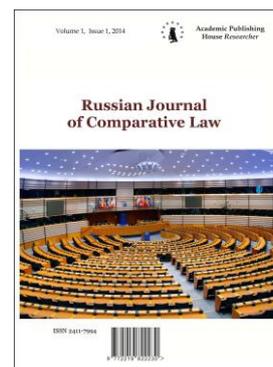


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Access to Mental Health Care in the Arctic: a Case Study on the Rights of Indigenous Women in Norway

Stefan Kirchner ^{a, *}

^a Arctic Centre, University of Lapland, Rovaniemi, Finland

Abstract

Indigenous women are often doubly under pressure when it comes to the full realization of human rights. In particular they might face increased risks to their health and life and suffer from a lack of access to health care. In particular language and cultural differences can make it difficult for indigenous women to access health care services. This research looks at the tip of the iceberg of this problem, taking as a point of departure problems of Sámi women in Norway to access mental health care service. This is the tip of the iceberg as indigenous women in other states suffer much worse forms of discrimination, Norway has an excellent health care system and has ratified ILO 169. Yet, indigenous women in Norway are significantly less likely than non-indigenous women to access mental health care services. In the context of the conference's overall theme this research project looks at the question whether international instruments applicable to the situation in Norway (such as CEDAW, ICCPR, ICESCR and ILO 169) give indigenous women a right to access to health care. Particular attention is given to the prohibition of discrimination and to the question of horizontal effect, which are necessary for effectively ensuring the right to access to health care.

Keywords: indigenous, women, Sámi, health, human rights, law.

1. Introduction

For a long time, the use of the indigenous Sámi languages had been outlawed in the four countries which govern Sápmi, the homeland of the Sámi people: Norway, Sweden, Finland and Russia. While the situation has improved in recent decades, indigenous language rights are still under threat in the region. Today, most Sámi people speak the dominant language of the country they live in in addition to their native language. For many elderly people, the native language becomes more relevant in old age (cf. [Dehler, 2013: 49](#)). Research into the situation of elderly indigenous persons is still limited ([Braun et al., 2014](#)), and there is a risk that groups of persons within minorities (the term is used in a general, rather than a legal sense here, on the distinction between minority rights and indigenous rights (see [Fresa, 2000](#)) benefit too little from academic research. This is particularly the case when it comes to women. In recent decades, international law has been used in an attempt to improve the rights of women and this study is also meant to enable an assessment of the effectiveness of the existing legal norms in this respect. With regard to access to health care and medical services, mental health remains particularly challenging due to the stigma associated with it and the need for adequate communication with the patient ([Iezzoni et al., 2006](#)). Additional problems arise in situations when patients do not have access to health care in their native language ([Röysky, 2015:31 et seq.](#); [Jacobs et al., 2006](#); [Schyve, 2007](#); [Meuter et al., 2015](#)).

* Corresponding author

E-mail address: stefan.kirchner@ulapland.fi (S. Kirchner)

This text aims at investigating the ability of international law to realize indigenous rights as well as access to health care for disadvantaged persons who often continue to suffer from longstanding institutional discrimination.

2. Materials and methods

The material researched, i.e., the sources for this article, consists of primary, secondary and tertiary legal materials. The primary legal materials utilized in this research include both international treaties as well as domestic legislation from Norway. The secondary materials include case law from different courts, in particular in the context of international human rights treaties. All of the treaties and cases are available online free of charge. In addition, academic research results have been utilized. This work is primarily based on literature research. The scientific literature used for this study, however, is not limited to legal research. Due to the nature of the topic and its practical relevance, medical research had to be taken into account as well.

In terms of methodology, the study is based on the analysis of international legal standards as well as of Norwegian law in a specific situational context, in this case the situation of the aforementioned elderly indigenous persons.

While the research undertaken for this text is based on a review of different forms of textual materials from several disciplines, the research would not have been possible without prior research in the Sámi home area and the willingness of indigenous and non-indigenous persons in Sápmi to share information about their situation in Europe's far north*.

3. Discussion

3.1. Indigenous Women as a particularly vulnerable group

The protection of the human rights of women needs to be improved in many ways just as the rights of women are violated in many ways, ranging from everyday discrimination to the systematic use of rape in armed conflicts (e.g. [Kirchner, 2008](#)) and the widespread murder of girls by their own parents in some cultures. Some of these issues are very individual, many, however, are the result of a systematic disregard for the value of women. International law seeks to find solutions for all of these problems as human rights are concerns which go beyond borders ([Gibney, 2008: 1](#)). Among the most important contributions of international law to the protection of the rights of women is the Convention on the Elimination of all forms of Discrimination against Women (hereinafter – CEDAW).

When we ask ourselves which contribution international law can make to the improved protection of the rights of all women, we will sooner or later come to a point at which declarations and international treaties no longer suffice. International law can be used to protect those who are most in need of protection, and in many places around the world, this still includes women. In an ideal world, there would be no need for international legal instruments like CEDAW because existing general instruments such as the International Covenant on Civil and Political Rights (hereinafter – ICCPR) and the International Covenant on Economic, Social and Cultural Rights (hereinafter – ICESCR) should be sufficient to protect the human rights of everybody. Yet, even these basic human rights obligations are often violated and the rights of women continue to be under particular forms of pressure. This raises the question how it can be possible that even in developed countries which have a very good human rights record most fundamental human rights of women are neglected by public authorities?

One group which is particularly vulnerable are indigenous women. Belonging to two vulnerable groups can translate into a particular vulnerability which can be overlooked if a problem is only seen from the perspective of one of these groups. This is even more so, when particular groups have experienced forms of discrimination and rights advocates now have a strong interest in preventing internal discrimination and unequal treatment, as it the case for both the women's rights movement as well as the indigenous rights movement. Indigenous women therefore are not only doubly vulnerable, they are also at an increased risk of being overlooked when it comes to defending human rights. In addition, existing forms of discrimination against both groups make it often more difficult for indigenous women to assert their rights effectively.

* All opinions expressed in this text are only attributable to the author.

3.2. Access to Mental Health Care for Sámi Women in Norway

A few months ago, news outlets reported the story of a pregnant indigenous woman in Mexico who had been turned away by a hospital and eventually gave birth on the lawn in front of the hospital building. While public authorities in Norway are not preventing indigenous patients from receiving medical care per se, it appears from research which has been conducted in Norway (Hansen, 2011:29 et seq. and 54 et seq.) that language barriers might contribute to the fact that Sámi women in Norway, in particular, it appears, Sámi-speaking women who live in parts of Norway outside Sámi settlement areas are about 40 % less likely than ethnic Norwegian women to seek help for mental health ailments (Øvreberg, 2012). Even when taking into account the fact that the overall health situation of the Sámi is significantly better than that of other indigenous groups in the Arctic (Hansen, 2011: 54), the aforementioned research project found a lower rate of mental health ailments among one group of Sámi women when compared to other persons (Hansen, 2011:50), the fact that indigenous women are so much less likely to seek medical help is striking. At the same time, this is only one example to illustrate a more widespread problem: “Research into indigenous peoples worldwide has showed a persistent disparity in health status among many ethnically native groups compared to the respective majority populations” (Hansen, 2011: 55). Discrimination can have a particular negative effect on mental health (Hansen, 2011: 26). An inability to communicate not only makes it more difficult to find information about available health care services, in the case of mental health issues, it can also make it more difficult to provide both diagnosis and treatment.

While Sámi traditions, such as a taboo not to speak about mental health ailments for fear of the “evil ear” (Øvreberg, 2012), may also play a role in this context (Øvreberg, 2012), it appears that there are a degree of discrimination and/or language barriers which are sufficient to prevent at least some women who are in need of health care from seeking the health they are entitled to. In particular in a health care system such as Norway’s, which is characterized by public funding and, under Norway’s Patients’ Rights Act (PRA), an equal (PRA, Section 1-1, sentence 1) right to the “necessary health care” (PRA, Section 2-1, sentence 2), such obstacles should no longer exist. This is especially so in the case of language barriers as Section 3-5 sentence 1 of the Patients’ Rights Act requires that the patient’s right to information (PRA, Section 3-2) has to be implemented with due regard for the patient’s “linguistic background” (PRA, Section 3-5, Sentence 1).

3.3. Are existing treaties not enough?

The obvious first question would be, whether Norway’s existing international obligations are not sufficient to ensure the necessary access to health care for everybody. After all, Norway is one of the wealthiest countries on the planet, has the third highest GDP (United Nations Statistics Division National Accounts Main Aggregates Database, 2014) and its health care system is highly regarded internationally (cf. Squires, 2013: 3).

3.4. Indiscriminate access to health care under CEDAW

Also, existing human rights norms already provide for access to health care. Article 12 CEDAW stipulates that “1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning. 2. Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.” The first paragraph of this norm already indicates that the right to non-discrimination when it comes to access to health care not only has a vertical but also a horizontal dimension in that the States are obliged to “take all appropriate measures to eliminate discrimination”

3.5. The Prohibition of discrimination under the ICCPR

The prohibition of discrimination based on gender is so important in international human rights law that it can be found several times in the ICCPR, in Article 3 and in Article 2 paragraph 1 ICCPR. The latter norm also prohibits discrimination based on other distinctions, which would seem to provide an additional level of protection for indigenous women.

3.6. Discrimination-free access to health care under the ICESCR

Also, Article 12 ICESCR obliges States to take measures which will result in universal access to health care.

3.7. ILO Convention 169

The International Labour Organization's Indigenous and Tribal Peoples Convention (hereinafter - ILO 169) remains the key binding international treaty concerning indigenous rights. While it has been widely adopted in South America, in a European context it applies to indigenous communities only with regard to the Norwegian part of Sápmi and with regard to the obligations by Denmark and the Greenlandic home rule government to the Inuit people. The Convention was drafted in the 1980s, a time when social rights were sometimes viewed with suspicion, at least in the Western Hemisphere. Also, it was meant to improve the situation of indigenous peoples as a whole rather than create individual rights. Therefore it hardly comes as a surprise that ILO 169 remains relatively silent on such matters, as an individual right to access to health care. The only reference can be found in Articles 24 and 25 ILO 169: Article 24 ILO 169 demands that "[s]ocial security schemes shall be extended progressively to cover the peoples concerned, and applied without discrimination against them." This rule does not create individual rights but obliges States to eventually include indigenous peoples in social security systems. In Europe, this is hardly a problem anymore, although it remains a challenge in other countries. Article 25 (1) ILO 169 obliges governments to work towards the goal of making the best health care possible also available for indigenous persons. Neither norm provides an individual right to access a specific medical service as such but imposes obligations on States to make the best medical service possible accessible in the long run. The idea behind these norms is that there should be no discrimination against indigenous persons when it comes to accessing health services. States which have ratified ILO 169 therefore have to remove structural inequalities.

While Article 2 (2) and Article 3 ICESCR require that all rights enshrined in the ICESCR have to be enjoyable without discrimination, it also has to be noted that the rights contained in the ICESCR are to be achieved over time. Notably, paragraph 1 of Article 2 ICESCR reads as follows: *"Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures."*

3.8. Non-Discrimination and Access to Health Care under the United Nations Declaration on the Rights of Indigenous Peoples

While ILO 169, as a binding international treaty, has not found universal acceptance, the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) is not binding (UN Charter, Article 10) but enjoys widespread support ([Anaya, 2009: 57 et seq.](#)) and which has already influenced national judges ([Cal et al. v. Attorney General, 116 et seq.](#)).

Articles 2 and 17 of UNDRIP prohibit discrimination of indigenous persons. Article 7 (1) UNDRIP reiterates "the rights to life, physical and mental integrity" of indigenous persons. Apart from that, one would not be surprised, would UNDRIP focus more on indigenous rights rather than human rights. While both sets of rules are closely interrelated, indigenous rights have a function which goes beyond traditional human rights. Both sets of rights can be enjoyed individually and as groups and indigenous rights in this sense are a subset of human rights. However, the *raison d'être* of indigenous rights is also tied to the structural injustices suffered by indigenous peoples and by the desire to have a say on matters which affect them. Therefore indigenous rights go beyond human rights in the classical sense of the term, as they are reflected for example in the ICCPR or CEDAW. Nevertheless does UNDRIP contain both a norms which takes into account the right to access to health care (Article 21 UNDRIP) and the risk of discrimination against women (Article 22 UNDRIP). Article 21 (2) UNDRIP even opens the door to affirmative action for the benefit of indigenous persons and requires the States to take the needs of particularly vulnerable groups of indigenous persons, including women, into account when taking measures in order to improve the social and health conditions of indigenous peoples. Therefore, UNDRIP already reflects an awareness of the particular vulnerability of certain groups of indigenous persons. What Articles 21 and 22 UNDRIP do not do, however, is to establish a clear right to access to health care. Such a right follows from Article 7 (1) UNDRIP, but it is not spelled out as such.

3.9. Interim Conclusions

While UNDRIP is not even legally binding, the other international human rights instruments mentioned so far all suffer from an enforcement deficit. This is even true for ILO 169, although the

ILO's supervisory system is rightfully praised (Swepton, 1998: 28) and noteworthy when compared to other standards. There are supervisory systems in place for ILO 169, ICCPR, ICESCR and CEDAW – but at the end of the day, more often than not, while legally relevant, these enforcement mechanisms hardly carry the full political effect enjoyed by the judgment of an international court. This might be different in inter-state cases but these are rare. Also, it has to be kept in mind that with the exception of the ILO procedures, international institutions will require that an applicant has exhausted all domestic remedies, which in turn will require years of court proceedings on the national level. Obviously, there will also be few cases in which an indigenous victim of such human rights violations will have access to sufficient funding to engage in lengthy legal battles with a national government.

3.10. The European Convention on Human Rights (cf. Koivurova, 2011: 1)

This is also true for proceedings before the European Court of Human Rights (ECtHR) in Strasbourg. However, the ECtHR can grant legal aid to applicants (Leach, 2005:26 et seq.) and enjoys a very high compliance (Hawkins et al., 2008; Hillebrecht, 2013) rate among the States which have ratified the European Convention on Human Rights (hereinafter – ECHR). While the Inter-American Court in San Jose can take into account not only the American Convention on Human Rights (hereinafter – ACHR) but all international legal rules applicable to the situation, i.e. also other international treaties such as ILO 169, the European Court of Human Rights applies the ECHR and its protocols. On paper, the protection enjoyed by indigenous persons under international law ought to be best in states which have ratified both ILO 169 and a regional human rights instrument, as is the case for example with regard to most South American states or Norway.

3.11. Access to health care as a human right under the ECHR

In Norway, most hospitals are of a public law character, meaning that the public authorities which operate them are bound by the ECHR. So far, there is very little jurisprudence on indigenous issues under the ECHR but that does not mean that the ECHR could not be used for the purpose of ensuring full access to health care for everybody.

The question to be asked is therefore whether the ECHR provides for a right to access to health care. Neither the text of the Convention nor the Protocols to the ECHR include a right to access to health care. Article 3 of the Convention on Human Rights and Biomedicine (hereinafter - Oviedo Convention), which, like the ECHR has been created under the auspices of the Council of Europe, provides for a right to equitable access to health care, dependent on the resources available. Equitable here means fair access – and does not necessarily require complete equality. For most practical purposes, Article 3 of the Oviedo Convention could be sufficient to provide for a right to access to health care also for members of marginalized groups, such as women or indigenous persons. However, unlike the European Convention on Human Rights, the Oviedo Convention does not allow for applications to the European Court of Human Rights for alleged violations. The Convention on Human Rights and Biomedicine therefore remains much less accessible to potential litigants than the ECHR, which is why we have to focus our attention on the European Convention on Human Rights, when looking for internationally enforceable norms. Likewise, compliance with the European Social Charter (hereinafter - ESC) cannot be controlled by the European Court of Human Rights. Articles 11 and 13 ESC aim at ensuring access to health care. In particular Article 13 no. 1 ESC seems to presume the existence of a right to access to health care.

However, to find such a right in the ECHR is significantly more difficult. Yet, the ECHR is more easily enforced due to the inherently legal nature of the European Court of Human Rights. This factor should not be underestimated. Despite occasional criticism, the European Court of Human Rights is very much respected in general. Of similar importance is that neither the Oviedo Convention nor the ESC spell out a direct individual claim against the state to provide access to a specific form of health care. While Article 13 ESC can give individuals a right to public funding for health care, it does not include an explicit right to access to health care. Article 3 of the Oviedo Convention on the other hand is phrased in the classical form of a social right, meaning that the states which have ratified this Convention should take measures to reach the situation envisaged by the Oviedo Convention at some point in the future. Therefore the question remains, whether there is a right to access to health care - especially health care in one's own language - under the ECHR.

Since no such right is mentioned explicitly in the ECHR, there are only a few cases which deal with the right to access to health care. In a number of cases, such a right was claimed by prisoners, with limited success (Ashingdane v. United Kingdom, para. 50; Winterwerp v. the Netherlands,

para. 51), as long as the lack of treatment did not amount to an inhuman treatment (*Riviere v. France*, para. 74). In 2012, however, the Grand Chamber of the European Court of Human Rights found that applicants who suffer from health problems and who lost their health insurance status due to a discriminatory treatment by the state could claim a violation of the right to private life under Article 8 ECHR (*Kurić and others v. Slovenia*, para. 21 et seq.). In this case, which concerned the treatment by non-Slovenian persons who found themselves residing in newly independent Slovenia after the dissolution of Yugoslavia, however, the loss of health insurance benefits was only one of several factors which led the European Court of Human Rights to the overall conclusion that Article 8 ECHR had been violated (*Kurić and others v. Slovenia*, paras. 21 et seq.). Also, in cases related to the right to a fair trial under Article 6 of the European Convention on Human Rights, the ECtHR has found Article 6 ECHR applicable to proceedings concerning health insurance benefits (*Feldbrugge v. the Netherlands*, paras. 26 et seq.; *De Haan v. the Netherlands*, para. 44).

While there are indicators to the effect that the ECHR presupposes a right to access to health care, this has to be taken with a grain of salt and it remains to be seen whether this indicates a right to a specific treatment (Reid, 2008:442, fn. 45).

3.12. Non-discrimination (Article 14 ECHR)

If we assume the existence of such a right to access to health care under the ECHR, states which have ratified the ECHR have the obligation to ensure that this right can be enjoyed without discrimination.

Unlike many other human rights documents, the ECHR does not contain a general anti-discrimination clause. However, Article 14 ECHR prohibits discrimination in the application of the Convention. As the Convention includes a right to access to health care, this right must be enjoyable by all “without discrimination on any ground” (Article 14 ECHR). While Article 14 ECHR does not make any reference to language skills, the wording of the norms makes it clear on two occasions (“on any ground”, “or other status”) that all forms of discrimination are forbidden. Likewise, indigenous persons are covered by Article 14 ECHR, although the norm only makes explicit references to national minorities. The lack of language skills in the majority language therefore must not be a barrier to the enjoyment of the right to access to health care.

4. Results

ICCPR. This conclusion, however, is not only valid under the ECHR. Under Article 27 of the International Covenant on Civil and Political Rights, indigenous peoples have the right to use their own language. Under Article 25 lit. (c) ICCPR, they have equal access to public services. This includes public health care systems.

Horizontal obligations. In order to be fully effective, the right to access to health care has to be both vertical and horizontal (Clapham et al., 2002), meaning that not only public but also private actors have to take this right into account. While many international human rights instruments don't make an explicit reference to the horizontal effect of human rights, states have an obligation to implement international human rights obligations domestically. This also requires states to enact legislation to ensure that this right is not denied by private actors.

In the context of the Council of Europe, this approach can now be found in Article 12 (1) of the Istanbul Convention, according to which states “shall take the necessary measures to promote changes in the social and cultural patterns of behaviour of women and men with a view to eradicating prejudices, customs, traditions and all other practices which are based on the idea of the inferiority of women or on stereotyped roles for women and men” (Article 12 Paragraph 1 Istanbul Convention). Although the wording might at first sight seem unfortunate from the perspective of those who are concerned with indigenous rights, as indigenous rights place a strong emphasis on the possibility to preserve customs and traditions, Article 12 (1) of the Istanbul Convention must not be taken out of context but interpreted in light of the aim of that convention, that is, to prevent violence against women.

5. Conclusion

In the Norwegian cases mentioned earlier, the problem is not so much that the State would prevent indigenous women from accessing health care. Rather, there appears to be a general environment which makes it harder for indigenous women to access medical services - for example a mutual lack of language skills on the part of both patients and medical service personnel.

However, the State has an obligation to create an environment in which the full realization of the right to health care is possible.

The European Court of Human Rights appears to be an underutilized forum when it comes to claiming rights of indigenous persons outside the realm of traditional indigenous rights claims, such as those relating to the use of land. Indigenous women who face discriminatory restrictions when it comes to accessing health care services can take States to court for such practices. However, it has to be kept in mind that the States' responsibility to protect human rights such as the equal access to health care, ought not to be engaged by legal proceedings, let alone on an international level. Rather, the State is the primary locus where human rights are to be protected actively, not just by refraining from further human rights violations.

It is this active dimension of human rights that is often overlooked. In particular when it comes to the rights of women, often small measures which aim at removing discriminatory practices can often go a long way. While there are also cases in which the State is guilty of actively discriminating against women, very often women suffer human rights violations by private actors. Dealing with this issue adequately does not always require new rules. It does require both all relevant actors to take their human rights obligations more seriously.

The right to access to health care has a horizontal effect. As under the ICESCR as well as the (non-binding) UNDRIP and, to some extent, ILO 169, this requires the States which have ratified the ECHR, including Norway, to take positive action to create an environment in which everybody involved is aware of his or her rights and responsibilities and in which the right to access to health care can be fully realized. It has to be kept in mind, though, that the legal basis for the right to access to health care under the ECHR is somewhat sketchy. A full realization of human rights therefore would be easier, would states ratify also ILO 169 and incorporate the rules contained in the UNDRIP into domestic law.

When it comes to language barriers, the question has to be asked how far the right to access to health care goes. Here specific indigenous rights norms go further than traditional human rights instruments. While not everybody has a right to health care in his or her mother tongue all over the world, indigenous persons have such a right in the state in which they live, even if their mother tongue is not that of the majority population. For indigenous women, who in many countries are still denied a sufficient access to education, this can make a big difference. What might be considered a mere inconvenience in Norway can be a "life or death"- issue elsewhere. By utilizing international norms, indigenous women might overcome at least some of the structural barriers they might face when trying to access health care services.

International law can be difficult to enforce on the national level. Therefore institutions such as the European Court of Human Rights are important because they give individual victims direct access to legal proceedings against the State. Given the importance of specific indigenous rights documents, the procedural options under ILO 169 are outdated and insufficient. Rather, indigenous individuals and groups should be given a judicial forum in which to bring claims for violations of indigenous rights. In an ideal scenario, this could include a binding treaty version of the most advanced rules contained in both ILO 169 and UNDRIP as well as a protocol to such a binding treaty which provides for an enforcement mechanism similar to that of the European Court of Human Rights. For the time being, however, such a system might not find widespread support from states. It is not, though, completely unrealistic to aim for such an enforcement system in the long run. A lot has been achieved in the field of indigenous rights in the last decades and the initial opposition by some states to UNDRIP has been given up as well. UNDRIP, though, is widely supported also because it is not a legally binding document. The discussions in Finland surrounding the potential ratification of ILO 169 show that a binding treaty which would include the provisions found today in the non-binding UNDRIP, complemented by a judicial enforcement system, would be even more controversial.

The widespread ratification of ILO 169 by Latin American states and their ratification of the American Convention on Human Rights and accordingly their experiences with the Inter-American Court of Human Rights could make the development of such a hypothetical international indigenous rights treaty possible. However, it is exactly in Latin America that the proposed protocol would not be necessary as the Inter-American Court of Human Rights (unlike the European Court of Human Rights) is not restricted to applying the regional human rights convention but can base its decision on any international laws and conventions which apply to the

situation in question. In this sense, the Inter-American Court of Human Rights can be used to implement ILO 169 outside the ILO supervisory system and therefore already functions as a potential indigenous rights court of Latin America.

In the long run, the creation of a protection system as described here, appears desirable. More important in the short term, however, is a fuller human rights awareness of public and private actors on the local level. Human rights training for public sector employees but also a general culture of human rights education is therefore essential for the creation of an environment in which the human rights of even the most marginalized members of society are to be protected.

Ways in which the right to access to health care for indigenous persons could be realized better would be the training of physicians who speak indigenous languages (as is hinted at in ILO 169) and UNDRIP but also language training for non-indigenous physicians in indigenous languages. As long as there is an insufficient number of indigenous persons who have access to medical training and to universities, this will remain a necessity. In particular in countries with a Nordic-style public health system, it should be possible to train a number of staff members in each medical institution in indigenous languages. For Norway, this would simply mean a deeper and more widespread implementation of Section 3-5 sentence 1 of the Patients' Rights Act.

Norway, it has to be noted, has already ratified ILO 169, while, other Arctic Nations, with the exception of the Denmark on behalf of Greenland, have not yet done so. Ratifying ILO 169 is not an uncontroversial question due to open questions concerning the effect of a ratification on land rights disputes. From the perspective of the right to access to health care, however, indigenous persons, and in particular indigenous women, could benefit if ILO 169 were ratified – and implemented effectively. It is this effective implementation with regard to horizontal effects of the right to access to health care which ought to be improved in Norway.

But when we look at the situation of indigenous women elsewhere, the shortcomings of the Norwegian system are only the tip of the iceberg. Indigenous women's rights to health care will be far easier to implement in Nordic countries with a relatively strong interest in human rights and with a few Sámi languages than in a developing country which might lack a human rights tradition and in which dozens or hundreds of indigenous languages are spoken in any given geographical area for which a medical institution is responsible. In principle, however, training medical staff on all levels to speak the locally spoken indigenous languages and to understand indigenous cultures, in particular in the context of health issues, can go a long way to fully integrating indigenous persons into existing social systems, as was envisaged already with ILO 169, and to ensuring access to all necessary health care. In particular the example of the taboo of talking about mental health issues in parts of the Sámi society indicates that language skills will often have to be complemented by cultural skills.

For the time being, though, the right to access to health care for indigenous women remains a problem – and in many countries much more so than in Europe. Both rich and poor States have to take decisive action for the improvement of both indigenous rights and women's rights, including the facilitation of access to all necessary medical services. Social rights are to be realized over time.

According to Article 2 paragraph 1 ICESCR, “[e]ach State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.” But this does not mean that States can fall short of their obligations indefinitely. At the very least, the conditions have to be created in which those who are most vulnerable have the possibility to claim their rights effectively.

International human rights instruments place direct, vertical, obligations on states. These obligations can be both positive and negative in nature. However, this is no longer enough. The full and effective realization of human rights, in particular the rights of women, requires the recognition of horizontal obligations. In the case outlined here, this does not mean that every physician will have to have language skills in indigenous languages. But it means that there has to be a way to make health care more accessible by removing language obstacles. This can require public health care providers to ensure some kind of translation service.

This example, access to mental health care for indigenous women in a very affluent country, is only the tip of the iceberg. Rights of indigenous women are threatened in many different situations and in many different forms.

International human rights law needs to be enforced in order to be effective (Gibney, 2008: 115 et seq.). As recent events in Ukraine show again, it is not enough to have rules on paper when they are not enforced. ILO 169 already benefits from a the ILO's exemplary mechanism and yet it is not enough. What will be needed in the long run are mechanisms which will enable indigenous peoples to access health services in their own language. This will require the majority society to become more aware of indigenous issues and to empower indigenous persons to become health care providers as well. In the long run, human rights, in particular for those who have long been marginalized and all too often continue to be marginalized, will require a horizontal dimension in order to be enjoyed by all. It remains the legal responsibility of states to ensure that human rights are given full effect domestically.

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