/indigenous/pdf/IASG%20Thematic%20Paper_Reproductive%20Health%20-%20rev1.pdf

[54] UN Women (2018). Indigenous Women's Maternal Health and Maternal Mortality: Fact Sheet. Joint publication of UNICEF, UNFPA and UN Women. New York https://www.unwomen.org/sites/default/files/Headquarters/Attachments/Sections/Library/Publications/2018/Fact-sheet-Indigenous-womens-maternal-health-and-mortality-en.pdf

[55] UN (2022). Report of the Special Rapporteur on violence against women, its causes and consequences, A/HRC/50/26 (2022). New York, https://docs.un.org/en/A/HRC/50/26

[56] Minority Rights Group (2025). Isolated and Recently Contacted Indigenous Peoples of the Amazon and Gran Chaco Regions. By Da Silva. https://reliefweb.int/report/world/isolated-and-recently-contacted-indigenous-peoples-amazon-and-gran-chaco-regions

[57] Inter-American Commission on Human Rights (2013). Indigenous Peoples in Voluntary Isolation and Initial Contact in the Americas : Recommendations for the Full Respect of Their Human Rights. https://www.oas.org/en/iachr/indigenous/docs/pdf/report-indigenous-peoples-voluntary-isolation.pdf

[58] OHCHR (2025). Briefing Document Indigenous Peoples in Voluntary Isolation and Initial Contact. Geneva https://www.ohchr.org/sites/default/files/documents/form/documento-informativo-sobre-pueblos-indigenas-contacto-inicial-briefing-document-indigenous-peoples-voluntary-isolation-initial-contact-aislamiento-voluntario-piaci-ipviic-1-en.pdf

[59] Government of Canada (2025). Indigenous Research Statement of Principles. Social Sciences and Humanities Research Council, Ottawa. https://sshrc-crsh.canada.ca/en/funding/policies-regulations-and-guidelines/indigenous-research-statement-principles.aspx

[60] National Indigenous Australians Agency (2024). Framework for governance of Indigenous data: Practical guidance for the Australian Public Service (Version 1.0). Commonwealth of Australia. https://www.niaa.gov.au/sites/default/files/documents/2024-05/framework-governance-indigenous-data.pdf

[61] Australian Institute of Aboriginal and Torres Strait Islander Studies (2020). AIATSIS Code of Ethics for Aboriginal and Torres Strait Islander Research. https://aiatsis.gov.au/sites/default/files/2020-10/aiatsis-code-ethics.pdf

[62] The Sámi Parliament of Norway (2019). Proposal for Ethical Guidelines for Sámi Health Research and Research on Sámi Human Biological Material. Karasjok https://uit.no/Content/588355/cache=1534848132000/Proposal+for+Ethical+Guidelines+for+Sámi+Health+Research+and+Research+on+Sámi+Human+Biological+Material.pdf

[63] UN (2014). United Nations System-Wide Action Plan on the Rights of Indigenous Peoples. UNDESA, New York. https://www.un.org/esa/socdev/unpfii/documents/2016/Docs-updates/SWAP_Indigenous_Peoples_WEB.pdf

[64] UN (2026). Restoring Indigenous health by connecting systems through the Indigenous determinants of health: local to global evidence. Document E/C.19/2026/5 Permanent Forum on Indigenous Issues Twenty-fifth session, New York, 20 April–1 May 2026, https://docs.un.org/en/E/C.19/2026/5