Indigenous languages and global health

Improving the health of the world's 370 million indigenous people is a crucial global health priority.[1] Indigenous groups worldwide tend to have worse health outcomes than corresponding non-indigenous populations.[2] These disparities stem from structural forces of colonisation, poverty, and marginalisation, as well as from barriers to accessing health care.[3]

In this Comment, we discuss language as an example of a barrier to health care and advocate for greater consideration of indigenous languages in global health. Our perspective is informed by our work designing and implementing linguistically sensitive health programmes for indigenous Mayan-speaking populations in Guatemala, a majority indigenous country with a large number of Mayan speakers who have limited access to health care. In our work, we have noted that indigenous languages are not frequently discussed in global health terms. This is a gap. We believe that indigenous languages are relevant within the field of global health for reasons of autonomy, rights, research ethics, programme efficacy, and revitalisation of such languages. We offer examples from Guatemala to illustrate each of these points.

First, language is a key feature of models of health put forth by indigenous people themselves. In Latin America, these models have viewed definitions of health used in North America and Europe as hegemonic and narrow, and instead advocate for diversity, identity, and traditional knowledge.[1] "Sumak Kawsay" (or "Buen Vivir" in Spanish) is an example of a powerful model of indigenous wellbeing and development originating in Ecuador and Bolivia that goes beyond traditional intercultural approaches to health. Indigenous linguistics are fundamental to the construction of this model,[4] which also has been applied in Guatemala.[5]

Second, there is a vigorous indigenous linguistic rights movement relevant from a global health perspective.[6] At the international level, a trend exists towards greater support of indigenous rights as evident in the UN Declaration on the Rights of Indigenous Peoples adopted in 2007. At the country level, the degree of state protection and promotion of indigenous languages varies substantially in the approximately 90 countries where indigenous people reside,[1] and legal status can differ from de facto policy. In Guatemala, for example, the 2003 Language Law codified the right to access government health services in indigenous languages, although this right is not protected in practice.

Third, conducting global health research with indigenous-speaking populations raises ethical implications regarding access to communities, consent, and dissemination of results. This is a complex topic, and we refer readers to international ethics guidelines.[7,8] In Guatemala, we have observed researchers use Spanish language fluency as an explicit or implicit inclusion criterion for enrolment in research trials—a practice we deem unethical. In our own research programme, we prioritise research in Mayan-speaking communities in view of their poorer health indicators than those of non-Mayan speaking populations, even though this prioritisation adds costs and complexity. In our research articles, we describe how language was incorporated into the intervention, detail the use of language in obtaining individual-level and community-level consent, and report the language breakdown of participants.

Fourth, global health programmes conceived and delivered using indigenous languages are likely to be more efficacious. True indigenous language sensitivity requires not only use of interpreters and translators, but also designing programmes from the initial stages with language in mind. The role of language, and the way language is embedded in a broader cultural and social context, is particularly salient for health interventions involving behaviour change or psychosocial support, such as lifestyle interventions for cardiovascular disease or caregiver interventions for early childhood development. In fact, the intentional prioritisation of indigenous language is itself a health intervention. In Guatemala, we have tried to generate evidence of the effectiveness of interventions to improve indigenous language sensitivity through mixed-methods research and ethnography.

Finally, global health work directly affects the vitality of indigenous languages. More than half of the world's 6700 languages are expected to become extinct by 2100, a trend which poses an existential threat to the survival of indigenous people.[9] Language loss is driven not by intrinsic linguistic factors but by social determinants of colonialism, oppression, and poverty.[9] In Guatemala, we have argued that the health sector's inability to deliver health care in Mayan becomes a

potent force for language shift, as it demonstrates that highly desirable services are only available to those who speak Spanish, the colonial language.[10] The implementation of linguistically sensitive health care thus can help revitalise indigenous languages by mitigating structural forces underlying language loss.

Global health workers and researchers must recognise the role of language when working with indigenous populations. The alternative approaches—to treat indigenous language as an "implementation barrier" or, worse, to avoid indigenous-speaking populations altogether—are not acceptable.

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